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COMPREHENSIVE REFORM OF THE HEALTH CARE SYSTEM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

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FIRST SESSION

ON

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COMMUNICATIONS

COMPREHENSIVE REFORM OF THE HEALTH CARE SYSTEM

MONDAY, SEPTEMBER 23, 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 2:08 p.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

Also present: Senator Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H-40, Sept. 17, 1991]

SUBCOMMITTEE TO HOLD HEARINGS ON HEALTH CARE ACCESS COSTS; RIEGLE CITES NEED FOR COMPREHENSIVE REFORM ON HEALTH CARE SYSTEM

WASHINGTON, DC—Senator Donald Riegle, Chairman of the Finance Subcommittee on Health for Families and the Uninsured, Tuesday announced two days of hearings on comprehensive reform of the health care system as a way of improving access to care and controlling cost escalation.

The hearings, in Room SD-215 of the Dirksen Senate Office Building, will be at *2 p.m. on Monday, September 23, and 10 a.m. on Monday, September 30, 1991.*

"Skyrocketing health insurance costs for those who have coverage—and the growing group of Americans with no health insurance coverage—are signs that our health care system must be reformed," said Riegle (D., Michigan).

"I am holding a series of hearings to solicit the views of interested parties on comprehensive proposals to reform the health care system. The hearings on the 23rd and 30th of September will focus on ways to control health care costs, while improving access to health care coverage and on the roles of the public and private sectors," Riegle.

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

Senator RIEGLE. The hearing will come to order. Let me welcome all those in attendance this afternoon. I want to begin by expressing a special welcome to Senator Hatch, who joins both the Finance Committee and this Subcommittee as a new member. I am delighted that Senator Hatch will be serving with us.

We had previously worked over many months on the issue of health care with your important role on the Labor and Human Resources Committee. So, the ability to interact in this subcommittee in a similar effort is a very important development and one I look forward to. I figure if a bill can be worked out, we ought to be able to work it out.

Senator HATCH. Thank you, Mr. Chairman. I appreciate being here.

Senator RIEGLE. Our hearing today continues the efforts of this subcommittee to address the issue of comprehensive reform of the health care system. Essentially I want to hear the view of parties on the bill called Health America that I recently introduced with Senators Mitchell, Kennedy, and Rockefeller, to reform the health care system.

I view Health America as a starting point and I'm interested in hearing about other proposals and suggestions and about how we can improve Health America.

Senator Simon, who is with us now, will testify today. Other Senators have introduced bills to amend Health America and I welcome their suggestions and I encourage others to do the same.

My Republican colleagues are also working on their own proposal under the leadership of John Chafee, ranking member of this subcommittee. I also welcome those efforts, and want to work together on a comprehensive health care reform.

The hearing today and another hearing scheduled next Monday will focus on ways to reduce health care costs and address the roles of the private and public sector in health care reform. We will hear today from government officials, experts, businesses and providers.

Comprehensive health care reform is a top priority of the Democratic leadership in the Senate. These and other hearings are serving an important purpose as we move toward developing a consensus on health care reform.

Senator Bentsen, the very distinguished Chairman of this full committee, is also having hearings where individuals or organizations who have offered specific proposals, including Health America, will testify.

America's health care crisis is part of a larger problem of a shrinking American middle class where our people have less and less economic power to meet their basic needs. Skyrocketing health insurance costs for those who have coverage and the growing group of Americans with no health insurance coverage are signs that our health care system has very serious problems and must be reformed.

Nationally, an estimated 34 million Americans have no health insurance coverage. Today, in my home State of Michigan alone, close to a million people are without a penny of health insurance and some 300,000 of those are children.

Those who do have health insurance are finding their rates rising sharply and their coverage being reduced by rising deductibles, copayments and diminished benefits. The United States spends the most per capita on health care when compared to other countries, over $2,000 per person per year. Yet very few people, as low as 10 percent, say that they think "that the system works well."

These problems affect us all. Hospitals, emergency rooms and trauma centers are closing. Doctors are finding it harder to treat a growing number of low-income people because of inadequate Medicaid payments or no payments for uninsured people.

In Michigan alone, hospitals lost over $350 million last year, providing care for those who could not pay those bills. When providers

who offer essential services are forced to shut down, we all suffer. As a nation, we spend over $70 billion a year on health care, almost 12 percent of our gross national product.

High health care costs hurt our country as a whole by making it harder for our industries to compete in the world market. The Chrysler Corporation, for example, pays $700 in health care costs for each car it produces and that is some $300-500 more than competitors in foreign nations are paying on comparable types of vehicles.

Foreign competitors, like the Japanese, can offer lower prices for their products because they are not spending so much on health care that makes its way directly into product cost. Therefore they can outsell us and that really hurts our economy.

Health America addresses two major shortcomings of our health care system; rising health care costs and lack of health care coverage for millions. We build on the existing private and public health care system which asks employers to provide health care for their employees and dependents.

Most businesses want to provide health care coverage for their workers. Some 70 percent of workers in small businesses defined as those with just less than 25 employees, have health insurance. So it shows, I think, a great interest on the part of employers to try to provide that basic health insurance benefit to their work force.

But health insurance coverage is currently unaffordable for many, particularly for small business. I want to briefly refer to the chart. I have a few more comments and then we will go to my colleague.

In terms of phasing in the HealthAmerica program with an AmeriCare program to replace Medicaid as a funded program and not a welfare program, for those businesses that would have their workers come in under AmeriCare, we have received the cost calculations for those companies not opting for private insurance in the private insurance market, but to come into the public AmeriCare program.

Depending upon the individual business with its tax circumstances, that cost would be something between 23 cents an hour and 34 cents an hour per worker. What I have put on this chart on the left, you see in the dark blue zone the current minimum wage paid for workers at the lowest wage level under the minimum wage law. That is $4.25. We have put on top of that the high end of the range from 23 cents to 34 cents, we have added the full amount in the case of this illustration, 34 cents would take that hourly wage then, in terms of both the direct wages and the cost of the health insurance coverage, up to $4.59 an hour.

Now it would be less than that by 11 cents if the individual business in fact their tax circumstances were such that it would bring it down to $4.48 an hour. But on the right we have depicted what the minimum wage would be if since 1978 the minimum wage had been indexed for just the CPI inflation of the year since that time. Of course, that did not happen and the minimum wage stayed in place for a very long time as inflation came along. That would be a comparable figure of $5.81.

But it gives you some idea of the amount of cost that would involved here. Most of the firms that would come in and opt for the

public program of AmeriCare would be firms with workers very near or at the minimum wage level.

It shows the scale of cost involved, which, I think, is not a very sizable cost given the important economic value. The reason that companies who do provide health insurance coverage for their workers struggle so hard to do it is that it is a good economic decision. It helps make for a healthier work force, for less absenteeism, less chronic development of health problems. Therefore, I think firms are helped by benefiting the health of workers and their families. Over time our society is more productive if we have healthy people creating a healthy work force.

So, I think that a health care investment is an investment that would come back not just in terms of reduced health costs in the future that would otherwise occur but also because I think it enables us to have more work hours from a healthier work force. Therefore more productivity and more income generated to firms and to the nation.

In any event, those numbers have just been made available to us and I wanted to share them at this point in this hearing.

Anyone who does not directly receive health insurance through an employer will have access to a new affordable high quality health care through our new public health insurance program, AmeriCare. As I have said, unlike Medicaid, which it replaces, AmeriCare is not a welfare program. All people will be eligible for its coverage, including workers and their families employed by businesses not providing private health insurance.

I need to add with this the fact that cost containment is a fundamental part of our proposal. By matching cost saving reforms with broadened coverage we can achieve needed efficiencies throughout the health care system. Health America proposes a number of cost cutting measures that would bring the price of health insurance down, making universal health care affordable. We do this by reducing unnecessary care, decreasing administrative costs, and limiting unrestrained price and volume increases of health care services.

It has been estimated that Health America will cost about $6 billion in the first year. But that is only one-half of 1 percent of our Federal budget which is running at the rate of $1.4 trillion. In fact, our cost reduction program which would save an estimated $80 billion over the next 5 years has to be seen in conjunction with the cost estimates on the other side.

The independent organization that did those estimates is here today to discuss the cost savings of this plan and we will hear from them later.

I, for one, am determined to see that we enact affordable high quality health care for all Americans and that we move legislation as soon as possible. I want to continue the dialogue with all interested parties in developing an efficient, sensible and comprehensive health care reform package.

With that, let me now recognize our very distinguished colleague from the State of Illinois, Senator Simon. He recently introduced a bill, S. 1669, that makes amendments to our bill, Health America. I want to say that I support what he did and I welcome others to do

the same. This type of effort will help this committee to reach consensus on health care reform.

Senator Simon, we are pleased to have you and we will make your statement a part of the record and would welcome your comments now.

STATEMENT OF HON. PAUL SIMON, A U.S. SENATOR FROM ILLINOIS

Senator SIMON. Thank you very much. I appreciate your making the statement a part of the record. Just a few background things and a few specifics.

First, let me applaud you for your leadership. I can remember two or 3 years ago having a meeting in your office where you had half a dozen of us there and you said, we have to do something about health care in this country. That is more and more recognized.

Six weeks or so ago the Labor and Human Resources Committee held a hearing. Testifying were the AFL-CIO, Chamber of Commerce, National Manufacturers' Association, American Medical Association, American Hospital Association, and everyone was saying we are going to have to do something to change the health delivery system in this country. It is universally recognized.

One aspect I want to mention briefly, that is not covered by your bill nor by the bill that I have introduced, but will be covered by a bill I will be introducing shortly, is long-term care. Nine years from now we are going to have about 1 million more senior citizens in nursing homes.

What my bill will do very roughly and we are still working on the final numbers, but very roughly it will do this: It will increase Social Security taxes by half a percent. It will take the cap off the Medicare assessment that is now at $125,000. And it will say to people you pay the first $500, and we will pay up to the average cost of nursing home care. That amounts right now to about $2,400 a month.

If you want to go to a nursing home that costs $3,000 a month, then you have to pay the extra $600 also. But we would not just devastate families as we do now. And without getting into the details, we also provide some incentive for more at-home care. About 30 percent of the people who go into nursing homes do not really need to go into nursing homes, but they have no option or they feel they have no option.

I would add long-term care is not a problem just for senior citizens. Any one of us here can go out in the street and get hit by a truck and we are going to need long-term care.

Now specifically on your bill, and you are one of the chief co-sponsors and I am down on that list of co-sponsors. I am pleased to be a co-sponsor. But I have introduced a bill that complements it and frankly does some things that I think need to be done.

Number one, it strengthens the cost containment program. The expenditure board can determine rates. If the negotiators do not agree on rates, the rates can be made mandatory. Frankly, just to have voluntary agreement on what costs are going to be, I do not

think is going to be satisfactory. I would love to tell you I think it will work. I do not think it will.

My bill also speeds up the process so that we have universal coverage in a little more than 1 year after enactment rather than 5 years after enactment. Each year that goes by we have 1 million more Americans who have no health insurance coverage. We have to move on this as quickly as possible.

The third thing it does, it provides a small incentive for States to experiment with a single payer, Canadian-style program. It would say to two States—we have the Governor of South Dakota here who is going to testify next—say to South Dakota or Michigan or Utah or Illinois, two States, you try an experimental single-payer system, and we will pay you $10 per resident for 3 years.

The program is going to cost a lot more than that, but it is a little bait out for States to try this. We have 50 State laboratories. We ought to be experimenting on this. Without going into great detail we also assist small businesses a little more than your bill does. As a former small businessman myself I think small businesses need that extra assistance.

It would call on the Secretary of HHS to publish a consumer guide book so that small business can figure out what is going on with their health insurance. We are very different than other countries. In Germany, for example, you have three or four companies that offer health insurance. We have 1,500 companies that offer health insurance.

For the average small business person to try to figure out where to go for health insurance and who is offering the best, it is an almost impossible task. The average small business person just does not have the time to do it.

Then finally our bill lowers the Medicare coverage to the age of 60, subject to finding the revenue to pay for it. Obviously Medicare has some real problems. But there is a sizable problem in the 60 to 65 age group. Increasingly you are hearing it from your constituents, Orrin Hatch is hearing it from his constituents, I am hearing it from mine.

Mr. Chairman, that is basically what our bill does. It complements your bill. It adds some provisions that I think are needed and are desirable. That is basically it. I would be happy to answer any questions. Otherwise, I know you have a long list of witnesses and I will let you proceed.

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

Senator RIEGLE. Well, Senator Simon, let me say first of all that I think these proposed amendments that you have brought forward and are describing here today are very helpful and I think they stimulate the debate on health care reform and will help us move the whole process forward.

I want to say that I fully agree with your concern on cost containment and I want to go absolutely as far as we can go in that area. I think that is a crucial aspect of the kind of change that is needed.

Following you today, we have both business and provider witnesses who will focus some of their comments on the Federal Health Insurance Expenditure Board and the whole issue of cost

containment. So, I think we will have some more input on that today.

I, like you, also have strongly supported the idea of covering the uninsured more quickly rather than in a 5-year phase-in period. We are currently developing alternatives and getting cost estimates. But our goal is the same and now it is the question of how we balance everything in a workable formula.

Senator Hatch, do you have any questions at this time?

Senator HATCH. If I could just make a comment or two. I appreciate your testimony. Sorry I had to be outside for a few minutes with some of the media. But not on this, by the way. I appreciate your thoughtful approach to this whole problem as I do the Chairman's as well.

Just a couple of thoughts. Your voluntary Expenditure Board, I think, will become a mandatory Expenditure Board. Of course, your argument is that voluntary just will not work. I agree with that because I think that rate regulation will not work. But I hasten to point out that the States that have a certificate of need approach or rate regulated States, their expenses are increasing faster than States who do not have it, according to the Lewin study or faster than the nonregulated States.

Medicare prospective payment commissions, the RBRVS, it is all a big mess right now. So all I can say is that I am very appreciative of people like yourself and Senator Riegle and others who are thoughtfully approaching these problems and at least trying to get the debate out there where we can figure out what to do and what best to do on these problems.

I have lots of problems with the pay/or play approach but at least it is out there and it has taken guts to put it out there. And frankly, it is being attacked on all sides and from my perspective rightly so, but nevertheless it is important that we have this debate. And if we ultimately do resolve these problems it is going to be because you Democrats were willing to bring this up.

So I think it is a good thing and I compliment you for it and I compliment you for trying to correct it with your five or six points that I think are certainly thoughtful.

Senator SIMON. If I can just thank both of you. Let me add, Mr. Chairman, I serve on two committees with Senator Hatch. I finally got on one committee where I had seniority over him because he came on the Foreign Relations Committee. Then he left the Foreign Relations Committee to come to the Senate Finance Committee and now he lords it over me on the other two committees.

Senator RIEGLE. I see.

Senator SIMON. But the basic point that Senator Hatch makes that we had better, let's get these ideas out on the table, I am not saying these ideas I have are perfect.

Senator HATCH. I know that.

Senator SIMON. Don Riegle is not saying that his ideas are perfect. But there is just universal agreement that we are going to have to change the system. We have to work it out so that we do not harm the health delivery people, hospitals, physicians, nurses and others, so that we protect the American taxpayer. But that we also provide good health delivery to all American citizens. And that is not happening right now.

Thank you very much.

Senator RIEGLE. Thank you. Well put, Senator Simon. I thank you and we appreciate your testimony. It was very helpful to us.

Let me now call to the witness table Governor Mickelson who is here. He is accompanied today by Alicia Pelrine. Governor, we are delighted to have you here with us today. You and I have had a chance one other time in another setting to talk a little bit about health care.

The Governors as a whole have been very active in health care issues. I know you are here to tell us today about the recent meeting that was held in August. Federal and State Governments, I think, have to work together to create a partnership in order to move health care reform legislation. I think this is an excellent opportunity for us to talk about how we go about accomplishing that.

So let me welcome you today. We are delighted you are with us and we are interested in hearing your views.

STATEMENT OF HON. GEORGE MICKELSON, GOVERNOR OF THE STATE OF SOUTH DAKOTA, ON BEHALF OF THE NATIONAL GOVERNORS' ASSOCIATION, ACCOMPANIED BY ALICIA PELRINE, NATIONAL GOVERNORS' ASSOCIATION, STAFF MEMBER

Governor MICKELSON. Mr. Chairman, thank you. Senator Hatch. I appreciate the opportunity to be here. I might indicate that I am here as one of the two lead Governors on the health care issue for the National Governors' Association. Governor Booth Gardner of Washington, who is on his way back from Japan, is the other one. It was under his leadership as Chairman of the National Governors' Association that the NGA undertook this and has spent many months, as you are aware, developing a study and making some recommendations.

So I did not serve on the health care task force of the NGA, but because of the interest that I have in this issue and it is indeed an appropriate issue, Senator, and we appreciate your leadership on this issue, I am one of the lead Governors and would hope that the result of my being here today and Governors of other States being here in the months to come, is that we might work out a mechanism with Congress and the administration to work on this all important issue and work through the politics of it and make sure that we do a good job for all of our constituency in this Nation.

This is the first time that I believe the NGA report has been presented publicly and I am honored to be able to be here. Health care reform obviously is a top priority for the Nation's Governors. In my State alone if we take away the dedicated revenues, we spend 26 percent of our budget on health care in a relatively small State.

Last month at our annual meeting we unanimously adopted a health care reform policy with specific recommendations that if enacted would develop a new Federal framework for a national health care system. Our health care reform policy describes a strategy under which States and the Federal Government can work together to reach consensus on health care reform. It also provides the Governors some long range vision for restructuring our health care system.

Since the adoption of our policy in Seattle there has been some criticism leveled at the Governors very frankly. Our critics complain that we did not put forward a plan for a national reform and that to rely on State experimentation is to let Washington off the hook. I think it is appropriate that we respond and talk about that a little today.

While the members of the Governors' Task Force on Health Care understood quite clearly that there were expectations that we would produce a national plan they also came to understand that without significant structural change to control costs our mutual dream of a universal access would never be achieved.

Yet many of the most promising structural cost control ideas have never been tried in this country and they need to be tried. The task force became quite convinced that these ideas need to be tested at the State level and evaluated so that we as a nation can learn more about how they would work in the United States.

What many have called the failure of the Governors to achieve consensus on a national plan reflects the lack of consensus among the people about how best to construct a health care system that provides affordable access to all.

In addition, while most policy experts inside Washington, DC, equate insuring the uninsured with access to care, the Governors recognize that without a service delivery system that is tailored to each State's geographic, economic and ethnic needs, real access to health care would not be achieved.

As I participated in the NGA on this issue I made mention several times of the rural health care agendas. We talk about rural health care in almost every State in this Nation as a real issue. A program that fits Illinois or Utah or Michigan may not fit in western South Dakota; 55 percent of my State is classified as frontier, not rural.

Problems are not only financial but are geographic. So it is important that the programs be flexible so that those kinds of things are taken into consideration.

The real question now before the Governors is how we will individually and collectively move to implement some of the comprehensive reform strategies that are available to us.

I would like to give you some illustration of approaches States may want to take as we talk about cost containment.

(1) Implementation of a managed competitive approach that would include strategies such as developing a State wide system for getting price and quality information to consumers, eliminating State mandated insurance benefits and anti-managed care legislation and deregulating providers.

(2) Creation of an all-payer system, including strategies such as instituting a statewide global budget for the allocation of capital resources and establishing a program to partially subsidize private insurance for unemployed individuals who are not eligible for Medicaid.

(3) The implementation of a uniform electronic billing system to reduce the administrative overhead which is also a topic of a lot of conversation.

Some illustrations of approaches States might like to test expanded access to coverage would include, expand the current

system and institution of a statewide play or pay system for expanding access to employees of small businesses; the creation of a statewide purchasing board to help small business purchase basic health insurance for their employees; provision of subsidies to small businesses that are purchasing health care for the first time; an expansion of the role of community-based primary care providers through programs to recruit and retain health professionals in underserved areas and to strengthen local community health centers and other sources such as school-linked health care.

Some illustrations of possible policies to address the access needs of specific populations include the creation of programs that ensure all children have access to affordable and adequate insurance coverage and comprehensive health care services and the expansion of small business insurance coverage and establishment of programs that focus on the needs of the uninsured populations currently below poverty but not eligible for Medicaid.

Now, more details on potential State strategies are outlined in the task force on health report that accompanies the health care policy. I will not attempt to outline them all here today. But as you will note many of the reforms I have listed are contained in the health care proposals pending consideration here in Congress.

There are several steps the Federal Government can do to facilitate State innovation if we believe that that should happen. The Federal Government should take a fresh look at how State waivers are approved to streamline the approval process for State reform efforts. Waivers should allow States more flexible use of Medicare, Medicaid, grant programs and other health funds.

This would allow experimentation with all-payer systems. It would allow expanded use of managed care and better integration among health programs. The waivers also should share financial risk over an extended period of time to allow States to test innovative ideas without unreasonable financial barriers, to increase access to care through the approved State approach, States also should be permitted to obtain waivers to ERISA preemptions.

For example, States that want to use a pay or play system for employers need to be able to ensure that employers who claim ERISA preemption from State law are in fact offering health care coverage to their employees.

To address market failures that are inherent in our current system that contribute to escalating health care costs, limit access to care and make it difficult to reorient our system to one that provides preventive and primary care, the Governors recommend in our report that the Federal Government do several things.

First, augment current efforts to organize and support research and technology assessment and medical practice guidelines. The result of such research may serve as a basis for medical practice guidelines and medical benefit guidelines to assist in the development of different kinds of cost effective insurance packages. Develop a systematic way to capture and report line item health care expenditures by State. National base line information is needed to assess whether efforts to control costs are successful. And thirdly, enhance opportunities and incentives for individuals to pursue careers in primary care, particularly in rural and underserved areas.

The Governors also believe strongly that reform of the health insurance market is necessary. These standards to be developed by State officials should restrict and prohibit the use of certain rating techniques and factors, ensure availability, renewability and continuity of coverage and encourage broader and more equitable sharing of risks.

Medicaid is the current vehicle to provide care to low-income families, children, seniors and persons with disabilities. However, it is an overburdened program struggling to serve these diverse populations and their diverse care needs. It is now a huge program that is difficult to administer and prohibitively expensive.

To provide better access to care and use public resources more efficiently the Governors' Report calls for the establishment of a new public program that would provide health care to individuals with incomes below certain levels of poverty and individuals who did not receive health insurance through their employment.

Funded with existing Medicaid resources, the new public program would be designed to address the health care needs of the nondisabled population from birth through age 64; include a service package of preventive, primary and acute care services and emphasize managed care.

The Governors also call for the establishment of a program designed to meet the needs of the elderly and people with disabilities. The new program should provide a continuum of service to meet the needs ranging from basic to preventive and primary care, rehabilitative, maintenance, social support and other long-term care services.

The Social Security and Medicare programs may provide the appropriate framework for such a program. And finally, the Governors recommend further study of the efficacy of a national catastrophic health care program. This would eliminate the public's fear of insurmountable health care bills. It would also limit the risk assumed by insurers and should lower the cost of health insurance across the board.

It is important before I conclude and if I may, Mr. Chairman, I would like to address a Medicaid issue of immediate concern to the Governors regarding our revenue raising authority in the States. Until new structured public programs are in place, States must be allowed to maintain their complete authority to raise funds to match Federal Medicaid dollars without restriction from the Federal Government.

This authority, however, as you know, is seriously threatened by a recently issued U.S. Department of Health and Human Services interim final regulation. The regulation will have a profound impact on State Medicaid programs by denying Federal matching payments for funds raised through dedicated taxes, donated funds and intergovernmental transfers. These revenue raising methods are permitted under current law and regulations must not be changed as States struggle to keep pace with runaway health care costs, the effect of down turns in the national economy and the increased demand for public assistance.

These regulations not only are inconsistent with congressional intent as stated in the Omnibus Budget Reconciliation Act, but also have an unfair and punitive affect because of the effective date of

January 1. The regulations are in fact permitted to take effect in January in the middle of the State's fiscal year. The consequences will be immediate and severe, forcing program cuts and emergency sessions of State legislatures.

The Governors seek the assistance of this committee to resolve the situation in a manner that does not so severely disrupt the provision of health care to the Nation's most vulnerable populations.

Mr. Chairman, the Governors stand ready to work with this committee and we believe that through a true partnership we can achieve the consensus necessary to lead this Nation toward a common goal—access to affordable health care for all Americans. I again appreciate the opportunity to be here.

As the Chairman has indicated, Alicia is here as a staff member for the NGA, who has worked on this issue for the last many months in the development of our report. I would be happy to respond to questions and hopefully would have the answers.

Senator RIEGLE. Thank you very much.

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

Senator RIEGLE. I appreciate your presentation today. There were a lot of constructive ideas there. Interestingly, many of the things on that list we have incorporated in our package. But, we are open to discussion as to adjustments that are needed.

On the last issue that you just mentioned, is it fair to say that all the Governors are of one mind on that issue or is there a division among the Governors on that question?

Governor MICKELSON. I would be presumptive, Mr. Chairman, to speak for all of the Governors in this Nation. However, I do know that the ones that I have talked about, particularly the effective date, if we are going to do something different, we are going to change the rules to do it in the middle of the States' fiscal years is going to create a real problem.

Senator RIEGLE. Right.

Governor MICKELSON. So I am sure that feelings are different in some States than others. Our State, for example, does not have the program. However, we are in the process of looking at it. We want to make sure that we conform. Other States have just put it into affect in the last couple of years and we're talking about several hundreds of millions of dollars in State programs.

Senator RIEGLE. Can I ask you, in South Dakota today, what kind of a ball park number do you tend to use on the number of people—urban, rural, wherever—who do not presently have health care coverage?

Governor MICKELSON. Mr. Chairman, we are about half of the national average. About 7 percent of our people, we have 700,000 people, and about 7 percent are not covered. However, and the point that I think is needed to be made is that may be about half of the national average. But we have an inordinate amount of our percentage that are not covered that are children. Therefore, are priorities.

In other words, I am making a case for flexibility. That is a perfect example of why we should under whatever the plan becomes, the States should be allowed to set their own priorities and the

flexibility and the waivers and those kinds of things are all important.

Example, we have 53 hospitals in South Dakota. All but three of them are classified as rural hospitals. We all know that the role of those rural hospitals particularly in the rural areas that have declining population as people move to population centers, the role of those hospitals is going to change and we need to be able to determine the mission of those hospitals and still qualify for some of the Federal programs that exist.

Senator RIEGLE. So you have something on the order of 49,000 or thereabouts which are weighted predominately toward children and that is why you make this point about it.

Governor MICKELSON. Yes, sir.

Senator RIEGLE. I am struck by the numbers of people uninsured, wherever the State, whether it is a State with a large basic population or not. We have about 9.5 million people in Michigan and about a million people who do not have health insurance; of which 300,000 are children.

Where are you in your own mind these days on the notion of how successfully each State can by itself device its own health care plan? After all, each State is different and people move from State to State, so citizens of this country can be in one State today and in another State 2 or 3 years from now.

The impression that I have, not having been a Governor, is that this is not an easy problem to solve alone as a Governor. No matter what the fiscal condition of the State, there are so many things that are both Federal and State in nature. You have to have an effective partnership, an effective overall system that is Federal in scope in which the States can operate effectively.

Do you share this view and if not, how would you express your view?

Governor MICKELSON. That is exactly correct. And some States are going ahead and formulating their own health care programs. However, they will not work without the partnership of the Federal programs in the Federal Government.

Example, I know there has been discussion about Oregon's plan and the rationing and devising a list of here is our priorities and here is what we are going to fund and below this line if we run out of money we will not. That is one plan.

I know that Governor Gardner in the State of Washington has devised a very comprehensive program to implement, however, getting some waivers under Medicare is essential to about a third of the people that would fit into that program. Other States, examples Connecticut, Florida and I believe a couple of other States have instigated some tax incentives, premium tax forgiveness for companies that provide health care coverage. There are a lot of those kinds of things that are going on in the State.

For our purpose in a small State with very limited resources like we have, vast areas, we have nine Indian Reservations, we have to work with the Indian Health Service and Public Health Service. That is all very important to us.

This is very timely because we have gone through for the last two or 3 years a process of building a consensus about the priorities in our State. Our priorities might be different than Florida or

Michigan, but nonetheless the health care providers and business people and so forth have agreed on what that is.

I do not have the resources to develop a whole health care system for our State. Therefore, it is very necessary that I sit here and work out a partnership with Congress and the administration to make sure we serve our people the best we can.

Senator RIEGLE. Now on the issue of medical malpractice, this is an issue that Senator Hatch and I discussed before. Senator Hatch is a very fine lawyer; I am not. So I look at it from the non-lawyer's point of view. We have had a history in this country of handling insurance from a regulatory point of view at the State levels, as you well know. We do not have a major national regulatory scheme fixated because it has been done at the State level in each of the 50 States.

Is it your view, I do not know how deeply you have had a chance to get into this, that the States by themselves adequately handle the malpractice issue? Or is that another area where you really have to have some help at the Federal level, and then try to integrate the State level of insurance regulation with an encompassing national view?

Governor MICKELSON. This is really shooting from the hip and I happen to be a lawyer also. I do not know that I would fit into that fine category as Senator Hatch does.

Senator RIEGLE. I am sure you do.

Governor MICKELSON. I believe that in certain cases appropriate national guidelines are appropriate. However, I also believe that insurance regulation and the licensing and so forth ought to be left at the local level. I do not think that those are contradictory views.

Malpractice is a problem. We have dealt with it in our State. We have taken a look at different things. What there is a real lack of is the ability, at least in my opinion to quantify the cost savings on certain things that might be done, such as double benefits and those kinds of things. Nobody has, at least to my satisfaction, quantified those. So I would be very hesitant to jump onto a bandwagon for a national law in that regard. Yet it is very much of a problem in the cost of health care and needs to be addressed.

Senator RIEGLE. I am finding in Michigan, in certain fields, obstetnatrics being one, are moving out of the practice of medicine because medical malpractice rates have become so high that they are prohibitive. I have talked with numerous doctors who have moved out of areas of specialty for precisely that set of reasons.

Is this happening in South Dakota as well?

Governor MICKELSON. Yes, sir.

You hear about that. I have talked with many doctors, especially specialists who have told me what the percentage of their total overhead costs is malpractice insurance and that is a real problem.

I do think in some areas progress is being made. I can remember 8 or 10 years ago when I was in our State legislature the issue that was being discussed at that time was simply availability of malpractice, that we were afraid there would be no one writing malpractice insurance in our area. I think that problem has been taken care of.

Senator RIEGLE. Now you can get it, but you just cannot afford to pay for it.

Governor MICKELSON. You can get it, but you cannot afford it in many cases. I do not profess it would be wrong for me to profess to know a whole lot about what those rates have done. My perception is it may have leveled off a little but it remains a concern.

Senator RIEGLE. Senator Hatch?

Senator HATCH. Governor, welcome to the committee. We are happy to have your testimony here today.

Governor MICKELSON. Thank you.

Senator HATCH. I have to say that I agree with a number of things you have in your testimony. For instance when you talk about implementation of a managed competitive approach that could include strategy such as developing a State wide system for getting price and quality information to consumers, eliminating State mandated insurance benefits and anti-managed care legislation and deregulating providers, that hits the nail right on the head as far as I am concerned.

I know that is just one of a number of points that the Governors have debated.

On the medical liability I am absolutely convinced that unless we get a handle on that we are never going to get a handle on spending and on costs because the defensive medicine is driving these costs to a large degree. It is not the only problem but it is a very serious problem. Every State has had some notable difficulties with regard to medical liability concerns.

We could talk about that subject all day. But let me turn to another subject. Could you outline for us the problems that the National Governors' Association has with the Medicaid program, the current Medicaid program?

Governor MICKELSON. Well I was not in the task force that discussed it. Maybe Alicia can talk about the specific things that were talked about at the task force.

Ms. PELRINE. I will take a crack at it. I think probably the summary statement, Senator, would be that the Governors feel that the Medicaid program which was designed to serve a relatively small population of people has become kind of the last train leaving the station. What we have done is put lots of other folks and lots of other services into a program that was never designed or had the capacity to handle that vast array of populations and services.

So it makes sense to the Governors in the long run to try and separate out the elderly and people with disabilities who they see as having a more similar set of needs which range from medical care to other services that might be described as health care services, but have to do with social supports, nutrition, needs for certain kinds of assistance in daily living, and to see if we could not develop a comprehensive program with a set of services designed for those unique needs.

And then use Medicaid resources as a basis much as the AmeriCare Plan does, as the basis for a program that would provide an array of primary and preventive and acute care services to the low income population.

Senator HATCH. We are hearing in Utah an incredible number of complaints about Medicare. Physicians dropping out. Patients unable to get care. Rural hospitals falling apart or the very surviv-

al of the rural hospitals seems to be at issue. Certainly their survival is threatened.

Is South Dakota having similar problems?

Governor MICKELSON. Well, we have, yes, all of those kinds of concerns. I think in the area of Medicaid the thing that—and I do not know if this is a major concern, but I think one of the things that we talk about in our State and when we comply, if there were to be a change that could be recommended in some of those areas, being State sensitive to poverty levels as opposed to a national standard might be one of them.

Poverty might be a little different in one State than another State. That is a place where maybe those could be localized. If that answers your question.

Senator HATCH. Well that helps. I think the question that rises in my mind is with the Federal Government record in Medicaid and Medicare, you know, what recommends having a comprehensive Federal Government solution to health care. I mean that is the thing that is worrying me. Because I have no doubt that you folks on the State level are going to do a better job on almost everything than we do back here with Federal bureaucracies. And that is not necessarily knocking our good Federal employees who are trying to do the best they can.

But I find that on the State and local levels things work a lot better. That is why I read that one paragraph from your statement because I think it does make a lot more sense than another massive big Federal program that may result in the same problems with Medicaid and Medicare that I have at least outlined and you have outlined in part as well.

Are you anxious as a Governor to have a national comprehensive health care program run from back here?

Governor MICKELSON. Well there are certainly changes that should be made. I happen to agree philosophically and personally with the concept that we have a system that perhaps should be changed and refined and worked on rather than totally thrown out and starting over.

I think that to a large extent States are experimenting with a lot of things that are being talked about. Medicare in the Medicare area, Senator, that you mentioned a minute ago, we instituted a program. I was interested in Senator Simon's comments about the institutional care or long-term care for senior citizens.

We are now diverting about 15 percent of the people who apply for nursing home care now with alternatives. We have to get a waiver in order to qualify for some of the home health care, some of the alternatives to institutionalization and those are the kinds of things that I think are being done on a State basis that are very important.

Senator HATCH. Well I appreciate hearing both of you. Governor, we appreciate your leadership in this area. It is a very complex, very difficult area. I do not think anybody has all the answers. You certainly have been very helpful to us here today and we appreciate it.

Governor MICKELSON. May I just, before I leave, Mr. Chairman, I want to make sure that you understand and this committee understands how much the National Governors' Association really appre-

ciates the sensitivity, albeit there are some differences in what has been proposed and pending before Congress with the plan that we have advanced as NGA.

But comments have repeatedly been made about the sensitivity that you particularly, Mr. Chairman, have to what the States and the Governors might be thinking about. Really, my whole purpose in being here today is to make sure that you know that we would like to forge a partnership with you. You said it a minute ago, we cannot do this alone. Hopefully, the NGA will be viewed as a very important partner in making some sense out of this.

Senator RIEGLE. I appreciate that comment. That is exactly the spirit with which we want to work. I have a great sense of urgency about getting on with this. Because I think many of the States, or most if not all of the States, cannot solve this problem by themselves, no matter how innovative they are, no matter how determined a given Governor is to do it.

The nature of this problem is such that it is both Federal and State in make-up, and if you had an unlimited amount of resources and time you could go in and reconfigure the system yourself. There is probably a way that you or another Governor might do it singlehandedly. But, I think the very nature of the problem cuts against that. So we have to find this way to reach one another and find something that is going to work.

I am confident that we can. We have tried to design Health America with that thought in mind.

Governor MICKELSON. Yes, sir.

Senator RIEGLE. We must try to make it as sensitive to the States as possible while workable over a period of time. By doing so, we can accommodate those differences and work from the existing system not try to turn the world upside down, and end up maybe further away from our goal than we are at present.

I am wondering if we were to have all 50 Governors here in the room today, just based on your discussions with them, how high on the list of priorities does the health care problem and reforming the health care system come? I know you have other very important. But where would this be in order of priority for most of the Governors in the country?

Governor MICKELSON. It would be right at the top, as is education and other issues. But it would be right at the top, simply because of the cost of this. We talk about these costs going up anywhere from 8 to 20 percent a year. It just has tremendous impacts on State budgets.

Senator RIEGLE. So if we can come up with something that will work here and be beneficial, would it be fair to say this would probably be as helpful to the States as any single action we might undertake?

Governor MICKELSON. Yes, sir. In my opinion it would be.

Senator RIEGLE. Well, we are determined to do that. Because, in the same way that you care so deeply about your people as the Governor of your State of South Dakota, we care about them, too. They are our constituents as well, and we want to help you see that their needs are met.

The rural hospital problem that you speak about, I also have in the rural areas of Michigan you also have the Native American

reservations situation that you speak about. We have some in Michigan as well. You know, the clock is ticking and there are all these folks out there who have health requirements and are counting on us for leadership. I think we can get it done.

So I would like you to take the message back, if you would, to the other Governors that I am determined as chairman of this subcommittee to work on a bipartisan basis, Federal and State, and work this out, and as quickly as possible.

I think if we talk this problem to death or talk around it for a few more years we really will not have covered ourselves with the kind of accomplishment that we need to. I think it is time to actually get some things done. So we are going to try to move with urgency. So if you would take that word back.

We really want to make the adjustments, work it out, have the debates, settle the issues, devise our package and then get it implemented.

Governor MICKELSON. Yes, sir. I will take the message. Thank you very much for allowing me to be here.

Senator RIEGLE. Good. Thank you. We appreciate your testimony.

I have to step out and take a call for one moment. But let me introduce our next panel and get them up to the table here.

Our panel consists of representatives of large and small business and of an expert on cost containment. Certainly as purchasers of health care services our businesses are particularly affected by rising health care costs.

So Mr. John Sheils is with us today, who is the Vice President of Lewin/ICF, the independent organization that has developed estimates of the cost savings of Health America, and I want to welcome him and invite him up, and appreciate his being here.

I am also pleased to introduce Morrie Stevens from my home State of Michigan. He is the president and CEO of Stevens Van Lines in Saginaw, MI. He is here today on behalf of the Small Business Legislative Council.

And Mr. Cole Tremain. Mr. Tremain is vice president for Industrial Relations of the LTV Steel Co. of Cleveland, OH. He co-chairs a working group of steel companies in the United Steelworkers who have been working together on health care reform, particularly as it relates to high health care costs.

I am going to have you just get seated, get comfortable. I have to step out for one moment. I will come right back and we will resume.

[Whereupon, a short recess was taken.]

Senator RIEGLE. Gentlemen, let me welcome you. We just had a gentleman here who was the Michigan representative of the American Cancer Society who has recovered from a very difficult bout with cancer and is here today to talk about some of the medical advances in that area. So I needed to speak with him for a minute and was pleased to do so.

Gentlemen, I am going to start right down through the list here. Mr. Sheils, why don't we start with you. Again, I welcome you and appreciate the work you have done in doing the cost estimates on our Health America plan. We would like to hear your statement at this time.

STATEMENT OF JOHN SHEILS, VICE PRESIDENT, LEWIN/ICF, WASHINGTON, DC

Mr. SHEILS. Thank you very much, Senator. I was asked to estimate the impact of the cost containment provisions of the Health America Act. I am delighted to have been asked to present the results here this afternoon.

The 1980's were a paradox of dramatic increases in national health spending and for many Americans diminished access to care. The percentage of our gross national product devoted to health care increased from 9.5 percent in 1980 to over 12 percent by 1990. Despite this massive infusion of national wealth and to the health care sector, the number of persons without insurance increased from 24 million in 1980 to about 33 million in 1990, an increase of 9 million persons.

The relationship between cost and access is an important one. Simply as costs go up fewer and fewer employers and households can afford the insurance. The effective cost containment strategies may be necessary to maintain even the existing level of insurance coverage in the country, let alone essential to any expansion efforts.

What are the consequences of doing nothing? Well in 1990 we spent about $600 billion on health care. HCFA currently projects that health expenditures will grow at about twice the rate of inflation. So that by the year 2000 in inflation adjusted dollars health expenditures will grow to about $960 billion, an increase of $360 billion.

Now this could be like going home, opening your mail and finding that your insurance premiums had gone up by 60 percent; and then coming back tomorrow and having to find some way to fund a 60-percent increase in your employee benefits and government programs.

If we could wrestle down the rate of growth in health spending just 1 percentage point a year from its projected rate of growth by the year 2000 health spending in the United States would be about $85 billion less than currently projected. That is with reducing the rate of growth by just 1 percentage point.

So you see even relatively modest efforts to contain cost, to contain the rate of growth in health spending, can have a dramatic impact over time.

Senate Bill 1227 introduces several cost containment initiatives. First, it would reduce unnecessary and ineffective utilization through expanded development and promulgation of medical practice guidelines. It would create a technology assessment program and it would expand the use of managed care among small employer groups.

Second, it would promote competition by preempting State mandated benefits and requiring publication of provider rates.

Third, it would reduce the cost of administering insurance through small group insurance market reform and creating an insurance consortia to administer claims.

Fourth, it establishes a Federal health expenditures board which will set national health spending targets and work with providers

to establish provider reimbursement rates consistent with these spending targets.

We estimate that over the 1992 through 1996 period these provisions together will save a total of about $83 billion in health spending. Now these savings will be offset in part by increases in utilization, resulting from extending coverage to previously uninsured persons.

The increase in utilization would be about $37 billion. So that the net savings, net reduction in health spending under the bill, would be about $45 billion over the 5-year period.

If you turn to the last page of my prepared testimony, it shows——

Senator RIEGLE. Let me stop you there. I want to make sure I understand, for the record, you are indicating that your estimates indicate that, even taking into account the service required to the new people coming in, getting insurance that are now not getting it, paying for the cost of that, that there is still a net saving over and beyond that of about $45 billion over the 5 years. Did I hear you correctly?

Mr. SHEILS. That is correct.

Senator RIEGLE. Now am I correct in assuming then that phasing everybody in, over a 5-year period of time, that by the time we got out there and had everyone coming into the program, we would still be coming out ahead in terms of savings. We would be covering everyone, and the savings off the cost savings side would still have us ahead of the game by roughly $45 billion. Is that a fair statement?

Mr. SHEILS. Well the utilization increase estimates we have here reflect the phase-in coverage schedule. If you accelerated the phase-in schedule then the net savings would diminish.

Senator RIEGLE. I understand.

Mr. SHEILS. We have run the numbers that way. In fact, it comes out that you still have a slight edge here. You save a bit. Which is to say it is a wash.

Senator RIEGLE. So even if you accelerate the phase-in period, your model shows us that we can save enough money, to, in fact, fully pay for the coverage of the people we would be bringing into the system, who now have no coverage?

Mr. SHEILS. That is what our estimates show.

Senator RIEGLE. Well, I think that is significant because that is just dollars in, dollars out, in the health care system.

Mr. SHEILS. That is correct.

Senator RIEGLE. That is the issue of payments, if you will, for service provided and cost savings set against that. There is another whole level of benefit, in my view, that is much harder to quantify if a nation has, healthy people out there in society doing the things they do rather than a higher number of unhealthy people. You are going to get more days work, higher work performance in the work place, and basically large economic benefit out of a healthy population that you do not get in the same degree, out of a population where you have more untreated walking wounded.

Quite a part from the humaneness argument, which I think is compelling in and of itself, I think there is a second level of economic benefit that comes from having a more healthy, productive

work force. You have not tried to measure that. That's a difficult measurement to make. At some point we may want to try to do a measurement of that.

Maybe what we could do is take a look at our profile of hours lost versus, say, other countries that have a more aggressive uniform national health coverage system in order to see the approximate economic gain from a work force that is, quite frankly, in better health.

Mr. SHEILS. I think we expect some benefits there. I think there is this whole question of nurturing our children as well; 25 percent of the uninsured are children. That is the work force of tomorrow. Those are the people who pay for our Social Security benefits. The more developed they are, the more healthier they are in the long run, the better nurtured they are, I think the more productive our future labor force will be as well. That is probably where the greatest benefits lie, actually I would say.

I think it is important to take a look at the distribution of the savings that we estimate from this program by the class of initiative. As I said before, the total savings due to these provisions was $83 billion. This is before you subtract the utilization increase.

Over half of these savings will be due to the elimination of unnecessary or ineffective utilization through expanded use of managed care and expanded promulgation and development of medical practice parameters.

Administrative savings will account for about $16 billion of these savings. Efforts to promote competition will account for about $9.3 billion in savings. And the Health Expenditures Board we estimate will result in savings of about $15 billion.

In doing the study we chose to be conservative in estimating the impact of the Health Expenditures Board. It is difficult to estimate how effective a program like that will be. In fact, it is possible that the program will be much more effective than we have estimated here.

Studies of State hospital rate setting programs have indicated that these programs have slowed the rate of growth in hospital spending by between 15 and 30 percent. If the expenditures board program were to be as successful as rate setting States in slowing the rate of growth in health spending, as the rate setting States have been, we estimate that savings over the 5-year period could be as great as $200 billion.

I would like to be careful here though to note that I think it is very unlikely that we will see savings of anything like that in the absence of a mandatory rate setting structure.

That concludes my prepared remarks. I just want to say that it has been an honor to address the committee. Thank you.

Senator RIEGLE. Thank you very much, Mr. Sheils, and I appreciate all the hard work that has gone on there.

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

Senator RIEGLE. I have already introduced Mr. Morrie Stevens, president of Stevens Van Lines, based in Saginaw, MI. We would like to hear from you now, Mr. Stevens.

STATEMENT OF MORRIE STEVENS, PRESIDENT, STEVENS VAN LINES, SAGINAW, MI, ON BEHALF OF THE SMALL BUSINESS LEGISLATIVE COUNCIL

Mr. STEVENS. Thank you, Mr. Chairman. On behalf of the Small Business Legislative Council I appreciate the opportunity to testify on Senate Bill 1227. Health America, Affordable Health Care of All Americans Act, and to share SBLC's views on health care system reform.

As you know, the SBLC is a permanent independent coalition of over 100 trade and professional associations that share a common commitment to the future of small business. SBLC's members represent the interest of small business in such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation and agriculture. A list of SBLC's member companies is attached to this testimony.

My company is a member of the National Moving and Storage Association and NMSA's president, Gary Petty, is a member of the board of director of SBLC and serves as the chairman of the SBLC committee with jurisdiction over this issue.

Thank you for allowing us to share with the committee SBLC's views on the health care crisis in America, and specifically on the subject of cost containment. SBLC believes it can say with utmost certainty that among small businesses there is virtual agreement that the number one problem facing small business today is out of control health care cost.

I would first like to describe my own company's experience with health care. Our company's health care costs have increased substantially in the past several years. In December of 1989 the cost per family unit was $212 per month. In December of 1990 this cost had increased to $247 per month. As of August 1991 this has increased to $283 per month.

Since December 1989 this represents a 33-percent increase in both single and family coverage. This is a considerable financial hardship on our company because many of the activities we are involved in are regulated by either the State or Federal Government and our pricing has not been increased to cover these costs which means they have been absorbed internally, reducing our profitability.

We have always maintained health insurance coverage for employees for the last 30 years. Several years ago, because of the consistently rising costs of health insurance, we had grown to the point where we were able to modify our program to partially self insure. We now absorb the first $25,000 of any claim during a 12-month period with no aggregate annual stop loss. Most small businesses are not able to do this and take advantage of the cost savings.

Had we not done this our current premiums would be 30 percent higher than they are now. Small businesses in general cannot take the risk of being self-insured and therefore left to the pricing in the market place which is not in favor of the small business buyer.

Due to the rapid and consistent increase in medical costs over the past several years we are evaluating co-pay programs, both in premiums and benefits to control our costs. For the past 20 years

we have paid 100 percent of health premiums. We do not offer health insurance to part-time, casual or seasonal employees.

They must be in our employ 90 days before they qualify for fringe benefits. This waiting period is common in the industry. Likewise, we do not cover anyone who works less than 28 hours per week because that is considered part-time and not eligible for benefits.

The increase in health care costs is a major concern to businesses such as ourselves. We are labor intensive, which is quite common for service businesses. Any increases in health care costs will have a major impact on our profitability and financial viability.

The trucking industry has been substantially depressed since government deregulation in 1980 and due to the recession. Direct and indirect labor costs represent close to 50 percent of our total revenues which is higher than many manufacturing industries.

While we are very concerned about the welfare of our employees and feel a need to provide them with adequate health coverage, the cost of health care benefits must be reasonable if small business is going to survive. A government program that simply mandates coverage for all employees without taking the costs into consideration will not be a workable program as it will put undue financial hardship on small businesses in the United States.

SBLC has conducted several surveys over the years. While one can quibble about the exact numbers, it is very clear that premiums have been increasing at significant rates of 30 to 70 percent annually. SBLC believes the current average cost of insurance is now over $3,000 per year per employee.

The SBLC Illinois study revealed that over the past 4 years health insurance costs for the firms in the sample rose by an average of 101 percent, far out pacing the rate of increase and other operating costs. Over the past 18 months the average increase was 38.6 percent.

I might note that 80 percent of the respondents have been in business 5 years or longer and employ on the average 20 full-time and 7 part-time workers.

SBLC has reviewed the proposal to create a Federal Health Expenditures Board to set national expenditure goals. The Board will also serve as a facilitator between providers and purchasers for negotiations on health care rates. It appears that while the proposal may be heading in the proper direction——

Yes, sir.

Senator RIEGLE. You can go ahead and continue. That light goes off after a certain period of time.

Mr. STEVENS. Okay.

Senator RIEGLE. It is just a guide.

Mr. STEVENS. It appears that while the proposal may be heading in the proper direction it lacks the teeth to make it work. It is not clear how the process will in fact lead to binding rate restrictions.

The system is a step in the direction of an all payer system that results in a universal negotiated rate and it has merit. It has merit because individual small businesses will never have sufficient clout or information to negotiate rates on their own.

We are enthusiastic about the preemption of State mandates. State legislators have forced insurance companies to increase the

number of specific diseases and health care services covered by their basic policies. In 1970 there were only 30 mandated health insurance benefits in the United States. But by 1988 the number had increased to 600 in 1986.

Today, 37 States require health insurance coverage for chiropractic services; 3 States mandate coverage for acupuncture; and 2 States require coverage for naturopath. physicians who specialize in prescribing herbs.

While SBLC cannot accept the proposed minimum package in the bill, SBLC does believe we are not that far apart and we can agree on a basic benefit package which can become the universal standard.

Now I would like to focus on the roles of the private and public sectors, particularly with respect to the establishment of the American plan. It is impossible to talk about America Care without discussing the proposal to require those employers not providing health coverage to contribute to the public plan, the so-called play or pay mandate.

SBLC must simply forcefully oppose this option for several reasons. First, most small businesses are philosophically opposed to any mandate on employers. Flexibility is the hallmark of any successful small business. A mandate strikes at the very heart of the formula that makes us successful. The one size fits all orientation of any mandated benefit ignores totally the unique circumstances of both individual firms and individual employees.

Technology in a demographic composition of the work force have been changing rapidly. This has created new problems in the world of work. However, for small businesses to respond effectively to change, there must be flexibility, not rigidity.

Second, even if a mandate were necessary we are troubled by the unfairness of the trigger mechanism in the play or pay proposal. Essentially the bill sends a message to the small business community that says we do not trust you. If you fail to move in the policy direction we wish we will impose a mandate on you.

Yet when it comes to imposing goals and targets for providers for insurers and for public policymakers the programs are voluntary.

Third, the public plan may very well prove to be too successful. I have heard estimates that the payroll tax, a business would be required to pay if the employer did not provide coverage, would be in the 7 to 8 percent range. Given the fact that SBLC estimates that the current cost of providing coverage is at least 12 percent of payroll, it seems likely that most small businesses would opt for the public plan.

Frankly, SBLC does not believe the public plan could handle the overload nor is a complete shift to the public plan a desirable result.

Fourth, the play or pay mandate imposes some extraordinary burdens on small employers. They would be required to provide family coverage and pay for 80 percent of it. This would be a significant change for most small firms. Most provide 100-percent coverage for employees, but family coverage varies widely and very few now can afford to absorb 80 percent of coverage.

In summary, the play or pay option has serious deficiencies. Rejection of this proposal does not mean small business is opposed to

the health insurance. In SBLC's Illinois study, over 90 percent of the small businesses responded indicating they believe health insurance coverage is a fundamental right for all Americans.

More than half the respondents clearly felt that the employer should indeed be responsible for coverage. There is a quantum leap, however, between undertaking a voluntary responsibility and absorbing a mandatory requirement.

There are a number of other initiatives in Senate Bill 1227 such as the proposal to create common claim forms that are worthwhile and merit praise. While they are not the subject of this particular hearing we want to at least acknowledge your efforts in these areas.

While it may take some time to provide a consensus, in the interim we can work on matters upon which there is broad consensus such as small group market insurance reform. SBLC looks forward to working with you and taking this debate to the next plateau.

I want to thank you, Senator, for your time.

Senator RIEGLE. Thank you, Mr. Stevens, for a very thoughtful presentation. I appreciate your coming from Saginaw to be with us today.

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

Senator RIEGLE. I appreciate the points that you make. We have put our proposal out there and you have reacted to it here today. We want it to be a program that helps get you out of the box that you are in now, not to take you out of one box and put you into a different box, but to get you out of the situation that you describe.

It is very interesting. If my notes are right, you have a self-insurance plan to insure your employees and you have had this history now over many years. As I understand it, you self-insure up to the first $25,000 in the event that somebody has a major problem that runs the bills up that high. Am I right?

Mr. STEVENS. That is correct, yes.

Senator RIEGLE. How many employees are we talking about, roughly?

Mr. STEVENS. We have about 220 employees currently covered, that would exclude the part-timers and the seasonal. So about 220.

Senator RIEGLE. Okay. So about 220.

Mr. STEVENS. Right.

Senator RIEGLE. Then with respect to their families, what kind of insurance status do the families of those workers get through your coverage? Are they partially covered, fully covered?

Mr. STEVENS. No, we provide full family coverage for all of our full-time employees.

Senator RIEGLE. Okay. So that is 220 roughly, they and their families fall into this category. But you are self-insuring on major medical costs for anybody in that universe of workers or families that have bills that run up to the $25,000 level; is that right?

Mr. STEVENS. That is correct and that is per year. Frequently you get illnesses that run more than 1 year, but this is per year.

Senator RIEGLE. So in terms of business risk you hope the profile of serious health problems will not cause some cluster of problems that kicks in the $25,000 times 8 or 10 people.

Mr. STEVENS. Correct.

Senator RIEGLE. Then with that out of the way, your rates with that deductible which you cover have still been climbing upward. They are nearly $300 a month, as I think I heard you say, up to $285.

Mr. STEVENS. Yes, per family unit. Right.

Senator RIEGLE. Per family unit at present.

Did I understand you to say your company pays it all? I mean there no contribution.

Mr. STEVENS. There is no co-pay on that right now.

Senator RIEGLE. No co-pay from the workers?

Mr. STEVENS. Yes.

Senator RIEGLE. But I take it you are getting to the point where something has to give with the financial pressures in light of the recession, the trucking deregulation and other things you say are squeezing down your margins if these health care costs continue to rise.

Mr. STEVENS. That is correct.

Senator RIEGLE. You cannot stay on that track indefinitely, unilaterally absorbing these rising health care costs, I would assume. Can you?

Mr. STEVENS. No, you are absolutely right. Because it is a 33-percent increase since December 1989.

Senator RIEGLE. Without getting into specific numbers, how close are we getting to the point where as a business that has been around for at least three decades that I know of——

Mr. STEVENS. I am fourth generation, 1905.

Senator RIEGLE. 1905. You have been going pretty much this whole century. How far away are we from a point where that profile of rising health care costs, even with the $25,000 self-insured provision, is going to be more than the company can handle?

Mr. STEVENS. Well, for us, it may take a little longer. But I think as an industry a lot of our people have not been around since 1905, nor do they have the financial depth that we do. So it is going to happen faster than we would like.

I think the companion problem you have with cost control in this area is worker's compensation. Because while it is not part of this hearing it is also health insurance cost driven. So we have both to contend with, not just the fringe benefit type of health coverage, but the worker's compensation cost as well.

Senator RIEGLE. I thought you made a very good point when you were saying that on one side you cannot have mandates that come down on one part of the equation and then sort of elastic voluntary guidelines on the other side that are something less than a mandate. That you must have equity.

Mr. STEVENS. That is a concern we have with the way it reads right now, yes.

Senator RIEGLE. Well, I think that is a point well made. Now Stevens has an excellent reputation, earned over now nearly a century of work. That has given you strength with the buying public and with the name that you have earned as a company. And that puts you in a stronger position. Even strong companies, however, are not of infinite strength as you, yourself, point out.

I think we have to find a way, and I think we can, along the general lines of what we have laid out here. A way to take and contain

these costs so that they do not crush small business. I take from what you said earlier that from the discussions with small business people, health care costs are generally the number one issue.

Mr. STEVENS. Substantially so, yes.

Senator RIEGLE. Yes, way ahead of anything else that is the number one issue.

I think we have to find an answer for small business. I think if small business in this country is not going to snuffed out that this area is one that needs some help. You cannot solve it by yourself.

Mr. STEVENS. That is correct.

Senator RIEGLE. I am getting that message from you and you have certain concepts as to how you think it can be addressed that it is going to help you. But I clearly hear within your message the notion that we cannot go on the way we are now because it is not working properly. Is that a fair deduction for me to reach?

Mr. STEVENS. I would agree with that. Yes.

Senator RIEGLE. Well, we are going to talk to the small business community to see if they can help us with your ideas as well as those that we have gotten from others to see what refinements we can develop in the area of small business.

Now we have a number of things in the bill in the sense that we provide some tax incentives, for small business as you probably know, in terms of a tax credit on insurance. We go into the cases where you get artificially high prices because you have too small an insurance universe over which those private sector insurance rates are being offered.

I thought you made a very important point with respect to the cross-over point with AmeriCare. See, part of the issue here is getting a broad enough insurance pool in place so that you are not arbitrarily injured on the cost side.

Now you have taken the finesse of the self-insurance part on the front end. But with a universe of 220 individuals in an insurance pool, if you were part of an insurance pool of 2 million or 200,000 or even a larger number, it would affect that rate structure.

Mr. STEVENS. Absolutely.

Senator RIEGLE. We think it would affect it beneficially for you. In my view, small business should not be in an adverse position in going out in the insurance market because of limitation on the size of the insurance pool. We think we can fix that.

We also think we can do some things in terms of uniformity with respect to what is on the list and what is off the list. It would help me, by the way, if you could provide for the record what constitutes the list of benefits that your employees and their families qualify for. In other words, what is on the list, what is off the list. I would like to just have it as a comparison for our own purposes.

Mr. STEVENS. Our particular company?

Senator RIEGLE. Yes.

Mr. STEVENS. Okay.

Senator RIEGLE. I would be interested in knowing for the amount of money. You gave us the rate schedule you are paying.

Mr. STEVENS. Okay.

Senator RIEGLE. And I would be sort of interested in seeing what that buys you in the way of an insurance coverage package.

Mr. STEVENS. All right. Let me send that to you in writing so you have it for the record.

Senator RIEGLE. Yes, that would be very helpful.

[The information appears in the appendix.]

Senator RIEGLE. But I appreciate the thoughtfulness of the points you have made here today and we will follow up on them. So this is not an exercise in going through the motions. We want to figure out how we tailor this so it is going to work properly.

Mr. STEVENS. Okay. Thank you very much, Senator.

Senator RIEGLE. Okay.

Mr. Termain?

STATEMENT OF A. COLE TREMAIN, VICE PRESIDENT FOR INDUSTRIAL RELATIONS, LTV STEEL CO., CLEVELAND, OH

Mr. TREMAIN. Thank you, Senator Riegle. I am the vice president of Industrial Relations for LTV Steel. We are headquartered in Cleveland, OH, just south of the great State of Michigan. The Nation's third largest steel maker, a wholly owned subsidiary of LTV Corp. Our company is also involved in aerospace defense and energy.

I appreciate the opportunity to appear today to share LTV's views and concerns about the health care crisis facing our nation. This crisis has affected the international competitiveness of the American steel industry. Most of our foreign competitors have health care provided through the national budget, but they do not see it in their steel costs.

As the chief negotiator fo. LTV Steel I can assure you it is placing a severe strain on collective bargaining as increasing resources must be dedicated to health care.

Our company, together with four other major steel companies have formed a joint national health care policy committee with the United Steelworkers of America. I have the pleasure of serving on that committee as the management co-chair and can assure you that we are working hard to understand this complex issue and develop joint recommendations for its solution.

I attached to my statement a set of principles, very basic in nature, which our committee has already developed for guiding future work. Today though I would like to speak from our experience at LTV Steel.

Our company is a merged product of three of America's oldest names in steel—Jones and Laughlin, Republic and Youngstown Sheet and Tube. Prior to our mergers our three companies had been serving America's needs for a combined total of more than 300 years. We are a mature company in a mature industry.

Our interest in health care cost is a product of our experience. In 1990 we spent $193 million providing health care coverage to 150,000 active employees and their dependents, retirees, their dependents and surviving spouses. Our responsibilities to provide health care are significant owing to the role we have played in downsizing the American steel industry.

In 1990 our 19,500 active employees worked to support the cost of providing health care for themselves, their dependents and for nearly 60,000 retirees, an extraordinary three to one ratio. Many of

those retirees are relatively young, having been forced into early retirement by the shutdown of outdated steel making plants. Major shutdowns in Buffalo, Chicago, Youngstown, Aliquippa and Pittsburgh, PA, resulted in the loss of 32,000 jobs in just the last 10 years.

Let me put some perspective on that $193 million for you. It was $26.50 of the cost of every ton of steel that we shipped last year.

Senator RIEGLE. Let me hear the number again.

Mr. TREMAIN. $26.50 of the cost. That's fundamentally about 5 percent of revenues.

Senator RIEGLE. So, what would a ton of steel sell for on average?

Mr. TREMAIN. Oh, on the average there's a great price range in steel.

Senator RIEGLE. Yes.

Mr. TREMAIN. It will range from about $300 to $800 depending on how much finishing is in it. But let's say $550 probably.

Senator RIEGLE. So if a ton of steel is $550 for every——

Mr. TREMAIN. Actually, you can multiply 20 times $26.50, if you can do that quickly, that is the average price.

Senator RIEGLE. All right.

Mr. TREMAIN. It is going to probably be 6 to 7 percent this year. Our costs are going up 15 to 20 percent and our prices are falling.

The total cost when you spread it across active employees was four times greater in 1990 than it was just 10 years earlier, and on a per hour worked basis our health care costs at LTV Steel of $4.87 an hour exceeded the minimum wage paid by many American employers. I wish I could tell you the numbers are improving; they are not. You know that.

We expect them to go up 15 to 20 percent this year and we have recorded nearly $2 billion on the company's books to reflect the present value of the future obligations to make health care payments. That is in accordance with the FASB rules.

The problem gets more serious each year for all of the nations health care bill payers, but especially for companies like ours who played a major role in building these United States.

I would like to share with you some numbers that underscore how devastating health care costs can be today for any American if his/her health fails. We look each year at the most expensive cases that we have provided coverage for and the cost that we have incurred. This year's list was headed by a Chicago employee's spouse who had a liver transplant at a cost of $1,025,000 to the company.

Last year the list was headed by a Chicago employee's thigh amputation, $876,000; and our lists include at least a dozen cases exceeding a quarter of a million.

A major driver of the increased costs comes from cost shifting. It is an accepted fact that costs not adequately covered by Medicare, Medicaid, or other social funds for the uninsured are passed to the privately insured patients, most of whom are covered by insurance provided by their employers.

I can assure you that this is no imagined problem. Here are several examples from our records. In 1990 Medicare paid $20,100 for DRG-106, that's a coronary by-pass; while LTV Steel paid an average of $32,000 at the many hospitals our employees entered.

For DRG-196, a cholecystectomy Medicare paid $5,200 while our costs were $10,800. Worse yet for DRG-307 our costs were $12,800 as opposed to Medicare's $2,713.

Not every comparison is that severe, but regularly the Medicare charge is less than LTV Steel's by generally an average of 40 percent.

Cost shifting from Medicare has thus far been a hospital issue. But I can assure you that those of us in the industry are concerned about the new resource based relative value scale for physicians, expecting another huge dose of Medicare cost shifting, this time from the physician community.

Senator RIEGLE. So doesn't what is happening here fit the phrase "cost shifting?" The cost of a procedure for one patient under one kind of a payment scheme is, in fact, artificially low and that has to get picked up somewhere else. It is coming over and getting picked up by you, isn't it?

Mr. TREMAIN. Yes, I think that is it exactly. Some part of that is the hospitals costs for providing health care to the uninsured which has to be passed on to the bill payer, some part of it Medicaid, which is woefully short of any realistic cost to the hospital in many States, and I suspect some part of it is Medicare's charge not really meeting the hospital's cost.

Senator RIEGLE. But when you stop and think about the ability, quite apart from the fairness and the equity, just the sheer financial strength of the private sector companies that pay health insurance provided now for their people, being able to pay the extra amount to subsidize the system for somebody else who isn't their employee, in a sense you have a partial public program that is being financed by the part of the private sector that is buying health insurance for its people. Isn't that what is going on?

Mr. TREMAIN. That is exactly right and it is really exacerbated by inflation rates in this 15 to 20 percent range. That doubles your cost every 4 or 5 years.

Senator RIEGLE. See, I would argue that what you have here is that you, in effect, have a quasi-public program, only it is masked. I mean it is not called a public program. It is a public program that is really paid for by private sector companies that have health insurance, such as you have and Mr. Stevens' company has. Your rates are bloated because you have to cover the cost of what is really a public program that we are not facing up to.

We are letting you pay for it rather than hitting it head-on with some kind of a direct effort of capturing that problem and trying to put some discipline on it. In other words, we simply now allow it to burgeon, get larger, and we cost shift over to you until such time as steel prices, per ton, get so expensive that you have to end up laying everybody off.

You have already laid off a lot of your people. Presumably, if taken to an extreme, we can cost shift so much money onto you that you will not be able to sell another ton of steel or Mr. Stevens is not going to be able to ship another houseful of furniture; because the costs that have come in from some other place, that is being loaded into your cost structure, sort of breaks the back of the company.

Isn't that the risk we run here?

Mr. TREMAIN. That is precisely what is going on. It is a hidden tax in the classic sense.

Senator RIEGLE. It seems to me that in effect it becomes a de facto public problem. I mean it is a way in which we pay for something for a certain group of users, but through this intricate system of cost shifting, we go over and load it on whatever train is going through. If LTV happens to be going through with a concern with an established health insurance practice, then you pick up part of the cost. Mr. Stevens' firm is out there and they have a practice of supplying health care coverage, they are asked to absorb a part of it.

But I do not know how over time any company today in this new economic environment is going to be able to survive under that kind of a cost penalty, which has nothing to do with their own business activity. You are completely a hostage to events that are outside your control in that case, are you not?

Mr. TREMAIN. Particularly when you are competing against folks that do not have that cost in their structure, whether it be a small business that is competing against someone that does not provide health care or an American steel company that is competing against Nippon Steel and a national health care system.

Senator RIEGLE. Right.

Well, excuse me. I just wanted to cover that point. Did you want to go ahead or have you finished?

Mr. TREMAIN. No.

Senator RIEGLE. Okay.

Mr. TREMAIN. We have covered the costs. If I could give you a few of our thoughts I would very much like to do that.

Senator RIEGLE. Please. No, go ahead.

Mr. TREMAIN. It should be clear to all that our Nation can no longer afford to turn our back on millions of our fellow Americans. I hope it is becoming equally clear to this distinguished audience that the health care problem cannot continue to be shifted to the country's businesses without devastating their competitiveness.

It is vital that you and your colleagues, Senator Riegle, press vigorously ahead with your effort to forge a comprehensive national solution to this problem. Nothing less will suffice.

Those of us in the private sector have utterly failed in our efforts to reign in runaway costs. The problem cannot be solved by applying a band aid solution either. This is one issue that the free enterprise system has clearly failed to solve. In fact, the combination of exploding technology and competition is exacerbating the problem. It seems as though every hospital must have the very latest in technology and it is expensive.

The health care crisis is real. It can be only solved by comprehensive Federal legislation that addresses the entire problem. We have become convinced, after a good deal of study I might add, that such legislation must effectively deal with all three of the major issues—access, cost and quality.

If access is attacked and the cost problem is unattended the cost shifting problem that I have described will be further aggravated for those of us in the private sector who pay health care bills. If cost is addressed and quality ignored, each of us will be genuinely concerned that quality will be sacrificed.

We have concluded there is no need to dismantle our existing network of insurers and providers. We do not have to start at ground zero to attack this problem. We support legislation that would mandate that employers provide a basic set of benefits or pay a modest payroll tax to have their employees covered by a new Federal plan, similar to but separate from Medicare.

This play or pay approach is readily adapted to our current systems. We support lowering the age of Medicare eligibility to age 60. Too many Americans, many of them who formerly worked for us, have been forced into early retirement, often without health insurance.

On the cost side we believe it is essential that legislation establish the principle that everyone is charged the same price, whether the bill is paid by Medicare, the business community, insurance companies or the new Federal system to cover the uninsured. Processes that are currently in place to determine what Medicare pays hospitals and physicians can provide the starting point for a new system which would set the price for everyone.

That process also needs to set national targets for health care costs. We have to put a brake on the share of GNP that is going to health care.

On the issue of quality it is clear that comprehensive medical practice guidelines and accreditation processes have to be established. They are needed to assist the effort to provide quality care while tempering the overpractice of medicine. Our medical community desperately needs reform in the law and policies governing malpractice. It is clear that defensive medicine adds materially to the costs we see, particularly in extensive use of tests.

One additional concern that we would urge you to consider. There is an inherent conflict of interest arising from ownership of laboratories and technology centers by physicians who in their daily practice refer patients to these very same centers.

Unfortunately the American entrepreneurial spirit seems to assure that these labs and centers are huge financial successes. Malpractice reform should be tied to reform in this questionable business practice in some form.

In Cleveland we are actively supporting a joint effort by the business and medical community to develop an accurate system for measuring the quality of hospital care, known as Cleveland Health Quality Choice. This joint effort is making excellent progress in developing a system we all believe will allow both providers and patients to assess with confidence the quality in health care provided by Cleveland area hospitals. It may well provide a model for national consideration.

Senator Riegle, if the Simon Amendment is incorporated into S. 1227, and we would urge that result to establish the critical all payer element, we believe your bill effectively addresses many of the fundamental concerns we have been discussing and is an excellent starting point.

I will not comment on how to finance it. I think you know better how to do that than we do. But it should be financed broadly I think.

Senator RIEGLE. Yes. Well it does have to be financed broadly. It is interesting that we have already heard from one expert witness

on your panel down at the other end of the table that the scale of the inefficiency of a gerry-rigged system, where you pass these costs around and you have all these multiple different accounting systems and formats and everything else, together with the defensive medicine and the malpractice problems and the other things, a very expensive system now that in their professional view you can actually go in, apply a range of new cost-saving disciplines and save enough money to actually extend coverage to everybody else that does not now have it.

Now one can quibble with their model, but I think it is significant that a top notch professional outfit on the outside looks at it and sees the scale of the inefficiency is now that large.

So I think we have waited so long to deal with this problem that it has become top heavy and financially inefficient. There is now enough money to be saved in a rigorous cost control program that we can actually pay for the coverage of the people, that we are not now covering, plus we get a healthier nation.

I want to make another point, however, with respect to something that you have illustrated, I think, so well. Being a larger business, you are directly competing in the international global economy. You have to go up against Japanese steel, Taiwanese steel, and Korean steel, whatever subsidies and currency manipulations not to mention everything else. Plus there is the fact that they have national health care in their societies and do not have health care costs as a direct cost to production. However, you must carry the health care costs, not only for your smaller work force, but also a big base of retirees that you are carrying from the past.

So you are at a profound financial disadvantage. I can see that the more we let the current health care system go on, and allow the cost shifting to go on, the more financial weight that comes back in on top of your company, and the more this cost shifted amount of money will put you in a downward spiral. Literally, other things being equal, that has to continue to push a company like yours down in financial terms until eventually there is a way you can survive. I am not just talking about your company but just looking at the dynamics of that kind of equation. I do not see how an American firm, going head on with an international firm with those built in advantages for them, can survive under that arrangement.

We have to get you out from under that kind of cost premium that frankly does not have anything to do with you. I am talking about the cost shifting part of it that is coming back in on you. As a matter of fact, the fewer firms that are left that provide health insurance, the fewer firms that have to carry a larger amount of that shifted cost.

So as you survive, you survive and you get a larger share of the amount of money that has to be cost shifted. That helps since you a little bit faster.

Mr. TREMAIN. Absolutely correct.

Senator RIEGLE. Now it seems to me this is where it catches up with Mr. Stevens. Mr. Stevens is essentially in a service business, so he is not going head to head with an international competitor the same way you are in the steel business. But Mr. Stevens' customers are the workers of this country who have to have income to

buy the various moving services that you sell. So you got caught on the question of people being able to buy the services on the one hand, but you are also being asked to carry your cost shifted burden as well. You are being stuck with that because you have had a history of being a company that provides health care for your workers because it obviously matters to you.

It is obviously part of the ethic and the history of the business. I would think if you ever got to the point where you had to discontinue it because it was too expensive or materially reduce it, it would be a terribly traumatic moment within the company. It may be coming, quite frankly, through no fault of yours.

I do not know how far we can go out here before the costs coming back in even with this risk you take on with this first $25,000 of insurance on the front end is a burden that you cannot carry. That there are not enough dollars except through the business to cover that.

It has hit him first because of the dynamics of his kind of a business, but it seems to me that the same dynamics effect you and maybe the time frames are a little different. But I think the result is probably the same in the end. That is, it will grind your business down over time, just as it is grinding their business down now at a somewhat faster rate.

Did you say that you have retirees in your program too?

Mr. STEVENS. We currently have limited participation with retirees. We tend to pick up the Medicare participation on them. But what Medicare does not pay, yes.

Senator RIEGLE. Imagine however if you were an LTV situation where you had three retirees for every one active employee.

Mr. STEVENS. We do not have that problem.

Senator RIEGLE. If you had that that would like trying to swim up Niagara Falls, you know.

Mr. STEVENS. Well, your option is you either reduce benefits or you go to a higher co-pay. For in our case where we do not have co-pay at all you go from that to a co-pay. So you are shifting the burden to something.

Senator RIEGLE. Yes.

I was struck, Mr. Stevens, by you saying that the health care issues become the number one issue among small business people. You are here representing them today. And I hear you, Mr. Tremain, saying that from the point of view of big business, certainly LTV qualifies as a big business enterprise in this country, that health care costs are right up at the top of your list, too; is that fair?

Mr. TREMAIN. That certainly is the case, Senator.

Senator RIEGLE. Before going to our next panel I just want to observe, those who say "let's just wait, we will get at this another time. You know, we have other problems to solve and there is a big world out there. There are a lot of issues kicking up around the world and so forth and so on."

The issue of how much urgency we assign to this problem is really a public issue. If the sense coming out of the private sector, out of the business community, should be to the Congress, to the public policymakers, is "look, this is a huge problem and it is really hurting us in the private sector, it is hurting our National efficien-

cy, please tackle this now and do something constructive about changing it."

If that message comes in loud and clear as it has from the two of you today, I think we will do it. We solve problems around here all the time. Why can't we solve this one? I think we can.

I would hope that we would be able to get even a louder chorus coming from the private sector in light of what is happening, saying "let's quit putting this off." I mean if we put this off another 5 or 10 years I think there are an awful lot of companies that are not going to be around anymore.

I do not want it to be too late by the time we finally get a solution. I do not know what the solution will look like, but it is going to be too late for a lot of companies. I do not want to see that happen.

Let me thank you very much for your testimony today. It has been very helpful and much appreciated.

Mr. TREMAIN. Thank you for the opportunity.

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

Mr. STEVENS. Thank you, Senator.

Senator RIEGLE. Let me now call our final witnesses today. Dr. Robert McAfee, who is the vice chairman of the board of trustees of the American Medical Association and president of the Maine Medical Society of Portland, ME. He is here testifying on behalf of the American Medical Association. Mr. William Kreykes is president and CEO of Rhode Island Hospital in Providence. He is here on behalf of the American Hospital Association. And Dr. James Ehlen, who is the chairman and CEO of MEDICA, a health maintenance organization in Minneapolis, MN, is here on behalf of the American Managed Care and Review Association.

Gentlemen, let me welcome you all and thank you for your patience today, this afternoon. We will make your full statements a part of the record. I want you to feel free to summarize your remarks.

Dr. McAfee, we will start with you, please.

STATEMENT OF ROBERT E. McAFEE, M.D., VICE CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, AND PRESIDENT OF THE MAINE MEDICAL SOCIETY, PORTLAND, ME, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Dr. MCAFEE. Thank you very much, Mr. Chairman. I am Bob McAfee, vice chairman of the board of trustees of the American Medical Association and a practicing surgeon in Portland, ME.

The introduction in June of Health America signaled that at the time for action on health system reform is now. Debate and study alone no longer are acceptable responses. On behalf of the AMA I applaud the leadership that you are showing today in the health system reform movement and commend these efforts. This, indeed, is a bold initiative.

The medical profession is also committed to improvements in our health care system. The AMA and 16 national medical specialty societies organized Physician Organizations for Access to Care found-

ed on the need to provide coverage for the uncovered and to build upon the current system as much as possible.

We agree with many elements of S. 1227. We disagree with some. We need further exploration of others. We are impressed by the creative thinking elements of the bill and concepts such as the National Expenditure Board challenge us all to reassess our view of the future of the American Health System.

A number of the provisions of Health America would establish an increased role for the Federal Government in health care delivery. Frankly, this raises serious concerns among some of our members who are not convinced that they can rely on fair administration. The current problems with implementation of the Medicare physician payment system by HCFA indicates that this anxiety and concern will not be easily overcome.

I would be remiss, Mr. Chairman, if I did not take this opportunity to thank you personally and members of your committee who have supported the efforts of fair and equitable physician payment reform during our current struggle.

Health America and AMA's reform proposal Health Access America, which has been our proposal for some 18 months now, share the common fundamental goals of broadening access, maintaining quality and controlling the costs of health care. While there are areas of concern which one can expect with a program as broad an innovative as Health America, areas that AMA and Health America share are striking.

Both proposals call for universal access to coverage for all Americans. Both call for a system that relies on the employer-based system to cover the vast majority of Americans by requiring employment based coverage. Both require small business insurance market reform to make policies available at prices that are affordable. Both require incentives to aid small business in purchasing group health insurance, including replacement of State mandated benefits and taxes and other improvements to assist new and very small businesses. Both require an improvement in public funding programs for the needy and other special populations to ensure that no American is left without access to quality medical care. And, indeed, both recognize that there is need for medical, professional liability reform.

Both of our plans suggest development of clinically relevant practice guidance parameters and integration of that guidance into patient care. Reduced hassles for both providers and beneficiaries of any health benefit plan, public or private, is part of each of our proposals.

Much attention must be paid to proposals that could have the tendency to overly micromanage and/or underfund needed health care and new technology for Americans. While budgets cannot and should not be ignored, major decisions should not be budget driven alone. Proclaiming that a certain percentage of gross national product is all that will be allocated for health care now and in the future may deny future generations of Americans their opportunity to benefit from advances that will improve not only their length of life but also the quality of that life.

To achieve consensus will not be easy. We will need to look at various models, choosing the best from each and discarding those

that will not work for America. Certain changes can and should be made now, such as small business insurance market and professional liability reforms. We need to continue to encourage work in developing practice parameters and on ways to properly integrate them into our medical practice. We need to reduce the paperwork burden that is swamping many physicians offices.

A Federal Health Expenditure Board as contained in Health America could be further developed to achieve these goals. Likewise, a regulatory environment like the model used by the Securities and Exchange Commission should also be explored. Perhaps there are lessons to be learned from the collective bargaining model. Even foreign systems, while not transferable to America in their entirety can provide insights.

For any negotiation or consensus building process to be meaningful each party much have a sufficient degree of bargaining power. A true negotiations process must have a real opportunity for negotiation and compromise, not a take it or leave it scenario.

Finally, I must point out a major problem in Health America in the failure to provide for adequate reform of the professional liability system now. The time for study of the liability issue has passed. Prompt reform is essential to reduce the significant cost and access problems associated with unrestrained medical liability. The viability and credibility of any reform proposal hinges in part on the inconclusion of significant liability reform measures.

In conclusion, Mr. Chairman, Health America is a positive step in the pursuit of health system reform. It is thoughtful and complex. And like the AMA's proposal, addresses accessibility, cost and quality of health care. We will continue to study and evaluate its bold initiatives. We encourage continuing dialogue among all reform participants for it is only through collaboration of the private and governmental sectors that we will achieve optimal reform.

We thank you for the opportunity to provide these remarks to you today.

Senator RIEGLE. Well let me thank you for your comments. I appreciate them very much. I find them to be constructive and helpful. I think you make some good points. I also feel that we have to move on the medical liability issue.

I keep hearing these stories, but just one that is very close to home. My wife and I have a 6-year-old daughter who was delivered by a very fine obstetrician here in the Washington area. My wife is expecting again and we have had to find a new obstetrician because our previous obstetrician discontinued his practice and he told me that the main reason on the margin was the fact that his malpractice insurance premium had become so high that it was just prohibitive in terms of the other costs of doing business, and so he has sadly left the profession.

I think the country is at loss for that. But it is commonplace all across the country. I certainly am finding it in Michigan, and other places as well, to a great degree .

I would like to say this before moving to our next witness, that I think time really is of the essence. I think there is a window here that we can move through together. Now that, obviously, means the give and take that involves any complex issue of this kind. But there really is no excuse for further delay. These issues have been

studied. You have analyzed them. The other major parties at interest have analyzed them. We have analyzed them.

It is time to debate these issues and settle these issues and to work out a reconstruction of the system and get it into place before more time is lost and more damage is done, in terms of premium cost and people. You know, I admire the medical profession very much for its willingness to devote itself professionally to saving people's lives and to solving terrible health problems that people face.

We have all these uninsured people out there that I think almost every doctor I have ever met would like to be able to help. I mean you do not go into medicine if you do not believe in helping people. It is often a rugged profession I think for people who are doing some of the most difficult procedures, who do it because they enjoy it and find great meaning in trying to save people's lives and ease their pain.

So those that are out there who need the help should get it. We have to match the needs up with the professionals that can provide it. I think we can do that.

My hope would be that we can convince the administration to take the window from now through the fall of next year, the time that we have to take our proposal, other proposals, debate them, sort them out, fit them together, and actually enact a plan so that by the time the Congress adjourns next year in 1992 we have reformed the system and everybody can come out ahead.

I think it is possible to do that. The AMA probably will have as much to do with getting a dynamite charge underneath the people who say "not now, later" of any group. So I really encourage that. I think that can make a big difference in us.

I am going to meet with Secretary Sullivan very shortly to talk about how we get this train rolling at a faster speed. But anything you can do to help that along would be much appreciated.

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

Senator RIEGLE. Mr. Kreykes, let us hear from you next, please.

STATEMENT OF WILLIAM KREYKES, PRESIDENT AND CEO, RHODE ISLAND HOSPITAL, PROVIDENCE, RI, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. KREYKES. Thank you, Mr. Chairman. My name is Bill Kreykes. I am the president and CEO of the Rhode Island Hospital in Providence and chairman of the American Hospital Association, Section on Health Care Systems. Rhode Island Hospital is a 700 bed academic medical center, the only trauma center in the State of Rhode Island, some 4,000 employees, so I can speak from the perspective of a large employer, as well as a health car provider.

We truly welcome the opportunity to meet with you today. I know that this committee is very sensitive to the problems my colleagues and I face as health providers and we applaud your leadership and efforts in order to achieve reform in a system that clearly needs reform.

Father Ted Hesburg, president of the University of Notre Dame, once stated, "The essence of leadership is that you have to have a vision. It has to be articulated clearly and forcefully on every possi-

ble occasion. You cannot blow an uncertain trumpet." If there is one thing we need in this industry today it is a clear vision.

The vision of the American Hospital Association is to have the healthiest nation in the world. We should have. There is no reason that we should not. We want to work with you and others to achieve that vision.

To achieve the vision health care must be redesigned around the needs of the population, not simply the needs of our providers. The measure of our success should be health status not full hospitals; manageable cost per capita not profitability; value not just cost control.

The AHA strategy "A Starting Point for Debate"—and you have a copy of our strategy paper; it is attached to the written comments—starts from the premise that all of us—citizens, providers, insurers, purchasers and the government—we are all part of the problem and we need to be part of the solution and to achieve the kind of change that we need will require a major change in everyone's behavior.

To change, incentives must change. We favor an incentive based approach in which all players are held accountable for their performance; providers, physicians and hospitals working together. We must eliminate unnecessary services, spurn the unnecessary costly duplication to technology and eliminate excess capacity.

These are difficult things to do and as providers we must be incentivized to do so. We need to be able to experiment and have the willingness to experiment in new types of health delivery that are lower cost. We are trying one, for example, in Rhode Island, a Cooperative Care program where the patient and a care partner are actively involved in the care process as one means of reducing cost.

Individuals must accept greater responsibilities for adopting healthier life styles. They must use health care services efficiently and more effectively. We simply must learn how to control demand. My institution, as a level one trauma center for the State of Rhode Island, will experience some 2,000 trauma admissions this year. These are admissions that require major, intense care. Thirty percent of our trauma admissions are a result of automobile accidents; 90 percent our of trauma admissions resulting from automobile accidents are individuals that do not wear seat belts. This is a major demand on health care that is unnecessary.

This year, the Rhode Island Hospital cost per adjusted admission will be less than 4 percent. Our total cost increase will be over 9 percent. Our increased volume of trauma activity, emergency activity, is greater than 10 percent. We are seeing a major impact on the demand side which constantly increases our cost of health care delivery.

Insurers need to focus on risk management rather than risk avoidance and keep the administrative cost of programs to a minimum. Financing and payment systems must be overhauled so that incentives are there to encourage disease prevention and the delivery of care in less costly settings than the high cost acute care operations.

Performance accountability, part of the AHA plan, needs to be built into the system through medical practice parameters. Wider availability of information on individual practitioner and provider

cost and quality. There is wide variation in cost and quality and we need to let that be known in order to bring all the providers to a more acceptable norm in both cost and quality, using guidelines on cost effective deployment and the use of new and existing technologies and specialized services need to come about.

Incentives among providers need to be compatible. We need to eliminate the conflicting incentives among hospitals and physicians, where hospitals are paid more and more on a per admission basis and other providers on a fee for service. They need to be brought in line. Managed care should be promoted with a broader, longer term focus in providing coordinating care to defined populations over a longer time and across providers.

Tort reform has been identified as essential to obviate the need for defensive medicine. Living wills and advance directives would limit nonbeneficial final care. Anti-trust laws would ease the needed greater collaboration among health care providers in order to stop the chase for high technology and do things more in a collaborative manner. We need to incentivize ambulatory care. We should have the capabilities to provide out-patient prescriptions as one example of the need to incentivize.

Let me close with a few comments on Health America Plan. It is very much in common with AHA's own national health reform strategy and we do applaud you for it. We think you are making major steps in the right direction.

We do, however, have a few areas of difference. We believe that setting expenditure targets for specific segments of the provider community could lock into place the current fragmentation of care and we believe we have to watch for that to make sure we achieve an integrated health delivery system and not continuation of the fragmented system.

Second, we believe it is unrealistic to effectively cap spending at current levels while simultaneously expanding access to millions unless we are able to find a way to reduce the demand that I have already identified.

Third, controlling health care spending by payers will not necessarily control health care cost experienced by providers unless the underlying incentives are changed. If the underlying incentives are not changed it could have an adverse impact on the quality of care.

Fourth, institutionizing inadequate payment rates in the AmeriCare Program will not in itself solve the cost shifting problem which is a major issue we all recognize.

And fifth, we support effective management of care. But we feel that some of the provision in the bill as currently written will yield managed cost, not managed care.

We would like to work with you to achieve true managed care which means assessing individual's needs and then planning and organizing care so that their needs can be maintained and met efficiently, effectively across the provider system.

We look forward to working with you in continuation of meaningful reform of the health delivery system. We clearly recognize it needs it and we need to strike the balance between cost, quality and access. Our collective leadership, once a vision has been agreed upon, can clearly bring about the necessary reform. We applaud

you for your efforts to achieve it and we welcome the opportunity to work with you.

Thank you.

Senator RIEGLE. Thank you very much.

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

Senator RIEGLE. You may know that we asked the GAO sometime ago to do a study on the impact of the system today on trauma centers throughout the United States. They came back with a very powerful study that showed that over 60 trauma centers have closed across the United States. Most all the remaining ones are under terrific financial pressure.

In the State of Michigan last year, hospitals alone had to shoulder about $350 million worth of uncompensated care, a lot of it of the trauma center, emergency room sort. The national figure is something on the order of $11 billion.

You were here when the LTV Steel gentleman testified. And the cost shifting problem from their point of view is quite apparent as he so ably described it. You have the counterpart of the same thing in a different form with respect to what is piling in on the hospitals.

I see no way for the hospitals to manage their way out of that problem. It is a situation where somehow or another you cannot, through some kind of an extraordinary internal hospital by hospital technique, fend-off a system that is out of control in that area and is going to saddle a hospital with a huge amount of cost that it has to incur and cannot cover in any direct and proper way.

Isn't that what is happening?

Mr. KREYKES. I agree with you, Senator. I believe we have to find ways to incentivize societal behavior to change. Again, the demand, whether it is seatbelts or crack babies or gun shot wounds or stabbings, whatever it may be, these are absolute needs to be met as they come to the institution. We have to start to put greater emphasis on educating society or other incentives to change that behavior so the demand on health care is lessened.

Because I do not see any way for hospitals, major trauma centers or others, or physicians to not meet that demand when it comes to us. We cannot just say you are going to die because of bad behavior. We have to meet it and somehow curb that demand. I do believe in the main health care providers are very conscientious in what we do. We are doing all that we can or are trying to.

We are doing more and more to control health care costs. But we all recognize we have a crisis and somehow collectively we have to meet that crisis and change how this industry performs and put a much greater emphasis on health status and health promotion to keep people healthy, not treat them once they become sick.

Senator RIEGLE. We have to have a system in place where when somebody gets sick the bills get paid and it gets paid in a direct fashion and not in an indirect fashion. We cannot end up loading on the costs. The hospitals cannot absorb the costs forever because it will break the hospitals. And we cannot cost shift it over to the person who has insurance, who is not the person who has come in for the service, because that sinks companies like LTV or like the Stevens Moving Co. here.

It seems to me that hospitals are also like the medical profession, a group today that have an absolutely profound and urgent need to help this country decide to deal with this problem and fix it, and come up with a better solution.

So it will be very helpful to us to have hospital administrators across the country pressing for a reform of the system. It does not have to be precisely the way we have talked about it here, although we think our plan is a pretty good one. But we are open to adjusting it where it needs to be adjusted.

But the time, I think, to apply the maximum pressure for change is now, and so I would urge you to pass that word out through your members.

Mr. KREYKES. Thank you, Senator.

Senator RIEGLE. Finally, let us go now to our last witness for today who is the chairman and CEO for MEDICA, in from Minneapolis on behalf of the American Managed Care and Review Association. Doctor, we are very pleased to have you as well.

STATEMENT OF K. JAMES EHLEN, M.D., CHAIRMAN AND CEO, MEDICA, MINNEAPOLIS, MN, ON BEHALF OF THE AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Dr. EHLEN. Thank you, Mr. Chairman. Thank you for the opportunity to come here and to testify today.

I am Dr. James Ehlen, chairman and chief executive officer of MEDICA. MEDICA is a health maintenance organization, enrolling more than 530,000 Minnesotans. Before joining MEDICA I was in private practice as an internist for about 12 years. I am involved with the Minnesota Council of HMO's and recently was its chairman. I currently participate as a member of the Rand Corp. Clinical Subcommittee Study on Quality Assurance.

I am pleased to be here today on behalf of the American Managed Care and Review Association (AMCRA), which is the national trade association for the managed care industry. AMCRA recognizes the efforts of the Chairman and the members of this subcommittee. You have demonstrated your willingness to confront the critical issues on the debate on how to deliver quality, affordable health care to all Americans.

Proposals like Health America and the American Health Securities Act of 1991 are positive, innovative approaches to reforming the health care system.

I want to make some comments on the role of managed care in the process of reform. AMCRA applauds the chairman's recognition that the process of managed care must play a role in any reform initiative. Health reform proposals must recognize that managed care is a comprehensive approach to health care delivery. It is fair more than a cost saving device.

Managed care improves the quality and efficiency of health care services through increased coordination between the plan and providers. An emphasis on preventative programs and wellness can be found in a managed care setting. Prenatal care emphasis, cancer screening, smoking cessation programs are examples.

Managed care organizations like MEDICA are rapidly developing procedure to access the outcomes of specific procedures to improve

the value and the quality of services delivered to our members. Increasingly as we manage the delivery of proper care at the proper time in the proper setting and for the proper price our partners in the market place and the health care professionals will see value in the process, the achievement of satisfactory outcome for our members and our patients.

Member satisfaction is reflected in the 1990 INTER Study report which reported that as of July 1990 33 million Americans were enrolled in HMO's. AMCRA also estimates that as of December 1990 about 65 million Americans were enrolled in some type of a preferred provider organization.

Further proof of the value added strength of managed care techniques comes from a unique study commission by AMCRA in May 1991. Results of this study demonstrated that managed care in rural areas were more satisfied with the cost of care as well as the advantages of less paperwork. Moreover these respondents believed that managed care delivered lower out-of-pocket costs and covered more services than indemnity insurance.

The study demonstrated better dollar value and suggested a continued trend towards increased membership with managed care organizations.

AMCRA believes that the managed care establishes a mutually beneficial relationship with providers of care. Managed care organizations can offer physicians and hospitals improve financial positions. This is based on dependable volume of patients delivered, cash flow and a reduction of bad debt through prompt payment of bills. Managed care organizations offer employers and their employee groups a conduit to quality providers of care.

I would direct your attention to two studies, one commissioned by the State of Connecticut and the other by the Urban Institute. Both demonstrating the ability of managed care programs to influence physician behavior positively with respect to practice patterns leading to higher quality at a more affordable cost.

Working in partnership with providers managed care assures quality of care through a comprehensive and coordinated approach, an approach that emphasizes prevention and intervention. Recent studies funded by HCFA compare care delivered in a managed care versus a fee for service setting. These studies have found that the quality of care in a managed care is as good as, if not better than, in a fee for service. And recommended elements in addition of routine and preventative care are more likely to occur in a managed care setting.

Managed care provides expertise in research on quality outcomes, medical practice guidelines, as well as in technology assessment. Managed care's inherent focus on quality and preventative care restrains the rise in health care cost.

Evidence of managed health care's ability to restrain rising cost is found in a recently released Forster Higgins study that compares HMO's and fee for service insurance. According to that study, looking at annual premiums for persons, HMO's on average cost 17 percent less than traditional fee for service care.

Given this scenario I am confident that managed care already has played a significant role in restraining costs and will continue to play a role in the constraint of future health care cost rises.

Because of these successes and the applicability of the methodologies managed care does and should continue to play a role in private and public health care initiatives. AMCRA has noted that small business reform found in Senator Durenberger's initiative as well as in yours will be a critical area of reform. Managed care has and should continue to play an important role in delivering quality, affordable health care to businesses of all sizes. This includes the small businesses that we have heard about today which employed two-thirds of America's uninsured workers.

We welcome reform initiatives to address the Federal override of State anti-managed care legislation and we appreciate the Chairman's foresight in identifying laws that pose barriers to effective managed care and utilization review.

AMCRA applauds efforts to include managed care in public programs. AMCRA's members are actively involved in Medicare, Medicaid, Federal employees health benefits plan and CHAMPUS. Our Medicare and Medicaid policy task force have identified several Federal issues critical to the expansion of managed care participation and they are in the detailed report.

In summary, AMCRA appreciates the consideration afforded by Chairman Riegle and other members of this committee. Managed care has demonstrated that quality of care in the managed care setting is as good if not better than fee for service. Managed care has received the continued endorsement of the public as more individuals choose to join managed care programs.

Answers to questions surrounding affordability and accessibility can be found in managed care programs. As health care reform initiatives focus on the issues of cost and access both in public and private programs, managed care would like to be an integral part of the debate.

Thank you for your consideration.

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

Senator RIEGLE. Gentlemen, let me thank you and thank all of you again.

You were here earlier so you heard the other witnesses ahead of you. On this subject of setting up a national board to look at these issues and to get everybody around the table, we would like to have you around that table. This would not be a board with somebody else and not you. It would be a board of which you all were a part.

The thought is that by getting the major players sitting down together on this issue of what is going on out there and the cost increases that we have been seeing, which have really been quite extraordinary, that a Federal Health Expenditure Board could really make a difference in terms of having the kind of face-to-face discussions. From that would come voluntary spending goals, not mandatory goals.

It seems to me that one of the things we hear the business side and others say, "well, look, we are not sure we are going to have enough confidence in what is being done here unless there is some very direct way in which an effort is being made to restrain cost and manage the development of this health care system and the increase in costs out over time."

If we take into account all the things that you have suggested, which we have attempted to put into this bill and performance ac-

countability among providers through practice parameters, managed care, medical liability, tort reform, wouldn't a board like this be a part of what we need to do? I would assume you would all participate if we set up a board like that. Wouldn't you?

Dr. McAfee. I would. Mr. Chairman, if I may. Yes. I think that this is an intriguing idea. It is something which I think would serve a very useful purpose.

The AMA has been very active in participating with other advisory committees, boards. It has itself coordinated several groups among the medical specialties, has tried over the last several years, and more particularly during the last 18 months that our proposal has been on the table, to look at any and all opportunities.

We are on record as supporting the advisory value of the MVPS under the Medicare system at this time. I think those things are indeed in concert with what we are all trying to do. As long as we have continuing concerns, doing outcome studies, getting the information that we need, and being sure that practice parameters can be applied across the board so we know how wisest to spend those dollars, then, when those advisory figures come down to us, physicians can limit some of the care that is now given—for whatever reason—if it is no longer proven of value to patients.

We are a little distance away from some of the information that will give us the ability to do that for some very common things. We are hopeful that with the Agency for Health Care Policy and Research, with our own guidelines within the profession, and with our ability to use these in a more proactive fashion to influence physician behavior, we not only would accept a seat at the table, but it would be a very high priority concern of ours.

Mr. Kreykes. Mr. Chairman, the AHA recognizes the value of having such a mechanism by which the goals and universal access and quality are reconciled with judgments of affordability. We propose a national public/private commission which would be a conduit for such key actors to advise Congress in setting per capita budget targets under the program and in reconciling the definition of basic benefits with the targets established. It would also provide a forum for debating cost effectiveness that we strongly recommend and want to be at that table in such discussions.

Dr. Ehlen. Mr. Chairman, from the standpoint of a managed care perspective I would echo some of Dr. McAfee's comments. Before a board such as you have proposed, which we would certainly want to be at that table, could be most effective the underlying drivers of health care cost and health care access need to be understood. The information previously referred to having to do with what works, what kind of a health care process works with a certain type of problem, what outcome should we be striving for, strong emphasis needs to be placed on continuing to encourage the research that will generate the information around which and upon which decisions will be made.

Senator Riegle. I have studied this now at great length and have talked with a vast number of professionals like yourselves. Also, my family and I have been a great user of medical services. In fact, I think everybody in my immediate family has had their life saved at one time or another by the great skill and devotion of somebody in the field of health and medicine. We are very grateful for that.

It seems to me we have to get the key players sitting down around the table together. One of the problems here is a disconnected system. While everybody is trying to get their part done, it is like the thigh bone is not connected to the knee bone and the knee bone is not connected to the next bone and so forth, you know, you can end up with something that does not work very well.

It seems to me that in this country we ought to be able to gather the right parties of interest around a table and thrash these things out and come to rational judgments. Sometimes you settle in the middle on some of these things. Somebody says, well, "let's do it this way" and somebody else says "no, I want to do it this way." And you talk and pretty soon you find a way.

One person says to the other, "you know, I think we can do it that way" and the other says, "let's try it." Then we go down that road and then we have something that looks like it is going to work better.

I think we have to quit talking about the problem and get it into an organized solution frame work. I think the President, quite frankly, has to decide this is one he wants to tackle. I think right now, you know, there is a predisposition toward foreign policy and I do not know what is on the short list of domestic policy issues. I noticed the President stopped through a classroom the other day. So education problem is obviously a bell ringer at the moment.

It seems to me that the health care issue is affecting just about everybody in our society now. It is certainly affecting everybody that has health insurance because the rates are going up and their coverage in many cases is being diminished. You have all the folks that do not have any coverage. You have everybody that is in the provider community that is struggling with the problem and having difficulties with it. And we want a healthy nation. You know, we want a healthy nation, we want to get this done efficiently and well in some major degree of fairness and equity in our society.

I think this issue is about as important an issue for the country to solve internally as any issue I see right now. When I go to Michigan everywhere I go people talk about it—small business, big business, people who have insurance, families, uninsured people, hospitals, doctors, HMO's, the insurance companies. Everybody says, that it is time to fix this problem and I think we can.

What you all have said today give us some very constructive suggestions and ideas that we will want to pursue with you. So I thank you very much for your testimony today. It has been a very good day of hearings. The committee stands in recess.

[Whereupon, the hearing recessed at 4:40 p.m.]

COMPREHENSIVE REFORM OF THE HEALTH CARE SYSTEM

MONDAY, SEPTEMBER 30, 1991

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

The hearing was convened, pursuant to recess, 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: Senator Durenberger.

OPENING STATEMENT OF 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. Other colleagues are coming back into town on Monday morning. I have spoken with Senator Durenberger who was here and will be shortly coming down to the hearing. I particularly want him to hear our first witness this morning. We just spoke by phone and he will be here momentarily.

I want to then indicate to you who we will be having this morning as our witnesses. We will be hearing first from Luann Eichler Nunnally, who is here from Wyandotte, MI. She is here on behalf of the Digestive Diseases National Coalition and is going to talk about the terrible travails that her sister, Cheryl, had to deal with. That is a very special and poignant story. It is one that we'll get into a little bit more when she comes to the witness table. I am delighted that she is here with her husband and three children today.

After we have heard from Luann Eichler Nunnally we will go to a panel consisting of William Hoffman, Ph.D., who is the director of the Social Security Department of the United Auto Workers and who will be testifying on our comprehensive health insurance legislation.

Then we will be hearing from Karen Kgnagni, who is the director of employee benefits over at the AFL-CIO. So we are very pleased that she will be testifying as well.

Then we will have a panel that consists of Jose Camacho, who is the executive director of the Texas Association of Community Health Centers based in Austin, TX and will be here on behalf of the National Association of Community Health Centers. Then Sara

Rosenbaum, who is the director of the Health Division of the Children's Defense Fund located here in Washington, DC.

Then finally we will hear from Mary Nell Lehnhard, who is the vice president for government relations of Blue Cross and Blue Shield based in Washington, DC, finally, Carl Schramm, who is president of the Health Insurance Association of America.

So we have a good breadth of witnesses today to bring us their testimony.

Let me now make my own opening statement. I think by that time we will probably have Senator Durenberger joining us.

This is the second of a series of hearings on health care reform legislation. We have been taking testimony on Health America which is the democratic leadership bill that I introduced along with Senators Mitchell, Rockefeller, and Kennedy, as well as other proposals that have been put forward to reform our health care system.

Last week Senator Simon of Illinois testified about his bill, S. 1669, that proposes amendments to Health America in several areas. I want to say again that I welcome such proposals and I encourage members to continue doing this. My Republican colleagues are also developing a comprehensive proposal and I look forward to working with them when that proposal is put forward.

Last week we heard from government officials, businesses and providers. Today we will be hearing from representatives of labor, health care advocates and insurers. We will also hear first hand how devastating the lack of insurance can be for people. Luann Eichler Nunnally has come here from Michigan today to testify about her sister, Cheryl, and the tragedy that occurred because she did not have health insurance.

It is increasingly clear that the problems of our current health care system affect all of us; both those with insurance, and the growing number of people without health insurance coverage. If we don't do something soon to solve this problem and correct our current system, many more people will suffer from suffering that can be avoided.

We learned last week that 1.3 million additional people lost their health insurance coverage between 1989 and 1990, bringing the total number of uninsured people to an official number of 34,600,000. The loss of coverage was due to reductions in private group coverage, which is mainly related to loss of, or changes in, employment.

In addition, almost 30 percent of Americans said they or a family member lacked health insurance at least part of the time during the last year. At the same time, the United States spends the most per capita on health care when compared to other countries; over $2,000 per year per person.

In fact, health care costs in America as a percentage of our gross national product are now approaching 12 percent. There is just no other nation that is even close in that respect.

Now the health care crisis is part of a larger problem facing America's middle class where our people have less and less economic power to meet their basic needs. Those who do have health insurance are finding their rates rising sharply and their coverage being reduced by rising deductibles, copayments and fewer benefits.

It was also recently reported that 3 in 10 Americans say they or someone in their household have, at some time, stayed in a job that they wanted to leave, in order to keep their health benefits. There was a major feature story on the front of the New York Times last week on that very point.

If one thinks about the need for workers to move throughout the labor force to find the best opportunities and be in a position where they can produce the most for the country and for themselves, to be locked into a given job situation because of the requirement of maintaining continuity and health insurance starts to create a different kind of second level economic affect and damage that clearly no economy wants for itself.

I talked with someone just the other day who has recovered from cancer treatment. He indicated that because of his situation and the need to remain insurable, he cannot think about changing job situations because doing so would involve disconnecting from his present employment insurance plan. He knows that what is now called a preexisting condition, he would not be eligible for health insurance in a new job.

So the fact that he runs that risk means he cannot consider a job change. Clearly, that is not anything that is good for this country or our people. This phenomenon which has now been given a name called "Job Lock" is actually most prevalent in middle-income households, and as I say, is a new kind of second level affect that is growing in the country.

Also, more and more people are expressing their dissatisfaction with our current health care system. A recent poll shows that 90 percent of the American people say it is time to overhaul the health care system. Skyrocketing health insurance costs for those who have coverage and the growing group of Americans with no health insurance coverage are clearly signs that our health care system must be reformed and the time to do that is now.

Now, under Health America, the program that we have developed, S. 1227, we build on the existing private and public health care system. However, we significantly restructure the current system so more people are covered and rising costs are controlled. We ask employers to provide health care for their employees and dependents.

Most businesses do provide health care coverage for their workers or would like to, but health insurance coverage is currently unaffordable for many, particularly for small business.

So we create a new public health insurance program called AmeriCare for anyone who does not directly receive health insurance through an employer. Unlike Medicaid, which it would replace, AmeriCare is not a welfare or second class program. All people will be eligible for a basic package of benefits, including workers and their families. Also, providers who participate in the program would be appropriately reimbursed for their services.

We heard testimony last week that one of the most significant aspects of our proposal is the cost reduction program. Health America proposes a number of cost cutting measures that would reduce unnecessary care, decrease administrative costs, and would limit unrestrained price and volume increases of health care services.

These measures would save over $80 billion during the next 5 years in national health care spending. Lewin-ICF, the independent organization that did these estimates, testified last week and said that even when one includes increased utilization of health care services due to expanded coverage, the net savings is still estimated to be over $45 billion over the next 5 years. This means we would be able to pay for the expanded coverage just out of the savings that we can achieve through cost effective reforms and still have a very material cost savings over and beyond that. I'm convinced that the savings could be even higher if the Federal Board that we envision creating proves to be more effective.

Comprehensive health care reform is a top priority, certainly of myself and of the Democratic leadership in the Senate. I know that there are Republican colleagues, like Senator Durenberger, who feels very keenly on this issue and who has given great effort to it.

These and other hearings are serving an important purpose as we move toward developing a consensus on health care reform which I think we can do and I know we must do. So I want to continue the discussion with all interested parties in developing efficient, sensible and comprehensive health care reform legislation.

Every American has the right to have affordable, high-quality health care and it is time that we accomplish that goal.

Senator Durenberger, let me welcome you, and again acknowledge your leadership over many years in the health care area. We would appreciate any opening comments you have.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much and thank you for these hearings. I want to express my regret for not having been here last Monday. But I spent the whole day, in fact, 16 hours of it with Dr. Gail Wilensky, the Administrator of HCFA, in my State of Minnesota. It is an illustration not of my commitment, but of hers, I guess, that she would spend that much time dealing with some of the physician reimbursement issues that we have discussed here.

I know I missed a very good hearing and a lot of good testimony. I appreciate your doing it.

You talk about leadership in this field. I recall one of the things she said to a group out there when asked what is the biggest problem in health care. She said it is that nobody is in charge in America. There is nobody who takes responsibility, either for defining what the system is or for resolving problems as they come up. I think that is why these hearings have some substantial value.

I guess that is why Americans are so unhappy with the system. When it worked to everybody's advantage we were all happy with it. When it now works to the disadvantage of some, those who are disadvantaged and those who believe they will become disadvantaged by the system because of its cost, because of the access problems, are the ones who worry the most about why isn't somebody in charge or why doesn't somebody take some responsibility.

I believe, as I have said before, that what the the Chairman of this Subcommittee has done in trying to pull all the democratic

leadership together and putting them on the line has got high value.

This is not an issue that is going to be resolved just by politicians. It is going to have to be all of us. It is not going to be resolved when George Bush makes his first statement on the subject, which I am sure he will. That will not do it either. I mean it is not that automatic.

But it is great to be able to be here. I certainly look forward to our testimony today and particularly that of our first witness who is from your State and who probably will illustrate the real pain in our not being able to come to grips with the problem.

Senator RIEGLE. Thank you very much, Senator Durenberger.

Let me now invite our first witness to come on up to the witness table. I see you taking a deep breath. You are among friends, so come right on up. Robert, if you would like to come up with her, why don't you come and sit with her. We want to welcome your three children who are with you as well today. It is nice that they could be here as well.

Let me just take a minute now and introduce this witness because this is a very special witness who really expresses what this problem is all about.

Luann Eichler Nunnally had a wonderful sister named Cheryl whom she is going to talk about today. Cheryl was a witness before one of our field hearings in Michigan at an earlier time. At the time we had that hearing, we had scheduled it some weeks in advance. Cheryl, who was suffering from Crohn's disease, had had a real setback and was in the hospital on the day of the hearing.

Yet, she felt so strongly about the hearing and the need to explain what happens to people in this country with terrible health problems and who lack health insurance, that Cheryl Eichler checked herself out of the hospital and came to the hearing room and testified that day.

I want to just show you a picture of Cheryl because she was such a lovely and powerful witness. I have never heard better testimony ever than I heard from her that day.

Within 6 months, Cheryl had died from this disease. I am convinced that she would be alive today if she had gotten the health care that she needed at different times along the way as she was struggling with this terrible problem. Cheryl worked. She was very successful in terms of the rise she had made to become a manager in the 7-Eleven store chain. She was earning about $12,000 a year and had prospects for further success.

No health insurance was available through that job. Over the years in the testimony that she gave us she explained the problem that she faced time and time again. She went on to say in her testimony how at different points she delayed going for treatment because she didn't have any health insurance, she didn't have any money to pay the kinds of bills that she was incurring and she just was afraid to go. She also, of course, was frightened by just the sheer dimensions of the disease that she was struggling against.

She said at the end of her statement the day that she testified, she said, "Ahead of me lies the frightening task of finding another employer who will be sympathetic to my disease. Even if I am lucky enough to find something I will be unable to find a job that

will provide coverage for my treatment. Those of us with Crohns could never work enough or make enough to pay for the long-term care that is involved with this disease. There is also the constant worry and emotional stress, how am I going to pay for these bills. The treatment involved in battling this disease is extremely expensive. Someone like me who earns about $12,000 a year could never afford to pay for this. I think there is a definite need for help to the uninsured people in situations such as this."

I am going to put the rest of her statement in the record here and I may make another reference to it a little bit later because it was such a powerful statement.

So Luann, who has come today, is carrying forward this effort on behalf of her sister and on behalf of other people in this country with problems just like this.

We can do something about this. I mean this is America. It is a self-government in this country and we do not have to let these things happen. So, Luann, I am very pleased that you are here today. I want you to just take your time and we want to hear everything that you have to say to us.

[The prepared statement of Cheryl Eichler appears in the appendix.]

STATEMENT OF LUANN EICHLER NUNNALLY, WYANDOTTE, MI, ON BEHALF OF THE DIGESTIVE DISEASES NATIONAL COALITION, ACCOMPANIED BY ROBERT NUNNALLY

Ms. NUNNALLY. Thank you.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear before you to speak on the issue of the health care reform. My name is Luann Eichler Nunnally and I am here today on behalf of the Digestive Diseases National Coalition and my sister, Cheryl Eichler.

Cheryl died 2 years ago after a 13-year struggle with Crohn's disease. Senator Riegle, I know that you have heard my sister's story before, but I would like to tell it to the rest of the people here with hope that it will somehow help the hundreds of thousands of other Americans who like Cheryl are not able to get health insurance.

In 1976 at the age of 16 Cheryl was diagnosed as having Crohn's disease. Crohn's disease is a chronic disorder of the digestive track for which there is no known cause or cure. Symptoms include abdominal cramps, persistent diarrhea, blood in the stool, fever and loss of weight. Abdominal pain is a constant companion of a Crohn's disease victim.

Treatment also involves the use of medications to control the symptoms. However, surgery is often required when the medications are no longer effective or when complications arise.

It is estimated that about two-thirds of people with Crohn's disease will have to undergo one or more operations in their life time. The treatment involved in battling this disease is extremely expensive and it is life long.

Cheryl underwent her first surgery for Crohns in 1977 when doctors had to remove part of her colon. She was hospitalized for 3 months. Fortunately, our mother was receiving aid for family with

dependent children at that time and most of the cost of Cheryl's medical care was covered by Medicaid.

Cheryl's next flare up of Crohn's occurred in 1982. At the time Cheryl was employed by manpower services and was supporting herself. Her employer, however, offered no health insurance benefits. Although Cheryl was in severe pain from Crohn's she waited about 6 months before going for treatment. She waited to get treatment because she did not have any medical insurance and did not know how she would pay the cost of her medical care.

Eventually Cheryl had to have more of her colon removed and the doctors performed an ileostomy. An ileostomy is a procedure in which an opening is created in the abdomen to facilitate the removal of body waste. Medicaid covered the cost of this care, but this, unfortunately, provided only a temporary solution.

Once Cheryl was well enough to return to work she no longer qualified for Medicaid and was again without any type of medical insurance or assistance.

In September 1986 Cheryl was again faced with the predicament of needing medical treatment but lacking any insurance or means to pay for it. Further complications from her disease had developed and she was suffering from peri-rectal abscesses. Perirectal abscesses are extremely painful and produce a great deal of drainage. At the time Cheryl was working at 7-Eleven and making about $12,000 a year. 7-Eleven, however, did not offer any health insurance.

Cheryl put off getting treatment for her condition because she was scared, had no insurance, and did not know how she was going to pay for any more medical care. In March of 1988 she finally received treatment for the abscesses and set up a payment plan to cover the medical bills.

Cheryl's health continued to deteriorate and in 1989 she had to resign from her job because of health complications. Cheryl was admitted to the hospital because she was losing weight, very run down and in a great deal of pain. Cheryl's condition did improve and she was eventually released and on a home parenteral nutrition. At this point Cheryl had been accepted by Medicaid, and the program covered the cost of her care.

In October 1989 Cheryl developed a severe infection. She was readmitted back to the hospital and on October 10, 1989 she passed away.

Throughout Cheryl's illness she tried to get some type of medical coverage so that she would not have to worry about how she would pay for treatment each and every time she got sick. She contacted several insurance companies, but because of her poor health the premiums were extremely high and too much for her to afford on her limited salary, or she was refused coverage altogether.

She repeatedly tried to get medical assistance from the State but was always turned down, either because she made too much money, had a job, a car or did not meet the Medicaid program's definition as disabled. Every time Cheryl got sick and needed treatment, her immediate concern was, "How am I going to pay for these bills?"

What is truly unfortunate and the reason why I am here today is that my sister's story is not an uncommon one. It is played out repeatedly across this country. There are thousands of individuals

who suffer from chronic disorders, such as Crohn's disease, who require a lifetime of expensive, urgent medical care. The 22 organizations of the Digestive Disease National Coalition represent thousands of individuals who suffer from the various disorders which afflict the digestive tract.

Many of these conditions require long-term medical care and attention. These individuals, like others, have to live with the constant fear that they may not be able to afford the critical life-saving treatment for their condition. Some may be fortunate enough to have a job that provides medical insurance, but there is a continual concern that they may lose coverage if they switch jobs, or were laid off.

Others, like my sister, are employed but their employers did not offer any coverage. Attempts to obtain coverage result in repeated frustrations. They apply for medical coverage, but because of their pre-existing conditions, are unable to afford the high costs of premiums or they are denied it altogether. The current public program also fails these individuals. Because my sister continued to work throughout her illness she was not able to qualify for State medical assistance.

Senator Riegle, I want to thank you for your continuing efforts to address this issue on the health care reform. The goal of providing universal access to health care is critical and we all must work together to find a solution to this current situation.

I know the constant worry and emotion stress which Cheryl endured throughout her 13 years of her illness because she did not know how she was going to pay for her medical care. It is important that we prevent others from having to suffer as my sister did, continually concerned that they will get sick and be unable to pay for care, putting off medical treatment because they have no way to pay for it, developing further complications because they did not receive prompt treatment.

Thank you, again, for the opportunity to appear before you today.

Senator RIEGLE. Luann, thank you. I know how difficult it is to talk about these things. I was just showing Senator Durenberger a picture of your sister. I remember her so vividly when she came to the hearing to testify because she was quite thin at the time because she had lost a lot of weight. And she was in some pain, but she felt so strongly about what was happening and not wanting it to happen to other people.

I remember her stressing that and I remember how saint-like she seemed to me that day because of that concern for others.

I am convinced that she would be alive today if she had received the help that she needed. The fact that she is not alive is really, I think, a crime. It is certainly a crime against her as well as your family. I think it is a crime against our whole society, that we are losing people like this because they are not getting the care they need for terrible health problems and diseases that we know how to treat.

But people are not getting the care simply because they do not have the health insurance coverage or they do not have the money.

Now we had a hearing the other day in Michigan where we had another young woman with the very same problem, Kim Cameron

from Lapeer, MI, who came and testified about the terrible difficulties that she is facing. She is alive today, but we may well lose her because we are not responding yet as a nation to this problem for people with this disease or other diseases like it and other health problems like it.

I took Cheryl's testimony from the hearing when she spoke, two pages, which I think is so powerful. I had an occasion the other day, Senator Durenberger, to go down and meet with President Bush. I was invited down on another subject. And I took a copy of Cheryl's statement with me. I did so because I know President Bush has a son with Crohn's disease. So, I know this is a terrible problem that the First Family understands because they have had to cope with it within their own family circle.

I asked the President to read Cheryl's statement and he said he would. I also asked that he think about getting to work on a national health care plan, an insurance plan, that could respond to problems like this to make sure that everyone in the country that needs help gets it.

I am very much of the hope that the rising level of concern across the country of individuals, hearings such as this, will cause a decision to be made that says now is the time to do this. It does not get any easier with time. I mean the problem is not going to be any less complex in the future by putting it off. There are going to be an awful lot of people that are going to suffer tremendous pain and risk losing their lives if we do not get this done and get the help out there to people now when they need it.

I appreciate more than I know how to say the fact that you are willing to press ahead and tell Cheryl's story.

Ms. NUNNALLY. Thank you.

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

Senator RIEGLE. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, thank you. To your whole family, Ms. Nunnally, I express all of our appreciation.

This is certainly not a partisan issue, nor is it strictly a partisan concern. Some of us were fortunate enough to be on the Pepper Commission for over a year. There were 15 members on the Commission and 12 of them were politicians—6 were from the House and 6 from the Senate. I think I got those numbers right. The best part about it was our education, because we went all over the country and we were able to listen to people just like you.

I know, too, that some of the people in Minnesota that testified and people in other parts of the country are sort of giving their lives now and have given their lives in one way or another so the problem can be better understood, so that others will not have to go through this.

I suppose that is the good thing about being an American. There is always the hope that if you offer yourself and your sister's life and her experiences and so forth, that at some point in time it is going to have value, you know. And that the love that you have had and continue to have, obviously, even more for her can be transmitted to other people, and it can come back to you in seeing things be different, so that it isn't just an appearance here and

some television coverage. Although television is an important part about extending this message.

I mean Cheryl is now known or will be known by many more people than she was before, and that is her gift, and not just to you. Now it is her gift to all the rest of us.

So I thank you very much, and everybody in your family, for your willingness to continue this effort to make all of us, not only more aware by your personal experience of the problem, but giving us the courage to continue to find the ways that need to be found to solve the problem.

Ms. NUNNALLY. Thank you.

Senator RIEGLE. Luann, I just want to make another observation. That is that when we talk about these individual stories we talk about them in terms of what was the medical problem and how long did the person suffer with it and how many tens of thousands of dollars of bills were incurred and so forth. There is also tremendous pain involved, tremendous suffering.

Ms. NUNNALLY. Right.

Senator RIEGLE. I know from conversations that we have had and I remember in speaking with Cheryl, although she did not dwell on this the tremendous pain that she had to endure in trying to cope with this illness, working as she was at the time to provide for herself and we have people all across this country today who are in that circumstance—who are not well, who are struggling to try to make a living and provide for themselves and provide for their families, who should be going for medical care, are not going for it because they do not have insurance and they do not have the money that they need to pay for those services.

I think we have a responsibility to one another in this country to put a stop to that. We do not have to be that way. Every other modern country today has developed some manner of health insurance coverage so that people in those societies get the help they need.

The social contract back in those countries is such that those problems are being met. We are the last country of the major industrial countries to not develop a way to see to it that our people have that kind of an opportunity and that kind of way of meeting and solving these health problems.

It is also true for the children. There was a picture the other day of a young working mother in Michigan, a single parent, and she has some health problems and she has limited coverage through her work site. But there was a picture of her 6½-year-old son who has no health coverage, not a penny of health coverage for that little fellow in this society today.

We have 300,000 children in Michigan today without any health insurance coverage and millions more across the country. What happens when a 6-year-old gets a serious problem and has no health insurance? I have had witnesses say with great embarrassment and shame that they at time have delayed taking a member of their family to the doctor or the hospital because they did not have any insurance. they did not have any money, they did not know how they were going to pay for the services that they needed.

I am convinced that the health insurance that we now have at the Federal Government for all of the top officials of our govern-

ment—the Senate, House, executive branch officials, President, Vice-President, their families—if the health insurance that is now there for this group were to suddenly disappear today, I asked myself how long would it take before we would have a proposal up here to put it back in place? I think it would be a matter of hours.

I think within hours we would have a plan to restore that coverage for the officials of our government. I think it is time that we have a plan developed by our government for everyone in our country. I do not think it ought to be put off for months and months. I do not think it ought to be put off for years and years. I do not think it should be pushed past 1992 or pushed past 1994 or pushed out to the year 2000 or some other date. There are people that need the help now and we are smart enough to figure out an answer if we decide we want to do it.

This country has engineered a way to take people to the moon and back successfully. We have spent literally tens of billions, probably hundreds of billions of dollars doing that. It was a stupendous accomplishment. We can solve this problem as soon as we decide that it is important enough to do it.

If we decide that people matter and this is urgent we can do it in a hurry. The time to do it, I think, is now. So I want to thank you again for coming. Robert, you as well, for your steadfast support and your three children.

Why don't you just tell us the names of each of the three again so we can know them all.

Mr. NUNNALLY. The little guy is Robert Paul; daughter, Jennifer Marie; and the big boy is Randy Lee.

Senator RIEGLE. Well, thank you all, Robert and Jennifer and Randy, for coming today with your mom and dad. We are very appreciative. Thank you.

Ms. NUNNALLY. Thank you.

Senator RIEGLE. Let me now call our next witnesses to the table. Mr. Hoffman and Ms. Ignagni, which you have introduced before. We would like to have you come up and be seated, please.

Ms. Ignagni, we want to welcome you and say again that you are the Director of Employee Benefits at the AFL-CIO. Why don't you being?

STATEMENT OF KAREN IGNAGNI, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT, AFL-CIO, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman. I do think that the first thing I should say is there is very little I can add to the poignancy of the previous testimony. It does point out that there have been too many victims and you and this subcommittee have an important opportunity to put an end to that. We are delighted to be here today to participate in the beginning of that process.

We do want to commend you for your leadership. I also must apologize to you, I am afraid I am in need of a little health care myself this morning. So I will endeavor not to cough or sneeze throughout the testimony and infect my colleague.

In short, the AFL-CIO, Mr. Chairman, believes that the time is right for Congress to take advantage of the growing national consensus for health care reform. We hope that you will take the lead

in fashioning a program that will reduce inflation, expand access and improve the efficiency of the system.

Increasing, union members are concerned about maintaining the health care provisions of their collective bargaining agreements. This concern is warranted. A recent study by the AFL-CIO found that in 1990 health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care.

Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue. But this turmoil is not confined to organized labor. During the 1980's the health care crisis further exacerbated the economic decline of the middle class. In my testimony we have provided some evidence of the effect of increasing health care costs on the middle class.

If health care costs continue to rise at current levels, they will crowd out increases in wages and other fringe benefits for working Americans to maintain their homes, educate their children and achieve income security in retirement. A similar trend is occurring nationally. Ironically, however, despite this commitment of resources, and it is growing daily, beneficiaries of public programs continue to lose ground.

In short, Mr. Chairman, the point we would like to leave you with today on behalf of the AFL-CIO and all organized labor is that we are paying more for less. As a nation we cannot afford to continue down the current path. Rather than becoming mired in esoteric debates about competition versus regulation, we hope that this committee and the Congress will recognize that the most costly solution before you is to do nothing at all.

Last fall the AFL-CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payers. They estimated that just a 2-percent reduction in the projected rate of growth in health care inflation between now and the end of the decade will save a staggering $165 billion.

Again, the alternative is to continue down the current path with health care expenditures consuming valuable public and private resources necessary for other domestic challenges, such as infrastructure and education. Even those who seek to preserve the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

We say that a nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis we are spending 40 percent more than Canada, 90 percent more than Germany and as astounding 125 percent more than Japan.

In short, the current crisis demands immediate action and the labor movement is united in its pursuit of fundamental restructuring of the system. We have four essential goals which I will describe.

The first is to contain the growth in health care cost. To achieve this objective we urge Congress to establish a national commission to administer a single national cost containment program for all payers. The type of system we propose would establish a limit on the rate of growth of health care expenditures and involve negotia-

tions between health care providers and purchasers of care on payment rates and other necessary measures to achieve these targets.

Our second goal is to provide universal access. To achieve this objective we urge Congress to establish a core benefit package to which all Americans are entitled, notwithstanding employment history, health status or State of residence. In our view, all employers should be required to contribute fairly to the cost of care for their workers and their families.

For those not in the work force, Congress should put an end to the patchwork quilt of Federal and State health care programs and establish one program that would cover the unemployed and those currently receiving protection through State Medicaid programs.

Third, we hope that part of the reform strategy will be to reduce waste, red tape and paperwork. We believe that it is time to overhaul the existing administrative structure by establishing at the Federal level requirements for administrative intermediaries that would standardize claims forms, develop a uniform health care information system and simplify paperwork.

Recently there has been a growing interest in reforming insurance practices in the small group market. While we support such long overdue reforms, the AFL-CIO believes that reforms should be developed by Congress, not the States, to assure uniformity across the country.

Our fourth objective is to solve the retiree crisis. The issue of retiree health care has become one of the most difficult at the bargaining table. We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age, which is 60 at present.

In short, and in conclusion, Mr. Chairman, our proposals are based on the experiences of millions of working men and women for whom the current health care system has become a nightmare. There is real suffering going on out there as you have heard this morning and nothing short of full scale reform will solve our problems.

We have reached the stage where quick fixes are no longer possible and where voluntary efforts no longer offer promise. For its part the AFL-CIO is prepared to consider each and every proposal that purports to address the issues that we have outlined. We are prepared to work with you and your staff to ensure that the U.S. measures up to its reputation as the best health care system in the world. In our view, the problem demands it, the people deserve it, and our ability to become competitive in the 21st Century depends on it.

Thank you, Mr. Chairman.

Senator RIEGLE. Thank you very much.

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

Senator RIEGLE. Dr. Hoffman, with the United Auto Workers, as I have said before, we want to hear from you now.

STATEMENT OF WILLIAM S. HOFFMAN, PH.D., DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), WASHINGTON, DC

Dr. HOFFMAN. Mr. Chairman, thank you. I want to thank you, Senator, for the opportunity to testify on behalf of the 1.5 million active and retired members of the international union and their families.

We are all aware the American health care system continues to be in a state of crisis. The problems are so enormous and out of control that nothing short of total reform and overhaul will remotely address the problems. You have heard before all of the specifics of that and I will not go into them in my testimony.

The skyrocketing health care costs, along with the inequitable system of financing adversely affects the international competitiveness of many businesses and threatens the job security of millions of Americans. In Canada, for example, employer health care costs are approximately one-half of those in the United States; in Japan about a third.

Escalating health care costs also unfairly affect the competitiveness of older, longer established companies compared to newer employers within this country. There are two major reasons for this. First, older companies tend to have a higher ratio of retired workers than to active workers than newer competitors. In addition the average age of older employers tends to have an older work force as compared to newer companies.

But I must tell you that in traveling 40 States and in negotiating contracts with large, small employers, with government as employers and with private enterprises the problems are across the board. They are only heightened for those that are a competitive disadvantage.

The UAW believes strongly that employers should not have to compete on the basis of their health care costs. Mr. Chairman, we commend you and Senators Mitchell, Kennedy and Rockefeller for accepting the challenge to deal with the need for reform. The introduction of your legislation is encouraging because it addresses the problem of lack of access to health insurance and health care services in the United States for working people, the unemployed and the poor.

We want to emphasize, however, that it will not solve the overall dilemma. We feel strongly that progressive financing must be a central element to any reform of the system. We also believe that legislation introduced by Senator Simon provides needed improvements. Mandatory expenditure limits would be established. Payment rates for hospitals, doctors and other providers would be negotiated, and importantly capital expenditures would also be controlled through the budgeting process.

It would address problems associated with employer-provided retiree health care by lowering the age of eligibility to age 60 and it would phase in universal coverage to access the coverage more quickly. We believe that effective reform can only be achieved through the enactment of a single payor comprehensive national health care program.

We have supported and continue to support the Universal Health Care Act introduced by Representative Marty Russo. More recently Senator Kerry has introduced proposed Health USA Act, another single payor proposal which merits serious consideration.

We believe such an approach would achieve systemic reform. First, by assuring universal access to health care for all Americans this approach would serve to improve the health status of the American people. Second, by establishing a uniform all payor system for reimbursing health care providers this approach would eliminate cost shifting between public and private payers, between employers, as well as the shifting of costs attributable to uncompensated care.

Third, this approach would achieve substantial administrative savings. Further, by establishing a mandatory enforceable budgeting process for services and capital this type of approach would guarantee that financial discipline would be a centerpiece of the system. Fifth, this approach can make significant strides towards improving the quality of care in this country.

I want to emphasize that any national health care reform proposal must embody a progressive financing mechanism. We would have great difficulty with any legislation which would require the majority of workers and retirees who already have health insurance coverage to shoulder a larger tax burden without receiving any additional benefits.

Obviously, a single payer national health program would represent a dramatic change from our current employer-based health care system. The UAW believes that such a change is necessary.

I want to thank you, Senator, for both your leadership and this opportunity to present testimony before your committee.

Senator RIEGLE. Thank you as well.

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

Senator RIEGLE. Let me just say some people have argued that a Federal board that regulates rates cannot work at a national level. Now certainly labor has a rather extensive experience on this kind of an issue. What kind of mechanisms would either of you think need to be in place for this kind of a process to work effectively and doesn't there need to be a process for adjusting rates and other payment methodologies to reflect State needs?

Dr. HOFFMAN. Sure. I think that the way we would envision it is that once mandatory targets are set that the process would include taking existing delivery mechanisms that are in place and working through the rate setting arrangement so that various different dimensions could be built in. Health care is delivered differently in different parts of the country and we would have to adjust by geographic regions.

One of the reasons we think that a Federal/State partnership is very important in establishing this single payer system is that the States and within the States can determine the mechanisms that are best for health delivery and reimbursement. So I would answer yes, we would have to make adjustments for the varying arrangements, the way health care is delivered and the custom in the country.

Ms. IGNAGNI. Mr. Chairman, I would like to follow-up. I agree with everything my colleague has said. While he was speaking I was remembering the comment Senator Durenberger made in his introductory remarks about the physician payment reform issue.

I do think that we can take some important lessons from that experience. That is, that the model of a commission with negotiation between purchasers and providers is the model that we are talking about this morning. It is a very different model than a administration or a Congress arbitrarily setting limits, depending upon a series of other agenda items which we do not have to go into but which are apparent given the current needs before us on the domestic situation.

But it is clear that one of the most effective ways to proceed is good old fashioned negotiation between the purchasers and providers with government part of that system, but not dominating those decisions.

Senator RIEGLE. Now let me ask you this, as long as Federal standards are established for the public program that includes universal eligibility, a defined core benefit package and standard payment rates to providers, would you agree that it makes sense for the States to administer the public program that we would develop under the heading of AmeriCare, given that States are different and have different needs? What would be your view on that?

Dr. HOFFMAN. Absolutely. We think again that there are variations that we know exist that make it imperative that the States have direct oversight of the administration of the delivery of health care.

I would strongly encourage that.

Senator RIEGLE. Would you agree?

Ms. IGNAGNI. Well there is administration and there is administration. And clearly, the way you framed the question the answer is yes, in our view. However, we would go beyond that to say that we would like to see a level of specificity with respect to the guidelines and the rules and the regulations that really do determine and guarantee every citizen in the United States that there will be some uniformity across States.

One of the things that I think my colleague was alluding to, that we need to see more of in public and private programs, is the introduction of managed care, HMO's, PPO's, and clearly you are most able to do that closer to where the beneficiaries actually live.

But I want to say again, Senator, that we are comfortable with that provided that the guidelines are uniform and are spelled out to guarantee that all citizens are going to be treated equally and appropriately.

Senator RIEGLE. Now let me just say this, Senator Durenberger made an important point in his opening statement, and that is, we worked for literally 2 years on a bipartisan basis, a large working group, to come up with a general set of principals that would provide a framework for a national health insurance program or system.

We got quite far down that track and then it became impossible to reconcile some of the outstanding issues. At that point, the issue broke apart and the Democrats went ahead because we felt we must put a proposal on the table.

Working with the two parties together or either party separately it is not an easy matter. There are enough different points to try to reconcile. This document is a compromise and there are tradeoffs in it. There are parts in it that I would like to change and parts in it that others would like to change and I am open to change.

I am convinced that if Dave Durenberger and I were locked in a room together we could come up with a health care plan that would bridge these differences and I think it would probably be a pretty good plan. It might take us a little while but we would get it done.

The more people that participate the harder the job gets because there are obviously real differences of opinion and differences in vantage point and what have you.

I appreciate what you all have said today. I mean you have a unique perspective and you have given us some reactions and suggestions here and I understand that. I guess I would say in response that I am prepared to move in a fashion where we give and take on the margins to try to get something done. What I do not want to see us do is get stuck because we have irreconcilable polar positions that stymie any break through and creates so much inertia that everybody finally throws up their hands and says "well we cannot do it. It is so tough, let's walk away from it."

I reject that 100 percent. I think this is an issue whose time has come and we can solve. Now let me just ask specifically, Mr. Hoffman, when Senator Simon was in here before he offered an amendment to the package that we have developed. If something like the Simon amendment were adopted and we could also develop a fair financing mechanism, do you think that our program would both improve access and control costs?

Dr. HOFFMAN. First of all, I did want to hear and you did say the financing mechanism would be made fair and that is very important. I think it does go a long way. I think it should be applauded. I think we ought to seriously, however, continue to consider the potential for spiraling down of a pay or play that allows for more shifting.

You think in terms of what is the gaming of the system if I were an employer, if I were a group, that was in or out and what happens 3 to 5 years later down the road of that kind of behavior and you come back to this notion of single payer arrangement.

You could accomplish a great deal at the same time. So we still have that concern. You can accomplish, I believe, all of the competitive advantages for health care through a single payer system and not have the disadvantages of a play or pay. So I would add that to my concern at that point.

Clearly, Senator, it does, however, make significant improvements on where we are at right now.

Senator RIEGLE. Well, let me share just one other thought that I have on it. That is that it is the job of this subcommittee to put together a package that can move ahead, hopefully with the President, because I think he ought to be on board and we ought to be working side by side to get this done. But we have to get it done no matter who is in or who is out because the problem will not wait any longer.

So what I am going to do as the Chairman of this Subcommittee as we try to reconcile legitimate and different points of view, is apply what I might call a Cheryl Eichler test. That is, is it taking us so long to get something done that people who need it are dying in the meantime. I am going to ask everybody in the end to move off of their positions to some extent in order to let us get something in place that is going to work a whole lot better than what we have now.

Because people are out there suffering, they are dying. I know you know that well because your union particularly has been in the forefront of fighting for health care coverage for your workers and for their families. Beyond that, not just for the people that you represent, but more broadly in terms of everyone outside the scope of your organization. So you bring as strong a record in that record as any organization, both of you do.

So that is well understood by and appreciated by me. I think now we have to get into the collective bargaining process in terms of the give and take that actually produces legislation. Because if it does not meet what I just called the Cheryl Eichler test of getting it done and getting it in place in time to help people, then all of the perfect notions on paper that I might have or that you might have or that somebody else might have really does not mean very much.

So what I am going to ask, and I am going to ask my colleagues up and down this committee and in the full committee and in the Congress as a whole and the President and his people and all the outside parties at interest, let's now do the cutting and fitting and the adjusting on the margins. I think this is a good place to start. If somebody can put something better on the table as a starting point I am open to that as well.

I want to go ahead and get something done here before more time and before more lives are lost. So I guess I would ask you to take the message back to your respective organizations that we have to make a major push to get a break through here. Give and take is part of the process and I am going to be very interested in your views and all the other parties at interest. We want to be fair with it as we go, but we want to get it done.

Ms. IGNAGNI. Mr. Chairman, I would like to just add a corollary to this discussion because you have posed a strategic dilemma. You noted no doubt that our testimony was slightly different. I speak for the AFL-CIO with Dr. Hoffman representing the UAW, an affiliate of the AFL-CIO.

I want to make it very clear that a number of our affiliates have thought long and deeply and for some very good reasons put forth the strategic argument that we ought to shoot for the single payer now because indeed it is the most efficient choice before us.

But there is no strategic disagreement within the federation. We all recognize precisely what you have said. There is fear out there. This has become a problem at the bargaining table. It is one of economics. And we need to begin to solve it and take the steps necessary to get us on their road to some of the ultimate solutions. So we do not have any disagreement with you. But we do join with our colleagues in the UAW in putting forth the case for the most efficient issues which you hopefully will take into consideration.

Senator RIEGLE. Thank you very much.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman; and thank you both for your testimony.

There are many values that unions have taught our society. I think the most important one is that religious leaders can talk about the value of labor in our society, but only unions have actually demonstrated it. Now I think religious leaders sort of affirm it, but at least they have an example they can deal with. Work and labor is in most societies at least as valuable as capital and in some, hopefully, more valuable. I think we are beginning to learn that in our society as well.

The second thing in the United States as a contribution of unions is that labor comes in the larger context of family and community. I do not think we would be debating health insurance reform today, because we would not have had very much health insurance to talk about, if unions had not bargained to protect families at the same time they were protecting workers.

The third thing that comes to mind of special value about unions is they taught us how to deal with our problems. When you are faced with two conflicting choices, how do you make it come out so that everybody is at least satisfied that they have not given up more than they have gained.

It strikes me that somewhere in this whole process of defining the problems and coming to a solution, we have to learn those three things. First, we have to learn about the value of persons. Then, we have to learn about how persons work and benefit others, and how to give up something in order to get something.

It strikes me, as long as I have sat up here, that the most frustrating part about the last 6 or 7 years is that we cannot get credit for investments. If we would like to invest in preventive health care, nobody gives us credit for the money that is saved 10 years from now or 20 years from now.

So it becomes difficult for people to make choices. I must say, among my memories, one I will never forget is when one of our large union companies—it happens to be an iron ore company—went bankrupt up in Silver Bay, MN. It was the only business in town and every worker was represented in the union hall the night that I went up there to try to just listen. It was jammed—600 to 700 people, something like that. I am sure its normal capacity was 300 to 400.

But one of the things I came away with that was most disappointing was that when the retirees were in trouble the actives were not willing to give up anything for them. You know, that was a few years ago. I would like to believe that would not be the case today. In other words, when you went to the active employees and said would you be willing, in this your part of the company, to give up a little something—they had then first dollar coverage, they probably still have for all I know, this is the Steelworkers—in order that we can have a little money to spend over here on maintaining some level of health for the retirees, they were not willing to do it.

Since that experience I have seen a lot of active employees making those concessions and saying, look if we did not do it, you know, they would not be able to have.

So I give you that not to be critical. I give it to you because I think people in the union movement have changed a lot in just the last few years, that people have been willing. I think Lane Kirkland sat here and said that he bought into this sort of plan, whatever it was, sort of reluctantly, as I recall it. It was not necessarily his way of solving the problem. But everybody seems to have given something in order to come to what is being portrayed as a position on behalf of organized labor.

Is that kind of a fair statement, that the workers have been giving up over the last few years something and that union leadership itself has been, you know, not insisting on a perfect solution to the problem?

Dr. HOFFMAN. You know, it is the study of looking at an elephant and describing it. What I see is a fairly consistent high principled kind of solidarity that has occurred in all the bargaining that I have been involved in and those that I know my colleagues have done. Bargaining, as you well know, is a very difficult situation.

When you are talking about paying substantially more for health care every 3 years and that is not for anything new, that is just for keeping what you had before, and the question is whether or not you can continue to operate a business at all versus giving up some hard won benefits, be it health care or something else. That is a very difficult situation.

I, frankly, have been amazingly impressed with the solidarity of committees and their retirees over the long haul. Sure you can find examples where scarcity and problems and when diversity hits people get into some difficult conflicts. Instead of looking at that in terms of intergenerational equity I look at it in terms of solidarity.

Most of the time, a vast majority of the time, we are all dealing with dividing up scarce resources more and more in this country rather than expanding resources. I think that the kind of situation that you are describing is more uncommon than common. But the point of what you are saying, I think, is very important.

I think everyone, any knowledgeable, looking at this problem and a reasonable fashioned person would say that, look, if we do not act now we are going to be in more and more trouble later. The very reason that we are arguing for the right way to fix this now is, Senator, we do not want to have testimony like the previous one to our panel any longer. We do not want to have to come back in 5 years because we fixed it inappropriately. We do not want to have problems where retirees and active workers are at each others throats because there are problems of scarcity in this country because we are not dealing with our international competitiveness problem of which health care is one issue.

So I agree with you a thousand percent that we ought to get about this business.

Ms. IGNAGNI. Senator, you are talking about a sea change and I think one of the most interesting evidence of that is what has been going on at bargaining tables, but then moving from bargaining table to public policy advocacy. That is, unions and management

teaming up to share with you the common theme that the current system is not working anymore. It is the least efficient choice and course before us; we simply have to have change if you want the United States to be competitive in the 21st century.

This is happening not only in the auto industry, which is frequently described. It has gone far beyond there. It is happening in steel, in paper, in retail, in food and in fact in State and local government with their employees. We think it is going to grow beyond what we have seen thus far.

So this is a point of one of economics and dollars and cents that we simply need to see relief now which is why we offer the testimony we do with respect to small market reform proposals.

Senator DURENBERGER. What I am trying to get at, I mean you have real life experience. One of the things that you have, that the previous witness did not have, is insurance. Those steelworkers up on the iron range in Minnesota, their jobs were threatened but they were not going to give up a nickel's worth of free health insurance.

I am sure that since then they have made some adjustment. So at least they have had real life experience in adjusting one need against the other. Cherly never had a chance. I mean, she did not have insurance to begin with. So her tradeoffs were health or no health.

What I am curious about is maybe what you have learned in the process of doing these tradeoffs as to what is the most practical series of changes that need to take place in the way health care is defined, paid for, and delivered in this country. What I hear is, you have made the leap to a solution. You have leaped all the way to Canada.

The best I can say for what the Republicans contributed to the democratic leadership plan is we stopped them at Massachusetts on their way to Canada. But they went right to a solution rather than a series of solutions. As we debate—I do not want to drag this out too long because there are other equally important witnesses here—one of the realities is going to be, can we go all the way to a solution or are we going to be faced with a series of solutions.

There is no doubt in my mind but what you are going to have to take is a series of solutions. Now Don can disagree with that and that is why we would spend a lot of time in a room. But if, in fact, we had to go to the series of solutions, in either of your testimony is there an indication of where we ought to start and what that process would be?

Ms. IGNAGNI. Yes, Senator. I think both of us would strongly agree. Again, I want to make it clear that the labor movement is united in the view that we have to take steps now. We are also united in what we see as the problems in the system. The two initial steps that we offer is to take the step to do something about rising health care inflation and to provide access, but we have to bring costs under control.

We cannot simply do that in a public program, in a Federal employees health care program or in a Medicaid program. We have to establish a uniform system that protects beneficiaries and purchasers against cost shifting.

When you face at the bargaining table, and our colleagues in the management community would come forth with similar testimony, average annual increases of anywhere from 15 to 25 percent per year simply to maintain what we have—things have to change. I do not know of many so-called first dollar health care plans, but for the plans that Senator Riegle spoke about earlier with respect to the executive branch and the legislative branch in Congress. We do not have much first dollar coverage anymore.

Senator DURENBERGER. We contribute a heck of a lot more. I am sure we contribute about 75 percent of the cost of our plan.

Ms. IGNAGNI. You would be surprised what people are contributing as well.

Senator DURENBERGER. By first dollar, I mean the first time you decide you think you are sick you can go to any doctor, any hospital in America and somebody else pays the bill. That is a first dollar plan. We do not have that.

Ms. IGNAGNI. We do not have any union member that thinks that, Sir. In fact, we have fought long and hard to deal with the cold reality of the rising costs over the last few years. You know it well from testimony of your constituents. So that is the first problem.

The second problem is that we have to do something with respect to the rules of the game out there for businesses. We have to decide in this country whether or not there should be some standards of equity and fairness with respect to what businesses are required to provide to their employees to do business in the United States.

There is simply too compelling an argument or an incentive now to try to avoid providing health care coverage to employees. I can give you chapter and verse about how businesses that do not provide health care protection are winning daily in competitive bidding situations against those businesses that do provide coverage because they have higher labor costs as a result of providing health and doing what they think is the right thing to do, and providing their fair share.

Dr. Hoffman talked about how that problem extends out with retiree coverage and we could go on and on, older workers, workers with chronic disease and employers that have had to bear that burden themselves.

We need to get to a situation where we can pool that cost, where we can poll that experience across a larger population group. That is what we are talking about. And the final thing is the whole administrative structure of the system. We think there are very definitely a series of steps one could say and to take and pose to get to a more efficient system, whether or not you go to a Canadian type or West German model or an Austrian model or any other country that might be before you. The point is that we have to get on the road soon.

Senator DURENBERGER. Thank you.

Dr. HOFFMAN. Well, just two quick comments. One, we have tried pretty much anything you can think of in terms of in the private sector. If you look at the cost trend lines in programs that would be designed your way and that are represented by UAW contracts, and we have those kind of contracts, and the ones which perhaps

could be considered more comprehensive, we see the same health care cost trends in both.

So it is clearly not a private sector initiative that can solve this problem. We cannot say, continue the competition, that is so-called competition. The end result is not going to get you where you want to be.

Secondly, I would like to tell you that I have had about 12 years of bargaining in Canada as well as in the United States. If you want to be a pragmatist you ought to try to understand that experience. The same companies, two different sides of the border and making often times the same product.

If you want to talk about taking good thinking, well-conceived ideas, that can get attention at the bargaining table in Canada that have very limited time for attention in this country because we are all tied up with the health care costs, I offer that as a pragmatic description for competitiveness concerns.

Senator DURENBERGER. I would just leave you with one thought. That is, we must continue this debate for my benefit, but not here.

If you think Canada is efficient then we really have to sit down and talk. I think Minnesota is efficient. Minnesota in every other respect is a very high cost State for anybody to live in or do business in, except medical services. The Twin Cities Metropolitan Area ranks 40th out of 40 metropolitan areas in America in terms of the charges by its doctors and the hospitals.

That is because the market can be made to work. All these philosophers around here may not agree with it. But it is working. It could be made to work a heck of a lot better if we did a lot of things to make it work.

I would look forward to talking more with you about your experiences in Canada if that is your definition of efficiency.

Dr. HOFFMAN. I would welcome the discussion.

Senator DURENBERGER. Yes, thank you. I promise you I will.

Senator RIEGLE. Okay. Thank you very much for your testimony. We appreciate it.

Let us now call our next panel to the table. Mr. Jose Camacho, who is here on behalf of the Texas Association of Community Health Centers and the National Association; and Sara Rosenbaum, who is here as the director of the Health Division of Children's Defense Fund, Washington, DC.

Dr. Rosenbaum, I know you have to go over and testify on the House side before the Waxman subcommittee today on the issue of Medicaid voluntary contributions and taxes. I appreciate the pressure on your time, so we will have you proceed first.

STATEMENT OF SARA ROSENBAUM, DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Ms. ROSENBAUM. Thank you very much, Mr. Senator. Before I begin I want to also submit for the record a statement on behalf of S. 1227 by the Children's Defense Fund and I will leave that with your staff.

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

Ms. ROSENBAUM. Thank you.

[The statement appears in the appendix.]

Ms. ROSENBAUM. I would like to make three points this morning. First, there is no single group of Americans who will be more affected by what you do over the next year or so than children.

Last week census figures show that, along with the rising number of uninsured persons, there has been an astonishing increase in the number of poor children. We now have almost as many poor children in this country as we did in 1965 before the major Great Society programs were put into place.

With every child who fell into poverty, probably about two-thirds of a child also lost health insurance if you look at the relationship between the poverty climb and the uninsured numbers. Children today are so deeply impoverished, and between 9 and 11 million are completely uninsured. Only about two-thirds of all children in the United States have employer-based covered which we, of course, think of as the norm. It is not the norm for children. And of the children who have employer-based coverage, only about half of those have coverage live in families whose employers pay the full cost of the coverage. This means that with any more erosion on the employer-based side, the number of children without private coverage will again leap as families who are not getting wage increases are unable to continue the cost of dependent coverage.

At the same time that the number of poor children has grown and the number of children without private insurance has grown, we have seen a tremendous increase in the number of children on Medicaid. A lot of that increase is due to the very fine work of this committee and the House Energy and Commerce Committee.

Without those changes these children would have nothing. Although Medicaid is fraught with problems as this morning's hearing on the House side underscores the achievements of the past several years of reform should not be lost on anybody.

Second, the Medicaid expansions have taught us a number of lessons about constructing a national health insurance program I want to talk a little bit about those lessons, and their implications for the public side of any NHI program.

It is not enough that a national health insurance plan guarantees coverage for everybody, although that is one of S. 1227's great strengths. The biggest issue that S. 1227 will face as a national health insurance plan is whether people enrolled in the public side of the program have benefits as good as those enrolled in the private side of the program.

Our concern is that the public side of the program, which will continue to ensure disproportionately young, disproportionately minority, and disproportionately low income children be every bit as good and every bit as accepted private employer based coverage.

Third, we make two key recommendations to strengthen S. 1227. First, to the extent that States continue to finance public insurance coverage for persons under the age of 65, the financing mechanism should be a centrally administered one that States pay into according to a methodology very different from the one used for Medicaid today.

The hearing that you alluded to on the House side concerns nothing less than a catastrophe. It points to the abject problems this country faces when a commodity as expensive as health insurance is heavily State-financed. States very often are either incapa-

ble or unwilling to spend at the level needed to maintain public insurance.

It is not enough that the program have uniform benefits and uniform eligibility criteria. It is very important that the program be perceived as truly a public companion to truly a national health insuring model.

Second, I want to touch on a particularly strong aspect of S. 1227. That is resource development. It is extremely important, especially for the children who have public insurance and who will continue to live in areas that are designated as areas medically underserved by the Federal Government or have severe shortages of health professions, that there be a resource development component, which is viewed as an integral part of the public insuring mechanism for the entire program.

However, not only the public insurance plan carries the financial weight for the resource development program. The cost of that program should be spread across both public and private payers.

One of the great strengths of S. 1227 is that it has recognized the need to combine resource allocation and health provider supply with insurance reforms, and we hope with some slight modifications in the public plan that it will go forward quickly.

Thank you.

Senator RIEGLE. Very good. Senator Durenberger has a question. I am going to pose a question and then we are going to excuse you for the other hearing and go to Mr. Camacho.

Ms. ROSENBAUM. Thank you.

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

Senator DURENBERGER. First, Sara, thank you for all you have done for me, just as one member of this committee, in both understanding and contributing to the solutions, the health care solutions for kids, particularly all the Medicaid work that we have done from both sides of this table.

Ms. ROSENBAUM. Thank you. Thank you for everything you have done.

Senator DURENBERGER. I think I have just one basic question. Maybe you can help me answer this. I am puzzled as to why we need to insure for preventive care needs. I am puzzled by why the Children's Defense Fund and other many organizations on behalf of our young, you know, who look at a society that has done 15 times as much for its over 65 as it does for its kids—I mean nobody in the world has that disparity—would want to put the help for the kids in these insurance plans. Why? You know, they all cost too much. We all want to reform them. Why do you want to put this stuff in there?

Ms. ROSENBAUM. I think that is an extremely fair question, Senator; and I do not think there is an easy answer to it. Actually, if I had to state my personal views, I would in a minute pull routinely recurring health care needs, particularly children's needs, out of a risk-based system. But third-party financing is no longer insurance as we once knew it.

Senator DURENBERGER. Right.

Ms. ROSENBAUM. It is simply medical underwriting. It is a medical subsidy. There are other ways to provide families with some

sort of financial subsidy to bring down the cost of primary and preventive health services.

Certainly if we had enough local health departments, enough community and migrant health centers, enough community hospital programs that simply made primary and preventive services accessible in all communities, and we financed those programs adequately, it would be a perfectly terrific way of taking care of the primary needs of children.

Unfortunately, the tendency is not to finance those programs adequately as we can see from the appropriations caps that now are imposed on programs such as community health centers. And the only way to keep getting money to these programs is in the form of third-party payments. I think it is very inefficient. I think the starkest example of this inefficiency is immunizations. I now pay $50 to get my daughter a measles shot. The same vaccine costs about $14 when bought in bulk by CDC and distributed.

Senator DURENBERGER. It is incredible.

Ms. ROSENBAUM. And yet we do not have a national purchasing and distribution system for vaccines in this country.

Barring a basic willingness to depart from third party reimbursement models for health care financing, we feel that we have no choice but to use that model for child health and for maternity care, even though both are probably inappropriate in a risk based system.

Senator DURENBERGER. A great answer. Thank you very much.

Senator RIEGLE. Let me just ask you one thing, Sara. That is, you recommended that State contributions be paid into a national program and be combined with other funding sources. In our bill we set up a new trust fund for AmeriCare. I am wondering if that is the kind of mechanism that you were generally referring to.

Ms. ROSENBAUM. Yes. I think that the mechanism that you have set up in S. 1227 is actually a good mechanism for pooling funding. I think the issue that probably bears closer scrutiny is the issue of how much of a burden each State bears and whether or not that burden can be lessened through the movement of other revenues from other financing sources to support the public side of the program.

I am concerned still that the burden is high, not necessarily in relation to all State's budget, but certainly high in relation to many States' current budgets. Most States are simply too small. They are too small as entities to withstand the buffeting covered by cyclical economic down turns like the ones we are in. We are in terrible pain in many States right now. They just cannot afford Medicaid. So I do not know how they can afford this.

Senator RIEGLE. I made a reference to this earlier today, but it is relevant before excusing you. This is a story that ran in the Detroit News newspaper on September 5, 1991. It is a story about the single parent, Cynthia Fyfe. She is 36 years old and here is her son, Anthony, who is 6. She lives in Westland, MI. She has some medical problems. She is working and she has partial insurance at her job. She is in arrears about $3,000 on medical bills that she cannot pay and it is a very distressing story.

The most powerful part of the story is that her health insurance, modest that it is that covers her at her work site, does not cover

her son. There is no coverage for her son. I mean this is just one of these little lost children out in America today.

Ms. ROSENBAUM. Right.

Senator RIEGLE. Just looking at his picture here. I wonder in his little mind if he may not—I am sure he understands the stress in the household on not having enough money to do the things. She says here they are living in a trailer park. She is paying $266 a month on the mobile home and $295 a month on lot rent. And if she were going to cover him it would cost her $200 a month to put him on the insurance policy and she just does not have the money.

So we have sort of decided as a society that this kid does not count. He is just off the radar screen, off the health care radar screen, because he does not matter enough; we are shrugging our shoulders.

I must say, the other day I was pleased to see the President talk about beginning to get rid of some of these nuclear warheads. We certainly have far more of that equipment than any kind of common sense would suggest. But, we spend nearly $1 billion a piece for a B-1 bomber and here is this kid and millions more like him out there without a penny of health insurance today and we just waltz right on down the road.

The one thing that I want to stress in this hearing is that what happens in this health care debate kind of ascends into a level of technical terms that is a language all of its own. You know, when it sort of elevates up to that level and there are all these code words used, then the people who are the professionals in the business understand it and can have a debate between themselves, and everybody else, basically, it is like a language from another planet. Nobody else understands what it all means.

As far as I am concerned, we have to bring the debate down out of all of the arcane sort of discussion and back down to the concrete question of how do we get health insurance to this kid. And if we cannot get that done, then we all ought to just turn in our jerseys and go into another line of work.

There is absolutely no excuse for the Congress, the President, the Secretary of Health and Human Services, all of the parties at interest to end up saying, "for the following 50 reasons we cannot solve this problem, or the following 5,000 reasons we cannot solve this problem, or the follow 2 or 3 reasons we cannot solve this problem." Meanwhile, this kid is out there waiting. He may have appendicitis today or tomorrow." Let's hope he does not. We are off in a world of our own of debate and without any answers to real problems.

I am willing to go up into the discussion of all the arcane terms and so forth and so on, but only with the thought in mind that after a reasonable period of time we then come back down to the absolute, direct, to the point issues of how we get health care to this child, and not after the 1992 election because it is a little too hard to deal with between now and then or some other time.

It is again the Cheryl Eichler test. Are we getting the help to people when they need it? So in any event, I just wanted to make the case with this little fellow because he happens to have gotten his picture in the newspaper the other day.

This country is in effect saying they do not care about this child. In fact, with some of our foreign assistance programs today we are doing more for children in other countries than we are for our own children.

Ms. ROSENBAUM. Let me just say, Senator, that I hope next spring, before we get into a second year under the 1990 Budget Agreement, there will be a serious debate about whether we continue to honor defense/nondefense spending allocations that prevent us from having programs like this or instead let people choose between continuing defense spending where it is and making a downpayment on a national health insurance plan.

I think the American people would be behind making a downpayment on such a plan.

Senator RIEGLE. Well, I wish I had my chart here on the fraud of the Federal budget. But that so-called agreement is—I mean if there was ever a fraudulent agreement, that is it and the numbers show that. I will get that up here before the day is over. You will be gone, but for others that are in the room because the notion that we cannot move on these things for that reason is just utter nonsense. That sort of insults the intelligence.

Thank you for your testimony.

Ms. ROSENBAUM. Thank you.

Senator RIEGLE. Let me excuse you.

Mr. Camacho, we would like to hear from you now. Thank you for being here.

STATEMENT OF JOSE E. CAMACHO, EXECUTIVE DIRECTOR, TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS, AUSTIN, TX, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. CAMACHO. Thank you, Mr. Chairman. I am not the great philosopher that is going to keep this debate going at a very high level. As a member of the National Association of Community Health Centers, I represent the centers that are aware of the failures in our health care system. We were serve the millions of Americans that seem to fall through the cracks, those that are left forgotten or left behind unserved, or partly served at best, by traditional health care providers.

In this context it should come as no surprise that the National Association of Community Health Centers strongly supports the call for significant and meaningful action to reform America's health care system at the earliest possible opportunity.

My purpose here today, however, is not to repeat the already lengthy and well documented litany of system failures. Rather, I am here to stress the vital importance of including as a central element of any reform package a plan and the resources necessary to develop a system of ambulatory, primary health care centers in those areas and for those populations that have historically lied beyond the reach, capability and interest of our traditional medical care system and which will remain there regardless of what financing system is finally agreed upon to extend coverage to the uninsured.

For these populations, Mr. Chairman, universal coverage will equate to access to a health care provider only if the reform accompanied by a systems development effort.

Not only do I want to stress the need for such an element, but I wish to offer a plan and to commend you, Mr. Chairman, for including most of that plan in S. 1227. I would be remise, however, if I did not note that that action to develop the vital necessary elements of care can and must be undertaken immediately even in advance of the broader effort to ensure universal coverage and to note with deep appreciation that Senator Chafee has introduced such legislation in S. 773 to accomplish this objective. We note the remarkable similarities between that legislation and S. 1227.

The National Association of Community Health Centers last year proposed Access 2000, a modest incremental initiative to develop comprehensive, well-staffed, primary care clinics in every medically underserved community by the end of the decade. To achieve that goal the Access 2000 initiative builds upon a program of proven effectiveness such as Federally funded migrant and community health centers and other non-Federally supported community health clinics providing health care to medically underserved families.

This effort is most appropriate as an intrical part of an overall plan to assure Americans access to basic health care. As is the case, Mr. Chairman, with your bill, S. 1227. By using such a system development approach the assurance is provided that the systems are built only where they are needed, are focused especially on the underserved families they are intended to serve and are directed toward providing in particular the services that patients need.

In summary, the effort would bring about a more appropriate distribution of health care resources through the development of a critically necessary health care delivery system that is essential to ensure the success of any health care financing mechanism in providing equitable real access to all Americans.

In my written testimony we have outlined several principals that we feel are important and commend you, Mr. Chairman, for including most of those principals in S. 1227. S. 1227 guarantees coverage for nearly all Americans with simplified enrollment procedures and forms. It ensures comprehensive benefits for all enrolled persons and enhances benefits for special populations, including low-income Americans.

It makes that coverage affordable for low-income persons and families with the assistance in meeting the cost-sharing requirements. Most importantly, it contains the strongest system development program found in any system reform legislation introduced into Congress to date.

However, there are certain concerns, Mr. Chairman, that we have with S. 1227. We are concerned that placing AmeriCare under State administration rather than Federal management will result in a diverse number of programs such as has occurred with Medicaid.

We are also concerned with the provider reimbursement provisions that allow States to substitute alternative payment systems subject only to an upper aggregate payment system.

In our written testimony, Mr. Chairman, we had misstated a part of your proposal and showed concern that special benefits would be available only to the unemployed poor. We understand that is in error and that all those benefits are available to those under 100 percent of poverty.

Because of the need for action being so great, Mr. Chairman, I want to assure you of our strongest support for your efforts in this regard and of our desire and willingness to work with you and your colleagues to fashion the best possible reform system measures. We commend you and Mr. Chafee for your leadership.

Senator Riegle. Thank you very much. That is a very helpful statement and I appreciate the support that you have given on some of the key aspects here.

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

Senator RIEGLE. Give us a sense of how long the waiting lists are now of people who are trying to get into our community health centers and our migrant health centers who literally cannot be accommodated because there are too many people in line and not enough medical services available. What does the profile look like as you see it?

Mr. CAMACHO. As of 5 years ago, Senator, we started to have waiting lists and now over two-thirds of our centers have to stop taking new patients. It takes anywhere from 6 months to a year and a half in Texas to get on as a new patient in a community health center. This is the same situation across the nation.

Senator RIEGLE. I visited a community health center the other day in Lansing, MI. On evenings when they are able to take people they can handle 40 people an evening. On every occasion they end up having many more than 40 come; and, of course, they have to then turn a substantial number away. That is common throughout the country at the present time.

Mr. CAMACHO. Yes, Mr. Chairman. Except in emergency situations that, of course, we treat, stabilize and transfer, non-emergency patients are not being seen for several months in some situations.

Senator RIEGLE. Yes. Well, if somebody cannot get on the list and it is a woman with a lump in her breast and it does not get discovered, it is going to be an emergency problem and probably is then. But someone might not know it simply because she is not able to get in and get looked at.

Mr. CAMACHO. That is correct.

Senator RIEGLE. Isn't that kind of thing happening?

Mr. CAMACHO. Yes, sir. It is happening all the time.

Senator RIEGLE. Senator Durenberger?

Senator DURENBERGER. Well, Mr. Chairman, I do not have a specific question because I think we all appreciate the difficulty that community health centers and a lot of other nonprofit outreach programs are having. They are the first to sustain financial contribution problems when there is a budget cutback. They are the first to sustain the same sort of problem when the economy goes bad and the nonprofit sector has to do its cutbacks as well.

So I think everybody here—the one issue on both sides of the aisle that we agree on—is that the proposal which our colleague,

John Chafee, has put before us, I think most of us may be co-sponsors on that. I think all of us, were we able to sit here without the constraints that have been placed on us by budget resolutions and things like that, would be fully funding those kinds of programs.

I thank you very much for being here.

Mr. CAMACHO. Thank you, Senator.

Senator RIEGLE. Thank you very much and I appreciate your leadership in this field. This is very important work and you have to have a big heart and a good heart to do it. I appreciate the fact that you have both.

Mr. CAMACHO. Thank you, Mr. Chairman.

Senator RIEGLE. Thank you.

Let me call our last two witnesses to the table. Mary [illegible] hard, who is the vice president for government relations for Blue Cross/Blue Shield; and Carl Schramm, president of the [illegible] Health Insurance Association of America. We are pleased to have you both here.

I want to just take one moment here. I said I was going to put a chart up here and I want to share this with those [illegible] and very particularly my colleague from Minnesota. We [illegible] ished getting this particular chart put together. But as you can see from the pictures, it shows the Federal budget deficits as they have been accumulating year by year since 1981 up to 1992.

The deficit is actually in three parts. The lowest part of the brightest red is the deficit if you leave out the amount of money that we are in effect borrowing from the trust funds to support operational spending in other areas of the government, so that the [illegible] ments are added on at the top so that the full height of each year is the full amount of the deficit spending for that year [illegible] either by borrowing in the capital markets or by borrowing from the trust funds.

What is significant about it is not only how sharply these deficits have risen over the last decade, but significantly this was the first budget deal—that is Gramm-Rudman-Hollings I—it was supposed to bring deficits down like this, but they went up like this. So that had to go into the ash can and we got Gramm-Rudman Hollings II which was supposed to bring deficits down like this, but they went up like this. So that went into the ash can.

Now we have Gramm-Rudman-Hollings III, which this is supposed to be the pattern, and I am very much of the view, I think this ought to go into the ash can for the same reasons because I think we are going to get the same pattern of rising deficits. I think this is designed in part to kind of pole vault over the 1992 election problem.

But the sheer fact of the matter is that these so-called disciplines have solved the deficit problem, it is just obvious to the naked eye that they have not worked that way. Now one can argue that maybe this time around, you know, we are going to see something different here. But, you know, this reminds me of the person that after the third time you bought stock in the Brooklyn Bridge which is nonexistent stock it seems to me we ought to figure it out.

But in any event, I do not think we ought to hold the health needs of the country, of the Cheryl Eichlers or this young fellow Anthony Phife I just pointed to, hostage to the notion that there is

some kind of a plan in place or some kind of a discipline in place, when in fact if we look at the record it just does not hold together.

But that is a whole separate debate and we could debate that a long time. But I think it is important when those issues are put into the debate that we sort of take a look at the road we have been over. I think there is someone sitting out here right now, a woman, for example, who may have a lump in her breast and may have the development of a breast cancer problem that needs to get into a community health center or better yet would have health insurance coverage and does not have it, the notion that she has to wait because we have this line in place and therefore we cannot do anything about her problem, I mean it is so astonishing that you sort of ask yourself, how do we get out of that kind of fantasy thinking and back into the real world where people, you know, have to try to survive each day.

That is the bind we are in. So in any event I just wanted to put that up there for reference.

Senator DURENBERGER. Mr. Chairman, if I might.

Senator RIEGLE. Yes.

Senator DURENBERGER. I do not have a chart to respond with, but I do have a couple of memories. I remember the night that the current Governor of California was wheeled in on a gurney to the floor of the U.S. Senate at 1:30 in the morning. That was before you had any of those lines. It was the end of March 1985. The majority of Senators at that time had proposed a way to deal with this problem. We had helped create it in 1981 with the tax bill and we proposed a way to solve it, by increasing some taxes and freezing some Social Security.

Neither you, nor any of your Democratic colleagues, other than one who is now passed away, would support it. The President, Ronald Reagan, would not support it. The Speaker of the House, on behalf of the members of the House, would not support it.

But I think perhaps a reflection of who holds whom hostage here is that we are all sort of in this together. I have heard about that vote of mine more than once. I heard it a thousand times in 30 second commercials in my campaign. That was a very responsible vote. That would have turned it down, at least until we got to another subject on which you are the most expert in this room, and that is the failures to keep up with the banking problems in this country, against which we also, I guess, insulated the consumer by saying to them, we are going to give you $100,000 per deposit worth of protection against the management skills, or lack thereof, of people who run banks and S&L's in this country.

I do not mean to open a large debate here, but that is a very attractive chart, but I also do not like to be in the position where I feel like I am somehow—for participating in efforts to restrain spending—participating in the deliberate killing of uninsured men and women. Because I for one have tried to do my best about our deficit, and I have even been voting periodically for tax increases and things like that, which does not help.

I do not say that in defense of myself. I just say that it is an issue which lends itself to graphing and charting. But there is much more to it than meets the eye.

Senator RIEGLE. Well, let me just say, Senator Durenberger, I did not, in any way, mean to make an inference or try to make a point that you or any individual person, but particularly you, were responsible for us not getting health care to people because of the explosion of the budget deficit. That is not my thinking and that is not what I want to be understood as having said.

But I do want to make the point that our adherence to this so-called budget straightjacket which we have put ourselves in in the name of solving the deficit problem, and then using that as an excuse for not doing anything on health care, I think is a false argument.

We are not solving the deficit problem and we are not solving the health care problem. We are using one to excuse the effort to do more in the other. That is the only point I am making. It is going to take an awful lot of people working together to get out of that straightjacket. I do not think we can, in effect, allow ourselves to believe, first of all, that we are solving the deficit problem, or secondly, that the plan we have in place that is purported to be doing that is, therefore, a reason why we cannot cross the line into major health care reform. Because I think we need to.

In fact, I think we can actually help get the deficit down if we can get a major health care initiative going that is properly structured. In any event, I will yield further if you want to make another comment.

Senator DURENBERGER. No, that is fine. I do not care to. We both made our point.

Senator RIEGLE. Okay.

Let me now call on our two witnesses. Mary Nell Lehnhard, why don't you start.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT FOR GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Ms. LEHNHARD. Mr. Chairman, Mr. Durenberger, we want to commend both of you for your leadership on this issue. We believe that the introduction of both of your bills have signaled a higher level of commitment to addressing the problems in our health care system.

Mr. Chairman, I want to assure you that the Blue Cross and Blue Shield Association believes we all have to work together to assure that every American has coverage and to assure that that coverage is affordable. And we share your belief that building on the pluralistic system is the best way to do this.

I would like to comment on three aspects of Health America—the cost containment strategies, the insurance reforms, and your mechanism to assure coverage for those who do not have employment-based coverage.

First, we strongly support many of the cost containment strategies. In particular we support the promotion of managed care and we think these provisions could in fact be strengthened by creating incentives for employers to use carriers that have a proven track record of managing utilization and price of services. We call these managed care qualified carriers.

Our primary concern with the bill's cost containment strategy is the heavy emphasis on all payer programs. We do not believe that these highly regulatory payment schemes can address what are the two basic problems in this country—excessive use of service and excessive capacity in our capital system. We, in fact, think these problems become locked into place if insurers can no longer negotiate the most effective payment rates for their subscribers.

We agree fully with you that the insurance market is in need of reform and we support immediate steps to assure that competition is based on ability to control costs, not the ability to select the best risks.

We support the general frame work of the insurance reforms. We believe that States should have the maximum role possible in regulating the insurance market and we would like to work with you on the right balance between broad Federal guidelines and State flexibility.

Our major concern with the insurance provision is with respect to rating reforms. We are concerned that the reforms laid out in the legislation will result in major and immediate disruption in the market. The immediate lowering of premiums for high risk groups will result in immediate and significant increases in premiums for lower risk groups.

We think that this redistribution of subsidies in the small group market needs to proceed much more incrementally so that you have a stable small group market and people are not dropping coverage because their rates are going up.

And finally, we would like to work with you to find an alternative to what we think is the most troubling aspect of the bill, the alternative of a public pool for employers who do not provide coverage.

Our concern with pay or play structure is that employers would over time have a very strong incentive to stop providing benefits directly and send their employees to a public pool. We recognize the intent is to set that tax high enough so that employers choose to provide coverage directly, but we think the dynamics are that very soon that tax will not cover the cost of coverage and employers will quit providing the benefits. We are currently analyzing private sector options to the public pool.

In summary, the Blue Cross and Blue Shield Association strongly supports the objectives of Health America to assure affordable coverage for every American. Our specific concerns are with the reliance on the public pool, the emphasis on all payer programs and the proposed rating reforms in the package of insurance market reforms.

We would like to work with you on alternative ways to address the problems, the very real problems, underlying these provisions.

Senator RIEGLE. Thank you.

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

Senator RIEGLE Mr. Schramm?

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

Mr. SCHRAMM. Thank you, Mr. Chairman. I appreciate the opportunity to come and share the views of the commercial health insurance companies. Our 300 member companies insure 98 million Americans.

Although we strongly share the goals of this legislation, improved access to health care and health care cost containment, we strongly oppose this particular bill and must urge its rejection by this committee. While many of the concepts contained in this bill are good ones and consistent with many of our own observations of the change that is necessary in the health care financing system, our analysis is that other portions of the bill would prove fatal, both to the private health insurance industry and to health care as most Americans know it today.

The pay or play provisions for employers are the keystone of this legislation and in our view are fundamentally and fatally flawed. Employers are given the option of providing their employees health coverage or contributing a percentage of payroll to have their employees covered under a public program, AmeriCare.

In practice, every employer will examine their work force and make a judgment. Who will enroll their employees in AmeriCare? Only those employers who expect their health care costs to exceed the AmeriCare premium. Those with young, healthy workers will buy their own health insurance. Those who expect high costs will elect the government program.

In other words, AmeriCare is guaranteed and structured to lose money from day one. It is also guaranteed to lose money on the nonemployed population which also has the ability to enroll in AmeriCare regardless of income. Open to all not covered by employer plans, regardless of income, AmeriCare premiums will be held down by political pressures just as the Medicare Part B premiums have been held down from their original 1965 50-percent level.

So older, sicker and more expensive lives will sign up. The young and healthy will stay away. The private sector will suffer from a competitor whose premiums are set by political pressures, not costs or market forces, and the program deficits will grow, demanding either a dramatic infusion of funds or a further take over of the system.

The second point I would make is that the bill relies on community rating in its funding mechanism. And I would just point out the community rating in and of itself will not save one dime overall. What it will do is that by averaging premiums it will increase the cost for populations least-able or willing to pay, particularly those with young workers. It will encourage those with lower costs to self-insure, perhaps unwisely, and increase game playing among employers and insurers alike.

On the positive side, however, I would applaud the bill for its focus on what needs to be done in the small group market. It is here that I think that I could join in your call for a joint partnership to solve this problem. On our side our industry is committed, as is Blue Cross, to fundamental structural reform at the State level in the area of small group reform. We share the goals that

are also articulated in Senator Durenberger's bill, to open access, to guarantee the market is open for insurance in the small group market place, for rating reform, for structural reforms, including the acceptance of whole groups, for the elimination of preexisting conditions and for the continuation of coverage once a person is insured.

And finally, we would establish pricing reforms that would guarantee to some extent a modified community rating structure that would make insurance a bit more affordable for small group employers in particular.

While we will do this, and commit to do this in a majority of States, we already have passed this legislation in four States and anticipate in the next year to advance this legislation in 15 States, which will provide access to over 70 percent of the small group market uninsured, you must do your share. That is, particularly focus on the restoration of public benefits through the Medicaid program.

Finally, we do endorse the notion of cost containment as a joint project and we applaud the goal of this program and legislation to advance the protections of managed care by approaches that are in their infancy.

As Senator Durenberger has pointed out, there is significant, concrete evidence that the management of care, in places such as the twin cities, by employers and insurance companies, as well as HMO's can substantially reduce the per capita cost of the medical system in those places where it is effectively tried and stuck with.

To that extent we seek also in our joint partnership your protection with our innovative ideas as regards managed care and join Blue Cross in their prayer to you for protection.

Thank you very much for this opportunity to testify.

Senator RIEGLE. Thank you.

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

Senator RIEGLE. Mr. Schramm, did I understand you to say at the outset that the insurance companies that you represent cover 98 million Americans?

Mr. SCHRAMM. Yes, sir.

Senator RIEGLE. We have about 250 million Americans. So you cover certainly less than half. Why is the coverage not greater than it is, would you say; and how do we make it greater?

Mr. SCHRAMM. Well, I point out quickly that the private sector is joined by the Blue Cross plans that cover about 80 million.

Ms. LEHNHARD. Eighty million.

Mr. SCHRAMM. So jointly we are covering well over the majority of the population.

Senator RIEGLE. Do you have a theory as to where your figure has been percentage wise? Has it been about where it is today in terms of a percent of the total market say over the last 5, 10 years?

Mr. SCHRAMM. Well, despite the fact of a growing number of uninsured persons, the absolute number of Americans, and indeed the percentage of Americans who are covered is relatively stable over the last few years. Historically, we have grown from almost less than 5 percent of the population with privately funded insurance

benefits in 1940 to the point where we now have, between us, almost 190 million Americans insured.

Senator RIEGLE. Did you see the census data last week that indicates the number of uninsured families each year has gone up?

Mr. SCHRAMM. Yes.

Senator RIEGLE. Now you both mentioned concern about the public program becoming too large. In fact, I feel that our program would encourage private coverage and it is built around a private coverage concept. When our program is fully implemented the majority of people will still get their health care through the private sector. In fact, we estimate that about 80 percent of the population would receive health care through the private coverage.

If that is right, and you are uncomfortable with that figure, what is the right mix in your view between public and private coverage? What should we be shooting for?

Ms. LEHNHARD. Well, we don't believe there should be a public program and we would like to work with you on a private sector alternative to that public program. We think that the inevitable consequence of trying to set a tax for employers at a high enough level to cover every employer or a substantial number of employer's health care costs, the inevitable effect of that is that the tax will not keep up with the cost of health coverage.

I have to question even whether you can get it at an adequate level in the beginning. An 8 or 9 percent tax on employers, particularly small employers, is going to be extremely difficult to achieve. We would prefer to structure, particularly for small employers, something where they do not have that choice to go into a public pool. There is some alternative way of getting coverage to their employees.

Senator RIEGLE. Mr. Schramm?

Mr. SCHRAMM. Mr. Chairman, I think, it is hard for me to guess at this, but I think a rule of thumb in the best of circumstances we could anticipate a balance somewhat like that you articulate, perhaps 80/20.

Senator RIEGLE. Eighty/twenty.

Mr. SCHRAMM. I must say I am sympathetic to Ms. Lehnhard's perception that in time there ought not to be a public option, only because I think the experience with the public option has proven so cumbersome and difficult. But I think the reality is there will always be, and it is the position of our companies historically, that there will always be a need for a public insurance system for people who cannot participate in the private market place.

As to the premise of the legislation, however, I believe that the legislation is intended on its face to preserve an 80/20 mix. I think our quarrel, both that of Blue Cross and HIAA, is that operationally setting a premium at 8, 9, or 10 percent is an invitation, covertly or unintentionally, to essentially force an enormous number of insureds into the public program.

Senator RIEGLE. Mr. Schramm, what kind of a program do you have today to get this little boy covered?

Mr. SCHRAMM. I am sorry, sir, I do not know the reference.

Senator RIEGLE. You were not in the room when I referred to this before?

Mr. SCHRAMM. I came during the second panel, sir.

Senator RIEGLE. All right. Let me give you the case facts. This is a story out of the Detroit News on September 5, 1991. It is about a woman who is working and she has some health problems. She has partial health coverage through her work place, but she is still accumulating bills over and beyond the coverage that, unfortunately, she cannot pay. She has a modest income.

She has a 6-year-old son here and in order to be able to cover him it would cost her an additional $200 a month to have him covered on her insurance through the private system that you folks have. She cannot afford it. It goes on to say what she earns a year, which is relatively modest, but she lives in a trailer park and pays $266 a month on a mobile home and $295 a month to rent the lot that the mobile home is on.

This is a picture of her and her son and he has no health insurance coverage. Now what is the answer in your industry to get some health insurance to that boy?

Mr. SCHRAMM. Well, sir, presuming that she is in a marginal work-related situation, that the employer does not cover the whole family as a result of that marginal connected to the labor force, it seems to me——

Senator RIEGLE. By the way, I have talked to thousands of people in that situation, who have coverage for themselves through their workplace, but not for their family members.

Mr. SCHRAMM. Oh, I have no doubt that there are thousands and tens of thousands.

Senator RIEGLE. I mean that is quite common.

Mr. SCHRAMM. There are tens of thousands of people in that situation.

Senator RIEGLE. I do not want the implication left on the record that anybody that has health insurance through their workplace covers their families because in many cases it does not, does it?

Mr. SCHRAMM. No, sir. I did not mean to give that implication.

Senator RIEGLE. No, I do not say that you did. I just want it clear on the record that in many cases it is not the case. But anyway, through your private insurance system, how do we cover this boy?

Mr. SCHRAMM. I am not sure we do. I think I got right back to the last answer I gave you. Ideally, it might be nice to talk about 100 percent private system. The fact is, history in America suggests that there are always people who cannot participate in a private system because of the lack of substantial income. It sounds to me like that is an absolute perfect case that fits that situation and that is the perfect case——

Senator RIEGLE. Is that what it costs to insure, by the way? I mean it says here if the numbers are right in this article, and I would assume they probably are, does it normally cost $200 a month to pick up the coverage for a 6-year-old child? That is $2400 a year. Would that be in the ball park?

Mr. SCHRAMM. That seems steep to me, but I do not know the history of the case.

Senator RIEGLE. What do rates run for children for parents who have to buy insurance for their children as an add-on from one of your private carriers?

Mr. SCHRAMM. I really could not speak to that. I mean there is just no sort of prevailing rate. It depends a great deal on the place.

Senator RIEGLE. Would it be over $100 a month? Would you imagine it is $10 a month, $5? It is not down in some insignificant figure like that, is it?

Mr. SCHRAMM. No. I just cannot speculate as to the composition of the case and the locale.

Senator RIEGLE. Well, let me ask you to do something. I would appreciate it if you would go back and find out what kind of average figures there are. I would like them State-by-State or if you aggregate them some other way.

What does private insurance cost today for a single parent like this or a family who does not otherwise have the health insurance if they want to cover a minor child? What does it run? Because my hunch would be that the numbers are probably in line with what she is experiencing. I would not think she is going to be that far off the norm if the story is accurate in the paper.

If that is right and if it costs $2,400 a year to insure this little guy across any kind of a decent pool of children, I am not sure how the pooling structure would be put together to calculate the rates, but it sounds like it would be an awfully profitable business to be in.

Mr. SCHRAMM. Well, we know it is not. I mean that record is pretty clear.

Senator RIEGLE. I would think that it is for that class of child. I mean if that rate—it is just hard for me to imagine that an actuarially sound rate would be $2,400 a year for a 6-year-old child or am I missing something?

Mr. SCHRAMM. I would be happy to take a copy of the paper and, in fact, show you prevailing rates that might apply there on a specific case exactly like that.

Again, I cannot testify as to the background or what the circumstances are. The one thing I can be sure of right away is to tell you that Michigan, and particularly if that is the Metropolitan Detroit area, is one of the five most expensive metropolitan areas in the country; and that only goes back to the question of be it a public program or a private program, somebody is going to be wrestling with the underlying cost of providing health care. That is what drives the insurance premium to the level at which it is.

Senator RIEGLE. Well, it does to me—I would like to see the data and you have offered to get it. I appreciate that.

[The following information was subsequently received for the record:]

$250 DEDUCTIBLE, COMPREHENSIVE MAJOR MEDICAL PURE CLAIM COST PER MONTH

[From Tillinghast Group Rate Manual]

	Area A (lowest)	Area D (approx median)	Detroit	Area M (highest)
Employee	$75.96	$92.57	$119.19	$169.91
Spouse	88.11	107.38	138.26	197.10
Children	56.46	70.84	94.00	140.25
Composite dependents	116.88	143.76	186.92	270.52
Location	All of VT			Parts of CA
Example of Two-tier rate structure:				
Employee	$75.96	$92.57	$119.19	$169.91

$250 DEDUCTIBLE, COMPREHENSIVE MAJOR MEDICAL PURE CLAIM COST PER MONTH—Continued

[From Tillinghast Group Rate Manual]

	Area A (lowest)	Area D (approx. median)	Detroit	Area M (highest)
Family	192.84	236.33	306.11	440.43

*Where a children rate is included, it is assumed that an average of 1.9 children are covered.

**Various combinations of the above can be combined to develop rating tiers. For example, a simple two-tier structure would include a rate for employees and another rate for families which would be equal to the employee and composite rate added together. In Detroit, this would mean that the family rate would be $186.92 more per month than the individual rate. If an employer were using a simple two-tier rate structure, there would be almost a $200 difference in pure claim costs between the family and individual rates. When a loading factor is then added, the difference would easily exceed the $200 per month difference mentioned in the testimony. This is a fine example of how any form of pooling necessarily results in one group subsidizing another. In this case, all of those with dependents are pooled into one category, that of families. By doing so, the single parent with one child is forced to subsidize those on the other end of the pool who have a spouse and more than two children. In other words, while the single parent with one child pays more than the $169 actuarial cost for her coverage, the employee and spouse with six children pay less than the $554 actuarial cost for their coverage. Conversely, the only way to lower the cost for the single parent is to raise the cost for the family of eight.

Senator RIEGLE. I would also like to see the Blue Cross data that would be comparable to this also from across the country.

What we have tried to do with our plan, quite frankly, is we have tried to maintain private coverage. There are people around that think it is time to get rid of private coverage, that private coverage is profit oriented and builds in extra costs that perhaps can be squeezed out in the name of getting health services to people. That is a debatable proposition.

There are a lot of people in the country, and I think quite frankly, the group is growing, that says the insurance companies, the private for profit insurance companies are part of the problem and not part of the answer. Now that may be a terribly unfair oversimplification. But I think if this train gets rolling fast enough it is going to come right over you folks. I think the way to deal with it is to make more of an effort to come up with some answers yourself, quite frankly.

I do not just say this to you personally, but I think there are going to have to be some more suggestions in the recommendations coming out of the private insurance sector is going to have to more forthcoming. I just give you that as one person's view. It is one thing to not like a plan that is designed to solve a problem here. But we have at least 34 million people out there without coverage. This is one of them right here.

This problem has to be dealt with. I think part of the responsibility is upon the private insurance industry. If it is not a problem that you can help us much with, then I think, we probably have even a bigger restructuring on our hands.

Mr. SCHRAMM. Mr. Chairman, I appreciate that. I do appreciate the architecture of this bill seeks to preserve a private option, both for Blue Cross and our companies. As I said, I think operationally it undoes us. I do not know if that is the drafter's mistake or if that is a covert intention. But to go to the other issue about the raft of ideas that we must come forward with, it seems to me that both Blue Cross and the commercial insurance companies took a lead in identifying the issue of uncovered people. The HIAA board began to work on this at least 4 years ago.

I dare say, and the record is very clear on this in terms of testimony and hearings that were not being held in the Congress 4 years ago, 4 years ago and 5 years ago there was little appreciation in the Federal legislature that this was a critical problem. And I

believe that over the last 4 years both Blue Cross and HIAA has led the debate in the formulation of ideas. And, indeed, many of the ideas percolating in the proposed pieces of legislation, both in the Senate and the House, mirror the research and the offerings that we are attempting to cast into statutory law in the States this very day.

Senator RIEGLE. Would it be feasible for the private insurance companies to get together and offer a minimum health insurance plan that deals with the critical prevention items. For example, immunizations, check ups, coverage for serious problems for children under the age of 10 or under the age of 5, where you take and create a national pool. After all, all the children of America are important to us? They do not have any choice as to where they happen to born, whether they are born in Westland or Wyndotte or Albuquerque or some other place.

Could the insurance companies of the United States get together and say, hey, look, here is a good solid basic plan. We do not want any kid walking around out there without basic health insurance and we want to provide it at the lowest cost and to be a good solid plan. We want it to be wall-to-wall, the whole country, because we care about the children of the country.

So we are going to offer a plan here and whether the mother or father does or does not have insurance for a certain amount of money we will take that child into a plan and the premium is set per month. If the family happens to move from Illinois to Minnesota it stays the same. They want to cover that child. Bang, here is the plan. And we want to do it because we want the private sector to offer a plan.

Is there anything like that available today?

Mr. SCHRAMM. There is nothing like that available today. We have had a good deal of discussion on that.

Senator RIEGLE. Is there anything on the drawings boards or anything coming?

Mr. SCHRAMM. Yes.

Senator RIEGLE. Are we likely to see something within 6 months or a year? I am talking about a concrete, tangible product that I can see on television and I can see offered and that I can say to people in Michigan, look, the private insurance companies have really gotten into this problem because they understand it is important to provide health insurance to children in America. So here is a basic plan. It is stripped down. It is right to the point. It has, I would hope, a low profit figure attached to it or a no profit figure attached to it in the case of Blue Cross, and here it is.

Any chance we could get something like that within 6 months?

Ms. LEHNHARD. Mr. Chairman, can I make two comments?

Senator RIEGLE. Well, let me ask Mr. Schramm first. Then I would like to hear your answer. Any chance out of the private insurance companies we could have something concrete, ready to go within 6 months in that area?

Mr. SCHRAMM. I am not sure there is any chance of that. I can assure you that we have been doing discussions and talking exactly on those types of questions. I might say that last year HIAA called together a coalition that included the Childrens Defense Fund,

from whom we just heard, and led a coalition to the advancement of the Medicaid legislation that came forward.

Senator RIEGLE. But in the private sector a plan, I mean nothing that we can see within the next 6 months of the kind that I have described?

Mr. SCHRAMM. Well, I must say we are already at the point of having had the discussions of all those basic benefits. It is a matter of getting our companies, 300 strong, to move forward to consider what legislative protections and so forth.

Senator RIEGLE. You can do that as a national association? I am glad the discussions——

Mr. SCHRAMM. We are working on that. Yes, sir.

Senator RIEGLE. Well, can you give me any kind of a commitment when you might have something done and ready to go?

Mr. SCHRAMM. No.

Senator RIEGLE. I for one am interested in having something done. I mean whether it is 300 companies or 3,000 or 3, I think it is time to make some decisions and put something on the table. Otherwise, I think the private sector system does not work very well, and I think if that is the conclusion, then we go from there.

Ms. Lehnhard, do you want to make a comment? Then I am going to go to Senator Durenberger.

Ms. LEHNHARD. Yes, I would like to respond to your question about children's programs. We have been working with our local Blue Cross and Blue Shield plans to put in place programs for low-income children that do not qualify for Medicaid. Their parents cannot or perhaps do not have health insurance. Twenty of our companies have now got these programs up and running. It is essentially free care for children under age 13.

We match the dollars and our companies, we raise money in the communities. There are 30,000, I think, children now insured in Pennsylvania under this program. As I said, 20 of our companies have this up and running and we expect it to spread.

That is not 50 States but it is a good start and we are proud of that program.

Your other point, the responsibility of the insurance industry to come forward with some solutions. We are very much aware of that. We are very sensitive to the need to do that and we are, in fact, working with our board right now on a three-part program. The program would assure universal coverage for everyone in the United States, assure that those benefits, a basic set of benefits are portable as you move from job to job and assure that those benefits are both affordable to both employers and the employee.

We are going back to the Board, in fact, this week and we hope to have a position by the end of this year, early next year.

Senator RIEGLE. Well, I think that is useful and I would like you to give us that for the record. I would like to know more about the children's program you are trying in different places, how that is going, how many people it is covering, how many people are left to be covered. That would be helpful for us to have.

Senator RIEGLE. Senator Durenberger?

Senator DURENBERGER. Mr. Schramm, in case you thought you had any friends left up here, I will call to your attention this headline from the New York Times last week, "Insurers Plan to Fight

Congress on Small Business Health Coverage." Seriously, I was going to say with regard to your answers to the Chairman earlier that if you came up for a vote in this committee it would be seven/seven. That was very cleaver how you handled some of those questions.

You can talk about this if you want. But my principal concern is getting to the answer to the Chairman's last question, but not doing it in 6 months. I mean most of the rest of the people who got here before you, do not like you. Not personally, but they do not like either one of you. They are anxious to get either to Canada or go to Massachusetts, where they can have the government do all this for them.

So there is no point to me in raising the costs of my health insurance by trying to use insurance in the near term to do all this work or to use health plans to do it. But I think this question implies from this person's standpoint the answer to all of our problems. I just firmly believe that all of us need the financial security of a risk spreading subsidized access into this health system. And that the low income need a larger subsidy than the higher income. And the people who have had promises made to them when they reach age 65 need a few politicians to stand up and say, we promised you health insurance but we did not necessarily promise you it would be a free ride.

Somebody needs to stand up to the notch babies and tell them they are selfish, greedy individuals who are depriving or creating all the problems that Sara Rosenbaum and the gentleman from the community health clinics and so forth have testified to.

So it seems to me that the other comment as we move in the direction of trying to provide a health plan, as the Chairman has suggested for everybody in this country gets to better understanding that the problems here are not in Mr. Schramm's organization versus Ms. Lehnhard's organizations.

I said earlier in my comments that the Twin Cities Metropolitan Area is 40 out of 40 in health care costs. Detroit we now know is 5 out of 40 or 5 out of a million or something like that, despite the efforts of Lee Iacocca and Joe Califano and everybody else. But we are 40 out of 40.

Across the Red River in North Dakota health care costs are substantially higher. They have just one insurance company in North Dakota and it is Blue Cross and Blue Shield. And they take care of all the doctors and all the hospitals. I mean their reimbursement rates for doctors and hospitals are probably on the average 20 to 30 percent higher just over the river because they have one nonprofit coverage.

So I do not know that the problem is so much in the for-profits versus the not-for-profits. Blue Cross/Blue Shield in Minnesota is a national leader. I mean they are the people that help the other Blues learn a lot about economies and so forth.

So to the degree that I heard, and I probably am not hearing very well today because we Republicans are going to sneak off in a half hour and conspire about how to do health care reform finally, for—I am not sure if there was an implication about profit and not-for-profit and things like that, I do not think it was there. And it certainly is not the most appropriate measurement.

Because there are some Blues out there that have been taking care of their doctors and their hospitals because that is what they were originally designed to do—to make sure that providers got their bills paid.

The heart of our problem and one of the things I guess is illustrated by the headline and disagreement that we may have on insurance reform seems to be in the way in which we think about the prices that we are all going to have to pay for this product called access.

What the chairman of this subcommittee, as a leader in the AmeriCare program, and I and the chairman of this full committee are up to is trying to get a fair price for the product called health insurance. I guess we would call it that.

It bothers some of us more than others that the American consumer is used to looking at a product like a television camera or a cup or whatever the case may be and, you know, the prices do not vary necessarily with where you work or whether you are poor or something. I mean a cup is a cup is a cup. And a television camera may have slightly different prices depending on who manufactures it and so forth. But there is a similarity in the pricing of most of these products everywhere except in health insurance.

I mean the same product will cost you one thing in Los Angeles and another in this small town in Michigan you were talking about. It costs you one thing if you are a United Auto Worker and quite something else if you are a self-employed farmer out in the rural parts of Michigan.

So one of the objectives of small group insurance reform is to find a way to get the price to relate as much to the product as possible. To that end, we are moving back in the direction of community rating, without going to community rating, which people object to very strongly.

But that is the pricing mechanism. The issue seems to be, what is the function of insurance in doing that. Because insurance is supposed to be a way to spread risk. I mean hiring an insurance company to help you is a way to spread the risk so the healthy pay a little bit more of the costs of the sick and the young pay for the old and that sort of thing.

But our problem today in America is that if we do too much of that then we discourage the healthy or we throw all the load on the sick. So we seem to be caught in that problem. But the main function of insurance, I guess, is supposed to be to get that price as approximate for everybody in the system as we possibly can. Is that at least one of the functions of insurance?

Mr. SCHRAMM. Yes.

Senator DURENBERGER. The other one is, I guess, the main function of insurance, which is to provide financial security against low probability events that have high costs associated with them. That gets important to distinguish because this product we call health insurance does not have much real insurance in it anymore. You have to buy your major medical or your catastrophic or something like that in addition to a lot of other things in most cases. Most of what we are buying today is bill paying services of one kind or another in most of our health plans.

Then you can also get a stop loss or a catastrophic plan or something like that. But we have much more health insurance in America than we have catastrophic insurance, do we not or insurances with stop loss provisions in them? Is that not true?

Mr. SCHRAMM. I do not think so, Senator.

Senator DURENBERGER. Then why do we debate catastrophic up here? We do not have a catastrophic feature in Medicare, for example.

Mr. SCHRAMM. That is right.

Senator DURENBERGER. Where all the bills get paid after a certain level, right?

Mr. SCHRAMM. Right.

Senator DURENBERGER. Do we have it in all private health insurance plans? Do we have a catastrophic feature today?

Mr. SCHRAMM. Well, it would depend on how you would define it. But operationally most plans do in the sense that the limit that is set is extremely high.

Senator DURENBERGER. Like a $1 million?

Ms. LEHNHARD. A million dollars is typical.

Senator DURENBERGER. Okay.

Well, anyway, that is the pricing function. The debate that we are going to conduct in this committee is going to be over the role of small groups, large groups and reinsurance and so forth in trying to get the price as close as possible.

One of the objections we are going to hear, I understand, at least from HIAA and maybe others is that we should not be making all of those decisions at this level, that that ought to be done 50 times at 50 State levels. Is that correct?

Mr. SCHRAMM. Yes.

Senator DURENBERGER. Whether it is done at the State level or it is done at this level, my impression and you can correct me if I am wrong, is that we cannot get to the business of getting approximate pricing unless we can decide exactly what that product looks like. We have to start with a basic product or a basic health plan and then we can say for that particular plan, you the seller, have to comply with certain rules and regulations on guaranteed issue and renewability and how these things that the folks here behind us here understand better than we do.

Is it not a fact that one of our problems is deciding what that basic benefit is?

Ms. LEHNHARD. Senator Durenberger, we would agree with you that what you charge for a premium for your sickest group—for the same set of benefits—compared to your healthiest group that rate range has to narrow. I think you understand as well as anyone if you narrow it too fast the rates for the healthy group go up substantially. So you have to approach it incrementally.

We believe that you do not have to start with a basic benefit to do this, that these rating rules should apply to all your products and, in fact, you want to continue to encourage multiple types of products out there to fit small employer's unique needs.

What we do believe is that there should be probably two basic products that are open on what we would call an open enrollment basis, what commercial industry calls a guaranteed issue basis, that those two are the ones that should be available to everyone.

If all products are available to everyone, with no waiting period, what you will have is like a Federal employees' program with open season all year round. I will take low option when I am healthy; I will switch into high option when I am sick. As a way to gain some experience with guaranteed issue we have said put two products out there that meet a basic set of benefits, a standard and a really basic, have those guaranteed issue, but put all of your products under the constraints of the rating bands.

But above all, do not create a situation where 80 percent of the market that is fairly healthy says, if this is reform, no thank you, we do not want it. We liked it the way it was.

Senator DURENBERGER. All right.

The last issue I want to ask you a question on is, we talked about the price, we talked about the product itself. The big issue this committee gets very concerned about is the affordability issue. If your average cost of this product is $300 a month, not everybody can afford $300 a month when most of their take-home pay is going into housing or some other things.

So that the way in which we in this country help people on the issue of affordability is first with employers, which is sort of a free, put some money in the pot. Secondly, is in some indirect way the particular tax benefits that go with employer paid health insurance. The third way would be directly through a social insurance contribution of some kind.

The employer paid benefit is a free good and not to be discouraged. In other words, it is laid on the table, the employer is willing to add it to the cost of goods or services and those who would take us to Canada forego that free benefit. Is that not generally correct or do the employers pay something out there that I am not aware of?

Mr. SCHRAMM. Just higher taxes.

Senator DURENBERGER. Pardon?

Mr. SCHRAMM. Just higher payroll taxes.

Senator DURENBERGER. Yes, they pay in the form of a tax but they do not pay it in the form of a contribution to a premium.

Then the employers' premium contribution in this country, of course, is not taxable income to the employee. Do either of your associations——

Senator RIEGLE. Senator Durenberger, let me just interrupt. You have a plan to catch.

Ms. LEHNHARD. That is all right.

Senator RIEGLE. I am happy to excuse you now if you want to try to catch it.

Senator DURENBERGER. I am happy to end my questions. I was just going to keep talking until 1:00.

Senator RIEGLE. I do not want to do that. Although I do not know what you may have at the other end. Feel free, I think, you have been very good as a witness, to leave if you must to catch a plane.

Ms. LEHNHARD. That is fine. I am all right. Thank you though.

Senator DURENBERGER. Do either of you have a formal position on changes to the tax treatment of employer paid health insurance?

Mr. SCHRAMM. We have a formal position against changes in the tax treatment, simply stated. I think we have that under constant

observation and constant examination because there is much to be made for the argument that there may be some disparities one way or the other in terms of the burden.

Senator, if I might I would like to make a couple of observations on some of the thoughts you raised.

First, as regards the New York Times headline, it is never the intention of HIAA to fight the Congress. Indeed, I think that is prima facie evidence of how unliked we are in America, that we are damned even as we attempt to do good. Which is to say our industry has committed itself to these very substantial reforms that, as I testified to, we hope to have in statute in 19 States—we have already accomplished it in four States—before the next 12 months is out.

Now, unless anybody can denigrate what those reforms are about, those reforms, as I outlined in my testimony, change the nature of the market in which we work significantly, and to the extent that there is more to be made by way of a demonstration, we establish an insurance industry funded, exclusively funded, reinsurance system to essentially subsidize prices for certain small group cases.

We go into those battles understanding that we come out with a profit disability on the other side.

The second thing I would suggest is that like Blue Cross the HIAA Board has been committed for 4 years to universal coverage. I think the issue that confronts us in the Congress and the State legislatures is how we get there. And Canada is clearly not the way, it seems to me, for the points you make, North Dakota being a very good example.

One of the problems North Dakota has is that it has a continuous problem of an influx of Canadian doctors, a demonstration of the ability of North Dakota to deliver health care in the American way.

But the real point you raise is the fair price issue. For example, the issue of the uniform benefit package issue, that is much overplayed, it seems to me. We have been doing extremely well, both Blue Cross and private health insurance companies, certainly in the assessment of our hundreds of thousands of customers' needs, with providing them an incredible array of plans that are tailored to each customer's need.

Now, to be sure, when it comes to basic benefits we are certainly ready to say on an actuarial quality basis we can establish some standard of basic benefits. But it is as if the issue is that we are ready to write a policy that will guarantee you psychiatric benefits and chiropractic benefits but no immunology or coverage for an emergency room visit or a doctor's visit.

I do not know what fantasies people talk about when they cook up this stuff, but it is not insurance as anybody finds it in the marketplace.

The issue of pricing I think is all important. Historically we have moved away from our job of managing risk. I think the fundamental five-point plan that we are offering in the States puts us right back in the position of understanding that our job is to balance risk. I believe that is expressly what our legislation drives to.

But when it comes to the question of fair pricing we in fact do confront America. And fair is fair depending on where you are. I do not think it is fair to construct a system that makes a price uniform in downtown Detroit and in downtown Minneapolis. That is categorically unfair it seems to me in the sense that citizens in those two places have done enormously different things, have made choices articulated in both publicly and privately as to what their health care is going to look like.

The one thing I want to leave is the notion——

Senator RIEGLE. Is that true for appendicitis?

Mr. SCHRAMM. Pardon, sir?

Senator RIEGLE. Is that true for appendicitis?

Mr. SCHRAMM. It surely is, yes. Absolutely.

Senator RIEGLE. For a 6-year-old?

Mr. SCHRAMM. Oh, it surely is. It costs a great deal more to deliver an appendectomy to a 6-year-old in Detroit than it does in St. Paul.

Senator RIEGLE. But it is just as important to get the appendix out in both children in both places, right?

Mr. SCHRAMM. You bet.

Senator RIEGLE. And we are not going to not do one because that kid happens to be in the wrong spot.

Mr. SCHRAMM. No.

But our quarrel is not delivering appendectomies to kids, the quarrel is, how can we make sure more kids get appendectomies when they want them.

Senator RIEGLE. Well isn't it both issues? It is both issues, isn't it?

Mr. SCHRAMM. Sure.

Senator RIEGLE. We do have cases of some kids that do not get appendectomies in time. We have cases of people who do not get treatment for Crohn's disease. You were not here to hear that testimony this morning but I am going to send you a copy because I want you to read it. We had a case history in here on that.

It is both things. I guess I would like to hear a little bit more of a sense of urgency about getting health care to the people that do not have it than, the concentration, proper as it is, on the mechanics of how we do it. We have to have the mechanics and we have to deliver it. We are not delivering it to a lot of people.

Frankly, I do not think the private insurance companies are working very hard at it, to get to the people who do not now have it. That bothers me.

Mr. SCHRAMM. It bothers me that you have that impression, Mr. Chairman.

Senator RIEGLE. Well, you just told me awhile ago that you are working on the possibility of something for children out across the country, a standard program, pretty simple. You do not have to be a genius in health care to figure out that something like that could be a very useful thing in this country. But you do not have a plan.

Your companies have been around for decades and decades and decades. This is not a new problem. It is an old problem.

Mr. SCHRAMM. I appreciate that, sir.

Senator RIEGLE. I would like to see some initiative.

Mr. SCHRAMM. That is fine. We are taking initiative. But we cannot leave this question without the observation that the single largest group of children who are uninsured today are below the proverty line. The number of uninsured children grows faster among the population that should be covered by Medicaid than the population that was ever intended to be covered in the private sector.

The rate of inflation of uncovered kids is growing much faster in the publicly funded programs.

Senator RIEGLE. I want you to come back with a plan that is going to catch kids like this. All right?

Mr. SCHRAMM. Yes, sir.

Senator RIEGLE. If you cannot do that, then, you know, I do not think you are doing your job right, quite frankly. I do not mean just you, I mean the association. You know, enough time has passed. If you cannot offer something then do not be surprised that we are going to offer something that may not be to your liking. That is why I would rather see some creativity on your part.

Let me just finish by saying, you also would have heard me say earlier today, Mr. Schramm, if you would have been here, I said to the representatives of the AFL-CIO and the UAW that everybody was going to have to give and take in this process. I said that to them and I am saying it to you and I am going to say it to everybody else that we have before this subcommittee.

That is, this is going to have to be a blend of views, there is going to have to be give and take and there is going to have to be a lot of goodwill in the process. So I would ask that in the areas we are going to weigh carefully the constructive criticisms that you folks have made today, and that others make and we will take those into account when we figure out what kind of adjustments are needed on the margin here or there.

What I would hope is that we do not have anybody that decides to sort of hang out to the side and not be in on the team play. I mean people can make that judgment and if they do then, we are going to go ahead and get it done one way or the other. I would rather have everybody participating fully and prepared to give and take because that is what the process is all about. I would like you folks to take that message back as the other witnesses have been asked to take it back.

Do we know if Senator Durenberger is returning? Very good. He has had another meeting that he had to leave for.

In any event, I thank you for your testimony and the other witnesses.

The committee stands in recess.

[Whereupon, the hearing recessed at 12:50 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR LLOYD BENTSEN

Mr. Chairman, I would like to express my appreciation to you for holding this hearing today. There are so many aspects to the issue of comprehensive reform of the health care system, and so many parties who can contribute constructively to the debate, that these hearings are critical in developing the legislative record. As you know, the full Committee will also explore these issues in its continuing series of hearings on health care costs and access.

I look forward to the testimony of the witnesses you have assembled and thank them for agreeing to share their insights on health care reform proposals. I would like to extend a special welcome to Jose Camacho, of Austin, Texas, who will share with the subcommittee members the perspective of community health centers as providers of care.

I know that the witnesses today will be focusing their remarks on the relative roles of the public and private sectors in assuring access to health care. In this regard, I am particularly interested in hearing the witnesses' opinions about the role of the Medicaid program in a reformed health care system. I am also interested, however, in hearing the witnesses' views about how to control the rapidly rising costs of health care. National health care expenditures increased 11.1 percent between 1988 and 1989, the third year in a row that growth accelerated. It is estimated that national health care spending was about $675 billion in 1990, over 12 percent of the Gross National Product. Total national health expenditures are expected to increase to about 17 percent of the GNP by the year 2000, up from 8.6 percent in 1979. I think we would all agree with 0MB Director Darman's statement at our April 16 hearing that the trend in growth of health care costs is indeed "unsustainable."

Given their expertise in purchasing and providing health care and health care insurance, I hope that today's witnesses can offer us guidance in the most effective strategies for enhancing access to health care while containing costs in both public and private insurance programs.

PREPARED STATEMENT OF JOSE CAMACHO

Mr. Chairmen and Members of the Subcommittee:

My name is Jose Camacho; I am Director of the Texas Association of Community Health Centers, representing 28 community-directed comprehensive primary health care centers that serve more than 225,000 low-income, uninsured and medically underserved Texans. I appreciate the opportunity to speak with you today, on behalf of the National Association of Community Health Centers and the more then 600 community and migrant health centers serving 6.2 million medically underserved Americans in urban and rural communities across the country.

GENERAL OVERVIEW

You have, no loubt, already heard—and will hear during the remainder of today's hearing—a good deal from many experts and observers about the current crisis gripping America's health care system, and the critical need for immediate, forceful action to address the system's ills and shortcomings. The National Association and its member health centers are well aware of the failures of our health care system, in particular because they care for millions of Americans who have been forgotten

or left behind—unserved, or poorly served at best, by traditional health care providers. In this context, it should come as no surprise that the National Association of Community Health Centers strongly supports the call for significant and meaningful action to reform America's health care system, and at the earliest possible opportunity.

My purpose here today, however, is not to repeat the already lengthy and well-documented litany of system failures; rather, I am here to stress the vital importance of including—as a central element of any system reform package—a plan and the resources necessary to develop systems of ambulatory primary health care in those areas, and for those population groups, that have historically lied beyond the reach, capability, and interest of the traditional medical care system—and which will remain there REGARDLESS of the mechanism chosen to extend coverage to the uninsured—unless that coverage is accompanied by a systems development effort. Not only do I want to stress the need for such an element, but I also wish to offer a plan—and to commend you, Mr. Chairman, for including such a plan in your bill, S. 1227. I would be remiss, however, Mr. Chairman, if I did not note that action to develop these vitally necessary systems of care CAN AND MUST be undertaken immediately—even in advance of broader efforts to ensure universal coverage, and to note, with deep appreciation, that Senator Chafee has already introduced legislation—S. 773—to accomplish that objective. In fact, we have noted the remarkable similarity between the systems development provisions in both bills.

THE MEDICALLY UNDERSERVED AND THEIR NEEDS

In the recent discourse on the sad state of America's health care system, much attention has been given to the 34 million or more Americans who lack any form of health insurance. To be sure, any effort at system reform, if it is to be meaningful, must include steps to provide health care coverage for these—and all—Americans. It is, however, most important to note that, for millions of Americans, the extension of such coverage *will not alone ensure access to REAL care, or at least care by the right types of providers.* We estimate that there are more than 30 million such Americans, whom we call medically underserved.

Who are these medically underserved Americans? They are overwhelmingly poor and low-income, disproportionately minority, mostly uninsured but also many who currently have public coverage, and others who live and work in areas with too few appropriate providers of care. They include members of groups such as:

• **Uninsured Low-Income Persons:** Nearly two-thirds of all uninsured Americans—or 22 million people—have incomes below 200 percent of the federal poverty level. Their lack of insurance, and the fact that most live neighborhoods or communities with inadequate numbers of providers, means that most have avoided or delayed seeking care in the early stages of illness when treatment is less complex and less costly; and that most have frequently sought care from inappropriate, and often very costly, providers such as hospital emergency rooms or "Medicaid mills."

• **Rural Residents:** Although rural Americans comprise about 25 percent of the general population, they account for more than half of those living in designated Health Professions Shortage Areas (HPSAs). While the growing number of physicians has worked to increase the availability of care generally, most rural areas have too few physicians, and many sparsely-populated areas still have no physician coverage.

• **High-risk Pregnant Women and Children:** Nearly 2 million deliveries each year involve low-income women, many of whom lack insurance or access to a regular provider of obstetrical care. The recent withdrawal of large numbers of obstetricians from direct care, due in large part to the current malpractice climate, has severely restricted access to care for additional thousands of pregnant women. Moreover, millions of low-income children lack access to even basic acute care, not to mention the vital preventive services so necessary to proper and healthy early childhood development.

• **Minority Americans with Special Needs:** The nation's more than 60 million Blacks, Latinos, Asian/Pacific Islanders, and Native Americans—and its growing population of recent immigrants from Africa, Asia, the Caribbean and Latin America—face seriously diminished access to care. Even when insured (and insurance coverage is significantly less likely), minority Americans have less access to primary and specialized health care, and in particular lack access to providers who understand their language and cultural needs.

• **Migrant Farmworkers:** The nation's more than 4 million migrant and seasonal farmworkers share all the health problems of other poor Americans, compounded by

factors associated with the hazards of farm work and the barriers to health care resulting from their mobility.

• **Other High-risk Groups:** These include the estimated 2 million homeless persons, those with HIV infections, the more than 6 million Americans who abuse alcohol and drugs, and the nearly 6 million low-income elderly Americans.

In this nation, health insurance is an essential prerequisite to adequate health care. But studies have shown that health insurance, while pivotal, cannot alone solve the grave maldistribution problems that affect so many inner city and rural communities. Nor can health insurance alone make care accessible to millions of Americans who remain severely isolated from decent care because of special needs or patient characteristics that make them unattractive to traditional private providers.

The impact of this isolation is profound, and results in infant and childhood mortality rates so high, childhood immunization rates so low, and hospitalization rates for preventable illnesses so elevated, that America routinely ranks near the bottom of all industrialized nations for standard health indices.

Thus, it is clear that any solution to our nation's health care crisis must include the elimination of not only financial, but also geographic, organizational, physical, linguistic, and cultural barriers to decent health care.

ENSURING ACCESS TO CARE FOR THE UNDERSERVED

To achieve the goal of universal access to basic health care for all Americans, the nation must make a commitment to develop comprehensive primary health care service delivery systems in all communities where they are needed. Toward that end, the National Association of Community Health Centers last year proposed ACCESS 2000, a modest, incremental initiative to develop comprehensive, well-staffed primary health clinics in every medically underserved communities by the end of the decade. To achieve that goal, the ACCESS 2000 initiative builds upon such programs of proven effectiveness as federally-funded community and migrant health centers and other non-federally supported community health clinics providing health care to medically underserved families. This effort is most appropriate as an integral part of an overall plan to assure all Americans access to basic health care—as is the case, Mr. Chairman, in your bill, S. 1227. The end result of such an effort would be the establishment, in all such communities, of clinics that are:

- **Community-based,** thus responsive to local needs;
- Focused on providing comprehensive primary and preventive health care;
- Family-oriented, caring for people of all ages;
- Quality-driven, staffed with well-trained providers and support personnel;
- Available and accessible, in terms of hours and locations;
- Affordable, based on ability to pay;
- Federally-monitored for quality of care and cost efficiency; and,
- Linked to the rest of the health care system.

By using such a systems development approach, the assurance is provided that the systems are built *only* where they are needed, are focused especially on the underserved families they are intended to serve, and are directed toward providing in particular the services that their patients need.

In summary, this effort would bring about a more appropriate distribution of health care resources through the development of a critically-necessary health care delivery system that is essential to ensure the success of any health care financing mechanism in providing equitable, real access to care for all Americans.

KEY PRINCIPLES OF A NATIONAL HEALTH INSURANCE PLAN

In addition to the vital systems development issue, I would like to present a series of concerns and ask that you take them into account as you proceed to develop a policy response to the current crisis. These come in the form of a set of Principles, developed by the health centers through their National Association to guide their evaluation of the effectiveness of the various system reform proposals already introduced in this Congress. These Principles deal with critical elements of any system reform policy, including provisions covering eligibility, benefits, provider participation and reimbursement, cost containment, and quality assurance—and their effectiveness in responding to the needs of America's medically underserved people.

1. *The plan should guarantee coverage and access to care for all Americans.* In order to fulfill the promise of universal coverage, it is critical that any plan extend coverage to all persons, regardless of family composition, state residence, immigra-

tion status, or relationship to family head. This coverage should include residents of all U.S. states and territories.

2. *Enrollment procedures and forms should be simplified, easy to understand, and available to everyone.* Enrollment forms should be standardized for all jurisdictions, and should be available in the work place and various community settings (including health care agencies), and enrollment assistance should be provided, in particular for those with limited literacy skills.

3. *The plan should prohibit pre-existing condition limitations and extended waiting periods, and coverage should be transportable across state lines.* These restrictions are vitally important, especially if a portion of the plan is to be state-administered.

4. *Basic benefits must be comprehensive and uniform for all persons, including essential preventive services, and important supplemental services should be provided for populations with special needs,* including all such populations referred to earlier in my statement. Critical services would include periodic screening, diagnostic, referral and treatment services for children and adults; special services for high-risk pregnant women and infants; translation or multilingual services; care for long-term chronic health conditions among children, homebound adults and frail elderly persons; substance abuse and HIV counselling and treatment services; outreach and home visitation; and respite care services.

5. *The plan's coverage should be affordable for all Americans, and should avoid creating financial barriers to care.* The cost sharing requirements of any plan must be reasonable for all individuals and families, and should be reduced or eliminated for low-income Americans. Also, certain vital services—such as maternity and infant care, as well as preventive services—should not be subject to cost sharing requirements.

6. *Provider reimbursement rates must, in general, be reasonable and consistent for all payers, and should recognize the special costs of providers serving large numbers of low-income or medically underserved Americans.* Also, the plan should recognize and cover the services of key practitioners (such as nurse practitioners and other midlevel providers), should require providers to accept assignment of claims, and should prohibit or severely restrict balance billing.

7. *The plan must have effective cost containment and quality assurance mechanisms that are universal and apply equally to all payers, but do NOT impede access to care for anyone.* To the extent that the plan encourages the use of managed care, individuals should not be forced to choose a single provider or inaccessible providers, and providers should be allowed to elect payments systems other than capitated payments. Also, the plan should establish uniform billing requirements and procedures, standardized reporting and data collection requirements, and common quality of care standards developed with strong consumer involvement.

COMMENTS ON THE SENATE DEMOCRATIC LEADERSHIP PLAN

On behalf of the National Association of Community Health Centers and the health centers it represents, I want to commend you, Mr. Chairman, and Senators Kennedy, Mitchell and Rockefeller, for the Senate Democratic Leadership Plan you have introduced in S. 1227. Of particular note is that your plan:

- Guarantees coverage for nearly all Americans, with simplified enrollment procedures and forms;
- Ensures comprehensive benefits for all enrolled persons, and enhanced benefits for special populations, including low-income Americans;
- Makes that coverage affordable for low-income persons and families, with assistance in meeting the cost sharing requirements;
- Contains the strongest systems development program found in any system reform legislation introduced in the Congress to date: and,
- Establishes a good beginning for effective cost containment and quality assurance mechanisms.

I would be remiss, however, if I did not mention some important concerns we have with regard to the current provisions of S. 1227. These include:

- Placing Americare under state administration, rather than federal management. Here we are most particularly concerned that a universal coverage system not repeat the experience of the Medicaid program, with 53 dramatically different programs across the nation. If the public program must, of necessity, be state-administered, we believe that it should be accomplished *only* under the strictest and most comprehensive of federal standards and oversight.

• Provider reimbursement provisions that allow states to substitute alternative payment systems, subject only to not exceeding upper aggregate payment limits. Here we are concerned that special providers serving large numbers of low-income or medically underserved Americans (such as disproportionate share hospitals and Federally Qualified Health Centers) might not have their costs of providing care adequately recognized and reimbursed.

• Limiting Americare special benefits to the unemployed poor only. Clearly these benefits need to be made available to all low-income Americans, regardless of their employment status.

Because the need for action is so great, Mr. Chairman, I want to assure you of our strongest support for your efforts in this regard, and of our desire and willingness to work with you and your colleagues to fashion the best possible system reform measure. We commend you and Mr. Chafee for your leadership on this vital issue, and thank you for the opportunity to express our views.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Thank you, Mr. Chairman for holding this morning's hearing. I regret that I was unable to attend last week's hearing on this same subject, however I was traveling in Minnesota with Dr. Wilensky, meeting with groups of physicians and other health professionals about the Medicare physician payment reform.

Mr. Chairman, thank you also for your continued efforts to assure that all Americans have access to quality medical care. While you and I disagree on how that goal should be accomplished, we do not disagree on the goal or its importance.

Mr. Chairman, as we continue to hold hearings on S. 1227 and other health care reform packages, I am struck by how little consensus exists among the relevant constituencies about what direction such a reform should take.

During several hearings on health care costs and access in the Labor and Human Resources Committee and the Finance Committee, we have listened to a plethora of economists, academicians, health care providers, small and large employers and insurers advise us about the nature of these problems and potential solutions.

We have also listened to many individuals and families such as that of Cheryl Eichler—who have been victimized by a system that falls to guarantee basic health care coverage for all.

Whlle the testimony has been educational, and sometimes enlightening, it has not—at least for this Senator—produced a clear sense of direction on how best to proceed. More than anything, it has served to reinforce my belief that the problems need better definition before we adopt widespread change to solve them.

For example, I believe it is not accurate to say that 31 to 37 million Americans lack access to care because they are uninsured. Some of these individuals choose to be uninsured because they can afford to pay their incidental medical costs out of pocket. Some are young adults who don't perceive a need for insurance because they don't believe anything serious is going to happen to them.

In this country, we generally do not allow sick or injured people to go untreated. The health status implications of being uninsured are not well defined. In addition, while much of the current rhetoric on the subject of access emphasizes health care as a fundamental right of all Americans, no one seems willing to define the parameters of that right. Just what is it we agree all Americans should have access to? Is it specific medical services, or is it protection from financial devastation due to a medical catastrophe?

Until we can answer those questions with some degree of confidence that our answers reflect the attitudes and feelings of the American people, Mr. Chairman, I am extremely reticent to see us pass comprehensive reform legislation.

In the meantime, however, I believe—and I perceive that many of the groups we have heard from previously and will hear from today belIeve—that there are a number of important Intermediate steps that we can legislate within the next year or two that will result in substantial improvements in access to health insurance.

The one action on which there seems to be the greatest degree of consensus is the need to reform the market for small group health Insurance. There is widespread agreement, even from within the industry, that the current market denies many small employers the opportunity to purchase reasonably-priced coverage for their workers.

As you know, Mr. Chairman, last year I Introduced the American Health Security Act to accomplish the desired reforms: guaranteed issue and guaranteed renewability of policies; limits on the use of pre-existing condition exclusions, and significant restrictions on the use of experience rating. My legislation, which was re-introduced

early this year as S. 700, would help make health Insurance more affordable to small purchasers by requiring all insurers in the small group market to offer two core benefit plans, which would be exempt from all state mandated benefits.

Mr. Chairman, I was pleased to see that many of the key provisions of the American Health Security Act were incorporated in Health America. In addition, I am encouraged by the fact that the distinguished chairman of the full committee Senator Bentsen—has indicated his intention to introduce legislation similar to mine before the end of the year. Through our combined efforts—yours, his and mine—we can help right some egregious wrongs in this market.

PREPARED STATEMENT OF JAMES EHLEN

INTRODUCTION

Mr. Chairman and Members of the Committee.

My name is Dr. James Ehlen. I am chairman and chief executive officer for MEDICA, a health maintenance organization covering over 530,000 members in the state of Minnesota. Prior to joining MEDICA, I was a practicing endocrinologist from 1976 to 1988. I am actively involved with the Minnesota Council of HMOs including having most recently served as chairman. In addition, I participate as a member of the Rand Corporation clinical subcommittee study on quality assurance, and I am a member of the American Medical Association, the Minnesota Medical Association, and the American Diabetes Association.

I am pleased to be here today on behalf of the American Managed Care and Review Association (AMCRA). By way of background, AMCRA is the national trade association for the managed care industry. AMCRA's membership includes health maintenance organizations (HMOs), competitive medical plans (CMPs), preferred provider organizations (PPOs), independent practice associations (IPAs), utilization review organizations (UROs), and other entities that offer managed health care services. AMCRA is the only trade association representing the entire spectrum of the managed care industry.

AMCRA recognizes the efforts of the Chairman and each member of the Subcommittee who has demonstrated their willingness to confront the critical issues in the debate on how to deliver quality, affordable health care to all Americans. The proposals, which include HealthAmerica cosponsored by Chairman Reigle and the America Health Security Act of 1991 introduced by Senator Durenberger, represent innovative approaches to reforming the health care financing system. These proposals will continue to generate the discussion necessary to help us identify where to start in responding to the challenge of delivering quality, affordable, and accessible health care.

WHAT IS MANAGED CARE?

AMCRA applauds the Chairman's recognition that all aspects of managed care must play a role in any reform initiative. We believe it is important for health care reform proposals, like HealthAmerica, to recognize that managed health care is a comprehensive approach to health care delivery; and far more than just a cost saving device.

Managed health care improves the quality and efficiency of health care services through increased coordination and quality review. This comprehensive approach is best illustrated by the emphasis placed on **preventive** health care. Managed health care has been at the forefront in developing "wellness programs" including pre-natal and well-baby care, encouraging annual physical exams and cancer screening, and CPR and smoking cessation clinics.

STATUS OF MANAGED CARE

Enrollee Acceptance and Satisfaction for Managed Care

According to the InterStudy report, *Managed Care: A Decade in Review*[1], as of July 1990, 33 million Americans were enrolled in an IPA, network, staff, or group model health maintenance organization. The same report indicates that over 77% are enrolled in an HMO that has been operating for more than 5 years.

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[1]. The Interstudy Edge, "Managed Care: A Decade in Review 1980-1990," p. 7.

Our data also estimates that in December of 1990 approximately 65 million Americans were enrolled in some type of preferred provider organization or arrangement.

As the trends in managed care enrollment increased, AMCRA set out to determine the overall satisfaction level of Americans enrolled in managed care plans and those in traditional health insurance. In May of 1991, AMCRA commissioned the widely respected Gallup Organization, Inc., to conduct a comprehensive study of the American public's satisfaction with their health care delivery systems. In the first survey of this type, Gallup contacted 1,402 Americans in seven geographic regions.

When asked to rank overall satisfaction on a scale of 1 to 100, enrollees of both groups rated their satisfaction an identical 79. When Gallup polled on specific elements of satisfaction, they found that 10 of 12 items tested showed no significant statistical difference between managed health care and indemnity health insurance. Of the remaining two factors (the amount patients pay for each physician visit and the time/inconvenience of paperwork), **managed care enrollees were more satisfied than indemnity members.**

Respondents also believed that managed care delivered lower out-of-pocket costs and covered more services than indemnity insurance, **making managed care a better dollar value than indemnity insurance.** Additionally, the study also revealed that managed care will gain a rising market share if current trends continue, as most new managed care enrollees are switching from indemnity plans.

Relationship of Managed Care to the Provider Community

AMCRA believes that managed care establishes an educational and mutually beneficial relationship between providers (hospitals, physicans, etc.) and managed health care organizations, and serves as a conduit to providers for enrollees and employers. Providers have good reason to be pleased with a managed care relationship. Managed care organizations such as HMOs, IPAs, and PPOs offer physicians improved cash flow, increased patient volume, a promising referral network, and in the case of a PPO or IPA the independence to retain the traditional fee-for-service patients. Managed care relationships offer hospitals a steady volume of patients, and prompt payment agreements which decrease bad debt and allow for more accurate long term financial planning.

AMCRA is aware that some providers have experienced difficulty in adjusting to the growing popularity of managed care. We believe the solution to diffusing such difficulties lies with better education and better communication between all players in the delivery of health care. Managed health care requires some providers to rethink their attitude towards the health care marketplace in light of patient and payer demands for both efficacy and accountability.

Managed care can effect positive change on physician practice patterns. In March of 1991, Dr. Joseph A. Fields, a University of Connecticut researcher commissioned by the Connecticut State Legislature, succinctly summarized this effect. According to Dr. Fields,

> *"Physicians as a group have a great range in qualifications, ability and type of practices. Many physicians operate in small or solo practices and simply do not have the time to change their practice patterns to reflect the current state of medical knowledge. Many operations that are routinely performed procedures such as hysterectomies, pacemaker insertions and bypass surgeries are not medically necessary in a large number of instances. The instances where these procedures are unnecessarily performed harms patients and increases the costs of medical care... Utilization review can be a sound and reasonable approach for controlling physician practice patterns."*[2]

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[2] Testimony before the Connecticut State Legislature on Utilization Review, March 14, 1991.

Managed health care's ability to effect change on physician practice patterns is also evident in a February of 1991 study by the Urban Institute analyzing the effect of the presence of Medicare managed health care in a metropolitan area on Medicare fee for service costs. According to the report,

> *"The results suggest that HMOs decrease Medicare expenditures: every 10 percentage points of HMO market share decreases Medicare expenditures by 1.2 percent in the short run and as much as 3.9% in the long run."*[3]

The report further attributed the decrease in Medicare expenditures to the impact of the IPAs that contract with the Medicare program. IPAs represent the majority of Medicare beneficiaries in managed care as well as over half of the general HMO marketplace. Because IPAs allow physicians to treat both HMO patients and fee for service patients there is a spillover effect with the physician practice patterns.[4]

MANAGED CARE AND QUALITY OF CARE

Many of us are accustommed to the belief that spending more results in receiving better quality. But spending more on health care services is by no means indicative of the quality of care received. Spending more may merely represent reimbursement for the quantity of care delivered, not the quality of care received.

As health care consumers, we need to rethink our attitudes about cost and quality. If spending more means higher quality, then how do we explain how proper pre-natal care especially for high risk pregnancies can actually reduce the potential costs of medical care for a premature child. In fact, the Institute of Medicine indicated for each $1 spent on providing prenatal care to low-income, poorly educated women, there is a savings of $3.38 for their infant medical care in the first year of life.[5] And, proper prenatal care can protect the family from the emotional challenges that can potentially arise from a difficult pregnancy and the rearing of a premature child. In the current delivery of health care, there are far too many women who go without proper pre-natal care. The Children's Defense Fund recently reported that the number of infants born to women who received no pre-natal care or care in the last three months of pregnancy climbed significantly in certain states including: 88% in Rhode Island, 82% in Massachusetts, 74% in South Carolina, and 50% in Pennsylvania.[6] Imagine the impact managed care could have in these states!

Managed health care provides quality care. Recent research has begun to compare the quality of health care delivered in managed care versus fee for service. Much of the research is being funded through grants by the Health Care Financing Administration (HCFA) and primarily focuses on the delivery of services to the Medicare population. This research has been finding that **the quality of care in managed care is as good as if not better than in fee for service.**

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[3] HMO Market Share and its Effect on Local Medicare Costs, W. Pete Welch, The Urban Institute, February 1991, (Abstract).

[4] HMO Market Share and Its Effect on Local Medicare Costs, W. Pete Welch, The Urban Institute, February 1991, p.4.

[5] Prenatal Care: Reaching Mothers, Reaching Infants, SS Brown, ed., Washington D.C.: National Academy Press; 1988.

[6] Faulkner & Gray's Medicine & Health, "Briefly This Week," August 1991.

For example, Dr. Sheldon Retchin, of the Medical College of Virginia, studied elderly patients with congestive heart failure (CHF), a chronic condition that frequently occurs in the elderly. Dr. Retchin's study compared the care of patients under prepaid care versus fee for service Medicare. The study concluded that

> *"HMOs enhance the continuity between hospital and ambulatory settings for patients discharged following CHF."*[7]

The findings further concluded that outpatient evaluation and management was similar in both settings although HMO providers were significantly more likely to advise reducing salt intake and were more likely to schedule follow-up within one week of discharge.

Other studies have reviewed conditions that most commonly afflict the elderly in order to examine the quality of care delivered in prepaid programs versus fee for service. This includes a 1990 study on ambulatory care which suggested that individual items of medical histories and physical examination were performed most often for HMO patients and least often for fee for service patients. In addition, the results suggested that recommended elements of routine and preventive care are more likely to be performed for Medicare enrollees in HMOs than in fee for service settings.[8]

Another study released in 1991 studied the management of geriatric hypertension in the outpatient setting comparing fee for service patients to HMO patients. The results concluded that, using criteria established by a panel of expert physicians, HMO patients consistently received more extensive history-taking, physicial examinations, and laboratory workup pertinent to hypertension relative to their fee for service counterparts.[9]

Bottom line: These studies are indicative of the fact that the quality of care in the HMO environment is as good as if not better than fee for service.

These studies are only the beginning. Both public and private research identifying quality indicators and establishing medical practice guidelines must continue. We in the managed care industry are actively investing in these areas, but we recognize we cannot and should not do this in a vaccuum away from the fee for service environment. HealthAmerica recognizes the importance of continued investment in quality indicators, medical practice guidelines, and technology assessment. Whatever reform measures are adopted, AMCRA supports further investment in these fields. In addition, we would offer the expertise of the managed care industry which has been working in consortium with researchers, and within the confines of anti-trust legislation, to focus on continuous quality improvement.

MANAGED CARE IMPACT ON CONTAINING THE RISING COSTS OF HEALTH CARE

Managed health care, in its focus on delivering quality care and its emphasis on preventive services, is able to restrain the rise in health care expenditures. Evidence of managed health care's ability to restrain rising costs is found in the recently released Foster Higgins study that compares HMOs and fee for service. According to the study, the average annual HMO premium per person in 1990 was $2,683. The average annual fee for

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[7] Elderly Patients with Congestive Heart Failure Under Prepaid Care, Sheldon M. Retchin, M.D., M.S.P.H., and Barbara Brown, PhD, The American Journal of Medicine, February 1991, p. 236.

[8] Quality of Ambulatory Care in Medicare Health Maintenance Organizations, Sheldon Retchin, M.D., M.S.P.H., and Barbara Brown, PhD, American Journal of Public Health, Volume 80, 1990, p. 411-415.

[9] The Management of Geriatric Hypertension in Health Maintenance Organizations, JA Preston and SM Retchin, Journal of the American Geriatrics Society, (at print in May of 1991).

service premium was $3,214[10]. HMOs on average cost 17% less than traditional fee for service making **managed health care a better value for every health care dollar spent.**

The Foster Higgin study went further to compare the rate of increase in health premiums in the HMO setting versus the fee for service. According to their findings, premium increases in the HMO setting averaged 15.7% annually versus the fee for service setting which averaged 21.6%. If this differential continues to occur, the average annual premium for HMOs will be at least 35% less in five years and up to 50% less in ten years[11]. Given this scenario, I feel confident that managed care has already played a significant role in restraining health care cost increases for the community it currently serves. In addition, I strongly believe it can play a significant role in restraining the rise in future health care costs.

In addition to the absolute difference in premium costs in fee for service versus HMOs, we cannot lose sight of the earlier study regarding the ability of Medicare managed care to actually reduce the Medicare fee for service expenditures. You can imagine if a 10% Medicare managed care market share can influence Medicare fee for service costs, then metropolitan areas with a significant enrollment in managed care, like Minnesota where we have over 1.3 million HMO members, must also exert reductions in the commercial fee for service costs.

MANAGED CARE IN THE PRIVATE AND PUBLIC SECTORS

AMCRA believes that managed care does and should continue to play a role in private and public health care initiatives.

Small business reform, found in both Senator Durenberger's American Health Security Act and in Chairman Reigle's HealthAmerica, will be a critical area for health care reform especially given the Pepper Commission's findings that over 20 million "uninsured" are full-time workers and/or dependents. Furthermore, two-thirds of these "working uninsured" are working with small businesses or are self-employed[12]. As an affordable health care option, managed care has and should continue to play an important role in delivering quality affordable health care to businesses of all sizes including the small business community.

We also welcome reform initiatives that are willing to address federal override of state anti-managed care legislation. In defining anti-managed care initiatives, we appreciate Chairman Reigle's foresight in identifying examples of laws that pose a barrier to effective managed care including barriers to the implementation of effective utilization review. We would welcome the opportunity to work with any member that would like to learn more about the impact of state anti-managed care legislation on the successful implementation of managed health care programs attempting to deliver quality, affordable health care.

Furthermore, AMCRA applauds efforts that include managed care in the delivery of care in public programs. Whether under a new public sector program or through the current public programs like Medicare and Medicaid, managed care should play a significant role in helping achieve the goals of access, quality, and affordability. Our members are actively involved in public health care programs including Medicare, Medicaid, the Federal

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[10] "HMO Premium Difference with Indemnity Sparking Growing Employer Support," Health Market Survey, August 14, 1991, p.3.

[11] Data extrapolated by the American Managed Care and Review Association based on the average annual HMO premiums and FFS premiums of the Foster Higgins study as well as their associated rates of increase.

[12] A Call for Action, The Pepper Commission Final Report, September 1990, p. 25.

Employees Health Benefit Plan (FEHBP), and CHAMPUS. In light of our experience with these programs, AMCRA would encourage that any reform initiative addressing changes to public programs, especially those that increase eligibility for public programs, also include actions to dismantle existing barriers that have prevented the expansion of managed care in these programs.

For example, AMCRA's Medicaid Policy Task Force has focused on the following federal issues as critical to the expansion of the Medicaid managed care program: the federal matching payment formula for managed care participation; the 75/25 enrollment mix rule; the administrative process for states to provide mandatory managed care plans for their Medicaid enrollees; and minimum standards for eligibility and benefits. Any reform initiative that proposes to increase eligibility for Medicaid must also remove barriers to the expansion of Medicaid managed care[13]. Otherwise, the initiative must be willing to confront the significant costs associated with just increasing eligibility -- a Congressional Budget Office estimate suggested that expanding Medicaid to individuals and families with incomes of up to 200% of federal poverty level would increase federal spending by approximately $16 billion and state spending by $12 billion[14].

In addition, AMCRA's Medicare Policy Task Force has focused on the following federal issues as critical to the expansion of the Medicare managed care program: focusing of Administration attention on improving the current managed care programs; reforming the Medicare managed care payment formula to assure adequate rates; and establishing a quality assurance mechanism that takes advantage of the sophisticated mechanisms inherent in managed care entities instead of relying on outdated proxies for quality[15]. Reform measures that also propose to assist Medicare beneficaries should be willing to address the integration of managed care. Medicare managed care has already helped to meet the health care needs of over 1.1 million Medicare beneficiaries - and has provided these beneficiaries with much more than traditional Medicare coverage at much lower cost to the beneficiary.

We would be more than pleased to work with any member on identifying other barriers to managed care as they exist in public programs like FEHBP and Medicare.

CONCLUSION

In conclusion, AMCRA appreciates the consideration afforded by Chairman Reigle and the other members of the Senate Finance Subcommittee on Families and the Uninsured. Managed care has demonstrated itself to be a better value for every health care dollar spent. Managed care has demonstrated that quality of care in the managed care setting is as good as if not better than fee for service. Managed care has received the continued endorsement of the public as more individuals choose to join a managed health care program either through their employer or through an individual plan.

Making quality health care affordable and accessible to all has been a cornerstone to managed care. As health care reform initiatives focus on the issues of costs and access -- both in public and private programs -- managed care should be integral to the debate.

Once again, thank you for your time. I would welcome any questions you may have.

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[13] The American Managed Care and Review Association Medicaid White Paper, 1991.

[14] "Reform Proposals Costly," American Hospital Association, July 15, 1991, p.2.

[15] The American Managed Care and Review Association's Medicare White Paper, 1991.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman: The agitation in Congress and anxiety within our constituencies over the malaise in our health care system continues. But it is a mistake to conclude that what our constituents are demanding is comprehensive health care reform. Further, that is a knee-jerk Congressional reaction to find a simple "one-size-fits-all" approach to our health care malaise. Most of our citizens are convinced that if the federal government gets involved, things will only get worse. Moliere wrote, Man more often suffers from his remedies than his maladies.

Just consider the Medicaid program. The nations's governors know our remedies are worse than the problems themselves. We keep passing mandates without resources. The States have better ideas about how to prioritize funding and test new systems of care. We prevent that from happening by our federal regulations. Let's begin health care reform by allowing our States to be laboratories for experimentation. Let's allow them to try their own ideas.

With the complexity of the health care system and the variety and magnitude of the problems, let us not be seduced by simplistic, revolutionary, heavy-handed regulatory approaches. We should address, incrementally, the real problems that are truly concerning our constituents and that we can remedy directly.

There is one overwhelming concern among our citizens. It is not quality, it is not access; it is not shortfalls in certain outcome variables, such as infant mortality. The major concern is the high cost of our current system. We will almost inevitably be spending 17% of our GNP on health care by early in the next decade. That compares to 6% currently for Japan, and 9% for West Germany, both major competitors internationally.

There are two focused, incremental interventions that will reduce costs and increase access—medical liability reform and small group insurance market reform. Initiatives in these areas could dramatically reduce our uninsured problem, while reducing, not just constraining, costs for all of us.

Combined with State empowerment in the Medicaid program, attention to liability and small group reform would address *real* problems, of real concern, to our constituents. And these efforts would reduce costs, not increase them. No new taxes would be required. No new onerous, heavy handed federal regulations would be necessary.

I hope we resist the temptation to meddle from on high. We need reform of our system. But it should be targeted and incremental. We must ensure that our remedies are not worse than the malaise that they are designed to address.

PREPARED STATEMENT OF WILLIAM HOFFMAN

Mr. Chairman, I am William Hoffman, Director of the UAW Social Security Department. I want to thank you for the opportunity to testify on behalf of 1.4 million active and retired members of the International Union, UAW and their families on the subject of health care reform proposals. We welcome the opportunity to join our efforts with those of other Americans who seek real solutions to the problems in our health care system, and who look forward to establishing a national health security program.

We are all aware that America's health care system continues to be in a crisis state. The problems we are confronting are so enormous and out of control that nothing short of total reform will remotely begin to provide an effective solution.

Great concerns face us in the interrelated and interdependent aspects of quality of care, health care costs, and access to services. The data are well documented and widely known. Medical care inflation far exceeds inflation for other goods and services each year. In 1989, the Medical Care component of the Consumer Price Index jumped 7.7 percent, in contrast to a 4.8 percent increase in the overall Consumer Price Index. From May, 1990 to May, 1991, we saw a similar disparity, with the MCPI increasing by 9.0 percent, while the CPI increased 5.0 percent.

As these out of control increases continue, more and more of the available income of the people of this country is going toward health care costs. In 1989, the United States spent over $600 billion dollars on health care, which amounted to nearly 11.5 percent of our Gross National Product. This amounted to over $2,300 per American. By comparison, Canada spent only slightly more than 8.5 percent, or $1,700 per person, in a system that covers everyone. Estimates by the Department of Health and Human Services indicate that during 1990, spending on health care leaped to an incredible 12 percent of the Gross National Product. Without immediate and effective controls, that number will continue to soar.

As the crisis of runaway inflation in the health care system continues to worsen, the quality of care received by millions of Americans remains suspect. When we look at those factors traditionally used as indicators for the quality of care, life expectancy and infant mortality, the United States compares poorly with other industrialized countries. Life expectancy is 74 years in the United States, compared to 75 years in Canada, and 76 in Japan. Similar disparities exist in infant mortality rates. The incidence of malpractice is too high, and retraining and/or disciplinary approaches for aberrant providers have largely been ineffective.

Compounding these tragedies is the fact that over 37 million people are without insurance, one-third of whom are children. More than 50 million people are without insurance for at least part of the year. Unfortunately, these numbers are not decreasing as the amounts spent on health care continue to rise. In fact, the opposite is true. As health care costs rise, coverage declines, both in terms of the number of Americans eligible for health benefits as well as the scope of benefits provided to those who remain covered.

Health insurance protection has been a fact of life in this country for over 50 years. In fact, until about 1980, led by organized labor's efforts, health insurance covered an increasing number of Americans for an expanding range of benefits. From the early coverage for hospitalization and medical-surgical benefits, protection grew to include many additional services, such as mental health and dental care as well as preventive health strategies.

Employer-based health insurance was thought to be the answer when combined with public programs for the poor and the elderly. Health insurance companies and the medical professions assured the American public that voluntary health insurance would protect that segment of the population not covered by Medicare and Medicaid. The promise was that those millions of Americans who live from paycheck to paycheck would be protected from the devastating costs of paying for personal health care services at the time of illness.

If it had not been obvious before, however, by 1980 it became evident that a voluntary approach would never finish the job. By then, it was becoming clear that an employer-based system could not handle the job on its own. For the first time since 1940, the number of Americans with health insurance protection began to fall. At the same time, employers began looking for ways to reduce health care costs. The more aggressive cost cutters, particularly at small firms, if not restrained by a collective bargaining agreement with a union, continually restricted coverage for their employees. As health care inflation continued to wreak havoc on costs, some employers dropped out. As a result, costs began to shift to other employers and households. Employers who continued to provide coverage suffered 15 to 20 percent increases per year in their health care costs.

In further attempts to reduce costs, many employers resorted to a nearly endless array of cost cutting techniques such as: reducing or eliminating prescription drugs, dental, vision, or mental health benefits; adding or increasing deductibles and/or copayments for basic health insurance and/or major medical benefits; reintroducing or increasing periodic worker contributions for health insurance, especially with respect to spouse and dependents' coverage; offering employees, who might have the opportunity for coverage as a dependent spouse under another employer's plan, a cash bounty or some other enhancement of employment benefits, to entice workers to drop their coverage; and reducing or discontinuing retiree/dependent health care benefits before age 65 and Medicare complementary coverage after age 65.

These are only a sample of the methods employers have used to reduce their costs. These methods do nothing to contain the increases in health care costs. They only serve to shift the burden of the costs of health care to the employees, a solution that the UAW knows does nothing to address the real issue: the need for a comprehensive national health care system with strong cost containment features. As was the case in the 1960s with the establishment of Medicare and Medicaid, it is again time for the public sector to step in and share a burden with the private sector that it cannot carry alone.

The skyrocketing costs of health care, along with an inequitable system of financing, adversely affect the international competitiveness of many businesses, and threaten the job security of millions of Americans. In Canada, for example, employer health care costs are approximately one half those in the United States; in Japan, about one third. That kind of disparity is seen as an incentive by multinational corporations to transfer more production and plant investments outside this country.

Escalating health care costs also unfairly affect the competitiveness of older, long established companies compared to newer employers within this country. There are two major reasons for this. First older companies tend to have a higher ratio of re-

tired workers than newer competitors. Thus, the older companies must bear the additional cost of paying for health insurance coverage for their retirees. Second the average age of the active work force often is higher in older companies than in newer employers. Since health care costs tend to rise with age, this also places an additional burden on older companies. It is extremely important that any reform to the health care system address the disparity related to older and retired workers.

The UAW believes that employers should not have to compete on the basis of their health care costs. There should be a "level playing field," with all employers sharing equally in the costs of providing a basic level of health care protection to all Americans. All employers currently pay the same contribution (i.e., the same percentage of wages) to Social Security in order to provide a basic level of retirement income to workers. The same principle should be applied to the financing of health insurance coverage for workers and their families.

For these reasons the UAW does not believe that simply expanding the current employment-based health care system will complete the job at hand. Expansion of the current system will not address the critical issues of: the need for strong systemic cost containment measures; equitably distributing the burden of health care costs among employers, including those employers with a higher proportion of older workers and retirees; and assuring access to high quality health care for all Americans.

The UAW commends you, Mr. Chairman, and Senators Mitchell, Kennedy and Rockefeller, for accepting the challenge to deal with the need for reform of our health care system. The introduction of S. 1227 is encouraging because it attempts to deal with the problem of lack of access to health insurance and health care services in the United States for working people, the unemployed, and the poor. We want to emphasize, however, that dealing strongly with only one aspect of the health care crisis will not solve the overall dilemma. Any proposal must deal with cost containment and quality of care, as well as access issues. In addition, we feel very strongly that progressive financing must be an essential element in any reform of the system. The system should not be financed on the backs of working people.

The UAW believes that the legislation introduced by Senator Simon (S. 1669) would provide needed improvements to S. 1227. The Simon amendment contains a number of important cost containment provisions. Health care budget expenditure limits would be established nationally and by region. Payment rates for hospitals, doctors and other providers would be negotiated. And capital expenditures also would be controlled through the budgeting process. In addition, the Simon amendment would address the problems associated with employer-provided retiree health care benefits by lowering the age for eligibility for Medicare to 60. And his amendment also would phase in more quickly universal access to health care. In our judgment, these are all positive improvements worthy of support. However, the Simon amendment, like the Mitchell-Riegle-Kennedy-Rockefeller bill, is still silent on financing. Our support for any legislation would be contingent on the inclusion of a progressive financing mechanism, which would distribute the costs of the program among all Americans who are able to pay, rather than shifting the burden to workers and their employers.

The health care system in the United States must be fundamentally reformed. Every industrialized nation, with the exception of the United States and South Africa, has some form of a universal, national health security program. This is not a goal attainable only through the sacrifices of our personal freedoms and liberties. When the ideological smoke screens are stripped away, we know that individuals in Canada, Great Britain, Sweden, West Germany, Italy, France, and other free societies are guaranteed basic health care protection by law.

Those who continue to look to classic free market forces to resolve the dilemma have missed the evidence of the last decade. Many, frequently with the UAW in the lead, have established health care programs which have as their goal the creation of competition between systems of care. The triple option—Health Maintenance Organization, Preferred Provider Organization and traditional coverage with utilization controls—is perhaps the best known of these.

Other competitive approaches include selective purchasing arrangements for specific services, drawing not only on price data but historical provider performance as selection criteria. The result of thousands of these efforts has been to mitigate the escalation of costs for the specific groups involved. But this has not had an appreciable impact on general health cost trends. In fact, where we have established such approaches, they have most often resulted in a one time adjustment to the trend, with accelerated cost increases following. Thus, these often well conceived and helpful approaches can only be viewed as individual attempts at health planning within

the wider morass of cross pressures of an out of control system of health care delivery.

I want to emphasize that until overall effective reform occurs, the UAW will continue to struggle to get a handle on the health cost burden. We have no choice. Further, the managed care—selective contracting approach has significant merit as the way of dealing with the more broadly defined quality and appropriateness of care issues. For example, the UAW recently joined with General Motors, Ford and Chrysler in a renewed approach to resolve mental health and substance abuse concerns in a holistic manner. Our new programs emphasize prevention, treatment and after care support. We have also joined with John Deere and the Mayo Clinic to set up a primary health care facility exclusively for John Deere employees, retirees and their dependents. Both of these initiatives hold great promise for improved access and quality enhancement. They are the continuation of our strategy to manage the care received under our programs.

The unique qualities of the American health care system can, and should be, incorporated into a universal, comprehensive single payer system of health care delivery that has its basis in a federal-state partnership. This uniquely American approach would establish federal standards for access, quality and costs. Access would be universal. Quality issues would be viewed in a dynamic continuous improvement model which would be made possible through universal data sets and strong professional oversight. Cost issues would be handled through prospective budgeting with professional fee schedules established, and capital expenditures planned. Building on the variety of experiences across America, the states would develop systems for service delivery. They could select competing types of systems from fee for service to fully integrated approaches employing provider financial risk sharing techniques.

Fewer and more coordinated centralized administrative entities would serve to address critical problems in the health care system which cannot be solved any other way. Such an approach would serve to allow the strengths of the current system to be organized and channeled in ways that are progressive and efficient and would eliminate, in large part, the waste that is rampant in the health care system today.

The UAW has represented workers in Canada for many years, and has come to see the many advantages of their national health care program. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost-effective manner. The General Accounting Office recently issued a report which estimated that a Canadian-style single payer system would save about $67 billion dollars, much of which would be administrative costs—enough to pay for the cost of extending health insurance coverage to the 37 million uninsured.

There are, of course, other dimensions to the cost problem. America's population is aging with an attendant need for health service intervention. We primarily depend upon a fee-for-service system that provides incentives to over-serve. We develop new technology with little or no planned implementation strategy or concern about whether existing equipment or treatments are appropriate or needed. We continue to permit capital expenditures with little regard to creating a rational and efficient system of health services delivery. And, we continue to emphasize treatment rather than prevention.

The UAW believes that effective cost containment can only be achieved through the enactment of a comprehensive national health care program. The UAW strongly supports the adoption of a single payer, social insurance program modeled along the lines of the Canadian health care system. In particular, we support the proposed Universal Health Care Act of 1991 (H.R. 1300), introduced by Representative Marty Russo. More recently, Senator Kerrey has introduced the proposed Health USA Act of 1991 (S. 1446), another single payer proposal which merits serious consideration.

The UAW believes that a Canadian style single payer social insurance national health care program would achieve all the goals of systemic reform. First, by assuring universal access to health care for all Americans, this approach would serve to improve the health status of American citizens. Universal access to a comprehensive set of benefits will assure that all citizens will have the opportunity to seek preventive services, as well as other needed health care.

Second, by establishing a uniform all payers system for reimbursing health care providers, this approach would eliminate cost shifting between public and private payors, between employers, as well as the shifting of costs attributable to uncompensated care. Private and public employers would no longer have to indirectly subsidize our public health care programs. To prevent providers from circumventing the all payers system by simply passing along increased costs to patients, balance billing would have to be prohibited.

Third, this approach would achieve substantial administrative savings. The waste and efficiency associated with the existing multitude of private insurance carriers could be avoided. In 1987, health care administrative costs in the United States amounted to about $400 per capita.

Fourth, and perhaps most importantly, by establishing a mandatory, enforceable budgeting process, this type of approach would guarantee that health care spending would be contained within certain limits. The budgeting process would involve all of the players—providers, consumers, and the government—in determining what the reimbursement rates should be for various types of services and what the aggregate level of expenditures should be. All parties would then be required to live within the agreed upon budgets. Our nation already utilizes a budgeting process to determine how we allocate our resources for national defense, infrastructure, and every other social good or service. It is time we adopted the same approach with respect to the delivery of health care services.

So-called voluntary goals or targets are no substitute for mandatory, enforceable budgets. Unless all parties are required to live within the agreed upon budgets, we will never achieve the discipline needed to contain rising costs.

The UAW also believes that the budgeting process should apply to capital expenditures, as well as payments to physicians and hospitals. Capital budgeting should encompass expenditures for expensive new technology, in addition to investments in new buildings. Only through this type of mechanism can we hope to eliminate excess capacity and over reliance on state of the art technology, and begin to establish priorities for the allocation of our health care resources.

We also believe that any budgeting process should retain incentives for the development of managed care delivery systems. It is important that we continue to build on our positive experiences with managed care and encourage the adoption of preventative and holistic approaches to medical care.

Fifth, by establishing a single payer system, this approach can make significant strides towards improving the quality of care in this country. In particular, under a single payer system, outcomes research findings can more easily be fed back into the system in a broad based effort towards continuous quality improvement. There is no question that the key to improving and ensuring quality of care is the collection and study of data for the purpose of determining optimum treatments for optimum outcomes. A central administrative source will provide the basis for consistent data collection and dissemination. Data analysis could take place at the national level, to promote a further understanding of issues, such as regional variations in practice patterns and the steps toward elimination of unnecessary and harmful treatments. It would also help promote continuing education for physicians and other health care providers This, in turn, can help reduce costs by eliminating much of the unnecessary and inappropriate medical treatments which are currently being provided to patients.

As previously indicated, the UAW believes that any national health care reform proposal must embody a progressive financing mechanism. In particular, it must establish a level playing field among all employers. And it must ensure that the costs of the program are distributed among Americans based on their ability to pay. In structuring any financing mechanism, the UAW strongly urges this Subcommittee to avoid the pitfalls which were encountered in connection with the Medicare catastrophic legislation. We cannot support any legislation which would require the majority of workers and retirees who already have health insurance coverage to shoulder a larger tax burden without receiving any additional benefits.

Obviously, a single payer national health care program would represent a dramatic change from our current employer-based health care system. The UAW believes that such a change is necessary. Mr. Chairman, now is the time for that change. The UAW is encouraged that the Democratic leadership views reform of the health care system as one of its priorities. We cannot continue to make small changes to small parts of the system. If we continue this approach, health care costs will eventually devastate the economy and health of this nation. Nothing less than a total overhaul of the system will give Americans what they need and deserve: access to high quality health care.

In conclusion, the UAW appreciates the opportunity to testify before this Subcommittee on the subject of health care reform proposals. We look forward to working with you, Mr. Chairman, and the Members of this Subcommittee as you consider these important issues. Thank you.

PREPARED STATEMENT OF KAREN IGNAGNI

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues for working people and their families.

At long last, this nation has reached an important milestone in the century-long debate over health care reform.

The AFL-CIO has long been on record in calling for federal legislation to assure all Americans access to essential health care services at a price they can afford. Now, organized labor, organized medicine and many in the business community are offering proposals to achieve these same objectives. This represents true progress toward resolution of these problems.

We believe that the time is right for Congress to take advantage of this growing consensus and to take the lead in fashioning a program that will reduce health care inflation, expand access and improve the efficiency of the system.

It is crucial that you achieve these objectives before this crisis does any more damage to American families, who have been called upon to absorb a major share of cost increases; American businesses that are attempting to do their fair share by providing health care coverage; and health care consumers who are frustrated with the paperwork burdens associated with the current system and, increasingly, concerned that they may be the victims of unnecessary tests and procedures.

Increasingly, union members are concerned about maintaining the health care provisions of their collective bargaining agreements. This concern is warranted. In recent years, the majority of labor-management disputes have been caused by the nation's health care crisis. When these disputes could not be settled at the bargaining table, all too often the workers found themselves permanently replaced when exercising their legal right to strike.

A recent study by the AFL-CIO Employee Benefits Department found that in 1990, health care was the major issue for 55 percent of striking workers. The study also confirmed the cold reality of the risk of job loss in a strike over health care. Last year a shocking 69 percent of all permanently replaced workers struck over health care benefits as the major issue.

This turmoil is not confined to organized labor. During the 1980s, the health care crisis further exacerbated the economic decline of the middle class. The average hourly wage dropped from $10.56 in 1980 to $10.03 in 1990, during the same period while health costs for households increased from six percent to nine percent of gross earnings.

If health care costs continue to rise current levels, they will crowd out increases in wages and other fringe benefits necessary for working Americans to maintain their homes, educate their children and achieve income security in retirement.

A similar trend is occurring nationally. In 1980, health care programs accounted for 17 percent of the domestic spending. Now that figure is 22 percent and by the middle of the decade, it will be 30 percent. At the same time, beneficiaries of public programs continue to lose ground. Senior citizens pay more for health care than they did prior to passage of Medicare and 60 percent of those with incomes below the federal poverty level do not qualify for Medicaid.

In short, we are paying more for less. As a nation, we cannot afford to continue down the current path. Rather than become mired in esoteric debates about competition vs. regulation, this committee and the Congress should recognize that the most costly solution would be to do nothing at all.

Last Fall, the AFL-CIO commissioned a study by Lewin-ICF, Inc. to determine how much could be saved if Congress established a single cost containment program for all payors. They estimated that just a two percent reduction in the projected rate of growth in health inflation will save $165 billion by the end of the decade. The alternative is to continue down the current path with health care expenditures consuming valuable public and private resources necessary for other domestic challenges, such as infrastructure and education.

As part of its deliberative process, we would urge the committee to compare the cost and performance of the U.S. health care system to those of our industrial partners. Without exception, all of these countries have universal access to health care benefits with government-based reimbursement controls.

We urge the committee not to be distracted by the myths of rationing, excessive government bureaucracy and inferior quality that have long been advanced by those who oppose reform. Taken together, the health care systems throughout the industrial world provide incontrovertible evidence that it is possible to provide coverage to all Americans far more effectively and at a cost that is measured and contained.

In comparison to our industrialized partners, the U.S. health care system fails the tests of fairness and equity. We also fail the test of efficiency, which is apparent to

both consumers and providers who are frustrated with red tape and paperwork. Even those who seek to preserve the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

In pursuing a "competitive" health care market, the U.S. has ended up with a system that operates on the principle of Social Darwinism. It punishes employers who provide health insurance to their workers by forcing them to, in effect, subsidize the health care of those who are employed by firms that seek a competitive advantage by refusing to provide such coverage. The system rewards purchasers with large groups or relatively young workers with short-term discounts, and it penalizes small employers and those with older, more experienced workers by forcing them to pay more for coverage. The system is replete with inefficiencies that have forced costs to rise sharply, and millions of Americans who are fortunate enough to be covered by health insurance have, as a result, suffered the financial burden of increased cost-shifting and reductions in benefits.

The view has long been held that, notwithstanding these structural flaws, the U.S. system provides better quality of care. But this too has proved to be another myth advanced by those who oppose change. It is virtually impossible to defend the high rates of surgery, the estimates of unnecessary tests and procedures, the relatively small attention paid to preventive care and the lack of technology assessment and the duplication of equipment in our current system.

A nation that seeks to be competitive in the 21st century can no longer continue down this road. On a per capita basis, we spend 40 percent more than Canada, 90 percent more than Germany and 125 percent more than Japan.

In short, the current crisis demands immediate action and the labor movement is united in its pursuit of fundamental restructuring of the system. We have four essential goals: to contain health care inflation; to provide all Americans access to care; to overhaul administrative procedures and to solve the retiree crisis. All of the unions within the AFL-CIO support these goals. Some of our affiliates support the implementation as soon as possible of a single payor approach. But all of the unions believe that we need Congressional action now to address the health care crisis, and they support the Federation's efforts to get legislation that conforms to our principles enacted as soon as possible.

1. CONTAIN THE GROWTH IN HEALTH CARE COSTS

To achieve this objective, we urge Congress to establish a national commission composed of consumers, labor, management, government and providers to administer a single national cost containment program. The primary functions of such a commission would be to establish a limit on the rate of growth of health care expenditures nationally and by state, to conduct negotiations between health providers and purchasers of care on payment rates and other necessary measures to achieve these targets and to establish controls on capital costs consistent with the overall national expenditure targets. Once the rates are negotiated, they should apply to all payors, including government programs.

Payments to physicians should be on the basis of a resource based relative value schedule, with geographic adjustments as necessary. Payment rates to hospitals should be on a DRG basis, with adjustments for facilities with special needs.

2. PROVIDE UNIVERSAL ACCESS

To achieve this objective, we urge Congress to establish a core benefit package to which all Americans are entitled, notwithstanding employment history health status or state of residence. In our view, all employers, including the federal government, should be required to contribute fairly to the cost of care for workers and their families. For those not in the workforce, Congress should put an end to the patchwork quilt of federal and state health care programs and establish one federal program that would cover the unemployed and those currently receiving protection through state Medicaid programs.

3. REDUCE WASTE, RED TAPE AND PAPERWORK

We believe it is time to overhaul the existing administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms develop a uniform health care information system and simplify paperwork.

Recently, there has been a growing interest in reforming insurance practices in the small group market. While we support such long-overdue reforms, the AFL-CIO believes that reforms should be developed by Congress—not the states—to assure uniformity across the country. Specifically, we believe regulation is warranted to put a stop to current insurance practices that keep individuals and employers out of

the health system or force them to pay contributions that are disproportionately high.

We also would urge Congress to re-evaluate the currency of the HMO law and move forward with setting minimum standards for all entities offering so-called "managed care." This would eliminate much of the confusion in the market place and level the playing field for organized systems of care that meet federal requirements.

We also support improved quality of care by developing practice guidelines for physicians and a national strategy to reform the current system of handling malpractice disputes.

4. SOLVE THE RETIREE CRISIS

The issue of retiree health care has become one of the most difficult at the bargaining table. The new accounting regulations put forth by the Financial Accounting Standards Board (FASB) that go into effect in 1993 would require companies—for the first time—to list on their Balance Sheets estimates of liabilities for providing health care benefits to current and future retirees. The new regulations have caused a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions have already seriously increased the number of retirees without coverage and the problem is growing.

We believe that the most effective way of responding to this crisis is to make the age of eligibility for Medicare more consistent with the average retirement age. Specifically, we propose reducing Medicare to age 60. This would spread the cost of retiree health care over the entire population and no longer disproportionately penalize employers who have attempted to protect their retirees against the high cost of getting sick.

CONCLUSION

Our proposals are based on the experiences of millions of working men and women for whom the current health care system has become a nightmare.

They are the ones who feel the sting of repeated cost containment exercises that have done little to limit the soaring cost of health care.

They are the ones who are losing access to a health care system that purports to be the best in the world.

And they are the ones who face the prospect of injury and illness without any idea on how they will pay for the decent and humane treatment they deserve.

Mr. Chairman, there is real suffering going on out there. Nothing short of full scale reform will solve our problems. We have reached the stage where quick fixes no longer are possible and where "voluntary efforts" no longer offer promise.

For its part, the AFL-CIO is prepared to consider each and every proposal that purports to address the three issues of cost, access and quality. We are prepared to work with you and your staff and to work in coalitions with consumers, employers and providers to develop an approach to national health care reform that takes the best of the systems around the world and is "made in the U.S.A."

PREPARED STATEMENT OF WILLIAM KREYKES

Mr. Chairman, my name is William Kreykes, president and chief executive officer of Rhode Island Hospital in Providence, RI and chairman of the governing council AHA's Section for Health Care Systems. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to have this opportunity to testify on the cost containment aspects of S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act" and, specifically, on the topic of cost containment strategies contained in some of the legislative proposals on national health reform. While there are many differences in the approaches to health care reform being discussed, all of the proposals share one thing: a desire to remedy the serious health care cost and access problems we face.

We understand that the committee will be hearing testimony later this month on other aspects of S. 1227. We appreciate the opportunity to testify on the cost containment portion of S. 1227, but we think it is necessary to underscore the importance of addressing all of the issues -- cost, quality, and access -- simultaneously. To address only the issue of cost ignores an important goal of health care reform: assuring access to high quality care. Reforming the health care system will involve a series of tradeoffs between improving access to care, maintaining the high quality of the care we provide, and keeping our health care system affordable. Striking an acceptable balance among these is key.

The Need for National Health Care Reform

As providers of care for the insured and uninsured alike, and as advocates for the health care needs of the poor, hospitals are distressed to see growing numbers of uninsured and underinsured, deterioration in private insurance coverage, and growing gaps in public programs, because this means people will seek too little care, and will seek it too late. We see the human consequences in our emergency rooms, where we deliver the tiny babies of women who received no prenatal care, and where we attend to the acute illnesses of children or adults with preventable, treatable conditions.

It is increasingly obvious that the cracks in the health care system are much wider and deeper than we thought, that all segments of the population are now affected, and that we won't be able to solve the crisis of needed access to health care services unless we simultaneously, and successfully, grapple with the equally profound cost crisis. The evidence is certainly grim on the access side, and touches all of us in one way or the other:

* Thirty-three million people lack health insurance entirely, and almost twice that many are intermittently uninsured. During a recent 28-month period, 63 million people lacked coverage at some point.

* Many more fear that their insured status is precarious, something they could lose as a result of any number of events they cannot control -- the death of a spouse, loss of a job, changes in an employer's insurance plan, or the simple deterioration of their own health.

* Many of those who do not have insurance still cannot pay for needed services, because they have pre-existing conditions excluded under their policy, or because the services they need (long-term care, psychiatric care, or rehabilitative care, for example) are not covered for anyone under their plan, or (in the case of public program enrollees) because reimbursements are so low that their insurance card has little purchasing power in the health care market place.

The news is also grim on the cost front.

* Health care costs are growing rapidly, at a time when our GNP is not. Between 1983 and 1989, non-hospital health care expenditures grew from 6.2 percent of GNP to 7.1 percent of GNP. While expenditures for hospital inpatient and outpatient care remained relatively steady (at 4.3 percent of GNP in 1983 and 4.5 percent of GNP in 1989), expenses for all health care combined rose from 10.5 percent to 11.6 percent of GNP during this period.

* Group health insurance premiums have been increasing at an average of 16 to 18 percent a year for the past several years, and increases for many small businesses are much higher still.

* The costs of unsponsored care (care for which no payment or government subsidy was received) are rising, and reached $9 billion in 1989 for hospitals. Hospital underpayments from Medicaid are rising even more quickly, and reached about $4.3 billion in 1989.

What makes the twin problems of access and cost so intractable is the fact that they feed on each other. Unsponsored care and government payment shortfalls lead to cost-shifting. Cost-shifting fuels already increasing health care costs, which translate to higher premium costs, followed by coverage cutbacks and more unsponsored care. Noncoverage and inadequate coverage lead to delayed care, which is also more costly.

AHA's Proposal

Hospitals can and should exert leadership in these issues, by working at the local level with their communities to attack these problems and working at the national level with Congress to achieve overall reform of the health care system. Hundreds of hospitals across this nation have spent more than a year discussing the pressing problems with our health care system and deliberating alternative plans of action. We began with the premise that all of us -- citizens, providers, insurers, purchasers, and government -- will need to be a part of the solution, and therefore will have to make changes that may be difficult to achieve. Specifically:

* Providers must eliminate unnecessary services, spurn the unnecessary duplication of costly technology, and eliminate excess capacity. Hospitals and physicians must forge effective partnerships to help bring these changes about.

* Individuals must accept greater responsibility for adopting healthy lifestyles. They must also use health care services efficiently and appropriately.

* Insurers need to focus on risk management, rather than risk avoidance, and on keeping program administration costs to the absolute minimum. It should be the goal of the insurance industry to create mechanisms that make universal coverage affordable.

* Financing and payment systems must be overhauled so that incentives support both disease prevention and care in the least costly setting.

* Government must live up to its promises.

Our resulting proposal is called *A Starting Point for Debate* -- because we intend it not as a blueprint but as a lightning rod for comment, criticism, suggestions, new ideas and approaches. A copy of our proposal is attached to our statement. In summary, the strategy we propose has five parts:

* *Universal coverage* would be provided through a combination of employment-based coverage of basic benefits and a new single public program consolidating and expanding Medicare and Medicaid. Catastrophic coverage would be provided under the public program for everyone, whether covered under the public or a private program. Tax and other laws would be revised to help employers sponsor coverage and ensure the availability of more affordable private insurance offerings.

* *A single set of basic benefits* would be defined for the public plan and would serve as a benefit floor for private health insurance plans. To ensure access to appropriate and effective care, a full range of services from preventive through long-term care would be included and would be linked to overall cost containment goals through budget targets for basic benefits set biannually by Congress, assisted by a new national public/private commission.

* *Value* would be ensured through health care delivery, financing, and other reforms designed to assure that care is managed and coordinated, that only appropriate and effective care is provided, and that system-wide costs are contained.

* *A sustained commitment to biomedical and health services research* would help to ensure that all Americans continue to benefit from medical and delivery system advances.

* *A coherent and comprehensive approach to meeting health manpower needs* also must be adopted in the United States if we are to realize the goal of adequate access to health care services to everyone.

Our plan has grown out of a vision to improve the current health care system and to refocus and redirect its goals. One focus of debate concerning the present system is cost. Employers, private payers, and public payers are each trying to control their own costs, most commonly by avoiding rather than managing risks, shifting costs to others, or simply limiting payments to providers. But these mechanisms do not address the root causes of rising costs, and they do not help to manage total costs within the health care system. In terms of cost containment, the dilemma is how to assure that costs are managed rather than shifted from one payer to another, and how to assure that the hard choices about containing costs are made fairly and in the public eye rather than taking the form of de facto rationing by providers in response to payment policies. We believe that this dilemma can only be solved--and long-term reform achieved--through a systematic and comprehensive strategy.

While cost will remain a predominant concern in the debate over the future of our health care system, we strongly believe that we also must guarantee necessary access to basic health benefits and, at the same time, fine-tune the effectiveness of the health care we deliver so that access and quality as well as affordability are hallmarks. The overall dilemma of health care reform is how to strike a balance between cost, quality, and access to health care services.

Economic Discipline Within AHA's Proposal

In response to comments and suggestions we have received on the *Starting Point*, the AHA is reexamining the cost containment approaches and provider payment mechanisms contained in our strategy. During this reexamination, we will be testing and going beyond the points of consensus reached by our hospital members last year. It is becoming increasingly clear that current provider payment mechanisms present serious shortcomings from everyone's perspective, and we must take a hard look at how to achieve a more rational approach. But a more rational approach is not a matter of simplistically capping the amount of money we spend on health care services. True health care reform must realign the incentives of health care providers, payers, and patients and change the way in which health care services are delivered and consumed. That is why we have favored an incentives-based approach to cost containment -- an approach in which individual physicians, hospitals, and other providers are held accountable for their performance. By changing providers' incentives to deliver health care services efficiently and effectively, we can begin to focus on changing the underlying causes of health care cost increases. Performance accountability would be built into the system through the use of medical practice parameters, wide availability of information on individual practitioner and provider cost and quality outcomes, and guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services.

Incentives among providers also should be compatible so that all providers work toward common objectives. This would mean eliminating the currently conflicting incentives of paying hospitals on a per-admission basis while paying physicians and other practitioners on a fee-for-service basis, which can encourage hospitals and physicians to work at cross-purposes. Per-admission payments encourage hospitals to economize while fee-for-service payments encourage physicians to do more.

Similarly, incentives between providers and purchasers should be realigned to make objectives compatible. Risk-sharing arrangements that focus both purchasers and providers on maintaining and improving the health status of covered populations should be encouraged. For example, purchasers and providers in a region might share each year any overall financial gains or losses incurred in serving a defined population enrolled under a particular arrangement for management of care. Managed care should be promoted with a broader, longer-term focus on providing coordinated care over time and across providers in order to improve the health status of enrolled individuals and control costs while ensuring quality.

In addition, the overall climate for cost containment and the opportunity for advancing new initiatives would be improved by reform of the medical liability tort system to obviate the need for defensive medicine; by widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care; and by changes to antitrust law and other legislative and regulatory barriers to effective cost containment.

By changing the incentives of providers, payers, and patients we can achieve more than cost containment -- we can foster a new sense of economic discipline among all of the participants in our health care system which could make for lasting reform. But if we are to achieve real and meaningful reform of the health care system, we need to form a partnership among providers, insurers, consumers and government aimed at addressing the underlying causes, not just the symptoms of the problem. The AHA will be working with a broad cross section of interested parties in an effort to better understand what propels our health care system and to develop recommendations for change. When our work is complete, we would be happy to share with this committee any further suggestions for maintaining economic discipline within the health care system.

Cost Containment in S. 1227, "HealthAmerica"

We applaud the efforts of the Democratic Leadership of the U.S. Senate and other members of Congress who have crafted legislative proposals for health care reform, ensuring that this issue will receive the serious attention it deserves. Despite differences in approach, some of these proposals are quite similar in philosophy to the AHA's national health reform strategy and many others. They are the bases from which to build consensus for national health care reform. In terms of cost containment initiatives, however, we find that many of these reform proposals fall short of what we believe to be the appropriate goal: addressing the underlying causes of cost increases.

One striking feature is that despite the large number and variety of reform proposals currently being considered, the cost containment aspects of these proposals are quite similar. Several of the major proposals employ a highly structured, top-down regulatory approach to cost containment; that is, they call for setting a single national health care expenditure target and then allocating that fixed pot of dollars in various ways among various types of health care providers.

S. 1227, "HealthAmerica: Affordable Health Care for All Americans Act" sponsored by Senators Mitchell, Kennedy, Riegle, and Rockefeller, has much in common with the AHA's recently developed National Health Care Strategy described earlier in my statement. We do have some concerns, however, about the cost containment approach in S. 1227. The bill uses three main strategies to control health care costs: it creates a Federal Health Expenditure Board, sets payment rates within the public plan, and promotes the use of managed care plans.

Federal Health Expenditure Board. S. 1227 would establish a Federal Health Expenditure Board, an independent entity that would set national expenditure goals in total, for specific segments of the health care industry, and for states and regions. The Board would then negotiate with representatives of providers and purchasers to establish rates "and other methods" (presumably capacity and volume restraints) to achieve these goals. If those negotiations were successful, the rates and other measures would be binding on private

payers except in those states where state purchasing consortia chose to go beyond their required function of consolidating claims processing to develop alternative payment methods that meet the state expenditure goals set by the Board. After eight years, AmeriCare (the new and expanded Medicaid program) would be required to come up to Medicare payment rates for all services. Over time, Medicare would be expected, but not required, to achieve rates comparable to those set by the Board. If the national negotiations were not successful, the Board would issue advisory rates for use by state purchasing consortia and individual payers.

First, we believe that this approach would merely perpetuate many of the current problems with our health care system. Setting expenditure targets for each sector of the health care field will lock into place the fragmentation of care, rather than moving toward more coordinated and better managed care. Past experience also suggests that there would be a great temptation to set spending goals and payment rates at current levels. But there is danger in doing so. Freezing into place current expenditure patterns and levels simply freezes into place all of the problems and conflicting incentives in our current system of health care delivery. This approach does not address the real problems that initiated the call for reform in the first place.

Second, it is unrealistic to effectively cap spending at current levels while simultaneously expanding access to millions of people. Any cost containment mechanism needs to be flexible enough to accommodate increased spending due to changes in the size of the population served, changes in the needs of the population served, and appropriate changes in utilization that result from the continuing evolution of health care technology and delivery.

Finally, controlling health care *spending* by payers will not necessarily control health care *costs* experienced by providers. Limiting the total dollars that are made available for health care services without somehow changing the underlying incentives for providing and using health care services is just another example of a budget-driven quick fix which, as we know through our experience with such fixes in the Medicare program, have not produced the needed solutions to our health care problems. Simply constraining spending may have the effect of manipulating provider behavior, but it may do so in ways that are neither optimal nor desirable in terms of assuring that patients have access to quality health care services.

Setting Payment Rates. Payments to providers under AmeriCare (the public plan) would be based on Medicare payment rates, adjusted to reflect the new populations covered by the bill and to establish payment rules for services not currently covered under Medicare. Medicare payment rates are certainly an improvement over current Medicaid rates which, for the U.S. as a whole, pay hospitals 22 percent less than Medicaid costs. But fixing provider payment rates at Medicare levels will still lock in inadequate payment rates. When applied to all services delivered under the public plan, this could have serious consequences for access to and the quality of care.

Overall, hospitals have been losing money treating Medicare patients for the last three years. The AHA projects that in FY 1992, aggregate Medicare payments to hospitals will be 10 to 15 percent less than the costs incurred treating Medicare patients. Because of increasingly inadequate Medicare payment rates, hospitals have shifted unfunded costs onto the shoulders of other payers. Institutionalizing inadequate payment rates in the AmeriCare program will not solve this problem. This approach may limit the financial shell game known as cost-shifting, but it does not provide a structure for making the difficult choices that would have to be made or for reconciling consumers' expectations with available funding.

Promoting Managed Care. S. 1227 also seeks to contain health care costs by encouraging private insurers to offer managed care plans. These plans would be afforded special status by providing them with exemptions from state laws governing such things as utilization review and selective contracting. While we support the effective management of care, we are concerned that to many, "managed care" has come to simply mean a system of selective provider contracting and/or external utilization review. This is managed *cost*, not

managed care. Many so-called managed care programs in operation today do nothing to assess or manage the health status of patients. They often do nothing more than enforce external utilization review, which can impose the discipline of cost-consciousness, but can also increase administrative costs, inappropriately interfere with physician-patient relationships, and cause distress over improperly denied health insurance claims. Although S. 1227 would replace state regulation with federal efforts to regulate abusive external review and other practices, it does nothing to promote the true management of care.

True managed care requires a broader, longer term focus on improving the health status of enrolled individuals and controlling medical care costs while ensuring quality. Managed care means assessing patient needs, and then planning and organizing care so that all needed services are efficiently provided and care is coordinated over time and across providers. Moreover, because managed care should seek to improve the general health status of its enrollees, it should be concerned with all aspects of care, including promotion of cost-effective preventive services and the long-term management of chronic illness. The AHA would be happy to work with the authors of the bill to refine the current approach to defining and promoting managed care.

Overall, we believe the main failing of these approaches to cost containment is that they do not address the issue of purchaser, provider, and patient incentives and do not encourage the efficient delivery and use of health care services -- they simply limit health care spending and provider payment rates, assuming that providers can absorb resulting losses and "adjust" the way in which they deliver care enough to be able to continue to provide high quality care to a greater number of people. The hard choices this nation faces demand more from us all. Providers should not be expected -- and are increasingly unwilling -- to be left alone to figure out how to "cope" with fewer dollars. We stand willing to do our part, but it is time for us all to pull together in this task.

Conclusion

Meaningful health care reform is not as simple as reducing spending. Limiting spending, primarily through squeezing payments to hospitals, physicians, and other health care providers will likely have serious consequences for the delivery of health care. Rather, health care reform must seek to strike a balance between cost, quality, and access. Reform efforts should encourage efficiency within our health care system and reduce costs where possible, but at the same time improve access to health care services and maintain the quality of the care we receive. Above all, health care reform should establish shared responsibilities among government, business, labor, insurance companies, providers, and consumers.

NATIONAL HEALTH CARE STRATEGY:

A starting point for debate

Approved by the Board of Trustees
For public circulation and discussion
May 1, 1991

American Hospital Association

Toward a healthy america

The healthiest nation in the world -- that is the American Hospital Association's vision for this country. To help achieve that goal, our focus is on affordable access to needed health care, including preventive services. This nation must come together on strategies to promote health and well-being and to assure judicious use of a health care system reshaped to put patients first. This will require strong leadership in forging partnerships with organized medicine, other health professional groups, business, government, labor, insurers, the educational system and, above all, the American public. The AHA asks simply, but importantly, that the give-and-take begin.

Health care in the United States is at a crossroads. Our system routinely delivers the best health care in the world but is beset by major problems: the ranks of the uninsured and underserved are large and growing; health care costs continue to escalate; and many providers of vital services are caught in a financial squeeze between resources and responsibilities.

The public shows increasing signs of concern about the state of their health care system. Even the overwhelming majority of Americans who enjoy easy access to needed care sense that something is wrong. They know that health care and health insurance are very expensive; that getting health services may depend on where you work, where you live, and how much money you have. Part of the problem is that the current health care system is a jumble of individual programs that have evolved by default, not by vision and design.

Significant reform is needed. We must clearly establish two central objectives for our health care system and its reform: improvement in the health status of all Americans by maintaining health and minimizing the effects of illness, and greater economic discipline in the use of health care resources.

Our starting point has to be the guarantee of necessary access to preventive health services and other basic health benefits for the 33 million Americans who currently have no health insurance and the millions more who are inadequately covered. At the same time, we must make changes to improve the efficiency and effectiveness of our system so that affordability as well as quality are hallmarks.

All of us--citizens, providers, insurers, purchasers, and government--will need to make changes.

- Individuals must accept greater responsibility for adopting a healthy lifestyle -- the effects of smoking, substance abuse, obesity, poor nutrition, and inadequate exercise on individuals' health and on the cost of health care are too great. They must also use health care services efficiently and appropriately.

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- Providers must develop a heightened awareness of economic concerns and weed out unnecessary services, spurn the unnecessary duplication of costly technology, and eliminate excess capacity by converting it to other uses or shuting it down. Hospitals and physicians must forge effective partnerships to help bring this about -- neither can do it alone.

- Financing and payment systems must be overhauled so that incentives support disease prevention and care in the least costly setting as well as efficient performance overall. Such systems must also be fair and provide adequate payment, lest the vitality of our health care system be compromised.

- Employers and other purchasers need to structure benefits and cost sharing under their programs so that they promote disciplined behavior on the part of insured beneficiaries.

- Insurers need to focus on risk management, rather than risk avoidance, and on keeping program administration costs to the absolute minimum. Mechanisms aimed at enabling universal coverage at an affordable price should be adopted as the central goal of the insurance industry.

- Government must live up to its promises.

As a society, we must address several hurdles to cost-effective care: the lack of consensus on the appropriate limits of treatment; unrealistic patient expectations; a medical liability climate that encourages defensive medicine; and deep-seated social problems like poverty, substance abuse, malnutrition, inadequate housing, and crime, all of which impair health status and drive up health care demand and costs. While the health care system alone cannot ensure improved health status, hospitals, physicians, other caregivers and major stakeholders can and should exert leadership in their communities, working with other social agencies and groups to attack these problems.

Hundreds of hospitals across this nation have spent more than a year clarifying and discussing the pressing problems with our health care system and alternative action plans. Based on this effort, the American Hospital Association now offers this *Starting Point* designed to sharpen and stimulate the debate on national health care reform.

Our hope is that in the months ahead this *Starting Point* will serve as a lightning rod for comment, criticism, suggestions, new ideas and approaches. Above all, we see it as a worthwhile basis for dialogue with everyone who has a stake in our health care system.

Important work lies ahead -- work that will test the collective leadership and vision of all. The American Hospital Association and the hospitals it represents ask you to join with us in meeting this challenge.

Goals for reform

As a beginning point, the Association offers nine goals that any reform plan must meet:

- **Basic health services available to all:** All individuals must have access to, at a minimum, a package of basic health care services.

- **High quality:** Delivery and financing arrangements must (1) ensure the effective management of medical conditions, including the coordination of care among providers and over time; and (2) promote continuous improvement in the quality of care.

- **Affordable:** Patients and their purchasers must be able to select benefits and delivery arrangements that emphasize value, so that needed care, delivered in the least costly, medically appropriate manner, is obtainable for what they are willing and able to pay.

- **Community focused/patient centered:** Delivery and financing arrangements must be managed at the local level to recognize appropriate community variations in medical practice consistent with national standards, health care needs, and the resources available in the community.

- **Sufficient supply for timely access:** Delivery and financing arrangements must encourage enrollees or beneficiaries to obtain care when and where it is most likely to change the course of a disease or prevent avoidable illness, loss or impairment of function, or death.

- **Efficiently delivered:** Delivery, financing, and insurance systems must align the incentives of facilities, caregivers, payers, and users, to eliminate conflicting interests, discourage unnecessary duplication of services, and promote continuous improvement in the efficient use of resources to restore or preserve health.

- **Adequately and fairly financed:** To eliminate cost-shifting, any public or private financing program must itself bear the full cost of the services provided to its enrollees or beneficiaries under the benefits it promises.

- **User-friendly:** Delivery and financing arrangements must enable patients, practitioners, providers, purchasers, and insurers to obtain, deliver, and pay for care with minimum uncertainty, confusion, and paperwork.

- **Conducive to innovation:** Delivery and financing systems must promote development and dissemination of new and more effective methods of treating and preventing illness and delivering services.

All of the goals may not be equally satisfied at any given point in time. Some may require staged implementation and some may need to be tempered to promote the achievement of others.

AHA's strategy for reform

This health care system reform strategy builds on the strengths of our existing pluralistic health care delivery and financing systems to enhance access by everyone to affordable, quality health care. Health care in a country as culturally diverse as ours is very much a local affair; what makes sense in some communities may be infeasible or ill-advised in others. Pluralistic financing facilitates local control over health care delivery, permitting variations based on area resources and priorities. Moreover, while the administrative costs of a pluralistic system of financing might be higher than a monolithic system such as Canada's, a pluralistic approach both spurs innovation and enables health care costs to be spread among individuals, business, and government rather than be concentrated as a burden on one funding source. But, to maintain a pluralistic approach, significant efforts are needed to overcome its serious flaws.

The pluralistic strategy we propose as the starting point for debate has four parts:

- **Universal coverage** would be provided through a combination of employment-based plans and a new single public program consolidating and expanding Medicare and Medicaid. Tax and other laws would be revised to help employers sponsor coverage and ensure the availability of more affordable private

insurance offerings. Catastrophic coverage would be provided under the public program for everyone, whether covered by the public or a private basic health benefits program, when required premiums and cost-sharing reach extraordinary levels compared to an individual's ability to pay.

- **A single set of basic benefits** would be defined for the public plan and would serve as a benefit floor for private health insurance plans. To ensure access to appropriate and effective care, a full range of services from preventive through long term care would be included and would be linked to overall cost containment goals through budget targets for basic benefits set biannually by Congress. A public-private commission would match the benefit package to the dollars available through the federal budget and beneficiary cost sharing by those able to contribute.

- **Value** would be ensured through reforms in health care delivery, financing, and other approaches aimed at managing and coordinating care, at providing only appropriate and effective care, and at containing both provider costs and consumer demand.

- The nation's **commitment to biomedical and health services research and to ensuring an adequate supply of physicians and other health care professionals** would be sustained and appropriately focused.

A staged and orderly transition is proposed to minimize disruption as the nation moves from the current system to the new program.

Universal coverage through employment-based plans and a new public program

The AHA proposes that all individuals be covered for basic health care services, either through employer-sponsored programs or a consolidated public program combining and expanding Medicare and Medicaid. The public program would also provide catastrophic coverage for all.

Employment-based coverage

The AHA proposes that employment-based coverage of basic benefits be encouraged in stages through a number of mechanisms. The first stage would grant the same tax advantages to self-employed individuals and owners of unincorporated businesses for the purchase of health benefits (100 percent, rather than 25 percent, deductibility of premiums as a business expense) that large employers and their employees enjoy.

Self-insured businesses would assume responsibilities and obligations for health care coverage that are equal to those of insured businesses, such as participating in state risk pools. Targeted tax incentives and hardship funds would be made available to employers to help finance benefits; for example, special tax credits for small businesses or for businesses in the first five years of operation.

Employers would be expected to pay at least 50 percent of health care coverage costs for full-time permanent employees and their dependents and a prorated amount for part-time permanent workers and their families. The coverage provided would have to meet the minimum specifications of the federally-defined basic benefit package, although employers would be free to offer more than basic health benefits if they and their employees so desire. Employees would be given strong incentives to accept employer-sponsored coverage, including tax incentives (e.g., tax credits) for low income employees to help cover their share of premiums.

To maximize the use of health care dollars for the actual delivery of care, private insurers must work with providers and practitioners to reduce the high cost of unnecessary paperwork and inefficient claims review and processing mechanisms.

The AHA also proposes that private health insurance be reformed to preclude the use of underwriting practices, such as preexisting conditions clauses, that are designed to avoid rather than manage risk, and to develop reinsurance mechanisms and insurance pools at the state level to spread risk so that more affordable insurance is available to small businesses and individuals, such as the self-employed and medically uninsurable. State laws requiring employers or employees to pay for coverage exceeding the federally-defined basic benefit package would be preempted, providing private insurers with the opportunity to design a broader array of insurance packages at different affordability levels.

As a backstop source of coverage, small employers (with fewer than 25 employees) and the self-employed would have the option of purchasing community-rated basic benefits protection from the public program (discussed below), as would any individual unable to obtain private health insurance within their financial means. For individuals not able to join a group for insurance purposes (such as the self-employed), the community-rated basic benefit premium under the public program would likely be lower than the premium for comparable private *individual* coverage.

There would continue to be an incentive for small employers and private insurers to develop innovative private group insurance arrangements, however. Coverage under the public program would likely be more expensive than premiums for comparable private *group* coverage, even though it would be community rated, because the public program primarily would cover individuals with higher than average expected costs, e.g., the poor, the elderly, and the disabled. This safety net of access to coverage should not pose any unfair competitive threat to private insurers so long as provider payment rates in the public program are adequate and eliminate cost shifting. Private insurers, government, and providers have a responsibility to ensure that this is the case.

At the end of a specified transition period, possibly three years, any individual unable or unwilling to obtain basic benefits coverage through the private health insurance market would be automatically enrolled in the public program when they seek services, if they do not enroll on their own. If employed, their employer would be responsible for paying at least half of the community-rated premium for that coverage. Individuals enrolled in the public program would be expected to pay premiums based on a sliding scale related to income.

A new public program

AHA proposes that a new federal public program be established to provide basic benefits coverage to everyone not covered by employer-based or other private plans, and to provide catastrophic coverage to everyone in the country.

The public basic benefits program would consolidate and expand Medicare and Medicaid, covering a broader scope of services than government programs now provide, in particular long-term care and outpatient prescription drugs. The same broad scope of basic benefits would be required as a minimum for private health insurance coverage. The public basic benefits program could be expected to cover not only the elderly, disabled, and all the poor, but the unemployed, temporarily employed, self-employed, and employees of small firms unable or unwilling to obtain private coverage.

The AHA proposes that government's first priority in funding this public plan be targeted at those least able to afford benefits. Enrollees in the public program with income less than 150 percent of the federal poverty level would receive fully subsidized basic benefits,

with the possible exception of minimal copayments and deductibles. Those with income greater than 150 percent of the federal poverty level would make contributions to premiums and copayments and deductibles scaled to their ability to pay.

Under these specifications, the public program would pay for all Medicaid recipients in full and would pay all or part of the premiums and cost-sharing for most current Medicare beneficiaries. Approximately 8.1 million elderly (27 percent of the elderly) and 46 million non-elderly (21 percent of the non-elderly) would qualify for fully subsidized coverage and many millions more would qualify for partially subsidized coverage.

The public program would also provide catastrophic coverage for all individuals, whether in private or public basic benefit plans, when required premiums and cost sharing reach extraordinary levels compared to an individual's income and ability to pay.

The public program would be financed by a combination of broadly-based federal tax revenues dedicated to an off-budget trust fund and premium contributions by those covered who can afford them. States would gradually be phased out of financial responsibilities under today's Medicaid program, although there could be an offsetting federal-state realignment of financial responsibility for other domestic programs.

The public program would be administered through regional contracts with private insurers who demonstrate the ability to hold down the administrative costs of the program and the sophistication to work with the federal government and providers at the regional level on the development of innovative contractual and payment mechanisms for effective management of care.

Basic benefits defined and linked to affordability targets

The AHA proposes an approach to defining coverage that would apply both to the new public program and to employment-based and other private plans. It is designed to ensure access to needed services, encourage health promotion and disease prevention, discourage inappropriate and unnecessary utilization, and reconcile universal access with judgments of affordability.

- **Basic benefits** would cover the full range of care -- from preventive through long-term -- to prevent illness, minimize disability, restore function and health, and alleviate suffering. Covered services would include effective preventive care, such as immunizations, prenatal and well-baby care, and mammography; outpatient care in physicians' offices and hospital outpatient and emergency departments; and inpatient care, including medical rehabilitation, psychiatric, and substance abuse. Other important coverage would include: skilled nursing, intermediate, and residential long-term care; prescription drugs; home health care; hospice care; and ambulance services. Rather than impose fixed limits on the types or quantities of services covered, a rigorous standard of medical necessity and reasonableness would be regularly applied to help keep costs down.

- **Deductibles and copayments** would apply to all services except preventive care (although they would be eliminated or reduced to nominal levels for those with limited financial resources under the public program). These cost-sharing provisions are intended to emphasize health and prevention by providing strong incentives for individuals to adopt healthy life-styles and seek early treatment. The catastrophic coverage provided under the public program would ensure that the combination of premiums and cost-sharing did not exceed an individual's ability to pay. This approach, coupled with the management of care provisions and treatment referral networks described below, would ensure access to services and help channel individuals to appropriate levels of care on a timely basis.

- **Explicit per capita budget targets for the public basic benefits program** would be established and biannually updated by Congress, to serve as an overall constraint in defining the specific features of the basic benefits package and to focus attention on the need to integrate costs and benefits. Since the basic benefits defined for the public program also serve as the minimum required benefit for private health insurance programs, a broad range of private and public groups will have a vital interest in both the setting of budget targets by Congress and in the work of the national public/private commission.

- **A national public/private commission** would serve two functions:

  - It would provide Congress the information and advice it needs to set the budget targets for the public program, including: the implications for the scope of benefits and the level of cost-sharing of setting the upcoming budget targets at different levels; the adequacy of current revenues to support the public program; and the adequacy of current provider payments under the public program.

  - Working from the targets then set by Congress, the commission would define basic benefits. Allowable approaches for meeting the budget targets would include phasing in expanded benefits, adjusting cost-sharing arrangements, and identifying cost ineffective treatments to be specifically excluded from basic benefits, but would exclude reductions in provider payment below the reasonable cost of delivering services. The commission would make these decisions through a public process. Providers would not be held liable for refusing to provide services excluded from basic benefits coverage because they are not cost-effective.

Achieving value through health care system reforms

The AHA proposes that significant changes be made to enhance provider and practitioner accountability for appropriate use of resources and to ensure that all care, whether provided under public or private plans, be managed so that patients receive the care that they need, that only appropriate, high quality care is delivered in the least costly manner and setting, and that care is coordinated across the full range of services and over time.

Provider accountability

AHA's recommended reforms in public and private benefit coverage and in delivery and payment arrangements would help sustain otherwise viable facilities that are needed but currently serve large uninsured populations. These recommendations, however, would not help any health care facility that cannot demonstrate value and fulfill legitimate community needs. In order to effectively compete for and manage risks under incentive-based contracts with private and public purchasers of care, all hospitals would need to continually evaluate their mission and performance from both cost and quality perspectives. In any given community, some hospitals might need to close, to merge, to consolidate specialty services, and/or to join systems or form alliances with other health care providers.

Providers and practitioners would be expected to coordinate the care provided to patients across settings and over time. Licensure and accreditation standards would ensure that, at a minimum, all facilities were linked by comprehensive referral and medical record information exchange agreements to facilitate the process of managing patient care across provider settings and to help consumers navigate the health care system more easily.

Performance accountability by providers and practitioners would be built into the system. Specifically:

- The use of medical practice parameters developed by clinicians would be required to foster state-of-the-art, effective clinical decision-making and to provide a sound basis for purchasers to judge the appropriateness of care provided.
- Information on individual practitioner and provider cost and quality outcomes would be made available to all purchasers and consumers.
- Guidelines on the cost-effective deployment and use of new and existing health care technologies and specialized services would be widely disseminated.
- Incentives which reward effective collaboration between hospitals and physicians in the management of care, assurance of quality, and utilization of resources would be established.

It is expected that as these data and guidelines are developed and proven over time, they will be used by some major purchasers of care to establish selective contracting arrangements for certain or all types of care within a region.

Management of care

To ensure adequate management of care, providers and practitioners would be expected to establish their respective roles and responsibilities for managing care to patients within enrolled groups when contracting with purchasers. Purchasers would have to ensure that their overall arrangements with providers and practitioners guaranteed reasonable access to the full range of basic benefits for enrolled groups in specific geographic locations. Negotiations with providers and practitioners would determine what care would be delivered by a given provider or practitioner; how care would be delivered, at what price, and under what conditions; and how quality would be monitored and assured.

A variety of arrangements for effective care management would be needed to reflect the different needs of specific defined populations and the different delivery capacity of providers in diverse geographic areas, but the ultimate goal would be the implementation of delivery arrangements that focus on improving the health status of specific populations and delivering value when it comes to needed medical care.

AHA is not proposing a single model for management of care. Various strategies are being tried around the country, with increasing sophistication, to improve health and to control medical care costs while ensuring quality. These range from early and periodic screening and pre-admission certification and concurrent utilization review programs carried out by insurers or third-party review entities, to PPO and HMO arrangements for managing and paying for the full scope of services from preventive and primary care to inpatient acute and long-term care. Through pluralistic financing, flexibility exists to use any approach that yields the desired result -- improved health status and effective and efficient patient care management -- for the key here is provider and practitioner commitment to effective management of all patient care, not simply a response to insurer incentives and controls.

Aligning payment incentives

To support these efforts, payment incentives for different types of providers and between providers and purchasers must be realigned, so that all parties work toward common objectives. First, new payment approaches for professional and institutional components of care need to be tested. For example, like hospitals, physicians could be paid under separate but parallel methods (for example, separate but prospectively set prices for the professional component of the same unit of service), while the necessary organizational relationships are developed and tested to support integrated payment for both the institutional and professional components of care in those areas where the concept is workable. Ultimately, integrated payment provides the greatest impetus for forging the institutional-professional partnerships needed to achieve cost-effective care. Even in the

long run, however, for some areas such as rural communities, a single integrated payment may prove unworkable.

Second, there is a need to identify and test new payment approaches which make a purchaser's incentives and objectives compatible with those of providers with whom they contract. For example, purchasers and providers in a region might share each year any overall financial gains or losses incurred in serving a defined population enrolled under a particular arrangement for management of care.

Improving the climate for cost containment

In addition, the affordability of needed services would be strongly advanced by:

- Reform of the medical liability tort system to obviate the need for defensive medicine.
- The widespread use of living wills and other advance directives to improve patient self-determination and limit non-beneficial final care.
- Changes to antitrust law and other legislative and regulatory barriers to effective cost-containment.

A sustained commitment to biomedical and health services research

Health system reform must include a sustained level of governmental and private support for innovation and the evaluation of new approaches. Biomedical research enhances our capacity to diagnose and treat illness; health services research is essential for more complete information on such critical issues as assessing the efficacy of diagnostic and therapeutic regimens and establishing the relationship between treatments and outcomes. Our future ability to improve the value of health care services will depend in significant part on rigorous evaluation of today's and tomorrow's delivery and payment system innovations.

A coherent approach to meeting health manpower needs

The United States must adopt a more coherent and comprehensive approach to ensuring the availability of the number and types of physicians and other health care professionals needed to provide adequate access to health care services for everyone. Public policy decisions at the national, state, and local levels and local program decisions should all work toward the central goals of adequate supply, efficient use of health care professionals, and appropriate geographic distribution of needed health manpower. Actions designed to deal with these issues should be based on sound assessments of manpower needs and should focus on both the near term and the future.

The AHA proposes the appointment of a national public/private commission to provide a regular and comprehensive assessment of future health manpower needs to support the development of national and state level strategies. It also should provide advice on national manpower training policies and federal funding priorities for educational program and student support. The direction and organization of graduate medical education should be a collaborative effort by hospitals, medical schools, affiliated programs in alternative settings, appropriate national standard-setting agencies, and the Commission.

Adequate supply

AHA proposes a series of actions designed to deal with today's well recognized crisis due to health manpower shortages. We must act now to stabilize existing training programs, promote new programs where needed, reorient training programs to future needs, and attract qualified students to the health professions. Specifically --

- Funding priorities for educational programs, faculty and students should be directed to those professions and occupations experiencing shortages, both specialty (e.g., primary care) and geographic, and to those programs that train and field more practitioners than educators and researchers.

- Financial barriers to entry into health care professions should be reduced, particularly for qualified students with limited means and students from minority groups, to expand the pool of potential health care workers.

- Alternative competency measures (e.g., national examinations or proficiency tests) should be developed to recognize and credit the knowledge and skills attained outside the formal education system through job experience and on-the-job training.

- Both public and private purchasers of care should pay for the costs incurred by hospitals and other types of providers in training various types of health care professionals. Provider payment arrangements should help solve, rather than exacerbate, access problems caused by shortages of health manpower in specific locales.

- Graduate medical education should continue to be financed primarily with patient care revenues. Clinical training is an integral part of graduate medical education; the educational function cannot therefore be separated from the patient care function. Extended periods of research by residents and fellows, however, should be supported by funds designated for research purposes.

- Educational entities, health care providers, and community leaders should form consortia at the local or regional level to avoid inefficiencies in manpower training by coordinating their health occupations education programs to make the most efficient use of faculty and other resources, facilitating movement of students from one program to another, and promoting innovative approaches to education.

- A national consortium of educational agencies, in collaboration with professional organizations and accrediting agencies, should develop national standards for both vertical and horizontal articulation among health care training programs to facilitate student movement from one level to another within a health care discipline and from one discipline to another.

- Institutions sponsoring graduate medical education programs should affiliate with ambulatory and extended care facilities and with health care delivery networks and systems to increase physician training experiences in these settings and in managing care across different provider settings. The innovative use of such affiliations can also help solve problems related to the distribution of physicians across specialities and geographically.

- Health care providers, as major employers, should make a commitment to the educational advancement of their communities by forming coalitions with educators, employers and community leaders to address basic skill and education deficiencies in the community's manpower pool and to expand the opportunities that health professions and occupations can offer to minorities.

Efficient use of health care professionals

We also must endeavor to make better use of our human resources by enhancing career mobility within professions and eliminating barriers to the efficient use of health care professionals.

- Federal and state funding programs should provide incentives for health professions education programs to consolidate core instruction in basic science courses to conserve resources and facilitate movement from one health profession to another.

- Career ladders based on measurable and observable standards should be established for health care occupations to enable an individual to move smoothly from one level to another.

- National standards and guidelines for the evaluation of professional and occupational credentialing alternatives should be developed to distinguish credentials awarded for professional recognition or individual achievement from those needed to protect the public health and safety so that regulatory requirements can be appropriately limited to patient needs.

- Provider licensure, certification, and accreditation program standards regarding the numbers and qualifications of personnel should be revised to eliminate those elements which unnecessarily limit institutional flexibility and discretion in the use of personnel, such as cross-trained and multiskilled practitioners. Recognizing the role that institutions must play in managing their human resources, standards should focus primarily on institutional patient care outcomes and total quality improvement rather than specific staffing criteria. Such requirements should clearly reflect patient care needs and considerations, not professional ambitions or market entry limitations.

- Unnecessary and duplicative paperwork must be eliminated and remaining requirements must be revised to take full advantage of the efficiencies offered by computerized information management systems so that more personnel and personnel time are available to deliver direct patient care.

Appropriate geographic distribution

And last, but not least, we must provide the incentives necessary to attract and retain health care professionals in poor, remote, or underserved areas so that everyone has reasonable access to needed services.

- Special financial support should be directed to those educational programs which provide outreach programs in remote and other underserved areas, including expanded support to the federal Area Health Education Centers program.

- Funding should be provided to help poorer communities recruit primary care physicians, nurses, and allied health practitioners. For example, the National Health Service Corps should be expanded to increase not only the number of primary care and selected specialty physicians, but nurses, physical therapists, and other professionals in short supply in underserved areas.

- Federal regulatory barriers to the recruitment and retention of personnel, particularly in underserved areas, should be removed (e.g., taxation of scholarship and loan funds tied to future service commitments and disincentives for those over 65 to work).

- Incentives should be established for the training and use of multiskilled personnel.

A staged and orderly implementation strategy

AHA proposes step-by-step implementation of the proposal to minimize disruption in current coverage patterns and to facilitate the introduction of broader benefits. Starting with mothers and children, coverage of the poor and the near poor who are not currently covered by Medicaid should be provided by the public program over a pre-established period of time, as cost savings from the system reforms outlined above are added to other available revenues. Those able to pay their own way should be added to the public program if they are unable to obtain basic benefits coverage in the private sector.

As new benefits are added, such as outpatient prescription drugs and long term care, current public program participants, as well as new enrollees with incomes exceeding 150 percent of federal poverty guidelines, should contribute, with premiums, deductibles and copayments scaled to ability to pay. Only in the final implementation stage, and only if anticipated reform savings fall short, would increased contributions for services that now are subsidized be sought from current Medicare beneficiaries who are able to contribute.

Staged implementation also provides the opportunity to deal with major transition issues, such as the Medicare trust fund, and realigning state and local government responsibilities as the federal government assumes responsibility for the public program to provide basic benefits and catastrophic coverage.

Cost implications of the strategy

To assess the effect of this draft strategy, AHA contracted with Lewin/ICF to develop cost estimates based predominantly on their Health Benefits Simulation Model which has been used to estimate the effects of several major national health reform proposals.

Overall, there will be a $55.9 billion increase in federal public program spending, offset by the $4.3 billion reduction in overall private insurance spending by employers, the $13.0 billion reduction in state and local government spending, and the $15.6 billion reduction in direct household spending, resulting in a net national health spending increase of about 4 percent ($23.0 billion) under the AHA plan. This is a relatively small increase in health spending when one considers the vast shortfall in access for 33 million uninsured persons and the many more who are underinsured, particularly in the area of nursing home and home health services. While utilization would increase under the AHA plan, there would be counterbalancing effects as coverage for preventive and primary care services is implemented and expenses due to delays in receiving care are avoided.

More specifically, the AHA plan will reduce health benefits costs for private employers by $4.3 billion, the result of offsetting new spending of $7.6 billion by employers who do not currently insure their employees and dependents with spending reductions of $11.9 billion for employers who do currently offer insurance. Employers who now offer insurance would see their overall spending go down due to the elimination of cost-shifting and the implementation of system reforms including expanded use of managed care. In today's health care system, employers typically pay higher than average charges to cover the cost of uncompensated care provided to uninsured persons and to compensate for inadequate provider payment under government programs. The AHA plan would eliminate this cost-shifting by assuring adequate payment under the public programs and eliminating most uncompensated care through universal coverage. Although many employers will be required to insure part-time employees on a prorated basis, the elimination of cost-shifting and the implementation of cost containment features will result in an estimated net savings of $153 per employee per year in firms that now offer insurance. The average annual premium under the AHA benefits package would be about $1,200, at least half ($600) of which would be paid by the employer. By comparison, the average premium in existing employer plans is about $2,290, of which the average employer pays about 75 percent

($1,720). The AHA plan premium cost of about $1,200 reflects a deductible of $500 for both inpatient and outpatient care, a $5,000 deductible for institutional long-term care, and coinsurance of 20 percent (but none for preventive care). Among firms that do not now offer insurance, premiums for basic benefit coverage under the AHA plan would be substantially less than among most existing employer health plans due to expanded use of managed care and significant consumer cost-sharing requirements.

Federal government spending for public programs would increase by about $55.9 billion if the program were fully implemented in 1991. However, spending by state and local governments will be reduced by about $13.0 billion due to reductions in uncompensated care provided in public hospitals. Increased federal spending under the public program would result from providing coverage to uninsured persons who cannot afford coverage ($9 billion), coverage of long-term care services ($23.6 billion), prescription drug coverage for Medicare recipients ($3.7 billion), and catastrophic coverage for all Americans ($21.0 billion). Provider payment increases under the public program to eliminate cost shifting will be offset by cost savings from system reforms including expanded use of managed care in public programs and other offsets to Federal programs for a net decrease in government costs of $1.4 billion.

Household spending would be reduced by about $15.6 billion, with reductions of $48.8 billion in out-of-pocket spending offset by an increase of $33.2 billion in premium payments as everyone becomes covered by a basic benefits plan and everyone receives catastrophic protection.

It must be noted that the estimated effects of a proposal such as AHA's are highly sensitive to assumptions regarding changes in use rates, as well as assumptions about the offsetting savings that would be achieved through effective management of care and the other reforms described above. AHA believes the estimates provided here are relatively conservative, particularly with respect to the savings that could accrue from the package of reforms aimed at changing provider behavior and eliminating the delivery not only of unnecessary care, but care that is futile or negligibly beneficial. Currently available research provides some basis for estimating the effect on utilization when previously uninsured individuals become covered, or when previously insured individuals enter managed care programs, but there is little research that provides a sound footing for estimating the effect on medical practice patterns and the effectiveness of care management techniques when conducted in an environment supported by tort reform, clearer medical practice parameters, broader use of living wills and advance directives, and so on. Consequently, the increased costs due to utilization increases may be more fully reflected than the decreased costs due to more prudent management of care and the other system reforms included in AHA's proposal.

The most critical assumptions used in generating the estimated effects of AHA's proposal are:

- Utilization of health services by previously uninsured persons is assumed to adjust to the level reported by insured persons with similar characteristics.
- Utilization of nursing home services is assumed to increase by 25 percent.
- Utilization of home health services is assumed to increase by 100 percent.
- For illustrative purposes, the estimates assume that the program is fully implemented in 1991 and that changes in utilization and managed care savings occur immediately upon implementation of the program, even though utilization responses and managed care savings are expected in phase-in over a period of five years.

- Effective management of care and the other system reforms (e.g., tort reform) are expected to result in savings of $29.4 billion. These estimates reflect, among other things, reduced utilization at varying rates for different populations, depending on their current form of coverage.

Everyone contributes but everyone benefits

In order for everyone to benefit from improved health care given current fiscal constraints and concerns about the efficiency of our health care system, all parties must be prepared to exercise greater economic discipline in the way they provide, use, and pay for health care services. This kind of discipline is the essence of a pluralistic system -- without more economic self-discipline, we will lose the freedom that a pluralistic system provides. AHA's proposal calls on everyone to contribute to reform, but it also provides benefits for everyone.

Consumers would be responsible for greater, but selected, cost-sharing, either paid out-of-pocket or through private supplemental coverage until catastrophic limits are reached. They may also find their choices narrowed somewhat by arrangements to manage care. In return, however, they would gain financial access to a full range of coordinated medical services, from preventive to long-term care, sharply reducing today's difficulties in obtaining needed care and the confusion that can accompany negotiating our current system. Delivery system incentives would focus on keeping them healthy, and no one would be impoverished by health care bills.

All employers would be responsible for contributing toward basic benefits coverage for their permanent employees and their dependents, but they would have much greater access to affordable health insurance. All employers would be treated equitably under tax and insurance laws. Tax incentives, hardship funds, and other subsidies would ease financial pressures of coverage. The hidden tax many businesses now pay to cover care for the uninsured and underinsured would drop dramatically as more and more corporations help underwrite insurance coverage for their employees and the government pays its health care bill in full.

Practitioners and health care facilities would be accountable for treatment outcomes on both economic and clinical grounds. Information on provider cost and quality performance and adherence to technology diffusion guidelines would be available for use by purchasers in making selective contracting decisions. Medical practice parameters would be used by third-party payers as payment screens but, more importantly, by hospitals and physicians to manage care more effectively themselves. To be eligible to contract with purchasers, providers would have to accept an appropriate share of the financial risk associated with the cost and utilization of services. Hospitals and physicians must forge effective partnerships that lead to the elimination of excess capacity, of duplicative and underused technology, and of unnecessary or ineffective care. At the same time, health care facilities would see a major reduction in uncompensated care over time, would be fairly paid for the care they deliver, and would be joined by government, purchasers, and the public in making difficult access choices when resources are inadequate to cover all services.

Private insurers would be required to change certain underwriting practices designed to avoid risk, and face competitive pressure to keep administrative costs down and premiums affordable. At the same time, they would have broader opportunities to market affordable basic benefit and supplemental insurance packages, to compete without negating the purpose of insurance through carefully constructed insurance reforms, and to administer an expanded public program.

Government would be expected to meet its obligation to ensure coverage for all those unable to do so themselves and to become a trustworthy partner in the financing and delivery of health care. At the same time, assisted through cost sharing by beneficiaries who can afford it and a more accountable health care delivery system, government would be better able to live up to its promises.

All purchasers would be expected to pay their own way without cost shifting, but all would achieve greater value for their health care dollars. They would have ready access to soundly developed medical practice protocols, guidelines on appropriate use of technology and special services, and information on the cost and quality of care delivered by specific providers.

Starting point: future plans

The American Hospital Association believes that the future lies in taking the best of the current American health care system and providing the necessary incentives to move it toward a more integrated system focused on improving the health status of all and ensuring the availability to all of affordable, quality health care services. The Association offers this strategy as a starting point to stimulate discussion and debate.

The Association seeks comments both on the overall thrust of the strategy presented and on alternative or additional specific measures that might be included in the strategy. In particular, the Association seeks comments on several controversial or unresolved issues that are central to the health care reform debate, for example:

- What incentives would work in promoting broader employment-based coverage?
- How can adverse selection be managed fairly and effectively in the private insurance market?
- What combination of federal taxes is most appropriate for funding an improved public program?

Our objective is to continue throughout 1991 to shape the *Starting Point* into a workable proposal for reform that has a broad base of support. By early 1992, the AHA Board of Trustees expects to reach closure on all major modifications and/or expansions.

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman and Members of the Subcommittee, I am Nary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefit protection for more than 70 million Americans.

Since their inception in the 1930s, Blue Cross and Blue Shield Plans have been committed to developing and improving the nation's pluralistic health financing and delivery system. To that end, we work in partnership with consumers, employers, unions, health care providers and government. That commitment continues today as we address the complex issue of providing access to care for the nation's uninsured.

We welcome the opportunity to address the Committee on this important matter. In my testimony today, I will:

- Discuss how we believe we can build on the employer-based system to assure coverage for all Americans; and
- Provide our comments on S. 1227, the "Health America" bill.

The Blue Cross and Blue Shield System is committed to finding ways to assure coverage for all Americans. We continue to believe strongly that the pluralistic system is the best way to meet the health care needs of all Americans. This is a

framework that helps assure Americans a degree of independence and choice, room for creative ideas, and the medical advances and quality care they have come to expect. We have identified three broad steps that we must take to make our pluralistic approach more effective.

(1) MAKE COVERAGE AVAILABLE FOR ALL AMERICANS

The first step is to assure coverage for all Americans. Given that over 80 percent of the approximately 37 million uninsured Americans are either workers or dependents of workers, we believe the best way to provide high quality health care that meets the needs of this population is through the employer-based system.

Currently, we are considering how to expand the number of people who have coverage through their employer. The challenge is to find the appropriate mix of incentives and direct subsidies to encourage employers to contribute to coverage and employees to accept coverage.

In assessing the most appropriate way to structure these incentives and subsidies, we have concluded that there are special problems—they require different solutions—in the case of small businesses and their employees. Many small businesses are new and have the attendant startup costs, many operate on a marginally profitable basis, and many have a very low-income employment base.

We also are considering how to address the coverage needs of non-working individuals. We believe a combination of public and private plans is appropriate. A key focus of our deliberations is how to maximize the use of tax subsidies to minimize reliance on public coverage and to bring private coverage within the reach of more lower-income individuals.

(2) MAKE COVERAGE AFFORDABLE

Before more employers and individuals can be encouraged to purchase health Insurance coverage, we must assure that coverage 15 affordable. It is necessary to consider both the absolute level of health care costs and the role that tax subsidies and benefit design play in the affordability equation.

Total health care costs are comprised of two factors: the price per unit of services and the number of services used. Price is affected by such factors as capital, technology, costs associated with medical malpractice and, to some extent, practice patterns of providers.

In general, Blue Cross and Blue Shield Plans have been fairly successful in controlling price, largely through provider contracting. Plans have a long history of controlling unit prices through contract arrangements with hospitals that limit subscribers' liability while assuring an appropriate amount is paid for covered services. Plans also have contract arrangements with physicians that limit payments to amounts that are reasonable and protect subscribers from "balance billing" by providers.

However, our ability to control utilization has been affected significantly by uncontrollable factors such as new technologies, demographic changes and consumer demand for health care services.

But there are major utilization factors that we—and other carriers with the same commitment—can influence, such as wide variations in practice patterns of providers. Insurers can implement cost management programs to make major modifications in provider practices by rewarding behavior that uses services efficiently and assures good patient outcomes. These utilization management programs include extensive use of pre-authorization of health care services, concurrent utilization review, post-payment review, review of new technologies, discharge planning, and individual case management.

While these utilization management programs have resulted in a lower rate of increase in health care costs, the most promising strategies are just developing. These newer strategies focus on identifying physicians with the most efficient practice patterns as well as the best patient outcomes, and increasing incentives for subscribers to use these physicians to manage their total health care needs.

All these utilization programs share the potential to reduce health care costs expenditures—from the traditional managed care programs to the newer "gate keeper" programs. We believe that the key to significant overall reductions in health care costs lies in encouraging employers to use these programs to assure the most appropriate utilization and quality of services for their employees.

In addition to addressing these larger cost issues, we also must consider how to make coverage more affordable for marginally profitable employers and low-income employees. This means making the best use of tax subsidies and assuring an efficient insurance market. In particular, we are examining how tax subsidies could be

used to reduce reliance on public programs, to increase private coverage for those currently uninsured, and mainstream lower-income individuals into private coverage.

A final consideration in improving affordability is the design of a benefit package. The Blue Cross and Blue Shield Association supports access to a basic set of benefits for all Americans, but we believe that the design of a benefit package balance the competing needs of adequate protection, affordability and incentives for appropriate use of services.

(3) ASSURE A NELL FUNCTIONING AND COMPETITIVE INSURANCE MARKET

The third and final step we support is assuring a well functioning and competitive insurance market. This step is essential to assure access through a pluralistic system.

One of the most important actions in improving the functioning of the market is to eliminate the current imbalances between self-funded and insured benefit plans. Because ERISA protects self-funded employers from state regulation, these employers are not required to meet the insurance reforms that have been enacted in several states, nor to participate in state-sponsored programs to increase availability of coverage, such as pools for high-risk individuals. They also are exempt from state mandated benefits requirements and state premium taxes. Thus, these costs are shifted on to insured employers, who tend to be small and medium-sized companies that can not the additional costs.

We also recognize that market reform is necessary to replace competition based on ability to select risks with competition based on administrative efficiency, service and ability to control costs. The specific small group market reforms the Blue Cross and Blue Shield System supports include:

- Assuring that small employers have access to private insurance, regardless of health status, occupation or geographic location;
- Assuring that states have a range of options to choose from in providing for the availability of private insurance to small employers;
- Assuring that small group coverage is provided at fairly established rates;
- Assuring that no small employer is dropped from coverage because of poor claims experience;
- Assuring the adequate effective enforcement of all carrier requirements;
- Assuring the equitable sharing among insurers of both high-risk small employers and the losses associated with covering these high risks; and
- Assuring the availability of lower-cost products.

With respect to making sure that small employers have access to private insurance, the Blue Cross and Blue Shield Association believes that states should have the flexibility to develop approaches to address the unique problems in their small group markets. The nature of the access problem varies from state to state, as do insurer practices. States should be able to choose or adapt approaches that meet their particular needs.

As for access to individual coverage, our current position is that states where Blue Cross and Blue Shield Plans do not provide coverage on an open enrollment basis to individuals should establish high-risk pools to provide access to coverage for uninsurable individuals. However, we recognize that changes may be needed in the individual market.

It is important to understand, however, that reforming the individual market will be much more difficult than reforming the small group market. Of all the health insurance markets, the individual market has the most severe problem of adverse selection.

Before leaving this discussion of the insurance industry, I would like to comment on insurers administrative costs. Many people point to the administrative costs of insurers as a target for cost-savings and question the "value" of a private health insurance system. Blue Cross and Blue Shield Plans are proud of their record of providing an average of 90 cents in benefits for every $1 in health benefits premiums.

COMMENTS ON S. 1227: THE HEALTH AMERICA BILL

I would like to turn now to our comments on S. 1227, the Health America bill. This bill would assure universal coverage through a "pay or play" approach. Employers would be required to provide a specific level of coverage directly to their employees or pay a tax to finance their coverage through state-run insurance pools.

These public pools also would provide coverage for low-income individuals, replacing Medicaid for acute care services. In addition, federal requirements—including

guaranteed issue and community rating—would be established for small group insurance insurers. Other provisions include cost containment and quality improvement initiatives.

We commend you, Mr. Chairman, and the other co-sponsors of the Health America legislation for your hard work in crafting this proposal. We are strongly supportive of the basic intent of the legislation—to build on the current pluralistic system of financing health benefits. While we support many of the approaches to addressing current problems set forth in the legislation, we also will highlight some areas where we would like to work with you on alternative approaches. The three areas our testimony will address are the bill's provisions for: universal coverage, affordability and insurance reform.

UNIVERSAL COVERAGE

We support the stated intention of the legislation to encourage employers to provide health benefits to their employees through the private insurance system. A key issue for us, and others who support continuation of the employer-based system, is whether this design, in fact, encourages employers to contribute to private coverage and employees to accept this coverage.

The major reason some employers do not currently provide coverage is cost. The bill addresses some of the specific affordability problems faced by employers—both those who currently offer coverage and those who do not, especially small employers. The availability of tax credits and provisions for new small employers and-marginally profitable small employers should modify the financial impact of the bill's requirements. In addition, the bill has a major emphasis on strategies to control overall health care costs.

Our fundamental concern with the "play or pay" structure—the requirement that employers either provide a specified level of benefits directly or pay a payroll tax and send their employees to a public pool for coverage—is its inherent incentives for employers to increasingly abandon their role in providing benefits directly, and send their employees and their families to the public pool for coverage.

We recognize that the intent may be to set the "pay" part of the program at a level that encourages employers to provide coverage directly, through private insurance, to their employees. However, there will be enormous pressure to set the tax on employers who do not provide benefits at a very low level—a level below the actual cost of coverage. And, even if the tax were set at a level sufficient to cover those costs at the outset of the program, it would be difficult to adjust the tax sufficiently each year to maintain an incentive for employers to continue providing coverage directly, as health care costs continue to increase at a faster rate than the wage base.

In other words, while the bill is designed to provide employees continued access to private coverage, we believe that over time, the increasing incentives to use the public pool as an alternative to private coverage would result in a massive, federal program as the major source of coverage for employees.

Further, we do not believe the public pool will be responsive to the needs of employees. The link between employers and employees in the current system provides for a degree of accountability and attention to individual employee needs that could not be sustained under a public program, for example, through the design of employees' benefit packages.

While we have serious problems with the public pool, we recognize that employees whose employers do not offer coverage need a source of coverage that is available regardless of medical condition, that has premiums established on an equitable basis, and that is affordable. We currently are analyzing private sector options to the large public pool.

AFFORDABILITY

Notwithstanding the need for subsidies for certain employees and employers, it is also fundamental to assure that benefits are affordable by establishing initiatives to control the cost of health care services. We commend the bill's sponsors for their commitment to a comprehensive cost containment strategy. We strongly support many of the strategies proposed, in particular the promotion of managed care.

We also strongly support the preemption of state mandated benefits provided by the legislation. In the absence of these mandates, insurers could reduce the cost of coverage, especially in the small group market. However, we are concerned that the comprehensive nature of the benefits required under the bill would impair insurers' ability to develop lower-cost benefit packages.

In addition, we support the bill's recommendations regarding investment in outcomes research and practice guidelines and a shared public and private sector responsibility for assessment of new technologies.

Our major concern with respect to the bill's cost containment strategies stems from the heavy emphasis on all-payer programs. This emphasis is reflected in the Federal Health Expenditure Board provisions which encourages negotiations between providers and purchasers to reach agreement on universal payment rates. There is a similar emphasis on all-payer strategies in the requirement that insurers make Medicare payment rates available to small employers. We also are concerned that all small insurers in a state would be required to use uniform payment rates for their entire enrollment.

We believe that current problems such as excess capacity and inefficiencies would become locked into place if payers were prevented from negotiating in the economic interest of consumers. Governmentally established payment rates would inhibit insurers' ability to make the most efficient contract and payment arrangements with providers.

All-payer systems also must rely on "rough justice" and are not capable of addressing unique needs at the community and institution-specific level. The inability to address these special needs could leave some communities without adequate access to services.

We believe that as an alternative to such regulatory payment schemes, there should be stronger incentives for employers to use entities to finance and deliver services that have a proven "track record" of managing the unit price, utilization and quality of services—managed care insurers. We believe that the most effective arrangements are those in which the parties at economic interest are free to negotiate and come to agreement on the price of services.

INSURANCE REFORM

The third major area I would like to address is the insurance reform provisions. The Blue Cross and Blue Shield System historically has supported state regulation of insurance. However, in the context of major health access legislation, we recognize that Congress may want to assure that some basic insurance reforms are in place in all the states, so there can be effective implementation of the overall reforms.

We support the maximum role possible for states in the regulation of insurance enrollment, rating, and pricing practices. Health America, while prescribing some federal carrier requirements, does retain a significant role for states to implement these requirements and regulate compliance. Me believe the proposed division of regulatory responsibilities offers an appropriate opening to a dialogue on the proper balance between federal and state authority in this area.

We are concerned about the "look behind" authority granted HHS. Under this provision, in addition to direct state regulation, HHS could review individual health plans to assure compliance. We believe this would result in burdensome and costly dual regulation for insurers, and we recommend that this provision be dropped.

With respect to the specific insurance reform provisions, we strongly support the legislation's inclusion of all financing entities, Including self-funded, Multiple-Employer Welfare Arrangements (MEWAs). Even application of these standards across all financing entities is critical to the effective implementation of these reforms. We also support the bill's requirements regarding carrier registration and guaranteed renewability.

Community Rating. We have major concerns about the community rating requirements. After a transition period, the bill would permit rate adjustments only for age and these adjustments would be limited to 10 percent within a block of business.

Our primary concern with these strict limits is that healthy small groups—and most small employer groups are healthy—would experience sizable rate increases under this proposal, further exacerbating affordability problems. On average, only four percent of enrollees generate 50 percent of claims, while 20 percent of enrollees generate 80 percent of claims. In simple terms, this means that as rates for the 20 percent high-risk enrollees were modified, rates for the 80 percent lower-risk enrollees would increase. We also are concerned that limiting geographic rating adjustments to Metropolitan Statistical Areas (MSAs) and non-MSAs would result in major redistribution of rates from lower-cost areas to higher-cost areas.

These requirements would result in competitive disadvantages for insurers that traditionally have had, or continue to have, more liberal enrollment practices. Their enrollment of higher-risk, higher-cost individuals would result in a community rate that would not be competitive in the market. Perversely, this requirement would

reward insurers that have been very selective in the risks they have previously accepted.

For these reasons, we support the rating reforms adopted by the NAIC last December. These reforms address abuses in current rating practices, which can result in very high rates for some small groups. The reforms would allow the use of demographic rating adjustments, but they would limit the extent to which a group's own experience or health status could be used in setting its rates. In this way, insurers' abilities to set rates that more closely reflect a group's experience would be balanced with the need to subsidize the rates for higher-risk groups.

The reforms also would take the important step of limiting the amount of annual premium increases due to a group's own experience or health status. As a result of these reforms, rates for higher-risk groups would be moderated over time, although rates for lower-risk groups would increase.

Quite simply, we do not know enough at this time about the consequences of rate compression to be able to support any provision that goes beyond the NAIC rating limits—even with the phase-in provided in the bill. We, therefore, recommend inclusion of the NAIC rating requirements in the small employer carrier provisions.

Alternatives to Guaranteed Issue. We also believe that approaches for assuring access to coverage for small employers other than guaranteed issue—a requirement that all insurers accept all groups—should be allowed. We recognize your strong interest in the guaranteed issue approach, and we agree that this approach may be appropriate in some states. Where such approaches are appropriate, we are particularly pleased that the bill would leave decisions about reinsurance mechanisms—which generally would accompany a guaranteed issue requirement—to the states.

While we support guaranteed issue with voluntary reinsurance as one option for assuring availability of private insurance, we believe that other approaches also should be permitted. Reinsurance mechanisms are extremely complex, requiring a strong commitment by the state to implement and administer them. More important, because reinsurance would allow insurers to shift most of the cost of high-risk enrollees to an outside entity, insurers would have a very limited incentive to manage reinsured claims, because they would not be finally responsible for those claims.

If federal legislation were enacted, we would recommend that the Secretary of Health and Human Services have the authority to approve approaches to assuring availability of private insurance other than guaranteed issue. These other approaches could include, for example, an allocation program, whereby groups that have been determined to be uninsurable could select coverage under a program that would distribute such groups equitably among all small group insurers in a state. The NAIC has developed a model that uses this allocation design. A major advantage of this approach is that insurers have an incentive to manage the claims of these groups. And significantly, this approach removes the need for a reinsurance mechanism.

Benefits Package. Another area of concern is the required benefit package. Rather than allowing insurers to offer only packages that include the minimum benefits outlined in the bill, we suggest requiring insurers to offer two standard packages in addition to their other products. These would be the benefit packages that would be available on a guaranteed issue basis. One package could be a comprehensive set of benefits, such as those outlined in the bill. The other might be a "standard," scaled down, package. Employers would have to offer their employees at least the standard package, but also could offer other, richer benefits. This modification would assure that all employers had a lower-cost, more affordable alternative available, and that benefits could be tailored to meet the specific needs of some small employer groups.

Small Group Size: We also would like to comment on the application of the insurance reforms to groups up to size 100. Because problems of availability and rating of insurance tend to be focused in the under-25 life market, we recommend limiting carrier requirements to this market.

We understand the interest in extending these reforms up to groups size 100, particularly because of the additional cross-subsidies in rates this would provide to smaller employers. However, as a result, the rates for medium-sized groups would have to increase.

In addition to concerns about applying rating rules to groups up to size 100, we also want to raise the issue of including these larger groups in any reinsurance programs. If the requirements were to apply to all coverage in this size range, we strongly urge that insurers not be permitted to reinsure groups over size 25. Insurers already accept the risk of insuring groups over size 25; their inclusion in a rein-

surance mechanism would increase significantly the size of the reinsurance pool, and thus increase the subsidy necessary to support its losses.

CONCLUSION

In conclusion, the Blue Cross and Blue Shield Association strongly supports the objective of S. 1227, to assure access to affordable health coverage to every American. Our specific concerns with the bill are its reliance on a public insurance pools, its emphasis of all-payer programs, and the need for insurance reform provisions. Despite these concerns, we believe the bill provides a good vehicle for moving forward the debate on universal access, and we look forward to working with you as this debate unfolds.

PREPARED STATEMENT OF BOB MCAFEE

Mr. Chairman and Members of the Committee: I am Bob McAfee, Vice Chairman of the Board of Trustees of the American Medical Association. The introduction in June of the "HealthAmerica" bill in the United States Senate marked an historic event. It signaled that the time for act ion on health system reform is now. Debate and study alone no longer are acceptable responses. It signaled the serious intent to forge reform. On behalf of the AMA, I applaud this leadership in the health system reform movement, and commend these efforts. This is a bold initiative.

The medical profession is also committed to improvements in our health care system to afford access to care for all Americans. This January, the AMA and 16 national medical specialty societies organized Physician Organizations for Access to Care. Our Statement of Principles (a copy of which is attached) is founded on the need to provide coverage for the uncovered and to build upon the current system as much as possible.

The AMA appreciates the opportunity to be here today to discuss HealthAmerica. We agree with many elements of the bill. We disagree with some, and need further explanation of others. We are impressed by the creative thinking in elements of the bill. Concepts such as a National Health Expenditure Board challenge us all to reassess our view of the future of the American.health system.

A number of the provisions of HealthAmerica would establish an increased role for the federal government in health care delivery. Frankly, this raises serious concerns among some of our members who are not convinced that they can rely on fair administration. Past experiences with the Medicare program, and the current problems with implementation of the Medicare physician payment system, indicate that this anxiety and concern will not be easily overcome.

HealthAmerica is tremendously important for the momentum that it adds to the reform agenda. It merits the scrutiny of all participants in the reform process. We hope that those participants who have proposals will study HealthAmerica and compare it to their own plans, as the AMA is doing. We also hope that those without proposals will come forward, join the debate and facilitate development of a solid reform package.

HealthAmerica and the AMA's reform proposal, Health Access America, share the common, fundamental goals of broadening access, maintaining quality and controlling the costs of health care. Our detailed analysis of HealthAmerica, which reflects the Association's preliminary reactions, is attached.

While there are areas of concern, which one can expect with a program as broad and innovative as this one, the areas that AMA policy and HealthAmerica share are striking. Both proposals call for:

- universal access to coverage for all Americans;
- a system that relies on the successful employer-based system to cover the vast majority of Americans by requiring employment base-coverage;
- small business insurance market reform to make policies available to small business at prices that they can afford;
- incentives to aid small business in purchasing group health insurance including replacement of state mandated benefits that increase the costs of policies and tax and other improvements to assist new and very small businesses;
- improvement in publicly funded programs for the needy and other special populations to insure that no American is left without access to quality medical care;
- recognition that there is a need for substantial medical professional liability reform;
- development of clinically relevant practice guidance for physicians and to integrate that guidance into patient care;

• reducing hassles for both providers and beneficiaries of any health benefit plan, public or private; and

• modifications that build on the best of America's existing health care system so that we can maintain the strengths that we have to offer and develop improved systems to assure quality and value for the services that are being provided.

Much attention must be paid to proposals that could have the tendency to overly micro-manage and/or underfund needed health care and new technology for Americans. As a nation and as a society, we will decide whether market forces or centrally controlled systems will determine the allocation of resources to the health care sector. While budgets cannot and should not be ignored, these decisions should not be budget driven primarily. Proclaiming that a certain percentage of gross national product is all that will be allocated for health care now and in the future, will deny future generations of Americans their opportunity to benefit from advances that will improve not only length of life, but also the quality of that life.

As a nation, we must decide what is important. Then we must decide how to achieve those goals. The budget-driven mentality of the last decade has not provided us with an improved health policy. It has, instead provided us with a system that has major problems.

To achieve consensus will not be easy. We will need to look at various models, choosing the best from each and discarding those elements that won't work for America or will not advance the needs of our people. Certain changes can and should be made now, such as small business insurance market and professional liability reforms. We need to continue to encourage work in developing practice parameters and on ways properly to integrate them into medical practice. A Federal Health Expenditure Board as contained in Health America provides one model, and as we discuss in our detailed analysis, could be further developed to achieve these goals. Likewise, a regulatory environment like the model used by the Securities and Exchange Commission where the rules of disclosure and competition are established, should also be explored. Perhaps there are lessons to be learned from the collective bargaining model. Even foreign systems, while not transferable to America in their entirety can provide insight as to what should be considered and what should be rejected.

For any negotiations or consensus building process to be meaningful, each party must have a sufficient degree of bargaining power. A true negotiations process must be carried out with a real opportunity for negotiation and compromise—not a "take it or leave it" scenario that exists in some nations that "negotiate" health budgets.

Finally, I must point out a major problem in HealthAmerica—the failure to provide for adequate reform of the professional liability system in this country.

The time for study of the liability issue has passed. Prompt reform is essential to reduce the significant costs and access problems associated with unrestrained medical liability. In fact, the AMA believes that the viability and credibility of any health system reform proposal hinges in part on the inclusion of significant liability reform measures.

The AMA strongly supports the liability reforms contained.in S. 489, the "Ensuring Access Through Medical Liability Reform Act of 1991," that was introduced early this Congress by Senator Hatch. The fundamental liability reforms contained in S. 489—capping noneconomic damages at $250,000 or less, providing for periodic payment of future damages, offsetting collateral source benefits, limiting suspension of the statute of limitations for minors and regulating attorney contingent fees on a decreasing index—have already been proven to work in California. They are an essential component of broader reform.

CONCLUSION

HealthAmerica is a positive step in the pursuit of health system reform. It is a thoughtful and complex proposal that, like the AMA's proposal, addresses the accessibility, cost and quality of health care. We will continue to study and evaluate its bold initiatives. We welcome the opportunity for discussion with this Committee, Mr. Chairman, and hope that our comments have been helpful to you. We encourage continued dialogue among all reform participants, for it is only through collaboration of the private and governmental sectors that we will achieve optimal reform.

January 16, 1991

Honorable Donald W. Riegle, Jr.
United States Senate
Washington, D.C. 20510-2201

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

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.

AMERICAN MEDICAL ASSOCIATION ANALYSIS OF HEALTHAMERICA: THE AFFORDABLE HEALTH CARE FOR ALL AMERICANS ACT (S. 1227)

I. ACCESS TO HEALTH CARE FOR ALL AMERICANS

HealthAmerica would expand access through the "pay or play" concept. Employers that do not provide private insurance coverage for their employees would pay a percentage of payroll to "AmeriCare," a new federal public insurance program. The employer contribution would be set at a level that would encourage private coverage, and the benefits essentially would be the same under the public and private options.

The "pay or play" model has received much favorable attention since its endorsement by the Pepper Commission. Proponents of the model note that it provides employers who cannot afford private insurance a means of ensuring employee coverage without risking financial ruin.

The AMA strongly concurs with the HealthAmerica concepts of requiring employment-based health insurance and assisting businesses to comply with this requirement. We would provide this assistance not through a residual public program, however, but through a series of significant measures designed to help employers purchase private coverage. The incentives include small group insurance market reform, replacement of state benefit mandates with a more affordable essential benefits package and financial and tax incentives for new and small businesses.[1]

We believe that enabling employers to purchase private coverage is preferable to creating a new federal insurance program for three reasons. First, we question the creation of another large governmental health bureaucracy. Large programs such as Medicare tout low administrative costs, but the provider community has found that program costs and "hassles" are merely projected onto their ledgers and into their practices. Large governmental bureaucracies historically have not been efficient. They have been subject to budget-driven administration that has often placed dollars before quality or accessibility. We question whether the outcome would be different for a program such as AmeriCare, and, if not, whether working Americans would accept that approach.

Second, there is a perception that enrolling employees in the public program always would be to the financial or administrative benefit of the employer. Financially prudent employers, therefore, would have the incentive to choose the public option even if they could afford private coverage. If this occurred, the AmeriCare program would swell with enrollees, ultimately draining government resources.

Third, unrestrained entry into a federal program could disrupt reform of the private health insurance market, especially as it relates to the small group market. If the federal program became the dominant mode of providing employment-based coverage, the private insurance market would have little incentive to respond to the current pressure for reform, or to seek innovations on a continuing basis. Thus, the market could stagnate, the risk-avoidance practices of many companies could continue, and employers would be further discouraged from purchasing private coverage for their employees.

These concerns might be alleviated by specific bill language requiring the percentage of payroll to be maintained at a level that would not induce a large influx into the public program. Careful oversight and administration of entry into the public program also would be helpful.

II. COST CONTAINMENT

The Federal Health Expenditure Board

HealthAmerica would create an independent agency within the executive branch called the Federal Health Expenditure Board. The Board, which would have 11 members, is intended to "fairly represent" the interests of health care providers. A majority of the Board would be experts in health care issues and would "fairly represent the interests of the general public in having access to quality and affordable health care."

[1]Health Access America also would expand the Medicaid program, support state risk pools and require the self-insured to contribute to risk pools. Many of the HealthAmerica measures designed to implement small market insurance reform and otherwise assist new and small businesses are consistent with the measures contemplated in Health Access America.

The Board would have many responsibilities, most notably including: (1) developing national health care expenditure, access and quality goals; (2) convening and overseeing negotiations between health care providers and purchasers "to develop payment rates and perform other activities necessary to achieve expenditure goals;" (3) establishing recommended payment levels and other recommended measures such as increased utilization of managed care and allocation of capital; and (4) establishing uniform billing and claim forms and mandatory reporting requirements.

As we understand it, the Board would develop a goal for total health expenditures in the US, and for each state and region. The Board would consider relevant factors such as inflation and demand, and allocate the goal to discrete sectors such as hospital services, physician services and laboratory services.

The Board then would convene negotiations between purchasers and providers to determine the terms and conditions related to providing health care within the expenditure goals. The Board would adopt the negotiating process to be followed. Negotiations would be held for each service sector, and could at the Board's discretion be conducted for sub-sectors.. Negotiators would attempt to agree on recommendations to be submitted to the Board regarding a health care payment system (which would be based on Medicare payment unless the Board decided otherwise) and uniform payment rates that would achieve the expenditure goals.

The Board would determine the institutions, individuals and organizations that would be eligible to represent purchasers and providers at the negotiation table. Generally, a potential representative would submit a petition identifying the organizations or individuals that it represents in a particular sector. If at least 25% of the providers or purchasers in a sector chose that representative, it would be approved as a negotiator. If at least 50% of the providers or purchasers in a sector chose that representative, it would be the exclusive negotiator for that sector. If, in a given sector, health services were primarily delivered through institutions or organizations, the Board would establish an election procedure that would be based on a weighted designation of all the institutions and organizations according to their revenues or patient load.

The bill contemplates the following three outcomes to the negotiations process.

- If the negotiators agree to recommend to the Board a proposal about a rate structure or "any other matter" that would lead to achievement of the expenditure goals, and the Board concurs that the recommendation will achieve the goals, the Board would promulgate regulations implementing the rates and other matters, all of which would be binding in the sector involved.

- If the negotiators reach agreement "concerning a goal that is different than a goal that has been developed by the Board," the Board would adopt the negotiators' goal if the Board determines that doing so would be in the best interest of the general public. If the Board rejects the negotiators' goal, the Board could request the negotiators to reach agreement on the original goal, and could promulgate regulations recommending rates and other matters to achieve the original goal.

- If the negotiators fail to reach agreement on a goal, the Board would promulgate advisory rates and other matters to achieve the goal.

The concept and details of a Federal Health Expenditure Board are extremely complex. The primary impediment to understanding the Board and its functions is that the bill language is at times unclear and inconsistent. Several examples follow.

- The bill states that providers would be fairly represented on the Board. It also states that the majority of the Board would represent the interests of the public. What is the meaning of "fairly represented?" Given the bill's broad definition of the term "provider," is it possible that the provider representatives on the Board might not include physicians?

- Giving the Board the power to establish the negotiations process and to determine the individuals or institutions that are eligible to negotiate gives the Board broad power over the process and the players.

- The actual content of negotiations is unclear. At times the bill states that the negotiations will address the "rates and other matters" necessary to reach the goals. At other times, the bill implies that negotiations will address the goals themselves.

- The outcome of situations where the negotiators agree to a rate system (or goal) that the Board rejects is unclear. If the Board requests the negotiators to return to the table, and the negotiators still disagree with the Board's goal, what is the outcome? Are the "recommended" rates that the Board promulgates binding? If not, who sets the rates? Similarly, if the negotiators reach no agreement and the Board promulgates "advisory" rates, is there any consequence to not adopting those rates? Is it acceptable in that situation for everyone to set their own rates?

- What is the result if binding rates are promulgated and followed, but the expenditure goal is exceeded?

- The procedure for appointment as a negotiator is unclear. What if one representative had the endorsement of 50% of the providers, which would warrant appointment as the exclusive negotiator, and one had the endorsement of 25%, which also would warrant appointment?

- What if the Board decided to break the sectors into sub-sectors? Could there potentially be negotiation with each medical specialty and sub-specialty, or with geographic sectors of physicians?

The creation of such a Board is probably the most innovative concept in HealthAmerica. The Board could, like the Federal Reserve Board for banking, help set the agenda for the future of the US health system. The concept merits further development, including the addition of safeguards to prevent federal micro-management of health care delivery and ensure that the views of participants are fairly represented.

The degree of uncertainty surrounding this process prevents a thorough analysis or any conclusions on our part. For any negotiations process to be meaningful, each party must have a degree of bargaining power. A true negotiations process should be carried out on both the expenditure goals and the means of implementing those goals. It is essential that the Board include physician representatives, and that the process overall presents a true opportunity for negotiation and compromise -- not the "take it or leave it" scenario that exists in some countries that negotiate health budgets.

Managed Care (Including Utilization Review)

HealthAmerica strongly promotes, but does not mandate, the use of managed care. For example, the bill would guarantee the employee the right to choose a non-managed care option if he or she is willing to pay up to 200% of normal cost-sharing. In addition, to assist small employers, the bill would require carriers that offer managed care in a community to offer that option to all small employers in the same community. The bill also would preempt virtually all state regulation of managed care and utilization review.

What effect the bill would have on future developments in managed care is unclear, but three entities that HealthAmerica would create -- the Federal Health Expenditure Board, state purchasing consortia and state quality boards -- apparently would have the authority to increase the development and use of managed care. In addition, states would, as part of their administration of AmeriCare, provide for managed care. Finally, the Secretary would, as part of AmeriCare, provide grants to states for demonstrations of cost-containment initiatives that involve the use of managed care.

The AMA always has supported management of care, which traditionally has been done by individual physicians on a case-by-case basis. With the advent of heightened cost-consciousness, "managed care" has proliferated, and become attenuated to the degree that it now encompasses broad activities that consume significant resources. Management of care, which includes utilization review (UR), no longer is reserved for individual physicians, but frequently is performed by third parties who have no contact with the actual patient or physician under review.

The AMA believes that managed care as it exists today is an alternative that should be available in a pluralistic health system. We oppose mandatory managed care, and arrangements that effectively foreclose the use of non-managed care through unreasonable financial penalties.

Our support of the availability of managed care options has several caveats.

- We urge caution in adoption of unproven management or review procedures that may exact more hassle, time and quality costs than they save. Many management procedures designed to eliminate waste have had the opposite effect. For example, the use of second surgical opinions, once heralded as a great cost-saver, has largely been discontinued as a cost-containment device. In addition, some observers have noted that the alleged savings due to inpatient UR are negligible.

- Those who implement managed care -- the reviewers -- must be qualified and accountable for their actions. At a minimum, the following standards should apply: (1) any physician whose services are being reviewed for medical necessity should be provided the name of the reviewing physician on request; (2) reviewing physicians who make judgments about the medical necessity or appropriateness of care should be of the same specialty and licensed in the same jurisdiction as the physician under review; (3) reviewing entities should be subject to legal liability for harm to the patient or physician caused by the entity's conduct; and (4) medical protocols and review criteria should be developed by physicians.

- Review entities and health plans that use review strategies have a disclosure obligation to patients and providers. Review or management entities should disclose upon the request of the provider the review criteria, weighting elements and computer algorithms, along with information on how they were developed. Health benefit plans also should disclose to prospective enrollees in clear and simple terms the benefits provided, coverage limitations and review or management requirements.

- All health plans that conduct review or management should be responsive to patient and provider inquiries and problems. Specifically, the plans should establish a process for meaningful review of adverse determinations, including the right to review by an independent physician of an adverse coverage determination. Also, plans should respond to prior authorization requests in two days, and other medical necessity inquiries within one day.

- State laws regarding managed care and utilization review offer vital protections to providers and patients, and should not be preempted by federal law. Many states have passed laws that protect the rights of providers and patients who participate in managed care plans. These laws typically guarantee that all qualified providers are free to contract with managed care entities, that providers and patients receive complete information and that review is conducted in a manner that is fair to both providers and patients.

State Purchasing Consortia

HealthAmerica would require each state (or region) to establish a consortium of every in-state health insurer that has a small market share. The consortium would process all the claims of member insurers, and, therefore, achieve administrative savings through economies of scale. In addition to its "superprocessor" function, the consortium would develop uniform billing and claim forms and procedures, establish a paperless processing system that includes the use of "smartcards" and achieve other administrative savings.

"Optional" functions of the consortium would include convening negotiations with providers, purchasers and others about coverage, reimbursement and other matters, developing capital allocation procedures and collecting data on providers that would be disseminated to consumers to facilitate choice of providers and encourage efficient provider behavior.

The AMA generally supports measures that increase administrative savings without compromising the quality or availability of care. We support the concept of allowing states to demonstrate health reforms, such as the cost control demonstrations that the bill contemplates. We believe strongly that new cost-containment reforms should be demonstrated on the state level, with the active involvement of state medical groups, before they are mandated at the federal level.

The "optional" consortium functions are troublesome by definition and by their vagueness. For example, the AMA is interested in proposals to reduce inappropriate expenditures on capital or technology, but we are unable to assess the bill's cryptic reference to capital allocation. Is this an effort to revive the ill-fated health planning program repealed by Congress? Similarly, the meaning of encouraging a rational distribution of health care

providers is unclear. We also find the vague reference to provider data collection and distribution troubling. (See related discussion under the heading Quality Improvement Board.)

Medical Liability Reform

HealthAmerica would provide grants to states to develop and implement liability reforms, and authorize the Institute of Medicine or a similar independent entity to study the liability issue and recommend reforms.

The time for study of the liability issue has passed. Prompt reform is essential to reduce the significant costs and access problems associated with unrestrained medical liability. In fact, the AMA believes that the viability and credibility of any health system reform proposal hinges in part on the inclusion of significant liability reform measures.

The AMA strongly supports the liability reforms contained in S. 489, the "Ensuring Access Through Medical Liability Reform Act of 1991," that was introduced early this Congress by Senator Hatch. The fundamental liability reforms contained in S. 489 -- capping noneconomic damages at $250,000 or less, providing for periodic payment of future damages, offsetting collateral source benefits, limiting suspension of the statute of limitations for minors and regulating attorney contingent fees on a decreasing index -- have already been proven to work in California. They are an essential component of broader reform.

Perhaps the most alarming aspect of the liability crisis is the effect it has had on the physician/patient relationship. Once grounded in trust, this relationship has become clouded with suspicion and finger-pointing. Physicians have come to view their patients as potential plaintiffs, and patients have been encouraged to believe that anything less than a miracle is malpractice.

Medicine cannot guarantee miracles. Yet, as the recent Harvard Medical Practice Study concluded, medicine's record is very good; patient care was found to be safe and free of negligence in at least 99% of all hospitalizations. What medicine wants is revision of the liability system to encourage realistic expectations and reduce the need for defensive medicine. When trust is restored to the physician/patient relationship, both parties will be able to work together more effectively to increase positive health outcomes.

Outcomes Research and Practice Guideline Development

HealthAmerica would seek to control costs through continued support and development of practice guidelines and outcomes research. It also would support technology assessment as a "quality" measure.

The AMA supports the development of practice parameters, and believes that appropriately developed parameters will enhance the value of health care by helping to eliminate ineffective treatments and services. We have been a leader in the development of parameters, and are working with the Agency for Health Care Policy and Research on this important issue. The AMA has formed two working groups -- the AMA/Specialty Society Practice Parameters Partnership and the AMA/ Specialty Society Forum -- to guide and coordinate parameter development and examine the complex issues involved in the process.

A prime example of the beneficial effect parameters can have is found in the guideline for the use of cardiac pacemakers that was developed by the American College of Cardiology in 1984. In the 1960s and 1970s, indications for the use of pacemakers varied. The College responded to this by coordinating development of clinically

relevant parameters that identified the appropriate use of pacemakers. The guidelines were welcomed by the profession, and the utilization rate for pacemakers decreased from 2.44 per 1000 Medicare beneficiaries in 1983 to 1.76 per 1000 in 1988 -- an approximate 25% reduction.

The AMA also supports outcomes research and technology assessment. These activities can achieve substantial cost savings and quality enhancement by assessing the effectiveness of medical treatments. The AMA devotes significant resources to technology assessment through its Diagnostic and Therapeutic Technology Assessment (DATTA) program. Since 1982, DATTA has been evaluating the safety and effectiveness of drugs, devices, procedures and techniques used in the practice of medicine. DATTA draws from a panel of 2,500 expert physicians who evaluate new and emerging technologies. The results of these assessments are communicated to practicing physicians and more than 1,150 health care organizations, primarily through AMA publications.

Additional Cost-containment Measures

Additional cost-containment measures that the AMA supports include replacing state benefit mandates with an essential benefits policy in the employment context, amending the federal antitrust laws to permit fee review by local medical groups, health promotion and providing incentives to reduce inappropriate health care consumption.

III. QUALITY

Under HealthAmerica, the Federal Health Expenditure Board would develop quality goals to improve the quality of the US health care system, and implement an extensive data collection system to amass data on particular providers. Each state would create a Quality Improvement Board (QIB) to review the quality of care provided in the state and implement the data collection process in conjunction with the Expenditure Board. Seven of the 15 QIB Board members would represent providers.

The QIB would have the four following functions:

- (1) adoption of guidelines for appropriate medical practice and for measures to improve provider quality (the guidelines would include those developed by the Agency for Health Care Policy and Research and could include those developed by professional societies);
- (2) recommendation of measures for continuous quality improvement, such as continuing education requirements and, for institutions, internal quality improvements (to be developed in conjunction with the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), associations and professional bodies);
- (3) certification of providers as "outstanding," based upon (i) conformity to guidelines, (ii) scientifically valid measures such as health outcomes, and (iii) adoption of measures recommended for continuous quality improvement; and
- (4) data collection on providers for ultimate distribution to consumers to empower consumers to compare providers based upon quality and cost.

The AMA strongly supports enhancement of the quality of the health care delivered in this country. As stated previously, we have been very involved with the development of parameters. We

support states' efforts to enact reasonable quality measures, and believe that appropriate data collection can be invaluable in measuring such things as outcomes.

We do not believe, however, that establishment of 50 QIBs -- the addition of another layer in the health care bureaucracy -- is the most appropriate and efficient way to ensure the delivery of high quality care. State licensing boards, which already exist, could assume many of the anticipated functions of the QIBs. Moreover, the relationship between QIBs, Medicare Peer Review Organizations, the JCAHO and other "quality" organizations is unclear. We believe that creation of 50 QIBs may increase administrative costs significantly and unnecessarily.

We are troubled by the bill's suggestion that QIBs could disregard use of guidelines developed by entities other than the AHCPR. The AMA supports and works with the AHCPR. We believe, however, that the medical profession must have significant involvement with the development and use of all medical guidelines. State and specialty medical societies have the ability to draw from the experience of their members, and in that respect are more attuned to the changes in practice than a federal agency.

We find the data collection and dissemination activities of the QIBs quite disturbing. The AMA supports data collection, and believes that this activity may, when it has been fully developed and refined, provide valuable information. We also believe that the goal of helping consumers make educated health care decisions is laudable.

The "art" of health care data collection and interpretation, however, is in its infancy. There is a perception that we can simply collect data, draw conclusions and "rate" providers. The innumerable variables involved with medical care -- complicating medical factors, patient behavior, the intervention of other health care workers -- however, prevent easy analysis of data. Even the highest quality care does not always result in a cure.

Data collection works well in computing baseball batting averages. We simply do not have the capability to use health care data to provide reliable score cards for physicians.

A good example of how misleading health care data can be is found in the recent -- and controversial -- release of hospital mortality data. It has not been shown to assist consumers and, in fact, has caused much confusion. We think a much better approach would be to provide the data to the providers, who can use the information to improve their practices if necessary. When quality is a problem, provider education has been shown to be far more effective than punishment.

Finally, we find the certification concept intriguing. As you know, physicians and other providers are reeling from the "hassle" factor in medicine today. We anticipate that the profession would welcome a mechanism that allowed providers who fall within certain parameters a degree of freedom from the virtually incessant review activities of third parties. In fact, we have long asserted that because most physicians provide high quality care at appropriate levels, review resources should be focused on areas with demonstrated problems. This alternate approach also would facilitate quality efforts while decreasing the hassle factor for the majority of physicians.

Our concerns with the certification concept include the definition of the term "outstanding," which is unclear from the bill. What would be done to assist providers who might not meet the definition, but in fact are exemplary providers? Would providers not labeled as "outstanding" be subject to express or implied penalties? Where a provider has had problems, we strongly encourage educational intervention, and not penalties.

PREPARED STATEMENT OF GEORGE S. MICKELSON

Good afternoon Mr. Chairman and members of the committee. I am pleased to be here today to present the Governors' views on health care reform.

The costs of our present health care system are out of control. Total health care spending in the nation has grown from less than 6 percent of the gross national product (GNP) in 1960, to 12 percent in 1990, and is projected to reach 37 percent of GNP by the year 2030. Yet the United States health care system currently fails to meet the needs of approximately 34 million Americans. Furthermore, our system does not ensure that people have access to important preventive and primary care. Too often treatment comes too late and at too high a cost.

NGA Policy and Report

Health care reform is a top priority for the nation's Governors. Last month at our annual meeting, we unanimously adopted a health care reform policy with specific recommendations to develop a new federal framework for a national health care system. We believe our health care reform policy provides a strategy under which the states and the federal government can work together to reach consensus on health care reform. It also provides the Governors' long-range vision for restructuring our health care system.

State-Based Comprehensive Reforms

Since the adoption of our policy in Seattle, there has been some criticism leveled at the Governors. Our critics complain that we did not put forward a plan for national reform and that to rely on state experimentation is to "let Washington off the hook." I'd like to respond to that criticism.

While the members of the Governors' Task Force on Health Care understood quite clearly that there were expectations that we would produce a national plan, they also came to understand that without significant structural change to control costs, our mutual dream of universal access will never be achieved. Yet many of the most promising structural cost control ideas have never been tried in this country. The task force became quite convinced that these ideas need to be tested at the state level and evaluated so that we as a nation can learn about how they would work in the United States.

What many have called the failure of the Governors to achieve consensus on a national plan reflects the lack of consensus among our people about how best to construct a health care system that provides affordable access to all.

In addition, while most policy experts inside Washington D.C. equate insuring the uninsured with access to care, the Governors recognize that without a service delivery system that is tailored to each state's geographic, economic, and ethnic needs, real access to care will not be achieved.

The real question now before the Governors is how we will individually and collectively move to implement some of the comprehensive reform strategies available to us.

Here are some illustrations of approaches states may want to test to contain costs:

- Implementation of a managed competitive approach that could include strategies such as developing a statewide system for getting price and quality information to consumers, eliminating state-mandated insurance benefits and anti-managed care legislation, and deregulating providers;

- Creation of an all-payor system including strategies such as instituting a statewide global budget for the allocation of capital resources and establishing a program to partially subsidize private insurance for unemployed individuals who are not eligible for Medicaid; and

- Implementation of uniform electronic billing systems to reduce administrative overhead.

Some illustrations of approaches states might like to test to expand access to coverage include:

- Expansion of the current system and institution of a statewide "pay or play" system for expanding access to employees of small businesses;

- Creation of a statewide purchasing board to help small business purchase basic health insurance for their employees;

- Provision of subsidies to small businesses that are purchasing health care for the first time; and

- Expansion of the role of community-based primary care providers through programs to recruit and retain health professionals in underserved areas, and to strengthen local community health centers and other sources such as school-linked health care.

Some illustrations of possible policies to address the access needs of specific populations include:

- Creation of programs that ensure that all children have access to affordable and adequate insurance coverage and comprehensive health care services;

- Expansion of small business insurance coverage; and

- Establishment of programs that focus on the needs of uninsured populations currently below poverty but not eligible for Medicaid.

More details on potential state strategies are outlined in the task force report that accompanies the health care policy.

As you will note, many of the reforms I have listed are contained in health care proposals pending consideration in Congress. We view

the Governors' request for federal support to test these strategies as an opportunity to work with the federal government to accelerate the debate on health care reform. Through state-based reform, we can provide needed evaluative information on the merits of differing reform approaches to contain costs and increase access. As with the states' experience with welfare reform, a national consensus can grow from tested state innovations on health care reform.

How the Federal Government Can Help

There are several steps the federal government can take to facilitate state innovation.

The federal government should take a fresh look at how state waivers are approved to streamline the approval process for state reform efforts. Waivers should allow states more flexible use of Medicare, Medicaid, grant programs, and other health funds. This would allow experimentation with all-payor systems, expanded use of managed care, and better integration among health programs. The waivers also should share financial risk over an extended period of time to allow states to test innovative ideas without unreasonable financial barriers.

States also should be permitted to obtain waivers to the Employee Retirement Income Security Act (ERISA) preemptions. This would enable states to increase access to care through an approved state approach. For example, states that want to use a "pay or play" system for employers need to be able to ensure that employers who claim ERISA preemption from state law are, in fact, offering health care coverage to their employees.

Overcoming Market Failures

To address market failures inherent in our current system that contribute to escalating health care costs, limit access to care, and make it difficult to reorient our system to one that provides preventive and primary care, the Governors recommend that the federal government:

- Augment current efforts to organize and support research into technology assessment and medical practice guidelines. The result of such research may serve as the basis for medical practice guidelines and reduce the need for defensive medicine and tort reform. This information also can be used in conjunction with state experience to develop medical benefit guidelines to assist in the development of different kinds of cost-effective insurance packages.

- Develop a systematic way to capture and report line-item health care expenditures by state. National baseline information is needed to assess whether efforts to control costs are successful.

- Enhance opportunities and incentives for individuals to pursue careers in primary care, particularly in rural and underserved areas.

Health Insurance Market Reform

The Governors also believe strongly that reform of the health insurance market is necessary to halt a number of insurance industry practices that seriously impede the ability of small businesses and individuals to find affordable insurance coverage. To address these practices, the Governors will provide for the establishment of uniform minimum standards for state health insurance reform. These standards, to be developed by state officials, should restrict or prohibit the use of certain rating techniques and factors; ensure availability, renewability, and continuity of coverage; and encourage broader and more equitable sharing of risk.

A New Public Program

Medicaid is the current vehicle to provide care to low-income families, children, seniors, and persons with disabilities. However, it is an overburdened program struggling to serve these diverse populations and their diverse care needs. It is now a huge program that is difficult to administer and prohibitively expensive.

To provide better access to care and use public resources more efficiently, the Governors call for the establishment of a new public program that would provide health care to individuals with incomes below a certain level of poverty and/or individuals who do not receive health insurance through their employment. Funded with existing Medicaid resources, the new public program would be designed to address the health care needs of the non-disabled population from birth through the age of sixty-four.

The program would:

- Provide for eligibility based solely on income, and not be tied to welfare or AFDC;
- Recognize economic variations among states in determining poverty levels;
- Include a service package of preventive, primary, and acute care services;
- Be state-administered and free of unnecessary and cumbersome administrative constraints so that states can integrate the program into other state delivery systems; and
- Emphasize managed care.

The Governors also call for the establishment of a program designed to meet the needs of the elderly and people with disabilities. The new program should provide a continuum of services to meet care needs ranging from basic to preventive and primary care to rehabilitative, maintenance, social support and other long-term care services. Those services should be fully integrated with other programs that provide services to the elderly and people with disabilities. The Social Security and Medicare programs may provide the appropriate framework for such a program.

Finally, to address the problems faced by million of Americans who have health insurance but face catastrophic out-of-pocket health care costs, the Governors recommend further study of the efficacy of a national catastrophic health care program. This would eliminate the public's fear of insurmountable health care bills. It also would limit the risk assumed by insurers and should lower the cost of health insurance across the board.

Short-Term Realities

Before concluding, I must first address a Medicaid issue of immediate concern to the Governors regarding our revenue-raising authority.

Until newly structured public programs are in place, states must be allowed to maintain their complete authority to raise funds to match federal Medicaid dollars without restriction from the federal government.

However, this authority is seriously threatened by an interim final regulation recently issued by the U.S. Department of Health and Human Services. The regulation will have a profound impact on state Medicaid programs by denying federal matching payments for funds raised through dedicated taxes, donated funds, and intergovernmental transfers.

These revenue-raising methods are permitted under current law and regulation and must not be changed as states struggle to keep pace with runaway health care costs, the effects of downturns in the national economy, and increased demand for public assistance.

These regulations not only are inconsistent with congressional intent as stated in the Omnibus Budget Reconciliation Act of 1990, but also have an unfair and punitive effective date of January 1, 1992. If the regulations are permitted to take effect in January -- the middle of states' fiscal years -- the consequences will be immediate and severe, forcing program cuts and emergency sessions of state legislature.

The Governors seek the assistance of this committee in resolving this situation in a manner that does not so severely disrupt the provision of health care to the nation's most vulnerable populations. If the federal government's goal is to improve access to care, we must work together under the current system and work together to develop a new more efficient system.

Mr. Chairman, the Governors stand ready to work with this committee. For we believe that through a true partnership we can achieve the consensus necessary to lead us as a nation toward our common goal -- access to affordable health care for all Americans.

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

PREPARED STATEMENT OF LUANNE EICHLER-NUNNALLY

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear before you to speak on the issue of health care reform. My name is Luanne Eichler-Nunnally and I am here today on behalf of the Digestive Disease National Coalition and my sister Cheryl Eichler. Cheryl died two years ago after a 13 year struggle with Crohn's disease.

Senator Riegle, I know that you have met my sister before and heard her story, but would like to tell it to the rest of the people here with the hope that it will somehow help the hundreds of thousands of other Americans who, like Cheryl, are unable to get health insurance.

In 1976, at the age of 16, Cheryl was diagnosed as having Crohn's disease. Crohn's disease is a chronic disorder of the digestive tract for which there is no known cause or cure. Symptoms include abdominal cramps, persistent diarrhea, blood in the stool, fever, and weight loss. Abdominal pain is the constant companion of a Crohn's disease victim. Treatment often involves the use of medications to control the symptoms, however surgery is often required when the medications are no longer effective or when complications arise. It is estimated that about two-thirds of persons with Crohn's disease will have to undergo one or more operations in their lifetimes. The treatment involved in battling this disease is extremely expensive, and it is lifelong.

Cheryl underwent her first surgery for Crohn's in 1977, when doctors had to remove part of her colon. She was hospitalized for three months. Fortunately, our mother was receiving Aid for Families with Dependent Children at the time and most of the costs of Cheryl's medical care was covered by Medicaid.

Cheryl's next flare up of Crohn's occurred in 1982. At the time Cheryl was employed by Manpower Services and was supporting herself. Her employer however, offered no health insurance benefits. Although Cheryl was in severe pain from Crohn's, she waited about six months before going for treatment. She waited to get treatment because she didn't have any medical insurance and because she didn't know how she would pay the costs of her medical care. Eventually Cheryl had to have more of her colon removed and the doctors also performed an ileostomy. An ileostomy is a procedure in which an opening is created in the abdomen to facilitate the removal of bodily wastes. Medicaid covered the costs of this care but this, unfortunately, provided only a temporary solution. Once Cheryl was well enough to return to work, she no longer qualified for Medicaid and was again without any type of medical insurance or assistance.

In September of 1986 Cheryl was again faced with the predicament of needing medical treatment but lacking any insurance or means to pay for it. Further complications from her disease had developed and she was suffering from per-rectal abscesses. Perirectal abscesses are extremely painful and produce a great deal of drainage. At the time Cheryl was working at 7-11 and making about $12,000 a year. 7-11 however, did not offer any health insurance. Cheryl put off getting treatment for her condition because she was scared, and had no insurance and didn't know how she was going to pay for any more medical care. In March of 1988 she finally received treatment for the abscesses and set up a payment plan to pay the medical bills.

Cheryl's health continued to deteriorate and in 1989 she had to resign from her job because of health complications. Cheryl was admitted to the hospital because she was losing weight, was very run down and in a great deal of pain. Cheryl condition did improve and she was eventually released and at home on parenteral therapy. Parenteral therapy introduces liquid calories directly into the bloodstream through a catheter in the vein. It is not unusual for this therapy to cost in excess of $100,000 a year. At this point, Cheryl had been accepted by Medicaid, and the program covered the costs of her care. In October of 1989 Cheryl developed a severe infection. She was re-admitted to the hospital and on October 10, 1989 she passed away.

Throughout Cheryl's illness she tried to get some type of medical coverage so that she wouldn't have to worry about how she would pay for treatment every time she got sick. She contacted several insurance companies but because of her poor health history, the premiums were extremely high and too much for her to afford on her limited salary, or she was refused coverage altogether. She repeatedly tried to get medical assistance from the state but was always turned down, either because she made too much money, had a job, or a car, or didn't meet the Medicaid program's definition of disabled. Every time Cheryl got sick and needed treatment, her immediate concern was, "How am I going to pay these bills?"

What is truly unfortunate, and the reason why I am here today, is that my sister's story is not an uncommon one. It is played out repeatedly across this country.

There are thousands of individuals who suffer from chronic disorders, such as Crohn's disease, who require a lifetime of expensive, urgent medical care. The twenty-two organizations of the Digestive Disease National Coalition represent thousands of individuals who suffer from the various disorders which afflict the digestive tract. Many of these conditions require long term medical care and attention. These individuals, like others, have to live with the constant fear that they may not be able to afford the critical life-saving treatment for their condition. Some may be fortunate enough to have a job that provides medical insurance, but there is the continual concern that they might lose coverage if they switched jobs, or were laid off. Others, like my sister was, are employed but their employers don't provide any coverage. Attempts to obtain coverage result in repeated frustrations. They apply for medical coverage, but because of their pre-existing condition, are unable to afford the high costs of the premiums, or are denied it altogether. The current public programs also fail these individuals. Because my sister continued to work throughout her illness she was not able to qualify for state medical assistance.

Senator Riegle, I want to thank you for your continuing efforts to address the issue of health care reform. The goal of providing universal access to health care is critical and we must all work together to find a solution to the current situation. I know the constant worrying and emotional stress which Cheryl endured throughout the thirteen years of her illness because she didn't know how she would pay for her medical care. It is important that we prevent others from having to suffer as my sister did, continually concerned that they will get sick and be unable to pay for care, putting off medical treatment because they have no way to pay for it, developing further complications because they didn't receive prompt treatment. Thank you again for the opportunity to appear before you today.

FACTS ABOUT DIGESTIVE DISEASES

- **DIGESTIVE DISEASES:** Digestive diseases encompass a variety of disorders, including cirrhosis of the liver, inflammatory bowel disease (Crohn's disease and ulcerative colitis), ulcers, gallstones, and various cancers of the digestive tract. Many digestive diseases are chronic and can often be life threatening. Digestive diseases are the leading cause of hospitalizations in the United States and treatment for these disorders costs an estimated $17 billion annually. Digestive diseases result in approximately 200,000 deaths each year.
- **COLORECTAL CANCER:** Colorectal cancer is the second leading cancer occurring in the United States. There are 145,000 cases of colorectal cancer reported each year. The rate of death from a diagnosis of colorectal cancer approaches 60%. Periodic screening, however, leading to early detection and treatment, can significantly increase the patient's chance for survival.
- **INFLAMMATORY BOWEL DISEASE (IBD):** Crohn's disease and ulcerative colitis, collectively known as inflammatory bowel disease, afflict about 2 million Americans. 30,000 new cases of IBD are diagnosed each year. There is no known cause or cure for IBD; treatment is life-long and frequently involves surgery.
- **GALLSTONES:** Gallstones are estimated to affect 20 million individuals in the United States. Each year 500,000 operations are performed for gallbladder disease.
- **ULCERS:** Ulcers affect approximately one out of every ten Americans. 46,000 operations are performed each year for peptic ulcer disease, and over 7,000 deaths result from complications associated with ulcers. Peptic ulcer disease is a chronic relapsing disorder. 50% of ulcer patients experience a recurrence within 1-2 years and long term maintenance therapy may be required.
- **LIVER DISEASE:** End-stage liver disease claims the lives of about 27,000 individuals each year. The only treatment available for end-stage liver disease is liver transplantation. Patients undergoing transplant operations face a long recovery period and require extensive medical follow-up.

SUBMITTED BY SENATOR DONALD W. RIEGLE, JR.

STATEMENT OF CHERYL EICHLER, WOODHAVEN, MI

Ms. EICHLER. My name is Cheryl Eichler. I am 28 years old, and I have had Crohn's disease for the past 12 years.

I was first diagnosed as having Crohn's in 1976. I was 16 years old at the time. I went to the hospital in Florida because I was experiencing a lot of pain in my side and lower abdomen. I was having dizziness, fainting, and tired very easily. The doctors told me I was anemic, and after many tests diagnosed Crohn's.

My family then moved back to Michigan in March of 1977. I was admitted to Wayne County General with the same symptoms. I had my first surgery when they found it necessary to remove part of my colon. I was in the hospital a total of 3 months. Luckily, my mother was receiving assistance through the Aid to Dependent Children Program, and because of this Medicaid we were able to survive my first battle with Crohn's.

I didn't have any problems until the middle of 1982. I had graduated from high school and found work at Manpower Services. Although I had no benefits, I was able to support myself. But soon I was in constant pain. My stomach had swollen so much that I couldn't even wear clothes very well. I waited until the pain was so bad, about 6 months, before I went for any treatment, because I didn't have any health insurance, and I didn't know how I was going to pay for the medical services.

I was finally admitted to the hospital when an abscess began draining into my stomach. I couldn't eat or drink anything for about 3 months. The drainage never stopped, so in August of 1983 they took out more of my colon and performed an ileostomy. I was able to apply and receive Medicaid to help cover the costs of the treatment. Unfortunately, Medicaid only solved the immediate problem, and when I had recovered so that I could return to work, I was again without any type of medical insurance.

I found a job at 7-11 and was again able to meet my daily living expenses. Eventually I was offered a salaried position and earned about $12,000 a year. In October of 1985 I was again suffering the effects of Crohn's. I waited about 2 weeks because I didn't have any insurance. I was dehydrated and anemic.

In September of 1986 I developed peri-rectal abscesses. They are extremely painful and produce a great deal of drainage; but, again, I didn't seek treatment until the end of 1986 or the beginning of 1987, because I was very scared, had no insurance, and didn't know how I was going to pay for it.

Finally, in March of 1987 I had outpatient surgery for drainage of the abscesses. I set up a payment plan for this bill and am still making payments for this surgery. I also have the added expenses for the care of equipment of my ileostomy and the doctors I was seeing every 2 weeks, and the additional expense of prescriptions.

On May 15 of this year I was forced to resign my position at 7-11 in order to be admitted into the Westland Medical Center. I was losing weight, very run down, had a lot of pain, and the abscesses were draining heavily. I am still in the hospital.

When I had my first surgery in 1977, my bill for 1 month of care was about $20,000. Now, after 1 month, my bill is over $84,000. Twelve years ago I had my mother's Medicaid to help pay for the

bill: today I have nothing. I applied for Hill-Burton Funds from Westland Medical Center, but I was rejected because my $12,000 a year income was too great to qualify. I have applied for Medicaid as well, but have been told that I do not meet the definition of disabled. They told me that they would review the case further, but it would take an additional 45-60 days to reach a decision.

In the meantime, I am ready to be released, but only if I can continue on my present I-V treatment for the next 3 months. But, without the promise that Medicaid will help pay for this treatment, the suppliers will not provide the equipment. One bag of hyperal for the I-V costs over $100, and since I have been at Westland I have used over 70 bags.

Eventually I will need more surgery to remove the rest of my colon. Without this surgery, there is a good risk that I would develop cancer. Until I get some kind of aid, I will have to remain an inpatient at the hospital.

Even if, by some miracle, I am granted Medicaid for this latest bill, that only solves the immediate problem. They don't know what causes Crohn's disease, therefore there are no cures. There are many people in my situation, and, for us, this is a life-long illness.

Ahead of me lies the frightening task of finding another employer who will be sympathetic to my disease. Even if I'm lucky enough to find something, I'll be unable to find a job that will provide coverage for my treatment. Those of us with Crohn's could never work enough or make enough to pay for the long-term care that is involved with this disease. There is also the constant worry and emotional stress of "How am I going to pay for these bills?"

The treatment involved in battling this disease is extremely expensive. Someone like me who earns about $12,000 a year could never afford to pay for this. I think there is a definite need for help to the uninsured people in situations such as this.

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

Senator RIEGLE. Cheryl, I think what you have just told us is about as powerful a story as most of us will ever hear, in terms of the difficulties that life can present us with and the tremendous courage and strength that you have shown and are showing.

I feel so strongly about it. I think if our country can't find a way to help people like you, there is something radically wrong with the way we do things. We talk about patriotism—there is a big controversy now about burning the flag, and a lot of other things yet we have got individuals like you and Arlene, who are what America is all about that need help right this minute. And it doesn't seem like there are very many people who want to help, or are at least willing to do the things necessary to see that help is there.

We are spending billions on what we call "defense." But we don't seem to be able to find any money to provide some defense for you against the Crohn's disease. We are building nuclear warheads. They cost millions and millions of dollars apiece. We have almost 13,000 nuclear warheads right now and are building more every day. We dare not even use them because, if we do, everybody in effect would be killed.

And yet, here you are at 28 years struggling with this problem, and you are our country. Were we investing in you?

PREPARED STATEMENT OF SARA ROSENBAUM

Mr. Chairman and Members of the Finance Committee: The Children's Defense Fund (CDF) is pleased to have this opportunity to testify before you today regarding children and national health insurance. Our testimony will identify what we believe to be the essential elements of any national health insurance plan for children, and review S. 1227, the Senate Democratic Leadership plan.

At the outset, we wish to commend you, Senator Riegle, Majority Leader Mitchell, and Senators Kennedy and Rockefeller for your collective leadership on the issue of national health insurance. No more important domestic issue will confront the nation over the next decade than the challenge of assuring that all Americans have access to decent, affordable health care.

Through concerted, bipartisan effort and strong leadership, this Committee has over the past several years, made major strides toward improving access to health care for low income pregnant women and children through a series of vitally important reforms in the Medicaid program. While Medicaid has significant shortcomings as a source of health insurance, its achievements for women and children over the past quarter century have been enormous. In great part as a result of this Committee's work, Medicaid will, by the end of this decade, reach an additional 4 million children and a half million pregnant women annually. Improvements in the Medicaid enrollment process will assure swifter access to benefits. The improvements in the Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program make Medicaid the single most comprehensive child health insurance program, public or private, ever to exist in the U.S. The improvements in Medicaid and Medicare support for community and migrant health centers and other community-based health care providers located in medically underserved areas will assure the availability of urgently needed funds to expand and improve primary health care services for literally millions of Medicaid beneficiaries and other low income persons. These improvements are the direct work of this Committee.

Some would have us believe that the Medicaid expansions have been all cost and no gain. This is simply not true. Early studies from states such as Utah, North and South Carolina and others show that when carefully tailored Medicaid reforms are actively implemented and combined with companion improvements in the organization and delivery of health services, the results are immediate and measurable improvements in infant mortality and morbidity rates and ultimately, general improvement in overall child health. Not only have the Medicaid expansions done substantial good: they have helped point the way toward the range of broader improvements which are still needed. They also have helped build public acceptance for the more direct role which government must play if the nation is ever to cure the grievous inequities which plague the American health care system.

The children's stake in the national health debate cannot be overemphasized. Children are now the poorest Americans. Today some 12 million children—one in five children, one in four children under age 6, one in three children in families headed by a young adult (under age 30) and nearly one in two black and Latino children—is poor. An equally large portion of children live in families with incomes below twice the poverty level who simply cannot meet the terrible cost of even basic health care. These poverty numbers are astonishing and have long term consequences for the nation.

Children's deep impoverishment has major health consequences. Poor children need more health services, because the health risks they face are greater. Poor children's risk of death in infancy and childhood is significantly elevated. Poor children are far more likely to be reported in fair to poor health, far less likely to be immunized, and are significantly more likely to suffer from activity-limiting impairments.

Moreover, their impoverishment places children heavily outside the health care mainstream. Depending on the national study used, between 8.5 and 11 million children are completely uninsured. Another 12 million (and growing) are completely dependent on the Medicaid program. No other group of Americans is so dependent on Medicaid. Data from the National Medical Expenditures Survey (NMES), a special study undertaken by the U.S. government in 1987 of U.S. health insurance patterns, show that less than two-thirds of American children (39.7 million out of 63 million) have employer-based health insurance. Other studies suggest that less than 40% of employer insured children have insurance which is fully subsidized by families' employers. In short, very few children fit the fully subsidized employer insurance mold that we tend to think of as mainstream. Millions of children are excluded from the private system by their families' poverty, employment patterns, limited educational attainment and other factors utterly unrelated to their need for health care.

Today, only about two in three American children have employer insurance. If high childhood poverty rates continue, if employers continue to reduce their contributions to family insurance coverage (a trend reported by the Pepper Commission in 1990), and if wages continue to stagnate, then in a few years, American children as a whole could easily resemble black children in working families whom, in 1986 (according to U.S. Census data) had less than one chance in two of having employer-based health insurance.

Even if legislation mandating significantly subsidized employer insurance for full-time employees is mandated, millions of children whose parents work only part-time or part-year will need public coverage. Only 73% of all children live in families in which a parent works full time. Approximately 16 million children live with adults whose nexus to employment is too attenuated to assure continuous coverage. The public insurance companion program contained in the Senate leadership bill is thus particularly important for children. My remarks today therefore will focus on the public plan.

KEY NATIONAL HEALTH REFORM PRINCIPLES FOR CHILDREN

During CDF's 18 years of health advocacy for poor children, we have gleaned several fundamental principles that we believe should guide the national health debate which is now unfolding. The first lesson is that as important as Medicaid reform is (and as essential as continued Medicaid improvements for low income children are in the absence of a national health plan for all Americans), no amount of reforms in a means tested program will ever change its essential nature. Even with improvements, Medicaid will always be Medicaid—a program whose beneficiaries are identifiable by their poverty and their disproportionate racial and minority status and whose recipients remain isolated by low reimbursement rates, but all too often, even more by stigma and prejudice. To be true reform, Medicaid must be subsumed into an overall national health programmatic scheme which leaves no American child behind. Much of the debate around the Senate leadership's plan must therefore necessarily focus on how well the public portion address Medicaid's ills.

The second lesson—and one that has been repeated time and again—is that for millions of American children and families, insurance reforms alone will not suffice. Millions of Americans (who are disproportionately women of childbearing age and children because of their extreme poverty), will continue to be excluded from comprehensive health care, whether or not insured, because of barriers created by rural or urban, inner-city isolation, and by racial, poverty, cultural and ethnic discrimination. Unless broadly tailored insurance reforms are coupled with efforts to create and sustain sources of comprehensive, community-responsive health care where they are needed, America's more than 30 million medically underserved citizens (two thirds of whom are women of childbearing age and children) will be deprived of essential, effective, and cost effective services.

Insurance reforms alone without health service delivery improvements will, in our opinion, succeed mainly in improving access to inpatient and specialty services. To be sure, these services are every bit as vital as primary care, and we remain deeply concerned about the problems that low income children far too often face in obtaining lifesaving specialized health care. But for children, it is the primary health services—prenatal care, immunizations, health exams, and ongoing, basic medical, dental, vision and hearing care—that will make a difference in their lives and health. It is these basic services which all industrialized nations but the U.S. and South Africa assure for all pregnant women and children. It is the lack of these services, combined with gross childhood poverty rates, which are primarily responsible for the nation's shameful international child health rankings. In 1989 the nation ranked 19th in infant mortality worldwide, 17th in the proportion of all infants adequately immunized, and 19th in mortality among children under age 5. A baby in the District of Columbia, within the shadow of the Capitol where we sit today, is less likely than an infant in Honduras to be adequately immunized against preventable childhood disease.

From these two broad principles we have developed the following basic working set of health criteria:

1. The plan should guarantee health insurance for everyone

The most basic criterion against which any proposal should be measured is that it guarantees an equal, basic level of coverage for everyone. No American should be left uncovered or covered only through a means-tested program which does not have the acceptance and recognition of health insurance. Barriers such as family composition, relationship to the family head, work status, state residence, lawful U.S.

status, pre-existing conditions, waiting periods, and health status should be utterly irrelevant to coverage under a health insurance plan.

2. Enrollment must be simple

To be universal, entry into any national health plan should be eminently accessible. Enrollment access points have to be broadly available, and applications forms must be as simple as possible.

3. Coverage must be stable, continuous and portable

One of the great dilemmas in health coverage today is instability. Americans, particularly lower income families, are incredibly mobile. Frequent job and residence changes are the reality today. Longitudinal studies show that an extremely high proportion of Americans—as many as one in four—is uninsured when insurance patterns over a multi-year time period are examined. Benefits that are not stable and that depend on portable residence and employment are incompatible with the needs of families who move and change jobs frequently.

4. Benefits must be comprehensive

Essential to any health plan for children is the comprehensiveness of benefits. Many essential maternal and child health services now considered routine—maternity care, family planning and reproductive health services, and complete pediatric care for children including check-ups, immunizations, vision, dental and hearing care and primary health services for children with diagnosed mental or physical conditions requiring further treatment—are services for which third party payment assistance is required because of their high risk nature but because of their relatively high cost in relationship to family income. The income of young families is lower today in real dollar terms than it was a generation ago. Millions of families simply cannot afford the most basic health care for their children without comprehensive coverage. Today it can cost $55.00 to get a child vaccinated against measles in a private doctor's office. At that price, it doe not take long for a family with two young children to conclude that its choice is either groceries for a week or two measles booster shots.

5. Cost sharing must be reasonable

It does little good to provide families with comprehensive benefits if cost sharing is so high that coverage is unaffordable. Keeping cost sharing low means setting premiums that are adjusted for family income, eliminating deductibles for basic services, keeping copayments low, and setting relatively low stop-loss levels for families with high out-of-pocket costs.

6. Provider reimbursement must be reasonable

Perhaps Medicaid's greatest failure is its grossly low provider reimbursement rates. These low rates so severely depress provider willingness to participate in the program that many of Medicaid's most essential benefits are virtually unavailable to the children entitled to them.

Payments must be high enough to assure provider participation. Moreover, payments must be set high enough so that balance billing—the practice of charging in excess of the amount paid by the plan plus uncovered deductibles and coinsurance—can be curtailed. Families should be able to depend on their premium, deductible and coinsurance payments as the sum total of what they will need to pay in order to secure health services for their children.

7. Cost controls must be in place and must be universally applicable

A national health plan should have a mechanism for setting cost controls that apply to all payers and that set limits which are universally applicable regardless of whether insurance is derived through public or private sources. It is simply unacceptable to have national health insurance without a national budgeting mechanism which sets coverage and reimbursement standards for all payers. Without nationally applicable limits, the tendency will be to limit the public plan, while leaving private payers financed through huge, indirect governmental supports (such as the employer exclusion cafeteria arrangement) free to cover whatever services they choose in addition to the basic minimum and to set whatever payment rates they select. The surest way to continue the inequities inherent in Medicaid is to not apply universal cost control mechanisms.

8. The plan must include funds for resource development

Because access to service cannot be assumed even when insurance is present, the plan must include a mechanism for underwriting the development and maintenance of sources of health care in medically underserved communities. The care and serv-

ices underwritten in these communities should be both those for which third party financing ultimately will be available, and services which fall outside the traditional scope of health insurance. Examples include case management services, outreach, translation services, applicant assistance, health education and special therapies and services for children with developmental delays and disabilities.

THE SENATE LEADERSHIP PLAN

The Senate leadership plan goes a long way toward meeting he health needs of children. While we believe that the most cost effective and fair approach to insurance is enactment of a single payor system (much like Medicare for the elderly), the Senate plan is impressive for the benefits and protections it includes and the for the equity and access considerations it addresses.

Children and families would benefit greatly from the Senate plan. We are particularly supportive of the following aspects of the plan:

- It guarantees that, when fully phased in, virtually all Americans will be guaranteed some form of basic health insurance;
- Considerations unrelated to the need for coverage such as work status and preexisting conditions are eliminated;
- The benefit package includes many essential items for children and women of childbearing age;
- Low income persons and families are eligible for assistance to meet the out-of-pocket cost of health services;
- Application procedures are simplified;
- Poor families and individuals receive enhanced benefits, which include virtually all non-long term care benefits (including all currently available EPSDT benefits) now available through Medicaid.
- There is a strong resource development program, modeled after S. 773, introduced last spring by Senator Chafee.
- The plan includes the first steps toward universal budgeting and cost containment features, which are essential to fundamental equity and cost concerns.

We believe that there are several important issues in S. 1227 that need to be addressed. This would inevitably be expected under any effort as broad as this one. These issues include the following:

- State financial contribution: We believe that states are simply not in a position to maintain their share of the direct public financed health care load. In many states the revenue base for a commodity as expensive as health care simply does not exist. In others, the desire to invest significantly in public health insurance does not exist. So long as states remain heavily liable for the cost of health coverage, children and families will remain captives of the unique conditions of each state. Moreover, we fear that the public plan will retain the outward appearance of Medicaid and that no matter what the reforms, most Americans and employers will chose to avoid coverage through it.[1] To the extent that state contributions must remain an essential source of funds for the program, we strongly recommend that such contributions be paid into a single national program and be combined with other nationally-based funding sources. State contributions should be kept to levels no greater than the proportion of state expenditures attributable to Medicaid prior to the explosion in costs in the mid to late 1980s.
- If states administer the public plan, they should do so strictly as intermediaries and should not have discretion over eligibility, benefits, provider reimbursement levels or eligibility and enrollment procedures. This is one of the great lessons of Medicaid, we believe. There are aspects of health care which do vary greatly from state to state. But there are also many bottom lines. All children should be covered for certain benefits at certain amount, duration and scope levels. All providers should be assured of adequate payment levels. No medically underserved community should be deprived of a health clinic because local providers fear the possible competition for middle and upper income patients. No person should lose public coverage because he or she does not meet a state's residency test.
- Additional public benefits equal now covered through Medicaid should be available at least to all low income families, regardless of whether their basic benefits are derived through the public or private sector. The current bill provides for gener-

[1] Indeed, to the extent that S. 1227's financing arrangements set high premiums for public enrollment and contain numerous tax breaks for private coverage purchase, this financial skewing toward the private market will help perpetuate the isolation of low income Americans who are covered publicly.

ous levels of coverage for children who are poor and enrolled in the public plan. We strongly urge the Committee to extend all current EPSDT benefits to all children with family incomes below 200 percent of the federal poverty level, regardless of whether the child's basic benefit package is derived through the public plan or through an employer plan. We also recommend the development of an identical "wrap around" package of EPSDT benefits for all families, regardless of income, who have children with activity limiting impairments and whose projected annual out-of-pocket costs exceed 5 percent of annual family income. The number of such children is quite small—only about 2.5 million—but their needs are great, and they should not be overlooked.

In closing, we wish to lend our support to S. 1227, and we look forward to working with you to enact the strongest possible program for children.

PREPARED STATEMENT OF CARL SCHRAMM

I am Carl Schramm, President of the Health Insurance Association of America (HIAA). The HIAA is a trade association of private health insurance companies which provide health insurance to some 95 million Americans. Over the past few years we have given a great deal of thought to the health care access and cost problems. We have presented our views at numerous Congressional forums. It is a pleasure to share with you some of our thoughts on S. 1227.

The breadth and detail of this legislation alone point up the complexity of the access and cost issues. History has demonstrated that simplistic solutions are often poor solutions in the health care arena. In my view, this legislation represents one of the first serious efforts to acknowledge the complexities of our system, and in doing so, to view the health care access and cost issues systemically. For this I strongly commend you. Many of the concepts contained in this legislation are very good ones and consistent with our thoughts. I will outline these. I will also outline areas where HIAA has significant reservations and disagreements with the legislation which force us to oppose the bill.

At the most general level, S. 1227 recognizes the importance of pursuing a joint public/private effort. Today, the vast majority of Americans have some form of health insurance coverage. More than 180 million Americans are covered privately. Moreover, our pluralistic system provides an important degree of choice and serves as a major driving force for innovation in health care financing and delivery (through, for example, managed care). The intent of S. 1227 is clearly to enhance and expand both the public and private financing systems. We think that such a strategy is consistent with both the will of this country and current fiscal realities.

It is clear that both public and private financing systems in this country are in need of significant change. S. 1227 recognizes that our current system fails to adequately meet the needs of low income populations. HIAA supports expansion of public coverage and financial assistance to the poor and near poor populations. We also support increasing provider reimbursement levels under public plans to adequate levels. However, we do believe that the expansiveness of the Americare program, as well as its structure, would present major operational problems.

The funding base for the Americare program is similar to that of our current Medicaid program. Historically, one of the principal problems with the Medicaid program has been its inadequate fiscal base. Medicaid has been chronically underfunded since its inception, and today covers only 40 percent of the poor and reimburses providers at inordinately low levels. Americare would also obtain its funding through a joint federal/state match but would vastly expand the covered population. Simply stated, government, and especially state government, is not in a position (and has not shown a willingness) to provide adequate funds to support an expansive public insurance program.

The problems associated with the fiscal base of Americare will be exacerbated by the method in which employees may become eligible for Americare coverage. Under S. 1227, employers would be given the option of either providing their employees coverage or contributing towards coverage of their employees under the Americare program. One of the major public policy objectives of such a "pay or play" option is to give financial relief to employers who find it difficult (if not impossible) to bear the full costs of providing health benefits. HIAA strongly supports financial subsidies that are efficiently targeted to those most in need. However, the pay or play system envisioned in S. 1227 will result in other counterproductive outcomes.

Because Americare plan eligibility is determined based upon a percentage of employer wages, only employers who expect their health care costs to exceed the required wage contribution will enroll their employees in Americare. In other words,

Americare is guaranteed to lose money on the employer-based population that opts into it. Americare is also guaranteed to lose money for the low income, nonemployer-based population for which premiums and copayments are partially, if not fully, subsidized by the program.

Confronted with large and mounting losses, Americare will be faced with the option of obtaining either a major new infusion of public funds or infusion of financing from populations originally intended to be outside the purview of the Americare program. That is, there will be strong incentives for Americare to obtain enrollment from a broader (lower cost) cross section of the population (rather than just those whose costs exceed a given percentage of wages) and/or to selectively lower provider reimbursement rates under Americare to offset mounting losses. The latter option will result in an unsustainable and unfair cost-shift from Americare to non-Americare enrollees.[1] Either scenario will result in unfair, direct and growing competition with private plans. In some local, higher cost areas, the program may lead to major or complete substitution of public for private coverage. The growing dichotomy between public and private markets will also strongly penalize providers that become disproportionately reliant on public coverage revenues and potentially threaten their solvency.

It's important to note that the dynamics described here will not be the result of any inherent efficiency of public coverage, but rather will be the outcome of the public program's artificial and unsustainable advantages over alternative private plans.

Our recommendation would be to begin with a more modest expansion of public coverage to the poor and near poor populations. For poor and near poor workers, public plans should begin by experimenting with workers who would normally be eligible for both public and employer coverage. We call this population the Medicaid buy-out population.

This course would avoid the financial woes associated with the implementation of a large public program. At the same time, additional thought and research needs to be devoted to developing a better and more sustainable interface between the public and private markets.

HIAA supports S. 1227's provision of additional financial relief to small and previously uninsured employers by extending a 100 percent deduction to the self-employed and special tax credits to low wage employers. We also support the concept of providing direct subsidies to assist low-income workers in paying their share of premiums and cost-sharing.

As you may know, HIAA has been a leader in the insurance reform movement and has developed a broad range of recommendations in this area. We support the objectives of guaranteeing availability, continuity of coverage and limiting excessive rating practices. We also support the concept of making lower cost benefit plans available to purchasers. However, we do have disagreements with many of the specifics in S. 1227.

For example, the legislation envisions the establishment of community rating in the small employer marketplace. A movement towards community rating would have negative side effects. A community rated system would increase costs for populations least able and willing to pay (especially young workers), subsidize populations with greater incomes who are already more likely to be insured (i.e., old workers), and substantially increase the risk of insurer insolvency. Community rating also compromises local accountability for health care costs since the actions of an employer have little if any effect on the costs that it bears.

On average, the currently uninsured population is younger than the insured population and often places less value on insurance. This reflects both their much lower average health cost experience as well as their lower earnings. While one in four 18-24 year old full-time, full-year principal earners have family incomes below twice the poverty level, only one in ten of such 55 to 64 year old workers have family incomes beneath this income level.[2]

Furthermore, low-wage workers tend to be concentrated in firms that are financially more fragile and are least likely to offer coverage. Younger, currently uninsured persons and their employers will be even less able to purchase coverage if premiums are raised to a community rate.

In addition, community rating creates incentives for employers who are currently insured to self-insure, and we see nothing in the legislation that would offset or pre-

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[1] While the bill intends to rectify the cost shifting problem by allowing for the establishment of uniform rates, experience in this country suggests that states tend to waive the all payer requirements for Medicaid. Cost pressures make this scenario also likely under S. 1227.

[2] Tabulations from March 1990 Current Population Survey.

vent this incentive. Low risk employers (e.g., those with younger populations) will often find it advantageous to pay rates reflecting their lower expected health costs rather than to subsidize heavily higher risk (e.g., older) populations employed by other firms. While self-insurance is a viable option for larger employers, it is not an acceptable option for small employers (which are too small to adequately spread the costs of a high risk individual). Nevertheless, our survey data suggests that the number of medium and small employers that are self-insuring (almost certainly unwisely), and who are operating outside any formal regulatory structure is increasing. The result of community rating could well be spiraling health care costs for insured populations and a growing number of employees without adequate protection as more and more lower risk populations leave insurance pool arrangements.

Community rating can also threaten the solvency of individual insurers. Individual carriers or competitive health plans need some latitude to adjust rates if they are to maintain financial solvency. For a variety of reasons, any given carrier may experience the enrollment of insureds who are, on average, older and sicker than marketwide norms. If a carrier who has an expensive enrollee population is required to charge one community rate for all clients, it would be put in an untenable position. In order to stay price competitive, the carrier could charge a premium that is less than its average cost experience, but it would immediately sustain large losses. If it charged premiums to cover current costs, it would lose its lower risk clients and be unable to attract new lower risk clients because its rates would be too high. As the carrier's per enrollee costs spiraled upward, and its enrollment of average risk persons declined, it would incur larger and larger losses. With some latitude to adjust rates, such a carrier can set a premium price that can attract new lower risk groups and thus improve its ability to spread the costs of higher risk groups over time.

Community rates that do not vary by geographic area compromise local accountability for costs. Such schemes would force lower cost, more efficient and often lower-income localities to subsidize higher cost, less efficient localities that often have higher per capita incomes. For example, rural areas could be forced to subsidize more costly urban areas. Market pressures to control costs would be muted as employers who use inefficient provider networks are shielded from the true costs of such inefficient care.

In expressing our opposition to community rating I do not want to suggest that substantial rating reform is not necessary. In fact, today there are rating practices which are simply unacceptable from a consumer, public policy, and industry standpoint. HIAA and others have developed rating reforms which would substantially curtail excessive rating practices without going as far as a community rating scheme which would bring with it the range of negative consequences I described earlier. (See the attached.)

We are encouraged to see the bill's emphasis on cost containment, and particularly to the key role assigned to managed care plans. HIAA has consistently taken the position that solutions to the access problem have to be coupled with, if not preceded by, effective steps to limit the escalation of health care costs. And we believe that any effective cost containment approach must promote development of managed care plans.

In particular we commend the provisions which prohibit states from hindering managed care plans' capacity to select providers to make up networks, to limit the number of participating providers, to pay providers in innovative ways and at alternative rates, and to incorporate incentives for consumers to use participating providers. Likewise, we heartily endorse the provisions which prohibit states from imposing barriers to effective utilization review, since this form of medical management is critical to implementation of cost-effective managed care plans.

HIAA is also a strong supporter of technology assessment and the development of clinical guidelines, practice parameters, and outcomes measures. We are happy to see that this bill gives increased support to efforts to improve the state of medical knowledge in these important areas. As an association we are already taking steps to implement one of the provisions of the bill in this area, specifically a public-private partnership to enhance the speed and efficiency of technology assessment activities.

HIAA concurs with the sponsors of this bill that malpractice-related costs are an element of cost escalation that deserves attention. We have no objections to the provisions of the bill which would provide grants for innovative efforts to reduce the administrative costs and burdens of malpractice disputes, and we also support the proposal to have the Institute of Medicine study the elements of the problem and make recommendations for change. In addition it is important to minimize the occurrence of malpractice by changing practices that cause malpractice, since this ap-

proach improves patient welfare as well as reduces costs. We are also on record in support of specific changes in legal doctrines that govern malpractice litigation.

In principle we support several of the directions for reducing administrative costs. We agree that movement toward uniform billing and claims forms and electronic submission of bills and claims is desirable. In fact, HIAA and a number of its member companies have for several years been actively pursuing these ends with other payers, including Blue Cross and Blue Shield plans and the federal government. Substantial progress has already been made. We cannot, however, support the proposal for requiring all small-share insurers (as defined by the Secretary) to submit bills through a state consortium. The uniform electronic billing approach we are pursuing would obviate any need for such an approach.

The portions of the cost containment sections in which we have the most serious reservations are those concerning the functions of the Health Expenditure Board (and potentially state consortia). While our association has no specific policy on the proposal to have the Board set and enforce expenditure targets, the idea raises a number of troubling issues. An overriding and critical question is whether or not an independent board, such as the one envisioned in the legislation is an appropriate and effective model for making decisions on cost, quality and access.

One specific issue of great concern is the Board's authority to set provider rates through a negotiation process. We have strong reservations about any system that would establish uniform rates for all payers. The ability to negotiate both the rate and form of payment with providers is a key element of managed care plans. The freedom to negotiate a mutually acceptable rate is necessary because innovative payment arrangements may be critical to providing incentives for providers to change behavior in desired ways. Although the bill precludes states from limiting rate negotiation arrangements for managed care plans, it apparently does not exempt such plans from the rates that are approved by the Expenditure Board. It is not at all clear how the imposition of uniform provider payment rates could be reconciled with the critical need that managed care plans have for freedom to negotiate with providers.

Moreover, we question whether such a process, whether done at the national level under the Expenditure Board or at the state level by the Consortia, can be successful in the United States where the climate is unique, particularly with respect to the adversarial nature of relations between purchasers and providers. Can providers and payers really be expected to reach an agreement, or will the more common case be a stalemate? Providers, in particular, have an incentive to refuse to accept rates that substantially constrain their incomes, since in the instance of such an impasse, the Board makes an advisory rate decision which is not binding on the parties with the result that everything is left largely as it is now. Such collaborative, voluntary efforts have in the past not met with much success in this country.

Before closing I believe that it is important to recognize that we have yet to find the "right" answer to our cost and access problems. I am a firm believer that answers require time and experimentation. As we travel down the road of health care reform, we will undoubtedly find that there is no single right answer. Some of the "answers" that we propound today may be found wanting and in need of revision. For these reasons, the HIAA believes that access and cost proposals should retain significant flexibility. The states should be the principal locus of regulatory and oversight activity. We are opposed to giving the Secretary of HHS the range of authority granted under this legislation. Moreover, we are concerned with the cumbersome and duplicative nature of the regulatory/oversight apparatus. We are particularly concerned with its potential negative impact on the development and evolution of managed care systems.

I will close by saying that we very much appreciate the opportunity to testify on S. 1227. We too have a series of recommendations on access and cost which I would like to submit for the record. Together I believe we can forge meaningful solutions.

Attachment.

(April 5, 1991)

HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL ON PROVIDING HEALTH CARE FINANCING
FOR ALL AMERICANS
(In Detail)

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen --- and become more costly.

These individuals represent the widening gap in our nation's health care financing system. The Health Insurance Association of America (HIAA) believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable a combination of public and private providers of health care coverage to meet the health care financing needs of all Americans.

The HIAA proposal takes into account the important policy implications of the relationship between income, the workplace and health care coverage. The vast majority of Americans with adequate incomes have health coverage. Ninety percent of all nonelderly Americans with incomes of over three times the poverty level have some form of coverage. Approximately 150 million nonelderly in this country obtain health coverage through an employment-based plan.

Yet most individuals without health care coverage are in families with some attachment to the work force. In fact, 66 percent of the uninsured are full-time workers or are dependents of full-time workers. Another 14 percent either work half-time (18 to 34 hours a week) or belong to families with one or more part-time working members. (Current Population Survey, U.S. Dept. of Health and Human Services, March 1988 tabulations)

Efforts to make coverage more available and more affordable should take into account the fact that most Americans receive their health care coverage through employment. A realistic approach is to focus on improving the ability of financially vulnerable employers to offer health insurance to their often low income employees. In addition, low-income employees need direct government assistance so that they can afford their share of premiums.

To be cost effective, expansion strategies should build on existing coverage and target public coverage to the poor and near poor. Extending public coverage to higher income individuals will inevitably lead to unnecessary tax increases to support substitution of public coverage for private coverage.

Finally, HIAA also believes that efforts to expand the nation's health care financing system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems. It also calls for greater scrutiny of one of the major causes of high costs ---the use of new, often unproven technologies and procedures. We also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be "cost conscious" in the use of medical resources and in choosing a health plan. A more detailed discussion of HIAA recommendations follows.

I. ADOPT REFORMS TO ASSURE THE AVAILABILITY AND RELIABILITY OF PRIVATE HEALTH INSURANCE COVERAGE.

The small employer health benefit market is receiving increasing attention. This is largely because a high proportion of workers without health care coverage --- fully two-thirds --- work for an establishment with 25 or fewer employees at that business unit's location. This is not surprising since only one in three firms with fewer than 10 employees offers health benefits.

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more likely to seek, and obtain, coverage at prices that reflect their low risk.

In turn, more and more insurers have found that to be price competitive for these low risk employers, they are less able to spread the costs of groups with employees at high risk of incurring large medical expenses broadly across the lower risk groups. This has led to a growing number of higher risk employers that cannot find coverage at an affordable price. Moreover, those employer groups that are lower risk today and thus initially obtain a lower premium, will likely have employees that develop expensive medical conditions. Those employers may face large premium increases when their experience deteriorates.

In general, then, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

We have now reached the point where substantial small group market reforms are needed if health insurers are to serve the broader interests of small employers and their employees. HIAA has developed and is recommending a comprehensive set of legislative reforms that we believe can be implemented while allowing a viable private marketplace.

- **Small Employer Market Reforms**

HIAA recommends market reforms and reinsurance recommendations that would ensure fair access to, and continuity of coverage for, small employers and their employees. When enacted by the states, these reforms will introduce a greater degree of predictability and stability to the small employer health benefit marketplace.

- *Guaranteed Availability.* All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

  The HIAA proposal would require the "top ten" carriers in a state (defined by their small employer market share) to guarantee to issue health care coverage to any legitimate small employer group. Other carriers would be strongly encouraged to guarantee to issue coverage through favorable reinsurance terms.

- *Coverage of Whole Groups.* Coverage would be made available to entire employer groups; No small employer nor any insurer would be able to exclude from the group's coverage individuals who present high medical risks.

- *Renewability of Coverage.* At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

- *Continuity of Coverage.* Once a person is covered in the employer market and satisfied an initial plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

- *Premium Pricing Limits.* Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

  More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate trends should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

In order for the reforms to succeed, the implementing legislation will have to pertain to all competitors in the small employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. It is therefore important that federal law give states clear authority to impose these rules on all competitors in the small employer marketplace. Within the scope of these rules, insurers would be allowed to use individual risk assessment and classification initially to assess risk, to set rates, and to determine which individuals for whom to purchase reinsurance.

- **Private Reinsurance**

A private marketwide reinsurance system would make these small employer reforms possible. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policyholder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will allow

carriers to assure small employer groups presenting a high health risk access to a basic set of benefits at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under the approach developed by HIAA, the "top ten" carriers in a state's small employee health benefit market (defined by small employer premium) would be required to guarantee to issue health coverage to any legitimate small employer group applicant. Other "non top ten" carriers would not be required to guarantee issue coverage but would be strongly encouraged to do so through better reinsurance terms for guaranteed issue carriers. Guaranteed issue carriers could: (a) reinsure entire high-risk small employer groups at a reinsurance premium price of 150 percent of average market costs or (b) reinsure high-risk individuals within groups at 500 pe cent of average market costs. (Individual reinsurance would include a $5,000 deductible.) To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels.) Nonguaranteed issue carriers would only be permitted to reinsure new entrants to existing groups through individual reinsurance. This reflects the fact that under the "whole group" rule, all carriers would have to make coverage available to any new employees entering a group they already insure.

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be limited in order to encourage carriers to accept high risk applicants, in the aggregate the cost of reinsured persons will exceed the reinsurance premiums. Under the HIAA proposal, the reinsurer's losses would be spread equitably across all competitors in the private marketplace--both the guaranteed issue and nonguaranteed issue carriers.

The losses would be covered first through contributions from all carriers in the small employer market. If losses were significantly higher than expected, a second "safety valve" of broad-based financing will be made available.

HIAA will aggressively pursue reinsurance and related small employer market reform at the state level. HIAA will also recommend Federal legislation to give states the authority, where necessary, to assure compliance with the market reforms outlined here and to finance the reinsurance system.

- **Establish State Pools for Uninsurable Individuals**

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage.

High-risk pools should be established to make coverage available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society.

As of December 1990, 25 states have enacted broad-based pools for uninsurable individuals.

II. ALLOW INSURERS TO OFFER MORE AFFORDABLE BENEFIT PLANS TO SMALL EMPLOYER GROUPS.

Over the years, the list of state laws mandating benefits and providers has grown dramatically. There are about 800 such laws nationwide --- and they mandate coverage of disparate services and provider categories such as chiropractic and podiatric services, acupuncture, expansive inpatient mental health services even where most cost effective alternatives exist, in vitro fertilization and pastoral counseling. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly to small employers who are most in need of affordable basic benefits and who are too small to self-insure and thus escape these mandates as larger employers often do.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only "Cadillac" plans based on a multitude of mandates from many states.

Many of these benefits, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study conducted by Gail Jensen, then a University of Illinois health care economist and now at the University of North Carolina, concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

State-mandated benefit laws do not apply equally to all employer sponsored health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Ironically small employers with limited income do not have this flexibility. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at limiting contractual arrangements

with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

III. PROVIDE TARGETED TAX ASSISTANCE SO THAT SMALL EMPLOYERS AND THEIR FINANCIALLY VULNERABLE EMPLOYEES CAN AFFORD HEALTH INSURANCE COVERAGE.

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 33 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 96% of firms with more than 25 employees offer health benefits.

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should:

- Direct new tax subsidies to assist employers and individuals with inadequate financial resources (e.g., certain small employers) in purchasing private coverage. Sliding scale subsidies should be targeted, for example, to small employers paying average wages of less than $18,000 annually. The subsidy rate for such employers should increase as the percent of total payroll going to hospital and medical benefits increases. A temporarily higher subsidy could be given to firms offering benefits for the first time;

- Target subsidies to low-income individuals and families. A refundable tax credit equaling 50 percent of the employee share of premium cost could be made available for taxpayers at or below the poverty level. (A ceiling on qualifying premium costs would equal the median employee share of premium for employer-sponsored coverage nationally or about $360 for individual and $800 for family coverage in 1989. Above poverty, the percentage credit would decrease as income rises and phase our completely at twice poverty. Advance payment of the tax credit through the employer should be made for employees with little or no income tax liability; and,

- Extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

IV. EXPAND PUBLIC COVERAGE FOR THE POOR AND NEAR POOR.

Thirty percent of the uninsured have family incomes below the federal poverty level ($10,560 for a family of three in 1990). Another 17 percent have family incomes between one and one and a half times the federal poverty level. The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the non-elderly generally fall far below the poverty level.

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government. HIAA proposes the following actions:

- The Medicaid program should be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of cash assistance programs such as AFDC. Moreover, fiscal constraints suggest first priority should be phasing in coverage to all poor children under age 18.

- For poor workers with access to employer-based private coverage, HIAA supports appropriate state implementation of recent federal legislation regarding a "buy-out" employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (co-pays and deductibles) associated with available employer plans when Medicaid outlays would be reduced on an average per capita basis. This will help ease individuals' transition into economic self-reliance and often improve access to medical care.

- Near-poor individuals with family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy in" to a package or primary and preventive care services only. Limited premiums would be based on a sliding scale related to their income. This would target government assistance to the primary and preventive services the near poor most often forgo and for which employer sponsored plans cost-sharing sometimes presents a financial obstacle for the near poor population.

- To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) While costly, these reforms would increase Medicaid costs by only about 25 percent while increasing the population served by the program by about 70 percent. This is because three quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

V. IMPLEMENT STRATEGIES TO CONTAIN HEALTH CARE COSTS

Efforts to improve access will be thwarted, at least to some extent, if we cannot find a way to constrain escalation of health care costs. As the cost of care continues to rise, employers who are on the margin with respect to decisions to offer coverage will find coverage unaffordable. Solving the cost problem is a prerequisite to solving the access problem.

- Although there are no simple solutions to the cost problem, a key component of any effective cost containment strategy is the further development of managed care systems of financing and delivery --- HMOs, PPOs, point-of-service plans, and the like. Since physicians make most of the key decisions that determine how expensive treatment will be, it is imperative to make sure that patients get care from physicians (and other providers) who use resources efficiently. Managed care systems build on that premise by selecting panels of providers for their networks who meet specified criteria and who agree to be monitored to assure that they continue to provide high-quality cost-effective care. Patients are then given financial incentives to choose these providers as their caregivers. By integrating the financing and delivery of care, managed care improves quality while constraining costs.

- A second major element in effective cost containment must be improved knowledge about what constitutes cost-effective care. New technologies that promise better care are often introduced into medical practice, often at great cost, before anyone has made a careful assessment of their cost-effectiveness. They may be better, but is the extra benefit sufficient to outweigh the extra costs? Insurers, government, and all who pay for medical services have a stake in developing better mechanisms and procedures for answering that question about new technologies and procedures.

- Related to the need for better knowledge about technologies is the need for better information about what constitutes good medical practice. There are many areas of medicine where there is broad variation in the way patients are treated even when their conditions vary little. Physicians often have insufficient information to know what constitutes cost-effective care. Increased efforts should be directed to filling this knowledge gap by establishing mechanisms and financing to develop medical practice guidelines and protocols which define the range of acceptable medical practice for particular conditions. The task is so large that it will require a large commitment of resources, from both government and the private sector. Providing these kinds of advances in medical knowledge will help to improve utilization review activities by

providing standards that are accepted by both physicians and, very likely, the courts as well.

- As implied, government also has a vital role to play in the battle against costs escalation. Government has a key role, particularly with respect of funding, in technology assessment, in protocol development, and in collecting and analyzing data that can be used to develop more accurate measure of cost, use, and medical outcomes. Government also needs to create a legal climate that is hospitable to the growth of managed care, which means not limiting insurers' ability to employ appropriate utilization review techniques and not outlawing managed care plans that require patients to pay significantly more when they opt to get care from non-network providers and thus generate significantly higher costs.

- Government can also help to reduce administrative cost by encouraging and cooperating with industry-wide efforts to utilize common claims forms and greatly expand electronic collection, analysis, and payment of claims. Finally government has to take the lead in malpractice reform, which has two components: (1) reducing the incidence of malpractice by encouraging better risk management activities by providers and by policing provider ranks to assure that only competent providers treat patients, and (2) by making legislative changes in the malpractice system to assure that awards are appropriate and that the process of adjudication does not absorb an excess percentage of the costs of righting the wrongs done to patients.

PREPARED STATEMENT OF JOHN SHEILS

My name is John Sheils. I am a vice president with Lewin/ICF, a Washington-based consulting firm, specializing in health care financing issues. I have performed financial analyses of various health care reform proposals for several public and private organizations including: the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission); the Congressional Research Service; the Advisory Council on Social Security; several state commissions; the American Hospital Association; and other private organizations. I was asked to evaluate the potential impact of several cost containment initiatives included in S. 1227. I am honored to have been asked to summarize my findings for the committee this morning.

The potential impact of changes in health care delivery systems and administrative procedures are very difficult to estimate. The estimates presented here are based upon the best available data on the potential savings associated with various cost containment models. Still, data on the likely impact of these provisions is often unavailable or inconclusive. Therefore, these estimates should be considered illustrative of potential impacts rather than definitive projections of cost savings.

In developing these estimates we assumed that these programs are implemented in 1992. Our estimates reflect assumed lags in the implementation of cost containment initiatives. The estimated impact of these initiatives on national health spending are presented for 1992 through 1996. Five year totals are also provided. The methodology used to develop these estimates is discussed below. I begin by summarizing several issues in cost containment.

A. HEALTH CARE COSTS AND ACCESS

The 1980s were a paradox of dramatic increases in health spending and diminished access to care. Health spending as a percentage of gross national product grew from 9.1 percent in 1980 to about 12 percent by 1990 (Figure 1). Despite the dramatic growth in the share of our national wealth devoted to health care, the number of persons without health insurance increased from 24.5 million in 1980 to over 33.3 million by 1990. Rising costs have made health insurance less affordable, which has

contributed to reductions in insurance coverage, increased uncompensated care costs, and increased the strain on state and local indigent care programs. Cost containment will be an essential element of any program to expand insurance coverage and could prove vital in maintaining even the existing level of access.

The importance of containing the growth in health spending is evident in current projections of health spending for the next decade. The Health Care Financing Administration (HCFA) projects that per capita spending on health care will increase at an annual rate of 8.6 percent per year through 2000. This is about twice the projected rate of inflation. In 1990 health care costs were about $605.9 billion (Figure 2). By 2000, health spending is projected to grow to $960 billion (in 1990 dollars). This is a real increase (inflation adjusted) in health spending of 60 percent.

A seemingly small change in the annual rate of growth in health spending would have a dramatic impact on health care costs in future years. For example, assume that we implement a cost containment strategy that reduces the rate of growth in health spending from the projected annual rate of 8.6 percent to 7.6 percent. By 2000, health care spending would be approximately $85 billion (in 1990 dollars) lower than currently projected (Figure 2). If the annual rate of growth were slowed to 6.6 percent, annual health spending in 2000 would be about $162 billion (in 1990 dollars) less than projected. These estimates suggest that even modest changes in health practice can have sizable long-term benefits.

S. 1227 includes a number of cost containment initiatives which could potentially reduce the rate of growth in health spending. These initiatives include efforts to improve the administrative efficiency of the health care financing system, promote competition, permit innovation in developing lowest insurance products, and creates a mechanism for controlling the growth in provider reimbursement rates.

The proposal would also promote cost effective medicine by encouraging managed care and developing and promulgating medical practice guidelines. Managed care and medical practice guidelines could potentially reduce costs while improving quality by eliminating excessive and unnecessary utilization (see Figure 3). These efforts to change medical practice will also promote needed preventive care thus avoiding preventable hospitalizations in future years. These efforts to change medical practice patters are designed to produce long-run savings by maximizing the use of cost effective medical practices.

The methodologies used to estimate the impact of the 5.1227 cost containment initiatives are discussed below.

B. NATIONAL HEALTH SPENDING: CURRENT PROJECTIONS

Estimates of national health spending under current policy in future years (see line B of Figure 4) are based upon health spending projections developed by the Health Care Financing Administration (HCFA). HCFA projects that per-capita health spending will grow by about 8.6 percent per year through 2000 which is about double the projected rate of inflation.[1]

C. UTILIZATION INCREASE FOR PREVIOUSLY UNINSURED PERSONS

Utilization of health services by previously uninsured persons is expected to increase as these individuals become insured (either through employer coverage or the public plan). Utilization of health services by previously uninsured persons is assumed to adjust to the levels reported by insured persons with similar age, sex, income and health status characteristics. The total increase in national health spending for newly insured persons would be about $14.7 billion if the program were fully implemented in 1992 which represents an increase in national health spending of about two percent. However the increase in insurance coverage and the resulting increase in utilization under S. 1227 would be phased-in between 1993 and 1997 as follows:

- Beginning in 1993, the employer coverage provisions of the Bill would apply to only firms with 100 or more workers. Coverage of pregnant women and children under the public plan would also being in this year.
- In 1996, the employer coverage provisions will be extended to all firms with 25 or more employees.
- The employer coverage provisions will apply to all firms beginning in 1997. Coverage of non-working adults under the public plan will also begin in this year.

This phased expansion of coverage is reflected in the utilization estimates shown in Figure 4.

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[1] Health Care Financing Review/Summer 1987/Volume 8, Number 4.

D. ADMINISTRATIVE SAVINGS UNDER THE PUBLIC PLAN

We estimate that under the provide-or-contribute model about 15 million workers who are currently insured under private employer health plans will be shifted to the public plan. These include workers and dependents in firms that now offer insurance who find it less costly to pay the tax than offer insurance.

This will reduce administrative costs by shifting individuals from small employer plans where administrative costs average about 28 percent of incurred claims to the public plan where administrative costs for small groups are estimated to be only about 15 percent of claims.[2] Total savings in administrative costs are estimated to be about $800 million in 1992.

The legislation also calls for insurance market reforms which will limit underwriting practices resulting in reduced insurer administrative costs. Estimated savings resulting from these changes are discussed below.

E. REDUCE UNNECESSARY AND INEFFECTIVE CARE

The proposal includes two provisions designed to reduce costs associated with unnecessary and ineffective treatments. These include:

Expanded Development of Medical Practice Guidelines

The proposal calls for expanded use of medical practice guidelines in both public and private sector programs. A growing body of research exists on Medical practice guidelines which would be implemented under the program.

Medicare—It is estimated that research performed to date on 20 major procedures has produced practice guidelines which if fully implemented would result in savings to Medicare of up to $2.5 billion (in 1991 dollars).[3] We assume that the savings from these practice guidelines will phase-in over a three year period beginning in 1992. Medicare savings from ongoing medical guidelines research is assumed to increase by $500 million per year (in 1991 dollars) starting in 1995.

Private Sector—It is estimated that existing practice guidelines data could reduce premium costs in employer based plans by as much as three percent.[4] We assume that these savings will occur primarily among persons not already enrolled in plans with selective contracting arrangements. Savings are assumed to be phased-in over a three year period. Potential savings are assumed to increase by 0.25 percent of premiums beginning in 1995 as new research becomes available.

Technology Assessment

A program would be initiated to determine the appropriate use and reimbursement levels for new technologies. For illustrative purposes we have assumed that this program induces a 12 month lag in the adoption of new technologies. We estimated the impact of this assumption by imposing a 12 month lag in the portion of health care inflation attributed to service intensity (It is estimated that about 25 percent of health care inflation is attributed to a growth in service intensity).[5]

F. PROMOTE COMPETITION

Provider competition would be encouraged by requiring providers to publish their rates. These data would encourage providers to be more competitive and would facilitate selective contracting. This competitive model is used in California and is estimated to have reduced the annual rate of growth in hospital costs by about 10 percent.[6]

We assume that under this provision, the growth in hospital spending will be slowed by 10 percent per year. Savings are assumed to occur only in states that do not now have hospital rate setting systems or a comparable competitive model (these include California, New York, Maryland, New Jersey and Massachusetts). Savings are assumed to be phased-in over a three year period.

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[2] Estimates of administrative loads under various public and private insurance models are based upon estimates provided by the Congressional Research Service.

[3] Unpublished data provided by Karen Davis of Johns Hopkins university.

[4] Presentation by Mark Chasim to the Florida Task Force on Private Sector Health Care Responsibility.

[5] Based upon Lewin/ICF analysis of HCFA data on the components of health price inflation.

[6] James Robinson and Harold Luft, "Competition, Regulation, and Hospital Costs, 1982 to 1986," JAMA, November 11, 1988, Volume 260, No. 18.

G. ENCOURAGE MANAGED CARE

The Legislation includes several initiatives to expand managed care. These include:

Pre-empt State Legislative Barriers

The proposed legislation would preempt all barriers to selective contracting, utilization review and other managed care practices. We assume that this will result in a 10 percent increase in the number of workers in HMO's.[7] We also assume that HMO's will reduce health spending for newly covered groups by about 10 percent. These savings are assumed to be phased-in over the course of three years.

Small Business Access to Managed Care Plans

Carriers would be required to offer managed care options to all small groups. We assume that HMO enrollment among firms with under 25 employees would rise to the level observed in large firms. Managed care plans are assumed to reduce costs by 10 percent for workers who enroll. These savings are assumed to be phased-in over the course of three years.

Provide Managed Care in The Public Program

HMO's will be made available to workers covered under the public plan. We assume that the percentage of workers enrolling in these plans will be comparable to the percentage of privately insured workers covered under HMO's. Savings are estimated to be 10 percent for persons who become covered under these plans. Savings are assumed to be phased-in over a three year period.

H. PRE-EMPT STATE MANDATED BENEFITS

The legislation establishes a federal minimum benefits standard which pre-empts state mandated benefits. State mandates include: newborn care (46 states), psychiatric care (37 states), chiropractors (35 states), Dental care (27 states) and other services. State mandated benefits have been estimated to add about 15 percent to the cost of health insurance.[8]

Of the benefits required by states, the federal standard would require coverage of psychiatric and newborn care which accounts for about 53 percent of the cost of state mandated benefits. Thus 47 percent of the cost attributed to state mandates (about seven percent of premiums) is potentially eliminated. These savings do not apply to self-insured plans because they are already exempt from state benefit mandates under ERISA.

We assume that half of all employers who now purchase insurance will eliminate coverage for state mandated benefits that are not required under the federal benefits standard (i.e., some may wish to retain dental coverage etc.). Utilization of these services for persons in plans that discontinue these benefits is assumed to decline by about 20 percent.[9]

I. ADMINISTRATIVE COSTS

The legislation includes several initiatives to reduce administrative costs in private insurance. These include:

Insurance Consortia

An insurance consortia is established in each state to consolidate administrative procedures for insurers with small market shares. It will also facilitate the system wide development of cost saving innovations such as "smart" cards for electronic claims transmittal.

Industry analysts estimate that electronic claims transmittal will save about 50 cents per claim for a maximum potential savings of $400 million per year. For illustrative purposes, we assume that under the consortia's leadership, all insurers will convert to the electronic claims transmittal systems over a five year period.

Establish Quality Improvement Agencies

Quality improvement agencies would be created in each state to work with providers to develop a program of continuous quality improvement and implementation of

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[7] About 15 percent of all workers are in a Health Maintenance Organization. GHAA's National Director of HMOs, 1990 edition.

[8] Jon Gabel and Gail Jensen, "the Price of Mandated Benefits," Inquiry 26:419-431 (Winter 1989).

[9] We assume that a one percent change in the price of health services to the individual is associated with a 0.2 percent reduction in utilization of these services.

cost effective methods of delivering care. The agency would periodically certify providers as practicing in a cost effective manner thus exempting them from utilization review for a period of up to a year. This will avoid duplicative provider review and focus limited resources on providers who appear to be inclined to over-prescribe.

We assume that the primary impact of this provision will be to improve the effectiveness of utilization review. For illustrative purposes we assume that this provision improves the cost saving potential of managed care plans by 10 percent.[10] These savings are assumed to be phased-in over a period of three years.

Small Business Insurance Reform

The legislation would substantially limit insurer underwriting practices and eliminate pre-existing condition limitations. This will reduce insurer administrative costs associated with approving a policy and reduce claims processing costs by eliminating the need to cross-reference claims with pre-existing condition limitations.

Administrative costs for small employers would be reduced from their current level of about 28 percent of claims to about 21 percent of claims. We developed this estimate by assuming that the portion of administrative costs in small groups attributed to general administration and claims processing costs would be reduced to the levels observed in larger firm size groups (i.e., firms with 25-50 employees).[11] These savings are assumed to be reflected in premiums immediately upon implementation of the program.

J. THE FEDERAL HEALTH EXPENDITURES BOARD

S. 1227 creates a Federal Health Expenditures Board which will set national expenditure targets. The Board will then attempt to negotiate rates with providers which are consistent with these spending targets. If the Board is unsuccessful in negotiating these rates, individual health insurance plans will be permitted to adopt these rates if they chose.

The impact of this provision is impossible to predict because we have no way of predicting the expenditure targets the Board will select and we can not anticipate how effective the board will be in negotiating rates. For illustrative purposes, we assume that the program will be roughly as effective as past voluntary expenditure target programs have been in slowing the growth in health spending.

Voluntary targets for hospital expenditures were attempted in 1978 and 1979 as an alternative to the mandatory targets that had been proposed in Congress. Hospitals achieved their targets in 1978 which slowing the rate of growth in hospital spending by about 12 percent (i.e., the percentage growth in hospital revenues in 1978 was about 12 percent less than cost trends would have indicated). Hospitals failed to meet their goal in 1979 possibly due to reduced Congressional interest in mandatory budget targets.

Based upon this experience, we assume that the Federal Health Expenditures Board Program would reduce the rate of growth in hospital costs by 12 percent. However, we also assume that some portion of these savings will overlap with savings achieved through efforts to increase provider competition (estimated to reduce the growth in hospital spending by about six percent). Thus, the net impact of the program would be an additional reduction in the rate of growth in hospital spending of about six percent. For illustrative purposes, we also assumed that the annual growth in spending for physicians' services will be reduced by 12 percent under the program.

The Federal Expenditures Board Program has the potential to be far more effective than assumed here. For example, Congress has slowed the rate of growth in per-capita spending in the Medicare program by about 10 percent per year since 1985.[12] If the Federal Expenditures Board were to control the growth in spending as effectively as Medicare spending has been controlled, national health spending would be reduced by about $66.0 billion over the first five years of the program (Figure 5). In fact the Federal Expenditures Board may prove as effective in containing costs as hospital rate setting has been in states with all-payor rate setting systems. In these states, hospital rate setting has reduced the annual rate of growth in

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[10] We assume that HMO's reduce costs by about 10 percent and PPO's reduce costs by about five percent. We assumed that the reduction in costs under these arrangements is increased by five percent.

[11] Based upon administrative data developed by Hay/Huggins Inc. for the Congressional Research Service (CRS).

[12] Per capita spending under the Medicare program grew at an annual rate of 8.75 percent between 1985 and 1990 compared to the nationwide average annual rate of growth in health spending of 9.81 percent.

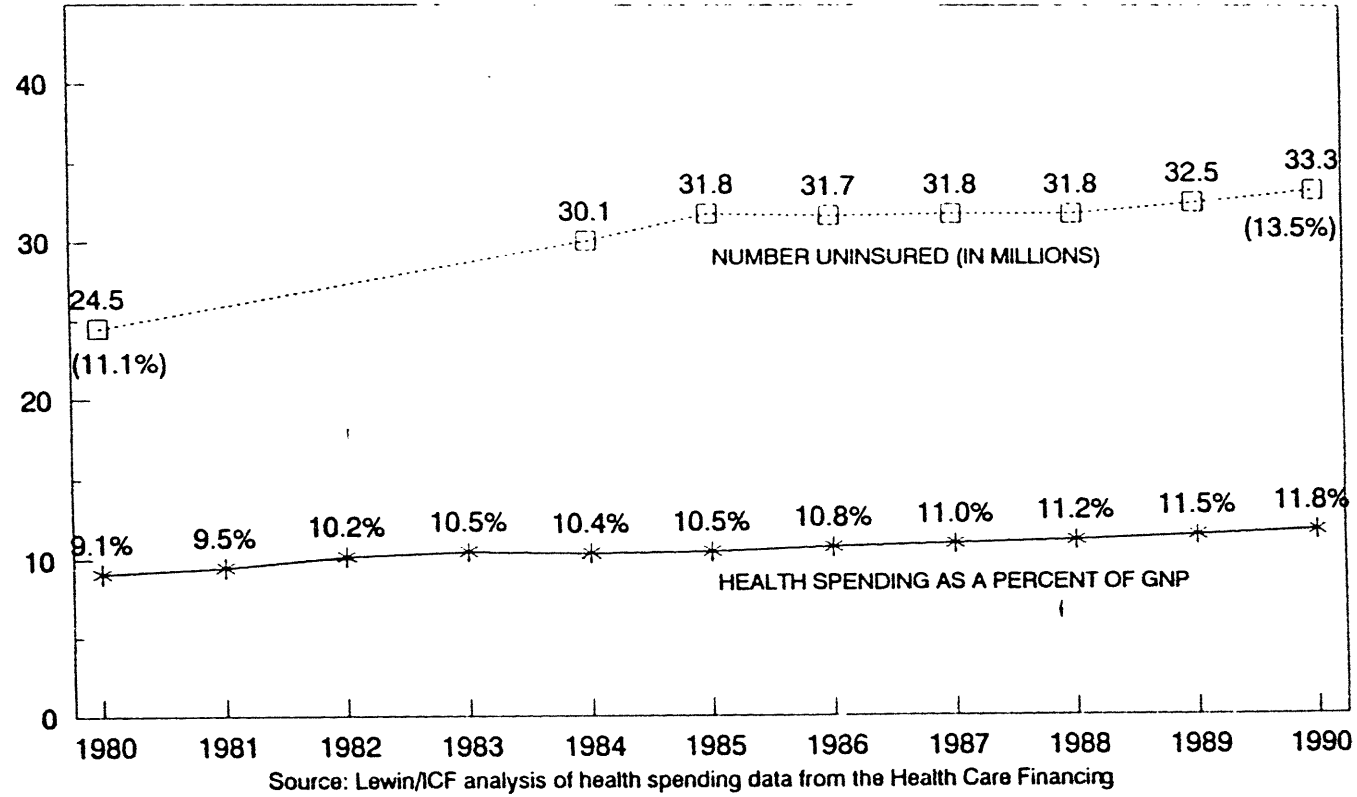
hospital spending by 30 percent in rate setting states. If the Board were as effective as hospital rate setting states in slowing the rate of growth in health care costs, national health spending would be reduced by about $226.6 billion over the first five years of the program.

SUMMARY

Total savings due to the cost containment initiatives under S. 1227 will be about $83.17 billion over the 1992-1996 period. These savings will be partly offset by increases in utilization among newly insured persons under the Bill of about $37.4 billion over this five-year period. Thus S. 1227 will result in net savings over the 1992-1996 period of about $45.8 billion (Figure 5). Over half of the savings under S. 1227 (Figure 6) will be attributed to efforts to change medical practice (medical practice parameters and managed care). The Health Expenditures Board would account for about 18.6 percent of projected savings ($15.5 billion). About 19.6 percent of the savings would be attributed to administrative efficiencies under S. 1227.

FIGURE 1

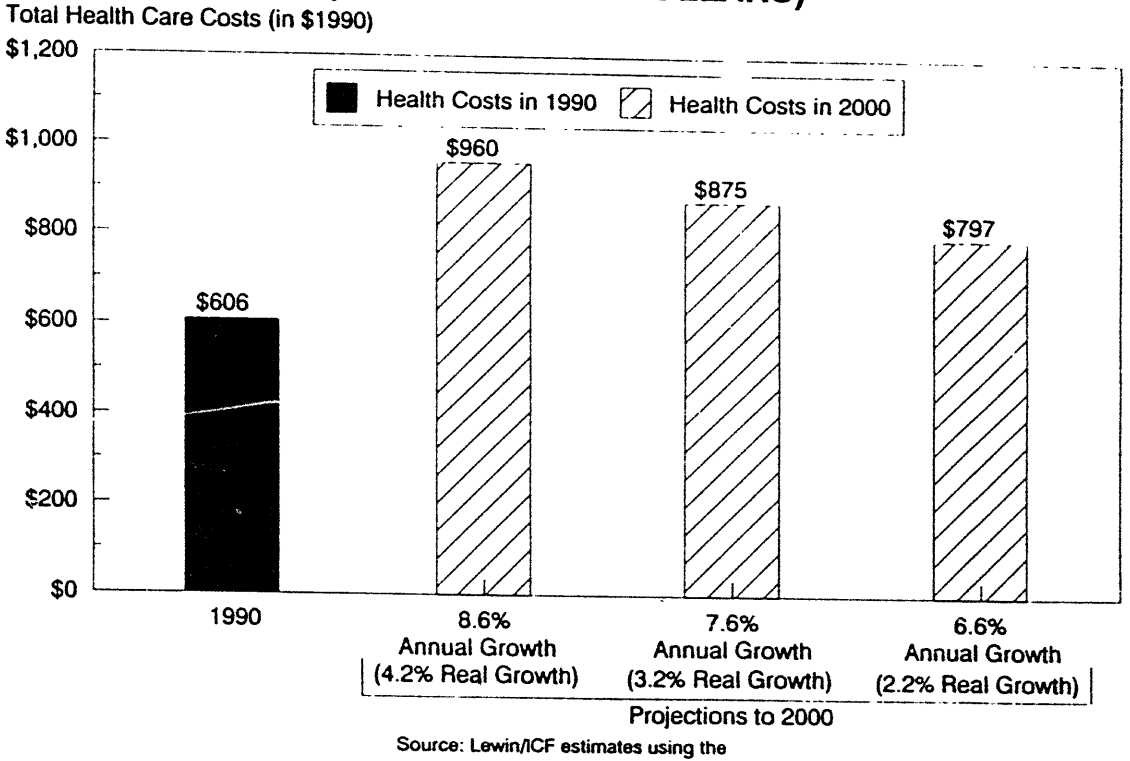
THE PARADOX OF INCREASED HEALTH SPENDING AND DECLINING ACCESS



Source: Lewin/ICF analysis of health spending data from the Health Care Financing Administration and March Current Population Survey (CPS) data for 1980 through 1990 adjusted for changes in Survey design in the March 1988-1990 CPS data

FIGURE 2

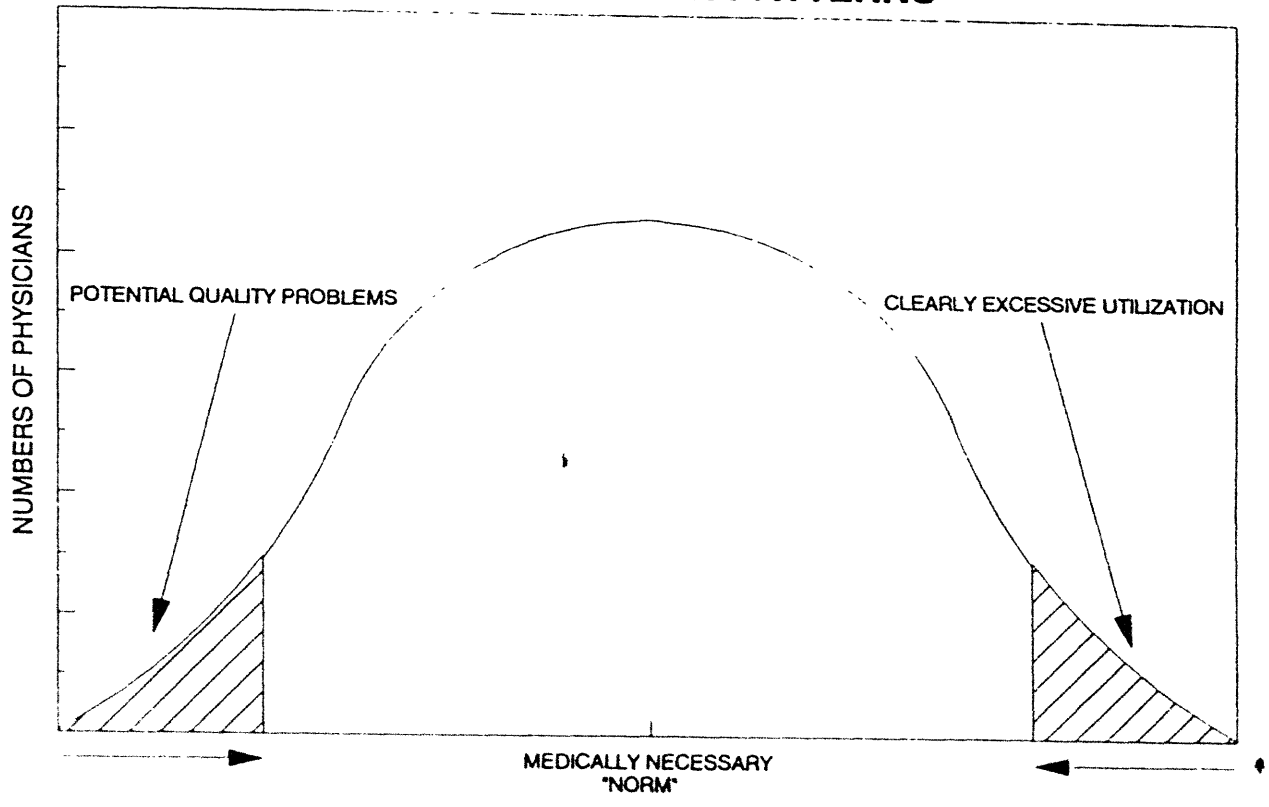
TOTAL HEALTH CARE SPENDING IN 2000 UNDER ALTERNATIVE SCENARIOS (IN BILLIONS OF DOLLARS)



Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

FIGURE 3

CONTAINING SERVICE VOLUME MEANS INFLUENCING OVERALL PRACTICE PATTERNS



PRACTICE PATTERNS ARE MODIFIED TO ELIMINATE EXCESSIVE SPENDING
WHILE ASSURING MINIMUM STANDARDS OF QUALITY

FIGURE 4

CHANGE IN NATIONAL HEALTH SPENDING UNDER S.1227 (in Billions)

	1992	1993	1994	1995	1996	Five-Year Total
B. National Health Expenditures (current law)	$723	$791	$864	$945	$1,033	$4,356
C. Increased Utilization for Newly Insured Persons	--	$7.24	$7.92	$8.64	$13.60	$37.40
SAVINGS UNDER COST CONTAINMENT EFFORTS						
D. Administrative Savings Under Public Plan	--	(0.35)	(0.38)	(0.42)	(0.68)	(1.83)
E. Unnecessary/Ineffective Care						
• Outcomes Research	(1.70)	(3.71)	(6.45)	(7.97)	(9.86)	(29.69)
• Technology Assessment	(1.10)	(1.31)	(1.55)	(1.83)	(2.14)	(7.93)
F. Promote Competition	(0.40)	(0.87)	(1.31)	(1.44)	(1.71)	(5.73)
G. Encourage Managed Care						
• Pre-empt State Legislative Barriers	(0.10)	(0.22)	(0.36)	(0.39)	(0.43)	(1.50)
• Small Business Access to Managed Care	(0.10)	(0.33)	(0.48)	(0.52)	(0.57)	(2.00)
• Provide Managed Care in Public Program	--	(0.10)	(0.22)	(0.32)	(0.48)	(1.12)
H. Pre-empt State Mandated Benefits	(0.60)	(0.65)	(0.72)	(0.78)	(0.86)	(3.61)
I. Administrative Costs						
• Insurance Consortia	(0.05)	(0.11)	(0.24)	(0.39)	(0.57)	(1.36)
• Quality Improvement Agencies	(0.18)	(0.39)	(0.65)	(0.71)	(0.77)	(2.70)
• Small Group Insurance Market Reforms	(1.69)	(1.84)	(2.02)	(2.21)	(2.41)	(10.17)
J. Federal Health Expenditures Board						
• Hospital Cost	(1.10)	(1.20)	(1.31)	(1.44)	(1.57)	(6.62)
• Physician Cost	(1.50)	(1.63)	(1.76)	(1.92)	(2.10)	(8.91)
Total Savings	$(8.52)	$(12.71)	$(17.45)	$(20.34)	$(24.15)	$(83.17)
Net Change in National Health Spending	$8.52	$5.47	$(9.53)	$(11.70)	$(10.55)	$45.77

FIGURE 5

NET CHANGE IN NATIONAL HEALTH SPENDING UNDER THE MITCHELL BILL UNDER ALTERNATIVE ASSUMPTIONS ON THE EFFECTIVENESS OF THE HEALTH EXPENDITURES BOARD

Year	NET CHANGES IN HEALTH SPENDING UNDER ALTERNATIVE ASSUMPTIONS		
	Impact Comparable to Voluntary Rate Setting (Lewin/ICF Baseline Estimate) [a]	Historical Medicare Per Capita Medicare Rate [b]	Historical Growth in Hospital Rate Setting States [c]
1992	$ 8.5	$ (5.2)	$ (13.3)
1993	5.5	(5.7)	(24.2)
1994	(9 5)	(12.1)	(42.2)
1995	(11.7)	(18 8)	(63.1)
1996	(10.5)	(24.2)	(83 8)
Five Year Totai	$(45.8)	$(66.0)	$(226 6)

a These are Lewin/ICF's baseline estimated savings under the Mitchell bill which assume that the expenditures board will slow the growth in health spending to rates observed under voluntary rate setting programs.

b Assumes that the board will reduce the rate of growth in per-capita health spending to the rate observed under the Medicare program bBetween 1985 and 1990 (i.e., per-capita costs under the Medicare program grew about 10 percent slower than National per capita spending).

c Hospital rate setting states have slowed the rate of growth in hospital spending by 30 percent. These estimates assume that the rate of growth in physician and hospital costs will be reduced by 30 percent under the program.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

FIGURE 6

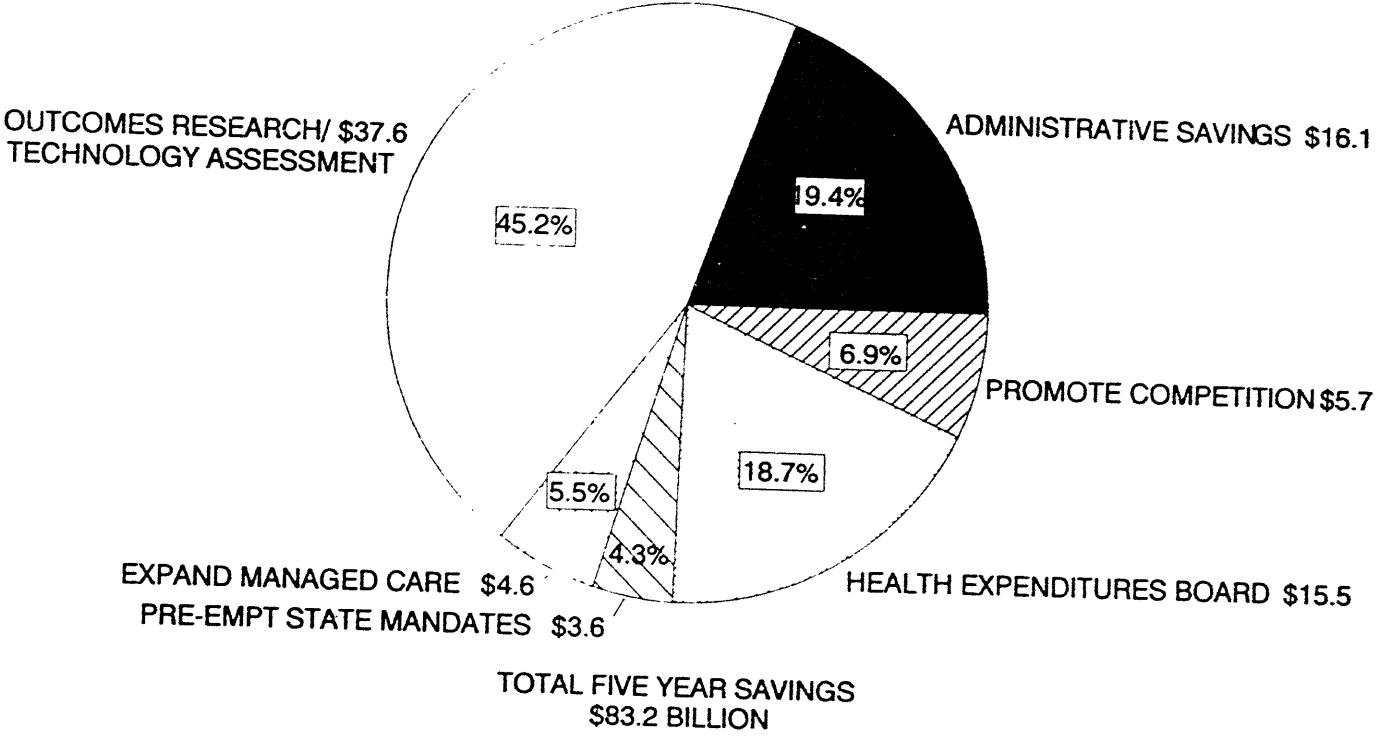
SUMMARY OF CHANGES IN NATIONAL HEALTH SPENDING UNDER S.1227 (in billions)

Year	Savings Under Cost Containment Initiatives	Utilization Increase for Newly Insured	Net Change in Spending
1992	$(8.52)	--	$(8.52)
1993	(12.71)	$7.24	(5.47)
1994	(17.45)	7.92	(9.53)
1995	(20.34)	8.64	(11.70)
1996	(24.15)	13.60	(10.55)
Five-Year Total	$(83.17)	$37.40	$(45.77)

SOURCE: Lewin/ICF estimates.

FIGURE 7

FIVE YEAR COST CONTAINMENT SAVINGS BY PROVISION 1992-1996 (BILLIONS)



PREPARED STATEMENT OF SENATOR PAUL SIMON

Mr. Chairman, I want to commend you for your leadership in this area. As you know, health care reform has risen to the top of Americans' calls for action in recent months. It is the number one topic of concern as I travel across the State of Illinois and around the country. We urgently need to put a stop to skyrocketing health care costs and address the crisis of health care now facing middle class families and the poor, working Americans and struggling businesses. No action we take in this area will please everyone, but we cannot afford not to act, and there is growing consensus on that reality.

Even when estimates differ, the figures are staggering. We spend approximately 12 percent of our gross national product on health care, and costs are rising at 8 to 10 percent a year faster than the rate of inflation. Americans are spending about $1 million a minute on health care, $2 billion a day, $700 billion a year. And about one-eighth of us have no health insurance at all. Some 30 to 40 million Americans have to hope every day they or their children do not need the health insurance they are not able to find or afford. Clearly, if we do not address health care reform in a way that brings costs under control, no American can be assured of access to the most basic health care services in the future.

We see examples every day of the devastating effects our current health care crisis is having on individuals and on families. Recently I saw some statistics that are particularly troubling for me as a member of the Subcommittee on Disability Policy and someone who has pushed for a number of years for better funding of special education programs for children with disabilities. A recent study shows the connection between lack of prenatal health care and an increasing need for special education. Estimates are that we are spending $371 million a year for the 85,000 children ages 6 through 15 who weighed less than 5.5 pounds at birth. This is just one tip of an iceberg of neglect of health care directly attributable to cost and access problems.

I commend you for your work, Mr. Chairman, on S. 1227, the HealthAmerica Act. The bill is an important step toward addressing the problems of health care in this country. Henry Aaron of the Brookings Institution pointed out recently the "pay or play" approach of HealthAmerica can achieve universal coverage for all workers and their families, and can control costs depending on how payments to providers are controlled. The introduction of S. 1227 has played the important role of demonstrating there is a will and commitment to act on health care reform, and it has stimulated a great deal of attention and productive debate.

It was my intention in offering S. 1669 as a perfecting amendment to S. 1227 to extend the debate and focus it in some specific areas. As the Chairman is aware, some have criticized the HealthAmerica Act because they see the need for stronger cost containment. Many of the bill's critics favor an approach that is closer to the single-payer system used in Canada. I have favored reform that would move us toward a universal coverage, single-payer system and will continue to support efforts in that direction. The reality is, however, that we need major reform as quickly as possible and S. 1227 is a vehicle that can move us in that direction.

There is another area in our health care reform agenda we should not ignore, and it is not part of S. 1227 or part of the amendments in S. 1669. Long-term care is an important part of what we need to provide if we are going to solve our current crisis, particularly if we intend to address the aspects of the problem that will grow at an the fastest rate in the foreseeable future. In just nine years, almost a million more senior citizens will be in nursing homes than today. The Health Care Financing Administration estimates that under current programs, with no legislative change, total spending for nursing home care will increase from the current approximately $50 billion a year to $129 billion by the year 2000. About half of all long-term care today is paid out of private sources, and 97% of that comes directly out of the pockets of consumers. Unless we act, seniors will increasingly be forced onto Medicaid as they try to shoulder these burdens.

As a brave young mother with multiple sclerosis testified in Springfield, Illinois recently, long-term care is an issue that affects not just senior citizens. We need to increase the options for those who can stay out of nursing homes with some care at home and in the community. And we need to give everyone the ability to handle their long-term care needs without bankrupting themselves and their families. I have drafted a bill and will be introducing it in the near future. Since it will be referred to this Committee, Mr. Chairman, I will ask for your favorable attention when it arrives.

The amendments in S. 1669, cosponsored by Senator Adams, attempt to build upon and improve the HealthAmerica Act. It is clear there will be many proposed

changes to the HealthAmerica bill as the legislative process continues. It is a bill we can work to make stronger, and the amendments are intended to do that. These amendments also are subject to improvement, and I support their modification. In addition, I intend to offer soon a long-term care bill to address part of our current health care crisis not addressed by HealthAmerica. I hope these amendments and that legislation will help move the process along and provide some benchmarks for the debate.

The amendments in S. 1669 would make the following five fundamental changes in S. 1227:

1. They would strengthen the cost containment program in S. 1227 by making federal expenditure board determined rates mandatory if negotiators do not agree.
2. They would make universal coverage take effect in slightly more than one year after enactment rather than being phased in over five years.
3. They would allow states to opt out of the employment based system if they adopt a single-payer, Canadian-style program, and provide authority for incentive grants for two states to implement such systems.
4. They would give small business greater protection from possible discrimination against "high risk" employees, strengthen their access to quality affordable policies, and provide them necessary consumer information on how to get the best insurance plan for their money.
5. They would lower the age of Medicare eligibility to 60, subject to the enactment of revenue changes to support this modification.

The emphasis of the amendments is on strengthening the cost containment and administrative features in S. 1227 and providing a greater involvement for and sensitivity to the needs of health care consumers. These proposals would assure rapid and significant cost relief for both public and private health plans. In addition they address the growing problem of retirees not yet eligible for Medicare, many of whom are at an age when they have increasing health care problems but cannot find insurance they can afford, if they can find coverage at all. This amendment is important as well because of the new Federal Accounting Standards Board rules that will have a significant impact on the ability of businesses to continue to fund retiree health care benefits.

The bill currently provides for a Federal Health Expenditure Board that sets global targets for hospitals and other health providers. The Board would convene negotiations between providers and purchasers on rates and other methods of achieving the expenditure goals. If the negotiators reached agreement, the recommended rates and other measures would be binding. In the amendments of S. 1669, if the negotiators fail to reach a negotiated agreement, the Board is required to promulgate regulations establishing rates and other measures to achieve the goals. The reality of having a final decision in the hands of the Board will result in more serious and successful efforts to succeed in the negotiation process.

Currently the HealthAmerica bill's coverage of all employees through employer purchase of health care insurance or contribution to the public health care plan begins in the second year after enactment and is phased in by year five. Because of the crisis situation in health care coverage, I believe we need more rapid coverage of all employees. S. 1669 would phase in the coverage after one year rather than five.

An important provision of these amendments is the authority to permit states to opt out of the employer-based system if they enact single-payer systems of coverage. In addition, grants of $10 per resident for three years are authorized for two states that choose to implement such systems. These states can be valuable laboratories for the demonstration of single-payer approaches to the rest of the nation. I might mention I am also in support of an amendment Senator Wellstone has said he will offer to S. 1227 that is an expanded provision for giving states incentives to develop single-payer approaches.

S. 1669 also makes several changes in the way the HealthAmerica bill addresses the health care problems facing small business. We are all aware of the special impact of America's health care crisis on small business. Businesses that employ fewer than one hundred people pay far too much in premiums because they have fewer employees among whom to spread the costs. They find that their policies are costly because insurers seek to provide insurance only to healthy employees who don't need it as much. Often, small businesses find they cannot obtain insurance at all.

The HealthAmerica bill took some steps to address these problems. S. 1669 goes further. S. 1227 prevents small businesses from being turned down for insurance. It requires insurers to offer small businesses a uniform, basic benefits policy package. And it sets federal standards for small business insurance coverage and gives the

states a full year to implement these rules. The legislation I am offering goes further in addressing the problems of small business. Insurers who want to provide coverage to small businesses must provide both a basic and a comprehensive policy. If they wish to provide other policies, those policies must be approved by the Secretary of Health and Human Services.

This will prevent small businesses from trying to sort through dozens of confusing policies that are difficult, if not impossible, to compare. S. 1669 will also require the Secretary to publish a consumer guidebook to the standard policies, making it easier for small businesses to choose the best policy for themselves. It will also prevent insurers from tailoring their benefit packages to make them attractive only to the most healthy and risk-free employees, which is in effect another, more subtle form of discrimination against the people who need coverage the most.

Finally, S. 1669 allows these new rules to go into effect immediately by having the federal government set and implement the rules governing these policies. This way, small businesses will not face fifty different sets of rules and will not have to wait in limbo one year while each state legislature develops rules and regulations to govern insurance coverage for small business.

These amendments are an attempt to move the process along in a positive direction. My colleagues on the Labor and Human Resources Committee as well as you on this Committee and people throughout the country will have many other suggestions on ways to address our problems. I look forward to continuing to work with you and with the many concerned people who are both consumers and provided of health care to solve the critical and fundamental problems we face in health care today.

PREPARED STATEMENT OF MORRIE STEVENS

On behalf of the Small Business Legislative Council (SBLC), we appreciate the opportunity to testify on S. 1227, "Healthamerica: Affordable Health Care of All Americans Act," and to share our views on health care system reform.

As you know, the SBLC is a permanent, independent coalition of over one hundred trade and professional associations that share a common commitment to the future of small business. Cur members represent the interests of small businesses such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation, and agriculture. A list of our members accompanies this testimony.

Thank you for allowing us to share with the Committee our views on the health care crisis in America, and specifically on the subject of cost containment. We believe we can say with utmost certainty that among small businesses there is virtual agreement that the number one problem facing small business today is out-of-control health care costs.

At the outset, we would like to describe a recent pilot research project we completed in Illinois. Like most groups with an interest in the problem and possible solutions, we have conducted numerous polls and surveys of our membership. The study was an effort on our part to reach the grassroots and develop empirical data on the problem.

Late last year, we surveyed 1,000 small firms in Western Cook County, Illinois. This survey was conducted with funds provided by that state's Department of Commerce and Community Affairs. The results are preliminary but the trends revealed by the survey are of significant interest to SBLC because they correlate with some developments which, based on anecdotal evidence, we believe are taking place within the small business community. We will share with you what we have learned and, throughout our testimony, we refer to this study as the "Illinois study."

Our comments today will focus primarily on the cost containment aspect of the debate and the roles of the private and public sectors. First, however, we would like to compliment you and the leadership on your legislation. While we have some rather significant concerns about it, we do recognize that it is a credible attempt to address the serious problems of our health care delivery system. For small business, any discussion of the current crisis could begin and end with health care costs. While there has been much discussion about the need for universal access to health care, a concern which we share, we believe lack of access is merely the tip of the iceberg of a more fundamental problem. We greatly fear that the 30-plus million Americans without health care coverage will become 50 or more million. Health care costs are escalating without rhyme or reason, and small business soon will be forced to discontinue this benefit. We believe S. 1227 shifts the debate toward a much needed, serious discussion of cost contact.

We have conducted several surveys over the years. While one can nibble about the exact numbers, it is very clear that premiums have been increasing at significant rates of 30 to 70 percent annually. We believe the current average cost of insurance is now over $3,000 a year per employee.

Our Illinois study revealed that over the past four years, health insurance costs for the firms in the sample rose by an average of 101 percent, far outpacing the rate of increased in other operating costs. Over the past 18 months, the average increase was 38.6 percent. We might note that 80 percent of the respondents have been in business five years or longer,, and employ, on average, 20 full-time and seven part-time workers.

In macroeconomic terms, the unending, upward spiral of health care costs has several ramifications. In a competitive world, especially when the competition is global in scope and labor costs are far lower in some other countries than in the United States, minimization of costs, including labor costs, is imperative for the employer. If it is possible to pass these additional costs to consumers through higher prices, the employer will do so. Rising prices exacerbate inflation and reduce the quantity demanded by consumers. Thus, even if the employer can pass all the additional costs to consumers, profits will be lower because less will be sold; employment will be lower because less will be produced; there is less incentive to expand operations, so economic growth will be slowed; arrested economic growth results in fewer job opportunities and reduces the rate of growth in living standards; and, since profits provide the resources for research and development, innovation will be discouraged.

More typically, some of the labor cost increases must be absorbed by the employer, which lowers profits. In such cases, the employer will have to evaluate whether it is profitable to continue to operate the business at all; or he may decide to escape the unfriendly cost environment by closing domestic operations and moving abroad. During the 1980s, American workers lost many high-labor-cost jobs, particularly in manufacturing, as employers moved their operations abroad to Mexico, the Pacific Rim countries, and Caribbean nations. Rising health care costs, and certainly concepts such as federally mandated health insurance, would accelerate this process. Jobs would be lost, the balance of payment problems would become more severe, and economic growth would be slowed. Again, diminished profits also would lead to less innovation, for there would be fewer financial resources to support research and development of new products and processes.

Moving operations abroad is a drastic step for any employer. For most small firms, it is simply not an option—so how can they control costs? First, they might attempt to minimize the impact in other ways. The most direct approach would be to try to lower labor costs by reducing other forms of employee compensation, such as pay scales and other fringe benefits that are not related by the government. Research has shown that increases in the minimum wage—a form of mandated benefit—have resulted in the reduction of other forms of compensation.

An employer's second option is to identify any means available, within the control of the business, to stem the rising tide of health care costs. Forty-four percent of the respondents in our Illinois study told us they had been forced to decrease benefits. A majority of the respondents also indicated that a variety of cost containment provisions were incorporated into their insurance packages as cost control measures—for examples second opinion for surgery (66 percent), outpatient surgery incentive (59 percent), a preadmission testing incentive (60 percent), and precertification of hospital stays (59 percent). Copayment options are also common; 67 percent of the respondents reported a copayment of 80/20. Most telling, nearly half the respondents had "shopped" for health insurance during the past 18 months, a phenomenon that creates additional problems in the insurance market. Most employers have had those painful meetings when they had to inform their employees of changes that must be made in order to continue to provide coverage. We can assure you no employer relishes having to break that kind of news.

As the above data suggest, we have already exhausted many of the obvious, simple ways to control costs. We have utilized the options that are exercisable by the businesses themselves, and at best they hold down costs only for a brief period of time. We therefore must conclude that effective cost containment cannot be achieved at the individual business level. We are convinced that some restraint must be imposed at the health care provider level.

We have reviewed the proposal to create a Federal Health Expenditure Board to set national expenditure goals. The Board will also serve as a facilitator between providers and purchasers for negotiations on health care rates. It appears to us that while the proposal may be heading in the proper direction, it lacks the teeth to make it work. It is not clear to us the process will, in fact, lead to binding rate re-

strictions. The system is a step in the direction of an "all-payers" system that results in a universal negotiated rate, and it has merit. It has merit because individual small businesses will never have sufficient clout or information to negotiate rates on their own. We must note that experience would suggest that a local negotiating component would be necessary, and if it is direction in which Congress decides to go, we would need to discuss with Congress how it could be set up to ensure effective small business participation.

Another cost containment component of S. 1277 is the grant program for reducing malpractice litigation. Here again, while we applaud the fact the Democratic leadership has recognized the importance of malpractice relief, we are disappointed at the measure's lack of teeth. The proposed legislation creates an incentive program with little chance of success. It would be better for the states to adopt civil justice reforms that have been identified by such groups as the American Tort Reform Association.

We are enthusiastic about the preemption of state mandates. State legislators have forced insurance companies to increase the number of specific diseases and health care services covered by their basic policies. In 1970, there were only 30 mandated health insurance benefits in the United States, but by 1988, that number had increased to 686. Today, 37 states require health insurance coverage for chiropractic services, three states mandate coverage for acupuncture, and two states require coverage for naturopatha, "physicians" who specialize in prescribing herbs. Insurance companies must dramatically increase the premiums they charge customers to offset the costs of increased benefits mandated by the government. It is difficult today to purchase a basic health insurance policy at low rates because of state government intervention in the market. While we cannot accept the proposed minimum package in the bill, we do believe we are not that far apart and we can agree on a basic benefit package which can become the universal standard.

The proposal does include some incentives for "managed care." This concept has significant merit. It is a marketplace approach, and it addresses not only cost but quality. We are concerned, however, about whether we can implement managed care on a nationwide level. Managed care, without universal acceptance, creates cost-shifting. Frankly, at the present time, that shift is from large firms to small firms.

Accountability is essential to cost control and, to borrow a phrase, it must begin at home. As health care consumers, we all have one thing in common: when a member of our family needs health care, we want the best money can buy. It's easier to say than to put into practice, but we simply must force the individual to participate in the health care process. At a minimum, co-insurance requirements and deductibles do encourage the individual to look more closely at what services are being provided. The component of what is loosely called managed care that imposes such discipline on employees is definitely worthwhile.

Now, we would like to focus on the roles of the private and public sectors, particularly with respect to the establishment of the AmeriCare plan. It is impossible for us to talk about AmeriCare without discussing the proposal to require those employers not providing health coverage to contribute to the public plan, the so-called "play or pay" mandate. We must simply and forcefully oppose this option, for several reasons.

First, we are philosophically opposed to any mandate on employers. Flexibility is the hallmark of any successful small business. A mandate strikes at the very heart of the formula that makes us successful. The "one size fits all" orientation of any mandated benefit ignores totally the unique circumstances of both individual firms and individual employees. Technology and the demographic composition of the workforce have been changing rapidly, and this has created new problems in the world of work. However, for small business to respond effectively to change, there must be flexibility, not rigidity. Mandates represent rigidity and inflexibility. Employers do not benefit from workers with low morale and high turnover; they have no alternative but to be sensitive to changing conditions and adapt to them.

The trend in recent years has been toward "cafeteria" fringe benefit plans which permit individual employees to choose for themselves the combination of fringe benefits which best satisfy their needs and circumstances. Each employee is given a specific sum which may be allocated as desired among a wide choice of fringe benefit alternatives. Under cafeteria plans, the costs to the employer are known in advance and controlled, while the benefit package is tailored by the individual employee to best suit his or her needs. Both employer and employee are better off under a program which emphasizes choice. No one could possibly be more informed about the unique circumstances and needs of each employee than the individual employee.

Mandated benefits are the antithesis of cafeteria plans and allow "third parties" to impose through regulations their ideas about what is best for employees.

Second, even if a mandate were necessary, we are troubled by the unfairness of the trigger mechanism in the play or pay proposal. Essentially, the bill sends a message to the small business community that says, "We do not trust you. If you fail to move in the policy direction we wish, we will impose a mandate on you." Yet, when it comes to imposing goals and targets for providers, for insurers, and for public policymakers, the programs are voluntary. We, in small business, are being held to a higher standard. It would be different if the proposal had said: "These are goals for cost-containment, these are the goals for the insurance industry, and these are Congress' goals for health care cost containment reform. The small business requirements will kick in only after five years, and only if we have attained these other goals." If you secure true cost control, then it is only fair that small business do its share, but it is unfair to impose firm requirements on small business without holding the other "players" to the same standards.

Third, the public plan may very well prove to be too successful. We have heard estimates that the payroll tax a small business would be required to pay if the employer did not provide coverage, would be in the seven to eight percent range. Given the fact we are reasonably confident that the current cost of providing coverage is at least 12 percent of payroll, it seems likely that most small businesses would opt for the public plan. Frankly, we do not believe the public plan could handle the overload, nor is a complete shift to the public plan a desirable result.

The bill does provide for the Secretary of the Department of Health and Human Services to set the contribution at a higher rate, but that brings with it a host of other problems. Our colleagues at the NFIB Foundation have published an excellent document entitled, *It's Cheaper To Pay Than It Is To Play.* It illustrates the pitfalls of this approach.

Fourth, the "play or pay" mandate imposes some extraordinary burdens on small employers, who would be required to provide family coverage and pay for 80 percent of it. This would be a significant change for most small firms. Most provide 100 percent coverage for employees, but family coverage varies widely and very few now can afford to absorb 80 percent of the coverage. This provision also may push many small employers into opting to pay the payroll tax and put their employees and dependents in the public plan.

Likewise, the requirement to provide coverage to employees who work as few as 17½ hours a week will hurt only one constituency—part-time workers. Frankly, an employer is going to try twice as hard to avoid creating a part-time position. The owner and the other full-time workers will work a little harder, but someone who needs the part-time position will lose out.

In summary, the "play or pay" option has serious deficiencies. We recognize that for the 30 plus million without health care insurance, access to coverage is their primary issue. However, mandating coverage does nothing for the 185 million individuals already covered by private insurance, because such proposals fail to provide any mechanism for controlling costs. Unfortunately, we do not believe cost discipline can be imposed in a public sector program such as AmeriCare.

We believe the sands are shifting within the small business sector. In our Illinois study, over 90 percent of the small businesses responding indicated they believe health insurance coverage is a fundamental right for all Americans. More than half the respondents clearly felt that the employer should indeed be responsible for coverage. There is a quantum leap, however, between undertaking a voluntary responsibility and absorbing a mandatory requirement. The respondents indicated that cost is the major obstacle to undertaking that responsibility. We are convinced most small business owners will voluntarily undertake coverage and, in fact, we would suggest the numbers of small businesses providing coverage is already higher than commonly reported. We believe it now is as high as 85 percent.

The focus for our efforts should be to assist the important contributors to the economy and job creation—the small businesses with 20 to 100 employees. These are the firms on the edge. They now provide coverage, and have been in business for more than five years, but they can no longer continue to provide the benefit. If we can control and stabilize costs so they can continue to provide health insurance coverage, we are confident we will have found the solution to the overall health care problem in our society.

For four years we at SBLC struck a single note—no mandates and no national health insurance. While small business remains unalterably opposed to those approaches for the reasons we have indicated, there is emerging evidence small business is prepared to accept some government participation to stabilize and control costs.

We are not so naive as to believe that "free" enterprise is completely free. We are long and ardent proponents of strong antitrust laws. We understand too well that a restrained government hand is necessary to protect and encourage competition. So this is not the first time we would suggest some limited government participation in establishing the playing field.

The truth is, we do not see true competition in the provider community. Indeed, there is competition for the best contracts and business, but it is not true competition. Given the unique role of health care in our society, as reflected in the comments of the small business owners in our Illinois study that health care is rapidly becoming a fundamental right, it may be time to revamp our thinking on how the price of health care is established.

While we are loath to advocate regulation of any business, and health care services are just that—businesses—we see no hope on the horizon unless we can stabilize and control health care costs. We know this will not be a popular view in the health care community, but it is the reality.

As everyone knows, the health care delivery system is a complex mechanism. Until you have dealt with it from the perspective of a small business owner, it is hard to appreciate how confusing the current system is. In Washington, we have a tendency to assume draconian actions are necessary. One fact which came out of our Illinois study is that most small business owners do not know what health care insurance options are available to them, nor are they certain who can provide them with reliable information. These owners find themselves struggling with comparing apples and oranges between different insurance and health care programs. Therefore, the first step toward enhancing access and controlling costs may be to provide better, more consistent information on health care insurance options. It is a simple step, but it can yield results.

We were surprised to learn how few Illinois small business owners knew that the State of Illinois had enacted the Illinois Comprehensive Health Insurance plan for state residents who could not obtain private insurance. While 93 percent of the respondents agreed with the statement "a state government-sponsored medical high risk pool is a good idea," fewer than 10 percent were aware the State of Illinois had enacted such legislation in 1989. Employers in the Illinois study indicated they need more information about rate setting, plan coverage, cost comparisons, regulations, and cost containment.

There are a number of other initiatives in S. 1227, such as the proposal to create common claim forms, that are worthwhile and merit praise. While they are not the subject of this particular hearing, we want at least to acknowledge your efforts in these areas.

In summary, the real health care crisis in America may he yet to come. That crisis could be the collapse of a system burdened by out-of-control costs that can no longer be economically supported. Our challenge, then, is to act now and try to avert such a crisis, and ensure that Americans continue to have the best health care possible. While our testimony suggests your proposal does not yet achieve that goal, we do want to applaud you for recognizing the significance of cost control in solving this very real crisis. We look forward to working with you in taking this debate to the next plateau. While it may take some time to arrive at a consensus, in the interim we can work on matters upon which there is broad consensus, such as small group market insurance reform. Thank you.

Attachment.

Members of the Small Business Legislative Council

Air Conditioning Contractors of America
Alliance for Affordable Health Care
Alliance of Independent Store Owners and Professionals
American Animal Hospital Association
American Association of Nurserymen
American Bus Association
American Consulting Engineers Council
American Council of Independent Laboratories
American Floorcovering Association
American Machine Tool Distributors Association
American Road & Transportation Builders Association
American Society of Travel Agents, Inc.
American Sod Producers Association
American Subcontractors Association
American Textile Machinery Association
American Trucking Associations, Inc.
American Warehousemen's Association
Architectural Precast Association
Associated Builders & Contractors
Associated Equipment Distributors
Associated Landscape Contractors of America
Association of Small Business Development Centers
Association of the Wall and Ceiling Industries-International
Automotive Service Association
Automotive Warehouse Distributors Association
Bowling Proprietors Association of America
Building Service Contractors Association International
Business Advertising Council
C-PORT
Christian Booksellers Association
Council of Fleet Specialists
Electronics Representatives Association
Florists' Transworld Delivery Association
Helicopter Association International
Independent Bakers Association
Independent Bankers Association of America
Independent Medical Distributors Association
Independent Sewing Machine Dealers Association
International Association of Refrigerated Warehouses
International Bottled Water Association
International Communications Industries Association
International Formalwear Association
International Franchise Association
Jewelers of America, Inc.
Machinery Dealers National Association
Manufacturers Agents National Association
Manufacturers Representatives of America, Inc.
Mechanical Contractors Association of America, Inc.
Menswear Retailers of America
NMTBA-The Association for Manufacturing Technology
National Association for the Self-Employed
National Association of Brick Distributors
National Association of Catalog Showroom Merchandisers
National Association of Chemical Distributors
National Association of Home Builders
National Association of Investment Companies
National Association of Passenger Vessel Owners
National Association of Personnel Consultants
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors®
National Association of Retail Druggists
National Association of Small Business Investment Companies
National Association of the Remodeling Industry
National Association of Truck Stop Operators
National Campground Owners Association
National Candy Wholesalers Association
National Chimney Sweep Guild
National Coffee Service Association
National Electrical Contractors Association
National Electrical Manufacturers Representatives Association
National Fastener Distributors Association
National Food Brokers Association
National Grocers Association
National Independent Dairy-Foods Association
National Knitwear & Sportswear Association
National Limousine Association
National Lumber & Building Material Dealers Association
National Moving and Storage Association
National Ornamental & Miscellaneous Metals Association
National Paperbox & Packaging Association
National Parking Association
National Precast Concrete Association
National Shoe Retailers Association
National Society of Public Accountants
National Tire Dealers & Retreaders Association
National Tooling and Machining Association
National Tour Association
National Venture Capital Association
Opticians Association of America
Organization for the Protection and Advancement of Small Telephone Companies
Petroleum Marketers Association of America
Printing Industries of America, Inc.
Professional Plant Growers Association
Retail Bakers of America
SMC/Pennsylvania Small Business
Small Business Council of America, Inc.
Society of American Florists
Specialty Advertising Association International
United Bus Owners of America

1156 15th Street, N.W. - Suite 510 Washington, DC 20005 (202) 639-8500 / FAX (202) 296-5333

STEVENS
worldwide van lines, inc.

February 21, 1992

Mr. Wayne Hosier
Senate Finance Committee
Washington, D.C. 20510-6200

Dear Mr. Hosier:

Enclosed is a copy of our health care plan that was requested from Senator Riegle. I have extracted 2-1/2 pages that cover the specific items in the policy. The balance of the policy deals with definitions and descriptions of the program.

The cost for the attached program as of December 31, 1991 is $90.97 per single employee, $272.91 per family.

Major items not covered or which have limited coverage are as follows:

1. Vision coverage is a scheduled benefit which is a cost sharing program with the employee in lieu of pure insurance.

2. Relative to dental coverage, likewise this is a scheduled benefit which is a cost sharing program as opposed to pure insurance.

3. Major items that are not covered by this insurance policy are orthodontics.

4. The surgical schedule is based on the 1964 California Relative Value Study.

If you have any further questions, please contact me.

Very sincerely yours,

STEVENS VAN LINES, INC.

Morrison M. Stevens
President

MMS/rfk
Encs.

BEKINS BEKINS BEKINS BEKINS BEKINS
Mailing Address: P.O. Box 3276 Saginaw, Michigan 48605 Fax 517-755-0570
527 MORLEY DRIVE • SAGINAW • MICHIGAN • 48601 • (517)755-3000

SECTION 7
SCHEDULE OF BENEFITS

All In-Hospital admissions are subject to compliance with **Republic Health Care Review Services.** This program will evaluate admissions prior to incurring any expenses for a non-emergency admission, and within 48 hours of an emergency admission.

In order to receive the maximum benefits available for Hospitalization under this Plan, a Covered Person must use this Pre-Hospitalization Review Program. Failure to use this program will result in a reduction of **20%** for all expenses incurred as a result of the In-Hospital admission. **The payment of the remaining 20% will be the responsibility of the Covered Person.**

Hospital Expense Benefit (Section 10)
Daily Room & Board.....Semi-Private Room Rate
Private Room Rate.....Semi-Private Room Rate
Intensive, Cardiac and Burn Care.....Reasonable and Customary
Maximum number of days
Illness or Injury.....365
Miscellaneous Hospital Expenses.....Reasonable and Customary
Hospice Care.....Reasonable and Customary
Extended Care Facility
Plan Pays.....50% of Semi-Private Room Rate
Covered Person Pays.....Remaining 50%
Maximum Number of Days Due to Same or Related Causes.....60
Home Health Care.....Reasonable and Customary
Maximum Number of Days.....40
Pre-Admission Testing
Within Seven Days of Hospital Confinement.....Reasonable and Customary

Surgical Expense Benefit (Section 11)
Maximum Benefit.....$1,200.00
Surgical Benefit Unit Value.....$6.00
Out-Patient Surgical Benefit (Deductible and
Co-Pay Waived).....100% of Reasonable and Customary

Pregnancy Expense Benefit (Section 12)
Hospital Expenses.....Same as Other Illness
Physician's Pre and Post-Natal Obstetrical Expenses...Reasonable and Customary
Birthing Centers.....Reasonable and Customary
Mother's Helper - Homemaker Service
Discharge within
24 hours of natural delivery.....3 Days of Service
48 hours of natural delivery.....1 Day of Service
96 hours of caesarean delivery.....3 Days of Service
Maximum daily benefit will not exceed $50 in any one day.

In-Patient Physician Visits Expense Benefit (Section 13).....
.....Reasonable and Customary
Consultations.....Reasonable and Customary

Supplemental Accident Expense Benefit (Section 14)
Benefits within 90 Days of Injury.....$150.00

Diagnostic Procedures Expense Benefit (Section 15)...Reasonable and Customary
Maximum Benefit per calendar year.....$100 Balance Subject to Major Medical Benefit

Major Medical Expense Benefit (Section 16)
Calendar Year Deductible
Per Person.....$100.00
Per Family.....$300.0
Co-payment per Calendar Year
Plan Pays.....80%
Covered Person Pays.....20%
Out-patient Mental and Nervous Disorders and
Substance Abuse (including Alcoholism)
Plan Pays.....50%
Covered Person Pays.....50%
Maximum Benefit per Visit.....$20.00
Maximum Number of Visits per Calendar Year.....50
Co-payment for all Services Ordered or Rendered by a
Doctor of Podiatry (D.P.M.)
Plan Pays.....50%
Covered Person Pays.....50%
Calendar Year Maximum.....$300.00

Jaw Joint Disorders (TMJ)
Plan Pays.....50%
Covered Person Pays.....50%
Lifetime Plan Maximum.....$2,000

Disability Income Benefit (Section 17)
Benefit for an Injury Commence.....30th Day
Benefit for an Illness Commence.....30th Day
Maximum Number of Weeks for Benefits.....22
Maximum Benefit per Week.....50% of Weekly Earnings not to Exceed $230

Dental Expense Benefit (Section 18)
Calendar Year Deductible per Person.....$100.00
Co-payment per Calendar Year
Plan Pays.....80%
Covered Person Pays.....20%
Pre-Certification Amount.....$250.00
Maximum Benefit per Calendar Year.....$1,200.00
Unit Value.....$12.00

*The Major Medical Expense Deductible may be used to satisfy all or part of the Dental Expense Deductible and the Dental Expense Deductible may be used to satisfy all or part of the Major Medical Deductible.

Vision Expense Benefit (Section 19)
(not subject to Major Medical Deductible)
Complete Visual Examination, Including Refraction
Maximum Benefit.....$17.25
Single Lens Maximum Benefit.....$11.50
Bi-focal Maximum Benefit.....$17.25
Tri-focal Maximum Benefit.....$23.00
Lenticular Maximum Benefit.....$23.00
Contact Lens, each.....$30.00
Frames.....$11.50
Maximum Benefit per Calendar Year per Person.....$77.25

Charges will be considered for either contact lenses or conventional type lenses, but not both, during any one Calendar Year.

Lifetime Plan Maximum
For Mental and Nervous Disorders
and Substance Abuse (including Alcoholism) $25,000.00
Type II Organ Transplant Procedures $100,000.00
For all Causes Combined $1,000,000.00

PREPARED STATEMENT OF A. COLE TREMAIN

Good afternoon, Chairman Riegle and members of the Subcommittee on Health for Families and the Uninsured.

My name is Cole Tremain, and I am vice president of Industrial Relations for LTV Steel Company. Our hea lquarters are in Cleveland, Ohio.

LTV steel is the nation's third largest steelmaker and is a leading manufacturer of high-quality engineered flat rolled and tubular steel products. It is a wholly owned subsidiary of the LTV corporation, a diversified company also involved in aerospace/defense and energy products.

I appreciate the opportunity to appear before this subcommittee to share LTV's views and concerns about the health care crisis facing our Nation. This crisis has affected the international competitiveness of the American steel industry. As the chief negotiator for LTV steel, I can assure you it is placing a severe strain on collective bargaining as increasing resources must be dedicated to health care.

LTV steel, together with four other major steel companies (Armco, Bethlehem, Inland and National), have formed the joint national health care policy committee with the United Steelworkers Union. I have the pleasure of serving on this committee and can assure you we are working hard to understand this complex issue and develop joint recommendations for its solution. We have identified a set of principles which we believe represent the essentials required to solve the problem, a copy of which I have attached. Today, however, I would like to speak from our experience at LTV steel. LTV steel is a merger product of three of America's oldest names in steel—Jones & Laughlin Steel, Republic Steel and Youngstown Sheet & Tube. Prior to our mergers, our three companies had been serving America's needs for steel for a combined total of more than 300 years. We are a mature company in a mature industry.

Our interest in health care costs is a product of our experience. In 1990 we spent $193 million providing health care coverage to 150,000 active employees and their dependents and retirees, dependents and surviving spouses. Our responsibilities to provide health care are significant owing to the role we have played in downsizing the American steel industry. In 1990 our 19,500 active employees worked to support the cost of providing health care for themselves and their dependents and for nearly 60,000 retirees, surviving spouses and their dependents. An extraordinary 3 to 1 ratio. as recently as 1980, those numbers were 76,000 active employees and 44,000 retirees. Many of our retirees are relatively young, having been forced into early retirement by the shutdown of outdated steelmaking plants. Major shutdowns in Buffalo, Chicago, Youngstown and in Aliquippa and Pittsburgh, Pennsylvania resulted in the loss of 32,000 jobs at LTV steel.

Let me put some perspective on that $193 million we spent for health care in 1990.

- It was $26.50 of the cost of every ton of steel we shipped.
- 5% of the revenue from each ton we shipped supported health care.
- Total cost per active employee was 4 times greater in 1990 than it was just ten yeas earlier.
- On a per hour worked basis, our health care cost of $4.87 exceeded the minimum wage paid by many American employers.

I wish I could tell you those numbers are improving in 1991. They are not! Our health care costs are rising in the 15-20% range. In fact, we have recorded nearly $2 billion on the company's books to reflect the present value of our future obligations to make health care payments. The problem gets more serious each year—for all of the nation's health care bill payers, but especially for companies like ours who played major roles in building these United States.

I'd like to share some numbers with you that underscore how devastating health care costs can be today for any American if his/her health fails. We follow case costs to help understand where our health care doers are being spent. In our most recent analysis, the list was headed by a Chicago employee's spouse who required a liver transplant. The total cost was $1,025,127. Last year the list was headed by a Chicago employee's thigh amputation at a cost of $876,000. In these surveys more than a dozen cases exceeded a quarter million dollars in cost.

A major driver of our increased costs comes from "cost shifting." It is an accepted fact that costs not adequately covered by Medicare, Medicaid or other social funds for the uninsured are passed on to privately insured patients, most of whom are covered by insurance provided by their employers. I can assure you that this is no imagined problem! Here are several examples from our records. In 1990, Medicare would pay $20,100 for DRG 106 (coronary by-pass), while LTV steel paid an average

of $32,000 at the many hospitals our employees entered. For DRG 196 (cholecystectomy) Medicare paid $5,247, while LTV steel paid an average of twice that much—$10,800. Worse yet, Medicare authorized payment of $2,713 for DRG 307 (prostatectomy), while LTV steel paid an average of $12,800. Not every comparison is that severe, but regularly the Medicare charge is less than LTV steel's—by a significant margin.

Massive cost-shifting from Medicare has thus far been principally a hospital charge issue. as you well know, in 1992 Medicare will revise its reimbursement schedules to physicians according to its resource based relative value scale. I can only report that industry is extremely apprehensive—expecting another huge dose of Medicare cost-shifting, this time from the physician community.

Before we leave the issue of cost-shifting, one final point. Each of us knows that more than 35 million Americans have no health insurance, even though two thirds of them are gainfully employed. They cannot receive adequate health care—they can't personally afford the kind of costs we have been discussing. When emergencies arise, however, they do get care in our hospitals—generally very adequate care. With no one else available to pay the bill, the cost is divided up among the only available source of inflatable revenue—the privately insured—America's employers who provide their employees with health insurance.

It should be clear to all that our nation can no longer afford to turn its back on millions of our fellow Americans. I hope it is becoming equally clear to this distinguished audience that the health care problem cannot continue to be shifted to this country's business and industrial concerns without devastating impact on our competitiveness in the international marketplace we all operate in today.

Senator Riegle, it is vital that you and your colleagues press vigorously ahead with your effort to forge a comprehensive, national solution to this problem. Nothing less will suffice. Those of us in the private sector have utterly failed in our efforts to rein in runaway costs. The problem cannot be solved by applying a bandaid solution here and there. This is one issue that the free enterprise system has clearly failed to solve—in fact, the combination of exploding technology and competition is exacerbating the problem. It seems as though every hospital must have the very latest in ipogy.

This health care crisis is real and it can only be resolved by comprehensive federal legislation that addresses the entire problem. We have become convinced that such legislation must effectively deal with the three major issues—access, cost and quality. If access is attacked and the cost problem is unattended, the cost-shifting problem will be further aggravated for those of us in the private sector who pay health care bills. If cost is addressed and quality ignored, each of us will be genuinely concerned that quality will be sacrificed.

We have concluded that there is no need to dismantle our existing network of insurers and providers—we don't have to start at ground zero to attack this problem. We support legislation that would mandate that employers provide a basic set of benefits or pay a modest payroll tax to have their employees covered by a new federal plan similar to but separate from Medicare. This "play or pay" approach is readily adapted to our current systems. We support lowering the age for Medicare eligibility to 60. Too many Americans have been forced into early retirement, often without health insurance.

On the cost side, we believe that it is essential that legislation establish the principle that everyone is charged the same price whether the bill is paid by Medicare, the business community, insurance companies or the new federal system to cover the uninsured. Processes that are currently in place to determine what Medicare pays hospitals and physicians can provide the starting point for a new system which would set the prices for everyone. That process also needs to set national targets for health care costs to put a brake on the share of GNP (now at 12%) going to health care.

On the issue of quality it is clear that comprehensive medical practice guidelines and accreditation processes have to be established. They are needed to assist the effort to provide quality care while tempering the overpractice of Medicine. Our medical community desperately needs reform in the law and policies governing malpractice. It is clear that "defensive" medicine adds materially to the costs we see, particularly in extensive use of tests.

One additional concern we urge you to consider. There is an inherent conflict of interest arising from ownership of laboratories and technology centers by physicians who in their

Daily practice refer patients to these very same centers. Unfortunately, the American entrepreneurial spirit seems to assure that these labs and centers are huge fi-

nancial successes. Malpractice reform should be tied to reform in these questionable business practices.

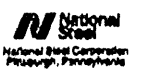
In Cleveland we are actively supporting a joint effort by the business and medical community to develop an accurate system of measuring the quality of hospital care. Known as Cleveland health quality choice, this joint effort is making excellent progress in developing a system we all believe will allow both providers and patients to assess with confidence the quality in health care provided by Cleveland-area hospitals. It may well provide a model for national consideration.

Senators, if the Simon amendment is incorporated into S. 1227, HealthAmerica, Affordable Health Care for all Americans act, and we would urge that result to establish the critical "all payers" element, we believe your bill effectively addresses many of the fundamental concerns we have discussed.

The issue of funding is not addressed in your bills as I'm sure you know. Clearly, the payroll tax for businesses electing to provide coverage to their employees through a new federal program would be appropriate. The remaining funds—funds to provide coverage to the uninsured—should be secured from as broad a base as practicable. This is a national problem. It should not be financed by any single sector of our society.

In conclusion, Mr. Chairman, I would like to thank you for bringing this discussion of the health care crisis to the forefront of American politics. The problem cries out for a solution—it does not require years of additional study.

Thank you for the opportunity to state my views.



STATEMENT OF PRINCIPLES ON HEALTH CARE REFORM

The USWA and the member companies of the Joint National Health Care Policy Committee have begun an intensive study of the health care crisis in the United States. This crisis has affected the international competitiveness of the American steel industry. It has placed a severe strain on collective bargaining as increasing resources must be dedicated to health care. This problem must be solved. Inasmuch as considerable work remains to be accomplished by the Joint Committee, the following principles will guide the Joint Committee's work.

1. Legislative and regulatory action needs to be taken which simultaneously addresses each of the three facets of the problem—access to affordable health care; quality; and cost containment to address accelerating fees, inappropriate utilization of services, excess capacity and new technology. Actions which address just one facet are likely to aggravate the others.
2. Immediate action is required even though it may entail a consideration of both short-term and long-term strategies.
3. Access to meaningful and affordable health care coverage should be provided all citizens of the United States, with the cost to society of such coverage spread over the broadest possible base.
4. Systems for controlling total health care cost escalation must be implemented based on explicit comprehensive limits on national health care spending.
5. Health care delivery systems should be encouraged, which optimize the utilization of health care, while minimizing administrative expense.
6. Federal cost containment legislation is needed to insure that public and private payors pay the same for health care.
7. Public programs such as Medicaid and Medicare and the cost of care for the uninsured have shifted significant costs onto the private sector. These cost shifts must cease.
8. Action is required to control inappropriate utilization of services through the establishment of national medical practice guidelines which would set standards for health care.
9. Specific efforts to maximize the quality of health care delivery should be undertaken, including the use of effective quality measurement systems and improved accreditation processes.
10. Federal legislation providing appropriate limitation should be placed upon provider ownership of ancillary facilities such as medical test labs, rehabilitation facilities and the like to assure elimination of conflict of interest.
11. A better system for handling medical malpractice disputes needs to be developed.
12. We must insure that Medicare remains the primary payor for the elderly.

The Joint National Health Care Policy Committee

Co-Chairmen

A. Cole Tremain, LTV Steel Co. Leon Lynch, USWA

David Alexander, Armco Steel Co., L.P. • Benjamin C. Boylston, Bethlehem Steel Corp. • William P. Buehler, Inland Steel Co • Richard P. Coffee, National Steel Corp.

COMMUNICATIONS

THE AMERICAN ACADEMY OF OTOLARYNGOLOGY—
HEAD AND NECK SURGERY, INC.,
Alexandria, VA, December 9, 1991.

Hon. LLOYD BENTSEN, *Chairman,*
Senate Committee on Finance,
215 Dirksen Senate Office Building,
Washington, DC.

Dear Mr. Chairman: The American Academy of Otolaryngology—Head and Neck Surgery is pleased to endorse S. 506, as introduced by Senator Tom Harkin, as part of his "Prevention First" legislative package.

Less than two percent of the time doctors spend today in training is dedicated to prevention. S. 506 would address this critical need for disease prevention and health promotion activities in the curriculum of medical schools and graduate training programs. While many institutions have incorporated such activities into their programs in a significant way, many others do not give prevention appropriate attention.

Senator Harkin's legislation would mandate hospital residency training programs to include training in disease prevention and health promotion in order to receive Medicare payment for direct graduate medical education costs.

S. 506 would also preserve and strengthen Medicare support for graduate medical education by placing a moratorium on reductions in Medicare payment rates for direct and indirect medical education costs beyond those in effect on or before January 1, 1991.

The Academy supports and applauds Senator Harkin's efforts to promote disease prevention and health promotion. The members of this Academy have continuously fought for and supported initiatives that promote early intervention in health care. The Academy was proud to be a supporter of public Law 101-582, The Health Objectives 2000 Act, which will improve and expand health promotion programs at the state and local levels.

As the Committee moves forward with its agenda, we 'trust that you will address this important legislation favorably. Early intervention and treatment of disease, as well as an intensive health promotion campaign, will move us one step closer toward a healthy nation.

Sincerely,

G. RICHARD HOLT, M.D., *President.*

STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA), and its 53 constituent state and territorial nurses associations, is pleased to have this opportunity to present our views on comprehensive health care reform.

The American Nurses Association is the only full-service professional organization representing the nation's two million nurses, including nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the U.S. Congress and regulatory agencies on health care issues affecting nurses and the public.

Access to high quality, affordable health care is of concern to millions of Americans—not only to the over thirty-seven million who are uninsured, but to the grow-

ing number of currently insured who fear that changing or losing their jobs will result in loss of coverage because of pre-existing conditions, or that the skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

America's two million registered nurses deliver many of the essential health care services in the United States today. Working in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care arrangements—nurses know first hand of the inequities and problems with our nation's health care system. Because we are there—twenty-four hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

We see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking help until they appear in a hospital emergency room in advanced stages of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services.

We know that delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

America's nurses believe that it is time to frame a bold new vision for reform—one that keeps what works best in our current system, but casts aside institutions and policies that fail to meet present and future needs—a plan that addresses the triad of problems that exist in the current system: **inequitable and limited access, soaring costs and inconsistencies in quality and appropriateness of the care delivered.**

For the past two and a half years, under the leadership of American Nurses Association (ANA) and the National League for Nursing (NLN), nursing has been developing a plan which encompasses the profession's best vision of a health care system for the future. To ensure that all areas of specialty practice and unique geographic differences were sufficiently represented in the development of this plan, ANA convened a special task force of nursing experts. They evaluated the current health care system in the United States, as well as those of other nations, and subsequently developed a plan for reform that is uniquely American.

The work of the task force was disseminated to all 53 of our state and territorial associations, all of the national nursing organizations representing specialty areas of nursing practice and to the chiefs of the federal nursing services for review and comment. Drafts of the plan were discussed and debated at state and national meetings and in regional conference calls throughout its development.

To date, in addition to ANA's state and territorial associations, fifty-one national nursing and health-related organizations have endorsed this proposal for health care reform, entitled **Nursing's Agenda for Health Care Reform.** Together, these organizations represent approximately 6,000 of the nation's two million registered nurses.

Many other highly respected and qualified groups have also studied the growing crisis in health care and have come forward with reform proposals of their own. Unfortunately however, many of those plans have focused primarily on the problems of the high cost and the financing of health care services. Nurses believe that framing the problem that narrowly will not result in solutions that will adequately achieve the desired outcome: *universal access to affordable and timely health care that is appropriate, necessary and that ultimately results in the improved health status of all Americans.*

Nursing defines the health care crisis problem in terms of the need to **restructure, reorient** and **decentralize** the health care system in order to **guarantee access to services, contain costs and ensure quality.** Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive, and not limited to addressing only one or two components of the problem. Nursing's proposal does not define the problem only in terms of the uninsured or underinsured; rather, it **addresses the health care needs of the entire nation.**

Nursing's Agenda for Health Care Reform calls for building a new foundation for health care in America while preserving the best elements of the existing system. Influencing the direction of health care reform is a complex, demanding task. Nurses know, however, that in order to preserve the health and well being of our

country and its people we must make important, fundamental changes in *how, where, and to whom* care is delivered.

Today, America's two million nurses are united in urging that the nation's health care system be cured . . . and cured **now**. We must reshape and redirect the system away from overuse of the expensive, technology-driven, hospital-based models we currently have. A **balance must be struck between high-tech treatment and prevention.** It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

We believe that **expanding the freedom of choice to include all qualified health care providers would improve access to quality health care.** Nurses are an essential component of the health care system. Nurses are frequently the first and sometime the only point of contact for the consumer and the health care system. Restrictive reimbursement laws have created an illness-oriented, hospital-based health care system that revolves around the interests of institutional and physician providers. We believe that both private and public insurers should expand coverage to include nurses and other qualified nonphysician providers. Freedom of provider choice laws can save the health care system money by reducing visits to emergency rooms and or other specialists who may be high cost providers. Studies have shown that nursing services can reduce the utilization of hospitals, emergency rooms and nursing homes and can reduce the costs of laboratory services and save physician time (Harrington, 1990 and Feldman, 1987). Nurses' style of practice has also been shown to be cost-effective to the consumer through increased compliance to treatment (Office of Technology Assessment, 1986).

In addition, we believe that a balance must be maintained between treatment of illness and promotion of health. Practically, that means valuing and incorporating as an integral part of health care delivery the health education and counseling roles which nurses have traditionally incorporated into nursing practice. The incorporation of these roles into practice has increased patient/consumer ability to manage their health status to achieve improved health outcomes, especially for those with multiple or chronic illnesses.

To improve access and reduce costs, **consumers must have more responsibility in making decisions.** Health care must be made a more vital part of individual and community life, and controls must be placed throughout the system to reduce spiraling costs.

The basic components of *Nursing's Agenda For Health care Reform* **include:**

• universal access for all citizens and residents provided through a **restructured** health care system;

• enhanced consumer access to services **by delivering primary health care in community-based settings;** the new system would facilitate utilization of the most cost-effective providers and therapeutic options in the most appropriate settings;

• a **federally-defined standard package of essential health care services financed through public and private plans and sources including preventive, pre-natal, well-child, mental health, acute and short duration long-term care services:**

—**the public plan,** based on federal guidelines and eligibility requirements, would provide coverage for the poor and create the opportunity for small businesses and individuals to buy into the plan. This public plan would be administered by the states in order to anticipate the health care needs and changing demographics of the population. Payments and deductibles would be eliminated for those under 100 percent of the poverty level and reduced for those between 100 and 200 percent of the poverty level;

—**the private plan** would offer, at a minimum, the nationally standardized package of essential services. This package could be enriched as a benefit of employment, or individuals could purchase additional services. If employers did not offer private coverage, they would be required to pay into the public plan for their employees.

• a shift in focus to provide **a better balance among treatment of disease, health promotion and illness prevention** such as coverage for:

—immunizations;
—prenatal care;
—health screening which has proven effective in preventing costly and devastating disease (e.g., colorectal and testicular exams, pap smears, and mammograms).

• the **phase-in** of essential services, starting with pregnant women and children under six years of age, and continuing with the vulnerable populations who historically have had limited access to our health care system.

• **Steps to reduce health care costs** such as:

—required usage of **managed care** in the public plan. Private participation in managed care plans would be encouraged by reduced consumer cost-sharing and federal prohibitions of state barriers.

—ensuring consumer access to **a full range of qualified health care providers** (including nurse practitioners);

—providing early **treatment and prevention service at convenient sites, such as schools, the workplace, and other familiar community settings;**

—**reducing defensive medicine and unnecessary practices;**

—**controlled growth of the health care system** through planning and prudent resource allocation; and

—elimination of unnecessary **bureaucracy and decreased administrative requirements through the use of uniform claim forms and electronic billing.**

• utilization of **case management** for people with continuing health care problems to promote active participation in their care and reduce fragmentation of the health care system.

• **public and private funding for long-term care services of short duration and a provision for public funding of extended care to prevent personal impoverishment.** This proposal will require more **shared personal and community responsibility for care.** It will prevent impoverishment due to extended long-term care needs. It will require use of new creative financing ideas, such as individual health accounts, similar to IRAs and home equity loans.

• insurance reforms are required to ensure improved access to coverage, including community ratings, affordable premiums, reinsurance pools for catastrophic coverage and other proposals to assist the small group market.

• access to services are ensured by **no payment at the point of service and elimination of balance billing** in both public and private plans.

ANA believes inclusion of managed care will encourage utilization of the most appropriate cost-effective and cost-efficient providers for most health care services, especially for those services which focus primary care and restorative care on health promotion and disease prevention. Nursing believes that the managed care system of the future can and must incorporate techniques that can be effective in improving quality and provider accountability. The managed care system envisioned by nursing provides needed preventive care, requires use of treatments of proven effectiveness, emphasizes proper health and controls health care expenditures. To encourage their use in non-managed care plans, preventive services will have lower copayments and deductibles.

The goal of managed care should be to provide timely, necessary and appropriate care by the most appropriate qualified provider in the most appropriate setting. Achieving this goal will decrease costs and improve quality of the services delivered. In the past, managed care has been used in many instances to protect the pocketbooks of insurers, rather than the needs and rights of consumers. Care must be taken to retain the maximum possible consumer choice and to place a premium on services that address the appropriate needs of the consumer.

Use of nurses in case management is one method increasingly being utilized within managed care to address the complex health care needs of clients with continuing and chronic health problems. The aim of case management is to make health care less fragmented and to allow health care professionals to integrate, coordinate and advocate on behalf of those clients requiring extensive services. Case management is also cost-effective because it allows early diagnosis and treatment of acute episodes of chronic illness often before they require treatment through expensive high technology.

While we would like to see reform of the health care system occur as quickly as possible, we recognize that it may be necessary to implement these fundamental changes incrementally. If this is necessary, we believe that the first priority should be the immediate coverage of all pregnant women and children under six years of age, and those individuals who have traditionally had limited access to health care services.

ANA strongly supports removal of financial barriers to health care as a major goal in health care reform. Health care reform must balance financial responsibility equitably among all segments of society; providers and suppliers of goods and services as well as individuals and public and private payors.

If all of these reforms are adopted, a **"health dividend"** will result in savings in the cost of providing health care services for this nation.

Nursing's Agenda for Health Care Reform represents a comprehensive solution to this critical problem. We will continue to examine our **Agenda** as well as proposals offered by others1 With nursing colleagues, business, labor and consumer groups, we will pursue implementation of common goals as well as clarification and resolution of differences.

We commend the Subcommittee for holding these hearings and attempting to find solutions to the health care crisis. As leaders who are on the cutting edge, we look to you for the development of legislative proposals that will result in true health care reform—reform that is comprehensive and that ensures access, quality and cost-effectiveness.

ANA would welcome the opportunity to discuss our views on this issue in more detail with the Members of the Subcommittee. In addition, we look forward to working with you as comprehensive health care reform legislation is developed.

STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.

Mr. Chairman and members of the Subcommittee, I am Robert H. Sweeney, President of NACHRI -- the National Association of Children s Hospitals and Related Institutions. On behalf of NACHRI's members and the families they serve, I thank you for the opportunity to submit this statement for the hearing record.

NACHRI represents more than 100 institutions in the United States, including free-standing children's hospitals, pediatric departments of major medical centers, and specialty hospitals such as pediatric rehabilitation and chronic care facilities. Virtually all of the children's hospitals are teaching hospitals and research centers. Many also function as regional referral centers for specialized pediatric care.

While they are best known as tertiary level hospitals providing specialized inpatient care for very sick, disabled, or injured children, children's hospitals also are major providers of outpatient care. This includes not only emergency and specialty care in ambulatory settings but also primary and preventive care. Indeed, the children's hospital functions as the primary care pediatrician for children in the community, as well as the specialized hospital for children with acute and chronic care conditions throughout the region.

Acknowledgment of Congressional Leadership

NACHRI commends Senators Mitchell, Kennedy, Rockefeller, and your self, as well as other Members of Congress, for demonstrating leadership in responding to the urgent need for reform of health insurance by sponsoring legislation to establish universal access. In particular, NACHRI is encouraged that several of these proposals, including S. 1227:

- provide universal coverage,
- build on a public/private partnership that expands private coverage while reforming public programs,
- establish a uniform national benefit package, including catastrophic coverage, as well as primary and preventive care, and
- include reform of the private health insurance market, particularly for small employers.

NACHRI appreciates also the provisions in S. 1227 and in other bills, which recognize that the health care needs of children in general and the patients of children's hospitals in particular are different from the needs of adults. Previous testimony and reports to Congress have documented in detail children's unique health care needs as well as the high incidence of uninsured children among low income, working families.

NACHRI notes with special appreciation the provisions for hospital reimbursement in S. 1227 and other bills, which recognize that Medicare prospective payment rules must be revised to reflect the different needs of children and children's hospitals. For example, in different ways bills by Senator Mitchell, Senator Rockefeller, Representative Waxman, Representative Rostenkowski, Representative Stark, and Representative Matsui call for modifications of Medicare DRG-based prospective payment for children and children's

hospitals, or for the exclusion of children's hospitals from them entirely. These provisions are consistent with the assessment of the Health Care Financing Administration (HCFA). For example, HCFA stated in its August 30th update of the Medicare DRG classification system for FY 1992:

> **While (HCFA is) aware of the fact that changes we make in the Medicare DRG system have an impact on...(children's) hospitals with regard to other payment systems that use our DRGs...the prospective payment system, and the DRG classifications in particular, are based on Medicare data and are designed for the Medicare population, that is, the elderly and the disabled. Therefore, changes and modifications that we make to that system may not always be appropriate for a younger population, such as the one treated most often in children's hospitals.** (Federal Register, August 30, 1991, page 43211).

Additional Points Requiring Consideration

The bills noted above take an important first step toward recognizing the different health care needs of children and children's hospitals. However, S. 1227 and other comprehensive reform bills should acknowledge them more specifically. I will discuss the kinds of specific responses that are needed with respect to five key issues raised by S. 1227 and other bills: 1) negotiated rate setting in the context of global budgeting, 2) DRG-based payment, 3) national rate setting that links private payment rates to public, 4) managed care, and 5) disproportionate share payment adjustments.

1) **If it enacts negotiated rate setting by sector in the context of global budgeting, Congress should make room at the negotiating table for specialized providers such as children's hospitals to negotiate rates based on the costs of providing care to their distinctive patient populations. Such unique providers cannot be represented by a single voice for an entire industry.**

The services of children's hospitals differ measurably from those of general hospitals -- because their patients are exclusively children, their services are highly specialized and often regionalized, and their commitment to caring for patients of low income families is exceptionally high. For example, pediatric patients -- in both the pediatric units of general hospitals and the general units of children' hospitals -- require about 50% more nursing care than do adult patients. The pediatric case-mix intensity of children's hospitals is about twice that of general, non-teaching hospitals. And the proportion of its care that a children's hospital provides to patients whose families depend on public assistance or charity averages more than three times that of a general hospital.

If health care reform legislation were to require negotiated rate setting -- regardless of whether it would be at the federal, state, or local level -- NACHRI believes it is essential that Congress afford children's hospitals the opportunity to negotiate directly to determine reimbursement that reflects the true needs of their patients and the resource requirements of the services they provide.

2) **If it enacts Medicare DRG-based payment methodology as the standard for all rate setting, with revisions for children and children's hospitals, Congress should recognize that the revisions require a good deal more than just modifying the DRG classification system.**

Even with a pediatric modified DRG classification system, DRG-based prospective payment would be limited in its applicability to children and children's hospitals for several reasons:

- **The Medicare cost report does not provide accurate data on the cost of pediatric hospital care.** Instead, hospitals report their average costs for all patients, which results in an under-reporting of the true costs of pediatric care and an over-reporting of the costs of adults' care.

- **Medicare payment policies do not reflect the much higher incidence of high cost and long stay cases among children than adults -- the so-called outlier patients -- resulting from children being more likely to become sicker, faster and to need intensive care more often than adults when hospitalized.**

- **Medicare reimbursement for medical education was not designed to address the specialized training required by pediatric physicians, nurses, and technicians.** Nor does it reflect the fact that children's hospitals -- with less than 10% of all pediatric hospital beds in the country -- account for nearly a quarter of all pediatric residencies.

- **Medicare reimbursement for capital was not designed to take into account the more intensive facility needs of children.**

It is important that legislation acknowledge explicitly the necessity of adjustments in DRG classification, cost reporting, rate setting, outlier policies, and GME, as well as capital reimbursement, in establishing payment methodology appropriate for pediatric hospital patients in general and the patients of children's hospitals in particular.

3) **If it enacts national rate setting linking private payment rates to public rates, Congress should recognize that discounted public payment rates that do not cover costs, as now exists under Medicaid, cannot continue.**

Over the last several years, children's hospitals have devoted an increasing percentage of their care to children under Medicaid -- nearly 40% on average in 1990. However, at the same time, Medicaid reimburses a declining percentage of the cost of their care -- about 72 cents for every dollar of cost in providing the service in 1990.

Several bills recognize that payment rates linked to public rates would have harmful consequences for the financial stability of providers. In response, the bills propose to establish Medicare payment rates as the standard against which payment adequacy should be measured, since it generally exceeds Medicaid.

However, the Medicare standard creates three problems for the providers of pediatric hospital care, particularly those serving large Medicaid patient populations. First and foremost, as discussed above, Medicare is an inappropriate standard for reimbursement for pediatric patients. Second, proposals such as S. 1227 foresee linkage of private reimbursement to public rates, but a gradual transition over a number of years in improving the public rates. This would have serious adverse consequences for providers such as children's hospitals that now are devoting a significant percentage of their care to publicly assisted patients and rely on higher paying, private pay patients to cross-subsidize the cost of care. Finally, to the extent that Medicare itself is discounted, the problem remains.

4) **If it enacts policies promoting managed care, Congress should make sure that it does not exclude regionalized and specialized health care services, including critical and emergency medical services, for children.**

In many states, children's hospitals have developed highly specialized services concentrated in a single location to serve children in need of such services throughout a large region. On the one hand, such regionalization responds to the lower incidence of congenital and chronic health conditions among children and the need for both economies and quality of scale.

On the other hand, such regionalization not only requires a significant investment of resources but also the continued referral of patients. If focused primarily on cost containment, managed care could undermine access to specialized health care services, unless it:

- includes the appropriate number and breadth of types of pediatric specialists in each region served by a managed care plan;
- establishes timely and well-publicized processes for approving referrals to less frequently used sub-specialists and providers with experience in the treatment of rare or unusually complicated illneses; and
- provides for contracting with and referrals to hospitals whose staff include the full range of pediatric specialties and sub-specialties to ensure essential care coordination.

While there should not be undue restrictions on managed care, as a number of the bills recognize, it is important to remember that state regulation of managed care has grown in response to documented cases of abuses. In establishing policy to promote managed care, legislation also should assure timely access to appropriate, quality services.

5) **If it enacts universal access policies based on a private insurance model, Congress should recognize that the need for disproportionate share payment adjustments will continue.**

Fundamental to the private insurance model of health coverage are co-payments by beneficiaries that both contain insurer costs and, hopefully, encourage more efficient health care utilization on the part of the consumer. However, providers of care, who see a disproportionate share of patients of low income families less able to meet their co-payment responsibilities, will continue to experience payment shortfalls.

Similarly, because patients of low income families have on average more intensive health care needs, even within a specific diagnosis, providers who serve a disproportionate share of such patients will be vulnerable to inadequate reimbursement under systems such as PPS that pay according to average patient experience in a community, region, or nationally, rather than according to the experience of the patients of an individual institution.

Because children are disproportionately represented among poor families -- one out of five children is poor -- providers specializing in the hospital care of children will incur costs of care, in both payment shortfalls and intensity of care, that other hospitals may not incur. Disproportionate share payment adjustments will be necessary to reflect these differences.

Conclusion

Mr. Chairman, in conclusion I would like to make two additional points drawn from the experience of children's hospitals which are pertinent to the legislation that you are reviewing.

NACHRI recognizes that while the specific issues we have identified need to be addressed by Congress, children's hospitals have a serious obligation, as do all health care providers, to be prepared to operate in an environment which will be much more attuned to cost containment. We know that involves more than children's hospitals seeking continually to improve the efficiency, appropriateness, and effectiveness of the care they provide. It also involves playing an ever greater role in promoting healthful behavior and informed health care consumption, in stimulating charitable donations to complement public investment, and in working with payers -- public and private alike -- to establish reimbursement policies that encourage more cost-effective behavior on the part of both patient and provider.

At the same time, NACHRI also recognizes that guaranteeing either private health insurance or public assistance for all Americans represents the beginning -- not the end -- of guaranteeing access to health care, as our member hospitals know all too well from their delivery of care to children who now are assisted by Medicaid and therefore are regarded as "insured."

These are the same children who, despite their Medicaid eligibility, have more intensive inpatient care needs, because the primary and preventive health care they require is not available in their communities. These are the same children who, despite their Medicaid eligibility, are admitted to our hospitals without such protection, because they have not been able to enroll in Medicaid. These are the same children who, despite their Medicaid enrollment, have not received their necessary immunizations because of inadequate parent education and awareness or service availability.

Much more is needed to guarantee access to care for all of America's children, but establishing financial access through universal coverage is the first major and essential step. NACHRI is eager to work with the Subcommittee in addressing the issues we have raised and in advancing health care reform.

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October 10, 1991

Healthcare Financing Administration
Department of Health and Human Serv.
Attn: MB-022-IFC
P.O. Box 26676
Baltimore, Md. 21707

Gentlemen,

On behalf of the Piatt County Board and our residents at Piatt County Nursing Home, we urge you to reconsider the Interim rule which eliminates the Illinois Medicaid Assessment Plan.

It is morally wrong for State and Federal Governments to continue to balance their budgets on the backs of the elderly poor. We are a 100 bed skilled nursing facility in a rural populated area with a high Medicaid occupancy. Elimination of the Assessment Program results in a loss of $158,000 for our home and would be devastating in terms of the cuts which would have to be made in rehab programs, food costs, and staffing.

The elimination of the Assessment Program will rapidly deplete the Medicaid beds available in rural populations. Most Long Term Care facilities in these areas are small, have sparse tax base, and attempt to take care of their elderly by living hand to mouth. Federal Mandates such as OBRA heaped costs on us this past year. The Federal Government now has an obligation to pay for its mandate.

We urge you to withdraw your opposition to the Medicaid Assessment Plan. It is vital to our survival.

Sincerely,

Marilyn Benedino
Administrator

MB/vh
cc: Il. Assoc. Homes for Aging
AAHA - Chicago Office
Honorable George Mitchell, Robert Dole, Lloyd Bentsen, Thomas S. Foley, Robert H. Michel, Fortney Stark, Henry A. Waxman, Willis D. Gradison, Jr.

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