S. HRG. 102—778

HEALTH-CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON EDUCATION AND HEALTH

OF THE

JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

OCTOBER 2, 16 AND 30, AND DECEMBER 9, 1991

Printed for the use of the Joint Economic Committee

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON: 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-039241-1

54-863 O—92——1

JOINT ECONOMIC COMMITTEE

[Created pursuant to Sec. 5(a) of Public Law 304, 79th Congress]

SENATE	HOUSE OF REPRESENTATIVES
PAUL S. SARBANES, Maryland, *Chairman*	LEE H. HAMILTON, Indiana, *Vice Chairman*
LLOYD BENTSEN, Texas	DAVID R. OBEY, Wisconsin
EDWARD M. KENNEDY, Massachusetts	JAMES H. SCHEUER, New York
JEFF BINGAMAN, New Mexico	FORTNEY PETE STARK, California
ALBERT GORE, Jr., Tennessee	STEPHEN J. SOLARZ, New York
RICHARD H. BRYAN, Nevada	KWEISI MFUME, Maryland
WILLIAM V. ROTH, Jr., Delaware	RICHARD K. ARMEY, Texas
STEVE SYMMS, Idaho	CHALMERS P. WYLIE, Ohio
CONNIE MACK, Florida	OLYMPIA J. SNOWE, Maine
ROBERT C. SMITH, New Hampshire	HAMILTON FISH, Jr., New York

STEPHEN A. QUICK, *Executive Director*
RICHARD F KAUFMAN, *General Counsel*
EDWARD W. GILLESPIE, *Minority Staff Director*

SUBCOMMITTEE ON EDUCATION AND HEALTH

SENATE	HOUSE OF REPRESENTATIVES
LLOYD BENTSEN, Texas	JAMES H. SCHEUER, Maryland, *Chairman*
JEFF BINGAMAN, New Mexico	OLYMPIA J. SNOWE, Maine
ALBERT GORE, Jr., Tennessee	HAMILTON FISH, Jr., New York
ROBERT C. SMITH, New Hampshire	

CONTENTS

WITNESSES, STATEMENTS, AND SUBMISSIONS FOR THE RECORD

WEDNESDAY, OCTOBER 2, 1991

WEDNESDAY, OCTOBER 16, 1991

WEDNESDAY, OCTOBER 30, 1991

MONDAY, DECEMBER 9, 1991

HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS: CURRENT REFORM PROPOSALS

WEDNESDAY, OCTOBER 2, 1991

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:30 a.m., in room 2359, Rayburn House Office Building, Honorable James H. Scheuer (chairman of the Subcommittee) presiding.

Present: Representatives Scheuer, Mfume, Armey and Snowe.

Also present: David Podoff, Teresa Sewell and Charla Worsham, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

REPRESENTATIVE SCHEUER. This hearing of the Subcommittee on Education and Health of the Joint Economic Committee will come to order.

This morning we are going to commence a crucial series of hearings entitled "Health Care Reform: How to Push Less Paper and Treat More Patients."

A couple of years ago, we had nine days of hearings on how we could get our health-care system under control in the sense that health-care costs were increasing more rapidly than the increase in the Consumer Price Index.

The question then and now is: How do we get this galloping cost of inflation in the health-care system under some kind of control?

In the best of all worlds, we could keep paying these exponential increases. In the real world of today, we know we cannot. We know there are limits. We know we operate within parameters.

If we are talking about the health-care system, monies that we waste in the health-care system are denying us precious dollars that we could very well spend elsewhere within the health-care system. Beyond that, we could spend precious dollars improving our educational system, improving our infrastructure, improving our environmental quality programs.

There is an infinite variety of things that we can do with monies. A dollar wasted is one dollar less to spend on very valuable and desperately underfinanced programs.

The current series is a logical extension of the comprehensive set of hearings that I chaired in 1988 on, "The Future of Health Care in America."

In a report entitled "Medical Alert," I summarized some of the major themes that emerged from those hearings, and I just want to read one brief quote:

> Overhauling the health-care system by significantly modifying the existing system in the short run and by ultimately providing national health insurance will not only rationalize health care delivery, but will also save billions of dollars....

The need for reform was transparently clear three years ago; the passage of time has only increased that sense of urgency and confidence in the sense of "doability" that many of us feel.

The United States has the world's most chaotic, expensive, disorganized, wasteful, and bloated health-care system in the world. I know from reading your testimony that the data on health-care spending and outcomes are all too familiar to the witnesses who will appear before this Subcommittee during this set of hearings. But the numbers are so astonishing that they bear repeating over and over and over again.

I believe that the American public is far ahead of the Congress in their feeling of urgency that the time for health-care reform has come, and they are an infinity ahead of the President and the Administration.

So, it is really up to the Congress to take the lead in the absence of any leadership whatsoever from the White House. To do this, the Congress needs encouragement and a little bit of goading from time-to-time from the people. So, let me get on with it.

Figures for 1990, just released last month by the Organization for Economic Cooperation and Development (OECD), tell the story.

In 1990 the United States spent 12.4 percent of its Gross Domestic Product (GDP) on health care, compared to an average of 7.6 percent for the 23 other OECD countries. Imagine, if you take that 12.4 percent, we spend over 50 percent more, and we get far less in terms of health results.

Canada, France and Germany spend 8 to 9 percent. Japan spends only 6.5 percent. Even more astonishing is the fact that for the last 10 years, the average for the OECD countries has increased only slightly, from 7.1 to 7.6 percent of GDP, just a half a point; while in the United States, the share of GDP devoted to health care has increased by one-third, from 9.3 percent to 12.4 percent of GDP— that is, 3 percent of our GDP that could be applied to other things.

You know, when you have a $6 trillion economy, that is $180 billion, which is about what our health-care system wastes that we could be spending on other things; that we could be spending on a failed education system.

Now, I would like to say to my friend Dick Armey, I do not believe that we can solve our educational problems, nor do you, by throwing money at them; but, surely, spending more money is part of the equation. And a longer school year, and a longer school day, and improved pay for teachers, and smaller classrooms, and remedial instructions for kids with reading problems are all part of an overall solution, Dick.

There are lots of other things we have to do that do not cost money. We can restructure the American educational system, and we should, but more money is part of the equation.

We are not rich enough to continue pouring about $200 billion down the rat hole. There was a time in our history when we could say: We can do everything. Now, we know that is not true. We cannot do everything. For us to be wasting the kind of money that we are talking about wasting in pushing paper is immoral and, in my view, absolutely indefensible.

We have 37 million people who are excluded from health care totally. They do not have access to the system through health insurance. Are they really excluded from health care? Of course not. Instead of having a well thought-through, simple, cost-effective system to which they have logical access to health care, we say, no, you cannot come in; but there is the emergency room at the local tertiary hospital, why don't you go over there?

So, we have our emergency room systems all across the country that are marvels of high-tech, both in the technology and in the quality of training and professionalism of the people who are qualified to take care of trauma, automobile accident wounds, shootings, stabbings, and heart failure. And what happens, we clog up our emergency room with kids with runny noses, with colic, with intestinal problems; so that people who come in on a really urgent mission with desperate needs cannot wade their way through the crowds of people who are using the emergency rooms of our hospitals as their family doctor. Now, if that makes economic sense, if that is a cost-effective way of treating 37 million people in America, I will eat my congressional hat. [Laughter.]

Recently, attention has focused on the huge differences in expenditures for administrative costs in the multipayer U.S. system, involving more than 1,500 payers stumbling all over themselves, advertising, promoting their wares at millions and millions of dollars of expense that ultimately falls on the American health consumer, compared to the single-payer system in Canada, where nobody has to buy radio, television, and newspapers ads in promoting health insurance. It is a universal system involving all Canadians. It is a comprehensive system involving all needed and necessary kinds of health care. That is a moral and an ethical system, as well as being a cost-effective system.

Study after study has documented the fact that in our country we waste tens of billions of dollars each and every year on paper-pushing activities that do absolutely nothing to improve health.

The GAO says that if we went to a single-payer system we would save $67 billion. In a recent article in the prestigious *New England Journal of*

Medicine, there are estimates by two very prestigious doctors, Drs. Himmelstein and Woolhandler, that the figure in the next couple of years is going to be up to $135 billion a year that we are wasting! I mean, that is a mind-boggling figure. The interesting thing is that for the $135 billion we are wasting we could pay the cost of going into a national health program. I think Judy Feder could testify to this; were you not Executive Secretary of the Pepper Commission?

Ms. FEDER. Yes.

REPRESENTATIVE SCHEUER. Well, the Pepper Commission documented that it would cost us approximately $60 or $65 billion to go into a national health program—a universal, comprehensive health-care program. Is that right, Ms. Feder?

Ms. FEDER. The new public costs were estimated in excess of $200 billion, but if you are talking about the Pepper Commission's own recommendation for health care and long-term care, those were in the neighborhood.

REPRESENTATIVE SCHEUER. All right. You brought me down a peg or two, and maybe I should not be winging it. Please correct me when your time comes, okay? [Laughter.]

In detail. The program that Senator Pepper and his colleagues recommended cost about $60 or $65 billion.

Ms. FEDER. That is correct, both for health care and long-term care.

REPRESENTATIVE SCHEUER. Yes. Well, I consider long-term care, health care.

Ms. FEDER. Absolutely.

REPRESENTATIVE SCHEUER. The seniors. You and I would both say that we are the only country in the civilized world—the industrialized world—that does not provide long-term care, and does not provide catastrophic care to seniors, as well as catastrophic care to everybody else; that does not provide first-class care from birth to 10 for our kids. We treat our kids from low-income families shamelessly, in my opinion, giving them third-world standards of health care, at best.

So, it seems to me that the time has come in our society to think long and hard about going to a single-payer system. There can be some reasonable discussion about what other things we should do, such as in what kind of fashion should we face up to the problem of malpractice, and the $10 or $15 or $20 billion a year that that costs us.

There are other elements of the system that could use close attention; for example, outcomes' research. But the fact that we could save anywhere from $67 billion, which GAO talks about, to $130 billion, which Drs. Woolhandler and Himmelstein talk about, is a riveting fact. It is an organizing fact.

It defines our society as having a pot of gold out there—anywhere from $65 to $130 billions of dollars of savings—that could be reallocated to patient care. We can retrain most of those people who are involved in shuffling papers to providing health care; they should not be unemployed.

They should still be employed in the health-care system. Virtually, all of them are educated, literate, talented people who could be involved in treating and counseling patients.

So, we are talking about stopping using people's valuable time in shuffling paper, and taking those same people and enabling and equipping them to provide health care and health-care counseling, and helping us move from a sick-care system into a preventive health-care system, where we teach people that they are responsible for their own health outputs.

It is more than 40 years since President Truman first proposed universal access to health care. The need for health-care reform is more stark and more clear and more urgent than it has ever been. The time for action is now.

[The written opening statement of Representative Scheuer follows.]

WRITTEN OPENING STATEMENT OF REPRESENTATIVE SCHEUER

Today we begin a crucial series of hearings entitled *Health Care Reform: How To Push Less Paper And Treat More Patients.* This series is a logical extension of the comprehensive set of hearings I chaired in 1988 on the *Future of Health Care in America.* In a report, entitled *Medical Alert,* I summarized some of the major themes that emerged from those hearings.

Let me read one brief quote. "Overhauling the health care system by significantly modifying the existing system in the short run and by ultimately providing national health insurance will not only rationalize health care delivery but will also save billions of dollars...."

The need for reform was clear three years ago; the passage of time has only increased the urgency.

The United States has the world's most chaotic, expensive, disorganized, wasteful and bloated health care system in the world. I know from reading your testimony that the data on health care spending and outcomes are all too familiar to the witnesses who will appear before this Subcommittee during this series of hearings. But the numbers are so astonishing that they bear repeating over and over.

Figures for 1990 released just last month by the Organization for Economic Cooperation and Development (OECD) tell the story. In 1990 the United States spent 12.4 percent of gross domestic product (GDP) on health care compared to an average of 7.6 percent for 23 of the OECD countries. Canada, France and Germany spend about 8-9 percent while Japan spends only about 6.5 percent. Even more astonishing is the fact that for the last 10 years the average for the OECD countries has increased only slightly — from 7.1 to 7.6 percent of GDP — while in the United States the share of GDP devoted to health care has increased by one-third — from 9.3 to 12.4 percent of GDP. Put another way, in other OECD countries increases in health care spending roughly match the growth in output. But in the United States, the growth in health care spending substantially exceeds the growth in output.

With the highest per-capita income, and a greater share of that high income devoted to health care, the comparisons on a per-capita basis are staggering. The United States spends over $2500 per-capita on health care compared to $1800 in Canada, $1300-1500 in Germany, France, Norway, and Sweden and only $1100 in Japan.

These comparisons might seem benign if there was clear evidence that we were getting something for this lavish spending. Instead the contrary seems to be true. Universal access to health care is assured in all OECD countries except in the United States where 37 million citizens have no health insurance coverage. We rank 24th in the industrialized world with respect to infant mortality and 18th with respect to life expectancy.

There are many reasons for the incongruence between lavish spending on health care in the United States and poor outcomes with respect to general measures of health status. Recently, attention has focused on huge differences in expenditures for administrative costs in the multi-payer U.S. system, compared with those in the single payer Canadian system. Study after study has documented the fact that we waste billions of dollars each and every year on paper pushing activities that do absolutely nothing to improve our health.

Congress's General Accounting Office, after a thorough review of the single payer system in Canada, concluded that the adoption of a single payer system in the United States potentially could save $67 billion—more than enough money in today's economy to provide quality health care for the uninsured and for the underinsured. Furthermore, the GAO notes that a Canadian style single payer system, with global budgeting and negotiated fee schedules, "could constrain the future growth of U.S. health spending leading to substantial further cost savings."

And based on their recent study in the *New England Journal of Medicine*, Drs. Woolhandler and Himmelstein estimate potential savings in 1991, from adopting a single payer system, to be $136 billion.

The Congressional Budget Office is also developing estimates of the administrative savings that could be obtained if we adopted a single payer system. In recent testimony before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, CBO Director Reischauer indicated that the savings from a single payer plan, now being analyzed by CBO, could be as much as $56 billion.

In two weeks, at the second hearing in this series, we will review (and perhaps refine) these estimates with a panel of insurance executives and actuaries. (This hearing, originally planned for September 25, has been rescheduled for Wednesday October 16.) For today's hearing, I pose a challenge to our distinguished witnesses as they propose alternative paths to health care reform. Whatever the benefits to consumers of a "pay or play" system or private individually purchased insurance, the question is: Are these benefits worth the enormous waste that the current multi-payer system, with 1500 insurance companies, now generates? And, given the potential to save enormous amounts of money under a single payers system, shouldn't we make every attempt to overcome the political and budget obstacles to a single payer system?

The time for reforming our health care system is now. I am a proud co-sponsor of H.R. 1300 the Universal Health Care Act of 1991 introduced by Congressman Russo. The legislation provides for universal access through a simple single payer system. There is a pot of gold out there in the single payer system. This pot of gold will allow us to provide quality health care for all Americans without increasing the amount of money our Nation now spends on health care. I know some dispute our ability to accomplish this objective. I am eager to hear from our witnesses their thoughts on how we should respond to the challenge that the American people have laid at our Congressional doorstep: Design a plan that provides affordable, quality health care for all our citizens.

Proponents of a system of reform that perpetuates our current chaotic pluralistic health care system must justify spending scarce resources on pushing paper rather than treating patients and answer the following questions:

1) Are the benefits of pluralism so great that we are willing to spend $50 to $100 billion on pushing paper, rather than on pre-natal care for pregnant women?

2) Are the benefits of pluralism so great that we are willing to spend $50 to $100 billion on pushing paper, rather than on health care for children living in poverty?

3) Are the benefits of pluralism so great that we are willing to spend $50 to $100 billion on pushing paper, rather than on health care for 37 million persons who have no health insurance?

4) Are the benefits of pluralism so great that we are willing to spend $50 to $100 billion on pushing paper, rather than on health care for employed workers who forgo preventive care, not covered by the company insurance policy, so that their children can get needed dental care?

5) Are the benefits of pluralism so great that we are willing to spend $50 to $100 billion on pushing paper, rather than on long-term care or catastrophic coverage for our senior citizens?

The burden of proof is on those who are prepared to accept a health care system that wastes billions of dollars.

An overhaul of the health care system will, in the final analysis, make our economy more productive. In the short-run, total spending and total employment in the health care industry will be unchanged, but the spending and employment will be reallocated to more productive uses. Workers will be liberated from pushing

paper, and therefore, better able to treat patients—the insured and underinsured—who will rightly now demand greater access to health care.

Doctors will spend less time explaining a complicated bill to frail elderly people, and more time treating them.

Nurses will spend less time filling out medical coding forms, needed as input for billing insurance companies, and more time caring for patients in hospitals and nursing homes.

Computer technicians will spend less time designing programs that track complicated billing procedures for doctors and hospitals, and more time designing procedures that improve our ability to interpret complicated diagnostic tests.

It is more than 40 years since President Truman first proposed universal access to health care. The need for health care reform was clear 40 years ago; the passage of time has only increased the urgency.

The time for action is now!

REPRESENTATIVE SCHEUER. Now, I am happy to yield to my colleague for so much time as he may need.

Congressman Dick Cheney.

REPRESENTATIVE ARMEY. "Dick Armey."

REPRESENTATIVE SCHEUER. Dick Armey, excuse me. [Laughter.]

REPRESENTATIVE ARMEY. I know Dick Cheney would feel complimented. [Laughter.]

OPENING STATEMENT OF REPRESENTATIVE ARMEY

REPRESENTATIVE ARMEY. Thank you, Mr. Chairman.

Let me welcome the panel today.

I think this is going to be a very important discussion. I am supposed to be simultaneously attending two committees. I hope to stay in this one, and intend to stay until the pressure from the other requires me to leave. So, let me quickly make my opening statement and get to the panel.

With close to 35 million Americans without health insurance, and our health expenditures accounting for 11.2 percent of GNP, it is not hard to see that our Nation's health-care system is in need of repair.

However, reforming our health-care system, either incrementally or in the form of a major overhaul, will have significant economic consequences in the long term, providing greater access to health care while also maintaining affordability will not be easy.

Reform proposals include social insurance programs that are based on the Canadian system—employer mandates requiring all employers to provide health insurance—and consumer-based systems that would change the tax treatment of health care. It is only logical that a reform proposal address the cause of the problem and not the symptoms. It is imperative that a reform proposal first ask the important question: What is driving up the cost of health care?

One of the major reasons for the increase in our Nation's health-care costs is the lack of a free market in the health-care industry. Government intervention into the health insurance market has reduced the cost of insurance below true market prices for some. Private insurers have compensated by raising the cost above market prices for others. The third-party payer system also contributes to the rising cost of health care by not allowing the consumer to be an active participant in the health-care insurance market.

Several other reasons, including the increases in state mandates, medical liability, technological advancements, and an increase in catastrophic illnesses, all contribute to the escalating cost of our Nation's health care.

The United States has the best health care in the world, with technologies and training far superior to that in any other country.

The balance between access, quality, and affordability must be carefully examined. We cannot adopt a plan that would sacrifice quality for the sake of access to all, nor can we adopt a plan that would hinder access for the sake of affordability.

I look forward to hearing from the witnesses as they help us arrive at some solutions.

I would like to make two heart-felt observations. One, it is my sincere belief that you do not even begin to resolve this dilemma unless you begin with medical malpractice tort reform.

REPRESENTATIVE SCHEUER. I agree.

REPRESENTATIVE ARMEY. The fact of the matter is that our health-care dollars cannot be expected to continue to support two professions——

MR. MARMOR. Politicians and medical care?

REPRESENTATIVE ARMEY. I am sorry?

REPRESENTATIVE SCHEUER. Three professions. [Laughter.]

REPRESENTATIVE ARMEY. I have not seen any evidence that lawyers are good for anybody's health.

[A chorus of boo's.]

[Laughter.]

REPRESENTATIVE ARMEY. Please forgive me if I betray a bias.

Mr. Chairman, are you a lawyer?

REPRESENTATIVE SCHEUER. I certainly am.

REPRESENTATIVE ARMEY. Well, there you go.

REPRESENTATIVE SCHEUER. And I agree with everything that you have said about lawyers. [Laughter.]

REPRESENTATIVE ARMEY. One last thing, if I may speak for just a moment on behalf of the beleaguered taxpayer—the compassionate and beleaguered taxpayer——

REPRESENTATIVE SCHEUER. I am also a taxpayer. [Laughter.]

REPRESENTATIVE ARMEY. I read my payroll stub yesterday and was struck by the fact that I pay, on my payroll stub, $81 a month for insurance for myself, my wife, and my one remaining dependent child—people I know and love. I pay $151 a month for insurance for people I do not even know. That, quite frankly, is a very generous contribution on my part in the Medicare-Medicaid allotment assessment made against me.

Frankly, since I am sacrificing nearly twice as much of my hard-earned dollars to provide coverage for others in addition to my family, I would like to have a confidence that the value for my dollar that accrues to those anonymous "others" is at least equal to the value for my dollar that accrues to the people in my family for the $81. I frankly do not have that confidence, and it is upsetting to me as a taxpayer.

Thank you.

Thank you, Mr. Chairman.

REPRESENTATIVE SCHEUER. I thank my colleague for a compelling and rational statement.

We will now hear from the distinguished group of witnesses on our first panel. Our first panel is composed of scholars who have analyzed alternative approaches to health-care reform. For this panel, I am pleased to welcome Ted Marmor, John Goodman, Judy Feder, and John Holahan.

We will take the witnesses from my left to my right.

First is Ted Marmor, Professor of Public Policy and Management, School of Organization and Management; and Professor of Political Science, Yale University. He has written widely on health and social security and has been a member of many commissions and panels that consider health-care and other public-policy options.

I am going to ask all the witnesses to restrict themselves to 8 or 10 minutes, to give the highlights of your testimony. I say to all of you, your prepared testimony will be printed in full at the point in which you testify.

So, Dr. Marmor, please take your 8 or 10 minutes, and relax, and just assume that we are all sitting around the living room, and give us the highlights of your testimony.

STATEMENT OF THEODORE R. MARMOR, PROFESSOR OF PUBLIC POLICY AND MANAGEMENT AND POLITICAL SCIENCE, YALE UNIVERSITY

MR. MARMOR. I was wondering at 5:30 this morning, as I got up to go to the plane, as to what sense it made to come to Washington, D.C., to talk in 1991 about a subject that has been with us for four-fifths of this Century. But I came because I respect this body, and I particularly respect you, Congressman Scheuer, for organizing in 1988 what was surely the most intellectually serious set of hearings on health care in the United States in the 1980s.

What I hope to do in my testimony is to engage two kinds of questions.

One is a question that people can reasonably disagree about, but on which there is factual material that at least falls on one side or another of a truth line. Then, to separate that from judgments, guesses, hints, hunches, about what will and will not fly politically in the United States—not that that cannot be analytically discussed. But I think the confusion between claims made about how systems operate and judgments made about who will support what, the conflation of those two muddles a lot of commentary on——

REPRESENTATIVE SCHEUER. Will the witness yield there? A lot of people say that Congressmen are overpaid. We make $125,000 a year. What we are supposed to do is make tough decisions. I really resent it sometimes when academics and health-care experts tell us up here what is politically doable or not doable. I think the role of academics is to tell us what ought to be, and then let us—Dick Armey, myself, and 433 other members of Congress—earn our pay by making the tough political decisions as to what will fly and what will not fly.

Now, having said that, you have been around the track so long, Professor Marmor, that I would be interested in making an exclusion to that rule. [Laughter.]

So, please proceed.

MR. MARMOR. The reason I introduced that is——

REPRESENTATIVE SCHEUER. But I expect Dick Armey to earn his pay, and I know he expects me to earn my pay by, to some extent, discounting the doubters among you, the professionals in health care, and the professional academics who say this is not doable; this is not practical.

Please, let Dick Armey and me decide what is practical and doable.

Okay, please proceed.

MR. MARMOR. Okay.

REPRESENTATIVE SCHEUER. And ignore everything that I have just said. [Laughter.]

MR. MARMOR. It is hard to ignore what you say.

The first point I want to make—in highlighting what is in my testimony—is that I regard the widespread judgment that we are in a crisis in medical care and something must be done as a misleading sign of great agreement.

Now, this is not necessarily what other people believe. I do not believe that there is anything like a deep consensus about American medical care. I think that there is a superficial consensus about American medical care. Because if you explore what people mean by the principles—problems about which there is critical difficulty—you will discover that they have very different emphases about what they think should be attacked first.

So, the incantation, for example, of 12.2 percent of GNP, or a $700 billion industry, does not in fact reflect agreement on what the problems are, priorities among them, or agreement on the shape of programmatic reform. That is why I entitle the first part of my testimony, "The risks of apparent consensus and premature compromise."

The second point I want to make is that, in the search for a workable policy reform, these differences among people and the priorities they have, their judgments about political support and their estimates of the consequences of various reforms, there is just tremendous disagreement. This is reflected in the wide range of proposals that are before the Congress now.

If you look back over the last 50 or 60 years, there is really an unbelievably recurring pattern of these proposals. There is very little new under the sun in my judgment.

Indeed, the book that Judy Feder, John Holahan, and I edited a decade ago, if you read the introduction, you are struck by the similarities of disputes that took place in the 1970s and those that are now taking place.

But what I want to emphasize is that four political constraints—four features of our political life—limit what we talk about analytically as options for health- care reform.

One feature is that our political system fragments discussion all over the map. We have an extraordinary number of different jurisdictions. We have an extraordinary fragmentation, both federally and nationally, and that means there are lots of players and voices.

The second constraint that I think is important is that judgments about American political beliefs—how much we are for or against government—often lead to premature closure on alternatives. We are ambivalent

about government, not "for" or "against" it. We are sometimes for it, as we were in the 1930s and part of the 1960s, and we are oftentimes very worried about it, as in parts of the 1980s. But the judgment that Americans have a stable set of beliefs about public authority is just false on the facts. It is not true.

There is ambivalence about government, and there is ambivalence about the market. There is plenty of evidence to support that view.

The third political constraint that I think is terribly important in this area is that the failures in American medical care, their failings, as well as their strengths, now reflect extraordinary amounts of political money. The $700 billion industry generates an enormous amount of political funds, as you well know. That has the effect of truncating a lot of discussion by generating propagandistic attacks on almost anything that is proposed, whether it is the Heritage Foundation's tax credits on the one side or, on the other side, German, or Canadian, or single-payer schemes. That leads me to say the following. If you want to get analytical, scholarly claims presented for and against, or about single-payer, you have to get through a fog of myth, misunderstanding, and mistakes.

Let me just turn to what I would say about single-payers as an analyst, not as an advocate. I can speak as an advocate, too, but for the moment I want to try to speak only as someone who can back up each proposition about single-payers with, if not determinative facts, at least, supportive facts that do not make it just a rash claim.

The first thing to be said about single-payer as an idea—I think this may seem odd to you, Congressman Scheuer, and maybe to you, Congressman Armey, as well—actually, single-payer is not a very illuminating or clear-cut concept. It refers to lots of different species under its rubric.

I think it would be fair to say that what single-payer proposals have in common is the belief that financial and political accountability for the operation of medical care should be concentrated. It ought to be in one clear unit; there ought to be a spigot through which the financing goes. That is roughly what it means.

The fact is that the concept can be applied all the way from the 10 Canadian provinces, which share the financing with the Federal Government, to the German system, which is a scheme of decentralized, in effect, HMOs, organized occupationally, to the British Cabinet system in which there is one Ministry of Health. It is a wide-ranging system that shares one property.

For a defined jurisdiction, there is one source of financial and political authority. So, you can have 10 provinces under their plan who use the same concepts to apply to the single, unitary British one. So, that is one.

The second point I want to make about single-payer is, it looks as if from the international experience what makes single-payer—what is correlated with single-payer schemes—not causally, but what is correlated with them is systems that group together people in the same boat, have clear political and financial concentration, and have very widespread

benefits as a feature of it. All three of those go together. It is hard to separate out what is contributed by single-payer because those three are co-joined, as you would understand from your own work.

It looks as if the following is true in comparative experience. All of the OECD nations, many of whom have what you might call single-payer schemes, experience rapid growth in medical-care expenditures in the post-war period, and especially in the 1960s and through the first half of the 1970s. All of the OECD data supports that.

It looks, as well, as if all of the other OECD Nations except the United States was capable between 1975 and 1985 to change the upward spiral of medical costs, not to tame them, but to lower the rate of increases, and, in some cases, to actually reverse it. That is what the analysis shows. The Poullier documentation from OECD supports that. The work on Sweden, West Germany, and Canada supports that, as well as the work on Australia.

What does that mean in the United States? What I think it means in the United States is that we ought to have a serious and thoughtful debate about the gains and losses associated with a single-payer, all-inclusive scheme of the kind that you have discussed. On the other extreme, we ought to have a serious debate about what would be required to make a market operate in medical care? That is, what would really be involved in having out-of-pocket costs be the rationer of it.

The probabilities of getting to either one need to be estimated. And I think if you did that, you would see two things. You would see that the tax credit—the so-called promarket interpretation of American medicine—is actually identical to the single-payer, left-of-center interpretation.

There is agreement on the diagnosis of what is wrong, and differences on both the form and desirability of particular remedies. There's no disagreement on the diagnosis.

I think what you find in the middle is something fascinating. It is fascinating to me as a political scientist.

I have professional schizophrenia. I am interested in what should happen, as well as professionally committed to understanding what does happen.

If you look and ask yourself analytically, not in terms of prejudging, or mocking, or criticizing, or celebrating, what it is that most of the Congress has spent most of the last six months talking about—the so-called pay-or-play alternatives, which I think Judy and John will probably represent later—what is striking about all of those plans is that very few of their advocates say that that is what they would really like. But all of their advocates say that is what they think, in the American political context, is a doable step in the right direction. So, you join both an estimate of support with a second- or third-best alternative.

My concerns about that set of schemes are two-fold. One, I am concerned about the reliability of the judgments concerning the levels of support. My own view is close to yours, Congressman Scheuer. I think

the public is far ahead of the Congress in this regard. I think that there is plenty of polling evidence to show it.

I would just call your attention to the facts here, to a recent—and when I talk about "recent," I am talking about yesterday—*Health Management Quarterly* document that shows unequivocally, if you ask Americans what their views are and then compare them with those of 10 other countries, their basic value orientation toward medical care is not identical, but so close as to make them birds of a feather that fly together. Now, that does not determine anything.

American politics is not just a funnel that takes people's beliefs and shoots them into the political system and produces legislation at the end. But I think it has been 20 years and a lot of research too late to continue to claim, as many people do in this industry, exactly what Americans will and will not support, because, in fact, the American public in this area is quite permissive with respect to national health insurance.

Where they are very concerned is whether they get value for money, and they are very ambivalent about whether they can expect it from the government or from the private-health insurance industry.

Well, those are the sorts of things I have raised in my testimony.

The only thing I would add—if it is all right for me to add just one point—is that the end part of my testimony is different from anything I have ever done in the U.S. Congress. I want to try to explain it, or at least to bring it up for discussion. I asked in the closing part of my testimony what it is about the single-payer systems that seems to produce comparatively greater energy, which is directed toward an overall restraint on rising health-care expenditures?

I am not interested, now, in the fact that it does; I am just stipulating that it does.

I am interested in explaining the political economy that produces it, because I find all too much of the discussion of single-payer treats it as if it is a Deus ex machina that comes in and produces the results by some kind of magic. Why should it? What about it?

Here is the claim, and you know it from the testimony, but I want to just raise it. What I suggest is that promarket advocates and single-payer advocates share an understanding of inflation control.

In the case of single-payers, the major organized forces to restrain medical expenditures are the losers to relative medical inflation in other parts of the government. Let's just take a concrete example.

In every province in Canada, in every part of Great Britain, in every part of Australia—and particularly you see it clearly in Australia and Canada and the provinces—if medical-care expenses rise at twice the rate of tax revenues, the losers are every other government department who cannot do what they want us to do.

The opportunity costs you talk about are the other side of it. The opportunity costs are experienced by those departments. So, that means you have political constituencies that do not need to mobilize every time to deal with the claims of medical inflation. The analogue in the case of

the promarket advocate wants individuals to do it, in which the costs and the benefits are weighed by individuals. I am just suggesting that you have a collective analogue to the weighing of costs and benefits in the form of cabinet departments that pay opportunity costs. That is, it seems to me, the central mechanism.

Let me make one more related point. It is fascinating to look at places like Sweden, which are single payers, which means that every county government pays for almost all of the medical care, but they are interesting in this regard. They do not have other organized, departmental constituencies at the county level. These single-payers do not have this other feature because all the county government pays for is medical care. It is a little like education boards that have their own tax source.

Now, what happens in those systems, it takes longer to mobilize anti-inflationary forces because it takes time to mobilize the taxpaying public in an area like medical care, where so many people believe more is better ... and I am not going to go into that question for the moment.

I am simply saying that political architecture, the political economic structure of representation of interests is terribly important in understanding single-payer schemes, and it is important not to confuse the mechanical feature—one-payer—with the political dynamic that it produces in this system restraint. I believe a more useful way of thinking about the dynamics is to take into account those who bear the opportunity costs, and how hard it is for them to organize and express themselves.

The related point is that if you have well-organized, anti-inflationary constituencies, as you do in these other regimes, it is always possible to cut back the benefit program, as well as to cut back the rate of inflation. That is, you can always shift costs backwards onto the patients, sideways onto other payers, or actually reduce the benefits, which is another way of shifting it backwards onto patients.

What is striking about all the universal schemes is that, because everybody is in the same boat, any effort to shift costs produces a political avalanche in opposition, and we will see that happening in the next year or so in Canada, where their fiscal strain is producing yet another round of efforts to shift costs backwards through cost-sharing; to shift it sideways by having private expenditure. And what the answer to that is that most of the Canadian health economists and policy analysts that I've talked with say, let's not fool each other; if you pull the money out of two pockets, you are still poorer by the amount you pull out in total, as opposed to if you pull out of one pocket. You do not gain anything by taking $10, dividing it up into $5 and $5, and adding one in each pocket. You delude yourself if you think that if you spend $6 public dollars and $6 private dollars that you have not spent $12 of social dollars, that could have gone to something else.

I think I have gone past my time.

I thank you for the indulgence that the red light did not produce any rays in my direction, and I think, unless you stop me, I will stop right there, Congressman Scheuer and Congressman Armey.

[The prepared statement of Mr. Marmor follows.]

PREPARED STATEMENT OF THEODORE R. MARMOR

The Future of American Medical Care Reform

1. *The Risks of Apparent Consensus and Premature Compromise*

American medical care, the media tells us regularly, is in serious trouble. Costs are too high, access and quality too variable. Indeed, there is relentless incantation about our $700 billion plus medical industry, consuming over 12 percent of our GNP, while failing to insure some 37 million Americans and leaving most of us one illness or one job change away from being medically uninsurable. These alarming numbers, moreover, emanate from all parts of the political spectrum. Most 'liberal' commentators would accept the pro-market Heritage Foundation's declaration that "America's health care system is on the critical list and needs intensive care."

It is not clear, however, that the extraordinary agreement on these ills — across party, occupation, income, region,and age — will produce effective policy reform. For while this consensus permits (and may indeed generate) reform, it does not guarantee any particular remedy. Moreover, the remedies most widely discussed as probable are likely to reflect as much the current constraints on political action as the critical needs for health care improvement. Those constraints are of at least three types:

First, our political system alone makes the process of legislative change difficult. It is designed for delay, not action—as every civics book explains. It is also characterized by myriad and conflicting governments (federal, state, and local) and an abundance of policy entrepreneurs. The standard result is many proposals and no agreement on which to enact.

Second, what our institutions make difficult our ideological predilections make even more so. Historically, Americans have been ambivalent about government, turning towards it in dire need (the Depression, world wars) and spurning it in times of greed (the 1920s, the 1980s). For two decades, as our recent book on America's Misunderstood Welfare State shows, the nation's most prominent leaders have stressed government's liabilities, not its capacities. The media has amplified the mocking and one result has been continued erosion of American confidence that its public institutions can right the obvious wrongs of American life. The further result is that reformers in a problem area like health care are powerfully constrained in what they can propose without unleashing propagandistic attacks.

Consider the following. Right-wing public relations and polling experts have already told the health industry what they would do if a Presidential candidate forthrightly advocated a national health insurance plan modelled on the *more successful* Australian, Canadian, or West German examples. "If you like the post office," they would say, "you'd love national health insurance." Another version of the same theme would claim that "if you think the Pentagon's $700 toilet seat is wasteful, wait until you see government health insurance." The same propagandists, one is assured, would go on to all manner of false and frightening images of 'government medicine': Canadians dying while waiting for emergency care, West Germans tied up in bureaucratic messes, never mind the socialistic excesses of the Australians 'down under.' With the S&L scandal fresh in the minds of our politicians, no wonder few have responded by reminding Americans that our Federal Reserve system is corruption free or that our Social Security Administration regularly gets its job done with admirable reliability, accuracy, and efficiency. Avoiding the label of socialized medicine,

genuflecting towards the "private provision of care" and rhetorically conceding that cost-sharing and competition may be part of the medical care answer — these are the misleading liturgies our contemporary ideological climate now practically forces on cautious reformers.

Finally, interests (and interest groups) further restrict our political maneuverability. America cannot finance medical reforms with "tax" dollars without the prospect of anti-tax dismay. This constraint —popularly identified with Ronald Reagan—is now embedded in the conventional wisdom of political reporting. It means that finding fig leaves—like patient charges and mandated health insurance coverage— to hide the tax implications of universal health insurance is a fulltime occupation for many policy technocrats in Washington and the state houses. A related constriction affects how private health insurers are treated in most reform proposals. Maintaining jobs in that industry — despite its widespread unpopularity among our citizens — appears necessary if one is to avoid the unleashing of well-financed campaigns against Washington bureaucrats seeking to limit the supposedly desirable "pluralism" in the way Americans pay for their health care.

2. *The Search for a Workable Reform Policy*

What does the combination of agreed-upon medical ills and these political constraints produce? So far, disappointing results. The most widely discussed reform proposals—advanced mostly by Democratic congressional leaders—combine bold rhetoric with timid policy. These plans would "mandate" health coverage by requiring every business to either provide insurance for each of its employees or pay a premium into a public

fund (which would also cover Medicare and Medicaid recipients). The schemes all have different monikers — Senator Mitchell's "Health America" is the perhaps the best known — but "play or pay" is the general descriptive slogan. They all seek to avoid the appearance of taxation, the fiscal necessity of a single-payor for care, and the clear statement that governmental health insurance — not shoring up a failing private insurance system — is required. Yet it is these plans that have attracted the most attention in the past year, just when universal health insurance has finally arrived at the top of the domestic political agenda.

Any of these reform proposals—if enacted— is likely to produce very unsatisfactory results. "Play or pay" is a misleading financial and athletic metaphor that confuses as much as it clarifies. Offering employers a choice of whether to use private or public plans ensures that the residual governmental program will attract the worst risks and hence incur the highest per capita costs. So implementing such programs would lead not to stability, but a sharp division between the more "expensive" government program and the less "expensive" private ones. And despite all the talk about "mandatory cost controls," continuing to use our present insurance apparatus would perpetuate the intrusive, complicated, and costly administration that so bedevils us.

Practically all the political leaders who have given us this problematic "play or pay" option are intelligent and well-intentioned. It is our institutional arrangements, our ideological inclinations, and the operation of political money and organizational self-interest—not stupidity or venality—that have convinced them that what is really desirable is not doable. But, if what is now doable is not desirable, we ought to be searching for better

combinations of policy designs and political feasibility. In my view, there are effective and acceptable alternatives available, if only our congressional leaders went beyond Washington's conventional conceptions of what is possible.

3. ***More Promising Proposals: Single-Payor Models***

Among the more effective reform proposals available, the most far-reaching are Canadian style national health insurance bills. Introduced by Illinois Congressman Marty Russo and Nebraska Senator Bob Kerrey among others, these universal, single-payor plans are, in the view of many politicians, too ambitious. But polling data suggests the critics are in fact too timid.

One 1990 survey of ten industrial nations, for example, found Americans the least satisfied with their health care arrangements. Only ten percent thought our system "works pretty well". Eighty-nine percent agreed it needs either "fundamental changes" or "complete rebuilding." The public—but not most of the special interest groups in medicine— seems prepared to accept big changes. More recent polls show unequivocally that the American social ethic is not very different from that of other industrial democracies with universal health insurance. As Taylor and Reinhardt note, fully 83 percent of Americans "believe that the government should be responsible for health care for the sick." [1] What these polling studies also show, however, is that Americans are ambivalent about whether governmental programs in health care can be administered without wasteful inefficiency.

Some Democratic candidates for President believe national health insurance will

---

[1] H.Taylor and W.E.Reinhardt, "Does the System Fit?", Health Management Quarterly, 3rd Quarter, 1991,p.5.

become a serious campaign issue. Variations on the theme of the Canadian single payor system have already been advanced by some of them. The race for the Presidency may therefore widen the debate over health care reform beyond the bounds imposed on it by Washington insiders.

Why is Canada's national health insurance (which they call "Medicare") so attractive to those advocating more far-reaching reform?

1. *Canada's economy, values and political institutions are similar to our own.* Like the United States, Canada is a large country with a highly urbanized and diversified market economy. Free enterprise and free spirits are valued. They have, like us, a federal system of government, with important powers (greater even than in the United States) reserved to provinces (the analogue to our states).

Every industrial nation in the world has adopted some form of national health insurance except the United States. All are happier with their health care systems than we are. If we are going to follow their example, it makes sense to look for models in those countries most like our own. An American system will have to be unique in many respects, but it would be foolish not to learn what we can from our neighbors.

2. *Canadian Medicare is responsive to local preferences and preserves freedom of choice while quaranteeing that every one has financial access to care without bureaucratic hassles.* Canadian Medicare is substantially financed and wholely administered by provincial governments. Provincial plans differ markedly from one another, reflecting local preferences. In fact, no province is required to provide health insurance benefits. It is the availability of federal matching funds (providing roughly 40 percent of provincial health care

budgets) that has led them to do so.)

The federal government does not prescribe the details of provincial health care plans. But it does require that they embody five principles to receive federal funding. They must be **universal** (covering all citizens), **comprehensive** (covering all necessary hospital and medical care), **accessible to all** (imposing no deductibles or co-payment obligations on individuals), **portable** (each province recognizing the other's coverage), and **publicly administered** (under control of a public, non-profit organization).

These principles are intelligible to all Canadians, and they enjoy broad support. Physicians work for themselves rather than the government, and full patient choice of physicians is preserved. Canadians can go to any doctor thay choose, as often as they and their doctor feel it is necessary. They never have to complete an insurance form for either hospital services or medical care. Physicians and hospitals never have to hound their patients for payment. There are no insurance claims adjusters looking over the shoulders of patients, and no "managed care" officials questioning individual treatment decisions.

Costs are contained through the provinces' control over aggregate budgets. If total billings by physicians exceed budgeted targets, physician fees are subsequently reduced. Hospitals (run by private not-for-profit organizations) operate on the basis of negotiated annual budgets rather than individual billings.

Budget negotiations between medical care providers and provincial health care administrators are periodic, noisy, contentious affairs — but unlike the negotiations of private insurance companies and providers of "managed care" in the United States, they are out in the open for the public to see and are subject to public influence through the political

process.

Provincial health administrators are constrained by the budget decisions of provincial parliaments. Hard decisions have to be made about how to allocate scarce dollars (e.g., do you fund more heart bypass operations or another well-baby clinic). Mistakes are made, but the provincial agencies are highly visible entities, accountable to the public for their decisions.

3. *Canadian Medicare has proved reasonably effective at controlling costs.* Before the introduction of universal health insurance in 1971, Canada financed its medical care the same way we did. They spent approximately the same percentage of their GNP on medical care as we did, and their costs were increasing at about the same rate as ours. Since then, Canada's health care expenditures—in relation to their national income— have somewhat flattened while ours have skyrocketed. Canada now spends thirty percent less of its GNP on medical care than we do, and the difference is growing.

4. *Canadian Medicare has met the test of public approval.*

In the ten-nation survey mentioned earlier, Canadians were the happiest with their health care system. Fifty-six percent reported overall satisfaction compared to our ten percent.

It would be foolish to ignore Canada's example, just as it would be foolish to try to replicate it in every detail. American problems require American solutions, but we don't have to reinvent the wheel. Canadian Medicare offers an attractive, practical model for dealing with our medical care woes, and many of our political leaders know it. To remedy our shortcomings we need more pressure from the public and less special interest group propaganda.

4. *The Political Economy of Single Payor Systems*

There is, however, a complexity here that we (like others) have not yet fully explored. Single-payor systems have, at least by comparison with the current non-system in the United States, produced relatively more restrained health care expenditures in the last fifteen years. But what about the single-payor structure is at work? Why should this cross-natrional result be the case? Without knowing that, there is too much of a black box quality about the explanation. We have discussed the results so to speak, but not the reasons.

This is, of course, a complicated subject in political economy and I can only sketch out what I take to be the outline of an answer.[2] But what I would emphasize is the distribution of the winners and losers from increases in health care expenditures. Everywhere among the industrial democracies, there are pressures to spend more on medical care; it is presumed, though with increasing expert dispute, that more medical care means better health. So the question is how expenditures for what is presumed social improvement are constrained? In pluralistic systems of finance, each payor is interested in her health costs, not the costs of health care. Any cost shifted represents a 100% gain to that payor; hence the competition in such systems to have someone else pay whenever possible. In the United States, that means attention to cost-sharing by patients (shifting costs backward), government requiring private insurance to pay Medicare benefits for certain retired workers (shifting costs sideways), and the reverse, as when companies reduce or eliminate their health benefits and turn employees into potential charity cases for local hospitals and doctors.

---

[2] This is the subject of an 1976 paper, "The Politics of Medical Inflation," in Marmor, Essays, op.cit.

Under such systems, total costs are reckoned at the end of the year, discovered, not chosen. The results are expensive, as the American experience testifies.

What are the implications of this analysis for understanding the Canadian (or other cross-national) experience with "centralized " funding? It appears there are two forces at work: competitors for the public dollars that might be available for medical care and politically powerful constraints on shifting costs back to patients. To have competition for the tax dollars collected, medical care must be administered by a general level of government with other responsibilities. It might be argued, for example, that the Swedish form of public funding was less constraining than either the English or the Canadian precisely because its county government has had medical care as its dominant responsibility and hence had few other organized, bureaucratic competitors for the income tax dollars raised by county councils for almost exclusively medical care purposes. Put another way, as the proportion of a jurisdiction's public expenditure going to health care approaches one, the restraint on costs will weaken. The grounds for this claim are that the political costs of mobilizing taxpayer restraint on valued services like medical care are higher than the costs of mobilizing restraint from other government departments who will suffer in their budgets if medical care expenditures rise more quickly than tax revenues.[3]

---

[3] This raises the question of functional substitutes for the constraining effects of cabinet competitors for public funds. In the German case, there is a clear presentation of costs and benefits to the bargainers representing sickness funds and professional association. The cost of care is identified clearly and yearly increases--and the immediate payment implications--produce the organizational incentives to weigh costs and gains that are comparable to the form discussed above. I want to make clear that the single payor of the Swedish model is not indifferent to cost; it just takes longer to organize the paying stakeholders. Recent Swedish restraint on their quite high health care expenditures is testimony to the capacity to act that exists when the will is mobilized. See the work by Poullier and Schieber on recent

54-863 O—92—2

This theory addresses as well the most obvious source of cost control relaxation in centralized schemes: increasing consumer cost-sharing as a revenue raising device. The Canadian example is quite telling on this point. The commitment to equal access has been strong enough to withstand the rather persistent efforts to introduce patient charges—or at least permit extra-billing—and that means the health professions face a unified consumer's cooperative in bargaining over what the health budget will be in any particular year. Provincial governments have been quite interested—from time to time—in off-loading this pressure onto patient charges. The Canada Health Act of 1984 reasserts the presumption against such practices and backs it up with financial penalties to provinces that allow extra-billing. Without the law's force, it is safe to say that Canadian physician expenditures would no doubt have grown more rapidly than they have through increased patient payments.[4]

Put together, this is a case for monopsony bargaining over the price and volume of health care in a political jurisdiction. It rests on the notion that, because every marginal dollar of expenditure for health care is income for identifiable and organized health care providers, the payor side must have correspondingly concentrated interest in those marginal dollars to balance those stake-holders who regard each unit of expenditure as benefit, not a

---

OECD cost developments in health care.

[4] There is an interesting Canadian feature here that helps to distinguish genuine cost control from cost shifting. The Canadian financial sanctions for extra-billing by physicians are simple: every dollar a province allows in extra-billing reduces the federal block grant by a dollar. If any of the provinces believed the physician contentions that patient cost-sharing would reduce needless and wasteful medical care at a rate where there was more than a dollar's reduction in care given for every dollar of penalty, they presumably would have permitted cost-sharing to continue. None have. Bob Evans made this nice point in a personal communication.

cost. The balancing of these interests does not mean health care expenditures will assume a particular level and stay there. But it does appear to provide the necessary conditions for establishing some equilibrium in expenditure levels. (Whether some system will emerge that can "harness" competitive forces to improve health care performance is at best speculative. What has emerged has not and Canada provides another illustration of the general type that throughout the industrial world has, in fact, restrained costs.)

The cost control question has been answered at the macro- level. At a micro-level, it involves the questions of medical care supply and payment details. The sharp increases in physician supply have everywhere strengthened the pressures for increased utilization and expenditures over recent decades. Other analysts have estimated that the Canadian physician supply has increased by over 70%, with the supply of physicians exceeding the growth in population by 2.3% per year. What is fascinating is that this rate of growth in physician numbers practically matches the increased per capita utilization of health care services over the same period.[5] I must warn that a belief in the restraining effect on expenditure of excess numbers of physicians is a very serious expensive mistake.

What about hospital bed supply? Here, the Canadian experience is best thought of in connection with more recent American experience. The trend line of length of stay is downward in both the United States and Canada. But it is clear that there are very substantial variations in length os stay and therein lies a clear lesson for others wondering about how much to augment the supply of hospitals in advance of expanding financial access

---

[5] See Woodward and Stoddart, "Is the Canadian Health Care System Suffering from Abuse?", CHEPA Working Paper Series #19 (Commentary), August 1989, McMaster University, Hamilton, Ontario, Canada L8N 3Z5, pgs.3-4.

to care. The relevant lesson seems something like this: the reduction of the supply of hospital beds may well be the single most important prod to primary and preventive care that lies within a nation's range of policy-relevant tools. How long one must stay in hospital varies not just with the relevant medical condition but the availability of alternatives to hospital use. This is relevant not only to the beginning of life—births—but to the treatment of the frail old. What Canada shows beyond doubt is that an ample supply of hospital beds, combined with increases in the old old, produces a substantial increase in the use of hospital beds for what is nursing home care. (Beyond that, there is simply wasteful use of amply supplied hospital beds: eg., patients coming in one or two days before surgery to "get ready.")

Thus, it is appropriate to consider the redistribution of health care supply across communities. Perhaps it is safe to say that the huge distances and spread out population of Canada do not present obvious parallels to the circumstances of other nations.

Turning to methods of payment for health care, the global (as opposed to line-item) budgeting of hospitals as against the per diem or method of insurance funding that had been the pre-NHI norm in the west has been strongly endorsed.[6] There are no panaceas here and each funding mechanism has the vices of its virtues. But among the virtues of global budgeting is ease in knowing what is committed to health care—particularly its most expensive component. Global budgeting in Canadian practice has involved a trade-off between the increased predictability (and controllability) of hospital spending and greater

---

[6] Robert G. Evans, The Canadian Health Care System: The Other Part of North America is Rather Different, A paper delivered to the International Symposium on Health Care Systems, Taipei, Taiwan, Republic of China, December 18-19, 1989.

autonomy of hospital decision-making about how to spend the global budget. There are ample means in the Canadian system to restrain capital expenditures (separately budgeted) and additional means through decisions on operating costs that will be included in the global amount. But analysts seem now to agree that Canadian use of hospital beds (as opposed to the technological use rates within hospitals) has been unnecessarily ample.[7] This is but one example that Canadian performance on health might be improved by less rather than more expenditure.

In sum the Canadian experience portrays a medical care system that works, that delivers decent care to an entire population at outlays that, while always pressuring decision-makers, are relatively stable and quite amazingly popular. If ever there was an example of a public institution that was both expensive and admired, it is Canadian national health insurance. None of these features depend on peculiarly Canadian values in politics, society, or economics. The particular institutional details do, of course, show their origins, but other nations could extract the essential features of the Canadian system and adapt them to their institutional architecture. Whether they would have similar effects depends on whether the new user differs in some significant way from those nations whose practices conform to the Canadian pattern as well.

We should by no means be oblivious to tensions and troubles within the Canadian system. But there are two areas where I think considerable amplification would be helpful to those unfamiliar with Canadian practices.

One is the degree of conflict which successful instances of centralized cost control

---

[7] Evans op cit, page 10.

experience on a regular basis. To the degree single-payor cost control "works", it is disappointing to the aspirations of health professionals; they, in turn, can reach out to publics for support in making sure that the restraints in cost do not "lower" the quality of care. The fights over this—and issues like "abuse" by patients or doctors—make the regular determination of hospital budgets and, especially, doctors' fees very contentious matters. It is of the greatest importance to anticipate such contentiousness and, within the limits set by the budgetary restraint goals themselves, to design formats, select negotiators, and employ modes of public explanation that do not worsen the pain which such struggles cause. This is not the place to say much more about the subject, but it is worthwhile, I believe, to give it pride of place in planning.

A second area is the legal liability environment and its impact on patterns of utilization. This was not an issue of any great moment when I began to study Canadian health arrangements in the early 1970s. The price per physician of malpractice insurance was, by American standards, incredibly modest. But, as has been argued in connection with alleged "abuses" through unnecessary testing and procedural elaboration, defensive medicine may well have something to do with the relentless increases in per capita utilization that Canada has experienced over the past two decades.[8] Some of it, undoubtedly, arises from physician-induced demand, itself a product of increased physician numbers, tough bargaining on fee schedules, and the income aspirations of doctors who can feel with some justification that more elaborate care is what their patients "want." (as against need) But some of the utilization pattern is consistent as well with substantial increases in legal liability. That too

---

[8] Woodward and Stoddart, op cit.

REPRESENTATIVE SCHEUER. I will not stop you from stopping right there. Thank you for your, as always, provocative and stimulating testimony, Professor Marmor.

Now, we will hear from John Goodman, President of the National Center for Policy Analysis. Mr. Goodman is also author of numerous books and articles in the area of social security and health.

Please proceed, Mr. Goodman.

STATEMENT OF JOHN C. GOODMAN, PRESIDENT NATIONAL CENTER FOR POLICY ANALYSIS

MR. GOODMAN. Thank you, Mr. Chairman, Congressman Armey.

I would like to begin by discussing the problem of rising health-care costs.

In my judgment, there is no mystery why health-care costs are rising. Most of the time, when we enter the medical marketplace, we are spending someone else's money rather than our own money.

If I have a blank check drawn on your checking account, there is almost no limit to how much of your money I can spend in the medical marketplace today, even if I am not sick. We could probably spend half of our gross national product just on diagnostic tests alone, and the other half on minor ailments without ever getting to anything serious.

There are 900 tests that can now be done on blood alone. They could become part of my annual checkup. I could also make an MRI and full-body scan part of my annual checkup. The opportunities to spend other people's money in this market are, again, almost unlimited.

This is also true in other countries. It is true in Canada. It is true in Britain. What other countries have done is limit the money that doctors and hospitals have to spend, and ordered the health-care bureaucracy to ration health care. They frequently ask very few questions about how the health care is rationed.

In our country, operating through the private sector, there is nothing natural about what we are doing. It is the consequence of a tax system under which we give unlimited subsidies to third-party health insurance, and encourage first-dollar insurance for everything. Yet, we penalize people who want to self-insure for small medical bills.

If an average family in a city with average health-care costs in the United States raised the family deductible from $250 to $2,500, which seems like a high deductible, the premium savings would be about $1,750. The coverage it would give up, considering the co-payment in the standard policy, would only be $1,800. So, it is almost a wash. The family would save in premiums about what it gave up in coverage. The difference is that the family could take the premium savings, put it in the bank, and have control over that money rather than giving it to Blue Cross.

Our tax system encourages the family to give all that money to Blue Cross, because, if the employer pays the premium rather than paying

wages, that money avoids a 28 percent income tax, a 15 percent FICA payroll tax, and a 4, 5, or 6 percent state and local income tax, which means that the government is subsidizing about half the health-insurance premiums of many workers. On the other hand, if the family tries to take the higher deductible and put the savings in the bank, government takes taxes out first, leaving the family with half as much money.

The Congress should reform the tax law, and give just as much encouragement to self-insurance for small medical bills as it currently gives to third-party insurance. Families ought to have the opportunity to choose the higher deductibles and put the premium savings in medical savings accounts tax-free. These accounts should be able to grow tax-free, and we should begin to shift both power and money away from bureaucracies and institutions to individuals.

One thing is clear about the health-care marketplace today, large bureaucracies and institutions are not controlling costs, and I have no reason to believe that they will ever control costs, especially those costs connected with small medical bills.

Families, on the other hand, would have a direct financial self-interest in making sure they got value for money if they controlled the funds. That is the direction in which we need to go.

If the Rand studies are to be believed—and this is the most comprehensive study of health-care demand that we have ever had in this country—allowing families to do what I just described would cut health-care spending in this country by over $200 billion, roughly the figure you, Mr. Chairman, referred to earlier, with no apparent adverse effects on health.

But I guarantee you that if you set up a health-care bureaucracy, like Canada or Britain, and let them ration health care, there will be adverse effects on health, because the people who need care the most will not necessarily be the ones that get to the head of the rationing lines.

REPRESENTATIVE SCHEUER. Mr. Goodman, let me just interrupt you. I invite Congressman Armey to interrupt from time-to-time. We have just the two of us here, so we can afford to be informal.

Under the Canadian system, they do have negotiations that take place between the government and the hospitals, and the government and the doctors, the provincial government and the doctors and the hospitals, and that provides fairly stringent cost containment, as I understand it.

You can call it rationing. Perhaps, in the United States, with the larger infrastructure of high-tech care, we might do a little bit less of that, but is there not, in the Canadian system, a reasonably rational means of controlling costs through the negotiations that take place between the hospitals and provinces and the doctors and provinces?

MR. GOODMAN. I am not sure what you mean by the word "rational." There is nothing efficient about it. What is going on is that the hospital managers are given a fixed budget and implicitly told to ration health care.

Interestingly, the government asks very few questions about how the health care is rationed, but the technology is limited. It is restricted to hospitals. Unlike the United States, Canada greatly restricts outpatient surgery, for example.

The sophisticated technology is kept in central locations. It is especially bad for——

REPRESENTATIVE SCHEUER. Is that not reasonable? Is that not a way of rationalizing the provision of health care by having some kind of planning on these high-tech installations that cost $1 million or more—the CAT scans and so forth? Is it not rational to provide CAT scanners per 100,000 or per 1 million of population, rather than have every little, two-bit hospital vying for a CAT scanner—though it does not begin to have the patient population to support it—just as a matter of prestige, and pride, and turf?

MR. GOODMAN. Well, what is going on up there is not fair. Now, all the citizens of British Columbia pay the same tax rates. They all face the same tax rates regardless of where they live.

But all the sophisticated equipment tends to be concentrated in Vancouver and Victoria. If you live in any of the rural areas of British Columbia, you do not have immediate access to the specialists or to the sophisticated technology. So, what you have to do is to travel to the cities.

Unfortunately, there is rationing by waiting. So, the rural citizens all over British Columbia are discriminated against. There is a brand new study out of the University of British Columbia that actually asks the question: How often do rural patients actually see a specialist, compared to someone living in the two major cities. There is a 6 to 1 difference. And for some specialties, it is a 40 to 1 difference.

REPRESENTATIVE SCHEUER. How about in the United States? How do we treat rural patients compared to urban patients?

MR. GOODMAN. Poorly, but——

REPRESENTATIVE SCHEUER. As bad as in British Columbia?

MR. GOODMAN. I think not as bad as in British Columbia, because at least our rural citizens can take their own money, or Medicaid or Medicare money, and go buy health care in the cities. But you cannot do that in Canada. You cannot take your own money and buy health care in Canada. An American can. An American can go jump to the head of the waiting line in Canada, but Canadians cannot.

REPRESENTATIVE SCHEUER. Well, 90 percent of the population of Canada resides within 100 miles of the United States border or less. So, they can jump over the border, and a small number of them do.

Let me ask you about rationing, and then I really want you to complete your statement.

When you talk about rationing, there has to be some kind of health-care rationing. Every country does it. There is not a country on earth that

can afford to provide all of the benefits of modern, high-tech health care to all of its people.

We exclude 37 million people from health insurance entirely. We deny long-term care to seniors entirely. We deny catastrophic care to everybody, entirely. We deny adequate care for children in low-income families, from birth to age 10. Would you not characterize this as a sort of rationing?

MR. GOODMAN. We do ration health care in this country. We do not ration it as much, however, as it is rationed in other countries. What we tend to do more of than any other country is to make available to everybody the most sophisticated modern medical technology that the R&D people came up with.

REPRESENTATIVE SCHEUER. We do not do that for 37 million people who are outside of the system.

MR. GOODMAN. Well, as you pointed out, once they get into the emergency room, then, they have access to the equipment.

REPRESENTATIVE SCHEUER. I see Ted Marmor——

MR. MARMOR. Could I just introduce a factual point, just one factual point?

REPRESENTATIVE SCHEUER. Yes.

MR. MARMOR. I think it ought to be noted for the record that in visits per capita and in hospitals days per thousand that Canadian citizens use more medical care per year than the Americans do. Just as a factual matter, the claim that less care is available—I am not talking about the kind, now—visits per capita per year, and hospital days per thousand per year does not support the generalization that the United States does less rationing in general in medical care. Only on that narrow point.

REPRESENTATIVE SCHEUER. Okay. Mr. Goodman, let me ask you to finish your statement. I have interrupted it.

MR. GOODMAN. Okay, but I want to respond to this misleading interjection here.

REPRESENTATIVE SCHEUER. Okay, you can answer him, and then take a long cannon and finish your testimony.

MR. GOODMAN. What Canada does is the same thing Britain does, and you can see this across Europe. They put lots of money into general practitioner services and into the kinds of services that do not cost very much money. Then, they skimp on the CAT scanners and all the sophisticated equipment.

The hospital managers prefer to fill their beds with chronically ill, elderly patients, using the hospital as an expensive nursing home. One-fourth of all the beds in Canada are filled with nursing home patients. The same thing is true of Britain. The same thing is true of New Zealand. While you have thousands of people waiting for surgery, the acute patients are not getting the care that their doctors say they need.

Now, Mr. Chairman, the only other point that I want to make is, why are there from 30 to 37 million Americans without health insurance? I

want to point out two ways in which bad government policy has encouraged this result.

The first is the tax system. As I have already said, if you are an employee of a large company who gets employer-provided health insurance, you get generous tax subsidies, with government paying as much as half of the premium through the federal tax system. But if you are self-employed, or if you are unemployed, or your are an employee of a small business, you must pay taxes first and buy health insurance with what is left over. We are generously subsidizing the health insurance of many, many people in this country, and yet we penalize other people.

We are getting what we subsidize. Ninety percent of all the people in the country who get health insurance get it through an employer because that is what we are subsidizing. It would seem to me that equity, fairness——

REPRESENTATIVE SCHEUER. Well, are you not endorsing a single-payer system that is not employer-based? Are you not, by those very words, suggesting that we ought to have a universal, comprehensive health-care system that is not based on the employer?

MR. GOODMAN. No, I am not. What I am suggesting is simple equity in taxation. I am suggesting that people who are self-employed and unemployed, and employees of small business who do not get health insurance through an employer ought to get the same kind of tax advantage that other people get when they purchase health insurance.

REPRESENTATIVE SCHEUER. All right, look. I will take this matter up with you when we get to the discussion period. So, please, you have been very thoughtful and stimulating. Why don't you complete your statement, and then we will go on to Ms. Feder.

MR. GOODMAN. One last point. State regulations on mandated health-insurance benefits that now number close to 1000 cover everything from acupuncture to in vitro fertilization. Heart transplants are mandated in Georgia; liver transplants in Illinois; hair pieces in Minnesota; marriage counseling in California——

REPRESENTATIVE SCHEUER. Hair pieces?

MR. GOODMAN. Hair pieces for bald people are mandated in Minnesota. Deposits to a sperm bank are mandated in Massachusetts. There has been an explosion of these kinds of regulations. We estimate that as many as one out of every four people who lacks health insurance in the United States has been priced out of the market by these costly regulations.

These regulations do not apply to most Americans. Employees of self-insured companies are exempt, and that is half the American workers. Federal employees are exempt; Medicare patients are exempt. Most state governments exempt their own employees and Medicaid patients. Therefore, the regulations only apply to a small part of the whole market.

Who they apply to are the self-employed, the unemployed, and employees of small business, the most politically defenseless part of the

market—the very areas where we see a rising number of people who lack health insurance.

So, I would say that if we would simply adopt two principles we would go a long way toward getting everyone in the United States insured. One is equity in taxation. We all get the same tax benefit from government. And, two, we all ought to have the same opportunity under the law to buy no-frills health insurance.

REPRESENTATIVE SCHEUER. When you talk about equity in taxation, you remind me of the French philosopher—I forget which one it was, and I am sure Ted Marmor will remember who it was—who said that to provide equity in taxation and the availability of other good things in life, both the rich and the poor will have the right to sleep under bridges. Do you recall that?

MR. GOODMAN. That is not what I am advocating. What we have——

REPRESENTATIVE SCHEUER. A tax-based health insurance is, *ipso facto*, grossly unfair. It seems to me to achieve the very things that you are talking about—universality and comprehensiveness—we ought to forget basing health insurance on a tax system and just provide universal, comprehensive health care, and eliminate all that excess baggage—all that baloney involving 400,000 or 500,000 people in our country employed in the health-care system. Just wipe them out and retrain those people to use computers for devising health-care tests, instead of devising all kinds of sophisticated computer techniques for penetrating the paper maze.

REPRESENTATIVE ARMEY. Mr. Chairman?

REPRESENTATIVE SCHEUER. Yes.

REPRESENTATIVE ARMEY. I wonder if I could interject some thoughts here before the next witness?

REPRESENTATIVE SCHEUER. By all means. Yes.

REPRESENTATIVE ARMEY. Let me interject a thought on this question of fairness in taxation. I guess I should not have read my payroll stub yesterday. I mentioned the $151 that I paid buying insurance for other people. I do not think that it is particularly fair for me to be required by the law to count that as part of my gross income when I pay my income tax.

MR. MARMOR. You are talking about the Medicare-Social Security part of your payroll deduction?

REPRESENTATIVE ARMEY. Sure. I pay income tax on that, as well. But it is interesting because I do think that Mr. Goodman—and I wanted to explore that later with Mr. Goodman—this whole question of the way we treat either the expenditure for medical, or the receipt of benefits, perhaps, employer-provided, as taxable income, and do we, by taxation, provide incentive or disincentive. I think it is an important point.

I am going to ask those of you who are on the panel, I am just going to alert you to a data point that I am looking for. You may have it, and if you do, I will be coming back to it later.

We have a lot of information about the uninsured. I think one very important piece of information that perhaps one of you might have is something about the demographic breakdown with respect to age of the uninsured. I will come back to that point later, but if you do happen to have it, I will be looking for that information later.

MR. GOODMAN. They are mainly young. I think two-thirds are under the age of 30.

REPRESENTATIVE SCHEUER. 65 and over are usually covered by Medicare. So, it would be the younger ones.

REPRESENTATIVE ARMEY. Well, let me just let you all chew on that, because that is something that I think is very important.

REPRESENTATIVE SCHEUER. Have you finished your statement?

MR. GOODMAN. Because of your comment, I want to clarify what we are saying.

All during the last decade, while Congress has been talking about what ought to be done, we have allowed a disgraceful situation to occur under which we are heavily subsidizing the health insurance of high-income workers and penalizing low-income workers who are not in the same situation. And what I am saying by "equity" is that we believe that people with equal incomes ought to get the same tax subsidy, and lower income people ought to get more of a tax subsidy. So, fairness, it seems to me, would dictate high tax credits to the lowest income people, phased down for higher income people; and we ought to treat people with the same income in an equal, fair manner.

[The prepared statement of Mr. Goodman follows.]

PREPARED STATEMENT OF JOHN C. GOODMAN

Introduction

The National Center for Policy Analysis (NCPA) is a public policy research institute headquartered in Dallas, Texas. In 1990, the NCPA convened a health care task force with representatives from 40 think tanks and research institutes, including the Hoover Institution, the American Enterprise Institute, the Cato Institute and the Competitive Enterprise Institute.

The task force concluded that America's health care crisis is the direct result of bad government policies and that we cannot solve our problems unless we correct those policies. In what follows, I will focus on the two most important problems we currently face: rising health care costs and the rising number of people without health insurance.

Controlling Health Care Costs

Health care costs are rising in the United States for the same reason they are rising in every developed country: most of the time when we consume medical services we are spending someone else's money. Currently, about 95 percent of all hospital bills and more than 80 percent of physicians' fees are paid by private and public third-party payers. On the average, every time a patient spends a dollar in the medical marketplace, 76 cents is paid by someone else.

When health care is virtually "free," there is almost no limit to how much we can spend on it — even if we are not sick. In recognition of this fact, other countries have limited access to technology and forced hospitals and doctors to ration health care. In the United States, we are moving in the same direction, as third-party payers attempt to limit physician choice and hospital access, and increasingly dictate the practice of medicine and interfere in other ways with the doctor-patient relationship. Yet experience shows that no country has succeeded in controlling health care costs from the top down without severely reducing the quality of patient care.

If we want to solve the problem of rising cost without government rationing or a deterioration in the quality of health care, we must change those government policies which have created an institutionalized, bureaucratized medical marketplace and have impeded the development of a competitive market.

How the Tax Law Encourages Third-Party Insurance and Penalizes Individual Self-Insurance. One strange feature of the tax code is that a physician's fee paid by an employer (or an employer's insurance carrier) is paid with pretax dollars, whereas fees paid out-of-pocket by employees must be paid with aftertax dollars. As a result, the tax law encourages (subsidizes) 100 percent health insurance coverage (with no deductibles and no copayments) for all medical expenses.

Because wages are taxed and health insurance benefits are not, health insurance is more valuable to employees than additional wages. [See Table I.]

- For an employee in the 15 percent tax bracket (and facing a 15.3 percent FICA tax), federal tax law makes $1.44 of health insurance benefits equivalent to a dollar of take-home pay — because $1.44 in gross wages will be reduced by 44 cents in taxes.

- For an employee who is in the 28 percent bracket, $1.76 of health insurance benefits is equivalent to a dollar of take-home pay.

- For a higher-paid employee also facing a 6 percent state and local income tax rate, $1.97 of health insurance benefits is equivalent to a dollar of take-home pay.

TABLE I

Value of a Dollar of Employer-Provided Health Insurance

(Relative to Taxable Wages)

Federal Tax Category	No State and Local Income Tax	State and Local Income Tax
FICA Tax Only	$1.18	$1.241
FICA Tax Plus 15 percent Income Tax	1.44	1.562
FICA Tax Plus 28 percent Income Tax	1.76	1.972

Note: Table shows the amount of taxable wages that are equivalent to a dollar spent on an employee benefit.
[1]State and local income tax rate equals 4 percent.

[2]State and local income tax rate equals 6 percent.

These relationships can also be used to show how much waste can be present in the purchase of health insurance and still allow health insurance to be preferable to wages. [See Figure I.] For example, if an employer attempted to give the higher-paid employee $1.97 in wages, the employee's take-home pay would be only $1.00 after taxes are paid. As a result:

- For an employee with above-average income, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of gross wages.

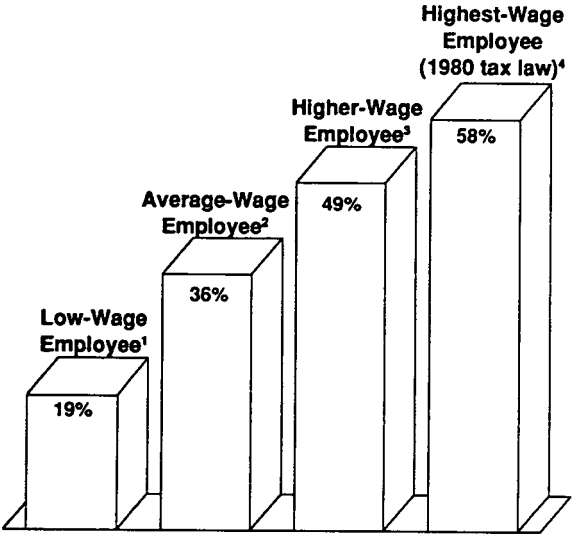
- Thus, 96 cents of $1.97 (or 49 percent of the premium) can represent pure waste and still leave health insurance preferable to wages for the employee.

[Insert Figure I]

Why Low-Deductible Health Insurance is Wasteful. Because employees (through their employers) are able to purchase health insurance with pretax dollars, but individuals are not allowed to self-insure (personal savings) for small medical expenses with pretax dollars,

FIGURE I

How Much Waste Can Be Present in Health Insurance and Still Leave Health Insurance as Valuable as Wages?



[1]Low-wage employee faces a 15 percent FICA tax and a 4 percent state and local income tax.

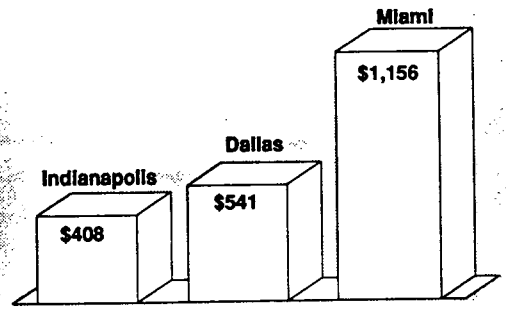
[2]Average-wage employee faces a 15 percent FICA tax, a 15 percent federal income tax and a 6 percent state and local income tax.

[3]Higher-wage employee faces a 15 percent FICA tax, a 28 percent federal income tax and a 6 percent state and local income tax.

[4]Employee faces a 50 percent federal income tax and an 8 percent state and local income tax.

FIGURE II

Annual Premium Savings If the Deductible is Increased From $250 to $1,000[1]

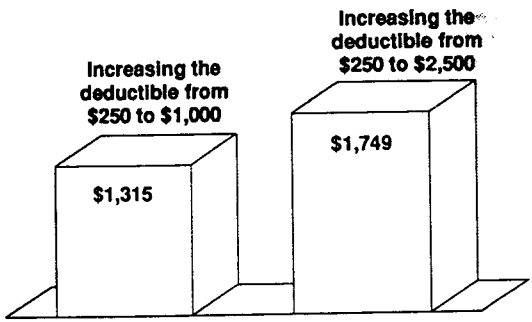


[1]Figures are for an individual policy for a male, age 40 in 1991. Because the policy has a 20 percent copayment, the increase in the deductible eliminates only $600 of health insurance coverage unless the policyholder has medical expenses in excess of $5,000.

Source: Golden Rule Insurance Company

FIGURE III

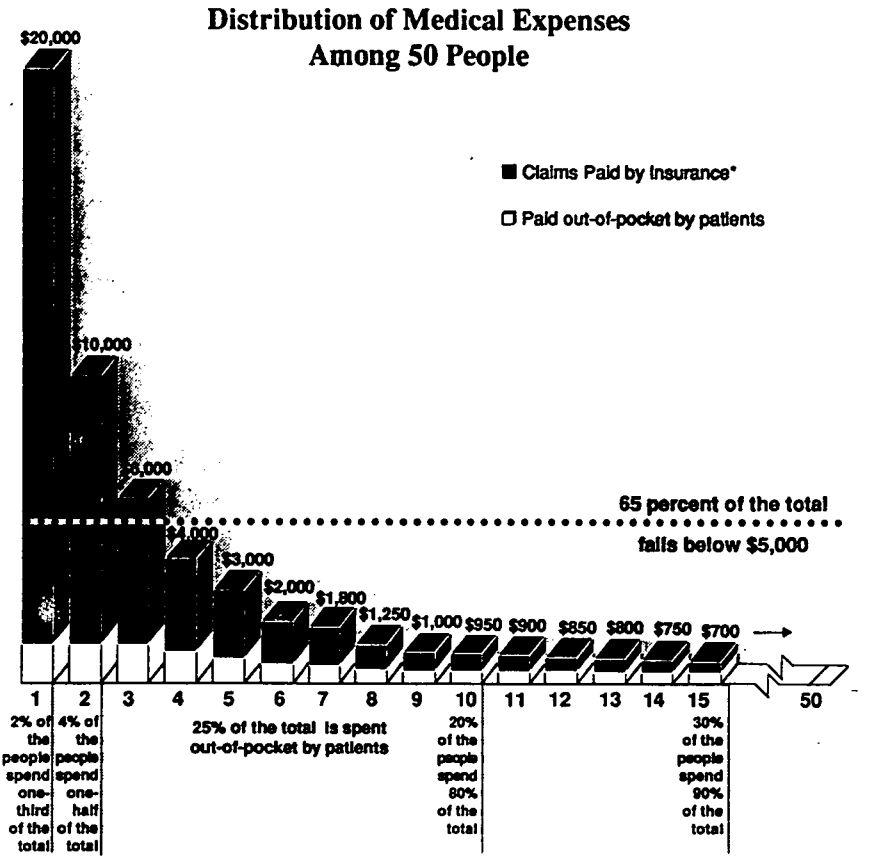
Annual Premium Savings From Higher Deductibles For Families in Cities With Average Health Care Costs[1]



[1]Figures are for two adults and two children in a city with average health care costs. For deductibles less than $2,500, policyholders face a 20 percent copayment up to $1,000. Unless policyholders have medical expenses of $5,000, they forego $600 of coverage by moving from a $250 deductible to a $1,000 deductible and $1,800 of coverage by moving from a $250 deductible to a $2,500 deductible.

Source: Golden Rule Insurance Company

FIGURE IV



Assumes a $250 deductible and a 20% copayment on the next $5,000 of expenses. Period of coverage is one year.

FIGURE V

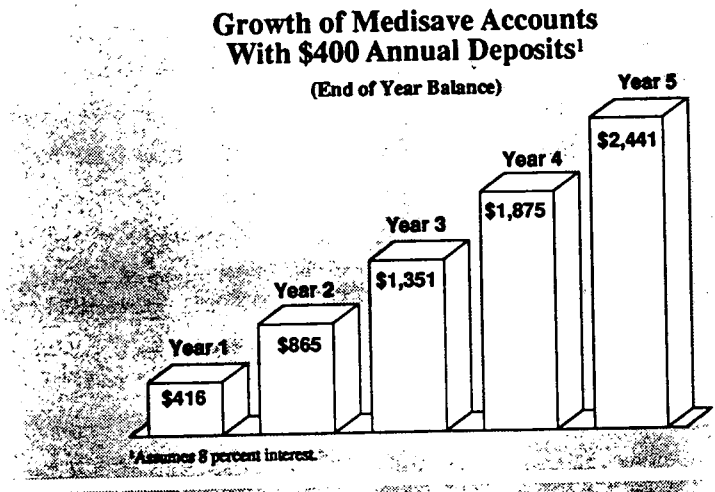
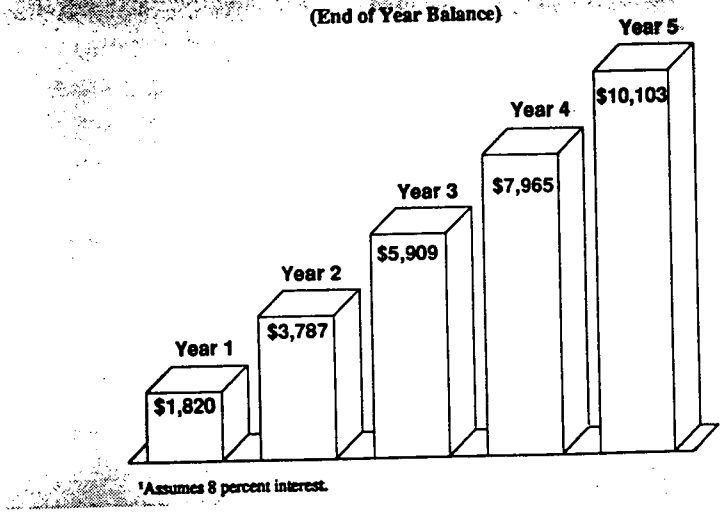


FIGURE VI



people often buy low-deductible health insurance and use insurers to pay for small medical bills. This practice is wasteful for two reasons.

First, when medical care is free at the point of consumption there is virtually no limit to how much we can consume of it. Medical science has identified 900 tests that can be done on blood. Except for the money and inconvenience, why not make all 900 part of our annual checkup? Similarly, an annual checkup could include a brain scan, a full body scan and numerous other tests — all of which are valuable even to people who appear healthy.

As an example of how the demand for the services of primary care physicians to treat minor ills could soar, consider that in any given year, Americans make about 472 million office visits to primary-care physicians. If only 2 percent of nonprescription drug consumers sought professional care rather than self-medicating, the number of patient visits would climb to 721 million, requiring a 50 percent increase in the number of primary-care physicians. If every person who now uses nonprescription drugs chose professional care over self-medication, we would need 25 times the current number of primary-care physicians.

Second, low-deductible insurance creates unnecessarily high administrative costs. Using insurers to pay small medical bills is comparable to using an insurance company to pay monthly utility bills. That might be convenient, but the convenience would be costly. Studies show that physicians spend an average of $8 for each insurance claim they submit. Most employers and insurance companies spend another $8 for every check they write. If the third-party payer investigates the legitimacy of a claim, a $25 physician's fee can easily generate another $25 in administrative costs — thus doubling the cost of medical care.

Allowing People to Self-Insure Through Medisave Accounts. Fortunately, there is a better way — one which has already been adopted in Singapore.

- Instead of having third parties pay for all medical bills, most bills could be paid by patients themselves — using health care debit cards to draw on funds in individual medical savings accounts.

- Instead of 100 percent reliance on third-party insurance, about half the nation's medical expenses could be covered by individual self-insurance.

- Instead of depending on health care bureaucracies to control costs, we could depend on the self-interest of individuals acting as prudent buyers in a competitive medical marketplace.

In substituting self-insurance for wasteful third-party insurance, people should have the opportunity to choose higher deductibles and to place the premium savings in individual medical savings accounts. Medisave accounts would grow tax free and could be used only to pay medical expenses. During retirement, Medisave balances could be used to pay medical expenses not paid by Medicare or rolled over into an individual's pension plan.

For individuals and families shopping for health insurance, high-deductible policies are often a much better buy even without the opportunity to establish a Medisave account:

- Increasing the deductible from $250 to $1,000 results in annual premium savings of $400 or more for a middle-aged male — a good deal even if he has a $1,000 medical expense every third year for the rest of his life. [See Figure II.]

[Insert Figure II]

- Increasing the deductible from $250 to $2,500 results in annual premium savings of about $1,750 on a family policy — which is about equal to the insurance coverage they would forego, considering the 20 percent copayment provision in most low-deductible policies. [See Figure III.]

[Insert Figure III]

Although the premium savings from higher deductibles tend to be smaller for group insurance, they are still substantial. Most companies could cut health insurance premiums by one-third by moving to a $2,500 deductible — even if employees' medical care consumption did not change. [See Figure IV.]

[Insert Figure IV]

Advantages of Medisave Accounts. If the tax law provided just as much encouragement for self-insurance through Medisave Accounts as it currently provides for third-party insurance, individual patients would assume increasing control over health care spending. If not spent, Medisave balances would grow over time — allowing individuals to rely even less on third-party payers. [See Figures V and VI.]

[Insert Figure V]

[Insert Figure VI]

If most medical expenses were paid by people using their own Medisave funds, patients would have a financial self-interest in eliminating waste and reducing costs in the medical marketplace. Patients would acquire greater control over how their health care dollars were spent. There would be far less interference in the doctor/patient relationship. And health insurance companies could specialize in what they do best: managing risks for rare, expensive, catastrophic medical events.

If all U.S. citizens had catastrophic health insurance for large medical bills and Medisave accounts for small medical bills, administrative costs and wasteful health care spending would be reduced significantly. Based on studies of patient behavior by the Rand Corporation and a study of administrative costs by the General Accounting Office (GAO), we conclude that:

- The widespread use of Medisave accounts would reduce the administrative costs of the U.S. health care system by about $33 billion.

- More prudent buying on the part of patients could reduce health care spending by an additional $207 billion.

- Overall, universal catastrophic health insurance combined with Medisave accounts could reduce total U.S. health care spending by as much as one-third.

Insuring the Uninsured

As many as 34 million people are believe to lack health insurance at any one, and federal and state policies deserve a large share of the blame for this development. To correct this problem we should (1) grant tax deductions (or tax credits) to people who purchase health insurance on their own, (2) make the tax subsidy more generous for lower-income families, (3) allow all individuals the opportunity to buy "no frills" health insurance and (4) reform employee benefits law in order to make it as easy as possible for small business to help employees obtain health insurance.

Equity in Taxation. The tax law gives employers and employees strong incentives to replace wages with nontaxable health insurance benefits. These incentives make the purchase of health insurance very attractive, even if it would not otherwise have been purchased. The total tax deduction for employer-provided health insurance is about $60 billion per year — roughly $600 for every American family. Yet most of the 34 million individuals who do not have health insurance (including about 16.7 million employees and their dependents), and about 12 percent of insured individuals who purchase health insurance on their own, have no opportunity to receive a tax subsidy. As a result some employees of large companies have lavish health insurance plans (all tax deductible) while other Americans have no tax-subsidized health insurance.

In general, the value of the right to exclude health insurance coverage from taxable wages ranges from about $1,200 per year in reduced taxes for an auto worker to about $300 for a worker in retail trade. Self-employed individuals are allowed to deduct only 25 percent of their health insurance premiums, and even this right has an uncertain future. Unemployed people and employees of firms which do not provide health insurance receive no tax subsidy for the health insurance they purchase.

Not surprisingly, people respond to these incentives. The more generous the tax subsidy, the more likely people are to have health insurance. Those most likely to be uninsured are people who receive no tax subsidy.

Equity in taxation requires that all Americans receive the same tax encouragement to purchase health insurance, regardless of employment. Accordingly, the self-employed, the unemployed and employees who purchase health insurance on their own should be entitled to a tax deduction or tax credit that is just as generous as the tax treatment they would have received if their policies had been provided by an employer.

Equal Tax Advantages for Families with Unequal Incomes. Under the current system, the ability to exclude employer-provided health insurance from taxable income is more valuable to people in higher tax brackets. Since the value of the tax subsidy rises with income, it is hardly surprising that the lower a family's income, the less likely the family is to have health insurance. About 92 percent of all people who lack health insurance have an annual income less than $25,000.

In order to give all people the same economic incentives to purchase health insurance, premiums paid by employers should be included in the gross wages of their employees, and all taxpayers should receive a tax credit equal to a percent (say, 30 percent) of the premium. This would make the tax subsidy for health insurance the same for all taxpayers with the same income, regardless of whether the policies are purchased individually or by employers. For low-income

families, the tax subsidy should be more substantial. For individuals who pay no federal income tax, the tax credit could be made refundable.

Creating Freedom of Choice in Health Insurance. A major reason why so many people lack health insurance is that state regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. In recent years there has been an explosion of state laws requiring health insurance policies to cover specific diseases and specific health care services. These laws are called mandated health insurance benefit laws.

In 1970, there were only 30 mandated health insurance benefits in the United States. Today there are more than 900. Mandated health insurance benefits cover ailments ranging from AIDS to alcoholism and drug abuse, and services ranging from acupuncture to *in vitro* fertilization. Mandated benefits cover everything from the life-prolonging procedures to purely cosmetic devices: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California and pastoral counseling in Vermont. These laws reflect the fact that special-interest groups now represent virtually every disease and disability and virtually every health care service. For example,

- Thirty-seven states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture and two states require coverage for naturopaths (who specialize in prescribing herbs).
- At least 13 states limit the ability of insurers to avoid covering people who have AIDS or a high risk of getting AIDS.
- Laws in 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction, and 30 states require coverage for mental illness.
- Five states even mandate coverage for *in vitro* fertilization.

Collectively, these mandates have added considerably to the cost of health insurance, and they prevent people from buying no-frills insurance at a reasonable price. As Table II shows, mandated coverage for substance abuse is very costly — increasing premium prices by 6 to 8 percent. Mandated coverage for outpatient mental health care is even more expensive — increasing premium prices by 10 to 13 percent. Psychiatric hospital care apparently has little effect on premium prices for the primary insured person. But if dependents are covered, premium prices can rise by as much as 21 percent.

These price increases are having an effect. According to the NCPA's own analysis, as many as one out of every four uninsured people lacks health insurance because state regulations have increased the price of insurance. This means that more than 8 million people lack health insurance because of current government policies. Employees of the federal government, Medicare enrollees and employees of self-insured companies are exempt from these costly regulations under federal law. Often, state governments exempt Medicaid patients and state employees. The full burden, therefore, falls on employees of small business, the self-employed and the unemployed — the groups which are increasingly uninsured.

Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This freedom is rapidly vanishing from the health insurance marketplace. Accordingly, insurers should be permitted under federal law to sell federally qualified health insurance both to individuals and to groups. This insurance would be free from state mandated benefits, state premium taxes and mandatory contributions to state risk pools.

TABLE II

Effects on Insurance Premiums of Specific Health Insurance Benefits

Feature	Change in Individual Premium	Change in Dependent's Premium
Home Health Care	+ 0.1 %*	- 5.0 %*
Extended Care	- 0.4 %*	- 5.1 %*
Substance Abuse Treatment	+ 7.9 %	+ 6.2 %
Psychiatric Hospital Care	- 1.7 %*	+ 20.8 %
Psychologists Visits	+ 10.4 %	+ 12.6 %
Routine Dental Care	+ 23.8 %	+ 11.8 %

* = not statistically significant

Source: Gail A. Jensen (University of Illinois at Chicago) and Michael A. Morrisey (University of Alabama at Birmingham), "The Premium Consequences of Group Health Insurance Provisions," September, 1988.

Giving Employers and Employees New Options For Cost Containment and Individual Freedom of Choice. Under current employee benefits law, employers have few opportunities to institute sound cost-containment practices without substantial income tax penalties, and employees have few opportunities to purchase less costly health insurance or policies tailored to individual and family needs.

To correct these problems, health insurance benefits should be personal and portable, with each employee free to choose an individual policy which would remain with the employee in case of a job change. Health insurance benefits should be included in the gross wages of employees who would be entitled to tax credits for premiums on their personal tax returns — so that employees reap the direct benefits of prudent choices and bear the direct costs of wasteful choices.

Suppose a small firm is considering purchasing an individual health insurance policy for each employee in order to take advantage of the favorable treatment of health insurance under the

tax law. As Table III shows, this firm will immediately confront four problems. The first problem is that the cost of the policy will vary depending on the age of the employee. (A 60-year-old male, for example, is about three times more expensive to insure than a 25-year-old male.) The obvious solution is to pay the premiums for the policies and reduce each worker's salary by the premium amount. The second problem is that not all employees may want health insurance (e.g., some may be covered by another policy). The obvious solution is to give health insurance only to those employees who want it, reducing the salary of each by the amount of the premium. The third problem is that some employees may have preexisting illnesses, and the insurer may want to insert exclusions and riders into their policies. The obvious solution is to get each employee the best possible deal. The fourth problem is that employees may have different preferences about the content of their policies. Some may want to trade off a higher deductible for a lower premium. Others may want coverage for different types of illnesses and medical services (e.g., infertility coverage). The obvious answer is to let each employee choose a policy best suited to the employee's needs and preferences.

TABLE III

Solving Health Insurance Problems For Employers and Employees

Problem	Solution
Employees have different preferences about health insurance coverage (deductibles, types of services covered, etc.)	**Allow each employee to choose a policy best suited to individual and family needs.**
Costs differ by age, sex, type of job and other employee characteristics.	**Reduce each employee's gross salary by the amount of that employee's premium.**
Not all employees want or need employer-provided coverage.	**Give health insurance only to employees who want it.**
Some employees have pre-existing illnesses.	**Negotiate the best coverage possible for each individual employee.**

NOTE: Each of these solutions requires changes in the tax law and in employee benefits law in order to avoid costly tax penalties.

Despite the fact that these solutions seem obvious and despite the fact that every single employee may gain from them, they are generally forbidden under federal law. In general, the tax law forbids employees from choosing between wages and health insurance and insists that all employees be offered the same coverage on the same terms.

The result is that the employer must turn to a more expensive group policy with a package of benefits that no single employee may want. To make matters worse, the employer is forced to adopt a health care plan in which benefits are individualized, but costs are collectivized. Although large employers have a few more options, they too are forced into a system which has two devastating defects.

First, under the current system there is no direct relationship between health insurance premium costs and individual employee wages. In many cases employees do not know what the premiums are. In those cases where they are made aware (e.g., when employees are asked to pay

part of the premium), each employee is charged the same premium — regardless of age, sex, place of work, type of work or any other factor that affects real premium costs. The upshot is that the individual employee sees no relationship between the cost of employer-provided health insurance and personal take-home pay. Small wonder that employees of large companies demand lavish health care benefits.

Second, there is no relationship between wasteful, imprudent health care purchases and salary under conventional employer health plans. Under most policies, it is as though the employee has a company credit card to take to the hospital equivalent of a shopping mall. The employee will find many interesting things to buy, all chargeable to the employer. Under this system, employees have no personal incentives to be careful, prudent buyers of health care.

In the face of constraints imposed by federal policy, employers are trying to hold down health care costs by taking actions that have very negative social consequences. Unable to adopt a sensible approach to employee health insurance, many large firms are asking employees to pay (with after-tax dollars) a larger share of the premium. Often employers will pay most of the premium for the employee, but ask employees to pay a much larger share for their dependents. These practices result in some employees' opting not to buy into an employer's group health insurance plan. More frequently, employees choose coverage for themselves but drop coverage for their dependents. Indeed, three million people who lack health insurance are dependents of employees who are themselves insured.

Because employee benefits law prevents smaller firms from adopting a sensible approach to employee health insurance, many are responding to rising health insurance premiums by canceling their group policy altogether. Often, employers will give bonuses or raises in an attempt to pass on to employees the gain from eliminating the health insurance benefit. Employees are then encouraged to purchase individual health insurance policies (with after-tax dollars) on their own. Many, of course, do not.

One of the great ironies of employee benefits law is that, although it was designed to encourage the purchase of health insurance, its more perverse provisions are increasing the number of people without health insurance. Because employers cannot individualize health insurance benefits, many are turning to other practices that are increasing the number of uninsured people.

To remedy these problems we recommend that: (1) health insurance benefits be made personal and portable; (2) health insurance premiums be included in the gross wage of employees with tax credits for those premiums allowed on individual tax returns; (3) individual employees be given the opportunity to choose between lower wages and more health insurance coverage (and vice versa); and (4) individual employees be given freedom of choice among all health insurance policies sold in the marketplace. These recommendations would have several advantages:

1. Rising health care costs would no longer be a problem for employers — health insurance premiums would be a direct substitute for wages.

2. Employees would have opportunities to choose lower-cost policies and higher take-home pay.

3. Employees would have the opportunity to select policies tailored to their individual and family needs.

4. Employees would be able to retain the tax advantages of the current system, but avoid the waste inherent in a system in which benefits are collectivized.

5. Employees would be able to continue coverage at actuarially fair prices if they quit work or switched jobs.

When there is a direct link between salary and health insurance premiums, employees will be more prudent about the policy they choose. For example, those who want policies with no deductibles and all the bells and whistles will pay the full premium cost in the form of a salary

reduction. Faced with this choice, employees are more likely to choose high-deductible, no-frills catastrophic coverage.

Why National Health Insurance Will Not Solve Our Health Care Problems

Countries with national health insurance make health care "free" to patients and at the same time limit health care spending and access to modern medical technology. As a result, there is widespread rationing, bureaucratic inefficiency and a lower quality of care.

Bias Against Modern Medical Technology. When health care dollars are allocated through the political sector, politicians soon discover than there is very little political payoff in spending money on exp ısive technology. Such spending helps only a small number of truly sick people (read: very few voters). The pressures instead are to spend on services that affect a large number of people (read: a large number of voters) even if the spending has only a marginal effect on health.

- A citizen of Canada is one-third as likely to have access to open heart surgery and one-eighth as likely to be able to obtain a brain scan as a citizen of the United States.

- England, the country which invented the CAT scanner and coinvented renal dialysis, has the fewest number of CAT scanners per person and one of the lowest dialysis rates in Europe.

Inequalities in Access to Health Care. Almost every developed country that has adopted national health insurance has pledged special efforts to create equal health care. And these commitments are periodically repeated in numerous public statements. Yet the rhetoric is very different from the reality.

54-863 O—92—3

- Despite 40 years of promises to create regional equity, Britain spends least on hospital services in those areas which are most underserved.

- Despite 40 years of promises to create equality of access to health care, spending per person varies by a factor of two to one across the regions of New Zealand and the number of surgeries performed varies by more than six to one.

- Despite 20 years of promises in Canada, the distribution of physicians per capita among the provinces varies by almost three to one and within Ontario by a factor of more than four to one.

Canadian provincial governments restrict modern medical technology to hospitals, usually in large cities, and actively discourage outpatient surgery. Rural residents must travel to the cities for the services of most specialists and for most surgical procedures. But considering the inconvenience of travel and the fact that specialized services are rationed by waiting, how often do rural residents actually get care? According to a study at the University of British Columbia:

- People living in British Columbia's two largest cities (Vancouver and Victoria) receive 55 percent more specialists' services per capita than rural residents, and for specific specialities the discrepancies are even greater.

- On the average, urban residents are 5 1/2 times more likely to receive services from a thoracic surgeon, 3 1/2 times more likely to receive the services of a psychiatrist and about 2 1/2 times more likely to receive services from a dermatologist, an anesthesiologist or a plastic surgeon.

If the health care resources available to people in Vancouver and Victoria are compared to those in specific rural areas (rather than to the rural average), the inequalities are even more extreme:

- Total per capita spending on physicians' services among British Columbia's 30 regional hospital districts varies by a factor of six to one, and spending on the services of specialists varies by a factor of 12 to 1.

- Spending varies by a factor of almost 6 to 1 for obstetrical/gynecological (OB/GYN) services, 15 to 1 for the services of internists and 40 to 1 for the services of psychiatrists.

Inefficiencies in Hospital Management. Despite many recent claims, there is little evidence of efficiency in countries with national health insurance. While people wait for months and even years for hospital admission, hospital managers appear uninterested in admitting more patients.

- While 50,000 people wait for surgery in New Zealand, at any point in time one in five hospital beds is empty and one in four is occupied by a chronically ill patient using the hospital as an expensive nursing home.

- While 800,000 people wait for surgery in Britain, at any point in time about one-fifth of all beds are empty and another one-fourth are being used by nursing home patients.

- As the hospital waiting lines continue to grow in every Canadian province for every type of surgery, at any time almost one in five hospital beds is empty and a fourth of all beds is being used by nursing home patients.

Victims of Rationing. Health care rationing almost always creates the greatest burdens for the poor, the elderly, minorities and residents of rural areas. The wealthy, the powerful and the sophisticated almost always find ways of moving to the head of the waiting line. And despite claims that care is available regardless of ability to pay, financial means is increasingly becoming essential to speedy, reliable health care.

- Although health care is theoretically free to all in Britain, 12 percent of the population now has purchased private health insurance.

- Although health care is theoretically free to all in New Zealand, one-third of the population has private health insurance and one-fourth of all surgery is performed in private hospitals.

- As Canadian waiting lists for surgery grow, an increasing number of Canadians are coming to the United States for health care, and a small private market is developing for outpatient surgery.

The lessons from other countries teach that America would not be well-served by an expansion of government bureaucracy or by any greater government control over the U.S. health care system. Instead, what is needed is to limit the role of government and allow the private sector new opportunities to solve our health care problems.

REPRESENTATIVE SCHEUER. Well, you raise a lot of interesting points, and we will get to the discussion period. I appreciate your testimony, Mr. Goodman.

Okay, now let us hear from Judy Feder, Co-Director of the Center for Health Policy Studies in the Department of Community and Family Medicine at Georgetown University School of Medicine.

Ms. Feder is a former staff director of the Pepper Commission, and she has written widely on matters of health care and public policy.

Ms. Feder, please proceed.

STATEMENT OF JUDITH FEDER, CO-DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Ms. FEDER. Thank you, Mr. Chairman.

Let me just first, if I could, shed a little light on a data point. I think it is accurate to say that, although I would want to check my figures, about 30 percent of the uninsured are children under the age of 18.

My recollection is that about half that are under the age of 25. But if you look at population groups at large and the risk of uninsurance, you find that the greatest likelihood, or the largest proportions without insurance, occur in the 18- to 24-year-old age group. If you have a dependent, or otherwise know about how that age group tends to think that they are invincible, and that they are often in low-wage jobs, it is understandable why that population group is particularly likely to be without insurance.

Now, I'll turn to the Pepper Commission's pay-or-play recommendations that you had asked me to testify on. In light of your earlier comment, Mr. Chairman, I want to indicate that I am going to describe the pay-or-play system—its rationale, the essential elements, and its likely impact—not simply as an academic or, perhaps, less as an academic, which I also am, but based on my perspective as the staff director of the Pepper Commission.

I think that you will acknowledge the legitimacy of my, then, presenting a political perspective, because, as you know, that Commission was a congressional commission made up of 12 members of Congress and three Presidential appointees; and the recommendations of that Commission were developed in an explicitly political process.

What that meant was that the members of the Pepper Commission looked not only at the kind of health-care system that they wanted to have, but they paid a great deal of attention about how to get from where we now are, which nobody is happy with, to the system they wanted. There is a great deal of focus on how to get from here to there. That is the essence, I think, of the rationale behind the Pepper Commission recommendations.

In the course of its deliberations, the Commission came to three fundamental conclusions, looking again at both what they wanted and how to get to what they wanted.

First, when they looked at the proposals that many made to patch the health-care system, with improvements in the Medicaid system, improvements in the tax structure, or improvements in insurance operations, they rejected those as likely to be totally inadequate in achieving what was a fundamental goal: health-care coverage for all Americans.

The estimates were that even substantial expansions of Medicaid and tax credits would leave about half the currently uninsured still uninsured. In addition, the Commission members were concerned that the cost of those expansions would largely be borne by the taxpayer—the compassionate and burdened taxpayer—rather than by the employers of many of the uninsured who could bear those expenses, if they, like most employers, were to provide coverage to their workers. On coverage and financing grounds, they therefore rejected that approach.

They also concluded that replacing the current system, which is a combination of public and employer-based coverage, with a government-run national health-insurance system would shift too many people and too many dollars—disrupting the majority of Americans to solve a problem that is most acute for, though not limited to, a minority— to achieve the political support that they believed is essential to reform.

This was, in essence, a political judgment that most Americans, seeking health-care reform, want assurance that they can keep their coverage where they have it rather than being shifted to an alternative system.

Furthermore, the members of this Commission believed that to have taxpayers bear the well over $200 billion in new public costs—though not new social costs—as government were to absorb payments now borne in the private sector, was both fiscally and politically unwise.

It was these judgments that led to the Commission's final and most fundamental conclusion that to get us from here to there, health-care reform can neither patch nor replace the current combination of public and employer-based coverage. Rather, it has to build that coverage into a true system that covers all Americans and operates effectively in its public and private components alike.

Now, let me give you the essential elements of that system.

First, under a pay-or-play approach, all workers and their nonworking dependents would be guaranteed health-care coverage through their jobs, just as they are guaranteed a decent minimum wage and participation in Social Security.

It is important to remember that two-thirds to three-quarters of the uninsured have jobs or are in families of workers. Extending coverage to all workers, therefore, takes us a long way toward universal coverage.

Second, they felt it was government's job to guarantee employers access to affordable health-care coverage for their workers. Most

important in providing this guarantee was to give employers a choice. This is where the pay-or-play language comes from in this system.

Employers could either play—that is, purchase insurance in the private sector, as most do now—or they would pay; that is, contribute to a public plan that would cover their workers.

The price for coverage in the public plan was set as a share of payroll for the explicit purpose of capping the financial obligations of insuring workers, particularly in firms paying moderate or low wages.

The third piece of the pay-or-play system is that the government takes responsibility for insuring nonworkers by extending the same public plan that would be available to employers for their employees, if they so chose it, to all Americans not covered through the work place.

The public plan would provide the same minimum standard of coverage that employers are required to provide, and would pay providers according to Medicare rules, eliminating the underpayment that has become endemic in the Medicaid welfare-based system. Those are the key elements of coverage.

Now, let me talk about the impacts of the pay-or-play system. The challenge facing a pay-or-play system or, indeed, any health-care reform proposal is to truly address the problems that it aims to solve.

First and foremost in this regard, pay-or-play would achieve and guarantee health-care coverage to all Americans, either through the public or private system.

Second and equally important, the pay-or-play system has the potential to contain costs and promote efficiency in the health-care system.

The cost issue, as you have been indicating, has two components: levels or rates of increase in health-care spending and administrative costs.

First, on the levels for rates of increase in health-care spending—as Ted Marmor has already indicated—international experience tells us that the key to control of a nation's health-care cost is not to have one single payer or one insurer for all Americans, as is done in the Canadian system where it is the government; rather, it is to have a single set of rules for payment regardless of the number of payers, a system that applies in Germany, as he was indicating.

The newest pay-or-play proposals introduced as legislation in both the House and the Senate incorporate these kinds of recommendations, essentially demonstrating that establishment of an effective system for cost containment is as compatible with a pay-or-play system as it is with a full government approach to health-care reform.

Pay-or-play can also achieve substantial administrative savings over the current system. Although administrative costs to large employers for their health insurance can be as low as for government programs, there is significant and undisputed administrative waste in the small group insurance market, particularly as insurers invest enormous amounts in making certain that they are insuring the healthy and avoiding the sick.

Pay-or-play proposal recommendations for underwriting reforms, consolidation of small insurers, use of a uniform claims form, and greater

reliance on electronic data processing can unquestionably reduce the administrative expenses that our current system now faces.

Although a system that must manage portability of benefits between jobs, and between jobs and government programs, will inevitably cost more to administer than any single-payer program, the fact is that many of the administrative savings we seek can be achieved in this system.

So, in conclusion, let me say that not only does the pay-or-play approach redress the egregious flaws in our current health-care system, it does so in a way that can assuage rather than arouse the fears of well-insured Americans who will inevitably be asked to pay the taxes to support it.

By retaining the employer-based coverage approach, this ensures them the coverage they now have. It does not ask them to give it up for something else.

By sharing costs among employers and government, it keeps new public costs—which must be raised through taxes—and new taxes within reasonable bounds. And, finally, once private insurance and the new public coverage are fully reformed and in place, it provides the flexibility for future policy to move toward a more public or private system, as experience and preference dictate.

In short, the recommendations of the Pepper Commission, and the subsequent legislation that has been based upon it, represent not only a system but a strategy for achieving health-care reform, and I commend it to you on both counts.

[The prepared statement of Ms. Feder follows.]

PREPARED STATEMENT OF JUDITH FEDER

Mr. Chairman, members of the Committee, I appreciate the opportunity to testify before you today on the health care reform proposals that have come to be called "pay or play," an approach that would ensure health care coverage for all Americans through a combination of employer-based and public insurance. This approach, given initial prominence by the congressional Pepper Commission in 1990, has been introduced as legislation in this Congress by Senator Rockefeller, the Pepper Commission's chair, both independently (S.1177) and with Senators Mitchell, Kennedy and Riegle (S. 1227), and by Congressmen Waxman (H.R. 2535) and Congressman Rostenkowski (H.R. 3205).

My perspective on the pay-or-play approach to health care reform derives primarily from my experience as staff director of the Pepper Commission. Based on that experience, I want to share with you the rationale behind pay or play, the essential elements of this approach, and the likely impact enactment of pay or play would have on the problems the nation's health care system is facing.

Rationale for pay or play. Unlike most other proposals, the Pepper Commission's recommendations for health care reform developed through a political process in which members of Congress (House and Senate) strived not only to identify reforms that would achieve universal coverage in an efficient, effective health care system, but also explicitly focused on how best to move from the health care system we now have, to one that would better serve the nation. In other words, the Commission considered not only where they believed the nation ought to go on health care but also how to get there from here.

In that process, the Pepper Commission arrived at three fundamental conclusions. First, they concluded that universal and efficient health care coverage could not be achieved simply by "patching" our current system. Even expansion of Medicaid to cover all the poor, provision of tax credits toward private insurance for the near poor, and insurance reform would leave an estimated half of today's uninsured still uninsured. Furthermore, it would have taxpayers bear costs that employers of the uninsured would bear if they, like most employers, provided coverage for their workers. New public costs for an example of this approach were estimated at $36 billion in 1990, 50% more than estimated for the Pepper Commission recommendations and an amount that daunted commission members who had favored this approach.

Second, the Commission concluded that replacing the current system with a government-run national health insurance system would shift too many people and too many dollars--disrupting the majority of Americans to solve a problem that is most acute for a minority--to achieve the political support that is essential to reform. The Commission believed that most Americans seeking health care reform want assurance that they can keep the coverage they now have at costs they are able to pay--not to shift from job-based to public coverage. Furthermore, they believed that to have taxpayers bear well over $200 billion in new public costs, as government absorbed payment responsibilities now borne in the private sector, was both fiscally and politically unwise.

These judgments led to the Commission's final and most fundamental conclusion: that to be enactable, health care reform can neither patch nor replace the combination of employer-based and public coverage we now have. Rather it must build that coverage into a true system, in which all Americans are covered and that works effectively in its public and private components alike. This approach not only can address the coverage and cost problems that are at the heart of Americans' understandable dissatisfaction with their health care system; the Commission also believed it can satisfy the American voters, who ultimately must support it, that they have more to gain than to lose from health care reform.

Essential elements of pay or play. The pay-or-play approach, as recommended by the Pepper Commission and laid out in related legislative proposals, would build universal coverage with the following components:

- All workers (and their nonworking dependents) would be guaranteed health care coverage through their jobs, just as they are guaranteed a decent minimum wage and participation in Social Security.
- Employers would be guaranteed access to affordable health care coverage for their workers. In part, this guarantee would come from private insurance reforms to end the underwriting and rating practices insurers now use to avoid rather than spread risk.
  Most important, however, this guarantee would come from the choice given employers: either "play"—purchase insurance in the reformed private sector or "pay"—contribute to a public plan that would cover their workers. The price for coverage in the public plan is set as a share of payroll, for the explicit purpose of capping the cost of insurance, particularly for employers of moderate and low wage workers.
- Nonworkers would be protected by extending the same public plan for workers whose employers find it more affordable to all Americans not covered through employment. That public plan would provide the same minimum standard of coverage that employers are required to provide and would pay providers according to Medicare rules--eliminating the underpayment that has become endemic in the welfare-based Medicaid system.

Impacts of pay or play. The challenge facing a pay-or-play system, or indeed, any reform proposal, is that it truly addresses the problems it aims to solve. First is the achievement of an adequate standard of insurance protection for all Americans. The pay-or-play approach does indeed achieve this goal. Through requirements for coverage through jobs; mechanisms that facilitate coverage for low wage, seasonal or part-time workers; access to the public program for non-workers; and, when both public and private coverage is fully in place, requirements that all individuals actually have insurance coverage, universal coverage is assured.

Second, and equally important, is the achievement of acceptable costs and efficiency in the health care system. Here, too, the pay-or-play approach can achieve success.

The cost issue has two components—levels or rates of increase in health care spending and administrative costs. International experience tells us that the key to control of a nation's health care spending is not a single payer or insurer for health care—as prevails, for example, in the Canadian system, where the government pays; but rather a single set of rules for all payers or insurers, most effective if payment rates are subject to a predetermined and enforceable budget for health care expenses. Congressman Rostenkowski's pay-or-play proposal reflects this "all-payer, budgeted" approach in full, while other legislative proposals for the pay-or-play system propose steps in that direction. Within the budgeted approach, these proposals also give employers the flexibility they favor to develop organized delivery systems. The fact is that the establishment of an effective system for cost containment is as compatible with pay-or-play as with a fully government approach to universal coverage.

Similarly, enactment of a single payer, government insurance approach is not the only way to achieve administrative savings over the current system. Although administrative costs for large firms can be as low as for government programs, there is significant and undisputed administrative waste in the small group insurance market, as insurers invest enormous amounts in making certain they are "insuring" the healthy rather than anyone who is actually or likely to become sick. Pay-or-play proposals' insurance reforms would eliminate these practices and their exorbitant costs. In addition, consolidation of small insurers, use of a uniform claims form, and greater reliance on electronic data processing can reduce the

administrative expenses insurers and providers now face in a multiple insurer system. Although a system that must manage portability of benefits across jobs and between public and private programs will inevitably cost more to administer than a single payer approach, the fact is that many of the administrative savings claimed for a single payer can be achieved in a combination public/private system.

Conclusion. Not only does the pay-or-play approach redress the egregious flaws in our current health care system; it does so in a way that can assuage rather than arouse the fears of well-insured Americans who will inevitably be asked to pay the taxes needed to support it. By retaining employer-based coverage, this approach secures them the coverage they now have where they have it, in their jobs. It doesn't ask them to give up that coverage up for a new government system. And, by sharing costs among employers and government, it keeps new public costs and new taxes within reasonable bounds. Finally, once private insurance and the new public coverage are fully in place, it provides the flexibility for future policy to more toward a more public or more private system, as experience and preferences dictate.

In short, pay or play represents not only a system but a strategy for achieving health care reform. As a system or a strategy, I commend it to your attention.

REPRESENTATIVE SCHEUER. Thank you very, very much, Ms. Feder.

Now, we will hear from John Holahan, Director of the Public Policy Research Center at the Urban Institute. He has directed several health research projects at the Urban Institute.

I recognize you for the same 8 or 10 minutes. Please summarize your thoughts for us.

STATEMENT OF JOHN HOLAHAN, DIRECTOR, HEALTH POLICY CENTER, THE URBAN INSTITUTE

MR. HOLAHAN. I want to summarize ideas for an approach to health-care reform that was based on work that I did with three colleagues at the Urban Institute—Stephen Zuckerman, Marilyn Moon, and Pete Welch.

It is an approach that builds heavily on the idea of the Pepper Commission and includes a number of the features of the Canadian system. So, you can think of it as a blend of the two approaches.

I will start by saying where our approaches are similar to and different from the Pepper Commission and Canadian system.

Our approach is similar to the Pepper Commission in that we would achieve universal coverage through both an expansion of the public and the private sectors. We adopt the pay-or-play approach. That is, employers would either have to provide health insurance or pay a tax. Medicaid would be replaced, and federal and state subsidies would be provided to cover the poor and much of the near-poor population. We would adopt the insurance reform provisions that were recommended by the Pepper Commission.

Where we would differ is that we would extend subsidies further up the income distribution to, at least, 250 percent of poverty, particularly for families. We would have a somewhat larger public plan that would be achieved by a lower tax rate on employers—and there are a number of reasons for this, which I will get to.

We also think that we would have somewhat stronger cost containment incentives than have been in these plans, but probably, more importantly, our approach would allow for more diversity and more choice as to how this would be achieved.

We are similar to the Canadian System in that we would rely on states for a substantial administrative and financial role in the system in the same way that the Canadians rely on their provinces. And, as in Canada, the federal contributions to states would be indexed to the growth in the gross national product. Where we would differ from Canada is that we would retain a large role for the private insurance industry.

The reason I think that we did not feel that we could recommend or get behind the Canadian system at this time is because it reflects such a large institutional change; and, second, a very large redistribution of income in terms of who now pays versus who would pay under such an arrangement.

The specifics of our proposal are, first, Medicare would remain as it is. There does not seem to be any reason to touch that or include that in the reform. Second, employers, as I said, would be required to provide health insurance or to pay a tax. The system would cover as many employers as would be administratively feasible—perhaps all employers who now have to pay the FICA tax.

We would have minimum standards for benefits and cost sharing, as in the Pepper Commission. Employers would be required to contribute at least 75 percent of the cost toward the plan, or a contribution toward the public plan.

I mentioned insurance reform. That is needed to ensure that private firms could not simply avoid the highest risk and force them into the public plan.

REPRESENTATIVE SCHEUER. Of course, that is precisely what is going on now.

MR. HOLAHAN. Right. And it is very important, I think, that that be eliminated, and the Pepper Commission called for that.

REPRESENTATIVE SCHEUER. I will take this up later, but we had the Empire State Insurance Company in New York where they have a proposal for a 50 percent increase in their premiums. They are squeezing out everybody but young, well people.

The very purpose of insurance is to spread the risk. If you are constantly redefining your policies to the extent of pricing out of the market everybody but young, well people, then you are really not part of an insurance program. You are into something else. But we should not be calling that insurance. "Insurance" means spreading the risk.

It seems to me that one of the gross failures of our present policy is that the private health insurance company is loading into the public sector everybody but the young, well population, which they avidly go after, to the extent of excluding everybody through the price mechanism who is not young and especially people who have had some prior health conditions, which most of us do have.

MR. HOLAHAN. We have experienced those problems at the Urban Institute. We do not have very many high risks, or a particularly old population, so I completely agree with you.

REPRESENTATIVE SCHEUER. I mean, it seems to me that anybody who wants to come up with an employment-based system of insurance has to face up to the question of the health insurance industry going down a very well-conceived and well-constructed path of excluding people who are going to have health problems, and going after with a high-powered rifle, with an 8-power scope—young, well people—as their target.

MR. HOLAHAN. I think it has been accepted by a lot of analysts that we need to move toward community ratings and the elimination of pre-existing exclusions.

We would also eliminate the tax deductibility of plans that offered more than the minimum benefits and less cost-sharing. In other words,

firms could offer more generous plans, but the difference between a generous plan and that which would meet the minimum standards would not be tax deductible.

I mentioned that we would have a system of subsidies for low-income people; everyone under the poverty line would be covered. Those above poverty, up to 250 percent of poverty, would be required to contribute more as their income increased. And once the system of subsidies was in place, then all Americans would be required to have health insurance.

REPRESENTATIVE SCHEUER. Who would be in the public plans?

MR. HOLAHAN. Employers would be required, as I said, to pay the tax. So, employees whose employers pay that tax would be covered under the public plan. The tax rate is an important variable in this approach.

We would structure it so that there would be incentives for, at least, 35 to 40 percent of the nonelderly population to find it economically worthwhile to buy into the public plan. This would probably mean a payroll tax today of about 8 to 9 percent of payroll. The longer it takes to enact this type of an arrangement, the higher that payroll tax will be due to the fact that health-care premiums are going up significantly faster than wages.

The public plan would also replace Medicaid, as I said, covering all people below poverty and others who chose to buy into the plan. The public plans would be administered and partially funded by states.

The financing of the public plans would be through the tax on employers. The funds would come through the limits on the deductibility of the employer. Health-benefit contributions would contribute to this. Beneficiaries, who choose to buy directly into the public plan, would contribute according to income. The remainder of the funds for the public plan would come through federal and state contributions.

The Federal Government would cover 50 to 75 percent of the cost of this residual plan initially. The percentage that the Federal Government would pay would vary inversely with state per capita income, as we now do with Medicaid.

We also think that it is important to have adjustments for cyclical downturns in the economy, as we do not do now for Medicaid, so that the states that follow a recession have a tremendous burden in those periods, and we think it is important in this kind of a system to alter that.

Once the federal contribution is established initially, it would be indexed to grow over time with the growth in the nominal gross national product. This is again taken from the Canadian system, and is a key element in the Canadian approach in the way the federal contributions in Canada go to the provinces.

In addition, to relieve some of the burden the states would face initially, we would recommend that the long-term care component of Medicaid be absorbed by the Federal Government. In doing this, then, the new financial burdens that states would face would be roughly offset by the loss of their expenses for long-term care.

States under this approach would have very strong incentives to contain costs; because if they didn't contain costs at the rate of the growth in GNP, their tax burden would increase disproportionately. But at the same time, we give them very strong incentives to contain costs. We allow for considerable freedom of choice in terms of how they do this. This is done to reflect the fact that there are different philosophies toward cost containment, which people believe in very strongly in this country.

Many people, as we have heard this morning, believe strongly in single-payer rate setting. But there is another school of thought that believes strongly in managed competition; that you can structure competition between HMOs and third-provider organizations, and achieve the same results, and at the same time, provide people more choice in their health insurance arrangement.

Others believe—those in Oregon, for example—that you should directly ration care, and that is an approach that could work.

I should mention that if a state wanted to go down the road of a managed competition—a competitive model—our approach would allow the individuals who enroll in the public plan in that state to be brought into private and health insurance arrangements.

So, we are trying to achieve something that allows for a considerable degree of flexibility. But at the same time, States have to realize, if it is not successful, they are going to have to face the taxpayer or cut other government programs.

I mentioned earlier that we would set the tax rate so that it would be worthwhile for 35 or perhaps 40 percent of the nonelderly population to join the public plan. The reason for that is to provide incentives for the public plan to maintain a high degree of quality and access. And that would be the result of the fact that that size of population would provide strong political support to assure that that would occur.

So, the cost control incentives, to summarize, would come from the fact that the states would have to control their own costs, or cut other programs, or raise taxes. The state would have strong incentives to control the rise in cost in the private sector, because the failure to do so would mean that more would choose to leave private plans and choose the public plan.

And, finally, the insurance industry would also have strong incentives to control their costs, because they would in fact lose market shares if they did not.

So, our approach builds on the existing employer-based system. It provides for broad subsidies for the poor. It has strong cost-containment incentives, and we think it also builds in the political support necessary to assure that there would be an adequate level of quality and access.

Thank you.

[The prepared statement of Mr. Holahan follows:]

PREPARED STATEMENT OF JOHN HOLAHAN

The major problems in the United States' health care system today are the large number of uninsured Americans, the high ani rising costs of the system, and the system's administrative complexity. With over 32 million Americans lacking health insurance at any time and 63 million Americans lacking health insurance at some point during a recent 28-month period, the problem of being uninsured is faced by a large percentage of the population.[1] [2] Despite this lack of coverage, the United States spends more on health care, per capita and as a percentage of GNP, than any other country. In addition, we also have one of the highest rates of increase—over 4 percent per year after adjusting for inflation.[3] Finally, it is estimated that the expenses borne by insurance companies, physicians, hospitals, and other providers are about $80 billion or 1.5 percent of GNP.[4] This does not include the administrative burdens faced by employers who must choose among plans and the efforts of individuals who must file claims.

While most would agree that these are serious problems, there is no consensus on what should be done. Some look to the Canadian system as a model for reform.[5] The Pepper Commission developed the most visible policy proposal that would build on existing American institutions.[6] We use elements of both the Canadian system and the Pepper Commission proposal to design a reform

---

*This testimony is excerpted from John Holahan, Marilyn Moon, W. Pete Welch, and Stephen Zuckerman, "An American Approach to Health System Reform," Journal of the American Medical Association, Vol. 265, No. 19, May 15, 1991.

option that would significantly expand insurance coverage and control costs with policies that are politically acceptable.

The Canadian System

The Canadian system offers universal coverage to all citizens through public sector insurance administered at the provincial level. Like the United States, Canada retains private sector provision of services. Unlike the United States, there is no cost-sharing and physicians are not permitted to bill in excess of the provincial fee schedules. The provinces constitute the single payer, with substantial monopsony power in negotiating budgets with hospitals and fee schedules for physicians. They also control the availability of new health technologies. The system is financed in part by federal contributions to the provinces. Before 1977, the federal contribution represented half of the cost of the system. Since then, the increase in the federal contribution has been tied to the growth in the Canadian Gross National Product, causing it to drop to about 45 percent by the late 1980s. If provinces are unable to control the growth in costs, they will increasingly bear more of the burden of financing the system. This gives them strong incentives to control the growth in expenditures.

The Canadian system has a number of important strengths. No Canadian is without health insurance. There is equity across income groups. The poor are treated as well as the rich. In addition, the costs of the Canadian system are under control. Growth rates of the system's cost are approximately those of the GNP. And finally, the administrative costs of the system are low. It is estimated that the United States would save about $30 billion or 0.5 percent of GNP if it had the administrative costs of the Canadian system.[7]

While the Canadian system is attractive from many points of view, there are serious problems that make it unlikely to be adopted in the United States.

First, taxes are higher than is politically feasible in the United States. It is estimated that the Canadian system would mean $250 billion of new taxes.[8] These are not new resources for the health care system; they would largely replace private insurance payments or individuals' out-of-pocket payments. But they would be on-budget and highly visible. The second problem is that the U.S. health insurance industry would be eliminated, or largely so. Insurance firms could continue to be agents to process claims, but they would no longer underwrite. Therefore, they would be likely to exercise strong political opposition to a Canadian-style system. The third problem is that the Canadian system is probably too egalitarian for the United States. The degree of equity in the Canadian system is probably not acceptable to Americans. The rich are not likely to want to be treated the same as the poor, again resulting in a group strongly opposed to this type of reform. Finally, there is no consensus on how to contain the cost of the system. Many Americans do not believe that a single-payer, rate-setting system is desirable or absolutely essential to efforts to control costs. Many, for example, fervently believe that managed competition can successfully control costs, provide more choice, and avoid large-scale government regulation.[9]

The Pepper Commission Proposal

The Commission's proposal of March 1990 went a long way towards providing a structure that could reform the U.S. health care system. The Commission proposed that all employers with more than 100 employees provide health insurance or pay a payroll tax. Eventually all employers would be required to do so. If employers choose to pay the tax, this would enroll their employees in a federally-administered public plan. The proposal included reform of the private insurance market that would eliminate experience rating and other practices that make it difficult for some employers to obtain coverage at

reasonable costs. The Pepper Commission proposal would also eliminate Medicaid, putting those now served by Medicaid and those whose employers pay the payroll tax into a single public plan. The proposal would essentially leave Medicare as it is.

The major weakness is that the Pepper Commission provided for only limited cost-containment efforts. Essentially, by covering the poor and near-poor at the federal level, Medicare policies for payment to hospitals and physicians would be expanded to apply to a broader segment of the population. While a step in the right direction, there are no cost-containment provisions affecting the rest of the population. The Commission's decision not to back a single clearly defined cost containment strategy reflects fundamental disagreements over what policies will work and can be implemented in this country. However, proposals that do not consider cost-containment ignore one of the driving forces for reform of health care in the United States today.

An American Approach

Our proposal builds on many of the ideas proposed by the Pepper Commission as well as important elements of the Canadian system. Like the Pepper Commission, we propose that universal coverage be achieved through a combination of both private and public sector expansion. We would also require employers to provide health insurance or to pay a payroll tax. These revenues, as well as other subsidies, would be used to finance a public backup program to cover the remainder of the population. We would also propose similar reforms of the insurance industry. Medicare would be retained for those currently covered.

Our proposal differs from the Pepper Commission in that we would provide for more generous subsidies to the poor and near-poor. One result would be that more of the nonelderly population would be in the public plans. Our

approach would also provide for stronger cost-containment incentives than does the Pepper Commission and allows for a range of approaches.

In the same way that the Canadian system relies upon provinces for administration and to ultimately bear the risk of rapidly growing costs, we would rely on the states. As in Canada, federal contributions to the public plans would be tied to the growth in GNP. Our proposal differs from Canada in that we would retain a large role for the private sector.

Our proposal, as noted above, is a pay or play approach—requiring employers to either provide health insurance to their workers or to pay a tax. All but extremely small firms would be required to participate in this system. The objective would be to cover all firms where administratively practical. One possibility would include all employers now paying the F.I.C.A. tax; this would then include employers with even one employee.

Employers would be required to provide health insurance meeting minimum standards in terms of benefits, with legislatively established maximum deductibles and coinsurance; employers would be required to pay at least 75 percent of the cost of this coverage. (ERISA rules would have to be modified to assure that these and other provisions of this plan apply to firms who choose to self-insure.) Employers could offer more generous plans but the difference in actuarial value between the offered plan and the required benefits would be treated as taxable income. Employees would be required to purchase insurance for themselves and their families if offered by the employer; individuals with incomes below certain specified levels would have the costs of insurance subsidized by the state.

Most basic acute care services including cost-effective preventive services would be covered; prescription drugs would be excluded at least initially. Deductibles would be approximately $200 per person and $500 per family, with coinsurance of 20 percent up to catastrophic limits of

approximately $1500 per individual and $3000 per family. Individuals and families below certain income levels could be exempt from cost sharing or have lower stop-loss limits.

Firms not wishing to provide such policies would be required to make a contribution approximately equal to the national average percentage of payroll now devoted to health insurance (about 7.0 percent) in the form of a tax on payroll. (Firms could choose to offer a private plan for full-time workers and to pay the tax for part-time workers but otherwise must choose one approach for all employees). States would be required to use these payroll tax revenues to establish new backup public health insurance programs. These new programs would provide insurance for workers whose employers choose to pay the tax and would also replace Medicaid for persons not in the workforce. The new public programs would provide coverage to all nonworking individuals and their families with incomes below poverty at no cost to the individual or the families. Individuals and families with incomes between 100 and 250 percent of the poverty line would be permitted to purchase this insurance on a sliding scale. Those with higher incomes could buy into the public plan at the full community-rated cost. Once affordable coverage is offered to all individuals, enrollment could be required so that everyone contributes to the cost of their health care.

The tax would be set (and, probably, adjusted over time) at a rate that would result in a large minority of employers choosing to pay it rather than provide private insurance. (The exact rate that would yield the desired mix of private- and public-plan enrollees would depend on the cost of the mandated plan and the distribution of payroll expenses across firms.) A relatively large public program, e.g., containing about one-third of the non-elderly, would ensure the establishment of payment standards resulting in a degree of access acceptable to voters, many of whom would also be program participants.

We would prefer to rely on the political power that a sizable number of public-plan enrollees would provide to assure that adequate minimum standards of quality and access are established. The alternative would be detailed federal rules and regulations for state-administered programs. If reliance on the political process results in inadequate access for public-plan enrollees, some minimum standards for provider reimbursement and utilization control may be necessary. Our concern, however, is that overly rigid requirements will limit state flexibility in the design of cost containment strategies.

Firms with relatively healthy, highly paid employees would probably choose to offer a private plan. Firms with large numbers of low-wage or part-time employees, or with disproportionate numbers of older workers or individuals in poor health, would probably choose to pay the tax. Because health care costs and, thus, private insurance premiums will be high (or low) in the same markets where payrolls tend to be high (or low), there should not be major geographic differences in incentives to choose the public plan.

The public program that replaces Medicaid would therefore cover three types of persons: (1) workers whose employers pay the tax, (2) the poor, and (3) workers and nonworkers who buy into the public plan. The program would be financed by the tax on employers, by limitations on the deductibility of employer health insurance contributions, by beneficiary contributions, and by federal and state subsidies.

This proposal has some important features in common with the Pepper Commission plan; thus the cost estimates for the Pepper proposal ($24 billion) offer some guidance as to the cost of our approach. Because our proposal would cover approximately 35 percent of the non-elderly population in the public plan, it would mean higher federal and state taxes beyond the payroll taxes (relative to the Pepper plan). The cost of subsidizing non-workers and dependents below 250 percent of the poverty line (including the cost of

increasing reimbursement rates for current Medicaid beneficiaries), and the cost of subsidizing workers whose employers choose to pay the tax would both be somewhat higher than in the Pepper Commission proposal. Offsetting these costs is the increase in federal (and possibly state) tax revenues from the limitations on deductibility of health insurance premiums (lower tax expenditures).

Estimation of these costs, as well as costs of all "pay or play" proposals, including the Pepper Commission, is complicated because of the lack of good data on the distribution of payroll expenses across firms. With regard to these cost estimates, however, two issues merit serious attention. First, much of the public costs are offset by expenses that would not be borne elsewhere in the system, e.g., privately purchased health insurance, out-of-pocket expenses, or uncompensated care. Second, the more important cost issue is the growth in health expenditures over time. The savings from gaining control over expenditure growth, as has happened in other industrialized nations, can swamp the additional first-year budget costs.

States and Cost Containment

An essential feature of our approach to controlling cost growth is that the annual percentage increase in the federal contribution to the states will be equal to the growth in nominal gross national product, as in Canada. (Because the kinds of individuals who will shift into the public plan may be more costly than expected as a result of unpredicted adverse selection, federal contributions may need to grow somewhat faster than GNP during an initial phase-in period.) The federal contribution would initially vary from 50 to 75 percent of the cost of subsidizing the public program, with the federal contribution varying inversely with state per capita income and directly with the number of persons in poverty. The federal government contribution would be

about 60 percent of the total cost, on average. The federal contribution could be financed by an earmarked tax such as a national sales tax or a payroll tax. While it is not essential that the federal contribution be earmarked, the federal contribution rate does need to increase in step with inflation and long-term real growth in the economy. It is also important that a mechanism be established to protect states from short-term declines in income during periods of economic downturn.

The effect of these provisions is that if increases in health care costs exceed the rate of growth in GNP, states would, by design, bear an increasingly large burden. The objective, in addition to sharing the burden of financing the system between both the federal and state governments, is to provide strong incentives for states to control costs. States could, of course, lobby to have the federal contribution rate increased.

States, therefore, would have a major role in our proposed scheme. They would gain a large influx of federal revenues that would finance much of the cost of covering the currently uninsured. In exchange, they would both administer the public plan and have major responsibilities for cost containment. Their success in developing strategies for cost containment would affect not only the cost of the public sector plan, and thus state tax contributions, but also the cost of those who are insured privately in the state.

States would have the freedom to choose among a variety of strategies for cost containment. We have argued that this freedom is essential because there are fundamental disagreements on how the system's costs should be contained; much of the disagreement exists across regional lines. For example, states could choose to rely on managed competition, i.e., allowing private insurance entities (e.g., preferred provider organizations, health maintenance organizations) to compete to control costs. This could include permitting the

public programs to buy individuals into private insurance arrangements or HMOs. Alternatively, states could choose to use some form of all-payer rate setting to control both price and volume of care. These regulations would be applied to both public- and private-sector plans. They could also choose to limit coverage to cost-effective procedures along lines that have recently been proposed in Oregon. States would also have Medicare policies available as a possible model. The key element is that states bear a measure of financial risk for failure.

The incentives for cost containment extend beyond the states' risk for excess growth in the costs of the care of public-plan enrollees. States have incentives to be concerned with the growth in costs of private plans as well. If private insurance premiums increase as a percentage of payroll, the number of enrollees in the public plan will grow, increasing the need for state (and federal) subsidies. In addition, the private insurance industry needs to control the growth in health care costs and thus premiums, because failure to do so will mean loss of market share and an increase in public plan enrollment. Finally, because insurance reforms should limit risk-selection opportunities, cost control must come through controlling provider payments and increased administrative efficiency.

The increase in costs at the state level would be a relatively large financial burden for many of them. One way to alleviate this burden would be to federalize the long-term care component of the Medicaid program. This would provide approximately $14.5 billion of fiscal relief to states in 1990 dollars. (While this is approximately the same amount as the increase in states' costs for the expansion of acute care, there would be gainers and losers among individual states. These may need to be addressed.) Long-term care is a large burden for states, and one that will grow substantially over time as the population ages. Relieving states of this burden may make the added

responsibilities for administering the acute care system significantly more acceptable. Federalizing long-term care would also facilitate the coordination of Medicare and Medicaid policies toward nursing homes and home health care.

Summary

In terms of the major objectives one would have for health system reform, this plan makes the following choices:

(1) It would cover everyone, through either Medicare (the elderly), employer-based coverage (some workers and dependents) or a state-level public program that would replace Medicaid (the poor, unemployed, and other workers and dependents).

(2) There would be a standard minimum package of required benefits for employer-based and public programs, with legislative requirements on maximum cost-sharing. Choice of provider might be restricted in some states.

(3) Administration of the private programs would be the responsibility, as now, of the employers and/or insurance companies. Administration of the public program would be the responsibility of the states, with the objective of maximizing responsiveness to local needs and conditions.

(4) It would control costs through giving the states a substantial financial stake in ensuring that the public program costs did not grow faster than general inflation. State control would also allow the testing of different mechanisms for cost control, with the ultimate objective of identifying the most effective cost-containment strategies.

(5) The cost would be borne by employers, employees, and taxpayers. Employers would be protected from exorbitant costs by being allowed the option of paying into a public plan rather than providing health insurance themselves. The poor and unemployed would be protected by having their coverage under the public program subsidized on a sliding scale.

(6) The political feasibility test would be met by retaining a major role for insurance companies and by retaining the role of employer-based coverage--thus reducing the tax increase needed to ensure universal coverage. By allowing flexibility in design of cost containment strategy, some of the controversy over this issue would also be deflected.

Our proposal is also not without problems. First, our approach would still have adverse effects on the profitability of small businesses and on the employment prospects for low-wage workers--although these effects would be less than under conventional mandates and less than under proposals with higher tax rates. Second, some states may not want the responsibility we envision, or have the capacity to carry it out. But several Canadian provinces are relatively small and are able to perform the same administrative functions within the Canadian national health system. In addition, since the federal government would continue to administer the Medicare program, states would have the option of tying their policies for hospital and physician payment and utilization control to those of Medicare. Finally, the proposal would require new tax revenues. Some of this replaces funds spent at the local level to finance public hospital deficits and to reduce uncompensated care in other hospitals. Some of it would also replace expenditures borne by corporations in purchasing private health insurance plans and some of the insurance premiums borne by individuals privately. There would, nonetheless, be a visible increase in taxes at the federal and state levels. But it seems a modest price to pay for resolving the problem of the uninsured and for gaining control over the growth in costs that now seems endemic to the U.S. health care system.

NOTES

1. Alan Monhiet and Pamela Short, "Mandatory Health Coverage," Health Affairs 8, no. 1, (Winter 1989); Eugene Moyer, "A Revised Look at the Number of Uninsured Americans," Health Affairs 8, no. 2, (Summer 1989); Katherine Swartz, The Medically Uninsured, Special Focus on Workers, (Washington, D.C.: The Urban Institute, July 1989); Sheila R. Zedlweski, "Expanding the Employer-Provided Health Insurance System: Effects on Workers and Their Employers," (Washington, D.C.: The Urban Institute Research Report, forthcoming).

2. Charles Nelson and Kathleen Short, "Health Insurance Coverage 1986-1988," Washington, D.C.: Bureau of the Census, U.S. Department of Commerce, Current Population Reports, Household Economic Studies, Series P-70, no. 17 (March 1990).

3. George J. Schieber and Jean-Pierre Poulier, "Overview of International Comparisons of Health Care Expenditures," Health Care Financing Review 11, no. 1 (Fall 1989); Jean-Pierre Poulier, "Health Care Expenditure and Other Data," Health Care Financing Review 11, no. 1 (Fall 1989).

4. David V. Himmelstein and Steffie Woolhandler, "Cost Without Benefit: Administrative Waste in U.S. Health Care," New England Journal of Medicine 314 (February 13, 1989): 441-445.

5. David Himmelstein and Steffie Woolhandler, "A National Health Program for the United States," New England Journal of Medicine 320 (January 12, 1989): 102-108.

6. The Pepper Commission (U.S. Bipartisan Commission on Comprehensive Health Care), A Call for Action, Final Report, Washington, D.C.: U.S. Government Printing Office (September 1990).

7. Robert G. Evans, et al., "Controlling Health Expenditures—The Canadian Reality," New England Journal of Medicine 320, no. 9 (March 2, 1989): 571-599.

8. The Pepper Commission (U.S. Bipartisan Commission on Comprehensive Health Care), A Call for Action, Final Report, Washington, D.C.: U.S. Government Printing Office (September 1990).

9. Alain Enthoven and Richard Kronick, "A Consumer Choice Health Plan for the 1990s," New England Journal of Medicine 320 (January 5, 1989 [Part I] and January 12, 1989 [Part II]); Spencer Rich, "Blue Cross-Blue Shield Chief Adds Private Plan to Health Care Debate," Washington Post, 20 September 1991, pg. A9.

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Holahan.

Now, I would like to recognize Dick Cheney for his questions——

[Laughter.]

REPRESENTATIVE SCHEUER. Excuse me, Dick Armey.

REPRESENTATIVE ARMEY. Thank you, Mr. Chairman.

I suppose there may be some sort of Freudian connection between the name "Armey" and "Cheney"——

[Laughter.]

REPRESENTATIVE SCHEUER. Both men of superb intellect and extraordinary ability.

REPRESENTATIVE ARMEY. Mr. Marmor, let me talk to you for a moment.

I am an academic by trade. I spent 20 years of my life as a university professor, and I always enjoyed the more free-wheeling, somewhat safe atmosphere of the university prior to the era of political "correctness," which we see now beleaguering freedom of thought in American universities.

One of the things that I have loved about this Subcommittee is that we can still feign some objective pursuit of truth in here, and even risk being politically incorrect, and even perhaps being labeled "insensitive," should we dare to question orthodoxy.

I do that with a great deal of relish, because I think most people are full of what we Texans so colorfully can describe as ... Well, you know, in other words, full of themselves, as it were. [Laughter.]

I am also a bit of a cynic.

First of all, I have a general proposition that private enterprise works; public enterprise does not. Armey's Axiom No. 1: The market is rational; the government is dumb. I have seen very little evidence to refute this.

So, I have a tendency to not trust the notion that we can create a government enterprise that can accomplish an end with either efficiency or equity.

MR. MARMOR. Right.

REPRESENTATIVE ARMEY. I find considerably more—

REPRESENTATIVE SCHEUER. Who said "right"?

MR. MARMOR. I said I understand the position.

REPRESENTATIVE ARMEY. You understand the position.

MR. MARMOR. Right.

REPRESENTATIVE ARMEY. I also believe that there are a great many people in the country who find it in their self-interest to have more government enterprise, who benefit from it.

Walter Williams describes them in the most colorful of terms, and I love him for it. I am not that politically incorrect. [Laughter.]

But at any rate, I also believe that there are at least six professions, which I call the six talking professions, that successfully get away with feigning altruism, and thereby do a great deal of mischief, which generally presents itself to me as a citizen in the form of some more government.

So, let me play—as it were—the role of the cynic for a moment and ask, first of all, what evidence do we have that we have a crisis in medical care in this Nation? In what way are we in this Nation deficient in providing the opportunity for the acquisition of the desired or needed medical services to our population?

MR. MARMOR. Could you state that question again?

REPRESENTATIVE ARMEY. In other words, for those people who decide it is in their best interest to have more government and want to achieve that——

MR. MARMOR. And you used the term "crisis"——

REPRESENTATIVE ARMEY. ——by feigning altruism, Armey's axiom is that the politic's greed is always wrapped in the language of love, and a love for my health, of course, is pretty endearing.

So, the first road to getting more of what I want, which is more government, is to first say, all right, we have a disaster out there.

MR. MARMOR. Right. Okay.

REPRESENTATIVE ARMEY. And I am asking, what evidence do we have that we have a crisis in medical care in this country?

MR. MARMOR. All right. Let me try to briefly answer that. I said, and I think you heard me——

REPRESENTATIVE ARMEY. I am not suggesting that you are one of these people. I am just saying that there seems to be a general consensus that there is a crisis there, and I am frankly prepared to risk saying that I, at least, do not see it.

MR. MARMOR. If you mean by a "crisis" that the failure to do something about it in the next month to six months will produce a disaster that you are not anticipating—if that is what you define as a "crisis"—there is not a crisis in American medical care.

What people use the term "crisis" for, and have for 20 years in this area, is a set of problems that they think are not getting better, but are getting worse, and those can be easily described.

The language has been debased by calling everything a crisis in American political life. Partly, because of the fragmentation, to get people's attention you have to act as if the roof is falling in, in order to say, "pay attention to me."

I disagree with "crying wolf," because I think it has produced not cynicism, but a kind of indifference to change over time because you have heard it so many times. But if you ask what are the problems rather than what is the crisis, the problems that are real, which people have attached different weights to, are the following:

One is that it is absolutely clear that there is a substantial portion of Americans for whom access to medical care and insurance, or no insurance, produces financial disaster for them.

The bankruptcy problem for a small number—we see it in California—where, in 1990, it was the second largest cause of personal bankruptcy. That is a small number of devastating cases.

The second problem area is that the wage battling between workers and management has increasingly been fought in such a way that people have to run to keep the same place in medical care. There, the problem is the relative rate of increase in medical care prices outdistancing CPI, which means, to get the same care, more of wages or more of the wage pool——

REPRESENTATIVE ARMEY. Let me just interject a thought here.

So, I think you and I could agree, and probably all of us could agree——

MR. MARMOR. I do not know about Mr. Goodman, but I think the three of us could.

REPRESENTATIVE ARMEY. Well, we see a trend in America for medical care and insurance to become more dear to the American consumer, more costly and difficult to obtain, or provide for the option—the emergency option—with reliability?

MR. MARMOR. Well, I would not put it, "the American consumer." I would say that this problem is largely defined by burdens on government budgets, the rising rate of Medicare/Medicaid——

REPRESENTATIVE ARMEY. Oh, no, see, because you already have an idea that the solution is the government.

MR. MARMOR. No, no, no.

REPRESENTATIVE ARMEY. I am saying that the cause of the problem ... in other words, I am saying that if I am born in America today, at the point at which I become prenatal—which for me is the point of conception, and that is another debate——

MR. MARMOR. I am going to stay away from that one.

REPRESENTATIVE ARMEY. ——but at that point, my chances of having medical care available at the point of my need, at what I need, are diminishing. There is a trend. It is harder to acquire that.

For example, I understand that the fastest rate by which people are leaving the medical profession, at least the specialties, is it gynecology?

MR. MARMOR. Obstetrics and gynecology.

REPRESENTATIVE ARMEY. Yes.

MR. MARMOR. Absolutely. But that is a separate problem, which you actually identified, that I think is very serious.

REPRESENTATIVE ARMEY. This is a case where the lawyers are winning.

REPRESENTATIVE SCHEUER. The malpractice.

MR. MARMOR. I think the malpractice——

REPRESENTATIVE ARMEY. The lawyers are clearly winning, and the children are losing.

MR. MARMOR. But you asked whether there are problems, and I think there are serious problems.

REPRESENTATIVE ARMEY. I am going to concede that there are problems, but I am going to——

MR. MARMOR. So, maybe I have answered the question.

REPRESENTATIVE ARMEY. Well, let me go on to one other point very quickly, Mr. Chairman, because this is such an extraordinarily broad concept.

What I am saying is, we have a tendency to see the problem, and if we really boil it down and get rid of all the rhetoric around it, we would probably pretty well agree on what it is.

My point of view is, I would begin immediately when I saw a problem to say, all right, now what is it that government has done to screw it up. A lot of people take the other approach.

MR. MARMOR. Absolutely.

REPRESENTATIVE ARMEY. I would say that because we have not had responsible tort law in this country, at either the state or federal level, we have the government screw in it.

I think the tax laws, too.

Let me ask you—it just struck me. I do not own a house. I got caught in the Texas real estate market, so I now rent. But as a renter, I do not have fire insurance for my property.

I know farmers who regularly plant without crop insurance. But nobody has suggested that the fact that 37 million Americans are without fire insurance means that there is an arson disaster out there, or that 10 percent of the farmers are without crop insurance.

The fact of the matter is that it can be a perfectly rational thing for somebody to determine that I am not going to choose to consume health insurance for me and my family.

It is an interesting thing, because we have somehow come to the conclusion—and it is taken as an article of agreement—that every American is entitled to a minimum standard of health care, whether they want it or not.

MR. MARMOR. Or whether they would choose it or not.

REPRESENTATIVE ARMEY. Whether they would choose it or not.

MR. MARMOR. I think that this would be illuminating only if we see where we differ.

There are two positions that are clear. One is a position that medical care is like other goods and services, and that there is no reason why income should not ration it. The other view is that medical care is a merit good, which you understand the concept of——

REPRESENTATIVE ARMEY. A what?

MR. MARMOR. A "merit good." That is, it should not be distributed by ability to pay.

Those two positions are philosophical starting points. If you are on one, and I am on the other, we can only acknowledge that we differ.

MS. FEDER. I would add, I think there are other issues there. I think that one issue is how you view health care, whether—as Ted is indicating—it is something that everybody has to have.

I think that there is another issue, which is that we tend in this country to be reluctant to deny care to people.

I think that we may have overstated it a little earlier in this discussion in indicating that people without insurance have access to health care. They do have some, but by no means is it appropriate. The point being there that when they show up, perhaps, sicker than they would otherwise be, or needing emergency treatment, we give it, and we pay for it.

REPRESENTATIVE ARMEY. Sure. So, it is a free-ride problem.

Ms. FEDER. That is right. So, the issue is to spread those costs out.

REPRESENTATIVE ARMEY. All right. Because, again, I have a 24-year-old son. He has a job where he does not qualify for a group cost, and he does not have hospital insurance.

I said, David, you have to get some hospitalization. His response was, "Dad, I have more important things to do with my money than buy hospital insurance, especially at these rates, and especially in light of the fact that I am strong as a bull, and if you give me any sass, I will throw you over the fence," which he could do. So, he is making a rational decision not to provide.

Now, the fact is that if David has an accident——

REPRESENTATIVE SCHEUER. Not "to provide"——

REPRESENTATIVE ARMEY. To provide for himself.

REPRESENTATIVE SCHEUER. He is making a rational decision not to get insurance.

REPRESENTATIVE ARMEY. Right. And it is a rational decision. For him, it is a good bet. It is just about as good a bet for him not to buy health insurance as it is for me not to buy fire insurance, which is a bet I made.

REPRESENTATIVE SCHEUER. Let me just interject that it may be a good bet for him, because the health insurance industry has zeroed in on his population group, excluding older people, people with perhaps pre-existing illnesses of one kind or another. They have zeroed in on the young and the well, and they have gotten rates down to a very, very low level.

REPRESENTATIVE ARMEY. But even at the lower rates, he says, "Dad, I have more important things to do with my money."

Ms. FEDER. And I have a 20-year-old son who is about to face that problem, and I am certain he would make the same argument.

And I, based on my assessment of Rick's risks, would purchase it for him, because I want to be certain—please do not tell him that——

[Laughter.]

REPRESENTATIVE ARMEY. I understand. [Laughter.]

REPRESENTATIVE SCHEUER. Because the rates are very, very favorable for the young and the well.

Ms. FEDER. But they would still be high for his income. But the issue is that I want to be certain that he has access to care.

REPRESENTATIVE ARMEY. Well, let us say that—and I know our time is waning, and I know my staff is going to be after me—

REPRESENTATIVE SCHEUER. It is waning, but please proceed.

REPRESENTATIVE ARMEY. All right.

Purely hypothetically, let's say that we could agree, and the government and Congress can make the choice. We can determine, as we did in 1936, that every American working man and woman must make a contribution to a retirement account, and therefore also be the worst possible one conceived by man run by the government, and called it social security, which is much more "social" than it is "secure."

So, we could replicate that kind of a decision, and we could say that every American must have health insurance.

MR. MARMOR. But you see the fundamental difference that I see—what I have seen from all three of the witnesses, except Mr. Goodman—is that you are all inclined to say everybody ought to have it, and we have to find out who it is we are going to mandate to provide it for, if they will not provide it for themselves.

REPRESENTATIVE ARMEY. Mr. Goodman is saying that we ought to see what we can do in the tax laws to make it a more rational choice for people to provide it for themselves, and that is what I was saying in my point.

I pay $81 for me and my family, and I pay $151 for people I do not know. Even after my generosity—and I am not complaining about the $151—but what really burns me up is, even after all my generosity, I have to pay income tax on that $151 a month.

MR. MARMOR. I think we are in the wrong forum. I think we should be having a forum for your problem in the reform of the Tax Code. That is, you are raising a problem that is serious. I am not mocking you.

REPRESENTATIVE ARMEY. No, no, no. The problem is that it is one thing for the government to say that we mandate that you all must have insurance coverage because we do not want to assume the risk for you. We do not want others to do that because there is a risk.

If David is in an accident, he will go to an emergency room, and somebody will pay for it.

Ms. FEDER. That is right.

REPRESENTATIVE ARMEY. So, we say that we mandate that you have insurance. Okay? Now, if we made such a decision, it does not follow that we would then necessarily say, "and we mandate that you will provide it, Mr. Employer," or, "you will provide it, Mr. Taxpayer, but you will find a way to provide it for yourself."

REPRESENTATIVE SCHEUER. There is also a point of view, is there not—and I will ask the gentleman to yield, and I will yield back—that the health insurance institution—as an institution, as an industry—is so unfair, is so uneconomic, is so uncost-effective that we should not handle health care through an insurance process. And that it is far cheaper, as well as far more equitable, to assume that everybody is entitled to a minimum level of health care, and that is a given.

The total cost to society of simply stating that we are going to provide adequate levels of health care—let us say—to the entire population is

significantly cheaper than what society is going to pay through this insurance institution that you are going to talk about.

If you are really interested in delivering medical care on a reasonably fair and equitable basis to everybody, you might well want to skip the whole insurance institution and just provide the care.

REPRESENTATIVE ARMEY. Well, Mr. Chairman, I agree with you, but let me just say this. The Federal Government has only been successful in getting people to accept more benefits when they have given the bill for the benefits to the people other than the recipients of the benefits. The only time that they ever slipped up in Washington and gave the bill to the people that were getting the benefits was the Catastrophic Health Care Act.

With catastrophic, we said to the seniors, you have to have more coverage than what you are getting, and you have to pay for it, and they said, "To hell with you; we do not want it." And they made us repeal it.

Now, what I am suggesting is, if we go to the American people—and we have some 37,000 out there, many of whom——

REPRESENTATIVE SCHEUER. 37 million.

REPRESENTATIVE ARMEY. ——37 million, maybe most of whom have voluntarily decided, "I am not buying health insurance because I have something better to do with my money," and if we tell them, "you have to buy this for yourself," we are going to have a revolt on our hands.

If we pull the oldest trick of government, which is to say, we are going to see to it that you get the insurance and give you the bill, Mr. Taxpayer, and if Mr. Taxpayer dares to speak up and talk back, we are going to say, "and do not be selfish and insensitive." The problem I have with this business of providing the benefit and the mandate to pay the bill here is that there is never an expression of appreciation to the poor old beleaguered taxpayer for the good he has already done. We pick up this burden. We make our contribution. And whoever says, "Thank you, Dick, for the $181 you are giving every month?" They are saying, "My God, you have to do more because we have a disaster here."

MR. MARMOR. May I comment?

REPRESENTATIVE ARMEY. And I will be doing more for those who cannot do for themselves; we will do it. But why should we do more for those who choose not to do for themselves, irrespective of their ability to do it?

REPRESENTATIVE SCHEUER. Let me interject one point. There are programs where the whole public pays, and I think individuals who benefit say, "thank you, my neighbors and fellow citizens."

Take the social security system. It has been around for 50 years. Nobody is saying the government cannot crank out checks efficiently and cost effectively to beneficiaries who are entitled to those checks.

REPRESENTATIVE ARMEY. Well, Mr. Chairman, you have not checked with my case workers in my office, because we get this complaint every

day. The social security people could screw up a bowling ball, and they do it every day. [Laughter.]

REPRESENTATIVE SCHEUER. That is true, but nobody is saying in a serious way that social security ought to be privatized and all those things——

REPRESENTATIVE ARMEY. Oh, I am.

MR. MARMOR. But not in a serious way.

REPRESENTATIVE ARMEY. Absolutely. It should have been privatized in the first place. We should have had a "security" system, not a "social" system.

You do not find anybody today that loves social security. You find a lot of people who feel dependent upon it, and a lot of people who feel abused by it, and a lot of people that are scared of losing it, but they do not "love" it.

MR. MARMOR. Congressman Armey, you spoke earlier about wanting to have an exchange on areas of factual knowledge, and you have made some comments about your academic background. The only thing we can offer here is clarification. At least, I differ fundamentally with you in your starting premise, but the last remark you just made, for example, I do not think that you can find supporting evidence for it.

REPRESENTATIVE ARMEY. For what?

MR. MARMOR. For the claim that you just made about social security. It turns out that the evidence we have from the polls shows a declining confidence from 1975 to 1990, confidence that we will receive benefits.

REPRESENTATIVE ARMEY. Oh, I do not expect to receive benefits. My 25-year-old daughter has already told me, "Dad, I have no plans to have social security in my retirement."

MR. MARMOR. In that way, you are typical of those in the age group, 40 to 55. A majority of those people do not expect to receive benefits. I regard that as an irrational expectation. I think it is the silliest thing I have ever heard, and I would be willing to make bets with you that you will, but leave that aside.

I want to go back to the point about your claim that——

REPRESENTATIVE ARMEY. You are saying that it is irrational to not trust the government?

MR. MARMOR. No. I am saying that it is irrational for you, at your age, to expect not to receive social security benefits ... I call upon you to make a bet with me.

REPRESENTATIVE ARMEY. But is it irrational for my daughter? Is my daughter being irrational?

REPRESENTATIVE SCHEUER. I believe that there is such a public consensus behind social security, the integrity of the program, and the fact that it works quite efficiently. I will admit that your case workers, my case workers, and Congresswoman Olympia Snowe's case workers, all spend most of their time finding lost social security checks and trying to work out the kinks in the system. But I believe that there is such a

national consensus that social security is good, and there is such evidence that the income is building up in the social security program, and that for the next several decades it will not be a problem. It seems to me that there is such a consensus in the Congress, in the House, and in the Senate that—come what may—we have to face up to the problems of the social security system, rationalize it; maybe, it will take a little tinkering, as we did a few years ago with the Greenspan Commission.

From time-to-time, we will have another Greenspan Commission to work out the kinks, and face up to the whistles and the bells, but that there is going to be a viable social security system, which we may have to tinker with from time-to-time to me, is a given.

That is a powerful national commitment, and I believe it will be there.

MR. MARMOR. All I was trying to say——

REPRESENTATIVE ARMEY. Mr. Chairman, I would not confuse fear of losing your benefits with a very nervous feeling that the government cannot be trusted to keep its word with affection for the system. That is what I am saying.

MR. MARMOR. What I was trying to get to is the polling results that have to do with approval or disapproval of the principles of the program. The data show two things. It shows extremely high levels of approval, and it shows somewhat declining levels of confidence that have actually reversed themselves since 1987. I am not drawing inferences from it. I am just saying that what you just said is not supported by public opinion data up to 1990, about approval.

MR. GOODMAN. May I say something about health care? [Laughter.]

REPRESENTATIVE ARMEY. Surely. Go ahead. I am sorry.

MR. GOODMAN. You are correct that the vast majority of people who are uninsured have not been denied coverage by anyone. They have made a rational choice not to purchase health insurance.

We made a back-of-the-envelope calculation of it. When people do not have insurance, that means they are paying higher taxes than if they had acquired health insurance through an employer and accepted lower taxable wages. So, people who do not have it pay more in taxes.

We made a back-of-the-envelope calculation that, relative to the average tax subsidy of those who have it, those who do not have it pay about $7 or $8 billion in taxes each year, and that is about equal to what the hospitals say that they consume in unpaid hospital bills.

REPRESENTATIVE SCHEUER. Through the emergency room?

MR. GOODMAN. Yes. So, they pay in taxes roughly equal to the "free" benefits that they get. The problem with the system is the unfairness of it; they did not have the choice between tax-subsidized health insurance and paying more taxes. They did not have the choice between a no-frills policy and a cadillac policy, maybe with lots of extra benefits that they did not want. It is the unfairness of it.

REPRESENTATIVE ARMEY. Well, let me just——

Ms. FEDER. I would just like to make a couple of points. When you say it is a rational "choice," I think we should say a rational "decision" of the 37 million, or really 34 million, not to have coverage.

REPRESENTATIVE ARMEY. I am sure that we would not suggest that is the case for everybody, but for some large portion.

Ms. FEDER. I just want to be clear that it is rational, given their income and the cost of insurance, as you say. It does not mean that they choose not to have protection against the cost of medical care, or the access that comes with coverage.

So, when we use the term "choice" for these individuals, I think we want to remember that a third of them have an income that is below the federal poverty standard; two-thirds have incomes below twice the federal poverty standard, which is still very poor, and simply cannot afford it.

REPRESENTATIVE ARMEY. If they have incomes below the poverty standard, they do not qualify for Medicaid?

Ms. FEDER. No. Medicaid is a very inadequate safety net. It covers only——

REPRESENTATIVE ARMEY. Safety "web." Sorry, I am big on political correctness. [Laughter.]

REPRESENTATIVE SCHEUER. And I would say——

Ms. FEDER. It covers only about 40 to 50 percent of the poor.

But the other thing I wanted to say is that the problem on health coverage, related to, but somewhat different from the cost problem, is not limited to the 34 million without coverage. It is the fact that those of us who have coverage and subsidized coverage find those benefits insecure, as a result of behaviors in the insurance industry in the small group market and cutbacks in large firms. So, it is a general insecurity. And in that regard, Congressman Armey, if we look at the present market, not to the government, but to the present market system, I think, I would challenge your argument, or your premise, that the market works and government is dumb.

REPRESENTATIVE ARMEY. No——

Ms. FEDER. The issue is that there are major difficulties in the way the market is responding.

REPRESENTATIVE ARMEY. See, what happens, of course, depends on your academic training. I, fortunately, read von Mimeses early in my career. If you have the kind of training I do, the question of what we would say is the aberrant behavior of insurance brokers these days is a bothersome part of the problem.

My immediate instinct is to say, then, what, in addition to the tort laws being written on behalf of the lawyers, does the Federal Government do to screw up the insurance industry? In other words, it is not irrational for the seller of a product to cut himself off from a large segment of the market. So, obviously, there is some intrusion into the market that biases against providing that service.

I would suggest, again, if I were going to—and this has been an historically effective methodology for me—look for the cause of the problem, I would look to the public sector and to some malfeasance of public policy rather than the failure of the market.

Ms. FEDER. And I hear that is where you would look. I suggest that you might find, after investigation, there are some problems in the market itself.

MR. GOODMAN. Congressman Armey is absolutely right. There is no reason why the health insurance marketplace cannot work as well as the life insurance marketplace. The difference is that health insurance is governed by employee benefits' law and the tax system, and that is precisely what has undermined the whole market.

MR. MARMOR. We could spend all of our time talking about tax reform and insurance, and I think that is an important subject, but frankly most of the conversation in the country has to do with whether or not there ought to be a plan of an immediate employment-based form, or a plan with a single payer.

While I think it is a fascinating discussion to either worry about the way the tax system biases toward certain purchases, or to engage in a colloquy about fundamental premises that go from von Miese to somebody else, that will not engage at least part of the health-care debate we are now in, which is: What can you say about not what would be the case if we transformed the market completely, but what can you say on the basis of the evidence about the likely effects of some of the changes that have been proposed; either the proposals of John, or Judy, or that I have.

I think that what Mr. Goodman suggested is a perfectly plausible plank in tax fairness reform, with utterly speculative notions about how it would actually work out in the medical-care market, as a whole.

To claim, for example, that there is no reason why the health insurance market cannot be like the life insurance market is to raise the question of why has the health insurance market gone through a period of self-disintegration over the last 10 years?

Now, maybe it is all government——

REPRESENTATIVE ARMEY. If you will, we are not accustomed——

REPRESENTATIVE SCHEUER. Excuse me, Dick. It is not government, at all. The health insurance industry has not gone down the road to constantly squeezing out people with predictable health risks in the years to come and to constantly focusing more and more narrowly on the young and the healthy because government is telling them to do that. Government does not want them to do that at all. Government wants them to be insurers.

REPRESENTATIVE ARMEY. Well, government is real sneaky, Mr. Chairman. The government gets its message out in the sneakiest of ways. They are really sending that little message through the lawyers.

You are absolutely right. The whole national debate is about the fact that we have a health-care crisis. The best evidence that the crisis exists is 34 million people are without health insurance. And then the debate is: What then, therefore, can the government do, or make others do, to solve this problem?

MR. MARMOR. And what——

REPRESENTATIVE ARMEY. And what I am suggesting is that perhaps another part of the debate that we ought to really wade into is what then, therefore, can the government do less of, or refrain from compelling others to do, in order to let freedom work, because we have so much evidence that the government does such sloppy workmanship.

MR. MARMOR. Well, I do not want to get into a debate about whether the government is all one thing or the other. There is evidence that it screws up, and there is evidence that it does some things well.

What I wanted to call your attention to, Congressman Armey, is that for 20 years we have spent a considerable amount of political and intellectual attention on the appeal of a market in medical care. A good deal of the commentary over the last two decades in the journals that I have edited and written in has been about the putative advantages of market reform.

Now, let me just summarize where I think most analysts would come to agreement. That kind of change has not happened to the degree the advocates wished. In the meantime, health-care costs have gone through the board. The prospects of getting the kind of market that would, if it were actually in place, produce the kind of decentralized restraint that you would like are sufficiently low that the expected value of that avenue is relatively low. That is the neutral way of putting it.

REPRESENTATIVE ARMEY. In other words, you are saying that in the Journal debates and discussions, the expected value of that kind of an option is low, because the probability that government would make the kind of policy adjustments necessary to move in that direction is low?

MR. MARMOR. I would not use the word "government." It is just the predictive exercise to say that all the changes you would like——

REPRESENTATIVE ARMEY. But first you must understand that if a market exists, that market is a strange anomaly. That market can only exist as a product of public policy.

MR. MARMOR. That is right, because you set the rules.

REPRESENTATIVE ARMEY. That is right.

MR. MARMOR. Absolutely.

REPRESENTATIVE ARMEY. So, if in fact I were writing in the Journals, I might argue, after some examination—I have had some experience with this area—that I might want to go more in the direction Mr. Goodman is going, but I would probably predict then that I could not predict that kind of rational behavior from the public policy process, as I know it.

My basic rule for predicting the outcome of the legislative effort is, people ask me, will Congress pass this or that bill? And my point is, if

I can, upon analysis, conclude that the bill will be good for the future of my children, then I can reasonably predict that this Congress will not pass it. I find my model works very well.

MR. GOODMAN. May I clear up another——

REPRESENTATIVE ARMEY. So, I would agree. You may have reached a despair in the literature, saying that we cannot predict with any degree of probability that Congress would enact legislation that would carry us in that direction.

MR. GOODMAN. That is right, and may I comment, Congressman Armey, on——

REPRESENTATIVE ARMEY. But they will not enact it, and nobody dares to talk about it. That is my point here today.

MR. GOODMAN. There is one other misconception here. If all the employees of Yale University like Canadian National Health Insurance, they do not need government. They can adopt it on their own. All the employees there can join a new Yale HMO.

They can, say, spend 75 percent of average health-care spending in the United States and ration health care. That is the Canadian Health Care Plan. Or, they could, say, spend half of the average spending in the United States and ration health care. That is the British Health Care Plan. They do not need government to do this. If they like it so well, they can do it on their own.

MR. MARMOR. Well, I think that is an unhelpful remark——

[Laughter.]

REPRESENTATIVE ARMEY. Well, Mr. Chairman, anybody who abuses the faculty of Yale University is making points with me——

MR. MARMOR. ——as a basis for judgment is a fool. [Laughter.]

REPRESENTATIVE ARMEY. Mr. Chairman, enough. I know that this has been a good and lively debate, and I do want to thank you, but I do think I ought to yield.

REPRESENTATIVE SCHEUER. All right. Thank you.

I think this has been a lively discussion, and a lot of points have been brought out. I am going to recognize you next, Representative Snowe—

REPRESENTATIVE SNOWE. Thank you, Mr. Chairman.

REPRESENTATIVE SCHEUER. I have not yet had a chance to take my own time, but I will do that after you.

REPRESNETATIVE SNOWE. You go right ahead, Congressman Scheuer.

REPRESENTATIVE SCHEUER. I realize that this hearing has been somewhat disjointed, compared to ordinary hearings, but I think it has been a lively clash of intellects, and a lot of ideas have been presented. It has been a bit rough-and-tumble, but I think it has been very constructive.

I do want to say, before I recognize Representative Snowe, that we cannot entirely ignore what is going on in the rest of the world. In the rest of the industrialized world, they spend an average of just under 8 percent, and we spend just over 12 percent. We spend 50 percent more than they do, and we get far less health output. Now, those are facts.

We rank 18th in the world in life expectancy. We rank 22nd in the world in infant mortality. Our health outputs for kids aged birth to ten, for low-income families, are a national disgrace.

They have learned how to produce better health care for far less. There is no question about that. That is a fact.

MR. GOODMAN. It is not a fact.

REPRESENTATIVE SCHEUER. Tell me why it is not a fact.

MR. GOODMAN. Our doctors and hospitals are not responsible for how many drug dealers shoot each other, and how many women take cocaine and deliver crack babies. They have nothing to do with any of that.

But when the premature baby is in their hands, they do a better job than doctors anywhere else in the world.

REPRESENTATIVE SCHEUER. Look, anybody who can afford health care has an excellent health-care system to take advantage of. But for the 37 million who are excluded from health care—some of whom use the emergency room of the local tertiary hospital for their family doctor—they do achieve health care—good health care—at a horrendous price to society—may I say—at an aberrational and ineffective way of delivering health care.

For senior citizens who do not get catastrophic and long-term care, our health-care system cannot compare with the rest of the developed world, and it seems to me that we have to face up to that fact.

It seems to me that we have to face up to the gross diseconomies in our health-care system; forgetting about justice; forgetting about fairness; forgetting about equity; it is a grossly cost-ineffective means of delivering health care, and we ought to do something about it.

I do not think you can ignore the fact that the GAO and the *New England Journal of Medicine* estimate that we are currently wasting somewhere between $65 and $130 billion a year just from the process alone.

Forget about health insurance. Forget about tax considerations. We have such an egregiously inefficient means of simply paying bills in our system that we could do all of the things that Ms. Feder said a few years ago that we ought to be doing in the Pepper Commission Report; we could do all of those things just from containing the utter waste in the mechanics of paying bills.

MR. MARMOR. Mr. Scheuer, could I just ask one point about that?

REPRESENTATIVE SCHEUER. Yes. Please do.

MR. MARMOR. You ask the question, not is it true that we spend disproportionately more on administration than other systems and get, in the sense of health, inferior average results; but at the top of the best of care, you said, not is this true, but why is it that the fall has not fallen in and everybody has come to agree with you and acted upon this so-called waste? I think the answer is clear and ought to be part of our discussion.

It is because all of what you call waste is equal to the income of current jobholders who are doing tasks in the medical administrative

world, which counts to them as their well-being. In other words, I think we have to take into account that the objections to acting upon the undeniable administrative costs that you cite, the problem of acting on it has a lot to do with the protection of those incomes. I think we misdiagnose the barriers if we do not call attention to that.

REPRESENTATIVE SCHEUER. Yes, but let me just do a balancing act here. You are talking about 400,000 or 500,000 people employed in the health insurance industry, as against the interest of the 37 million people who are excluded from health insurance, as against the interest of 250 million people whose emergency rooms in their local tertiary hospital are screwed up beyond belief by the pressure of the 37 million people for whom that is their only access to medical care, instead of, say, a family doctor. You are ignoring that senior citizens are desperately underserved. We grind them into poverty as a means of getting them into Medicaid. There is no long-term program. There is no catastrophic program.

I have mentioned the problem of low-income kids, and you are talking about millions of people in each of these categories, and we are balancing their welfare against the welfare of 500,000 people employed in the insurance industry. It seems to me that society has to bite the bullet and come to some major public policy decisions.

MR. MARMOR. I agree with you.

REPRESENTATIVE SCHEUER. The first is that that is unacceptably unfair. It is unacceptably wasteful. And they are not going to stand for it anymore.

If you could tap into the brains of senior citizens around this country, you would not find disinterest. You would not find ignorance. You would find outrage. If you could tap into the brains, if by some computer process we could do that, not just the poor, not just for the unemployed, but for the young working families—working families whose incomes do not permit them to take advantage of health insurance programs—if they are not poor and not elderly, then they do not have access to those national health programs, such as they are.

We do have two national programs—willy nilly—one for the poor and one for the elderly.

Some middle-aged, employed people cannot afford private health-insurance programs because they are in a family—where, because they, their wives, or their kids may be ill, or may have pre-existing illness—that has been squeezed out of the pool of people who can get inexpensive insurance. The health insurance industry has focused on and come up with very attractive policies and rates for young healthy families. Conversely, for families with "unhealthy members," the rates are very high. For example, Empire Blue Cross-Blue Shield charges such families somewhere between $9,000 and $11,000 a year. And if they cannot afford that, then they have no health insurance.

So, we have an egregiously uneconomic and unfair system, and the people out there are way ahead of the Congress. They are way ahead of the President and Secretary Sullivan. And they want something. They

have a sense of crisis. They have a sense that something ought to be done now. Yes, to them it is a health emergency.

MR. MARMOR. I agree with your conclusion. I was just pointing out that one of the reasons that that is not agreed to in the Congress is that those who would lose by some of the policies you propose are well represented, and have changed some people's minds about what the range of politically feasible plans there are to enact. That is my only point.

I could not agree more with your diagnosis of how serious it is. I certainly agree with your point that the public is more upset than a lot of commentary within Washington would suggest, but that nobody should ever expect the American public to rise up and demand a program of a particular form, because it has never happened that we have gotten any kind of detailed public opinion that actually selects, among 10 national health insurance plans, exactly the one it wants.

If you wait for that to happen, you wait until hell freezes over, frankly.

REPRESENTATIVE SCHEUER. That is impossible. But if we wait until we get a clear signal out there among the American population that we have a Rube Goldberg structure here——

MR. MARMOR. You have that clear signal.

REPRESENTATIVE SCHEUER. ——if we have that clear signal, then the American population is telling us, look, we were not elected to Congress; we are not being paid $125,000 a year to make these very difficult public policy decisions. This is what we elected you for.

Here is the problem, and we damn well think that you ought to come up with some doable, practical, workable answers, and give us a universal system of comprehensive health care like every other country in the civilized world has.

Every advanced country in the civilized world has a health program that would take care of me. You are not taking care of me. I am suffering, my kids, and my spouse are suffering, and we are worried sick about what is going to happen when we get older and sicker; and we think that you guys ought to get down to brass tacks and make some tough, hard decisions if you are going to pretend to be worth $125,000 a year. But there is a barely rebuttable presumption—the American people are telling the Congress—that you ain't worth $125,000 a year. And if you want to prove to us that you are, you had better get down to brass tacks and pass a health program—be it insurance, be it any other thing—that makes sense for me, and I am the American public.

Now "me" as a Congressman, or I as a Congressman, that is the message I am getting when I go back to my District and travel around the country.

MR. MARMOR. That is the product of the research that I have done about the state of demand, or concern about the problem, publicly. I think that most of us here at the table would agree that the public is permissive with respect to this. The disputes have to do with the competitive notions of how best to move in a way acceptable to the public, but is likely to get

the support and produce the effects you want. That is where the disagreement, at least, takes place among Judy, John, and myself.

I think Mr. Goodman is onto a slightly different diagnosis of what the problem is and has a very different notion of what the solution is.

But I think we are agreed on your conception of where the public is. What we differ on is the remedy side, the two parts of it. One is estimating effects; and, two, estimating support in opposition. Those are the two areas where you have disagreement, at the table, among the three of us.

REPRESENTATIVE SCHEUER. Well, this has been a very interesting panel.

I want to yield now to Congresswoman Olympia Snowe from Maine, a very valuable and productive member of the Joint Economic Committee.

Take your 10 minutes, generously counted.

REPRESENTATIVE SNOWE. Thank you, Mr. Chairman.

I think we have certainly heard all dimensions of this issue this morning. I guess it is an indication of the importance of this issue and also the complexity.

I think that you just summarized the problems that we are facing in Congress.

There is no question about the necessity for a total overhaul of our current health-care system.

The question is how best we approach it. This is probably the most frequently asked question that I get at home, in addition to the economy. This is next, without a doubt.

I would like to ask you, first—and obviously there is a diversity of opinion, and that reflects what is in Congress and in America—would you agree or disagree with, currently in toto, that we are spending enough on health care in this country? I guess it has been estimated to be $758 billion in health-care expenditures. Would you say, in toto, that that is a sufficient number of dollars?

MS. FEDER. I think, Representative Snowe, that is a hard question to answer. If I could answer it another way, I think that we might all agree that those resources could do a great deal more if better allocated.

REPRESENTATIVE SNOWE. Right.

MR. MARMOR. I would actually have an easier time. I agree with Judy's last point, but I regard that as a claim on resources that could not possibly be justified by the benefits we now have. I think we could get acceptable forms of medical care for a considerably less share of our wealth.

So, that figure alarms me as a symbol of excessive spending for inadequate benefits.

MR. GOODMAN. I would say that we are spending too much, but only because what people are doing is spending other people's money.

On average, in the medical marketplace today, we spend only 25 cents out-of-pocket for every dollar we spend. Therefore, each of us has an incentive to get CAT scans, get tests, and buy everything else until it is worth 25 cents on the dollar to us. That is the major cause of waste.

REPRESENTATIVE SNOWE. Also, the medical providers, as well, have the incentive to pay for the costs of technology and services.

MR. MARMOR. I have this wonderful image of myself trying to decide whether to buy a car or a CAT scan. [Laughter.]

REPRESENTATIVE SNOWE. The point in seeing how we have tried—and not very successfully, I might add—to control health-care costs in government—for example, the prospective reimbursement system—we have not done a very good job. That is my concern about a single-payer system.

MR. MARMOR. Let me just challenge that, Ms. Snowe.

I think it is fair to say that what we have shown in the Medicare Program is that we can actually squeeze quite tightly on hospitals and physicians, squeeze so tightly that the hospitals are demanding compensatory payment, and, therefore, we have the wrong architecture. It is not that the government is not very interested in cost containment in Medicare.

REPRESENTATIVE SNOWE. We have gotten interested, but——

MR. MARMOR. Gotten interested, and in the hospital sector, has actually done it. But what has happened in Medicare is that the Medicare hospital bills rise less rapidly. But because of the architecture of payment, those costs are, to some considerable degree, but not entirely, shifted to other payers.

REPRESENTATIVE SNOWE. Absolutely. Because the hospitals, in order to cover their costs, shift the costs to the private insurance claims.

MR. MARMOR. And the argument for both the single-payer or a coordinated multi-payer scheme of the kind Judy and John were talking about, the argument for either one of those is that unless one set of rules apply to the allocation, unless that happens, you are going to have an orgy of cost-shifting. And that is exactly what we have experienced in the last 20 years.

REPRESENTATIVE SNOWE. You think the single-payer approach would correct that problem?

MR. MARMOR. I agree with Judy on the following point. I think you can imagine either a single-payer scheme that would address that or a very complicated, but nonetheless, imaginable integrated, coordinated, and multipayer scheme.

We have examples of both in the world. It is not a matter of having to invent the wheel.

The question is not whether it is possible. It is possible. It has been done. The question is what has been done, is that imaginable with a high degree of probability in our particular political system? That is the great leap of faith.

MR. HOLAHAN. Could I add to that?

REPRESENTATIVE SNOWE. Yes.

MR. HOLAHAN. I think that there is considerable evidence that the prospective payment system in Medicare has been successful in controlling hospital costs. Clearly, Medicare expenditures are lower than they would have been, even after accounting for the shift onto physician care,

nursing homes, and home health care. In addition, the states that have adopted all-payer rate setting systems for hospital care have also been very successful, and there is very clear evidence of that in a number of studies.

So, I think there is strong evidence to support that.

MR. MARMOR. If you could get——

MR. GOODMAN. It is my turn. [Laughter.]

REPRESENTATIVE SNOWE. Yes. Go ahead.

MR. GOODMAN. The DRG system is an improvement over cost-plus-reimbursement.

REPRESENTATIVE SNOWE. Oh, yes. No question.

MR. GOODMAN. It is hard not to think of any system that would not cause costs to go up faster than cost-plus-reimbursement. Nonetheless, it is a price-fixing scheme. What we have is increased rationing of health care.

There are certain technologies, such as the cochlear implant, which I understand is a marvelous invention—three or four years old now—that could restore hearing to millions of elderly people, and, yet, most Medicare patients do not get it, because the government refuses to reimburse at anywhere near the rate that covers the hospital's costs.

And to the degree that you eliminate cost-shifting and still fix prices, if you move in that direction, we are going to have more and more rationing through our Medicare program.

REPRESENTATIVE SNOWE. Well, will not the consolidation, the standardizing of claims, and the consolidation of reimbursement offset that in a single-payer system?

MR. GOODMAN. What matters is whether you fix prices. What price fixing means is that the hospital has to treat the patient, whether the cost is more than the price or under the price. And if you do not allow them any way to cost shift, which is what the other three do that you are proposing, then, hospitals will be forced to ration health care.

MR. MARMOR. Ms. Snowe, could I just make this adjustment?

REPRESENTATIVE SNOWE. Yes.

MR. MARMOR. I think the word "rationing" has been used a number of times in this hearing in a way designed not to illuminate, but to inflame.

There is no way of talking about medical care without talking about rationing, if you mean by that you are not going to do everything——

REPRESENTATIVE SCHEUER. For everybody.

MR. MARMOR. ——for everybody. You cannot do that. Nobody does that. Thinking about a world without rationing, in that sense, is frankly fiction.

Now, to talk about the United States as if it does not engage in considerable amounts of rationing is, I think, misleading.

Every system does it by one or another way, and I think it would be useful, instead of using an inflammatory word like that, to ask a question like this: Tell me, what is it that seems to be the devices in other systems

that have restrained expenditures below that of the United States? And to what extent does it involve denying life-saving care? To what extent does it involve lower incomes for providers? To what extent does it involve lower access to technology of a life-saving kind? That is the thing we could communicate to you in a factual way.

But if we use terms like "rationing," meaning denial of people's lives of the kind Oregon is involved in, I think we will not illuminate.

The only thing that we can do is to supply you with information about what we have studied concerning this. We cannot supply the conclusion that you draw from it.

MR. GOODMAN. Well, then, I will answer your question. The Brookings Institution did a major study of how health care is rationed under the British National Health Service. They concluded that, relative to care people get in the United States, there were 9,000 kidney patients every year that do not get renal dialysis or a kidney transplant, and who presumably die.

Relative to the United States, as many as 15,000 heart patients every year in Britain did not get the kind of treatment they would in the United States. Another 15,000 cancer patients were not getting the care that they would have received in the United States. These are real.

There are another 7,000 to 8,000 elderly patients who do not get their hip replacements. These are real people living in pain, some of them dying because they are not getting real care.

REPRESENTATIVE SCHEUER. And real Congressmen in the United States are paid $125,000 a year to make those tough public policy decisions.

MR. GOODMAN. Why should I let you decide whether I am going to live or die?

REPRESENTATIVE SCHEUER. Well, because we have a representative form of government, and your health care——

MR. GOODMAN. I should just "trust you?"

REPRESENTATIVE SCHEUER. ——system, in some way, is going to reflect Congress's distillation of the views of 250 million Americans.

Now, I can tell you that some of those means of rationing, which are apparently accepted in England, would be totally unacceptable here.

MR. MARMOR. It is a red herring.

REPRESENTATIVE SCHEUER. I will divulge to you that I am 71 years old. I will also divulge to you that nobody over the age of 55 in England gets kidney dialysis.

I would be among the people who would say that that is unacceptable, and I would have a vast population out there who would be enraged if Congress ever presumed——

MR. MARMOR. And no one is proposing it.

REPRESENTATIVE SCHEUER. And no one is proposing it.

MR. MARMOR. There is nobody asking for——

REPRESENTATIVE SCHEUER. And there are plenty of ways that the British System underserves their people. There are some significant ways in

which the Canadians underserve their people with health care. Most of those are already provided in our current health-care infrastructure.

MR. MARMOR. By the——

REPRESENTATIVE SCHEUER. I will yield to you in a moment.

We have the doctors. We have the specialists. We have the tertiary hospitals. We have a variety of highly sophisticated, high-tech institutions that provide us CAT scanners, open-heart surgery, kidney dialysis, renal transplants, and the rest, organ transplants of all kinds—they are already here. We would not eliminate them if we went to a national health-care program.

I suppose it is possible that, if the Canadians went from the current 8.5 to 9.0 percent that they spend to our 12.4 percent, they would be able to supply some of these things, too, that they do not supply now, and for which many of the Canadian citizens—90 percent of whom live within 100 miles of the U.S. border—come across the border to Detroit and other places, and purchase those things that their government does not wish to pay for.

We would make different public policy decisions on many of these things. I think we would end up underserving our people far less with health expenditures at 12.4 percent of GDP.

I think, perhaps, we might also convince the American public that the salvation of their health-care needs is not in open-heart surgery, is not in kidney transplants, is not in an additional profusion of CAT scanners; maybe, it would rely more on our convincing the American public that we have all met the enemy and he is us and that we all control, to a great extent, our own health outputs.

And if we modified our own health behavior, in terms of smoking, in terms of drinking, in terms of ingestion of drugs, in terms of diet, and in terms of sexual behavior, yes, we could improve our health outputs remarkably. We would reduce addiction. We would reduce AIDS.

As difficult as it is to change health behavior, we have had remarkable changes in America. We have had remarkable changes in our smoking addiction—vast improvements.

The cattle industry will tell you that Americans are not eating as much fatty meat. The poultry industry will tell you that we are not eating as many poached eggs or fried eggs in the morning as we used to, because Americans are watching their cholesterol.

There has been a reduction of drunken driving accidents.

We have modified our health behavior considerably.

We ought to do it more in the field of our sexual behavior. There are vast possibilities in reducing the toll of AIDS.

We have a long way to go, and I think we have to convince the American public that the answer to their own future health outputs is far more in their own behavior than it is in the window of opportunity offered by kidney transplants and open-heart surgery.

That is the end of my questioning for this morning.

Please proceed, Olympia.

REPRESENTATIVE SNOWE. Thank you, Mr. Chairman.

I think I lost my train of thought. [Laughter.]

REPRESENTATIVE SCHEUER. You will get your 10 minutes with a generous count.

REPRESENTATIVE SNOWE. No, that is all right, Mr. Chairman.

I think we probably could go on and on on this subject. There is no doubt about that.

REPRESENTATIVE SCHEUER. We have and we probably will.

REPRESENTATIVE SNOWE. Yes. I guess, getting down to it all, is how best should Congress proceed? I think that is the big issue. Should we do this overhaul? Whichever way we go, frankly, whether it is public/private, or single-payer, it is going to require an overhaul of the total system. So, how do we begin that process?

MR. MARMOR. Well, my own view about that is that this is such an important area, and the Congress finds it so hard to focus its attention on this area for a long enough time to look at it, that it might require an institutional innovation as to how to address it. In other words, I would take a procedural approach first, and then a substantive conclusion second.

For instance, leaving aside Congressman Armey's remarks about social security—which I do not agree with and do not think can be substantiated, but he is entitled to what he thinks—it is regarded as a successful American program. It cannot be simultaneously a sacred cow and an endangered species, politically. If it is a sacred cow, it is not endangered.

Now, how do we get that? We get that by a process where analytical work is done on an alternative means of securing the security of Americans.

The Committee on Economic Security in 1935 did not operate within a congressional context, but supplied to the Congress the product of a year's work of alternative ways to secure solutions against problems. Each of the alternatives had their barriers and troubles identified. So, when they chose in the Congress, they chose coherent packages.

My implication for this would be this: I would identify three possible scales of change that you could imagine.

One is restricted to no federal change in outlays at all, but to solely the rules of the game—the malpractice, the tax adjustments, and the like—and you would have a set of tasks there that would be identified, a set of options that would have no big fiscal implications.

The second set would be ones that assumed that you had to live with the very complicated present, private/public mix, and then you would ask, how could you do that in a way that would not produce more trouble and actually secure the future of it.

And the third is imagined adaptations to single-payer.

Give a menu to the Congress of a form that can be defended, not cite materials drawn from Heaven without documentation, without persuasion, but, in fact, say that it is the Congress's job to think through the value choices represented by each of these three and to balance the political

gains and losses. But if it chooses to go down one road rather than another road, it ought to have coherent packaging.

It is the idea that you want to produce a national health insurance reform, in the conventional way of congressional committees, then with a conference in which decisions made about benefits and taxes, which will affect this whole $750 billion industry, I think, is wrong.

That is the longish, but short answer.

MR. GOODMAN. I will give a short answer.

Congress needs to do two things. The first thing that it needs to do is to listen to the message coming from all over the world. From every Continent the message is: Bureaucracy does not work. Collectivism does not work. Socialism does not work. We should hear that message. Whenever I go to countries with national health-care plans—whether it is Sweden, or Britain, or New Zealand—the message that I hear over and over again is: Socialism in health care is not working.

How can we privatize? How can we introduce competition into our systems? We do not know how to do it, but we have to find ways of doing it. We should hear that message.

The second thing that Congress should do is to examine all of the things that the Federal Government is doing right now to make our problems worse; to cause people to be uninsured; to cause health-care costs to rise; and begin by undoing the harm that you are doing before you go out and jump on some revolutionary band wagon.

MS. FEDER. Representative Snowe, I think that I would take issue to some extent, or perhaps to a considerable extent, with what Ted Marmor suggested. I do not think that you should take it outside the normal congressional process. That process may be difficult, but I think it is the only one that produces action.

It sounded to me like Ted was calling for a commission. I was staff director of that Commission—the Pepper Commission.

We have already done much of what he suggested. I think the sense at the time was that we needed a commission, not so much because Congress needed advice on how to act, but explicitly because Congress was not ready to act, and this looked like action. Fortunately, I think, we got a set of principles that the Congress is, and can begin to, and is using to guide its debate.

It is my sense that you simply have to get moving. You have legislative proposals introduced, and you have chairs of the major committees that have to act committed to proposals, and I think you have to begin to move through the legislative process and push on the President to engage in that process.

Another related but side point. With the debate about comprehensive health-care reform, there is an ongoing discussion of incremental improvements in the health-care system.

The insurance reform that we have talked about is a major issue. Malpractice is a major issue. Proposals exist to address these issues, both of which are very serious problems that require attention.

But I think, as you look at an increment of improvement in the health-care system and attempt to move forward on that, you have to look very carefully at how that relates to where you are going next, and be certain that a particular modest action is not oversold as a solution to a much broader problem.

REPRESENTATIVE SNOWE. Mr. Holahan.

MR. HOLAHAN. I guess I would add a couple of things.

I think I largely agree with what Judy just said. I think to think that the Congress and the Senate could pass a system, modeled on the Canadian system, is just incorrect. I do not think it can happen. I could be wrong, and that is your call, as Mr. Scheuer said.

I think the Pepper Commission laid out a proposal that really makes a lot of sense in the context of American institutions. There have been bills introduced in Congress to build on that and to change those recommendations to some degree. There have been organizations and people like ourselves that have tinkered with it and modified it in some fashion. Karen Davis is another who has recommended a similar modification.

I would recommend that you strongly get a hold of those approaches and figure out a system that would work within that context.

That, by the way, does not preclude melding it with an all-payer, rate-setting approach.

The other thing that I would recommend is that you pay a lot of attention to what is going on in the States these days. There is an enormous amount of concern and activity at the state level in dealing with both the issues of the uninsured and cost-containment. The Robert Wood Johnson Foundation is going to support a major effort to help states launch new initiatives, because they really believe that it is not going to happen at the federal level.

REPRESENTATIVE SNOWE. Thank you all, very much.

REPRESENTATIVE SCHEUER. Let me say that you are absolutely right there, that there are a lot of initiatives, and a lot of creative thinking going on at the state level.

Wherever there is a vacuum in leadership in the Federal Government, you can almost be sure that the governors are going to be doing innovative things in that area.

For example, Lamar Alexander, who is our Secretary of Education, did very interesting things in his state when he was governor. He and a number of other governors, about a dozen of them—a baker's dozen; I think there were 13 or 14—had targeted tax increases for the purpose of education. Voters approved the tax increases, and they reelected the governors.

Now, this is in comparison to a Federal Government that seems absolutely paralyzed in facing our education situation. Similarly, in the field of energy. In the national energy policy, there is virtually nothing about energy conservation, virtually nothing about energy efficiency,

virtually nothing about developing alternative forms of energy to fossil fuels, and yet states are doing it.

In California, utilities are offering to help private companies, and office building owners, and so forth pay for energy conservation installations, capital equipment, new motors, new glass panes, new heating, air conditioning, and ventilation. They are offering rebates. They are offering cost-sharing arrangements to businesses that do that.

So, similarly, in the field of health care, New York State is developing its own single-payer system.

MR. HOLAHAN. Right.

REPRESENTATIVE SCHEUER. The chairman of the health committee in the New York State Assembly is developing that, and there are at least a half a dozen other states that are doing remarkable things.

Maybe, the absence of federal leadership is proving that the federal system of limited powers to the Federal Government and the rest of the powers to the states is really working, and that governors, mayors, state legislatures, and private utility corporations of all kinds—private corporations of all kinds—are quite capable of exercising initiative and foresight and accountability in moving in where there is a vacuum of need. That is happening.

I want to thank this panel. I have been a pitifully poor chairman. We have been going for two-and-a-half hours. I assure the next panel that we will go for at least an hour-and-a-half. I have to Chair another committee at 2:00 o'clock, but we can go until a quarter to 2:00.

I want to thank this panel very much, and we will excuse you.

I will call up the next panel as soon as I go and vote on this roll call vote.

[Recessed, to reconvene at 12:35 p.m., this same day.]

REPRESENTATIVE SCHEUER. This Subcommittee of the Joint Economic Committee will come back to order.

I want to apologize to the witnesses for the lateness of the hour. It may have been my fault in letting this rough-and-tumble hearing proceed as it did. Be that as it may, we will have a full hour, maybe an hour-and-a-quarter, so that we will get a full hearing for this panel.

This second panel will present a review of health-care reform proposals from the perspectives of consumers of health care, including knowledgeable representatives of retirees, labor, consumer groups, and business organizations.

I think we are fortunate to have on this panel Linda Lipsen, Judith Brown, Karen Ignagni, William Dennis, and Walter B. Maher.

We will go right down the list, from my left to my right.

So, first, let us hear from Linda Lipsen, Legislative Counsel of Consumers Union. She represents the consumer interests on health-care and insurance reform.

And let me say to all of you that your full statements will be presented in their complete form at the point in the record at which you speak.

We would ask you to limit your statements to seven or eight minutes, and then we will have adequate time for questions.

So, Ms. Lipsen, please proceed.

STATEMENT OF LINDA LIPSEN
LEGISLATIVE COUNSEL, CONSUMERS UNION

Ms. LIPSEN. Thank you very much, Chairman Scheuer.

I am Linda Lipsen. I am the Legislative Counsel for Consumers Union. We publish *Consumer Reports Magazine*, which I brought as a reminder of who we are. We have been looking at health issues for 54 years. Our articles, dealing with various health issues, appear in the very first pages of *Consumer Reports Magazine*. In our August and September issues in 1990, we published a prize-winning, two-part series called, "The Crisis in Health Insurance." I can make that series available for your hearing record, if you so desire.

REPRESENTATIVE SCHEUER. Please do. This is from a few months ago, is it not?

Ms. LIPSEN. It is from August and September 1990.

REPRESENTATIVE SCHEUER. Yes. That would be fine.

Ms. LIPSEN. In these articles, we documented the dimensions of the health-care crisis. Many of the statistics that you have recited today—and I do not need to revisit them—say that we have 37 million Americans that are uninsured; 50 million may be underinsured for much of any given year. We lag behind most other industrialized countries in meaningful health indicators. In sum, we spend more, get less, some get nothing, and we at Consumer Reports think that it is time to do something about it.

Because of our commitment to reform in this area, we looked at a number of proposals that are presently dominating the national debate. We concluded that the best approach was one that established a single payer for financing health-care costs. We decided this because a single-payer system would meet the twin goals of universal access to health care and containment of costs.

The response to the articles was extremely impressive. You have heard these stories in your town meetings and across this land. We got letters from hundreds of consumers, every one telling us heart-breaking stories.

Some were telling us stories about selling their homes to pay for cancer operations. We heard from those that were holding onto dead-end jobs because they were worried that if they left they would lose their health-care benefits.

This phenomena now has a name. The *New York Times* called this "job lock," and we are very concerned about that.

We heard from many who could not get insurance because of some past medical condition. What has changed now is that the past medical conditions that are denying coverage are getting less and less serious.

We used to see diabetics and cancer patients not being able to get medical insurance. Now, the illnesses are much less severe.

REPRESENTATIVE SCHEUER. What kind of illnesses?

Ms. LIPSEN. We heard from a consumer that could not get insurance because they admitted to going to a marriage counselor. We found this to be offensive.

REPRESENTATIVE SCHEUER. I agree. That is totally offensive.

Ms. LIPSEN. Many told us that they could not get life-saving tests because their health insurance just would not pay for it. Also, many told us that they were taking from their savings to pay medical bills.

These stories are not particularly new. We have heard them at various times throughout the 55 years that we have been writing about this.

But the profiles of the storytellers are changing dramatically. Individuals, of course, without health insurance may be poor, since only 38 percent or 40 percent of the poor are covered by Medicaid. But increasingly, lack of health insurance has become a middle-class phenomenon.

Now, individuals finding themselves without adequate health insurance include men and women who are beginning their own businesses, or are employed by small businesses; part-time workers; young people, most of which are just starting out in their careers; divorced, disabled; many taking early retirement that cannot qualify for Medicare yet; workers whose employers are going out of business, many with pre-existing conditions that I discussed earlier; and students. In other words, rich/poor, young/old, employed or unemployed, black/white/red/yellow, we all are at risk for losing health insurance. And even those of us who feel relatively comfortable with our employer-paid systems can be really just one illness away, or one injury away from losing both our health insurance or our savings.

The middle-class—and you know this from your town meetings—are profoundly insecure in this area. Consumers believe that insurance is only available to those that are extremely healthy.

REPRESENTATIVE SCHEUER. To a large extent that is true.

Ms. LIPSEN. Now, we are—and I am sorry that Congressman Armey is not here for this—an organization that does not always come to Congress asking for public policy solutions. We believe in the private marketplace. I mean, anyone who has read *Consumer Reports Magazine* for years knows this about us. But this is a marketplace that is not terribly responsive.

In this marketplace, the competition is not about lowering prices for consumers or improving services. In this marketplace, the competition has become a struggle amongst the 1500 insurance carriers to attract the healthiest risks. In this marketplace that we all have to live in currently, the health insurers have a clear incentive to deny coverage to people who need it and to limit other coverages.

We do not feel, although we are involved in the process of working around the edges and tinkering in the area of insurance reform, that some of the proposals, like small-group market reform and some long-term care

reforms, which also have some benefit, are going to solve the access problem that we raised earlier.

Thus, we will turn to public policy solutions. Poll-after-poll shows that the American people are extremely unhappy with their health care.

A 1988 Harris Poll found that 61 percent prefer a system of national health insurance similar to the one in Canada. This year, a Los Angeles poll, asking a similar question, found that 66 percent would prefer a national health-care system similar to ones provided by our neighbors to the north.

The benefit of a single-payer system—and I will be brief in this—is simplicity. Simplicity. When I listened to some of the distinguished representatives from the academic community describe alternative proposals, I was hard-pressed to really understand what they were talking about, and I work in this field. [Laughter.]

Consumers are so confused by the paperwork burden. This is not an informed marketplace. So, to provide a single payer that will just take care of this aspect of our daily lives would be extremely preferable to the morass of paperwork that we presently find ourselves in.

Also, cost containment. A single-payer system, according to the GAO—and you have heard these figures—will eliminate administrative waste. This study says to the tune of $67 billion. Other estimates are higher than that.

Also, remember that if you have a different system—a single-payer system—consumers would no longer have to pay for the health benefit in their workers comp insurance, or in automobile insurance. I think this has to be looked at because that payment is just going to go away.

Also, I think that the cost containment works because of the global budgeting feature that is currently in a single-payer system.

The third reason why we like a single-payer approach is because of its universality. Everyone would be covered under such a system, regardless of their ability to pay or employment status.

And finally, consumers do want to choose their doctors, I think, largely. A single-payer system has this feature to recommend it. The consumer is allowed to find their own doctors. I do not believe that consumers want to choose from 1,500 competing insurance companies.

We believe that the United States should take the best features of the Canadian system and do it better here.

In conclusion, we are hopeful that the debate over health-care reform will ignore the entrenched interests and create an equitable and humane system for all our citizens.

Thank you, very much.

REPRESENTATIVE SCHEUER. Thank you very much, Ms. Lipsen.

[The prepared statement of Ms. Lipsen, together with two magazine articles, follows:]

PREPARED STATEMENT OF LINDA LIPSEN

Mr. Chairman and Members of the Committee, I am Linda Lipsen, the Legislative Counsel for Consumers Union[1], the publisher of Consumer Reports. I greatly appreciate this opportunity to share our views on the crisis in American health care and the pressing need for comprehensive reform of our system. In recent years, few topics have so dominated our concerns as the failure of the health care system to accommodate all citizens.

Most recently, Consumer Reports published a 2-part series, **The Crisis in Health Insurance**, in the August 1990 and September 1990 issues. In addition to documenting the dimensions of the health care crisis, the articles concluded that a single payer approach to health insurance would meet the twin goals of universal access to coverage and containment of costs. The reader response to the CR articles was impressive. The letters were extremely personal and moving accounts of tragedy and despair due to the lack of access to affordable health care.

We were greatly encouraged that the GAO Report on the

---

[1]Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumers Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 4.9 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

"single payer" Canadian system found such enormous cost savings through curtailing administrative waste and global budgeting. It is our hope that this important study will embolden policymakers.

Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 per cent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government sets all fees charged by doctors and hospitals." This year, a Los Angeles Times poll asking a similar question found that 66 per cent of Americans would prefer a health insurance system similar to Canada's.

As you have heard throughout this series of hearings, our health care system is the costliest in the world. The U.S. spends 171 per cent more per capita than Great Britain, 124 per cent more than Japan, 88 per cent more than West Germany and 38 per cent more than Canada. We pay more, much more--but get less. We lag behind numerous countries in important health indicators. As this Committee is well aware, 37 million Americans are not covered by health insurance at all and at least 60 million may be underinsured for much of any given year.

Individuals without health insurance have many faces. They may be poor, since only 38% of the poor receive Medicaid. But increasingly, lack of insurance coverage is a middle class

phenomenon. Individuals finding themselves uninsured or uninsurable include:

(a) men and women employed by small businesses

(b) the self employed

(c) part-time workers

(d) young people just starting their careers

(e) the disabled

(f) the divorced

(g) those taking early retirement, but still too young for Medicare

(h) workers whose employers go out of business

(i) those with pre-existing conditions

(j) students

With the present patch-work private insurance system, everybody--rich and poor, employed and unemployed, male and female, young and old---is at risk of being without health insurance. Even those of us who feel our employer-provided policies protect us well could be just one illness or one accident away from losing both our health insurance and our savings.

Our August 1990 article told the story of David Curnow, formerly a partner in a San Diego law firm. He was injured in an accident, when (while riding his bicycle) he was struck by an uninsured motorist. While his insurance carrier paid most of his

bills (which totaled nearly $250,000), he has considerable out-of pocket costs for the home-health aide services he needs every day. But before long, his health insurance benefits will run out. Eventually he will qualify for Medicare because of his disability, but he will be unable to get coverage for expenses not covered by Medicare. If he is able to return to work, it is not very likely that he will find a firm that has an insurance company willing to accept the health risk he poses.

While there is growing understanding that a large per cent of the poor have inadequate health insurance and limited access to health care, recognition that the health access problem is a major problem for the middle class is more recent. The case above of a partner in a law firm shows how an accident can suddenly create a health insurance problem for someone who not long before was a gainfully employed, healthy person.

The middle class can be affected in many other ways as well. Since many employers have dropped or cut back on their health insurance benefits, many relatively well-paid employees, especially individuals working in small firms, may lack access to an affordable health insurance policy.

Consumer Reports told the story of a small employer in California whose health insurance premiums doubled in one year, with premiums for one employee of over $10,000 per year. Over half of the non-elderly population without health insurance are working adults. And the spiralling health care costs are leading to high premiums that force the middle income consumer--both

employees of firms and the self employed to drop coverage in too may cases. In 1987, 25 per cent of the uninsured worked for very large employers who offered health insurance.

Moreover, the number of employers paying premiums is declining. In 1984, Hewit Associates, a benefits consulting firm, found that 37 per cent of large employers paid full premiums for their workers. By 1988, only 24 per cent provided these benefits. Consumer Reports noted that 48 per cent of the low wage members of the Service Employees International Union (whose members are hospital workers, janitors, and government employees) were offered insurance but turned it down because they could not afford the premiums. Health conditions of some employees, like Kay Nichols (who, at age 38 has glaucoma) lead employers to be either locked-into existing health insurance policies (unable to shop around for a lower-priced policy) or to face difficult-to-accept exclusions from new policies.

Working Americans can lose their health insurance when their employer goes out of business. When individuals not covered under a group policy seek out coverage for their families, they discover a bleak marketplace. Even less than adequate coverage may cost thousands a year, with premiums ever rising. Individuals shopping for coverage soon discover that insurers want to cover fewer and fewer people. Insurers compete ardently for the healthiest applicants. While no carrier wants to cover individuals who have had a history of cancer, heart disease, or life threatening illnesses, increasingly insurers are turning

down people with far less serious health conditions. Virtually no commercial carrier, and only a handful of Blue Cross and Blue Shield companies, will sell policies to anyone who has had heart disease, cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol abuse, depression or even visits to a marriage counselor can mean rejection. If you have less serious conditions, you may get coverage, but on unfavorable terms. Some insurers will offer coverage, but only if the preexisting condition is excluded. Companies in our survey told us that between 1/4 and 1/2 of their policies carry exclusion riders, higher than standard premiums or both.

Moreover, if you are rejected, that fact will be recorded at the Medical Industry Clearinghouse, which is accessible to insurance carriers. The clear message to consumers is that only those in excellent health need apply. People who have medical problems, however minor, are second class citizens in the world of health insurance.

Other middle income consumers are affected by the health insurance quagmire because their health insurance concerns lock them in to their present jobs. Pre-existing health conditions and the fear of losing critical health benefits keep them from being able to change jobs, or careers.

We are deeply concerned that people are forced to make career decisions purely based on health insurance issues. They may be unable to accept new and more promising positions because of insurers' "existing conditions" practices. It is entirely

possible that fears about health insurance may be stifling the mobility and motivation of workers in American companies.

The lack of health insurance affects people's health and often has deadly results. Consumer Reports told the sad story of John Andrusyshyn who died of a malignant melanoma, after treatment was delayed because he delayed going to the doctors since he could not afford to pay another bill. He was not eligible for insurance from his employer until he had been on the job for a year. There are many tragic examples like this one. In response to these articles, one reader with an annual income of $11,000 wrote that a hospital would not perform his wife's needed cancer operation because of his inability to pay $7,000 up front.

It is especially troubling that many Americans become educated about the inadequacies of our health care system just when they already have major problems on their hands: a severe accident an acute illness, the development of a chronic health condition, the loss of a job. It seems especially unfair to burden people with what amounts to an unsolvable problem just when other crises hit.

Women without adequate coverage are particularly at risk for bad health outcomes. Uninsured women are much less likely than insured women to have screening tests for breast cancer, cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Five million women between the ages of 15 and 44 are covered by private health insurance that does not

include maternity coverage. Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 22 other nations in infant mortality behind Germany, Spain, and Singapore.

The health care problem has many dimensions, including the critical need for controlling costs. When the uninsured are unable to afford health care, everyone pays. In 1988, unpaid hospital bills totalled more than $8 billion--up 10 per cent from the previous year. To recoup the costs of unpaid care, doctors and hospitals raise the price for everyone else. This cost shifting in turn drives up the price of insurance, resulting in more people not being able to afford coverage. Cost shifting accounts for about one-third of the increase in insurance premiums which are rising as much as 50 per cent a year. The cost of medical care--which is increasing 2 to 3 times faster than the rate of inflation--accounts for the rest.

During the past 50 years, health care expenses (as a per cent of gross national product) have grown rapidly.[2] In 1940, national health expenditures were 4.0 per cent of GNP. The per cent rose to 8.3 per cent in 1975, and to 11.1 in 1987.[3] The corresponding figure (in 1986) for Britain is 6.2 per cent, for

---

[2]Robert B. Henderson, M.D., Health Care in the United States Metropolitan Insurance Companies, 1982, p. 15.

[3]Source Book of Health Insurance Data, Health Insurance Association of America, 1989, p. 49, quoting, U.S. Department of Health and Human Services, Health Care Financing Administration **Health Care Financing Review**, Winter 1988.

Canada is 8.5 per cent, and for Germany is 8.1 per cent.[4] If present trends continue, health care will consume 15 per cent of GNP in the year 2000.[5]

Insurance companies are beginning to pay close attention to what their dollars are buying. Insurers are now more involved in monitoring the quality of treatment and determining whether the treatment was appropriate to the condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals and to obtain approval from insurance companies before starting a proposed course of treatment. While these measures may have some minimal effect on costs, these controls on doctors have created a new field of health care cost management---one of the fastest growing fields in the health care area. Health care cost management firms are expected to generate $7 billion in revenue in the next few years--revenue that will, of course come from insurance premiums. These expenditures contribute not one iota towards improving health care for people who need it.

These firms are expert in teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system. Brochures

---

[4]Ibid., p. 48.

[5]For the Health of a Nation: A Shared Responsibility , Report of the National Leadership Commission on Health Care, Health Administration Press Perspectives, Ann Arbor, Michigan, 1989, p. 3.

tout, "You'll improve your reimbursement or get your money back." The primers sold by these firms tell physicians how to choose certain billing codes over others that would net them less income. To fight back, insurers are rebundling the bills that come into their claims departments. Indeed a rival industry has sprung up to scrutinize bills for evidence of billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers computer software that will rebundle a $2500 bill for performing an appendectomy ($1,500) with a laparotomy ($1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only $1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on this expertise is doing little to improve the health of Americans.

Consumer Reports concludes that the best approach that could both provide universal access to high quality health care while controlling costs is a model that features a single payer, rather than thousands of private carriers competing for the healthiest applicants. Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

We are encouraged that the House Committee on Government Operations is undertaking a serious examination of the American health care system and look forward to working with this Committee to move the concept of universal access to health care towards a reality for our nation.

A REPRINT FROM **CONSUMER REPORTS** MAGAZINE

Consumer Reports

PART 1

THE CRISIS IN HEALTH INSURANCE

- **WHO LOSES IT? WHAT HAPPENS?**
- **WHICH POLICIES ARE BEST?**

A reprint from the August 1990 issue of Consumer Reports magazine.

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Part Two examines some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorcee, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

Photos: CYNTHIA JOHNSON

Crisis: Delayed care

John Andrusyshyn worked in a Nevada casino. Three summers ago, he noticed a mole growing on his chest, but said nothing about it to his family. He could not afford to pay another bill, so he put off seeing a doctor. Andrusyshyn was not eligible for insurance from his employer until he had been at his job for a year; he couldn't afford his own coverage on the $880-a-month he was bringing home to support his wife, Karen, and two children, Laura and Nikolai (pictured at right).

Several months went by before Karen insisted he go to a doctor. Because dermatologists in Reno were booked up, three more months passed before a doctor examined him. By then, the mole had ulcerated, and John was so desperate for treatment he paid for the visit with a bad check.

The diagnosis was a malignant melanoma that was already coursing through his body. By the time he underwent surgery, he was eligible for insurance from the casino. But Karen had to scrape together $56 a week to pay his share of the premiums, forgoing food and other necessities. The policy covered the hospital bill, but not the $4000 surgeon's fee. On John's medical records, doctors noted: "Patient has no money; we'll do the best we can."

Soon afterward, the Andrusyshyns traded in their mobile home for a '62 Airstream trailer plus $1500 in cash, borrowed a credit card from a relative, and headed for Canada where John was born. As a Canadian citizen, he was entitled to free medical care. In Montreal, doctors tried various cancer treatments, including brain surgery, which he could not have paid for in Nevada. But treatment came too late. Last fall, at the age of 54, John Andrusyshyn died.

"Had we had the medical care available in Nevada like we have here, he would have said something to me," Karen says. "A little thing like an early diagnosis could have added four or five years to his life. That would have meant a lot to this family."

Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 23 other nations in the percentage of babies born with an inadequate birth weight and ranks 22nd in the rate of infant mortality, behind such countries as East Germany, Spain, and Singapore.

Shifting the cost

When the uninsured are able to obtain health care, everyone pays. Each year thousands of people are dumped into emergency rooms of public hospitals because private hospitals don't want patients who can't pay.

In 1988, unpaid hospital bills totaled more than $8-billion, up 10 percent from the previous year. To recoup the costs of unpaid care, hospitals and doctors simply raise their fees to those who do pay—primarily the private insurance carriers and the Federal government.

Such cost-shifting drives up the price of insurance, resulting in even more people who can't afford coverage. In New Jersey, for example, every hospital bill now carries a 13 percent surcharge, reflecting the hospital revenue lost to unpaid bills. That, in turn, feeds into higher insurance premiums.

Cost-shifting accounts for about one-third of the increase in insurance premiums, which are rising as much as 50 percent a year. The cost of medical care—which is increasing two to three times faster than the rate of inflation—is responsible for the rest.

Unaffordable premiums

The higher the price tag for insurance, the more people who go without it. Firms with fewer than 100 workers employ about one-third of the work force in the U.S., but only about half of them offer health insurance to their employees. Small-business owners say they have enough trouble staying afloat without assuming the heavy burden of health-insurance premiums.

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 48 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987, 25 percent of the uninsured worked for very large employers, most of whom offered health insurance.

People who want coverage and must buy it on their own have little choice but to pay what the insur-

ance company demands. In many instances, that can mean thousands of dollars each year. And premiums continue to rise dramatically.

Consider Stephen Beidner, a part-time worker at a California winery. When he first took out a policy with a company called Consumers United Insurance in 1985, he paid $912 a year. By 1989, his premium had jumped to nearly $3600.

In 1989, after Beidner had arthroscopic surgery for a knee injury, the company hiked his premium a whopping 93 percent to $6900. After Beidner protested, the company reconsidered his case and let him raise his deductible from $100 to $1000. His new premium: $2177 a year.

Less coverage for many

Beidner is hardly alone in having to settle for less coverage. Spiraling premiums also affect millions of people whose employers provide their health insurance.

One major employee-benefits survey found that employers now spend an average of $2700 annually to cover each employee. In many cases, employers are shifting some of those ever-increasing costs to their workers by requiring them to pay a greater share of the premium and a larger portion of their medical expenses through higher deductibles and copayments. Other companies, such as American Airlines, try to reduce their insurance bill by refusing to cover preexisting health conditions for new employees.

In 1984, Hewitt Associates, a benefits consulting firm, found that 37 percent of large employers paid the full premium for their workers. By 1988, that figure was down to 24 percent. In 1984, 53 percent of large firms paid all hospital room-and-board charges for their workers; in 1988, the figure was 29 percent.

Losing coverage

About half of all large- and medium-sized firms try to trim their

Crisis: Benefits end, costs don't

David Curnow, 47, was a partner in a San Diego law firm. One Saturday, while riding his bicycle, he was struck by an uninsured motorist. After two months in intensive care, Curnow emerged a quadriplegic, paralyzed from the chest down.

His law firm had self-insured its employees' health coverage, agreeing to cover the first $7500 of a worker's claim, and paying premiums to an "excess-risk carrier" to cover the rest.

After the first $7500 was paid, the carrier refused to pay its share of Curnow's bills. Months passed. Doctors, hospitals, and companies providing necessary medical supplies dunned Curnow for payment.

Eventually the carrier paid most of Curnow's bills, which totaled nearly $250,000. But he is still waiting to be reimbursed for the services of the home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some $1500 each month—comes out of his pocket.

Curnow has another problem—how to pay for his continuing medical bills when insurance benefits from the law firm run out. If he doesn't work again, his disability will eventually qualify him for Medicare. But he will still have no insurance for services Medicare doesn't cover. Nor will he be able to buy any. Companies usually don't sell Medicare-supplement policies to the disabled under age 65. If he goes back to work, he must find a job in a large law firm whose insurance company doesn't require employees to be in perfect health. If he opts for a conversion policy from the company now insuring employees in his old firm, he will have to pay $6000 a year.

"How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance?" he asks.

insurance outlays by self-insuring. They invest the money they would otherwise spend on premiums and pay employees' claims directly when they arise.

The Employee Retirement Income Security Act (ERISA) exempts these self-insured plans from state insurance regulations meant to protect consumers. For example, employers may not have to offer certain coverages, such as care for newborn children, or provide for continuation of coverage when employees leave.

Employers hire a third-party administrator, or TPA, to handle the claims. Because the administrator may be the local Blue Cross plan, employees may think that Blue Cross (or some other insurer) is actually underwriting their coverage. Little do they know that the loopholes created by ERISA can leave them without insurance if things go wrong.

If the employer goes out of business or drops the coverage, employees could be out of luck.

The woes of HMOs

When a health maintenance organization closes its doors, the people who received medical care there may also be left uninsured.

Established as alternatives to traditional insurance policies, HMOs provide a variety of prepaid health services to their members. Unfortunately, a number of HMOs have fallen on hard times.

Several states don't require conversion policies or continuation of coverage for members whose HMO has gone out of business. Even in states that do, HMO members have no assurance that their new coverage will be anything like the old. They may well find themselves assuming a greater portion of their medical expenses.

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

After the bankruptcy filing, Blue Cross and Blue Shield of Ohio took over Maxicare's subscribers. Stroup assumed that his $12,000 annual drug bill would be covered for the rest of his life. But Blue Cross had other ideas. It offered Stroup, who had turned 65, a Medicare-supplement policy that covered his drugs only after he paid a $2500 deductible and $1000 in coinsurance.

Stroup and his wife must now pay some $7000 a year for insurance premiums and drugs out of their $10,000 income from Social Security disability. They expect their $60,000 life savings to be depleted in 3½ years.

Clinging to coverage

Millions of Americans have yet to lose their insurance but could at any time fall victim to an insurance company's business practices. As health-care providers continually raise their fees and pass on the higher cost of medical care to insurance companies, the companies respond by insuring fewer people. People who must buy coverage on their own and workers in small firms feel this pinch the hardest.

Insurance companies are not charities. Their goal is to make a

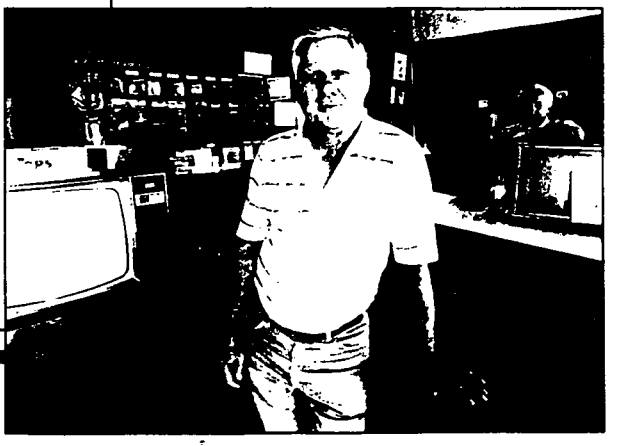
Crisis: Unaffordable premiums

Lloyd Pudiwitr owns a TV repair shop in Bakersfield, Calif. He has seven full-time employees and one part-timer. For years, he paid half the premium for his employees' health coverage. But by the end of 1988, the premiums had become so high he could no longer afford to pay his share. "It's one of those things that could break you," he says. His employees now pay the entire cost of their coverage.

Like many small employers, he changed carriers every few years, searching for the lowest premiums. Two years ago Pudiwitr, who is 55, had a heart attack, and the wife of one of his employees, Ian Sutherland (pictured in background), had cancer surgery.

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from $272 to $543, and the premium for Sutherland doubled from $421 to $842.

Luckily, Sutherland turned 65 and became eligible for Medicare, but he still must pay $450 a month for his wife's coverage. Pudiwitr has a long way to go until Medicare pays his bills, and he doesn't know what he'll do when his premiums rise again. "It's almost to the point where I can't afford it. If it doubles again, there's no way I can pay $1000 a month for health insurance," he says. "I didn't have any idea this would happen to people."



Crisis: Locked In

Kay Nichols, a fitness counselor at a Gainesville, Fla., health club, is in the pink of health except for glaucoma, an eye disease that can cause blindness if not treated. Not long ago, her employer wanted to switch insurance carriers to take advantage of lower premiums. When the health club found another insurer, the agent told Nichols that she would not be covered, even though her glaucoma is under control.

Nichols looked into a conversion policy from her present company but found she would have to pay $6000 for six months of coverage for her family. She tried Blue Cross, but its policy would have excluded coverage for glaucoma.

When her employer learned of her plight, he decided to keep the current policy despite its higher premiums. "If the premiums get phenomenally high, they can't keep the policy just for me, and I understand that," Nichols says. At the same time, she realizes she has a problem that won't go away. "Maybe I don't want to stay with this company the rest of my life," she says. "It makes me worry."

Nichols is 38.

profit, and they can increase their odds of success by insuring good risks who are unlikely to have health problems. Competition among carriers for the healthiest risks has become cutthroat.

In large businesses with many employees, it doesn't matter if some employees have serious medical conditions. The risk they pose can easily be spread among the healthy workers. But in a small group with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. So the rules for insuring workers in small businesses are more rigorous.

Insurers use a controversial scheme to insulate themselves from risk. They offer to insure employees in a small firm (usually those with fewer than 25 workers) at a "lowball" premium for at least the first year. If members of the group experience costly health problems in the second and third years, the carrier tosses the firm into a pool with other groups whose health-care costs are high and jacks up its premiums as much as 200 percent.

By placing firms into several "rate tiers," insurance companies can bid for the healthiest groups with rock-bottom premiums. But employers and their employees who have had serious health problems are stuck with their present insurance carrier; they can't move to another because no other company is likely to take them at any premium. Worse, the present carrier may decide not to renew the group's coverage, forcing employers and employees to find other insurance. And that may be impossible.

No coverage for the sick

Companies insuring small groups require employees and their dependents to meet tough health requirements, just as they do for individuals buying policies on their own. No carrier wants to insure employees and dependents who have had heart attacks or cancer. They will either exclude them from the policy or decline to insure the group altogether. Sometimes a single employee with a serious disease is enough to earn a rejection slip for the whole group.

Increasingly, insurance companies are turning down people with far less serious health conditions than cancer or heart disease, excluding everyone except those in perfect or near-perfect health. "We don't want to buy a claim," is how one company official puts it.

Many people who become ill while they are working may find themselves without insurance when they leave the security of their employer's policy. Indeed, many are held hostage to their current job just to keep their insurance.

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns $19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to five weeks, she needs a lifesaving infusion of antibodies that costs about $2400.

The firm's Blue Cross policy has been paying most of the bills. But as a result of those expenses, the cost of coverage has risen sharply—both for the firm, which pays the premiums for its employees, and for the employees, who must pay the premiums for their dependents.

"When I was given my review, I was told I might look around to see if I can find another job," Turner says. "They intimated that if I did leave, it could lower the cost of their insurance."

If Turner leaves her job, it's unlikely her daughter will ever again have coverage. And there's no way she can pay for the monthly infusions herself. "Without the medicine, my daughter dies. That's the black and white of the situation," Turner says.

WHICH POLICIES ARE BEST?

If you lose your health-insurance coverage for any reason, you can remain uninsured and take your chances, or you can venture into the marketplace for an individual policy. Be forewarned: You won't find a buyer's market. And even if you're in good health, you may have few options.

This report will help guide you through the process. We evaluated 71 policies from 40 insurance companies and Blue Cross and Blue Shield organizations. We rate those policies and list their features beginning on page 14. Before plunking down $2000 or $3000 for coverage, however, you'll need to know a little about how these policies work.

Declining coverage: The proportion of employees in group health plans at large- and medium-sized firms dropped 14 percent from 1986 to 1988.

Types of policies

There are three basic kinds of health-insurance coverage:

□**Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.

□**Hospital-surgical policies.** These cover hospital services and surgical procedures only.

□**Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 8.

What's covered?

Major-medical policies typically pay for most hospital services, including room and board; operating and recovery rooms; nursing care; and treatment in intensive-care units, emergency rooms, and outpatient facilities. They also pick up the tab for lab tests, X-rays, anesthesia, medical supplies, ambulance services, and physicians' office visits. Most pay for prescription drugs and cover confinements in skilled-nursing facilities, if necessary, following a hospital stay.

Some policies, however, don't pay for assistant surgeons or for standby surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

Hospital-surgical policies cover hospital room and board, often for a specified number of days; treatment in intensive-care and outpatient facilities; medical supplies; surgeon's fees; diagnostic tests relating to an operation; some radiation and chemotherapy; and sometimes second opinions. But they cover almost no expenses incurred outside a hospital. They won't pay for a doctor's office visit to check on a persistent cough, or to have your child's cast removed, or for any medical condition that does not require hospitalization. Most don't cover prescription drugs that you may need outside a hospital.

Generally, both major-medical and hospital-surgical policies pay for 30 days of inpatient treatment for mental illness and substance abuse. Some major-medical policies cover outpatient treatment as well. If they do, insurers limit the number of visits per year or even the dollar amount of their payments.

Maternity benefits

All the major-medical and hospital-surgical policies in our study pay for expenses arising from pregnancy complications. But with the exception of some Blue Cross and Blue Shield plans, they usually don't cover routine prenatal care or routine deliveries.

If you want coverage for that, you'll have to buy a separate rider, and at some companies, you'll need to decide on the rider the day you take out the policy. Some carriers won't let you buy the rider later (on the grounds that you'll probably use the coverage, and they'll be stuck with a claim). Many major-medical and hospital-surgical policies don't offer riders for routine maternity care, period.

Riders will pay up to a maximum benefit that policyholders select, usually $500, $1000, $2000, or $2500. Rarely do they cover the full cost of a normal delivery, which averaged $4334 in 1989.

Another drawback is that companies don't pay the full benefit during the first two years the policy is in force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

Annual premiums for pregnancy riders ranged from $316 at Golden Rule for a $1000 benefit to $2640 at Prudential for a benefit that would cover the hospital stay but only $1050 of an obstetrician's fee. (An obstetrician's services for prenatal care and delivery can cost as much as $4500 in some areas.)

What's not covered

Both major-medical and hospital-surgical policies cover only medically necessary care. Don't count on them to pay for routine physicals or other preventive services. (Some of them, however, cover Pap smears, mammograms, and well-child care.) Nor do companies pay for cosmetic surgery, fertility treatment, dental care, hearing aids, surgical treatment of obesity, treatment for self-inflicted injuries, or procedures that are considered experimental.

How policies pay

Insurance companies compute the amount of your reimbursement check according to their own complex formulas. The amount may be higher or lower depending on the following:

Eligible expenses. When you submit a bill for a service covered by a major-medical policy, the insurer compares it with the amount it normally pays for that service. If the charge is lower than what the company determines is "usual," "customary," "reasonable," or "common," then the entire bill is eligible for reimbursement. If it's greater, the carrier will consider only a portion of it.

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 90th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

hospital's posted charge, the hospital's cost, or a negotiated fee.)

Obviously, the higher the reimbursement standard, the more you'll receive. Unfortunately, policies don't spell that out, and some insurance companies were reluctant to explain their reimbursement standards to us.

Some hospital-surgical policies work differently, paying up to a maximum amount for each covered procedure or service listed in the policy. There's usually a fee schedule for hospital room and board, one for surgeon's fees, another for outpatient services, and a maximum amount the policy will pay for all other hospital services. This is the equivalent of a hospital-surgical policy's eligible charge.

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon who performs an appendectomy as little as $260 or as much as $480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was $846 for an appendectomy. The policy pays as little as $390 or as much as $720 for a hysterectomy; but a hysterectomy cost an average of $1737 in 1989.

Coinsurance. Once the insurer determines how much of your bill it will consider, it still pays only a portion. You pay the rest. That's called "coinsurance."

Most major-medical policies pay 80 percent of eligible expenses, leaving policyholders to pay the remaining 20 percent plus that part of the cost not covered at all.

Suppose a physician charges $3000 for an angioplasty (a cardiac procedure), but the carrier considers only $2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive $2088 (80 percent of $2610). He or she will then have to pay the remaining 20 percent, or $522, plus the $390 that's not eligible for reimbursement.

With some policies from Blue Cross and Blue Shield, a policyholder who used a "participating physician" would pay less. Participating physicians agree not to bill patients in excess of what Blue Cross and Blue Shield pays. This can be a significant advantage. Plans with this feature are noted in the Ratings.

Some major-medical policies require policyholders to pay less than the usual 20 percent coinsurance. For example, American Republic's *UltraCare* policy requires no coinsurance at all. Policies from Bankers Life and Casualty and its affiliated companies require none if policyholders select a deductible of at least $5000—that is, if the policy-

Pay by the Day? By the Disease?

THE WORST TYPES OF INSURANCE

The worst buys in health insurance are hospital-indemnity policies and dread-disease policies. Hospital-indemnity policies pay a fixed amount each day you're in the hospital. Dread-disease policies pay benefits only if you contract cancer or some other specified illness.

Such policies are a profitable staple for many well-known insurance companies and for the American Association of Retired Persons (AARP). They're sold to unsophisticated buyers through enticing but sometimes misleading advertising.

"Cash benefits of $2250 a month, $525 a week, $75 a day . . . You cannot be turned down . . . No salesman will call . . ." reads a flyer for a hospital-indemnity policy from Physicians Mutual. "Use these cash benefits any way you choose . . . Get extra benefits when you may need them most," promises an ad for a policy sold by the AARP.

The deal is simple and understandable. You get a fixed dollar amount for each day you spend in the hospital. No complicated deductibles or coinsurance. Trouble is, the fixed benefit is skimpy to start with and grows less valuable with each passing year.

At Physicians Mutual, a person can choose a daily benefit of $30, $50, or $75. AARP's top benefit is $75 for those age 50 to 64 and $45 for those 65 and older. But with the cost of a day in the hospital averaging around $800, even the most generous hospital-indemnity plans will barely dent your bill. Furthermore, to collect the high benefits touted by some of the ads, you'll need to be hospitalized as long as a month—an unlikely prospect, since the average stay is only about seven days. Finally, the benefit does not change. In time, inflation in hospital and medical costs inevitably shrinks its value.

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a $19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American Family Life, a large seller of this type of insurance, would pay a maximum of $4100; a policy from American Fidelity Assurance would cover as much as $6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

Companies also sell riders to cover such dread diseases as smallpox, polio, rabies, diphtheria, and typhoid fever. We don't know why anyone would buy them, since these diseases are now extremely rare.

Compared to other health coverages, these types of insurance are cheap. For the top daily benefit from Physicians Mutual, a 45-year-old man or woman would pay about $233 a year. A family would pay $540.

Insurers usually issue hospital-indemnity policies to anyone, whether or not they are in good health. But carriers often require a waiting period before covering policyholders for preexisting health conditions.

Most companies selling cancer insurance will not, however, issue policies to people who already have cancer. Nor do they usually pay benefits to anyone who is diagnosed as having the disease before the policy has been in force for 30 days.

These policies are no substitute for comprehensive health coverage. The price is low, but so are the benefits. With a dread-disease policy, you're also gambling that you'll contract one of the covered diseases. If you don't, the policy won't cover you.

Companies often market these policies as a supplement to other insurance. But we don't recommend them even for that. The $300, $400, or $500 you'd spend for inferior coverage may equal the difference in premium between a skimpy hospital-surgical policy and a more comprehensive major-medical policy. Or it may cover the cost of taking a lower deductible on a good major-medical policy.

holder pays the first $5000 of covered expenses.

Other companies require policyholders to pay more. You might find policies with a 70/30 percent or even a 50/50 percent cost-sharing arrangement, especially if you don't use doctors and hospitals specified by the insurer.

Coinsurance maximums. Most policies specify a maximum dollar amount of coinsurance, typically $1000 (but it can be as much as $2500 or $5000), that policyholders must pay annually. After they've reached that amount, the carrier pays 100 percent of all additional, eligible medical expenses.

A few policies tie coinsurance maximums to the size of the deductible you select. The higher the deductible, the lower the maximum.

Several policies give a break to families. Usually two members must each pay the maximum coinsurance amount. The company will then pay 100 percent of all eligible expenses for other members who have not reached their maximums.

Lifetime maximums. Most major-medical and hospital-surgical policies cap the benefits they'll pay over a lifetime at $1-million or sometimes $2-million. A few have no cap, and others have a separate lifetime maximum for each illness or injury.

A company will sometimes give new lifetime benefits to policyholders who have generated enough claims to reach their lifetime cap. This is an important feature if the cap is low.

Deductibles. Most companies require policyholders to satisfy deductibles each year before benefits are paid. (Some hospital-surgical policies have no deductibles.) Deductibles can be as low as $100 or as high as $20,000. That means a policyholder must pay the first $100 (or $20,000) of expenses before the company pays any benefits. Obviously, a $20,000 deductible buys only catastrophic protection.

Sometimes a policy links the deductible to an illness or health condition; you would have to satisfy the deductible with each new illness. If the deductible is large and you have several different illnesses, you may never collect any benefits.

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a $1000 deductible," says John Hartnedy, the chief actuary at Golden Rule. "You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill."

As with most insurance, the higher the deductible, the lower the premium. A 45-year-old man in Chicago who chooses a $500 deductible for Benefit Trust Life's *Tele-Med* policy would pay an annual premium of $1443. If he selected a $2500 deductible, he would pay only $839.

Sometimes, for a small, extra premium, companies will waive the deductible or a portion of it if you are injured in an accident.

Truth will out: When you fill out an application for health insurance, be honest about your medical condition. If you don't reveal all your health problems and the company finds out about them when you file a claim, it could rescind your policy and leave you without coverage when you need it most.

Can you renew?

Few companies will guarantee to renew your coverage. Of those in our study, only American Republic, Benefit Trust Life, and Metropolitan sell "guaranteed renewable" policies. The company can raise the premium, but it must continue your coverage.

Most policies, however, are now "conditionally renewable." The company can refuse to renew your policy only if it also refuses to renew all other similar policies in your state. You have some protection because the company can't single you out for cancellation. But you can still lose your coverage.

Some insurance companies use conditionally renewable policies as a lever to force insurance regulators to grant the rate increases those companies want. Certified Life, First National Life, Golden Rule, and Washington National told us they had canceled policies. In some cases, they offered policyholders alternative coverage.

A few policies are "optionally renewable." A company can opt not to renew your insurance whether or not it renews coverage for others who have the same policy. Prudential, State Farm, and Blue Cross and Blue Shield plans in Illinois, Kansas, Ohio, and Oklahoma have optionally renewable policies. (Prudential and Blue Cross and Blue Shield of Oklahoma at least say they won't cancel your policy if your health has deteriorated.)

Many companies also give themselves the option of not renewing if they find you have another policy that is similar.

Are you insurable?

People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Virtually no commercial carriers and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

If you have less serious conditions, you may get coverage, but on unfavorable terms.

Conditions that usually affect one part of the body are candidates for "exclusion riders." That is, companies will offer a policy, but exclude coverage for those conditions or that body part, either for a short period or for as long as the policy is in force. If you have had a recent knee operation, glaucoma, migraine headaches, varicose veins, arthritis, a cesarean delivery, or if your child suffers from chronic ear infections, your policy will probably carry an exclusion rider. "Any condition that would produce an immediate claim would be ridered out," says Frank Fugiel, a vice president at Washington National.

If you have a medical condition that affects your general health—for example, you're significantly overweight or have mild high blood pressure—you may get coverage, but at a price 15 to 100 percent higher than the standard premium.

Companies in our survey told us that between one-quarter and one-half of all their policies carry exclusion riders, higher-than-standard premiums, or both.

Insurers, however, are not restrictive in identical ways. Washington National will exclude coverage for your eyes if you had a cataract operation a year ago. Prudential will not. If you suffered from migraine headaches in the past but have had no treatment for the last two years, Central States Health and Life will cover future treatment for such headaches; Time will issue a policy but exclude coverage for migraines.

If a company rejects you, that fact will be recorded at the Medical Information Bureau in Boston, an industry clearinghouse. The next time you apply for coverage, the new carrier may check your file at the bureau. If it finds you've been turned down, that rejection could trigger further scrutiny of your health.

Even if your health is perfect, you still may be a less-than-perfect risk. In their quest for applicants who are

unlikely to file claims, insurance companies blackball people in certain occupations. Some companies have long lists of jobs that are unacceptable, either for an individual policy or for a policy sold to employees in small firms. Chances are the insurance company won't cover you if it considers your work hazardous or if people in your profession are more likely to file claims or switch jobs frequently.

Better off at the Blues?

Historically, most Blue Cross and Blue Shield plans took all comers for individual health insurance, offering "open-enrollment" policies that anyone could buy. Even if your health was bad, you could count on getting a policy from the Blues.

In mid-1990 only 22 of the 74 Blue Cross and Blue Shield plans in the U.S. still make policies available to everyone. But their "open-enrollment" policies may require policyholders to pay a larger portion of their expenses than policies offered to those in good health. For example, the open-enrollment major-medical plan sold by Empire Blue Cross Blue Shield in New York requires 20 percent coinsurance for all services. By contrast, its high-rated *Tradition Plus Wraparound* policy, sold only to those with no medical problems, requires no coinsurance on hospital services and also offers a much lower deductible.

Most Blue Cross and Blue Shield organizations now "underwrite." That is, they evaluate an applicant's health much the same way their commercial competitors do. They decline people with cancer and heart disease and sometimes issue policies with exclusion riders and higher premiums.

It's hard to say whether you'll have an easier time buying coverage from the Blues than from commercial insurers. Most of the Blue Cross plans we contacted refused to respond to our survey. Through other sources, we obtained the plans sold by uncooperative Blues and evaluated them along with the others.

Blue Cross plans that do not exclude health conditions or charge higher premiums for them may simply refuse to sell you a policy. On the other hand, a Blue Cross plan might be more lenient than a commercial insurer. Empire Blue Cross Blue Shield does not require blood tests to detect AIDS. Kentucky Blue Cross and Blue Shield insures women with fibrocystic breast disease. Commercial carriers often require blood tests and almost always exclude coverage for fibrocystic breasts.

Preexisting conditions

If you get a policy from Blue Cross and Blue Shield or a commercial insurer, you still may have to wait a year or two to be covered for medical conditions you already have.

Most policies say that a preexisting condition is one for which a policyholder has received treatment or for which a reasonably prudent person *should have sought* treatment during the previous two years. Some policies have shorter or longer "look-back" periods. Those are noted in the Ratings. *Continued*

The Last Resort

HIGH-RISK POOLS

If you can't buy health insurance and you live in one of 23 states listed below, your insurer of last resort is a high-risk pool created for the people insurance carriers don't want. Similar to the high-risk plans for drivers who've been in accidents, health-insurance pools originated in the 1970s as the industry's alternative to national health insurance. But only in the last few years have states begun to get serious about them.

To obtain coverage, you usually must be a state resident for at least six months (a year in some states), and must have received a rejection notice from at least one carrier (Montana and Florida require two rejections).

If a carrier will insure you only at a premium exceeding the price of coverage from the pool, or if the insurance you're offered carries exclusion riders, you will also be eligible for a pool policy in most states.

The rules differ from state to state. Illinois, Iowa, Minnesota, and Nebraska, for example, allow people infected with the HIV virus to obtain a pool policy; South Carolina does not. In some states you can't get pool coverage if you're eligible for a conversion policy when you leave an employer group, even though the pool policy may be better than the conversion option.

Florida, Illinois, Iowa, Minnesota, North Dakota, Tennessee, Washington, and Wisconsin make Medicare-supplement policies available through their pools. That's a boon to the disabled under age 65 who rely on Medicare but can't find insurance to fill Medicare's gaps.

Pool coverage is similar to that offered by a major-medical policy, although benefits for mental and nervous disorders, organ transplants, and pregnancy may be less comprehensive. You may, however, pay more out-of-pocket than you would with a major-medical policy. Some plans require a high deductible, greater coinsurance, and relatively low lifetime-benefit maximums—$500,000 or even $250,000.

Premiums are no bargain, which is not surprising since policyholders in the pool will almost certainly file claims. For example, a policy with a $500 deductible from the Illinois pool will cost a 45-year-old man living in Chicago $3844 a year. That's twice as much as he'd pay for the most expensive individual policy in our study available to Chicagoans.

Long waiting lists

Pool policies provide decent coverage, but they are available only to a fraction of those who need them. CU surveyed the pools in the spring of 1990 and found that they now cover only 55,500 people nationwide. Pools in Illinois, Maine, and Oregon currently limit the number they can insure. The Illinois pool can issue only 4500 policies. The wait to buy into the Illinois pool is now at least a year.

It's hard to see how the pools can meet even the existing need. They operate at a loss, despite the high premiums. In most states, losses are covered by assessments against all health-insurance carriers doing business in the state. In return, some states relieve insurers from part of their obligation to pay taxes on the premiums they collect.

But the insurance industry is pressing the states to pick up more of the bill from the public purse. "We're not in the business of giving away insurance at a loss to these people," says Carl Schramm, president of the Health Insurance Association of America.

The 23 states with high-risk pools are: California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Louisiana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. (The pools in California, Colorado, Georgia, Louisiana, Texas, Utah, and Wyoming are not fully operational.) Your state insurance department can tell you how to contact your state's pool.

To encourage applicants to reveal all their medical conditions, some companies waive their usual waiting periods *if* you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

The wrong job: Occupations some insurance companies consider unacceptable for health coverage:

Tree trimmers
Explosives handlers
House painters
Window cleaners
Heavy-equipment operators
Rodeo performers
Police officers
Doormen
Models
Freelance artists
Waiters
Masseurs
Hospital aides
Maids
Musicians
Bartenders
Fry cooks
Janitors
Street cleaners
Doctors
Lawyers
Pro athletes
Fishermen
Railroad workers
Test drivers
Car-wash workers
Dancers
Beauticians
Movers
Zoo attendants

What policies cost

The premiums you pay are based on your age, your sex, and where you live.

At Bankers Life and Casualty, a healthy 45-year-old man living in Chicago would pay $1245 a year; a 45-year-old woman, $1625; a 55-year-old man, $1748; and a 55-year-old woman, $1852.

The premium for a 40-year-old man, his 35-year-old wife, and two children would come to $3382.

A few Blue Cross plans still use "community rates," charging everyone the same premium regardless of their age or where they live. Other things being equal, older people are usually better off at a company using community rates. A 45-year-old man and a 60-year-old man living in Philadelphia would pay the same $2192 premium at Independence Blue Cross and Pennsylvania Blue Shield. But at Time, a company not using community rates, the 45-year-old man would pay only $1580; the 60-year-old, $3375.

With most policies, premiums increase as you get older. If you buy a policy at age 40, expect the premium to increase when you turn 45.

In addition to age-related increases, the rising cost of medical care also pushes up premiums every year or two. The premiums for policies in our study increased an average of 11 percent a year over the past five years. But premiums for some policies rose as much as 40 or 50 percent in a single year.

Pricing tricks

As a sales gimmick, some companies use a pricing scheme that gives policyholders a deceptively low premium the first year and very high premiums in later years.

When a company that uses so-called select and ultimate rates accepts you for coverage, it knows you're in good health and charges a low (select) premium to reflect the fact that you're not likely to file claims in the immediate future. But as the years go on, and as you make claims, the company will jack up the premium to the highest (ultimate) level.

Companies that don't use select and ultimate rates spread the anticipated costs of your claims over all the years you own the policy, so your premiums will be more stable. If you buy from a company using select and ultimate rates, you may face premium increases that far exceed what you can afford.

State insurance regulators don't require insurers to disclose whether they use select and ultimate rates, so it's often hard to know. It's a good idea, though, to ask whether a company you're considering uses such rates and to avoid their policies, especially if you plan to keep the coverage for several years. One carrier, Aid Association for Lutherans, gives buyers in some states a choice between policies with select and ultimate rates and those without, and clearly points out the differences in its sales material. (Our Ratings include Aid Association's policy without select and ultimate rates.)

Managed care and PPOs

Until recently, insurance companies seldom questioned physicians' fees. But to hold down their own costs, companies have now inserted a variety of "managed care" requirements into their policies.

As a result, you may have to ask the insurance company for prior approval for any elective surgery. You may have to use an outpatient facility for such procedures as arthroscopic surgery, dilation and curettage, and cataract removal. You may be required to seek second opinions before surgery. If you don't follow the rules, the company may reduce your benefit or increase the coinsurance and deductible you'll have to pay.

Some Blue Cross and Blue Shield plans offer Preferred Provider Organizations (PPOs). Those are groups of doctors who have agreed to discount their fees. If you sign up for a PPO and use a non-PPO doctor, you may have to pay as much as 40 or 50 percent of the doctor's bill yourself and also suffer other penalties.

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

A few other insurers also declined to participate. Celtic Life, a company waging a public campaign to educate people about shopping for health insurance, refused to shed any light on its policies or selling practices. A newcomer to health insurance, A.L. Williams, a company better known for its life-insurance policies, also declined to participate. A third company, World Insurance, claimed that if it won a favorable rating from CONSUMER REPORTS, it would not have the capacity to handle all the applications.

We rated the major-medical and hospital-surgical policies by measuring the coverage and cost-sharing features of each against actual claims, ranging from minor to catastrophic, filed by 25,000 employees. The average annual claims for a single person in the reference group totaled $1387; for families, it was $3175.

A policy that covers everything would pay 100 percent of those amounts. Of course, health-insurance policies are not designed to cover 100 percent of claims. But the best policies pay the most.

The best policy we found, a major-medical plan sold by Blue Cross and Blue Shield of Minnesota, would pay $1230 (or 89 percent) for singles and $2810 (or 89 percent) for families if you used physicians in the plan's preferred-provider organization. The worst, a hospital-surgical policy from Pyramid Life, would have paid only $490 (or 35 percent) for singles and $950 (or 30 percent) for families.

The Ratings show what percentage of the average annual claims each policy would pay after accounting for deductibles, coinsurance, coinsurance maximums, and other cost-sharing features spelled out in the contract.

Since most people want a policy that provides coverage for catastrophic expenses, we also measured how well each would pay for two major illnesses. One was a $19,774 claim for colon-cancer sur-

gery and follow-up chemotherapy. The other was a $49,767 claim for care of a serious heart attack, including an angioplasty procedure (see box on page 13).

A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's lifetime benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

We could not obtain rate-increase histories or certain other information for noncooperative Blue Cross and Blue Shield plans or for new policies. Where we lacked information that might affect a plan's score,

Blue Cross and Blue Shield

ABANDONING THE MISSION

Sick people cannot buy a policy from Blue Cross and Blue Shield of Kentucky. The plan evaluates an applicant's health and rejects those with such afflictions as cancer, heart disease, emphysema, and AIDS.

Competition from commercial carriers has forced the plan to turn sick people away in order to keep its premiums affordable and attract new customers. At one time, Kentucky's Blue Cross and Blue Shield plan sold as much as 90 percent of all health insurance in the state. In 1990 it sells just 30 percent.

The Kentucky plan, typical of many Blue Cross and Blue Shield organizations in 1990, is a far cry from what such plans used to be. Founded by organized medicine in the 1930s, Blue Cross (and later Blue Shield) had two missions. The first was to make sure hospitals and doctors got paid. The second was to provide health insurance for the greatest number of people.

For years, the Blues had a virtual insurance monopoly. In some places, they were so powerful that they were able to negotiate large discounts from hospitals and use the savings to carry out their mission of community service. For example, Blue Cross plans subsidized such money-losers as individual health policies for the sick and Medicare-supplement coverage for the elderly.

As nonprofit organizations, the Blues had certain privileges. They paid no Federal income taxes and, in many states, no taxes on the premiums they collected.

"Community rating" was once the Blues' trademark. Everyone in the community—large employer groups, small employer groups, and individuals buying policies on their own—were in the same risk pool. They paid the same rates regardless of their age and sex, where they lived, or how sick they were.

That all began to change in the 1960s. Commercial insurers started skimming the best risks from the Blue Cross pool by offering lower premiums than the Blues charged. As large groups and then small ones took out cheaper policies with commercial carriers, the Blues increasingly found themselves covering people with health problems the commercial carriers didn't want. As healthy people deserted the pool, the Blues had little choice but to raise premiums higher and higher to cover the claims made by the sick people who remained.

In many areas, the plans also saw their hospital discounts whittled away. Some states now mandate smaller discounts and allow all insurers to receive them.

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned community rating a few years ago in favor of the kind of pricing used by its commercial competitors.

Most Blue Cross and Blue Shield plans now resemble Kentucky's. Many have become mutual insurance companies. They've lost their tax exemption from the Federal government, and they no longer try to provide coverage for everyone. Less than one-third still take all comers for health insurance. Of the 37 state regulators responding to a CU survey, only nine consider their local Blue Cross and Blue Shield plan an insurer of last resort.

"We think the Blues in our state do a pretty good job. But everyone here dislikes them, from their subscribers to the legislators," says one state insurance regulator who asked not to be identified. "They are some of the most defensive people you can imagine. Everything we ask for is a fight."

We know what he means. We asked 29 Blue plans to send us information about their policies. Only nine would do so, forcing us to seek information from state regulators, who sometimes couldn't or wouldn't help us. The California Insurance Department told us it had no rates on file for Blue Cross of California. When we asked the plan for a history of its rate increases, an official told us that information was "proprietary." When we asked the Washington Insurance Department to give us rate-increase data for the Washington and Alaska plan, the department said it could not oblige because Blue Cross had a right in that state to keep such information a secret.

"As their risk pool gets creamed, there's mission schizophrenia at the Blues," says Susan Sherry, an official at Families USA, a health-advocacy group. "It's the classic example of competition, and consumers are the real losers."

Some Blue Cross and Blue Shield plans, mostly in the Northeast, still cling to the old mission. But even for them, holding on is increasingly difficult.

In New York, a person no matter how sick can always get health insurance from Empire Blue Cross Blue Shield. It won't be the top-of-the-line policy, but it will provide some coverage.

Empire, which still uses community rates, can sell insurance even to people with terminal illnesses because their policies are heavily subsidized from premiums paid by large employer groups and from the savings obtained by negotiating a 13 percent discount with New York hospitals.

Even so, Empire officials say that the discount is not large enough, and that over the last few years some 100,000 people have left the pool, either going with commercial carriers or doing without coverage altogether. The plan has had to increase premiums on all its policies 40 to 50 percent to cover the claims of the sick people who remain.

"Our goal is to stay with the mission," says Eric Schlesinger, Empire's chief marketing officer. "But in the end, we will have a community price so high that no one will pay it, and the number of uninsured will skyrocket."

we assigned values representing the average for all plans in our survey. This lack of actual information for a plan is denoted by a dash in the Ratings. The plans are listed in order of an overall quality index that takes into account all the rating factors.

Recommendations

Naturally, you want a policy that will pay as many of your bills as possible, so coverage should be your first concern.

Unfortunately, there are few policies for any one individual to choose from. Your options boil down to a policy from one of the few remaining commercial carriers selling this insurance or one from your local Blue Cross and Blue Shield plan.

The best coverage is provided by a good major-medical plan. The plans listed high in the Ratings require policyholders to pay very few of their medical expenses.

A number of Blue plans—in Minnesota, New Jersey, New York, and Pennsylvania—ranked high. People in those states should certainly consider them. As the Ratings show, however, Blue Cross and Blue Shield organizations in other states offer mediocre or poor policies.

Fortunately, some good commercial plans are widely available. Look first at the high-rated policies offered by American Republic and Benefit Trust Life.

Maternity benefits from some of the Blues were better than those offered by most commercial carriers. Many Blue plans treat pregnancy as an illness and pay normal benefits, which will cover most of the cost of having a baby. But some offer maternity benefits only on family policies. Presumably a single woman who became pregnant would not have coverage.

Some Blue Cross and Blue Shield plans offer a choice of a regular insurance policy and a PPO. You might consider a PPO if you're willing to use its doctors rather than your own. The PPOs offered by Blue Cross and Blue Shield in Arizona, Illinois, Minnesota, and Washington and by Blue Shield of California ranked higher in our Ratings than those organizations' traditional insurance plans because they require their subscribers to pay less coinsurance.

Policies from First National and Washington National provide good benefits for catastrophic expenses but fall short in other important areas, such as policy cancellations or rate increases.

Note that the policy from the largest seller of individual major-medical insurance, Golden Rule, ranks near the bottom. The policy provides only average coverage. And the company has a history of large rate increases and canceled policies.

Once you have considered a policy's coverage and other dimensions, look at the premium. If two policies are comparable, pick the one with the lowest premium.

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay $808 a year for a hospital-surgical plan, compared with $1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

The highest room-and-board coverage offered by the hospital-surgical policy from Blue Cross and Blue Shield of Maine, for example, is $276. Some of the state's hospitals have room-and-board charges that exceed $400.

Hospital-surgical plans provide fewer benefits, and those benefits may not increase with the cost of medical care. Unless the carrier lets you upgrade, the benefits you buy today may be inadequate if you need hospital care several years from now.

If you can't swing the premiums for a high-rated major-medical policy, consider reducing the premium with a higher deductible, then budget to cover small medical expenses yourself.

If you're not in perfect health, it's hard to buy coverage at any price. It may nevertheless be worthwhile to shop several carriers to see if they'll issue coverage with exclusion riders.

If you live in Alabama, Hawaii, Maryland, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, or the District of Columbia, you will be able to buy an "open-enrollment" policy from Blue Cross and Blue Shield at least sometime during the year.

In Maine, the Blue Cross and Blue Shield organization accepts anyone for coverage, but will add exclusion riders for three years on policies for people with various health conditions.

If you live in one of 23 states with a high-risk pool, you may be able to purchase coverage from the pool.

There's no insurer of last resort for people living in the other 15 states. Short of getting a job with a large business or marrying someone who works for one, people who are unacceptable to insurance companies are out of luck. They have no choice under the current system but to join the growing ranks of the uninsured.

Ratings begin on page 14

Catastrophic Claims

PERCENTAGE GAMES

As part of our evaluation of health-insurance policies for the accompanying report, we measured how much each policy would help defray the actual bills run up by two patients in apparent good health who were suddenly stricken with a life-threatening illness—colon cancer and heart attack.

The case of colon cancer cost a total of $19,774, including $13,471 in hospital bills and $3665 for surgery.

The best plan we found, from Blue Cross and Blue Shield of Minnesota, would have paid about 92 percent of the $19,774 if the policyholder used only "preferred provider" doctors. (If the policyholder went to other physicians, the plan would pay up to 88 percent.) The highest-rated policy from a commercial carrier, American Republic's *UltraCare* with no coinsurance, would have paid 97 percent. A less generous major-medical plan, from Washington National, would have paid 87 percent of the claim. Least helpful was a hospital-surgical policy from Pyramid Life. It would have paid only 49 percent of the bill, leaving the patient about $10,000 in debt.

The treatment for the heart-attack patient came to $49,767. It included an angioplasty (a procedure to open blocked arteries) that cost $8730 in surgical fees, and a 21-day hospital stay that piled up bills of $34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the $49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a $28,000 debt as well as the heart attack.

RATINGS

Health-insurance policies

Listed by types. Within types, listed in order of estimated overall quality, based on policies for a single person. (Family policies closely tracked single policies in overall quality.) Differences of less than 5 points were judged insignificant. Companies marked with an asterisk did not respond to our survey. Dashes indicate we could not obtain information; in those cases we assigned values representing the average for all policies.

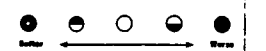
1 Annual premiums. These are annual premiums for 45-year-old **men** and **women** living in Chicago. For a company not selling there, the premium is for the company's major operating territory. **Family** premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with $500 deductibles. If the company does not offer a $500 deductible, we show the premium for the closest deductible to $500; footnotes (on pages 16-17) state the deductible on which the price is based. Premiums for **maternity rider** show the cost of adding coverage for routine pregnancies.

2 Quality index. A summary of how the policy performed for a **single** person.

3 Payout. The percentage the policy paid for a **single** person and for a **family** on an average mix of claims filed by 25,000 policyholders. We used a $1000 coinsurance maximum for each policy. If the policy did not offer this amount, we used its maximum that was closest to $1000. Most plans require 20 percent coinsurance. Exceptions are noted in the Comments.

4 Catastrophic claims. Measures how well a policy would have paid after the deductible was met on two actual claims involving catastrophic illness—one for treatment of colon cancer; the other, a serious heart attack. A policy that scored a ● paid more than 96 percent of the expenses for both claims. A policy with a ◒ paid more

Policy	1 Annual premiums: Men	Women	Family	Maternity rider
Major-medical				
Blue Cross and Blue Shield of Minnesota — Aware Gold (F2844) PPO	$1493 1 2	$1962 1 2	$5100 1 2	Included
Capital Blue Cross w/Penn. Blue Shield — Major Medical	1815 2	1815 2	3923 2	Included
American Republic — UltraCare, no coinsurance	1904 4	2240 4	5012 4	$608
Blue Cross and Blue Shield of New Jersey — Mediation	1843 2 5	1843 2 5	4759 2 5	Included
Benefit Trust Life — MMI	1794 3	2096 3	4319 3	Included
Empire Blue Cross Blue Shield — Tradition Plus Wraparound (LGL 3252)	2392 2	2392 2	5126 2	Included
Independence Blue Cross w/Penn. Blue Shield — Major Medical w/Plan 100	2192 2 5	2192 2 5	5159 2 5	Included
Blue Cross and Blue Shield of Minnesota — Aware Care (F2239)	658 2	882 2	2226 2	Included
American Republic — UltraComp	1632 2	1953 2	4333 2	636
American Republic — UltraCare, 20% coinsurance	1596 4	1877 4	4200 4	608
Blue Cross of Washington and Alaska* — Personal Prudent Buyer, Low Option 200 Wash	1092 2 3	1092 2 3	2376 2 3	None
Blue Cross and Blue Shield of Alabama* — ALPHA Plan	1308 2 3 5	1308 2 3 5	3432 2 3 5	72
Blue Cross and Blue Shield of Illinois* — Non-Group PPO	1543	1932	4363	261
Blue Cross and Blue Shield of Montana* — Personal Choice Plan	1851	1851	4241	Included
Blue Cross and Blue Shield of Montana* — Healthy Montanan Plan	1553	1553	3554	Included
Blue Cross and Blue Shield of New Jersey — Direct Payment Supplemental Major Medical	3167 5	3167 5	5135 5	Included
Blue Cross and Blue Shield of Indiana* — Personal Security	1293	1374	2935	1164
Blue Cross and Blue Shield of Oklahoma* — Health Check	1764 4	1764 4	3780 4	Included
Blue Cross and Blue Shield of Maryland* — Personal Comp	1001	1001	2604	Included
Central States Health & Life — Individual Major Medical (569-570, 571-572)	1463 2	1900 2	3721 2	781
Time — 24 Karat (502)	1580 2	1876 2	3854 2	490
Benefit Trust Life — Tele-Med	1443	1822	3878	1257
Bankers Life and Casualty — PPP V (CR-G002)	1245 2	1625 2	3382 2	None
Bankers Multiple Line — The Spectrum Plan (D-G002)	1245 2	1625 2	3382 2	None
Union Bankers — The Spectrum Plan (MM-89)	1245 2	1625 2	3382 2	None
Blue Shield of California* — Preferred	1952	1952	3299	None
Blue Cross and Blue Shield of New Jersey — Blue Care	1261 2	1261 2	3400 2	Included
Blue Cross of Washington and Alaska* — Traditional Individual in Alaska	1933	1933	4123	None
Blue Cross of California* — Personal Prudent Buyer	1680	1680	3888	3360
Blue Cross and Blue Shield of Illinois* — Non-Group Comprehensive	1838 5	1992 5	4886 5	None
Blue Cross and Blue Shield of Maine — Blue Alliance	1294 5	1294 5	2580 5	Included
Empire Blue Cross Blue Shield — Tradition Plus Comprehensive (LGL 3253)	1507 5	1507 5	3228 5	Included
Benefit Trust Life — MM2	1496	1751	3603	None
Blue Cross and Blue Shield of Arizona* — Preferred Care	716	716	928	None
Aid Association for Lutherans — TotalMed II (4945)	1708 2	1724 2	4032 2	1860



than 90 percent. A policy with a ○ paid at least 81 percent, and a policy with a ◒ paid at least 75 percent of the expenses.

3 Lifetime maximum. Total benefits a policy will pay over a policyholder's life.

6 Maternity coverage. This shows the quality of the maternity rider that covers routine pregnancies and deliveries. If a policy offered coverage for complications only if policyholders buy a rider for routine coverage, it scored a ●. It scored a ◒ if it offered coverage for complications without requiring purchase of the rider.

7 Renewability. **Guaranteed** means the policy is guaranteed renewable for the policyholder's life. **Conditional** means that the company can cancel it along with all similar policies. **Optional** means the company can cancel an individual policy.

8 Rate history. A ◓ indicates that over a five-year period the company has raised rates on the policy less than the medical consumer price index, which averaged 7.2 percent each year over the period. A ◒ means that it raised rates at least 17 percent a year.

9 Preexisting illness. The **waiting period** is the number of **months** a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for disclosed illnesses. The **look-back period** is how far back in time the insurance company will investigate for preexisting illness.

10 Available to anyone. A "yes" indicates the policy is available to any applicant regardless of health status.

11 Exclusion riders. A "yes" indicates the company will issue coverage with exclusions for certain conditions or for certain parts of the body.

12 Higher rates. A "yes" means the company will issue coverage but at higher premiums for some medical conditions.

13 Other coverage. Additional coverages and features a policy may offer. See Key.

	1 Payout						7	8	9 Preexisting illness								
	Quality index	Single	Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mos.	Look-back period, mos.	Available to anyone	Exclusion riders	Higher rates	Other coverage	Comments	Telephone
	1			4	5	6					10	11	12	13		
	85	89%	89%	●	None	●	Conditional	●	24	3	No	Yes	Yes	a,b,c	A	800-382-2000
	83	84	87	●	None for basic policy	●	Conditional	◓	12	12	Yes	No	No	a,c,d	C	717-255-0820
	81	82	68	●	$1-million per condition	○	Guaranteed	●	24	24	No	Yes	Yes	a,d	B	800-247-2190
	80	88	88	●	None	●	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500
	80	86	85	○	1-million	●	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	80	83	82	●	1-million	●	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757
	80	83	83	●	None for basic policy	●	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100
	79	76	72	●	None	◓	Conditional	●	24	3	No	Yes	Yes	a,c,h	—	800-382-2000
	78	74	60	●	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190
	77	75	61	●	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190
	75	82	67	—	1-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663
	75	75	60	—	None for hospital	○	Conditional	●	12	24	No	Yes	No	a	J	800-392-5705
	75	73	61	—	1-million	◓	Optional	●	12	12	No	No	No	a,c,h	E	312-938-7209
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	74	74	●	None for basic policy	●	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500
	74	82	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075
	74	77	72	—	1-million	●	Optional	●	12	6	No	Yes	No	a,c,h	K	913-560-2121
	74	73	72	—	1-million	●	Conditional	◓	9	No limit	No	Yes	No	a,c,d	—	800-992-2308
	73	73	60	●	1-million	○	Conditional	●	12	24	No	Yes	Yes	a	—	402-397-1111
	73	72	60	◓	2-million	○	Conditional	●	24	12	No	Yes	Yes	a	—	800-333-1203
	72	71	58	◓	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	214-939-0821
	71	73	60	—	2-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150
	71	70	70	◓	100,000 per year	●	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500
	71	75	60	—	1-million	◒	Conditional	◓	12	12	No	Yes	No	a	—	800-752-6663
	71	68	55	—	2-million	◓	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-6000
	71	70	56	—	1-million	◒	Optional	●	12	12	No	No	No	a	—	312-938-7209
	70	67	72	—	None for basic policy	◓	Conditional	●	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966
	70	61	59	●	500,000	●	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757
	69	72	60	○	1-million	◒	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	69	75	62	—	1-million	◒	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	800-543-2944
	69	71	60	◓	2-million	○	Conditional	●	24	No limit	No	Yes	Yes	a,d	—	414-734-5721

Ratings
Continued

	Policy	Annual premiums: Man	Woman	Family	Mat.
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 926	$ 987	$2108	$1164
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 F	2044 F	4359 F	Included
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 F	1169 F	2454 F	Included
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2065	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1209	1209	2653	Included
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Included
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 E	2042 E	4030 E	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 B	1748 B	3382 B	None
First National Life	Major Medical (MM-286)	1005 E	1137 E	2142 E	748
Blue Shield of California*	Coronet	2941 E	2941 E	4229 E	None
Pyramid Life	G91	1501 B	1863 B	4015 B	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3823	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 E	940 E	1814 E	None
Prudential	Pru-Med (PM-83)	1228 B E F	1584 B F F	3127 B E F	2640
Washington National	Classic Choice (AM2836)	1764 B	2205 A	3249 B	900
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 F	1579 F	3451 F	Included
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 F	1968 F	4729 F	Included
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 F	2004 F	3742 F	Included
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 F	1250 F	2472 F	Included
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 G	1216 G	2966 G	Included
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 D	756 D	1848 D	Included
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 F	1162 F	2846 F	None
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 F	1033 F	2058 F	Included
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 D	814 D	1844 D	Included
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 F	1266 F	2683 F	515
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 F	1336 F	2796 F	Included
Blue Cross and Blue Shield of New Jersey	Co-op Protection Plan and Series 14/20	1992 F	1992 F	3439 F	Included
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	808 B	1043 B	2137 B	None
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	808 B	1043 B	2137 B	None
Union Bankers	Major Hospital Surgical (HS-89)	808 B	1043 B	2137 B	None
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 A	853 A	2177 A	None
Certified Life	Hospital Surgical Protection (CER-G020)	808 B	1043 B	2137 B	None
Pyramid Life	G95	1018 B E	1250 B E	2472 B E	645
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 F	839 F	1886 F	Included

A *$500 deductible on hospital services only.*
B *Rates for nonsmokers.*
C *$350 deductible on nonhospital only.*
D *$500 deductible for each condition every 3 years.*
E *$300 deductible only for supplies and drugs.*
F *$250 for nonhospital services.*
G *$300 deductible.*
H *$200 deductible.*
I *$200 deductible for each hospital admission.*
J *$500 deductible on nonhospital only.*
K *$400 deductible.*
L *$750 deductible.*
M *$300 deductible for each hospital admission; $500 for all services.*
N *$1000 deductible.*
O *$200 deductible for nonhospital services.*
P *Atlanta rates; $500 deductible for each condition.*
Q *$100 deductible for hospital inpatient stays only; $1000 for other services.*
R *No deductible required.*
S *$250 deductible.*
T *$60 deductible for each hospital admission.*

Key to Other Coverages
a–Prescription drugs for home use.
b–Preventive care for all ages.
c–Participating physicians for all families.
d–Mammography.
e–Pap smears.

	Payout				Preexisting illness									
	Quality index	Single	Family	Catastrophic indem.	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mo.	Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage	Comments	Telephone
	69	74%	60%	—	$1-million	○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075
	68	66	65	—	1-million	●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164
	68	66	65	—	1-million	●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164
	68	70	62	—	1-million	◒	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600
	68	74	61	—	1-million	◒	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663
	67	70	58	◓	1-million	○	Conditional	◓	12	No limit	No	Yes	No	a	—	800-868-2500
	67	70	67	—	1-million	●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622
	67	71	68	—	1-million	●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011
	65	62	51	◓	1-million	○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211
	64	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	64	65	53	●	1-million	○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850
	63	65	53	—	2-million	◒	Conditional	◒	12	12	No	Yes	No	a,c,d	—	800-624-5150
	63	72	60	◓	2-million	○	Conditional	◒	24	24	No	Yes	Yes	a,d,e	—	913-722-1110
	62	74	60	●	1-million	○	Conditional	◒	12	24	No	Yes	No	a	—	817-297-4123
	61	62	51	—	1-million	◒	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944
	61	63	55	○	None	○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642
	61	71	59	◓	2-million	○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500
	81	77	80	●	None	●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820
	77	76	77	●	None	●	Conditional	○	12	12	Yes	No	No	c	C	215-584-2100
	76	70	70	—	None	◓	Conditional	◓	6	6	Yes	No	No	c	B,L	313-225-8000
	76	76	75	—	None	●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200
	71	63	66	—	None	●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200
	70	71	75	—	500,000	●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797
	68	58	50	◓	none	◒	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211
	67	55	53	—	none	◓	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3536
	67	59	59	—	1-million	◓	Conditional	—	12	12	No	No	No	c	F	406-444-8210
	66	62	66	—	1-million	●	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	218-687-7218
	62	65	67	○	None	●	Conditional	◒	12	12	No	No	No	f	B,H	201-822-4500
	61	63	66	○	None	●	Conditional	◒	12	12	Yes	No	No	f	C,H	201-822-4500
	58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	53	55	45	◓	1-million	◒	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311
	50	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	42	35	30	●	2-million	○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110
	67	68	72	◒	None	●	Conditional	●	11	24	Yes	No	No	d	B	212-490-4757

f–Participating physicians for families below some income levels.
g–$50/year for preventive care per person.
h–Well-child care.
i–Major-medical coverage after $2500 deductible is met.
j–Major-medical coverage after $25,000 of covered expenses are incurred.

Key to Comments

A–Coinsurance on hospital and $10 copayments for physicians' visits.
B–No coinsurance.
C–Coinsurance only for certain services.
D–Less coinsurance after the first year.
E–If PPO doctors not used, coinsurance and coinsurance maximums are higher.
F–30 percent coinsurance.
G–Pays a set amount for hospital room and board.
H–Surgical-fee schedule.
I–Pays set amount for all services for each day in the hospital.
J–Routine maternity rider offered only with family policies.
K–Routine maternity coverage is included as part of policy only with family policies.
L–Maternity coverage only for delivery and hospital stays—no doctor visits covered.
M–Routine maternity coverage and coverage for maternity complications offered only with family policies.
N–No maternity coverage even for complications unless rider is purchased.

CONTINUING COVERAGE

WHEN YOU LEAVE A GROUP PLAN

If you leave a job, you may have two options for continuing your health insurance short of shopping for an individual policy on your own. Depending on the size of the firm you worked for and on your state's insurance regulations, you may be able to continue your group coverage for a short time as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Or you may be able to obtain an individual policy through a process known as conversion. Both options, though, will usually cost a lot more than you would spend for group coverage.

Because it is less expensive and generally offers better coverage than a conversion policy, your first line of defense should be COBRA.

COBRA: How it works

If you worked for a business with 20 or more employees, COBRA entitles you and your dependents to continued coverage for at least 18 months under your former employer's plan. If you are disabled and eligible for Social Security disability benefits when your employment ends, you can obtain an additional 11 months of coverage, for a total of 29 months.

If you are insured through your spouse's plan at work and your spouse dies, you become divorced or separated, or your spouse becomes eligible for Medicare, COBRA provides for coverage of up to 36 months.

COBRA requires that you pay 102 percent of your group insurance premium. If your employer has been paying a portion, you will have to assume that cost in addition to what you were already paying, plus an extra 2 percent for administrative costs. Disabled people who take COBRA coverage must pay as much as 150 percent of the premium for the extra 11 months.

You can lose coverage if you don't pay the premiums, if you become eligible for Medicare, if your employer discontinues health insurance for employees still working there, or if you join another plan.

However, if you join another plan and have an existing medical condition for which that plan imposes a waiting period, you can still keep your COBRA benefits until they would normally run out. By that time, your preexisting condition may be covered under the new plan. But you could be without coverage for that condition if your COBRA benefits stop before the waiting period on the new policy is over.

If you work for a company that has self-insured its workers' health coverage, you are entitled to COBRA benefits, even though such plans are normally exempt from other insurance regulations.

If you are not eligible for COBRA because your former firm employs fewer than 20 workers (or is a church organization), you may still have some protection under state laws. If your state provides for "continuation" of benefits, you may be able to stay on your employer's group policy for as little as three months in some states or as long as 18 months in others. (Those benefits are usually not available to workers in self-insured plans.)

The following states do *not* have comprehensive continuation laws: Alabama, Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Pennsylvania, Wisconsin, and Wyoming.

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

After COBRA coverage runs out, or if you're not eligible for it, your next options are to take a conversion policy or shop for individual coverage. (Unless, of course, you're covered under a new employer's health plan or become eligible for Medicare.)

The law requires that every employer who normally offers conversion policies to workers who leave also offer them to former employees once their COBRA benefits run out. Fifteen states, as well as the District of Columbia, don't require employers to offer conversion policies to employees who leave. They are: Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, and Oklahoma.

If an insurance company terminates a group plan, employees may also be out of luck. Two-thirds of the states require insurers that cancel group policies to offer conversion options to people losing their coverage.

Even when it is offered, conversion coverage is almost always inferior to what you received from your group plan. (Twenty-four states require companies to offer conversion policies with major-medical or comprehensive benefits.) If you currently have major-medical coverage, a conversion policy may provide only hospital-surgical benefits and only pay up to a fixed amount each day for hospital room and board and surgical procedures (see page 7).

For example, CIGNA, an insurer that offers several conversion options to employees converting from the group policies it underwrites, pays only $250 for hospital room and board if an employee chooses its top-of-the-line conversion coverage. For employees in a top-of-the-line group policy, CIGNA would pay most of the hospital charge, which runs considerably more than $250. (The average cost of a day in the hospital is about $800.)

While benefits are low, the prices of conversion policies are high, reflecting the fact that it is mostly people in poor health who buy this coverage. CIGNA, for example, charges a 45-year-old man or woman living in Chicago an annual premium of $4736 for its most generous conversion policy with a $500 deductible. By comparison, American Republic, the top-ranked commercial company in our study, would charge a 45-year-old man in Chicago $1904; a 45-year-old woman, $2240.

Despite those drawbacks, a conversion policy may be your only option if you have health problems. (Insurers must make these policies available to anyone regardless of their health.)

If only one member of your family suffers from some medical condition, you may want to take the conversion policy for him or her and try to find cheaper, individual coverage for the rest of the family. In some states, a person with health problems may be eligible for coverage from the high-risk pool, although in certain states, if you're eligible for a conversion policy, you can't have pool coverage.

If you're considering buying an individual policy instead of taking your conversion option when COBRA coverage ends, do your shopping well in advance. The slightest health problem can disqualify you, and it may take time for an insurer to collect your medical records and decide if it's willing to issue coverage. Once your COBRA benefits run out, you have only 31 days in most states to sign up for a conversion policy.

A REPRINT FROM CONSUMER REPORTS MAGAZINE

Consumer Reports

PART 2

THE CRISIS IN HEALTH INSURANCE

- **HEALTH INSURANCE FOR ALL?**
- **A LOOK AT THE CANADIAN ALTERNATIVE**

A reprint from the September 1990 issue of Consumer Reports magazine.

THE CRISIS IN HEALTH INSURANCE

In the first part of this series, we looked at the problems millions of Americans have in obtaining and keeping health insurance. We evaluated 71 individual health-insurance policies sold by 40 commercial carriers and Blue Cross and Blue Shield organizations, and discussed other alternatives for people who lose their group insurance.

In Part 2, we go beyond the short-term remedies to examine the various solutions to the health-insurance crisis that have been proposed by insurance companies, physician organizations, and the business community. We also visit Canada to look at how that nation pays for its health care. The Canadian example is considered by some as a model for the U.S.

HEALTH INSURANCE FOR ALL?

The American health-care system is the costliest in the world. The U.S. spends 171 percent more on health care per person than Great Britain; 124 percent more than Japan; 88 percent more than West Germany; and 38 percent more than Canada.

Over the last five years, the cost of health care in the U.S. has risen 42 percent, faster than the cost of food, housing, or transportation. In 1990, the nation's medical bill will total some $666-billion, or about $2664 for every man, woman, and child. Health-care spending now consumes 11½ percent of Gross National Product; by the end of the decade, it could account for as much as 15 percent.

Not all of those dollars pay for medical treatment. The cost of administration, claims handling, and insurance-company bureaucracy eats up at least $65-billion, almost 10 percent of the total. "We waste more of our medical dollars on bureaucracy and paper pushing than any other country," says Dr. David Himmelstein, national coordinator of Physicians for a National Health Program.

Despite the vast sums poured into health care, the U.S. ranks 12th in life expectancy, behind Japan, Italy, France, and the Scandinavian countries. It ranks 21st in the number of deaths of children under age 5; 22nd in infant mortality; and 24th in the percentage of babies born with an adequate birthweight (Bulgaria, Hong Kong, and the Soviet Union all do better on that last measure).

Among industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens.

A joint venture

The U.S. health-care system is built on a lucrative partnership of fee-for-service medicine and private insurance. For years, doctors and hospitals had carte blanche to set their own fees and pass the cost of their services along to private insurance carriers or to their patients. Insurance companies (and patients) rarely questioned the amount of those bills. "No one ever paid us to go fight with doctors," says one insurance executive.

If fees rose higher than the premiums the insurance companies needed to pay claims and turn a profit, the insurers simply raised the price of coverage. Policyholders could either pay the higher premiums or go uninsured.

The cost of medical care has now forced insurance premiums so high that millions of people *are* going uninsured. "The whole system keeps pricing more and more people out of it," admits Howard Bolnick, president of Celtic Life, a seller of health insurance. "The mar-

ket is working efficiently, but it's less than optimum from society's point of view."

Decades of debate

As more people are squeezed out of the American health-care system, and as basic public-health statistics underline the system's comparative inadequacies, a decades-old debate over public-health policy has been rekindled. The debate has been simmering for some 80 years.

In the years before World War I, in the 1930s, in 1949, in 1965, and again in the 1970s, the U.S. seemed on the verge of establishing universal health insurance. A 1939 issue of CONSUMER REPORTS noted: "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'"

A decade later, in 1949, we reported: "As the new Congress meets, prospects for national health insurance have never looked better. There are a number of reasons why 1949 may see a Federal insurance law passed at last. The American public has overwhelmingly demonstrated its approval of health insurance in many surveys, in legislative programs of consumer, civic, and labor groups, in government policy reports, and in endorsements by political leaders. Soaring prices have made the cost of medical care even more difficult for most families to afford."

Sixteen years later, a national health-insurance program still hadn't come to pass, despite the committed leadership of President Lyndon Johnson. In 1965, after powerful lobbying against national health insurance by organized medicine, Congress voted to authorize it only for the elderly, in the form of Medicare. (At the same time, it established Medicaid, a new government program for the poor.)

Even then, the Medicare Act was tailored to the economic demands of the American Medical Association and Blue Cross and Blue Shield, the primary insurance carrier of the day. Fee-for-service medicine and the Blue Cross method of reimbursing health-care providers became part and parcel of Medicare. They laid the foundation for today's towering health-care costs. (Blue Cross and Blue Shield also got the job of paying Medicare claims for the Government.)

Again in the 1970s, there was serious talk of universal health insurance. But President Jimmy Carter could not muster the political backing needed to fulfill his campaign pledge to implement it.

How has a system that costs so much and still falls short managed to survive and resist reform?

The power of the AMA

Fearful that universal health insurance will lower the incomes of its 271,000 members, the American Medical Association has for years denounced national health insurance as "socialized medicine." More to the point, the AMA has paid politicians handsomely to view national health insurance in the same light.

The AMA is one of the largest contributors to political campaigns, appearing near the top of almost every list of the big money raisers, the big contributors, and the big trade association political action committees (PACs) compiled by the Federal Elections Commission.

During a 15-month period ending in March 1990, the AMA ranked second on the election commission's list of the top 50 PACs in amount of receipts, second in total spending (which includes funds for advertising and mailings as well as contributions), and seventh in the amount of cash on hand, with some $2-million in reserve to bankroll future campaigns.

In the 1988 Congressional elections, the AMA spent $5.3-million, including $2.3-million in direct contributions to House and Senate candidates. From January 1989 through March 1990 it has given money to 348 members of Congress, including eight of the 12 Congressional members of the Pepper Commission, a bipartisan group composed of members of Congress and industry representatives that was established to study health-care financing and recommend changes. The Commission was chaired by Sen. John D. Rockefeller IV, D-W.Va.

To replenish its coffers, the AMA embarked on a special effort last year to discredit the Canadian health-care system, often viewed as a model for reform in the U.S. In what it called its "Strengthening the U.S. health-care system" campaign, the AMA wrote to member physicians: "We need your help to continue reaching millions of Americans. We must tell them the facts about the dangers in a Canadian-type health-care system—before it's too late. Help us continue publishing our messages in leading magazines and newspapers...." Enough doctors sent checks that the AMA was able to buy ads disparaging the Canadian system in major magazines. (For one example, see the illustration on page 3.)

The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some $4.1-million on behalf of political candidates.

Insurance clout

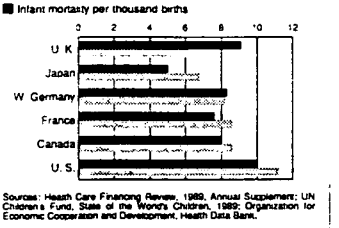
The insurance industry's stake in the battle is the $175-billion it collects each year in health-insurance premiums. In a letter sent to member companies last summer, Carl Schramm, president of the Health Insurance Association of America (HIAA), warned that "a move in the United States to a Canadian approach to health-care financing is antithetical to our interests." Schramm subsequently told CU: "We'd be out of business. It's a life-and-death struggle."

The insurance industry also shovels money at politicians. American Family Corp., the fifth-largest seller of health insurance, particularly dread-disease and cancer policies, ranks eighth on the election com-

Doctors on the picket line: Just as organized medicine in the U.S. has opposed universal medical insurance, many Canadian physicians were none too fond of the notion. When Saskatchewan became the first province to adopt universal medical coverage, doctors there went on strike. When Quebec followed suit in 1970, its doctors also staged a short strike.

HIGH COSTS, POOR RESULTS

Though the U.S. spends a higher percentage of its Gross Domestic Product on health care than these five other industrialized nations, its record on infant mortality is the poorest of the group. (Gross Domestic Product is the monetary value, at market prices, of all goods and services created in a country in a given year. Infant mortality is a commonly used measure of the overall health of a nation, reflecting how well medical services are delivered throughout its population.)



Sources: Health Care Financing Review, 1989, Annual Supplement; UN Children's Fund, State of the World's Children, 1989; Organization for Economic Cooperation and Development, Health Data Bank.

mission's list of the top 50 corporate campaign contributors, ahead of such giant corporations as Boeing, Citicorp, and Ford Motor Co. It donated some $250,000 from the beginning of 1989 through March of 1990. Three other large sellers of health insurance—The Travelers, Metropolitan, and Prudential, all of which collect well over $1-billion in health-insurance premiums each year—are also among the top 50 corporate contributors.

But the insurers don't limit themselves to campaign contributions. Their forte is "educational" lobbying. "We produce lots of research bulletins that are classy little numbers," HIAA president Schramm told CU. When the Pepper Commission issued its report in March 1990, its recommendations for reforming sales practices in the small-employer market were strikingly similar to those of the HIAA. "The Pepper Commission basically ceded the small-group issues to us," Schramm says. "They [the commission's recommendations] are our proposals."

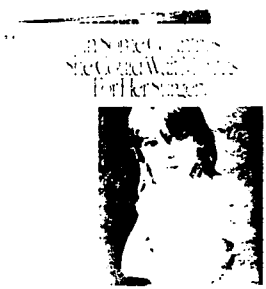
Changes in the wind

But public dissatisfaction with the current system has once again brought health insurance onto the national agenda. Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 percent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals." In 1990, a Los Angeles Times poll asking a similar question found that 66 percent of Americans would prefer a health-insurance system similar to Canada's. "People are far ahead of the political leadership on this issue," says Susan Sherry, an official at Families USA, a senior citizens health-advocacy group.

The business community has also become vocal on the issue. Some corporate leaders are calling for changes that they would have considered unthinkable a few years ago. "We need fundamental reform. Whether we have the courage to move forward remains to be seen," says Walter Maher, a lobbyist for Chrysler Corp. Chrysler says that workers' health insurance adds $700 to the cost of every car it builds in the U.S.—an amount that must come down if the company is to remain competitive.

Not all doctors side with the AMA. The 68,000-member American College of Physicians is calling for reforms that would guarantee all Americans access to medical services and reduce the waste and inefficiency in the present system. The 3000 members of Physicians for a National Health Program have a similar goal. (Those groups, however, don't back their programs with political contributions.)

Privately, even some insurance-industry executives recognize that universal health insurance is probably inevitable, and they have been preparing for their eventual role in it. "Some companies are saying, 'If we can survive until there's national health insurance, we have a shot at administering it,'" says an official at one Blue Cross and Blue Shield organization.



On the offensive To counteract positive media portrayals of universal health insurance programs in Canada and elsewhere, the American Medical Association launched a national advertising campaign in 1989. This ad ran in Newsweek.

Solving the crisis

A number of remedies for the health-insurance crisis have been proposed by various interest groups. Some are limited; others are more far-reaching. Some deal only with controlling costs of the health-care system. Others confront the more basic question of providing access to care for everyone. Among the proposals likely to be part of the public debate in the coming months are these:

1. Encourage people to use fewer medical services by writing higher deductibles into policies. The theory behind this proposal is that when people pay a greater share of their bills, they'll use health care more frugally. As a result, the argument goes, health-care costs will decrease, premiums will rise more slowly, and more people will be able to afford coverage.

Such a notion assumes that people prescribe their own medical care. Most of the time they don't; their doctors do.

Health-care providers also stimulate much of the demand for elective medical care. Hospitals now advertise in magazines, on television, and on billboards—drumming up business for their inpatient psychiatric services, for example, when such cases might be handled more appropriately on an outpatient basis. As part of its corporate-image promotion, General Electric advertises magnetic resonance imaging machines (MRIs) on television. "It doesn't hurt to have people aware of MRIs," says a GE spokesperson. If people ask for MRIs instead of ordinary X-rays, hospitals will have no choice but to shell out $1.4-million to $2-million for a machine.

Higher deductibles may indeed make some people think twice before seeking care in the first place. While discouraging unnecessary services is a reasonable goal, there's an obvious danger that people will postpone *necessary* treatment. Then more costly procedures may be necessary, or it may be too late.

There is even some doubt as to whether any savings would result from a switch to higher deductibles. "Our experience has shown that higher deductibles have not prevented our [claim] costs from going up," says Andy Perkins, a vice president at The Travelers.

2. Do away with state-mandated benefits. Each state requires that health-insurance policies sold there include certain coverages. These so-called state mandates vary among states, but many require insurers to cover newborn babies, adopted children, prenatal care, and

mammographic screening. They may also offer employees the option of continuing their coverage when they leave a job.

The insurance industry contends that some mandated benefits, such as coverage for visits to psychologists, podiatrists, chiropractors, and social workers, are of questionable value and unnecessarily raise the price of insurance. However, the industry has no estimate of the overall premium savings that would result.

In CU's view, repealing mandated coverage moves in the wrong direction—toward less access to care. To shave a few dollars off premiums, more women would lose their prenatal care, more newborns and children would go without preventive treatment, and more employees would have no coverage when they left their jobs.

3. Design stripped-down policies. Some insurance-company and Blue Cross and Blue Shield executives have suggested designing policies with limited benefits that they can sell for about half the price of more comprehensive coverage.

While such basic policies might improve the overall statistics on the uninsured, they, too, would result in less coverage for individuals. We reported on some of them in Part 1. An "affordable" basic policy from Blue Cross and Blue Shield of Oklahoma, for instance, covers only 21 days of hospital care. That might be enough for most sicknesses, but a catastrophic illness or injury would leave a policyholder uninsured and possibly on the road to bankruptcy. A person whose serious heart attack cost almost $50,000 would have been left $10,000 in debt by an affordable hospital-surgical policy sold by Pyramid Life, the policy that ranked at the bottom of our Ratings in Part 1.

4. Institute "managed care." Under the rubric of "managed care," insurance companies are belatedly paying attention to what their dollars are buying. Managed care includes formal programs for monitoring the quality of treatment and determining whether it's appropriate for the patient's condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals, and to obtain approval from insurance companies before starting a proposed course of treatment.

Managed care attempts to put controls on doctors—ironically some of the same controls doctors have feared from a national health-insurance program. In the process, it is creating a brand-new profession, health-care cost management, one of the fastest growing segments of the health-care industry. Health-care cost management firms are expected to generate some $7-billion in revenue in the next few years—revenue that will, of course, come from insurance premiums.

Whether the savings in the cost of health care will be greater than the money spent to "manage" it remains to be seen. "None of this stuff has done anything to make the fundamental health-care system cost less and [be] more efficient," says Curt Fuhrmann, president of the individual health division of Washington National. And even if managed care eventually reduces the nation's health-care bill, it will do nothing to expand access to medical services for people who currently have no insurance coverage.

5. Establish risk pools. The insurance industry wants each state to set up a high-risk pool that would provide policies for people the companies don't want to insure. Such pools are yet another way for the industry to shed a group of policyholders who are not profitable. The HIAA further proposes that the states pick up the tab for pools' losses; that is, make up the difference between what the pools collect in premiums and what they pay out in claims.

In the spring of 1990, when we surveyed the risk pools that had been organized in 19 states, we found that they covered only about 55,500 people in total, and all the pools were operating at a loss. Pool administrators estimated that at least 413,000 people in those states needed pool coverage but couldn't obtain it. In Illinois, for example, the waiting list was so long that people have to wait at least a year for coverage.

6. Expand Medicaid coverage. When Medicaid was first established in the mid-1960s, it covered some 70 percent of those with incomes below the poverty line. Today Medicaid covers just 38 percent, because states and the Federal government have raised their eligibility standards.

The insurance industry and the American Medical Association want to reverse that trend by requiring Medicaid to cover anyone whose income falls below the official poverty line, currently $12,675 for a family of four; $8075 for a couple; and $6314 for a single person.

Under some proposals, people whose incomes are as high as twice the poverty level could "buy" Medicaid benefits. Under other proposals, these people would have to turn to the private market for their coverage. It's hard to see how any family whose income is around $13,000—or even $26,000—can afford some of the policies we rated in Part 1. Premiums for families of four ranged from about $2000 to more than $6000 a year.

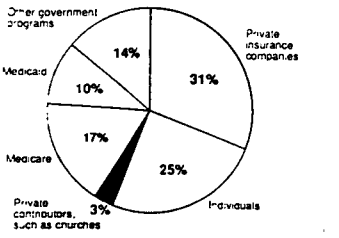
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

Putting Medicaid cards into the hands of more people wouldn't necessarily assure them access to health care. Many doctors refuse to treat Medicaid patients because reimbursement rates are low. Reforming Medicaid would expand coverage for some, but it would also increase the government bureaucracy needed to determine eligibility. It is at best a stopgap measure that will do little to curb waste in the health-care system.

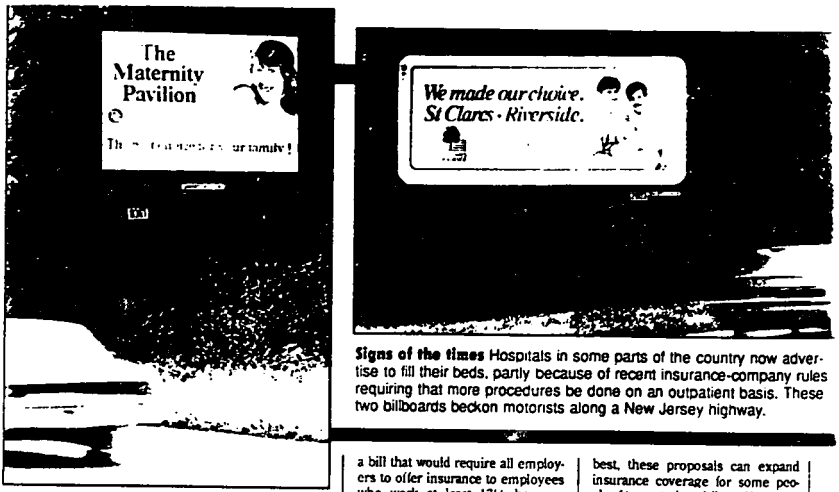
7. Reform insurance-company practices. One plan proposed by insurers themselves would excuse people who were once covered under a small employer's group policy from satisfying a new waiting period for pre-existing illnesses

WHO WRITES THE CHECKS?

As costly as the private-insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988.



Signs of the times Hospitals in some parts of the country now advertise to fill their beds, partly because of recent insurance-company rules requiring that more procedures be done on an outpatient basis. These two billboards beckon motorists along a New Jersey highway.

when their employers change carriers or when they change jobs. In those cases, people with health problems would have immediate coverage. This proposal would also prohibit insurers from excluding coverage for certain health conditions or parts of the body by means of exclusion riders.

But insurers still don't want to take on any unnecessary risk. So their proposal also calls for the establishment of a reinsurance agency (essentially a company that insures insurance companies) to assume the risk of waiving pre-existing conditions clauses and eliminating exclusion riders. Insurers themselves would fund the reinsurance program through assessments, but if assessments proved to be inadequate, the government could be called on to make up the difference.

Another industry-sponsored proposal would limit the sometimes huge annual increases experienced by employees who work for small firms—to no more than 15 percent above an insurance company's general yearly rate increase for all its policyholders.

Both of those proposals would help people already safely inside the insurance loop. But they won't help people with health problems who are outside the system or who must buy their own coverage.

8. Require all employers to offer coverage. The main proponent of this approach is Senator Edward Kennedy. He is sponsoring a bill that would require all employers to offer insurance to employees who work at least 17½ hours a week. Under Kennedy's bill, employers would also have to pay 80 percent of the cost of a basic package of benefits for their full-time employees.

Others have proposed variations on Kennedy's plan. These so-called pay-or-play approaches to health-care coverage would require employers to offer insurance to their workers or pay into a special government-operated fund that would provide the coverage. In other words, employers would either "play" by providing coverage or "pay" into the special fund. The Pepper Commission recommended such a plan.

To win support of the AMA, Kennedy's bill does not address cost containment. More people would be covered, but most doctors and hospitals would still have a blank check. That omission, a serious one in CU's view, has also given employers and the insurance industry reason for opposing this approach.

Lobbyists for small business argue that the costs of providing coverage are too great for many marginal firms. Unless small businesses received tax relief in exchange for providing coverage, this approach could give them a powerful incentive to hire employees to work fewer than 17½ hours a week. Seasonal and part-time workers could still be left without insurance.

Congress is likely to give pay-or-play proposals serious consideration in the next few years. At best, these proposals can expand insurance coverage for some people. At worst, they fail to offer a way to curb health-care costs. They also perpetuate the current system of private insurance with all its administrative waste. In fact, they would add another layer of administrative bureaucracy in creating the special government fund for workers whose employers would still not provide coverage.

9. Introduce universal health insurance. This is the approach Canada has taken to fund medical care for its citizens. Under this system, everyone is entitled to health care, and the public pays the bills through tax dollars rather than through insurance premiums.

Providers of health care charge a fee for their services, just as in the U.S. But their fee schedules must be negotiated with the government, which has an incentive to control costs, since tax increases are as politically unpopular in Canada as in the U.S.

In CU's view, the first eight of these proposals fall short of the goal of affordable health care for all Americans. They would still limit employment options—forcing some people to stay on a job that may otherwise be unsatisfactory simply to keep their health insurance. They could still force a person to spend as much as $12,000 a year to cover a family under a conversion policy. Some sick people would still have to settle for an inferior hospital-indemnity policy just because it is better than nothing. Worst of all, many Americans would still be denied proper health

Paying for long-term care: The Pepper Commission has recommended a publicly funded program to pay for nursing-home expenses and for home care needed by people of all ages. That would eliminate the need for most nursing-home insurance. CU supports this approach.

care simply because they couldn't afford to buy insurance.

Recommendations

The few reforms that were won in the past were simply bargains struck with doctors and insurance companies. People who could least afford the cost of medical care or insurance were sloughed off onto public programs. The public assumed the cost of health care for those patients through Medicare and Medicaid while health-care providers and insurance companies kept control of the system and retained for themselves the ability to profit from those who could pay.

Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

The only model for reform that attempts to meet those criteria is the Canadian system. It is not a system

Doctors vs. Insurers

THE BATTLE OVER FEES

Insurance companies and the Federal government say they're trying to control health-care costs. And in the process, they're going head to head with the medical establishment.

Insurers are now requiring many policyholders to obtain approval before beginning a course of treatment. They require that policyholders have certain types of surgery done in hospital outpatient facilities and that they obtain second opinions before having any surgery performed. They are also establishing preferred-provider organizations, PPOs, in which doctors agree to reduce their fees to the insurer in exchange for more patients; the insurer lowers deductibles and coinsurance as an inducement for policyholders to use PPO doctors.

Since 1984, the Federal government has limited the fees it pays to doctors who treat Medicare patients. It will soon implement a new way of paying doctors based on the relative value of the various services they perform. This new system is aimed at reducing the fees of some highly compensated specialists, such as anesthesiologists and radiologists, and increasing the fees of others, such as family doctors. The system also includes limits on billing and on the number of services performed.

So far, all these efforts at taming health-care costs have been about as successful as trying to squeeze a balloon. When insurers or the Federal government clamp down on costs in one area, costs expand rapidly in another. "We pay less per claim, but we pay for more claims," says Curt Fuhrmann, president of the individual health division of Washington National, a seller of health insurance. "A lot of this stuff works initially, but after a while the system adjusts and finds a way around it." Nowhere is that more evident than in the war over bills that has erupted between doctors and insurance companies.

The fine art of bill coding

Pressure from insurance carriers to limit physician payments, as Medicare does, has spawned a new industry devoted to teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system.

"Reimbursement guaranteed. You'll improve your reimbursement, or you'll get your money back," reads an advertisement for one such company, Medbooks. "Start now to bill for *all* of the services you provide—and receive *all* of the payments you're entitled to!" reads a flyer for St. Anthony Publishing Inc., a company that proclaims it has grown into an industry leader in "five short years."

The primers sold by these new firms tell physicians how to choose certain billing codes over others that would net them less income. There are some 7000 codes representing all the services physicians perform, and doctors customarily list the codes on the bills they present to patients and their insurance companies.

For example, one newsletter reported that insurance companies are not paying if doctors use the code for "hospital discharge day management" when they discharge hospital patients. It advised doctors to use either the code for "medical conference by physician regarding medical management with patient, and/or relative, guardian, or other; approximately 25 minutes" or a code for a higher level of daily hospital visit. The newsletter recommended that doctors use both codes for a while and see which one insurance companies will go for.

A physicians' newsletter from St. Anthony Publishing carried this headline: "Updating superbill brings financial rewards." Superbills are the detailed bills that patients receive for the procedures doctors perform. St. Anthony advised doctors in family practice that adding and billing separately for such services as minimal [office] visits, brief [office] visits, injections such as tetanus and DPT, new patient office visits, supplies, and brief follow-up consultations could bring an increase in weekly revenue of $845, or $40,560 a year (based on 48 weeks).

The books and newsletters also offer guidance on "unbundling"—that is, charging separately for services that were once priced together or "bundled." Unbundling almost invariably means more income.

Another newsletter from St. Anthony Publishing described one medical office in which doctors were performing dilatation and curettage procedures 10 to 15 times a week. When the doctors were shown how to charge separately for dilatation and for curettage, and even for sterile surgical dressings, the average payment from insurance companies increased from $300 to $535, and the practice increased its revenue some 78 percent.

Insurers strike back

To combat these practices, insurance companies are now hiring firms to "rebundle" the bills that come into their claims departments. Indeed, a rival industry has sprung up to scrutinize bills for evidence of the billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers "medical claims editor" computer software that will rebundle a $2500 bill for performing an appendectomy ($1500) with a laparotomy ($1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only $1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on books, seminars, and software is doing little to improve the health of Americans.

of "socialized medicine," in which doctors and hospitals work for the government and patients are assigned to clinics. Canadians are free to pick their doctors and hospitals. The Canadian health-care system costs less than the U.S. system and delivers more, mostly because it spends less on administration and bureaucracy. Canada spends about 1 to 2½ percent of every health-care dollar on administering health claims, compared with 10 to 11 percent spent by private insurers in the U.S.

A move to a universal health-care system modeled on Canada's would save money in other ways. Because medical care would be available to everyone, there would be no need for medical-payments coverage under workers' compensation insurance or automobile-insurance policies, or for the liability portion of homeowners insurance that goes to cover injury claims.

As we explain in the following report, Canada has by no means found the ideal system. It is facing the same cost pressures on medical care as the U.S. and European countries, and, like those nations, it is examining ways to contain them. But public debate there has long since moved away from reforming insurance practices and toward targeting the country's resources to improve the health of its people.

The U.S. should take the best of the Canadian system and add to it the techniques that have shown the most promise for controlling health-care costs and curbing the overuse of health-care services that occurs in both countries. Those techniques include establishing "practice guidelines" for physicians (which define procedures that are effective under various circumstances) and assessing whether new technologies are effective in treating disease. Borrowing the best from Canada and adding effective cost containment would produce a uniquely American system that would serve all citizens.

It may be that the American model will evolve first in one of the states. (The Canadian system was patterned after universal hospital coverage introduced in the province of Saskatchewan in the 1940s.)

Some states are already looking for ways to improve access to health care for their residents. In California, for instance, there is a serious proposal in the legislature for the state to pay for health care, including long-term care, for all Californians. In New York, the state legislature recently passed a state-subsidized insurance plan for young children of the working poor, a step some see as a move in the direction of universal health insurance.

"In the next decade, if you don't have a national health system, the insurance companies will continue to selectively deinsure. No matter how many premiums you've paid, you'll never know if you'll be next," says Dr. Jane Fulton, a professor of health policy at the University of Ottawa. "That risk should be intolerable to Americans."

A LOOK AT THE CANADIAN ALTERNATIVE

Near downtown Montreal, a pregnant woman arrives at a *centre local de services communautaires*. Here at the CLSC, as the center is called, she receives regular checkups and counseling on the right foods to eat during her pregnancy.

When it's time for her to deliver, she will go to a local hospital. One of the two doctors who has been caring for her will deliver the baby. After the baby is born, she can bring it back to the CLSC for immunizations and follow-up care.

A social worker at the center will help her adjust to the demands of motherhood if she needs help, and a staff nurse will visit two weeks after the baby is born to give breast-feeding advice and answer other questions.

If the nurse finds that the mother lacks the skills to care for her baby, or detects more serious problems such as child abuse or neglect, more intensive counseling, either in the mother's home or at the CLSC, will be scheduled. When the mother needs a break, she can take the baby to the CLSC's day-care center, where women from the surrounding community drop off their children for a few hours each week.

The woman will pay nothing for these services. She simply presents her orange-and-yellow health card, issued by the government of Quebec. That card entitles her to free medical care at any of the 158 CLSCs in the province or from any doctor or hospital she chooses.

The CLSCs in Quebec, as well as similar community health centers in other provinces, represent an attempt at integrating medical care and social services within the framework of Canada's universal health-care system.

CLSCs help community residents find housing or day care for elderly or sick parents. Some offer smoking-cessation clinics. At others, elderly residents from the surrounding community can come by for a hot lunch at noon or for flu shots. A few CLSCs function as mini-hospitals where patients are admitted and kept overnight for observation and treatment.

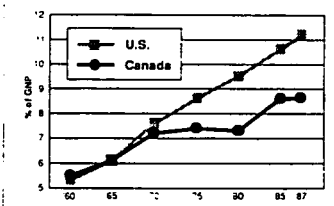
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

How the system evolved

Twenty-five years ago, just before Canada began phasing in universal insurance for medical services, the U.S. and Canadian health-care systems were on parallel tracks. Both

THE ROAD NOT TAKEN

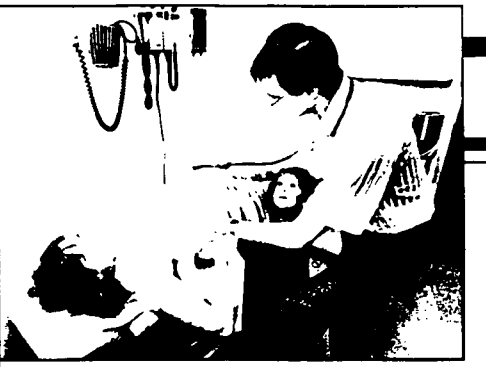
Canada and the U.S. were spending about the same percentage of their Gross National Products on health care in 1965, just before Canada established its publicly funded insurance system for medical services. Since then the U.S., which has retained private insurance, has spent a greater portion of GNP on health care



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988

countries were spending about 6 percent of Gross National Product on health care. By 1987, as health-care costs increased throughout the industrialized world, Canadians were spending 8.6 percent, while Americans were spending 11.2 percent.

But by then, the two countries were already on very different tracks. In 1966, Canada passed its Medical Care Act, entitling all residents to medical care funded through the tax system. (Free hospital care had been established in 1957.) About the same time in the U.S., the president of the American Medical Association declared that health care was a privilege, not a right—an issue still not fully resolved in the U.S. today.



Photos: CYNTHIA JOHNSON

Prenatal care At a clinic near downtown Montreal, Dr. Stephen DiTommaso examines Sandra Gail Dalgleish while her son Antoine watches. Pregnant women are closely monitored at Canadian clinics and offered services ranging from nutritional counseling to home visits after their babies are born.

No private insurance

Canada outlawed private insurance for any services covered by its universal programs. Insurance companies there can sell health policies only to pay for uncovered services, such as private rooms in hospitals, medical expenses incurred in foreign countries, and dental care. When Canadians go to a hospital or see a doctor, they simply show their medical card, issued by the provincial government. The doctor then bills the government and is reimbursed according to fee schedules negotiated earlier. (Hospitals receive an annual budget that covers virtually all patient costs. They are paid one-twelfth of their budget each month.)

Since the billing forms used by doctors are standardized and only the government pays the bills, processing costs are low and providers receive payment in about 30 days. Patients don't have to cope with the deductibles, coinsurance, coinsurance maximums, or out-of-pocket expenses that are part of virtually every American health-insurance policy. Nor do they have to fill out complicated forms. There are no user fees, and doctors cannot "balance bill"—that is, charge more than the negotiated fee. (In the U.S., doctors can bill patients for more than the insurance company's allowable charge.)

Canada's program covers most medical services. However, eyeglasses, prescription drugs for people under 65, out-of-hospital dental care for adults, and cosmetic surgery are usually not covered in most provinces. Some provincial governments also pay for a few nonphysician services, such as physiotherapy, podiatry, and chiropractic treatments.

Fee-for-service doctors

Although Canada replaced private insurance policies with a public-insurance system, it retained fee-for-service medicine; that is, most doctors receive fees for the services they perform, rather than a salary. Today physicians' incomes are among the highest in Canada—four to five times higher than the average industrial wage. (In the U.S., the average physician in private practice earns five to six times the average industrial wage.)

Each year, medical associations and the provincial governments negotiate an overall increase in the fee schedule. The associations then allocate the increases among various specialties and services.

The negotiated fees, however, tend to be lower than in the U.S. (where doctors also care for patients who can't pay). In Quebec, for instance, medical groups have negotiated a fee of $217 for doctors who perform cesarean sections (they receive $87 more if there are complications and $109 more if the delivery is at night or on the weekend). They receive a fee of $174 for performing an appendectomy. (Here and elsewhere in this report, all Canadian figures are given in U.S. dollars.) In the U.S., the average physician fee for delivering a baby by cesarean is $1222, and the surgeon's fee for performing an appendectomy averages $846.

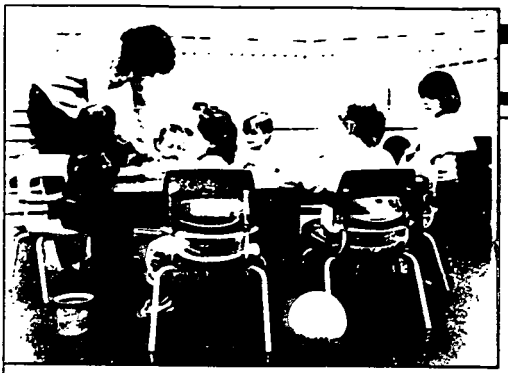
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two health-care systems, according to Dr. David Himmelstein of Physicians for a National Health Program.

Compared with the U.S., Canada spends much less on health care, but its system is still the second most expensive in the world, a statistic some trace to an oversupply of doctors who bill for too many services and to overutilization of medical services by patients. The government gives Canadian doctors considerable autonomy in their practice of medicine. And they have no insurance companies looking over their shoulders as do doctors in the U.S.

Hospital budgets

Hospitals also negotiate their budgets with the provincial ministries of health. Budgets are based on a baseline amount that the hospital spent in 1969. Each year, the ministries grant increases for inflation, for new programs, and for increased activity in the hospital's services.

Because the ministries have tended to hold increases to less than the actual rate of inflation, hospitals



Child's play Pierrette Croteau, a child-care worker at the Montreal clinic, helps toddlers and preschoolers at the facility's day-care center. Each day the center looks after 10 to 20 neighborhood children whose parents drop them off either for half-day or full-day care.

have had to redistribute their funds internally to live within their budgets. Ottawa Civic Hospital, for instance, closed 82 beds in 1989 but was able to serve more people than the previous year by shifting patients to outpatient care and surgical day-care centers, eliminating overnight stays for preadmission testing, and shortening the length of stays. Canadian health-policy planners say that reducing the number of days patients spend in hospitals is vital if the system is to get its costs under control.

In the U.S., hospitals in states without limits on hospital rates can simply raise their daily charges and pass them along to insurance companies that pay the bills for patients who are not on Medicare. Insurers then pass them along to policyholders. (For Medicare patients, the Government pays a fixed amount based on the diagnosis.)

New technology

Provincial governments also control the introduction of expensive new technology like magnetic resonance imaging machines, which take sharp pictures of internal organs, and lithotripters, which crush kidney stones and gallstones with sound waves. A hospital can raise private funds to buy an MRI, but since the money to operate it comes from the government, hospitals generally don't do that. Furthermore, doctors can't bill the government for use of the equipment unless it is authorized.

The introduction of new technology has, therefore, gone more slowly than in the U.S. Critics of the system, mostly doctors and hospitals, contend that as a result, some people are being deprived of state-of-the-art treatment. But other Canadians, including health-policy planners and government officials, say there is a benefit in introducing new technology more slowly. They argue that by waiting for reasonable evidence that new technology really works they can make a more informed decision about whether to commit scarce resources to it.

In the U.S., when a new machine comes on the market, its use tends to spread rapidly throughout the medical community—often before there has been time to assess the technology's effectiveness. Once a hospital or a group of doctors buys a new machine, the incentive to use it to recoup the investment exists side by side with the need to use it to improve medical care. That inevitably drives up health-care costs.

No Canadian who is acutely ill is denied prompt medical care. If patients need emergency care and the local hospital has no facilities or equipment to provide it, they are transported to the nearest hospital that does. If necessary services are available only in another province, or in the U.S., the patient goes there, and his or her provincial government pays the entire bill.

The slower implementation of technology sometimes means waiting lists for some procedures, however. A person complaining of headaches doesn't immediately receive a CAT scan and may have to wait several weeks for one. But if doctors suspect the person has a life-threatening ailment such as a brain tumor, a CAT scan will be done right away. The same is true of such costly procedures as coronary-artery bypass surgery.

"None of my patients has ever suffered or been deprived of medical care because of this system," says Dr. Philip Berger, a physician who treats AIDS patients in downtown Toronto. "I treat the poorest and the sickest, and they get everything they need." Even the costly drug AZT is supplied free to AIDS patients by the Ontario government.

Who pays the bill?

The Canadian federal government pays part of the health bill for each province. It pays more of the cost for poorer provinces and less for wealthier ones. The provinces themselves fund the rest of their health-care budgets, which usually account for about one-third of their total annual spending.

At both the federal and provincial level, the money to pay for health care is raised through a combination of personal income taxes; corporate taxes; excise taxes on gasoline, tobacco, and alcohol; and lottery profits.

In Alberta and British Columbia, residents also pay a special insurance premium earmarked for health care. In Alberta, a family of any size pays $552 a year; a single person pays $276. Ontario did away with insurance premiums earlier this year and replaced them with an employer health tax. In Ontario, employers with a payroll greater than $347,826 (U.S.) would pay a rate of 1.95 percent. Employers with smaller payrolls pay less. (Quebec and Manitoba levy a similar tax.) Unlike U.S. payroll taxes, the employee does not pay a matching amount.

A Canadian with a taxable income of $26,086 (U.S.) living in Ontario would pay about $7184 a year in Federal and provincial taxes. Of that, roughly $1340, or about 19 percent, goes to fund health care.

In the U.S., a person with $26,086

A place for the elderly The Montreal center feeds about 100 elderly men and women from the surrounding community each noon. The cost of lunch is nominal—the U.S. equivalent of $2.39. The 158 clinics across the province of Quebec tailor their programs to the needs of the communities they serve.

in taxable income would pay $4776 in Federal income taxes and perhaps another $1304 in state taxes, bringing his or her total income tax to about $6080. None of that money would pay for his or her health care. The person would also pay Social Security taxes, of which about $378 would go to fund Medicare.

The American (or his or her employer) would pay for his or her medical care through private insurance; that typically costs $1500 to $2000 a year. In addition, he or she would have to pay out of pocket the deductibles, coinsurance, and other expenses not covered by the insurance policy. Together, those out-of-pocket costs can easily run between $500 and $1000 per year.

Looking ahead

There's virtually no debate in Canada about whether there should be a publicly funded insurance system or whether all people should have access to health care. There is plenty of debate, however, about whether the dollars the country spends on health care are spent in the right place.

Like other industrialized countries, Canada is also experimenting with ways to control costs. In Quebec, for example, there are caps on doctors' incomes. When a general practitioner's gross quarterly income (before taxes and practice expenses) reaches the U.S. equivalent of $37,102, the government will pay him or her only 25 percent of the usual fee for the rest of the quarter. In effect, then, Quebec has put a damper on the ability of general practitioners to gross much more than $148,000 a year. (In the U.S., the typical general practitioner earns about $216,900 before taxes and practice expenses. But high practice expenses, including the cost of dealing with the fragmented private and public insurance systems and the cost of malpractice insurance, reduced that to a mean net income of about $95,000 in 1988.)

In Canada, as elsewhere, doctors and the medical establishment have been vocal in demanding more resources. The community health centers are controversial, for example, because traditional medical practitioners see them as diverting health-care dollars from new equipment, more operating rooms, and larger fees.

Most Canadians like their health-care system, and would dispute the American Medical Association ad in U.S. magazines last year that characterized their system (without actually naming it) as "underfinanced, overextended, and ill-equipped."

Dr. Eugene Vayda, a U.S. and Canadian citizen who is a professor of medicine at the University of Toronto, has practiced under both the Canadian and U.S. health-care systems. "It's a pleasure to practice in a system where everyone has the same buying power," he says. "It allows you to focus on the patients and their needs. The Canadian system is so much better than the U.S., you can't even speak of them in the same breath." ■

REPRESENTATIVE SCHEUER. And now we will hear from Judith Brown, Member of the Board of Directors of the American Association of Retired Persons—AARP. For several years, she has been an executive with AARP, and we are keen to hear your views, Ms. Brown.

Please proceed, Ms. Brown.

STATEMENT OF JUDITH N. BROWN, MEMBER BOARD OF DIRECTORS AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BROWN. Thank you very much, Mr. Chairman.

AARP, I think you know, believes that the issue of health care is one of the most important issues facing America today, and we commend the Subcommittee for holding this hearing.

We would like to help move this issue forward to make reform a reality. We believe that it is essential that health- and long-term care be made available to all Americans, regardless of their age or income.

As you have heard, all across America people are suffering. Families are being forced to make untenable choices.

I run an investment company in Minneapolis. Two days ago, I saw five people; and yesterday morning before I caught the plane, I saw one other person. All six of these people are different ages, some are richer, some are poorer; and when they came to see me, they all had an issue that relates to health care.

In our newspaper in Minneapolis last week, there was the story of a family whose child was born prematurely. The child's lungs had never developed properly. The child is now living at home and needs 24-hour-a-day health care. Their insurance has already paid $1 million and is now saying that they can no longer continue to pay. The family is faced with how are they going to pay for this child's health care. The company that the father works for is faced with the issue of how they will be able to continue to attract good employees when they have such a burdened health-care system because of this child.

No one today has talked about the issue of the economics of America remaining a competitive industrial power in the world. We have heard many times, and the representative from Chrysler will tell you, for every car manufactured in America today, $700 goes for the health care of their workers and retirees. This is a terrible burden, and we must do something about it.

Another phone call that I got yesterday was from a woman who is 60 and her husband is 70. He has had one open-heart surgery, and now is facing a second surgery. She wanted some help in figuring out how they were going to pay their piece of the cost. They have Medicare, but no supplement.

She is concerned that they will use up every bit of money they have. He will be coming home from the hospital, and she does not know how

she will be able to buy his medications, or feed him, or take care of herself. She is only 60. The odds are she will live many years.

The two families that I have just talked about have done everything right. They worked. They educated their children. They functioned in our society. They have paid taxes. And now, one very young family that is trying to grow, and one very old family that is trying to survive, are faced with choices that we should not be asked to make.

Up to now, we have had a piecemeal approach to fixing health care in America. At AARP, we believe, as many other people today have said, that that is no longer possible.

We have heard about three different types of cures to the problem. One is the primarily private sector; the second, employer-based play-or-pay; or the third, single-payer government-sponsored approach.

We believe that all of these approaches have strengths and weaknesses. We believe that we would like to see Congress study these issues now and come to some conclusions. We have to step up to the table and do something about it.

We know that health-care costs have increased more than 8 percent per year over the last 10 years. You have heard the numbers. We now pay $2,600 per person. By the year 2000, it is estimated that we will pay $6,000 per person, which will be approximately $1.5 trillion. I have to write that number down every once in awhile. It is so big! There are so many zeroes. We cannot afford that. We have to find an answer.

AARP believes that a fundamental right in our country is the right to health care. If we want to be purely economical about it, it will be much more cost efficient—and you have stated this yourself—if we will treat children prenatally, and then from birth to 10, and so on, treat them before they become so ill.

Give people an opportunity to get medical care before they are so sick that it may cost us ten times as much to care for them, when they go to the hospital, than if we had had basic, fundamental health- and long-term care for all Americans.

We face issues of cost; we face issues of access; we face issues of quality; we must deal with them.

AARP commends the Congress for the bills that have presently been submitted. We believe that cost containment must be a part of anything we do. Without it, we are just going to be exacerbating the issue even more.

I am going to tell you some more stories, because I hope you will remember them—and I am sorry that other members of the Subcommittee are not here.

Another woman who came to see me two days ago is 65. She is still working. Her husband has Parkinson's. He is becoming more and more disabled. She is faced with the issue of going home to take care of him and quitting her job. If she does that, and if he continues to be ill, he is, in all likelihood, going to have to go to a nursing home. The prognosis for her husband is not good. By the time she is 75, he may no longer be

living, and in all likelihood, she will be poor. She will have nothing. She will probably have a lien against the value of her home for up to 50 percent of its value, and she is not going to be able to afford to stay there even under present legislation that enables her to keep a little money. That, plus her social security, will not do it. So, at 75, she will have to sell her home and try to live on social security, and SSI, and other welfare programs. We do not think that is okay.

The American system is based on our growing families, putting those families into the system, and having the system appreciate that.

I think what you were saying before is that it does not look like the system is doing that at the moment.

We believe that the single-payer system does have some value. It does appear to have the opportunity for significant savings. It could eliminate the cost-shifting. But we also know that there is a heavy price to this—but people are already paying a heavy price.

Medicare out-of-pocket costs in 1980 were about $400 a person. In 1990, they were over $1,000 a person. That number is going up very rapidly.

In one young family that I know, both parents work. They had one child. The mother became pregnant with the second child. They paid their health-care insurance premiums every month. That is the good news. The bad news is that the company that they worked for did not send the premiums in. The second pregnancy was difficult, lots of big medical bills. The bottom line is that the hospital and the doctor said the company did not send the premiums in, therefore, the family was liable.

The company went into Chapter 11. The young family went into bankruptcy. We do not think that is the way we it should manage health care and "support" families in this country.

We would like to encourage the Congress to overhaul our current system; to assure that all Americans must have access to long-term care and health insurance; and to develop strong cost-containment. This problem is not easily solved.

As a Nation, to be competitive in the global marketplace, we must find an answer that is better than what we have. As a Nation, we must move forward and face this issue and stand up to it.

As an AARP member, as the parents and grandparents of millions of Americans, we all want this to happen. We want our grandchildren and our children to have the same chance we had, because it is a wonderful country. We urge you to move on this issue.

Thank you.

REPRESENTATIVE SCHEUER. Thank you very much for your eloquent statement, Ms. Brown. That was truly a fine statement.

[The prepared statement of Ms. Brown, together with an attachment, follows.]

PREPARED STATEMENT OF JUDITH N. BROWN

Good Morning. My name is Judith Brown. I am a Member of the Board of the American Association of Retired Persons (AARP). I would like to commend the Committee for holding this hearing to focus attention on one of the foremost problems facing our nation today — the need for health care reform. AARP is committed to making health care reform a reality — to making affordable health and long-term care available to all Americans, regardless of age or income.

As a nation, we can be proud of our achievements in health care, but we cannot continue to allow these achievements to be diminished by our failure to assure all Americans access to basic medical and long-term care. The key to access for those without health insurance coverage, as well as for the millions of us who are at risk of losing coverage, is to bring health care costs under control. To do this we need comprehensive reform which includes strong cost containment measures, as well as equitable and affordable financing, while providing access to quality acute and long-term care services for all individuals. Otherwise, we will likely see millions more Americans joining the ranks of the uninsured and underinsured, and the burden on all of us as taxpayers continue to grow unabated.

The Problem: Rising Costs, Decreasing Access

Undoubtedly, the phenomenal increase in health care costs is the most substantial barrier to access that extends across all age groups and income brackets. Expenditures for health care in the United States totaled $672 billion in 1990, an increase of 11.3 percent from 1989. During the past decade, medical price inflation has averaged 8.3 percent annual growth, compared to an average of 5.6 percent annual growth in general inflation. Moreover, the rate of increase in national health expenditures has grown each year since 1986, when the increase was 7.7 percent. These sharp increases have limited access to health care and imposed a heavy burden on the government, industry and individuals.

Approximately 34 million Americans under the age of 65 have no health insurance and millions more have inadequate insurance protection. Even though two-thirds of employees receive health insurance from their employers, working people represent more than half of uninsured adults. Even when workers are insured, their dependents may not be. Indeed, the largest decrease in health insurance coverage between 1979 and 1986 occurred in coverage obtained through another family member's employment.

Employees of small firms and their dependents are especially vulnerable. About one-half of the working uninsured are in firms with fewer than 25 employees. Primarily because of their inability to spread the risk of serious illness over a large workforce, health insurance for workers in small businesses is significantly more expensive than it is for larger employers. Also, since these employees are often low-wage workers, health care costs as a percentage of total compensation are becoming increasingly burdensome for small employers.

The lack of comprehensive federal programs also contributes to the access problem. The Medicare program, for instance, has restrictive eligibility requirements and significant gaps in coverage. Most importantly, it provides very minimal coverage of long-term care services — care that is often needed most by the older and disabled population that Medicare serves. Home health and skilled nursing facility services are fairly limited in the number of covered days, and there is no coverage at all for long-term nursing home, home health and community-based services. Furthermore, the required copayments for those services that are covered are more than some elderly can afford.

The Medicaid program, which was intended to serve as the "safety net" for our nation's low income population for both acute and long-term care services, is also severely limited. In addition to constant budgetary constraints, particularly at the state level, a means-tested program like Medicaid does not receive the broad public

and political support granted to social insurance programs like Social Security and Medicare. Welfare-based programs, such as Medicaid, typically have:

- restrictive income and eligibility requirements which result in the exclusion of millions, regardless of income;
- complex administrative procedures;
- variations in covered benefits resulting from the tremendous differences between the various state programs;
- generally inadequate reimbursement to health care providers, which results in reduced provider participation in the program and cost-shifting to private payers; and
- a pervasive negative stigma that inhibits many otherwise eligible individuals from seeking coverage in the program.

The result is that in 1988, only 51.4 percent of the approximately 33 million Americans living below the federal poverty line were estimated to be enrolled in Medicaid.

AARP believes that individuals of all ages have a right to receive quality health care services when they need them, and that the public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed services. All individuals should be assured of a standard benefit package through either a public or private health care plan.

"Piecemeal" Approaches to Reform Have Yielded Little

So far, our approach to the health care problem has been largely characterized by "piecemeal" or "band-aid" efforts at reform. Although Congress has made significant efforts to reduce costs in our health care system, costs continue to rise at or near double digit rates. As we attempted to control costs in one area, we have merely shifted the burden to another. We also continue to add increasing levels of complexity to an already complex and fragmented system.

Efforts to control provider costs have increased the lack of uniformity between public and private sector programs in reimbursement rates and practices, and further contributed to the problem. Clearly, much can be done in these areas to make our health care system more efficient; both in the delivery of services and reducing unnecessary administrative costs.

The problems caused by piecemeal solutions are also quite evident in long-term care coverage. We are all at risk of needing long-term care, yet, in a typical year, Medicare covers less than three percent of nursing home costs. Medicaid — the only public program providing major support for long-term care coverage — requires a process which can leave Americans in jeopardy of losing their life savings. In addition, the demands on Medicaid have made it increasingly difficult for that program to carry out its mandate of providing basic health and long-term care services to the nation's poor. On the private side, long-term care insurance has not been able to adequately pool the risk to make long-term care policies affordable to a majority of Americans.

Incremental Steps Toward Reform

However well intended, piecemeal approaches to the problems of cost and access are no longer adequate. We need a comprehensive health care reform plan that assures access, adequately reimburses health care providers and is able to achieve real cost control. Meaningful incremental improvements can be important steps towards this goal, so long as the ultimate objective remains comprehensive reform.

In this regard, AARP strongly supports recent steps to control the costs of the Medicare Part B program. In addition to the affect on the federal treasury, skyrocketing costs have also dramatically increased out-of-pocket costs paid by

beneficiaries. In 1989 alone, physician charges that exceeded Medicare's approved rate resulted in over $2 billion in additional direct costs — over and above deductibles and coinsurance — to beneficiaries.

The Physician Payment Reform package enacted by Congress contains two key provisions intended to bring these costs under control: (1) a volume performance standard to control the rate of increase in physician spending; and (2) a strong framework of beneficiary protection, including a limit on physician balance billing. These two incremental improvements, coupled with the new Medicare fee schedule, can make a significant difference in the costs associated with Medicare Part B and should be implemented according to the timeline established in the 1989 legislation.

As increasing health care costs — for everything from prescription drugs to long-term care — place a greater out-of-pocket burden on individuals by absorbing a growing share of their fixed incomes, protection from the additional costs of high physician charges is even more important. Balance billing limits prevent the shifting of unreasonable extra costs onto beneficiaries. Without this protection there is little control over the high costs of physician services. Balance billing limits are a key to making the Medicare Part B payment system more equitable for beneficiaries, and AARP believes that further erosion of this protection is unacceptable.

Requiring states to adopt care management systems to target appropriate services and control their utilization would allow more people access to improved services. In addition, including respite and adult day care in the menu of services available could reduce institutionalization and permit caregivers to continue to pursue productive careers.

AARP also encourages additional steps that will control costs and improve access to prescription drugs, especially for older Americans. An expansion of the Medicare program to cover outpatient prescription drugs could help reduce unnecessary hospitalization and other health care expenses caused by the increasing unaffordability of drugs. Cost containment methods should be part of comprehensive reform, including provisions permitting negotiations on prices charged by drug manufacturers.

Despite repeated warnings by Congress, the pharmaceutical industry has failed to control costs. AARP hopes that Senator David Pryor's recent report on the increase in prescription drug prices will help focus public attention on the need to contain these costs. The Association will continue to work with Congress to find the means to slow the pattern of excessive price increases and expand access to needed drug therapies. We hope that the pharmaceutical industry will assist and not stymie such efforts.

Another incremental step towards comprehensive reform is assuring health care access to some of the more vulnerable populations. Individuals between the ages of 55 and 65 — the near-elderly — are not yet eligible for Medicare and are significantly less likely than those under 55 to have employer-provided health care coverage. This is due, in part, to the fact that only about half of the near-elderly are in the workforce. Other factors that lead to the loss of health care coverage for this population include:

- early retirement, for health or other reasons (until the individual becomes eligible for Medicare);
- lay-offs, terminations or starting a new job with a pre-existing condition; and,
- a younger spouse who has relied on insurance coverage thorough his or her older spouse's employment who may lose coverage as the older spouse leaves the workforce or loses employer coverage upon becoming eligible for Medicare.

Expanding Medicare eligibility to include the near-elderly and other vulnerable populations is a feasible and important way to eliminate these inequities.

AARP also supports the following incremental steps to improve the Medicaid program: (1) at a minimum, enable everyone whose income is at or below the

federal poverty line to be eligible for Medicaid; (2) require states to have medically-needy programs for people of all ages; (3) adjust Medicaid reimbursement to help ensure adequate access to services; and (4) improve and update Medicaid data collection.

Basic Approaches to Comprehensive Health Care Reform

In the ongoing health care reform debate, three basic approaches have emerged as possible models or blueprints to health care reform: (1) the Primarily Private Sector Approach; (2) the Employer-Based "Play-or-Pay" Approach; and, (3) the Single-Payer Government-Sponsored Approach. Each of these approaches has strengths and weaknesses, some more serious than others.

1. The Primarily Private Sector Approach

The "primarily private sector approach" to health care reform typically includes reforming the pricing and availability of private health insurance for small employers, providing tax subsidies to small employers to encourage the purchase of private health insurance coverage for their employees, and expanding the Medicaid program to cover all of the poor. In addition, tax incentives are sometimes provided to encourage the purchase of long-term care insurance.

Small business insurance reforms alone — as proposed by Rep. Nancy Johnson (R-CT) in H.R. 1565, the Health Equity and Access Reform Today Act, and Sen. David Durenberger (R-MN) in S. 700, the American Health Security Act of 1991 — however, offer very£ little or no cost containment. In fact, these measures could actually increase premiums for many Americans. The escalating cost of health care in America is the most significant problem of our current health care delivery system. The uninsured and underinsured, employers, the insurance industry, as well as government health care programs are all adversely affected by the uninhibited growth in health care costs. Therefore, significant cost containment measures must be an important component of any health care reform proposal.

In addition, such proposals provide no guarantee that all individuals will have access to health care coverage. Expanding Medicaid to cover all of the poor is a step in the right direction, but it does not completely solve the access problem. There is still a great potential for people to "fall through the cracks"—much the same as they do now.

When the twin flaws of this approach — little or no cost containment and no assurance of access — are taken together, their impact is compounded. In a system, such as the one we have now, in which some people are left uninsured, the potential for cost-shifting is great. The unrewarding experiences of the last several decades have amply demonstrated the serious inadequacies of this approach.

In the area of long-term care, many of the tax incentives to encourage private sector involvement — as proposed by Sen. Lloyd Bentsen (D-TX) in S. 1693, the Private Long-Term Care Insurance Act of 1991, and Sen. Bob Packwood (R-OR) and Sen. Bob Dole (R-KS) in S.1668, Secure Choice — while providing additional options to some individuals, are of limited benefit to most persons. For the most part, the private sector initiatives contemplated would be too costly for the average individual. As a result, tax benefits for the enhancement of private sector involvement in long-term care would flow mainly to the more affluent. Further, such proposals do little to help develop an infrastructure through which those who need coordinated long-term care can get it.

While the Association believes that the public sector must be primarily responsible for the financing of long-term care, the development of private sector approaches to supplement the public sector responsibility can and should play a

role. AARP believes, however, that it is premature to enact tax incentives that, by their very nature, are directed almost solely towards the more affluent.

AARP believes that private health insurance reforms combined with Medicaid improvements could bring improvements in health care coverage, but should never be viewed as a solution to our system-wide health care crisis. Such an approach only postpones the day when we as a society will have to address the serious system-wide problems of cost and access to both acute and long-term care services.

Taken alone, these steps would simply perpetuate the problems and frustrations we have experienced with "piecemeal" solutions over the last several decades. However, combined with other reforms that would accomplish universal coverage, private market reforms do have merit.

In this context, we believe that reforms of the private health insurance market for small employers should focus on making insurance more available. Coverage should not be denied when one of a company's employees is considered to be "high risk" in terms of his or her potential for incurring substantial medical costs. Further, once insured, termination of coverage should not be allowed due to the deterioration of the health of a member or members of the group. Insurers should also be required to set rates on the same terms for all groups in a particular area by eliminating discriminatory and selective premium increases and limiting insurers' ability to screen out relatively unhealthy or high risk groups or individuals.

2. The Employer-Based "Play-Or-Pay" Approach

The employer-based approach, otherwise known as "play-or-pay", requires employers to "play" by providing health insurance for their employees, or to "pay" a tax to provide coverage through a public plan. A broad public program based on Medicare's reimbursement principles is generally created to cover all those not otherwise covered by an employer plan.

In addition, proposals advocating this approach:

- require minimum benefit packages including preventive care, well child care, and pregnancy-related benefits;
- mandate small business insurance reforms to encourage small employers to purchase health insurance for their employees;
- contain some cost containment features; and
- maintain the Medicare program for older Americans and the disabled.

AARP commends both the Senate Democratic leadership, led by Sen. George Mitchell (D-ME), for introducing S. 1227, the Affordable Health Care for All Americans Act, and Ways and Means Committee Chairman Dan Rostenkowski (D-IL) for introducing H.R. 3205, the Health Insurance Coverage and Cost Containment Act of 1991. Chairman Rostenkowski's bill, in particular, contains strong cost containment measures and financing, and a provision that AARP finds appealing — the expansion of Medicare eligibility to include the 60 to 64 age group. In addition to closing the health care coverage gap for individuals in this age bracket, this provision would significantly reduce employers' health care costs for this group of workers. As a result, proposals of this type should take this employer advantage into account in determining the appropriate level of employers' contribution to financing. H.R. 3205 provides one model for how this can be done.

While both bills go a long way in furthering the debate on health care reform, neither addresses one of the most significant problems Americans of all ages face today — the lack of affordable coverage for long-term care services. AARP believes that comprehensive health care reform should not only provide access to basic health care services, but also provide access to needed long-term care services. Failure to address this issue leaves American families exposed to costs which devastate families, not just the aged, since families provide much of the financing and care to those needing long-term care.

3. The Single-Payer Government-Sponsored Approach

The single-payer government-sponsored approach is the most comprehensive of the three approaches to health care reform. It offers universal health care coverage through a single national program which would provide basic hospital and physician services to everyone, with additional benefits for low-income individuals, children and pregnant women. In addition, long-term care benefits are generally provided for all chronically-ill individuals, regardless of age or income.

The best known example of this approach is the Canadian health care system. The General Accounting Office recently concluded a Report on the Canadian health care system which showed that there are valuable lessons that can be learned from both the successes and shortcomings of a single-payer system. For instance, the report shows that the administrative efficiency in the single-payer Canadian system achieves savings by reducing administrative costs. The lesson here parallels the lesson from our own Medicare program. The Medicare program returns about 98 cents in benefits for every dollar it takes in.

On the other hand, this Report raises a variety of important questions, including how a single payer system balances the savings it achieves through administrative efficiency with steadily increasing costs for physician expenditures and a rising level in the volume of services.

Clearly, a single payer health care system — as proposed by Rep. Marty Russo (D-Ill) in H.R. 1300, the Universal Health Care Act of 1991, and Rep. Pete Stark (D-CA) in H.R. 650, the Mediplan Act of 1991 — could virtually eliminate cost shifting problems and provide significant opportunities for administrative cost savings. Such an overhaul of our current system, however, would not come without a price, in terms of the need to increase taxes even more than the "play-or-pay" proposals (with some offsetting of private sector savings) and job dislocation in certain areas - although this could happen as well with an employer-based approach.

Achieving Health Care Form

AARP believes that comprehensive reform of our health care system must become a national priority if we are to achieve the goal of assuring access to quality care for all our citizens and to gain control of escalating health care costs.

We recognize that broad public consensus about the scope of the problem, and the need to share the risk of health care costs, will be key to Congressional action. To help increase public awareness about the need for health care reform and to guide AARP in its participation in the public debate, the Association has adopted health care reform principles — addressing both acute and long-term care.

The principles (included at the end of our written testimony) encompass what we believe are the four broad elements of health care reform:

- Controlling health care **costs**;
- Assuring **access** to health care services and coverage;
- Guaranteeing a high **quality** of health care; and,
- **Financing** health care reform.

AARP believes that to achieve meaningful health care reform, the Congress and the Administration must establish a blueprint — the broad architecture — of a reformed system that reflects these principles.

Equally important to developing a blueprint for reform is a better public understanding of the nature of the problem — the rising cost of health care — and its pervasive effect on all Americans should the present status quo continue. AARP believes that to achieve broad public consensus about the need for health care reform, continued public education is essential. AARP is making this a priority in our activities, and we are continuing to educate our members about the nature of the problem and the costs involved. We cannot, however, do it alone. It is incumbent upon the Administration and a bi-partisan Congress, as well as AARP

and other groups, to lay the groundwork that will focus public attention on the tough questions that must be part of the solution, such as:

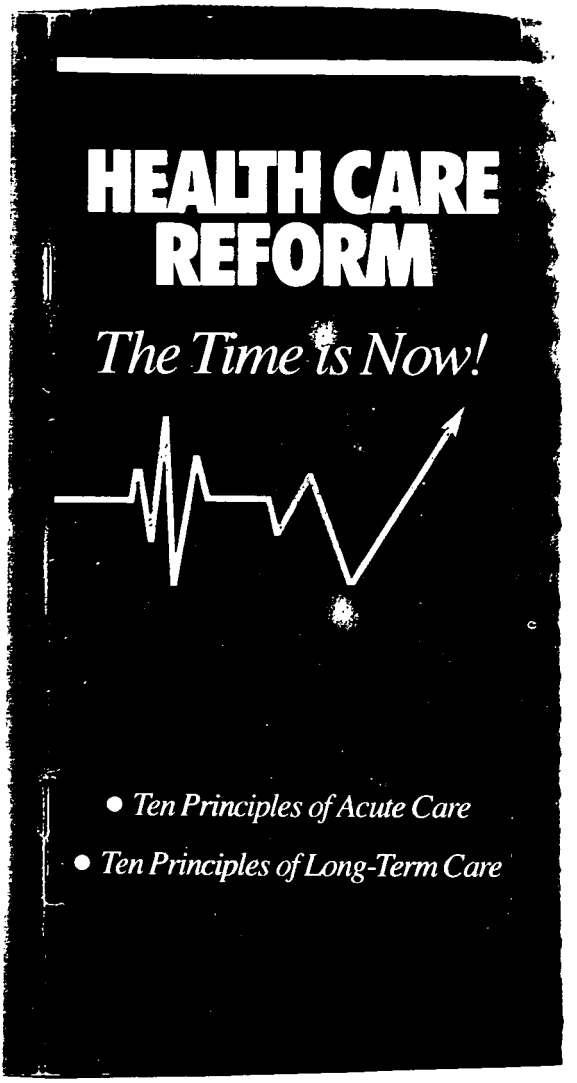
- What elements of the health care system are most important to Americans?
- Are we willing to pay the costs of these benefits, not only in the aggregate, but as individual taxpayers?
- Are we willing to adjust our patterns of use and coverage and make the trade-offs that will be necessary to ensure affordable access for all Americans?

These questions — which ultimately focus on our willingness to pay for a reformed health care system — will be at the center of the debate. AARP believes that any financing of health care reform should be broadly-based and equitable. Social insurance programs, like Social Security and Medicare, enjoy considerable public support. Comprehensive health care reform will only achieve broad support if it is primarily financed through a social insurance structure.

We have an obligation to raise these questions with the American people. Comprehensive reform of our health care system will only be possible when Americans understand the need for protection and recognize the inherent dangers involved in continuing a piecemeal approach to a system-wide problem. We are confident that, with your help, we can answer these questions and form a clear and strong message to our elected officials.

We have no illusions about a quick solution, but clearly, the 1992 elections offer an important opportunity to help solidify America's commitment to reforming our health care system. AARP and thousands of our volunteer leaders stand ready to help make health care reform a focal point of debate in the upcoming national elections.

Mr. Chairman, I appreciate the opportunity to testify before you today. AARP stands ready to work with you and your colleagues in achieving the goal of comprehensive and affordable health care for all Americans.


HEALTH CARE REFORM
The Time is Now!
• Ten Principles of Acute Care
• Ten Principles of Long-Term Care

OUR GRANDCHILDREN OUR CHILDREN, OURSELVES: OUR HEALTH CARE SYSTEM AFFECTS US ALL

Chances are someone you know has had a serious problem with our health care system. Chances are that these problems will get a whole lot worse unless we do something to change the system.

Today in America, an estimated 34 million people cannot afford health insurance to cover such basic acute care services as doctor's visits, hospitalization and — in some cases — even emergency treatment. Millions more need, but cannot afford, long-term care services such as home-health or nursing home care.

Obtaining needed health care is not just a problem for the poor or the unemployed. Spiraling health care costs and problems of access affect each one of us — and our children, and our grandchildren. Three-fourths of uninsured Americans are workers and their families. One-third are children under age 18.

Many Americans lack insurance because they have existing medical conditions and were turned down for health coverage. Some lack insurance because their employers don't provide health care benefits and they can't afford private insurance. Others have insurance, but can't obtain treatment because health facilities in their communities have closed. Still others live far from health services and lack adequate transportation.

Each of us is vulnerable to the problems plaguing our health care system. Even if you have private health insurance or Medicare, you may have to pay 20 percent or more of the total cost of your care — and hospital stays exceeding $1 million are not that uncommon. What if you had an accident and your private insurance or Medicare did not cover all of your costs? Could you afford to spend $10,000? How about $100,000? And then there is the cost of long-term care. What if a loved one needed to be in a nursing home, but had no form of insurance? Could you pay $30,000 or more a year for that care? Few of us can.

Piecemeal tinkering will not solve our health and long-term care crisis. The only meaningful solution is comprehensive reform. The time is now.

THE HIGH PRICE OF OUR HEALTH CARE

Health care costs are out-of-control — and out of reach of many Americans. In 1970, America spent $74 billion on health care — about $350 per person. By the year 2000, this could soar to $5,500 per person — or $1.5 trillion.

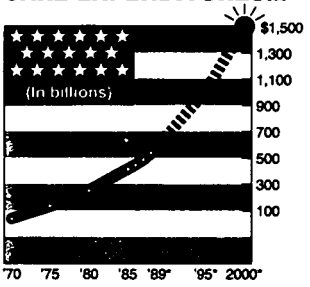
It's clear that we are not getting the value we should from our health care system. We spend more per person on health care than any other nation in the world, yet millions of Americans go without needed health and long-term care because they lack insurance or access to services.

Having health insurance helps. But even that doesn't guarantee protection against high cost. Hospitals increase their fees to make up for uninsured, non-paying patients. Insurers raise rates in response to higher hospital and other medical charges. Employers, hit with higher group insurance rates, reduce or drop health coverage for workers or workers' families. And so the vicious cycle continues. Each new round raises costs higher and makes access to health care more difficult.

Even if you are covered by Medicare you are not safe. Medicare doesn't cover many important services, like prescription drugs or extended nursing home care. Despite this, Medicare costs have risen faster than nearly all other items in the federal budget and each year Congress ponders ways to curb program spending. Meanwhile, Medicare beneficiaries are paying more and more out-of-pocket for hospital and physician services. It's a situation that is likely to become far worse.

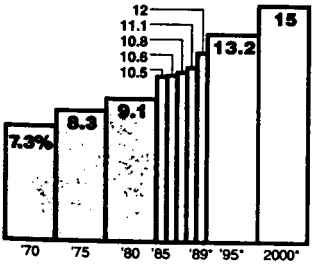
The high cost of health care burdens individuals, it burdens employers, and it burdens our government. How much longer can we afford to spend so much money for such an inefficient and ineffective system?

NATIONAL HEALTH CARE EXPENDITURES...



*Estimates

... AS A PERCENTAGE OF GROSS NATIONAL PRODUCT

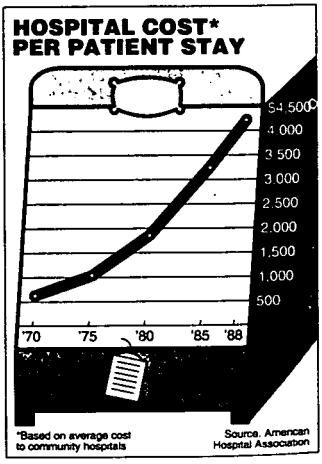


Source: Health Care Financing Administration, 1990

THERE'S NO "QUICK FIX"

Over the years, attempts have been made to control costs and improve access to health care through government regulation and private incentives. Nothing has worked. Few proposals have taken a comprehensive approach to solving access, cost, quality, and long-term care problems.

However, we need to recognize that fixing our health care system won't be easy. We are going to have to make difficult choices. Choices like what type of benefits we want, and what we are willing to pay for them. If we make the right choices, we can build a system that is financed fairly and that provides much more value for our money.



WHAT YOU CAN DO

Health and long-term care reform will only happen if Americans understand the benefits and the costs of building a better health care system. We need to understand, too, the risks we and our families face if we sit back and do nothing. *And, finally, we need to let our members of Congress and the President know that we want action on this important issue.*

As you consider the principles of acute care and the principles of long-term care described in this brochure, think about the health care system you would like to be a part of. Talk with your friends and neighbors about the various options. What health care benefits do you want most? What are you willing to pay for those benefits? What choices are you willing to make so that all Americans have access to health and long-term care services?

Change will occur only when you and thousands of others insist that Congress and the President act... and act now.

HEALTH CARE PRINCIPLES: A PREAMBLE

AARP believes that the United States has the resources to ensure access to acute and long-term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long-term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprehensive, affordable acute and long-term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long-term care systems. The principles do not address every specific issue relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

AARP'S TEN PRINCIPLES OF ACUTE CARE REFORM

1. **All individuals have a right to receive health care services when they need them.**

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed health care services for all individuals.

2. **All individuals have a right to reasonable access to health care coverage that provides adequate financial protection against health care costs.**

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

3. **All individuals have a right to high quality health care.**

   The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

4. **All individuals should have a reasonable choice of health care providers.**

   Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

5. **Financing of the health care system should be equitable, broadly based, and affordable to all individuals.**

   Government, employers, and individuals share the responsibility to participate in health care financing. Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

6. **Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly.**

   Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

7. **Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination.**

The distribution and allocation of health care resources (e.g., capital, technology, and personnel), should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

8. **Health promotion and disease prevention efforts should be strengthened.**

The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: 1) increase citizen understanding and awareness of health, environmental and safety issues and problems; 2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; 3) conduct health, environmental, and safety-related research; 4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and 5) assure compliance with health, environmental, and safety standards.

Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety, and well-being.

The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

10. **The acute and long-term care systems should be coordinated to ensure a continuum of care across an individual's lifetime.**

THE CRISIS IN LONG-TERM CARE

The most serious financial threat confronting older Americans and their families is long-term chronic illness. The average stay in a nursing home currently exceeds $30,000 a year. Private insurance and Medicare, combined, pay only a tiny fraction of it. Medicaid — the state and federal assistance program for the poor — will cover nursing home care, but only after a person has depleted nearly all of his or her savings and financial assets.

The picture is equally grim for those who need help taking care of themselves, but want to remain in their own homes. Our health care and social service systems offer little financial help or caregiver support for those who opt for home care. Access to home-health care and other community-based services is very limited, especially for those with chronic illnesses. Family members often become the primary caregivers in addition to their other responsibilities, such as raising young children and working full-time jobs.

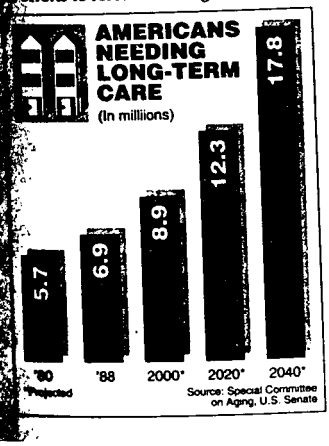
As our population ages and a significant number of people require help caring for themselves, these problems will become worse. And long-term care isn't a problem just for older Americans. One-third of those who need care are disabled or chronically ill people under age 65 — 12 percent of these are children under age 18.

[illegible]ritical for all of us — old and young — that a [illegible] of long-term care options be part of any [illegible] care proposal we adopt.

[illegible]P has long been seeking solutions to the long-[illegible]care crisis. We believe that a social insurance [illegible]ystem — Social Security is one such pro-[illegible]— can best provide long-term care protection [illegible]eryone in the nation. The ideal system would [illegible]e in which everyone pays into the program so [illegible]veryone can receive long-term care, if and [illegible]n it is needed.

[illegible]RP recognizes that such a solution can work [illegible] if all parts of our fragmented health system [illegible]fixed. Only then can we guarantee health *and* [illegible]-term care for all.

[illegible]following principles guide the Association in [illegible]efforts to reform our long-term care system.



AARP'S TEN PRINCIPLES OF LONG-TERM CARE REFORM

1. Long-term care services should be available to all people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive functioning, including limitations in performing activities of daily living (e.g., eating, bathing and dressing) and a person's need for supervision. Uniform, national assessments should determine whether a person meets the eligibility criteria for the program and the type and level of care that a person needs.

2. A national long-term care program should provide a comprehensive range of services. These services should include: 1) in-home assistance; 2) community services; 3) long-term care services in a full range of supportive housing options; 4) institutional care; and 5) rehabilitative services. Long-term care should be provided in the least restrictive setting possible.

3. The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

4. Implementation of the public program must be phased-in to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community and institutional services.

5. The principles of social insurance (e.g., Social Security or Medicare), and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

6. The new long-term care program should be financed primarily through taxes earmarked to a trust fund. Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

7. The new public program must provide a solid foundation for protection, upon which the private sector can build. The private sector could supplement the public program by covering the program's copayments and deductibles, as well as services that the public program does

not provide. Any private sector approach (e.g., long-term care insurance) should be subject to strong standards to protect consumers from inadequate products.

8. Payment to providers of long-term care services must be reasonable and provide financial returns to providers who deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

9. Cost containment mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also should be included. However, people with low incomes should be protected.

10. The federal and state governments should assure delivery of quality care under the new long-term care program. Recent improvements in the quality assurance systems for nursing homes and home-health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

WHERE AARP STANDS

Health care has always been a priority at AARP. We have been doing our best to alert our members, the general public, and policy-makers to the need to reform our health care system. We are convinced that piecemeal solutions won't work. We need a comprehensive solution that achieves three important goals. It must: 1) bring cost under control while ensuring quality; 2) ensure access for all, young and old; and 3) provide long-term care.

The ten principles for acute care, and ten principles for long-term care described in this brochure underscore the Association's belief that America's challenge this decade is to build a health care system that contains costs and ensures quality health and long-term care service for all Americans.

YOU CAN MAKE A DIFFERENCE

AARP welcomes your comments and suggestions regarding health and long-term care. If you would like further information or want to become involved, please contact us at:

National Legislative Council
American Association of Retired Persons
Washington, DC 20049

REPRESENTATIVE SCHEUER. There is a roll-call vote going on now. We will take one more witness, and then I will go and answer that roll call and then come back.

We will hear from Karen Ignagni, Director of Employee Benefits Department of the AFL-CIO. Ms. Ignagni directs the AFL-CIO's activity on health care, pensions, and social security. We are delighted to have you, Ms. Ignagni. Please take your seven or eight minutes, and then we will adjourn for a roll call.

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

Ms. IGNAGNI. Thank you, Mr. Chairman.

At this juncture, it is important to recall the Winston Churchill quote. He said—and I am sure I am bastardizing it in some way—"you can always trust the Americans to do the right thing once they have tried everything else." [Laughter.]

On behalf of the AFL-CIO, we believe that is where we are in health care.

The message I would like to leave with you this afternoon is that Congress needs to move ahead before the problem does anymore damage to working families.

There was some discussion in the last panel about whether or not it is appropriate to use the word "crisis." I would invite any one of your colleagues—you or your staff—to sit with us as we bargain across the table with employers, legitimate people trying their best to do the right thing.

The problem has gotten out of hand, untenable, and no amount of hoping it will go away will make it so.

So, that is why we are here to talk about public policy intervention and action. I would also like to give you another perspective about how this affects us as labor, but also our colleagues in the management community.

A recent study by the AFL-CIO found that in 1990 health care was the major issue for 55 percent of strike 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 were on strike over health care.

This turmoil is not confined to organized labor, as you know. During the 1980s, the health-care crisis further exacerbated the economic decline of the middle class.

You are well familiar with the statistics about the decline in the average wage. Let me suggest that we juxtapose those figures with the increase in disposable family income that health care is now consuming, and you have a real catastrophe and crisis on your hands for the American family again.

REPRESENTATIVE SCHEUER. And therefore leaves less and less and less for everything else.

Ms. IGNAGNI. Well, that is the point.

It is this crowding-out phenomenon. I think what we have got to deal with, and what you in Congress are dealing with is that as health care consumes more and more of the family budget it really does crowd out increases in wages and other fringe benefits necessary for Americans to maintain their homes, educate their children, and achieve income security in retirement.

My colleagues have already talked about this in a very eloquent way, and I am not going to add to it.

But the point, again, is that a similar trend is occurring nationally with respect to the federal budget. Health care is consuming a growing proportion. Ironically, despite this commitment of resources, beneficiaries of public programs continue to lose ground.

I think the lesson and the conclusion that are incontrovertible is that we are paying more for less. As a Nation, we cannot afford to continue down the current path.

We would implore those of you in Congress that, rather than becoming mired in esoteric debates about competition versus regulation, the most expensive course for the Nation is for you in Congress to do nothing at all; for you in Congress to continue to debate the merits of moving forward to either a single-payer or multipayer system.

The point is that we must get started on the program. We have to have a vision of where we would like to go, and we have to get started on achieving that objective. I think it is clear that working families are depending upon your resolve to move in that direction.

Last fall, we commissioned a study by Lewin-ICF, Inc. to determine how much in terms of national resources could be saved if we were to move forward on an all-payers' cost-containment plan, whether through a single-payor or multiple-payor mechanism.

We found an astounding $165 billion could be saved over the next 10 years if you held the rate of increase in health-care inflation to 2 percentage points below what it would be otherwise if the current policy continues. Now, there have been——

REPRESENTATIVE SCHEUER. I do not understand that. If we held the cost of health care to 2 percent—

Ms. Ignagni: ——below the rate of increase that would otherwise occur, absent any kind of national controls, you could save $165 billion.

That number would grow under a number of proposals that have been recently introduced, with respect to confining and limiting health-care increases to percents of GNP. So, there is a lot before you, and the potential for savings is enormous.

Even those who defend the current system, can no longer defend the excessive overhead and administrative costs associated with the pluralism that you spoke about.

REPRESENTATIVE SCHEUER. What price pluralism?

Ms. IGNAGNI. Precisely.

REPRESENTATIVE SCHEUER. Pluralism, as an abstract thing, is great. How could anybody object to pluralism? The question is: What price pluralism?

Ms. IGNAGNI. That is exactly right.

REPRESENTATIVE SCHEUER. When you talk about the price tag not covering 37 million people; not providing long-term care for seniors; not providing catastrophic care for anybody; grossly underserving kids from disadvantaged families—prenatal, birth to 10—you have to come down on the side of let's save these people. Let's improve the quality of their lives. Pluralism is not worth those price tags.

Ms. IGNAGNI. We agree. We think that pluralism, competition, rationing, and socialized medicine are code words that have been used and put forward by those who have a vested interest in preserving the fragmented system that we have today.

We hope that in this debate the Congress will look beyond the pure appeal of those issues. We talked a lot about competition with the previous panel. We would love to see a competitive health-care system. I can tell you and provide hard evidence that it does not exist today.

What we have is a system of social Darwinism. It is survival of the fittest. That is what we need to deal with in both economic and social terms.

Now, with respect to the Federation, we are united in our pursuit of the goal of fundamental restructuring of the system.

REPRESENTATIVE SCHEUER. Ms. Ignagni, I have to leave in less than a minute to catch this roll-call vote. So, why do you not see if you can wind up your testimony.

Ms. IGNAGNI. We have four essential goals. With respect to containing health-care inflation, it involves negotiation and mandatory cost-containment. With respect to providing universal access, it involves setting, at the federal level, overturning state mandates, and providing a core benefit package for all Americans. We are in favor of, and we have some very specific proposals about reducing waste, red tape, and this pluralism and fragmentation that we spoke about.

And then finally, we have a proposal with respect to solving the retiree crisis that has become such a problem for labor and management at the bargaining table.

We would reduce the age of eligibility for Medicare to age 60 to make it more coincident with the average age of retirement.

What all this adds up to, Mr. Chairman, is that we think the single-payer system—over the long term—is the best system, and we are prepared to engage in reasonable debate with you and your colleagues to figure out how we can get from point A to point B.

We think there are a number of ways to do that.

What we want to do is to see the health-care system that is reputed to be the best in the world live up to that objective. Thank you.

REPRESENTATIVE SCHEUER. It is the best in the world for some people.

Ms. IGNAGNI. For some people.

REPRESENTATIVE SCHEUER. Who can afford to pay for their own health care?

Ms. IGNAGNI. And I am afraid that portion is declining.

REPRESENTATIVE SCHEUER. I think that is true.

[The prepared statement of Ms. Ignagni follows:]

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 belive 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."

REPRESENTATIVE SCHEUER. Okay. I will be back in about 10 or 12 minutes.

[Recess.]

REPRESENTATIVE SCHEUER. All right. Now, we will hear from Mr. William Dennis, Research Fellow at the National Federation of Independent Business.

Mr. Dennis has directed research activities at the National Federation of Independent Business for 15 years.

We are delighted that you are here, Mr. Dennis.

Please take seven or eight minutes, and then we will have some questions after we hear from Mr. Maher.

STATEMENT OF WILLIAM J. DENNIS, JR.
SENIOR RESEARCH FELLOW, THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

MR. DENNIS. Thank you, Mr. Chairman.

I should emphasize from the outset that I do not represent all business. Clearly, there are differing views within the business community, as we will shortly see. However, my views tend to represent mainstream America rather than large corporate firms.

It is important to point out that, as early as 1986, small business owners were already saying that the cost of health insurance was their single most important problem.

In 1991, we are going to go back and check that again in terms of a very large sample survey, and I fully expect that the cost of health insurance will again be a major problem.

I emphasize cost even though there are up to 1.5 million small business owners and self-employed people who do not have health insurance themselves.

It seems to me that there are three generic approaches to resolving the health-care problem.

One is what I would call a bureaucracy-driven system. That is where large entities, which could be either public or private, are really the ones making the rules, in terms of both price and treatments.

There is a provider-driven system, much like we have now, where the provider is king. There is no effective constraint really levied on any of them.

Then, we have the consumer-driven system where patients really make the majority of the decisions—or at least look for prices from providers—and alternatives.

You will notice that I omitted purposefully mandates, because mandates I do not consider to be a viable approach to the entire problem. Mandates are not viable for several reasons.

The first one is that they effectively make low-income people purchase insurance. It is the same thing as saying to low-income people, you must

buy your own insurance. Remember that wages plus benefits equal total compensation.

So, what happens is that in the short term, if you make a mandate, a small employer indeed will absorb that cost. But in the long term, the employee——

REPRESENTATIVE SCHEUER. Would it be at the cost of his wages? Will his wages go down?

MR. DENNIS. In the long term, if they do not go down, they will be held constant while compensation is being made, and/or there will be a disemployment effect that will come into play. So, over the long term, the employee is going to pay for this. This has numerous implications, not the least of which is to the competitiveness argument.

REPRESENTATIVE SCHEUER. The disemployment effect, I take it, is substituting capital and technology for workers?

MR. DENNIS. It could be technology. It could also be more effort, quite frankly, by the owner and/or his family in a very small firm. It could be any number of substitution effects just like that. It could be overtime, any one of those sorts of things.

The second reason is that a mandate is a terribly inefficient subsidy. You will see, for example, that many of your mandate-type pieces of legislation, pay-or-play, things of that nature—the Mitchell bill—all provide subsidies for certain types of small employers without health insurance.

The problem is that the subsidies should be going to the low-income individual, not to the business, because not all businesses without insurance hire 100 percent poor workers. In other words, you have a distribution of employees in your firm, some of which make reasonably good wages, some of which might make reasonably poor wages, but be in a family with a relatively high income.

So, what happens by targeting the subsidy to the firm rather than to the individual, what you are doing then is making a terribly inefficient subsidy program.

The third reason is that it still does not cover everybody. You still have a large number of people who are not covered.

The fourth one is that you are still going to have to establish minimums, and those minimums are just like state-mandated coverages with all their inefficiencies.

I have done a few very crude estimates, and I have come to the conclusion that approximately 1 to 2 million small firms would find it advantageous under the Mitchell program—the S.1227 bill—to opt into the public program today. They would find it financially to their advantage to do so, which basically means that you are starting out with a very inefficient state program. So, it seems to me that that is off the table.

I think fundamentally what we must look at is that we must eliminate the bias in favor of employer-based systems. Right now, we have a tax

system that gives great bias for an employer-based system, since that is the only system that really enjoys the advantage.

REPRESENTATIVE SCHEUER. The advantage of what?

MR. DENNIS. What happens, Congressman Scheuer, is that you have a tax subsidy going to an employer-based system.

But if I want to have a block system, if I want to have the local Moose have a system, or if I want to get together with a series of people who have a similar disability or a similar health condition, and want to try and get someone to bid on it, I am not getting the tax subsidy that everyone else is getting. In fact, I am paying after-tax income, so it makes it even more expensive for me. So, all the incentives are to go to this employer-based system under current law.

Now, the employer-based system is really very bad for smaller firms for several reasons. One is that there is a real small group underwriting problem. That is, when you have a small group, it is very difficult to actuarially have set it in such a manner that the rates will be competitive with those that larger firms would pay for the same type of coverage. That is the first problem. In fact, you cannot find anyone who will underwrite brand-new firms.

There are certain occupations that cannot be underwritten or will not be underwritten for the same thing.

Portability is a problem in an employer-based system. What happens if you go from one job to another? What happens if there is a change in the family status? It clearly does not work. In fact, COBRA is the single most expensive type of mandate that is put on employers, and indeed it causes some, indirectly, not to elect an employer option.

Again, you cannot target subsidies under the system, and again not everyone is employed. Therefore, an employer-based system does not always make a lot of sense.

Now, when you add the ERISA to that, the ERISA exemption that larger or self-insured firms enjoy, then it really puts smaller groups at an enormous disadvantage. So, the employer-based system seems to me to be out.

We have then a choice between what I would call——

REPRESENTATIVE SCHEUER. Let me just ask at this point, do you favor a national system based on single-payer? A single-payer national system?

MR. DENNIS. No.

REPRESENTATIVE SCHEUER. It seems to avoid most of these problems that you have just ticked off.

MR. DENNIS. It certainly would avoid a large number of them. That is absolutely correct. But we think it creates a whole series of additional problems. In other words, I would agree with the single-payer group on a whole series of things, including the problems with employer-based insurance. I would agree with them on the rising cost as being the problem. I would agree with them on a whole series of things.

Where we fundamentally disagree is that I believe that 250 million consumers, making health-care decisions on where to spend their money, will much more efficiently determine where our health-care dollars should be spent than will a government bureaucracy, without a pejorative connotation put to it, than can any 500, 600, 700, 800 people that we have in this country. That is the fundamental difference.

We basically agree on the problem, I think, and we agree on a whole series of things. But on the solution, we clearly do not.

REPRESENTATIVE SCHEUER. Mr. Dennis, your time has expired.

I thoroughly enjoyed your testimony and learned from it.

[The prepared statement of Mr. Dennis follows:]

PREPARED STATEMENT OF WILLIAM J. DENNIS

Mr. Chairman, thank you for this opportunity to offer my observations on small business and health care, and the alternatives open to us in addressing our current health care problems. As early as 1986, small business owners identified the "Cost of Health Insurance" as their most important problem.[1] I have no doubt that today health insurance holds the same dubious distinction for small employers that it did five years ago.

The views I express and the analysis I offer today are my own. They are not necessarily the views of The NFIB Foundation nor of the National Federation of Independent Business (NFIB) with which it is affiliated. However, having spent most of the last 15 years of my professional life surveying, preparing surveys, or analyzing surveys of small business owners, I feel comfortable that my remarks reflect Main Street opinion.

THE SMALL BUSINESS PROBLEM

Small business has attracted unusual attention in health care debates. The reason is evident. While most individuals in the United States procure their health insurance through our system of voluntary employer-sponsored employee benefits, many small business owners choose not to provide an employee health insurance program.

A recent Health Insurance Industry of America (HIAA) survey, for example, estimated that 36 percent of all firms sized 1 to 24 employees provided insurance covering 44 percent of their employees.[2] By contrast, 98 percent of firms sized 100 employees or more provided health insurance for 99 percent of their employees. Moreover, large firms are substantially more likely to offer family coverage than are small firms.[3] That implies that the portion of the uninsured "attached" to small businesses is even greater than their portion of employees.

Cost is the primary cause for nonprovision, though other factors including industry exclusions, new business waiting periods, expected future costs increases, high employee turn-over, and employee preference for wages instead of benefits, also influence decisions.[4] Such a consideration is understandable. The average price of a family health insurance policy now runs about $3,000 per year, and escalating at anywhere from 10 to 30 percent annually. Obviously, small employers are not alone in facing the problem. But what makes cost particularly acute for them are inherent small group underwriting problems, the marginal profitability of many small firms, and the advantages provided self-insured businesses, almost all of which are large. The latter benefit from the ERISA exemption from state service mandates and taxes on insurance sales.

Some analysts characterize a small employer's decision to not provide health insurance in employee compensation as unfair, irresponsible, etc. Small business owners do not agree, even those who provide insurance. They argue that the first responsibility for provision of health insurance lies with the individual.[5] The individual, they believe, has the primary responsibility to provide health care for himself and his family just as he has primary responsibility to provide food and shelter. Nonetheless, mandating employer-provided employee health insurance or some variant is a frequently offered solution to the coverage problem.

"Pay or Play"

The most popular mandate variant appears to be "pay or play." In essence, "pay or play" requires employers to purchase a specified, minimum amount of insurance for each employee. Should an employer choose not to purchase employee health insurance, he pays a fine (tax or penalty) and the employees becomes insured through a publicly supported fund. Massachusetts' failed

universal health program and S. 1227, the Mitchell bill, are two examples of this approach.

Members of this committee do not need to be reminded that wages plus benefits equal compensation. Nor is there any need to point out that most employees not covered by employee health insurance are low wage. The Employee Benefit Research Institute (EBRI), for example, estimated that nearly three of every four employees without health insurance earned less than $10,000 in 1985 while only about seven percent earned more than $20,000.[6] Thus, though the immediate effect of "pay or play" falls on small business owners, many of which cannot afford health insurance for themselves, the longer term impact falls precisely on those employees the legislation is intended to benefit. The impact is felt in the form of lower wages and/or fewer employment opportunities. In fact, "pay or play" is a less than candid way of requiring uncovered employees to purchase their own health insurance, and it is often proposed without tax credits or other means to cushion the blow for the lowincome. (Parenthetically, the same principle implies that those promoting "competiveness" as a reason for dumping their contractual health care obligations onto a publicly-financed system would be in for a rude awakening should their argument prevail. Wage increases would offset any compensation reductions resulting from lower health costs.)

"Pay or play" schemes also effectively subsidize some employees who do not need to be subsidized while offering no subsidy to some employees that most would consider deserving. The reason for the anomaly is that the subsidy is attached to the firm—which in the longterm does not pay the cost—not to the individual. For example, if one employer finds it financially advantageous to "pay" rather than "play," the subsidy falls to all employees in the firm regardless of individual economic status. On the other hand, if the employer finds it to his advantage to "play" rather than "pay," then the public subsidy will be lost to every employee regardless of individual economic status.

Too often we stereotype the American economy as consisting of wealthy employers and poor employees. A far more apt model, though still overly simplistic, consists of relatively wealthy and relatively poor employers and relatively wealthy and relatively poor employees. The problem for present purposes is that relatively wealthy employers tend to be matched with relatively wealthy em ployees and vice versa. Small employers who do not offer employee health insurance take comparatively little income out of the business; the reverse is also true.[7] Thus, even if one doesn't accept the "compensating differentials" principle, pay or play still produces the anomalous result of one comparatively poor entity subsidizing another comparatively poor entity, while the comparatively wealthy watch from the sidelines.

"Pay or play" has still another impact. It adds demand to the health care system and pushes up prices even more rapidly than they ordinarily would have risen. Higher prices in turn make employers reduce coverage if they have policies with generous benefits, transfer higher premium costs directly to employees, and more frequently opt into the public system.

The importance of this inflationary impact remains unappreciated. I cite a paper by Stephen Long, using calculations like those in the Pepper Commission report, as a case in point.[8] Long concluded that requiring all employers to provide employee health insurance (with specified "minimum" benefits) would raise total health care costs only about $15 billion, or approximately two percent. That is $1,000 for every newly covered person. Of course, if so comparatively little were to be added for such a relatively large and medically under-served population, the health care problem of the working uninsured would appear to be relatively minor and easily addressed. But even taking these calculations at face value, a two percent increase in demand adds to the inflationary spiral. And, inflation has the effect of reducing demand for services among those least able to afford them, in this case the uninsured or under-insured paying cash for services.

In the long term, the pay or play alternative is not viable. Elsewhere I have roughly estimated that the Mitchell version of pay or play provides financial incentives for from one to two million employers—virtually all small—to move into the Federally subsidized program.[9] The Massachusetts version, as enacted, would have made it financially attractive for virtually every employer in the state to drop their private plans, where they had one, and to throw their employees into the state pool.[10] Thus, "pay or play" is not a permanent policy, but an inefficient transition to something else. That something else I believe to be a system of national health insurance.

A Simple Mandate

Long argues in favor of a simple mandate.[11] However, the important part of his analysis is the Congressional Budget Office (CBO) estimates, he cites, of the changes in the sources of health care financing under a simple mandate. Those estimates should provide the coup-de-grace to any mandate proposal.

According to the CBO, a simple mandate would increase employer-based payments by $42 billion or about 20 percent. Governments' share would decline $11 billion. Direct patient payment would decline by $10 billion, and individual policies by $5 billion.

What is the social effect of those financing changes? Is it progressive or is it regressive? Assume that the benefits of coverage accrues to a lower income population, which would be true in most instances. Compare that to who pays when the sources of financing change. The employer-based payments over the long term will be made in lower wages and less employment by the employees that are not now insured. Since the uninsured tend to be lower income employees, the $42 billion increase would fall on that income group. The declines in direct patient payment and individual policies probably represent reduced expenditures on health care by lower income people. Those reductions offset the $42 billion increase to the employer-based payment by about $15 billion. Governments' $11 billion dollar share is, on the other hand, at least less regressive than the other financing sources. As a result, the financing of health care for the working uninsured under the simple mandate is no more progressive and probably somewhat less so than with current arrangements. It would also be no less regressive than if the working uninsured were simply compelled to purchase their own insurance—and far less so, if targeted tax credits accompanied the individual mandate.

THE SMALL BUSINESS PROBLEM II

Health care has two potential problems—cost and quality. Availability, the issue that most concerns policy makers, is really an issue of cost. Poll after poll suggest that the major concern of the American public with its health care system is not quality which they generally believe is quite high; it is not the avail ability subset of cost either, even with 31 million Americans lacking health insurance; the concern is over direct costs which many Americans believe could strip them of their health insurance at some future date and financially cripple them.[12] Small business owners share the public's concern.

Many factors contribute to the 1. absolutely high and 2. relatively high insurance rates small business owners face. The most obvious factor is high and rising health care prices brought about by an aging population, quality improvements in health care, and so forth. But rising insurance costs are also related to the small group underwriting problem, differing regulatory and tax treatment of self-insured and conventional plans, etc. But at its heart, insurance prices are rising to small business owners because the consumer/patient has generous incentives to use the health care system profusely and almost none to use it wisely. The exceptions are those who must pay inflated health care costs out-of-pocket. Third party payment,

which now constitutes the bulk of payment for health care, isolates consumers from prices and often functions as a health care spending account. This type of payment conceals health care prices not only because they are prepaid, but also because the individual is not rewarded for using health care judiciously. Thus, prices function which we use so effectively else where to tell how much of what to produce and sell is largely absent in health care. And, we have made it so.

Employer-Based Health Insurance

Most Americans think in terms of an employer-based health insurance system. While perfectly understandable given the historical development of health insurance in this country, the model is no longer appropriate for today's problems and confines possible changes to narrow and not particularly promising alternatives. Look at the problems an employer-based system creates: Start with portability. The United States is a very mobile society. Yet, an employer-based system needlessly ties people to jobs, particularly if they are older or have experienced health problems. Changes in family constitution or a family member's age can also create health insurance related problems. These types of rigidities are precisely what we do not need hobbling our labor force when flexibility and adaptable are the major American competitive advantages.

An employer-based system vastly complicates public policy's capacity to deal directly with low-income individuals and families. Instead it forces policy to direct attention to firms not providing insurance regardless of individual circumstance. We easily might find ourselves in many situations where a few comparatively wealthy employees distributed among a comparatively poor labor force re ceive indirect employment based health insurance subsidies, while a few comparatively poor employees among relatively wealthy labor forces receive none.

An employer based system is particularly difficult for small employers. The small group underwriting problem makes it inherently more expensive for them to purchase insurance. Certain industries and occupations, virtually all focused in small firms, apparently incur large underwriting losses; many insurers won't write their business. Finally, new firms—those less than a year or two depending on the insurer cannot be written. Those working for the firm, including the owner, can't purchase employee health insurance even if it were affordable for such fledgling operations.

And most obviously, not everyone is employed. Insurers consider these people poor risks, and it is difficult and/or very expensive for them to obtain individual coverage. Current public programs are not the answer. Medicaid covers about 40 percent of the poor. Moreover, many unemployed Americans are not poor, though they may be experiencing temporary cash flow problems.

Given these problems, it very difficult to understand how a reshuffling of the bodies within the employer-based system as is sometimes proposed can be helpful. For example, Blue Cross-Blue Shield offers a series of proposals designed to reform the small group market, including prohibition on carriers canceling or refusing to renew small group coverage because of high claims loses, guarantees on availability regardless of health status, occupation, etc.[13] Most would consider these desirable outcomes. But in offering their proposals, the Blues include a telling commentary. They note,

> "These reforms, while significant, are not intended to address the underlying problem of high health care costs - the most frequently cited reason small employers give for not purchasing health insurance. **These reforms would actually increase the cost of coverage for some small groups** (bold provided). These increases would be caused in part by the claims generated by the coverage of previously "uninsurable" groups and in part from redistributing the cost of high-risk groups and individuals throughout the market."[14]

The Blues' proposal includes amending ERISA so that cross-subsidies in the health care premiums will be born by all insured rather than just those who are not in self-insured plans, i.e., small busi nesses. Unfortunately, the inability of State officials to address the ERISA question has not given many pause to consider who is subsidizing whom, and whether or not that is good policy.

The problems with employer-based health insurance do not mean that employer-based health insurance must be eliminated, though some disagree.[15] Rather it suggests that employer-based systems must stop receiving preferential policy treatment, treatment which virtually mandates that it be the only system used. It also suggests that we begin to think about other bases on which to form voluntary insurance groups whether they be social clubs, Census tracks, or something more imaginative.

POLES APART

The United States has two generic alternatives from which to choose. We can have a state-driven model in which large bureaucracies make the fundamental allocations for health care. The Russo proposal and the British or Canadian system are examples of public systems. (Many of the managed care ideas put forward are a private version of the same thing.) Or, we can have a consumer-driven model. The patient/consumer makes the fundamental deci sions. Champions of the consumer-driven model include the conservative Heritage Foundation and the National Center for Policy Analysis among others, although basic elements of the changes occurring in the hardly-conservative Netherlands fit it as well.[16]

There is a third model, a provider-driven system. It resembles the American health care system of the 1960's, 70's and early 80's. In effect, providers are "king." They dictate the type, frequency and price of care. Constraints on them are limited. But with the expansion of Medicare/Medicaid, the introduction of managed care, and continued escalation of health care costs, the provider-driven model is in its twilight. The issue is—will we move toward a bureaucracy-driven system toward or a consumer-driven system.

Bureaucracy-Driven

The public bureaucracy-driven model offers one important benefit to small employers. It allows them to escape the employer based insurance problem. Small employers would not have to worry about purchasing or helping administer an employee health insurance program. And, as long as the program was not funded through a payroll tax, it would influence work or hiring decisions minimally. Moreover, employees of small firms would receive the same amount of insurance for the same price as would others, a condition which does not now exist.

Total outlays for health care could also be minimized if bureau cracies arbitrarily fixed the number of procedures, treatments, hospital days allowed, etc., and similar means of rationing care. That would raise real quality issues, and the resulting lines or waiting periods would test the American public's patience. But while Medicare and, to a lesser extent, Medicaid cost increases suggest that politicians would be loath to let bureaucracies engage in such severe rationing schemes, it could be done here as it has been done elsewhere.

The problem created by a bureaucracy-driven system can be illustrated by the experience of a Computer Tomography (CT) Scanner at York Central Hospital in Richmond Hill, Ontario, Canada.[17] There, Canadians must wait up to three months to use this expensive diagnostic device because by law people cannot pay for the service and budget constraints in the Ontario Health Insurance Plan limit the number of scans allowed. So, while humans, including those with "excruciating headaches," queue up waiting to be diagnosed, a local veterinarian scans his pooch patients any night for $300 each.

The issue in Richmond Hill is not malfeasance. No human frailties were exposed. Rather the story simply demonstrated how a bureaucracy-driven system misallocated resources as a result of an artificial budget cap and the leveling Canadian social philosophy. However, add politics—the inevitable concomitant of such a system—and the illustrations become less amusing.

Look at what the British National Health Service will spend money on and what it won't. In one recent year, the NHS spent $70 million on tranquilizers, sedatives, and sleeping pills and paid for 21 million ambulance rides (about one ride for every two people in the country), 91 percent of which were for non-emergency purposes. Meanwhile, as many as 9,000 died because they could not get kidney dialysis. According to one analyst,

> "If the British National Health Service did nothing more than force people to pay the real cost of sleeping pills and tranquilizers, they would save enough money to treat another ten to fifteen thousand cancer patients the same way patients are treated in the United States. On top of that, they could save an additional 3,000 kidney patients by giving them dialysis."[18]

The problem with bureaucratic arrangements is that the important health care decisions will be made by politics and bureaucracies rather than by the individuals needing care. Rules will govern rather than people. All will fit in a neatly drawn budget, a budget which arbitrarily dictates how much the society will spend on health care overall and how much in total it will spend for speci fied services. In effect, we will have a monopoly made no better by the fact that the monopoly is government owned and operated.

Representative Marty Russo argues that the country could save $67 billion a year by instituting a single-payer system.[19] The savings would come from eliminating advertising, marketing, sales commissions, eligibility determinations, etc. But, the same rational could be advanced for any industry. Why don't we have one auto mobile company? That way we could eliminate advertising, marketing, sales commissions, bailouts of weak competitors, etc., and the public could pocket the savings. Why not one airline? Think of all the cheap fares! How about a single national grocery chain? Grocery prices would surely tumble and our newspapers wouldn't be filled with those fliers that keep falling out! Of course, that is silly and so is the idea of a health care monopoly, or more technically in this case, a health care monopsony.

One analyst took a slightly different tack. He noted if one were to argue for a national monopoly/monopsony that the cosmetic and perfume industries should be near the top of the list as a very large portion of the value-added is tied to advertising and sales rather than to making the products.[20] Health care would rank quite low by contrast. Moreover, the potential costs associated with limiting choice in health care is quite high compared to limiting choice in other industries.

But whatever the argument made, a monopoly is a monopoly to small business owners whether it is public or private, in health care, autos, airlines, groceries, or perfume and cosmetics. And, that is bad—corrupting and inefficient.

Consumer-Driven

Health care markets work. Evidence lies in the fact that people who directly pay little for health care, i.e., the insured, use the system often, and people who directly pay a lot for health care, i.e., the uninsured, use it much less. Elasticities for different health conditions also vary, as well they should. Being hit by a bus brings on one set of demands for health care, while catching a cold brings on quite another. That we often don't like health care outcomes does not mean that health care markets don't work; it means that the incentives applied are misdirected. The task is to capture the market's power to obtain the outcomes we want—high quality, lower relative prices, and universal accessibility.

The heart of the health care debate is prices. Congressman Russo argues that "Cost sharing is inappropriate and unnecessary to control costs under a single payer system."[21] Little could be more incorrect or more clearly demonstrate differences between the two approaches to health care reform. Consumers/patients must understand and act on relative costs in a consumer-driven system. They not only can choose, they must choose. If not, everyone will want everything and that is not possible. Should you need a personal illustration of the principle, give a stranger your credit card.

Reformers preferring the consumer-driven model understand that policy impediments to market operation must be eliminated, policy "grease" should be selectively added, and provision made for those who under current circumstances lack the resources to reasonably participate in the health care market's operation. That implies a limited number of concrete policy actions.

The Tax Exclusion

Since its earliest days, insurance and third party payment were designed to protect individuals from random, catastrophic events. Health insurance in the United States was designed to serve a catastrophic function as well, but developed into a system where it became a vehicle for paying all but the smallest health care bills. In effect, it became a health care "slush fund" or "spending account." So, health insurance not only protected the individual from the extraordinary random event, but also isolated him from routine health care payment. The reason for the fundamental change in the insurance function in health care was the tax subsidy granted it.

The Federal government now provides a $30 billion subsidy to beneficiaries of employer provided health insurance. The subsidy is dispensed by excluding from taxation premiums paid for employee insurance. States do the same, adding a second subsidy layer. Thus, in the extreme case, an individual can purchase $1.97 worth of insurance for $1.00.[22]

The subsidy encourages people to insure. It also encourages people to "over-insure," i.e., to spend more for insurance than they would without the subsidy. One frequent result of over-insurance is a lower deductible. But look how lowering the deductible effects insurance costs: If a 40 year old male lives in a city with average health care costs, and decides to lower his deductible from $1000 to $750, the additional premium will be $97.49 or 49 cents for every dollar of additional coverage.[23] However, if the same individual chose to lower his deductible from $250 to $100, the additional premium would be $256.82 or $2.14 for every dollar of additional coverage.

The dilemma is that we would like people to be protected against financial ruin or severe hardship when a serious illness occurs, but we don't want to subsidize expenditures for normal health maintenance. Thus, the tax exclusion for health insurance premiums should be limited to a specified amount. The precise number is open to discussion. Yet, the result would be continued incentives to purchase basic insurance, accompanied by elimination of incentives to purchase what effectively is a "health care spending account."

Markets Including the Low Income

If health care markets are to work the way we would like them to work, provision must be made so that the poor or near poor have access to the system in much the same way as do wealthier citizens. Access can never be perfectly equitable either under a consumer-driven system or a bureaucracy-driven system. Yet, the important differences can be minimized.

Here, we need to consider some type of subsidy for the purchase of health insurance. Any number of methods exist to accomplish the task including tax credits and vouchers. The proposal could in volve a 100 percent subsidy for select

people and a partial subsidy resembling a Medicaid "buy-in" for most. The revenue to provide the subsidy might be claimed from the cap on the premium exclusion, an elimination of Medicaid, and reductions in other Federal spending programs. However, one point is critical. The subsidy cannot shield a recipient from the consequences of choice.

Information

Another critical area of activity is information. Consumers cannot make rational choices without information on alternative costs and outcomes (quality). Cost data for most goods and services are readily available; if the numbers are not already posted, just ask. Quality data can be more difficult to determine and be more judgmental in conclusion, but objective sources can usually be found. Unfortunately, health care has been a different matter.

A Gallup poll recently showed that 72 percent of Americans do not discuss fees with doctors prior to treatment.[24] Three of five would like to have discussed price. (Twenty percent didn't because insurance coverage made it irrelevant.) Thus, most health care consumers do think about prices. But, some type of social norm, probably couched in terms of 'how can you consider money when your life is at stake?' works against health care price shopping. Steps must be taken to counter this norm and to sensitize the American consumer to prices and health care.

Both price and quality information are beginning to emerge. The Health Care Financing Agency (HCFA), for example, publishes data on death rates of Medicare patients at nearly 6,000 hospitals across the country. While a number of caveats, including the health of the population served, must be incorporated with the raw numbers, the data can help the public make important health care decisions.[25]

Unfortunately, they are emerging too slowly and I don't understand the reason(s). For example, why don't health insurers form an organization like the Insurance Services Organization (ISO) to publish pooled data on provider prices? Why won't the state of New York, which has the data, publish the names of doctors whose surgical mortality rates are multiples of the state average?[26]

Service Mandates and Minimum Policies

State laws and regulations governing contents of health insurance policies have proliferated. Today, over 850 service mandates exist. Their effect is to raise the overall cost of insurance for those not in a self-insured plan.[27] The reason is that mandates force consumers to purchase coverage they do not wish to buy. For example, why would a single male want to purchase mammogram coverage? Why would anyone want hair-pieces in their insurance? What is politically interesting about these mandates is that they are pressed by provider groups, not by consumer groups.

State service mandates must be eliminated. Only in that way can health care consumers enjoy real choices, including the choice to purchase relatively inexpensive catastrophic coverage and nothing else.

Imagination

You can't legislate imagination, but you can be ensure that legislation doesn't impede it. I was recently told by a friend living in the area that a particular operation he was about to undergo would cost $15,000. A few days later, I was in the South and mentioned my friend's condition to a doctor attached to a major university center. He suggested that his institution could conduct the identical operation from 33 to 50 percent less with equally competent personnel. The problem was that my insured friend had no incentive to leave Washington, and he wouldn't unless someone made it worth his while.

Israel Kirzner, one of the great contemporary thinkers on entre prenuership and economic change, argues that people must look for new ways of doing things or

they won't find them. The act that most impedes searching for new ways is for government, or some other authority such as a corporate executive, to outlaw an activity. People then stop searching for new and better ways, and stagnation sets in.

Someone has to use imagination to get my friend to have his operation outside Washington. Someone has to use imagine to resolve the thousands of glitches, inconsistencies, and special circumstances that arise daily. I submit that is far more likely to happen in a consumer-driven health care model where millions of consumers make billions of self-interested decisions than it is in a bureaucracy-driven model where a handful of people make decisions for millions of others.

ENDNOTES

1. William J. Dennis, Jr., Small Business Problems and Priorities, The NFIB Foundation, Washington, D.C., 1986.

2. Clare Lippert and Elliot Wicks, Critical Distinctions: How Firms That Offer Health Insurance Benefits Differ From Those That Do Not, Health Insurance Association of America: Washington, D.C., 1991.

3. Promoting Health Insurance in the Workplace, American Hospital Association: Chicago, Ill., 1988, p. 179.

4. William J. Dennis, Jr., Small Business Employee Benefits, The NFIB Foundation: Washington, D.C., 1985; The State of Small Busi-ness: A Report to the President, Small Business Administration: Washington, D.C., 1987, Chapter 4; Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage, Op. Cit.; Charles Hall and John Kudor, Small Business and Health Care: Results of a Survey, The NFIB Foundation, 1990; Pro-viding Employee Health Benefits: How Firms Differ, Health Insurance Association of America: Washington, D.C., 1990.

5. Hall and Kudor, Op. Cit.

6. Promoting Health Insurance in the Workplace, Op. Cit., pp. 18-20.

7. Hall and Kudor, Op. Cit.

8. Stephen Long, "Winners and Losers in Reforming the U.S. Health Care System," An EBRI Special Report, June, 1991.

9. "It's Cheaper to Pay than It Is to Play," NFIB, August, 1991.

10. Charles D. Baker, "The Massachusetts' Debacle: "Universal Health Care," Rescuing American Health Care: Market Rx's, The NFIB Foundation, 1991.

11. Long, Op. Cit.

12. Larry J. Freshnock, "The Public's Paradoxical View of Health Care," Rescuing American Health Care, Op. Cit.

13. Reforming the Small Group Health Insurance Market, The Blue Cross and Blue Shield System: Chicago, Ill., March, 1991.

14. Ibid., pp. 2-3.

15. See, for example, Warren Greenberg, "Eliminate employer-based health insurance," Hospitals, October 5, 1990, p.80.

16. Wynand P.M.M. Van de Ven, "From Regulated Cartel to Regulated Competition in the Dutch Health Care System," European Economic Review, (34) 1990.

17. Kevin Donovan, "Dogs get no-delay brain scans - while humans have to wait," The Toronto Star, June 13, 1991, p. A4.

18. John C Goodman, "Canada and Britain: The Consequences of a Greater Government Role," Rescuing American Health Care: Market Rx's, Op. Cit., pp. 75-76.

19. Marty Russo, "Health Care: There Is a Plan That Works," Washington Post, September 10, 1991.

20. Gene Steurle, "The Case for a Tax Credit or Voucher for Providing Health Care to the Nonelderly," Tax Notes, September 9, 1991, p.1318.

21. Russo, Op. Cit.

22. Aldona and Gary Robbins, "Tax Treatment of Health Care Benefits," Rescuing American Health Care: Market Rx's, Op. Cit., p. 16.

23. An Agenda for Solving America's Health Care Crisis, The National Center for Policy Analysis: Dallas, TX, 1990, p. 17.

24. Freshnock, Op. Cit., pp. 35-36.

25. Victor Cohn, "Death Rates in Hospitals: What the New Government Figures Mean," Washington Post, p. Z10.

26. Malcolm Gladwell, "Evaluating Physicians Can Be Delicate Operation," Washington Post, May 27, 1991, p. A1.

27. Gail A. Jensen, "Regulating Health Care: The Question of Mandates," Rescuing American Health Care: Market Rx's, Op. Cit.

REPRESENTATIVE SCHEUER. All right, now we will hear from Mr. Walter Maher, Director of Federal Relations in the Human Resource Office of the Chrysler Corporation. He serves as a member of several health policy advisory boards.

If you could take about six or seven minutes, we will have about five minutes left for questions.

STATEMENT OF WALTER B. MAHER, DIRECTOR FEDERAL RELATIONS, HUMAN RESOURCE OFFICE CHRYSLER CORPORATION

MR. MAHER. Thank you, Mr. Chairman.

I regret that Congressman Armey is not here because I was jumping out of my socks during the morning session of this program.

Let me discuss a question raised by Congressman Armey. Is there a problem? Or are we just wasting our time here?

My industry—forgetting about Canada, forgetting about lots of other countries—pays particular attention to Japan and Germany.

This country, the United States, consumes health services at a rate 90 percent per capita more than Germany, and 125 or 127 percent more per capita than Japan.

We may not like their systems, but the fact is that this Subcommittee, this Congress, this country has to keep that fact in mind, because we are operating in a world economy.

REPRESENTATIVE SCHEUER. Ninety percent more for health care?

MR. MAHER. Yes, per capita in Germany, and 127 percent per capita more expensive than Japan.

REPRESENTATIVE SCHEUER. Those are astonishing.

MR. MAHER. Again, going to Congressman Armey, is this voluntary? Do the people in this country want to do this?

I submit that every payor or every proxy of a payor is saying, no.

You have Dick Darman. You have the Speaker of the House. You have the Majority Leader of the Senate. You have all 50 Governors. You have big business. You have small business. You have labor. You have consumer groups—AARP—everybody saying that we are spending too much money on health care. Now, if we had that type of consensus for anything else in this country, it would be done this afternoon.

REPRESENTATIVE SCHEUER. Why is it not done? What is holding us back?

MR. MAHER. Because we do not have a policy in this country. We do not have a process in this country to control health expenditures. Pure and simple. We have a pluralistic but uncoordinated pluralistic system.

Now, is there any harm? Is this excess harming anything?

We have, as you pointed out this morning, a fixed pot of wealth in this country. And we have a fact of life that business, if they want to remain a business, has to stay competitive.

So, what happens in the fragmented system?

Government, to restrain their spending, has the ability to not cover people, like in Congressman Armey's State of Texas—one of the lowest Medicaid eligibility levels in the country, 30 percent uninsured. That is one way of dodging the bullet.

So, government has the ability to control its spending by just not covering people or cutting Medicaid reimbursement. That is another easy way of doing it.

Business? They have a way. If NFIB members want to not cover people——

REPRESENTATIVE SCHEUER. Tell us what NFIB is.

MR. MAHER. National Federation of Independent Business that Mr. Dennis represents.

If an employer does not want to offer it, he does not offer the coverage. If he has it and they cannot afford it, they drop it. If they hire people, they may say, look, I am going to out-source this work to a Taiwanese supplier; I do not have to pay Blue Cross for the Taiwanese supplier. I may buy a machine because I do not have to pay insurance for a machine. I may curtail wage growth because I am paying too much for insurance.

Meanwhile, health costs continue to spiral. And what is the impact on the citizens of this country?

Certainly, their taxes are not reduced because, whether it is state, federal, or local, those taxes are impacted by rising health-care costs.

There are higher out-of-pocket payments for deductibles, co-payments, fewer jobs, less real income; and employers are less competitive because their employers cannot immediately shift all of these costs to people. So, they are feeling this in lower profits, and they are confronting purchasers—American citizens—who are less vibrant purchasers because they have more and more of their disposable income consumed by health.

Now, solutions. Is there something that the business community can just do all by itself? There are limits to self-help.

The best employer-sponsored plan still remains exposed to government cost-shifting; remains exposed to cost-shifting from other employers; remains exposed to excesses of the malpractice system and technology diffusion.

I do not care how low "the market" can drive a price. A desperate governor, a desperate Congress, confronting a deficit, can legislate it lower and shift costs to the private sector in the process.

When you look, and you step back and say, all right, what do we want in this country?

We are a member of the National Leadership Coalition for Health Care Reform. When we joined that together with other businesses, unions, consumer groups, we all had to agree up front to some principles that really sound rather benign.

We want universal access. We want a system that uses resources prudently. We want to spread the cost over the broadest possible base so that we do not disproportionately impact any segment of the economy.

And we want to have a quality system. We want to have equity within payers and within the economy. But the key is, do you want to end up with universal access and avoid cost shifting?

If you want to do that, your options, as Ted Marmor pointed out this morning, are sharply constrained. For example, one easy way is to say, "all right, we will have a single-payor system; we will run this thing through the tax system." Then, you have a lot of people who say, "oh, my God, we do not want to turn this thing over to the government. Let's build on what we have. Let's build on a public-private partnership."

You have a lot of big business groups, as Mr. Dennis pointed out, who say, "we want to build on the employer-based model." All right, if we want to build on the employer-based model, and we want to have equity within the economy, then let us have all the small businesses join us. If the small businesses say, "hey, I do not want to do that; I cannot afford it; I cannot even afford a 7 percent payroll tax on a minimum-wage employee," then, fine. My point to Mr. Dennis is that NFIB has to either say, "we don't support universal access," and, if they say, "oh, no, we support universal access," then, I agree with your point that they have to support a tax-financed system. It is illusory to say that we'll take that $6 wage-earner and turn him loose in the market, that we will have him go out and be one of the million points of light confronting health-care entrepreneurs and buy prudently health care. That will not happen.

REPRESENTATIVE SCHEUER. I regret that I have to leave now to chair another hearing that starts in exactly two minutes. This has been a marvelously interesting and stimulating hearing.

It is now 2 minutes to 2:00 o'clock. You have been here for hours, and I am terribly grateful to you for your patience, your tolerance, and for the depth and the brilliance of your testimony.

Please continue, Mr. Maher and your remarks will be recorded.

Thank you, so much.

MR. MAHER. People have been sitting here for hours. Rather than finishing any of my oral remarks, I would really like to just take a minute or two and respond to some of the points that Mr. Goodman made in the earlier part of the session, which I would have mentioned.

As you recall, he was particularly outspoken on the fact that we really ought to effectively turn consumers loose, really working with tax credits, and confront the entrepreneurial health-care system. I think we have some absolutely classical evidence that that does not work.

From the day Medicare was enacted, it was loaded with substantial cost-sharing, not only premium contributions, cost-sharing on the physician's side, cost-sharing on the hospital's side, and what did the beneficiaries do? They went out and took—most of them—after-tax dollars and bought a Medi-Gap policy to protect them against what Medicare did not cover. So, you are still left with the quandary, which the health system has, and what I think is driving the system, that you have consumers who effectively pool their money through the insurance and tax system to buy health care, interacting with a very entrepreneurial

health-care system, and, given that interaction, the entrepreneurs will always win.

He commented that—and I think this was particularly inaccurate—in his world travels he is finding all the foreign health systems wanting to privatize their system. False. He completely obscures the point that Mrs. Thatcher, for example, in England, while she very definitely wanted to interpose competition in the delivery of health care, did not have the foggiest intention of taking away from the Chancellor of the Exchequer the reins on the budget, in terms of how much the government was going to spend. She wanted to make more efficient use of that money by having the delivery system more competitive and challenging, in effect using market forces, confronting the limits to do a better job.

So, to that extent, I agree wholeheartedly with the recent findings by the GAO that the United States should not adopt page, chapter, and verse the Canadian system or the German system, but, instead, we should adopt some key features of those systems.

One, the concept of universal access. Two, the concept that we will have a process to determine fair-provider reimbursement and have that binding on all payers. Third, we will have a process to control aggregate health expenditures. But within that structure, you deploy the best managed care that we have been able to develop in this country. You can feed that system—that type of delivery system—through the tax system. You can feed it through the employer and employee system. So, to say that the rest of the world is trying to go private is just not accurate.

MR. DENNIS. What about the Netherlands?

MR. MAHER. The Netherlands may be doing something. My industry is not particularly worried about the Netherlands. They are not knocking our socks off. It is the Japanese and the Germans.

I will conclude by simply saying that, true to form, Mr. Goodman did rely on the "R" word, "rationing," as a scare word. Again, obscuring the difference between having a process for determining how much you want to spend as a Nation for health care and the size of the budget.

You can have a huge budget and give everybody instant gratification, or you can have a very minuscule budget and have everybody stand in line. That is for citizens to decide.

I will stop there. Thank you.

[The prepared statement of Mr. Maher follows.]

PREPARED STATEMENT OF WALTER B. MAHER

I appreciate the opportunity to share with you our views on the need for national health care reform. In particular, I am pleased to comment on those reform proposals we believe are most likely to accomplish the most necessary tasks of increasing access and controlling spending, without impairing the quality of care.

BACKGROUND

Starting first with basics, it is the inexcusably high cost of health care in America which is at the source of all our concerns regarding the plight of the uninsured, the ruinous costs to federal and state budgets, to businesses and to families, and the damage to our economy. This is a direct result of the fact this nation, and this nation alone, lacks any sort of process to control aggregate health spending. Consider for a moment, if we had such a process would we witness our country's chief budgeteer, Mr. Darman, all 50 of our state governors, the leaders of both houses of Congress, big business leaders, big labor leaders, the heads of major consumer organizations, all crying uncle . . . crying for help?

And they have good reason to cry. Currently, medical costs dominate the federal budget, just as military costs used to. Costs are also borne in part by employers, and ultimately by all citizens. The result is the crowding out of wage increases, job opportunities, and spending for other social needs, and a slow but steady erosion in our standard of living, threatening the very vibrancy of our economy and our competitiveness in the world's markets.

Health spending in America is clearly out of control. We spend 40% more per capita than the second most expensive country (Canada); 70% more than number three (Switzerland). The situation is even worse when we are compared with Germany and Japan, home of our major international trade competitors. Were we to consume health services in America at the same rate they do in those countries, we would have $300 billion per year available to redeploy in our economy (see Exhibit 1).

This is a problem that besets any American business offering health coverage to employees. It is not just a problem for mature companies with many retirees; it is not just a problem for unionized businesses. Chrysler is a member of the National Leadership Coalition for Health Care Reform, a group dedicated to being a constructive participant in the solution of this problem, and we find in our midst many varied firms, as well as consumer, provider and labor interests.

Businesses are finding there are limits to what they alone can do in response to this problem, other than managing their benefit programs as effectively as possible. The best managed health care plan remains exposed to government cost shifting, to cost shifting from employers not offering coverage and to the excesses of our malpractice system. Further, excessive technology development and diffusion impacts physician behavior and consumer expectations, just as excessive fees impact provider expectations. Finally, excessive capacity of all sorts breeds excessive utilization, fees and costs.

It is not surprising, therefore, that a recent survey of Fortune 500 CEOs sponsored by the Robert Wood Johnson Foundation revealed that fully 75% have concluded their businesses, all large, cannot solve this problem alone. Over half agreed some form of government intervention is required. During hearings before the Senate Finance Committee in April of this year, top officials of firms as varied as Bethlehem Steel Corporation, Dayton Hudson Corporation, and Southern California Edison Company, carefully detailed the seriousness of the problem for their businesses and the need for prompt action by the federal government to frame a health policy for this nation enabling the public and private sectors to work in tandem to accomplish the necessary goals of access and cost control.

Chrysler likewise is convinced that to accomplish overall health system reform, satisfying business concerns regarding cost and public concerns regarding the

uninsured, government must be involved in the solution. We cannot, for example, continue to permit the public sector to operate its enormous health plans without regard to their impact on private sector payers. Coordination is required if costs are to be managed; and management of costs is a prerequisite to solution of the access problem.

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

As noted above, the public sector is not alone in shifting costs to businesses offering health coverage. Some private sector employers are doing the same thing. Clearly, for example, a disproportionate share of employer paid health costs is borne by the manufacturing sector of the economy to the benefit of the service sector. Consider the fact that 49% of those employed in retail firms (excluding eating and drinking places) are either uninsured or insured elsewhere (usually by the employer of their employee's spouse or parent). For eating and drinking establishments the comparable figure is 76%! As a result of this phenomenon, rather than having the opportunity to spread part of the cost of financing health care delivery to American citizens by adding to the cost of every hamburger, beer or necktie sold in this country, where none of the sellers are threatened by foreign competitors (which would be the ultimate result if such employers sponsored health benefit plans), we instead add to the costs and prices of U.S. manufacturers who do face serious competition from abroad.

We submit the need for reform of our health care system has been well established. But what direction should this reform take? First, we need to establish some objectives.

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

To accomplish these objectives certain principles are key:

EQUITY AMONG PAYERS

This obviously is only an issue were we to have something other than a single-payer system, for example the public/private partnership inherent in some "pay or play" models. Clearly, public coverage must be available for all the poor. Further, given the government as a "partner", this requires a process for the determination of fair provider fees for fee-for-services medicine, with such fees applicable to all public and private sector payers. There should be no room for cost shifting from the public to the private sector other than through the valid process of appropriating tax revenues to fund public programs.

EQUITY WITHIN THE ECONOMY

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

FISCAL INTEGRITY

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

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

TWO REFORM OPTIONS

To put such a system in place, I see two options. Both would foster a pluralistic, private-sector-oriented, competitive health care delivery system. Both would assure access to affordable health care for all residents. Both would embody a process for the determinations of fair provider reimbursement, with the result binding on all fee-for-service payers. And both would have a process to assure control over aggregate health spending.

One option would be financed by building on the current public/private model. The other would be financed principally through the tax system. Chrysler could support either model.

For a reformed health care system to achieve maximum efficiency, there will have to be maximum use of organized systems of care. However, those advocating "managed care" as a panacea fail to make clear that it carries with it very clear constraints on freedom of choice of provider. While this may well be the prudent course to follow, most Americans have long been accustomed to such "freedom" and many providers have preached it as gospel. Further, no other leading country resorts to constraints on choice as a cost control tool. Accordingly, while we believe a reformed health system making maximum use of organized systems of care can create for Americans the most efficient health system in the world, "managed care" advocates had better start educating the public about the trade-offs involved if they hope to yield the achievable benefits.

SMALL BUSINESS CONCERNS

There are many obstacles to systemic reform and the views of some opponents are being registered with the Subcommittee today. For example, a major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S.

businesses employ fewer than ten persons. The majority of them do not currently offer health coverage. They represent an obstacle to universal access if employer-based coverage is to be the chosen financing vehicle. If the concerns of these employers cannot be satisfied because of worries about tieing health coverage in any way to employment and the resulting impact on hiring and production costs, and as a result the health system reform needed by all employers, including many small employers, currently offering coverage is stalemated, then we believe it would be appropriate to reconsider the tie to employment and move to a fully publicly financed system.

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

THE REAL POTENTIAL FOR REFORM

When Chrysler and others became members of the National Leadership Coalition for Health Care Reform, we agreed to certain fundamental principles, among which were:

- Providing all citizens of this country access to affordable health care.
- Controlling costs.
- Equitable financing, including the elimination of cost shifting from the public to the private sector.

Having agreement on these principles, as benign as they may seem, is critical for we believe it significantly constrains your reform options.

For example, if you want universal access . . . which is achievable given the experience of Canada and the rest of the world . . . one option, as noted earlier, is a fully tax supported system available to all. Some in this country are opposed to that solution and prefer to build on the employer based system, coupling the expansion of publicly financed programs for the unemployed poor with a "pay or play" option for employers. However, if you expect to realize universal access, your solution cannot be: build on the employer based system, but use only incentives to encourage employers to offer coverage. That will not produce 100% coverage. Accordingly, it appears any business association taking this approach either has to change it or concede they do not expect to realize universal access.

Further, if you want to eliminate public to private sector cost shifting, one option, again, is to have a single payer . . . no one to shift to. As with universal access, some in this country prefer to maintain a role for private sector health plans. However, when one confronts the reality of private sector health plan sponsors coexisting with government sponsored plans, with only the latter having the authority to pass laws that lead to cost shifting, the need for some form of all payer strategy as exists in Canada, Germany, Japan and many other countries, becomes apparent. You cannot expect to eliminate cost shifting and yet advocate continuation of a process which facilitates the subsidization of public payers by private payers. Frankly, it appears the regulatory trappings of an all payers system are a necessary result of having a public-private system free of cost shifting. Getting to the heart of the matter: I do not care how low "the market" can drive

down prices, any governor or Congress, desperate about their respective deficits, can legislate them lower and shift costs in the process. It should be noted, however, that even with an all payer strategy in place for fee-for-service medicine, both public and private sector payers could remain totally free to experiment with alternative reimbursement strategies, such as capitated programs, so long as they were not a subterfuge for cost shifting.

Another issue those working on health system reform must contend with, particularly with reference to the cost shifting issue, is the matter of funding for public programs. Businesses complaining about the failure of government to cover all the poor, about the failure of Medicaid to pay providers fairly, and about the magnitude of the costs being shifted to business as a result of such failures, as they develop strategies to reverse this cost shift . . . i.e., to have the expense transferred from their books back to the public sector books where it belongs . . . must be prepared to support efforts to properly fund such public programs. The purpose here is not to spend more money in this country on health care. It is instead to see to it that funds required for public sector programs are raised through the tax system and not through cost shifting to the sponsors of private sector health plans.

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

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

Another myth, a classic red herring, is that any control over aggregate spending will cause citizens to stand in line for services as health care is rationed. This "your money or your life" threat is contained not so subtly in many outcries from some in the provider and insurance communities and is as bogus as it is unworthy of its proponents. It clearly fails to differentiate between a budgetary process and the size of the agreed upon budget. The distinction is important.

First, we should never fear rationing excess; instead we should seek to eliminate it. More fundamentally, however, having a "budget" process does not necessarily imply deprivation or queues. It is simply a function of how much a society chooses to spend on health or anything else. If you have a large enough budget for Medicare or any other population, you can get instant gratification. The key is to create a process where citizens can choose where they want to spend their resources. The alternative to a budget is not to have one . . . to have no control on spending. Yet this is what we have today and it is the reason spending for health is soaking up so much of our nation's resources, leaving less for other needs.

Having a budget process is important for in America, like Canada and elsewhere in the world, citizens mainly pool their money to buy health care. Here we do it through the tax system and by purchasing insurance. In Canada its virtually all through the tax system. In neither country, however, do individual

citizens take out their wallets or checkbooks and pay for health services rendered in the normal course of events. In both countries, some other party is usually responsible for all or most of the bill.

Accordingly, given the subject matter of the transaction . . . life, death, pain and suffering; given the fact citizens pool their money to pay for it thus destroying any semblance of a market which could normally be expected to efficiently allocate resources; given a private sector, entrepreneurial minded medical industrial complex "selling" to such "consumers," absent some legislated process to control aggregate expenditures you are assured the entrepreneurs will win and you will have runaway spending . . . precisely what we have in America today. In all other fields of commerce, save health care, entrepreneurs must confront limits . . . typically measured by the amount of a consumer's disposable income. This forces choices. In health care today, the choice is automatic . . . the dollars go to health care regardless of consumer or payer wishes. This must change.

When the subject of health system reform comes up, proponents of reform are told about Americans' strong appetite for health care, that Americans would not put up with a reduction in health care services. We hear this argument, however, from the sellers of health care, not the consumers. I, personally, do not believe Americans want too much health care. I believe our entrepreneurial health system wants to sell too much health care and extract too high a price for it. As a nation we pay far more than is needed to provide care for all citizens and I believe we are hearing that message loud and clear from all health consumers or their payer-proxies.

In Canada, for example, the recent GAO report indicates a conscious decision is made regarding how much money citizens are willing to pay for health care (a decision citizens can obviously change if they wish). At times this has required some Canadians to wait for some services. With the savings produced by this process, however, Canada has provided extensive preventive care for all citizens and has spent far less of their nation's resources than their American counterparts.

In America, by contrast, as a result of our non-system and an excessive investment in hospitals and an excessive diffusion of hi-tech equipment, we often provide instant gratification for those citizens with health coverage at inflated prices. HCFA then pays additional sums to researchers, such as those at Rand, who regularly report on the huge waste inherent in such unnecessary surgeries and other procedures. Our country then, not surprisingly, finds itself with little if any funds available to immunize infants for rubella, leading to a five-fold increase in this horrible disease and lifetime costs of $200,000 for each infant stricken, not to mention failing to adequately meet the health care needs of tens of millions of other citizens.

Fixing our country's health care system will not be easy. However, as with every other important issue - education, crime, trade, and the deficit - reforming the health system is clearly not insoluble. It is simply a matter of having the will to confront and overcome the problem, including the obstacles arrayed by the many forces with a vested interest in the status quo.

The recent bill introduced by the Senate Democratic leadership is helpful in moving this issue forward. However, it needs to be strengthened in several key areas if it is to accomplish the system reform our country needs. Considerably more attention needs to be devoted to assuring that health costs are controlled, that cost shifting from the public to the private sector is eliminated, that costs are allocated equitably across the economy to help insure a competitive business environment, and that all of this occurs within the shortest possible time period.

Senator Robert Kerrey (D-Neb.) has introduced an interesting bill that proposes to use government for those things it does efficiently - raising and dispensing money - and not to use it to micromanage the health system. The system suggested by Kerrey is taxpayer-financed, and eliminates the connection between

employment status and health care entitlement by requiring everyone in each state to choose between competing public and private health plans. There would be controls on aggregate spending and very real incentives for private sector development and management of organized systems of care. The bill looks to employers to help finance the system through a payroll tax and an increase in the corporate income tax.

One inappropriate criticism of the Senate Democratic leadership proposal was that the pay or play tax rate may not be based on "real risks." Apparently the critic contends that health insurance should be priced like term life insurance; that if an individual wants to buy health insurance an agent would check the person's age, medical condition, and peg the premium accordingly. That is not insurance; it certainly is not insurance designed to make health care affordable for all citizens and businesses. Further, there is no earthly reason why the sole source of support for the proposed Americare program need be payroll taxes and individual premiums. The much more critical needs are for the program to be administered efficiently, for health services to be rendered efficiently, maximizing the use of quality driven organized delivery systems, and for costs to be distributed fairly throughout the economy, including support from employers and employees.

In conclusion, Americans are clearly not aware of the growing costs they continue to bear as a result of inaction . . . as a result of failing to step up to the need to reform our nation's health care system. Barring change, we believe health costs will easily exceed $2 trillion by the year 2000 and absorb over 20% of our nation's GNP. Health costs are growing far faster than family income, than business income, than local, state or federal government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses.

For example, as is noted in Exhibit 2, in 1991 alone 36% of the growth in our economy will be accounted for by increased health spending. Indeed, as this exhibit further notes, given the Administration's assumptions of future economic growth and the Department of Commerce's assumptions for health spending, by 1996 spending for health will consume 17-19% of our GNP and, more significantly, 30-40% of every single dollar of economic growth.

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

As the GAO report referred to above properly concluded, the U.S. should adopt a structure which embraces some of the good elements of the Canadian and other foreign systems: the concepts of universal access, a uniform fee for service payment system to assure cost shifting from the public to the private sector is eliminated, and a process to control aggregate health expenditures, and within such a structure deploy the best of American managed care and competing, organized delivery systems. We would then have in place a process which not only determines the appropriate level of national health expenditures, but also a process to assure the health system accomplishes its patient care responsibilities within the agreed upon limits. This is a far better solution than the "trust me" approach advocated by those who would arm individual citizens with tax credit vouchers and dispatch them to confront America's medical-industrial complex where they would attempt to buy health care as they would a loaf of bread. They wouldn't have a prayer, but they most assuredly would need one.

EXHIBIT 1

HEALTH SPENDING PER CAPITA

	1980		1989	
	$	% U.S. HIGHER	$	% U.S. HIGHER
UNITED STATES	$1,089	-	$2,354	-
GERMANY	$ 704	55%	$1,232	91%
JAPAN	$ 522	109%	$1,035	127%

SOURCE: ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT: FACTS AND TRENDS

EXHIBIT 2

HEALTH CARE COSTS

- ABSORBING A GROWING SHARE OF U.S. RESOURCES -

($ Billions)

YEAR	GNP[1]	HEALTH SPENDING[2] LOW EST.	HEALTH SPENDING[2] HIGH EST.	% GNP LOW EST.	% GNP HIGH EST.	% OF GNP GROWTH ALLOCATED TO HEALTH SPENDING LOW EST.	% OF GNP GROWTH ALLOCATED TO HEALTH SPENDING HIGH EST.
1989	$5,201	$ 604.1		11.6%		---	
1990	$5,465	$ 675.7		12.4%		27%	
1991	$5,689	$ 756.3		13.3%		36%	
1992	$6,095	$ 847.1	$ 869.7	13.9%	14.3%	22%	28%
1993	$6,536	$ 948.7	$1,000.2	14.5%	15.3%	23%	30%
1994	$6,990	$1,062.5	$1,150.2	15.2%	16.5%	25%	33%
1995	$7,451	$1,190.1	$1,322.8	16.0%	17.8%	28%	37%
1996	$7,931	$1,332.9	$1,521.2	16.8%	19.2%	30%	41%

[1]As reported and estimated in Budget of the United States Government, Fiscal Year 1992, as submitted by President Bush, February 4, 1991

[2]As reported and estimated by U.S. Department of Commerce, U.S. Industrial Outlook 1991 - Health and Medical Services

[Whereupon, at 2:05 p.m., the Committee adjourned, subject to the call of the Chair.]

HEALTH-CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS — COMPARING ADMINISTRATIVE COSTS IN U.S. AND CANADIAN HEALTH-CARE SYSTEMS

WEDNESDAY, OCTOBER 16, 1991

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:30 a.m., in room 2325, Rayburn House Office Building, Honorable James H. Scheuer (chairman of the Subcommittee on Education and Health) presiding.

Present: Representative Scheuer, and Senator Bryan.

Also present: David Podoff and Teresa Sewell, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

REPRESENTATIVE SCHEUER. We hope that Representative Richard Armey will show up. He has an opening statement that I would like to ask unanimous consent be placed in the record.

There being no objection, so ordered.

[The written opening statement of Representative Armey follows:]

WRITTEN OPENING STATEMENT OF REPRESENTATIVE ARMEY

Good morning. It is a pleasure to be here today. I'd like to take this time to welcome our distinguished panel of guests from the insurance and medical community.

Concern over containing the rising costs of U.S. health care has focused our attention today on one health care cost; administration. With the recently released Health and Human Services report stating that health care expenditures in 1990 exceeded 12% of our gross national product, reforming the U.S. health care system is certain. The issue of excess cost in administering health care has been brought to the forefront of the debate by two reports; The GAO report and the report in the May 2 New England Journal of Medicine by Dr's Woolhandler and Himmelstein. Both reports itemize the cost of administering our nations health care.

However, the administrative savings achieved by moving to a Canadian style health care system , as outlined in both reports are greatly exaggerated, according to many economists and medical

practitioners. What is not fully disclosed in these reports is the cost to the U.S. of moving to a Canadian style health care system.

Contrary to savings outlined in both the GAO report and the study done by Dr's Woolhandler and Himmelstein, the National Center for Policy Analysis reports that adopting a national health care program similar to Canada's in the U.S. would require at least $339 billion in new taxes, which would make the United States more heavily taxed than most countries with whom we compete in international trade.

Accurate cost studies must look not only at inefficiencies in the U.S. health care system but in Canada's as well. While health care expenditures as a proportion of GNP have not grown as fast in Canada as they have in the United States, the rate of increase in per capita health spending exceeds that of the United States (The average annual increase was 4.28% in Canada as compared to 3.93% in the United States.) Health care costs in Canada consume on average one-third of total provincial expenditures. To combat these increases, the GAO reports that Canadians are looking to the United States for a way to improve their system, particularly in the areas of managed care and patient information systems.

Not only is Canada experiencing cost control problems, they are experiencing efficiency problems in the delivery of services. The GAO reports that under Canada's single-payer system, tight hospital operating budgets and restraints on the diffusion of new technology result in limited access to some high-technology

> North American experiment demonstrates conclusively that the single-payer system has contained costs more effectively than has the U.S. multipayer system. Although this fact alone doesn't mean that the Canadian system is superior, it would be unfortunate for Americans to ignore the cost containment results from the North American experiment.

So, let's talk about the quality of care, about waiting lines and their effect on health status. Let's talk about alternative approaches to cost containment, such as managed care versus global budget constraints. And let's talk about the effect of global budgets on innovation and advances in medical technology. Let's talk about the tradeoff, if there is one, between high-tech specialized treatment for some versus primary preventive care for all of our citizens.

Let's try to refine the estimates of GAO and Woolhandler and Himmelstein on how much we would save if we adopted a Canadian-type system. What would be the costs and what would be the benefits, what we might give up and what we might achieve.

But let's also accept some indisputable facts.

Figures for 1990 just released last month by the OECD (the Organization for Economic Cooperation and Development)—the organization that includes all the Western democracies, such as Japan, Australia, New Zealand and so forth—tell the story. In 1990, the United States spent 12.4 percent of gross domestic product on health care, compared to an average of 7.6 percent for 23 OECD countries and 9 percent for Canada.

Canada spends less on health care than the United States, because for the last 20 years, its single-payer system has done a better job of controlling costs than the multipayer system in the United States. In 1970, Canada and the United States both allocated a little more than 7 percent of national output to health care. But by 1990, the United States, compared to Canada, was spending 3 percent more of gross domestic output on health care. In other words, we're spending 12.4 percent; they're spending about 9 percent or a little bit over. So, it's fair to ask: What is it that the United States has gained by spending that extra 3 percent of national output on health care?

Clearly, not access. Everyone in Canada has access to health care; whereas, in the United States, 37 million persons have no health insurance, and for the elderly, they have no assured access to long-term care, whatever. Nobody has assured access to catastrophic care. And among low-income families, the access to care from birth to 10 is a national disgrace. Access by low-income mothers to prenatal and post-natal care may be available theoretically, but they aren't taking advantage of it. So, there's something very wrong with our outreach system that such a large percentage of mothers from disadvantaged families do not actually receive prenatal and post-natal care. So, clearly, access is not equal.

Clearly, better health status is not the answer. We have lower health outputs than Canada does in return for spending 3 percent more. Life

expectancy is about two years higher in Canada, and infant mortality is about 20 percent lower than in the United States.

Clearly, not compassionate care for our seniors and kids. As I said before, alone in the industrialized world, we fail to assure long-term care for the elderly and health care for kids, birth to ten. Interestingly enough, 10 percent of the kids from birth to 10 have no regular access to health care.

Clearly, not protection against financial ruin from catastrophic health-care expenditures for anybody in our society.

So, I ask: What do we get for indisputably having created the world's most expensive health-care system? Well, it seems to me that what we get is a woefully wasteful, chaotic, bloated, and cost-ineffective health-care system that clearly must be reformed now. All of the developed countries have managed to provide universal access to comprehensive care at demonstrably lower cost. We must not delay any more as we seek to mold a financing system that provides universal access to quality health care for all Americans. As many of you know, it's been more than 40 years since President Truman first proposed universal access to quality health care for all Americans.

The need for health-care reform was obviously clear to President Truman 40 years ago. The passage of time has only increased the urgency.

Now, we'll hear from a truly distinguished group of witnesses on two panels. We'll start with our panel of health insurance executives and experts, including Gordon Trapnell, Seymour Sternberg, Mary Nell Lehnhard, James Doherty, and W. Pete Welch.

We'll begin our panel with Gordon Trapnell this morning. He's a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and a fellow of the Royal Statistics Society.

We have a large set of excellent witnesses. So, to leave us some time to question them, we're going to stick rather rigidly to a ten-minute rule. So, please try and sum up your testimony. And let me say to all of the witnesses on both panels that your prepared testimony will be printed in full at the point at which you testify.

Mr. Trapnell, when you feel comfortable, please proceed.

STATEMENT OF GORDON R. TRAPNELL, PRESIDENT, ACTUARIAL RESEARCH CORPORATION

MR. TRAPNELL. Thank you, Mr. Chairman, for the privilege of being here.

REPRESENTATIVE SCHEUER. It's a privilege for us to have you, and that's true for all of the witnesses.

MR. TRAPNELL. Let me start by noting that the $35 billion that has been attributed to the cost of administering insurance is a 1989 figure from HCFA's actuaries, or really from a small group of economists that work with the actuaries in HCFA. It includes $27 billion for private health

insurance and $8.5 billion for government programs. I realize these do not add because there's rounding.

The first point I want to make is that several billion of the $27 billion in private insurance is neither administrative cost or profit, but amounts that are collected to help pay for health care in the future by the insurers.

For example, there are increases in active life reserves that are set aside for higher claim levels as policyholders age. In addition, each year the insurance industry collects several billion dollars more in premiums than it needs to pay claims under what I call participating policies, because they pay the balance back at the end of the year. A portion of these dividends are held by insurers in "rate fluctuation reserves," which really belong to employers. There are other amounts that insurers have collected and will be paying back in the future to meet their loss ratio requirements. I'm sure the insurance industry can give me several dozen other items.

And there is also the matter of premium taxes, which are not strictly an administrative expense, but a source of revenue for the states that would have to be addressed in any appropriation of these funds to pay for the uninsured.

Taking all this into account and projecting to the present, I estimate that we now spend $28 billion to administer private health insurance in 1991, including the insurer profits and the increases in surplus of nonprofit organizations.

We spend another $9 billion on government programs, or $37 billion altogether. This includes $2 billion of premium taxes that the states regard as one of their important revenue sources and that would probably not be available to appropriate into a government program.

So, I should cut that figure back to $35 billion as a target, of which $27 billion is the private health insurance expenditure. This is still around 7 percent of the benefits paid, an expenditure that the Canadians do not make.

There are two other matters that I would like to discuss. One is, why do we spend so much now on administering private health insurance and how it might be reduced within the context of a multipayer system; and the other is the potential of savings if we do move to a Canadian-like system.

The cost to administer private health insurance varies by the type of insurance and the size of the group, from as much as being equal to the benefits being paid for some types of insurance—such as hospital indemnity and similar policies—to being only a few percent of the benefits paid.

The extreme is where the benefits are very low and only a single individual is covered, which characterizes much of Medicare supplement insurance. And I would guess we spend as much to administer Medicare supplement insurance as we spend to administer the entire Medicare program, despite providing only one-tenth of the benefits.

And I also would mention, in passing, that one of the faults of the Medicare catastrophic program and reasons for its demise is that it reduced the benefits being paid by Medicare supplement policies but did not eliminate them. The administrative cost of the insurers providing Medicare supplement were not significantly reduced by the reduction in benefits, so you had the worst of both worlds. You retained nearly all of the Medicare supplement insurance, administrative expenses, in addition to adding to the cost of Medicare.

The cost of administration of private health insurance falls rapidly with the size of the group, but we need to look further into the reasons. It's not just economies of scale, there are other flaws in the market that lead to this high level of expenditure.

As I have explained in some detail in my written testimony and will not try to take up here, it is largely the turnover from one insurance company to another that explains this high level of expense. In addition, it is the natural financial incentives that competitive markets give insurers that are directly responsible for this. The facts of life are that the greatest financial rewards to the insurance company managements that are best at things like screening new applicants; rerating the policies to reflect what they're going to cost in the next year, based on whatever health conditions exist in each group; and, in motivating their sales forces, especially to reward those who bring in only healthy groups. These are the things that lead to profitable operation by insurers in these markets, and, conversely, drive insurers out who try to give people more stable rates and to spread the risk of high cost conditions around. The competitive edge of those who effectively select is so great that others must either imitate or be driven out. These incentives could be corrected through regulation. There are also many other ways that we could reduce the cost of administration of private health insurance.

I'd like to direct my last comment to "a general warning." It is crucial in redesigning the health-care system to correctly identify the reasons why we spend so much more on administration than the Canadians do. There are other possible causes. One is the pervasive impact of our legal system. A necessary component of defense in any court of law against a malpractice suit is very extensive documentation of the care that was provided.

I've spent a lot of time in emergency rooms during the last few years because of my son's athletics. And it seemed to me that they're more busy documenting what they did than doing it. After all, if you can't prove you did it, it won't hold up in court.

Another aspect is that managed care requires very extensive documentation, and we do this in a very different way than the Canadians do. I would like to note that the Congress has been the leader in adding managed care procedures, such as the peer review organizations and mandatory utilization review.

Finally, we have paid hospitals and physicians for over 50 years on a cost-plus-basis. The more a hospital spent, the more it received. We used

a slightly more subtle way to pay the doctors. We paid them what they collectively charged within each specialty for any procedure. So, why is it a surprise that after decades of this we spend more on practically every aspect of medical care than the Canadians do? It's not just limited to insurance or to billing costs. It's pervasive. It's throughout our health-care system. We must make sure that any new system we devise is going to provide the incentives for efficiency that would lead to a lower cost health-care system. To do this, we must be sure that we identify correctly the causes of present inefficiencies.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Trapnell follows:]

PREPARED STATEMENT OF GORDON R. TRAPNELL

The Cost of Health Insurance Administration

1. Introduction

I am going to discuss:

- o Estimates of what we spend to administer health insurance in the U.S.
- o What specific functions this administrative spending is for
- o The impact of turnover of insurers on the level of expense
- o Components of turnover costs
- o The implications for national policy.

2. Estimates of Administrative Costs by Type of Insurer

In 1991, around $28 billion will be spent on the administration of private health insurance in the U.S. Governments will spend another $9 billion to administer Medicare, Medicaid and other government health programs. Together these will constitute approximately 6.7% of personal health expenditures in the U.S. Insurers will also collect around another $4 or $5 billion from policyholders, which will be held to pay for future health care costs or returned as dividends credited against future premiums. The $25 billion includes around $2 billion of premium taxes, which is really not a cost to administer insurance, but rather a revenue source for state governments. Thus the relevant expenditure for private health insurance administration is closer to $26 billion.

This estimate differs from that published by the Health Care Financing Administration by excluding amounts collected by insurers that are retained to pay future health care costs or otherwise held on behalf of policyholders. This includes the increase in policyholder "active life" reserves, amounts that will be used to pay dividends or rate credits and "rate stabilization reserves". (It excludes claim reserves, which are part of claims incurred, and comparable items.) The estimate includes an allowance for the average profits earned by insurers (including contributions to the surplus of Blue Cross and Blue Shield plans and HMOs) over underwriting cycles. (The profit that will be earned by insurers in 1991 is unknown, and will undoubtedly be either higher or lower than estimated.)

Although these estimates are compiled from public data sources (supplemented by some data obtained from associations), the estimates reflect my own analysis. The estimates differ in minor ways from those of my colleagues in the Health Care Financing Administration, but the story is the same familiar one concerning the order of magnitude. As noted, the estimates do not include the costs of hospitals, physicians and others to bill patients and insurers and keep track of payments, or the costs imposed on providers by "managed care" systems.

Table 1 shows an administrative cost model for employer sponsored health insurance constructed partially from data obtained from HCFA's Survey of Health Insurance Plans in 1984 and partially from data furnished by Blue Cross and Blue Shield Plans and insurers, with the aggregate expenditures by the Blues and the insurance companies controlled to the aggregates reported by their associations. It represents an average over many Plans and insurers with very different levels of administrative expense, and reflects a substantial degree of judgment.

It shows the impact of size on the average cost to administer an employer health insurance plan. The variation is greater for insurance companies than for the Blue Cross and Blue Shield Plans for several reasons. For smaller groups, and for individual policies, the cost of administration for policies insured by insurance

companies is double that for those insured by the Blue plans. The administrative costs of the Blue plans also do not vary as much between individual and group arrangements or by the size of the groups. A major reason for this is the lower sales costs of the Blue plans, many of which do not use outside salesmen, and few of which pay commissions. The Plans also do not spend as much to screen new applicants, with some of the plans accepting all applicants.

Table 2 shows how the cost of selling through agents and brokers affects the administrative costs of health insurance for small group. Data is presented for commissions and other sales costs by size of group. As can be seen, sales costs are far higher when sales are made through insurance agents than the salaried sales forces that most of the Blue plans rely on. (The comparison is not absolute: some of the smaller Blue plans now use agency forces or sell through brokers in a manner similar to the typical insurance company.) For larger groups, there is little difference in sales costs between the Blues and insurance companies, since most of the latter use employees rather than independent agents or brokers in their sales to large employment groups.

HMOs have administrative expenses for employer accounts that are similar to group insurance, averaging around 11% of benefits paid. The cost to administer individual contracts is somewhat higher, around 17%. HMOs that enroll individuals do not usually deal with insurance agents and thus do not incur the very high cost of maintaining sales forces.

3. What is the Administrative Spending For?

As can be seen in Table 1, there are large differences in how much it costs to pay for the administration of health insurance programs. Some of these differences relate to economies of scale for the types of persons or groups insured. But most of the differences relate to what functions the insurers perform. Some insurance arrangements require a number of operations that need not be performed in others, can be performed by employers or can be performed more efficiently in some insurance organizations than in others.

The great variety of functions performed in the administration of health insurance can be summarized conveniently as follows.

- Product development
- Obtaining regulatory approval of products and rates (and rate increases)
- Agency development (or recruitment of brokers)
- Sales commissions and bonuses
- Sales support (sales supervision, training, advertising, printing, conventions, etc.)
- Compliance with regulation intended to improve information provided by agents (e.g. approval of brochures and outlines of benefits, special forms approving replacements, requirements to disclose exceptions, etc.)
- "Underwriting" (i.e. the process of screening applicants)
- Issue expenses
- Collection of premiums and associated accounting
- Maintaining records of eligibility
- Preparation of annual accounting and actuarial data for state regulators and IRS
- Claim administration
- Utilization review (and other managed care functions)
- Legal counsel, investigations and litigation
- Provider relations (and negotiations if preferred providers or similar arrangements)
- General regulatory expenses (e.g. examinations)

Another function, investment of the accumulation of funds that occurs as a result of the lag between collection of premiums and payment of claims or from a rising level of payment over time that is prefunded - are customarily subtracted in determining net investment income, rather than considered as a functional administrative cost. In fact, the apparent cost of administration is often reduced by subtraction of such investment income from administrative charges.

The general corporate overhead costs inherent in any insurance organization can be considered separately, or apportioned over other functional activities, as can the cost of capital tied up in an insurance business and any unamortized portion of original organization expenses.

The list above is very general. For example, the most essential function, claim administration, which is part of every insurance arrangement, can be divided into operations as follows:

- Determine if patient eligible (e.g. premium paid and/or member of the insured group at the time the service was performed or in extended coverage period)
- Determine whether service covered
- Determine whether service for a pre-existing condition
- Determine coverage not fraudulently obtained
- Determine service medically necessary
- Determine COB if employer paid
- Determine any other insurance offset (e.g. workmens' compensation for work connected disabilities)
- Determine if participating provider (if appropriate) and relevant fee scale
- Determine customary and prevailing charges
- Determine cost sharing (deductibles, copayments, deductibles, maximum "out of pocket" or "stop loss")
- Determine validity of assignment (if assigned)
- Determine proper payee
- Prepare and mail check
- Accounting and reporting functions relating to claim payments.
- Data processing for claim studies and rerating

These direct functions must be supported by others, for example:

- Update fee schedules
- Maintain rules to keep pace with federal and state legislation and regulation
- Legal review (increasing affects all procedures, the need to document that all actions fully justified and documented, for legal protection).

The list above does not include the managed care functions that are increasingly incorporated into claim payment procedures on a routine basis by nearly all insurers and many self insured groups.

Claim payment procedures are part of all insurance administrative arrangements. Managing utilization is a function that can be incorporated into any insurance arrangement, although with different potential results. But as complex and pervasive as these procedures may be, they account for less than half of what is spent on administration of health insurance in the U.S. Further, although it is somewhat more expensive per capita to pay claims for small groups and individual insurance than in large groups (where among other advantages the employer may be able to perform some functions more economically), the cost of the basic operations performed does not vary anywhere near as much as the overall cost of administration. Thus although the overall cost of administration by type of insurance arrangement and group size varies from as low as 3% to 4% of benefits paid to as much as 100% of the benefit payments, the cost per capita to process

claims consumes a relatively stable percentage of benefits over different group sizes and insurance arrangements.

This is because it is the administrative functions other than claim processing and managing care that explain most of the variation in health insurance administrative costs by the type of insurance arrangement or the size of the group. In fact, in the administration of very large employment groups, claim processing and managing utilization constitute most of the administrative costs. But overall administrative costs are still only a small percentage of the benefits paid, e.g. in the range of 3% to 5% for employment groups of 10,000 or more. But in small groups and individual insurance, processing claims accounts for only a minor portion of administration, perhaps around 10% of the most expensive arrangements.

4. Impact of Turnover of Insurers

What drives up the price of insurance administration for individual insurance and small groups is the cost of functions that occur primarily because of a turnover of insurers. As I have described in other testimony (Subcommittee on Health, Committee on Ways and Means, Hearings on Health Insurance in the Small Group Market, April 3, 1990), the turnover occurs primarily as a result of the rating practices of insurers and the reactions of the purchasers to rapidly rising rates. Also as explained in testimony to the Congress, these rating practices and the screening by insurers are the expected behavior in response to the economic incentives given to insurers in these markets. (Committee on Ways and Means, U.S. House of Representatives, April 17, 1991) The financial incentives in these markets primarily reward those insurers that insure only healthy persons to begin with (mainly through rigorous screening of new risks, but also by enforcement of pre-existing exclusion clauses and active use of rescission rights) and to set premium rates as close as possible to the expected cost in the next rating period (which may be only six months) for those insured by any policy. Such expected cost based rates are high enough to cover the average cost of continued care of any expensive conditions that are discovered within a group. (I will note my appreciation of how eloquently Dr. Koop was able to illustrate the effect of this kind of rate setting on Public Television. He explained with a couple of episodes of Cinema Verite what I have been unsuccessfully trying to explain for several years in terms of economic incentives and "select and ultimate" actuarial rates.) The results are a high rate of turnover of insurers (with consequently high administrative costs) and that much of the insurance sold is illusory, covering only the conditions that may arise unexpectedly in an otherwise healthy group of individuals, and leaving groups without protection against the cost of deteriorating health of its members.

The point I wish to stress here is that most of the sales and issue activities do not involve first time purchases by either previously uninsured employers or persons not previously covered by health insurance. Most of the turnover is caused either by the rating and administrative methods used by the insurers (responding to the economic incentives given them by the market place) or by changes in employment (in which individuals lose access to an employer plan). These circumstances are outlined in the testimony given before the Committee on Ways and Means, U.S. House of Representatives, on April 17, 1991.

As already noted, a very large proportion of the cost to administer individual, association and small group arrangements is attributable to turnover. Thus we as a nation incur high administrative costs to insure again those already insured. This waste of resources occurs as a result of our failure to regulate these markets in a manner that will reward those insurers that administer and manage care most efficiently, rather than those that are most adroit in sales, screening and raising rates to match the deteriorating average health in each group of individuals insured. Only if these incentives are changed, which would require a radically different

approach to regulation than any contemplated by the NAIC or the insurance business, will the cost of administering insurance likely to fall significantly.

Other costs are associated with a different kind of competition, to shift costs to others - and in some cases - to prevent having costs shifted to them. Some of the activities of insurers are more directed to shifting the cost of care to other payers than to reducing the overall cost (e.g. by paying a lower portion of hospital overhead than other payers). Other activities are more directed to persuading providers not to bill rather than reduce services, by requiring excessive paper work. Such activities may reduce the cost to particular payers, but do not reduce overall expenditures.

5. Components of Turnover Costs

The costs directly associated with turnover include commissions, bonuses, sales support, underwriting, and issue expenses. Indirect expenses that occur mostly as a result of turnover also include the cost of recruiting and maintaining an agency force or brokerage force, and most of the activities of the management of insurers, since most sales are to transfers, and only a few are to first time buyers. Similar considerations lead to including nearly all of the cost of administering preexisting exclusion clauses, rescissions, etc., of which only a very small part is for persons being insured for the first time, and most of the cost to regulate sales (e.g. all those additional forms that have been the regulatory response to agent abuses, that you sign without paying much attention if you trust your agent).

The cost of turnover also varies by the type of insurance arrangement and the size of the group insured. The cost is by far the highest with individual insurance, for which it is not unusual for nearly all of the first two years premiums to be taken up by administrative expenses. On the other hand, many of the Blue Cross and Blue Shield Plans and most HMOs that enroll individuals do not pay commissions or support expensive sales staffs. Consequently, their expense ratios are only moderately higher than for group insurance. The cost of transferring the smallest groups from one insurer to another are similar to those for individual insurance, and the rate of turnover for many insurers is higher than the case for individual insurance. At the other end of the size spectrum, sales and issue related expenditures require only a small portion of premiums, and do not increase the cost of insurance significantly. This is especially the case when the group is self insured, and there are no commissions or other agency costs involved.

Unfortunately, the rate of turnover is highest for individual insurance and very small groups (under ten employees). The rate of turnover falls dramatically as size increases - and as the cost of transition falls. At the extreme, there are no turnovers by definition among self administered self insured plans.

These considerations lead us to examine why there is a high rate of turnover among individually insured persons and small employers. The major reasons for this include:

- o The facts of life of competition that face the insurers, which favor those insurers that rerate the most aggressively and screen new applicants most rigorously.
- o Misunderstanding by the public, including many employers, of the nature of insurance, and their often misguided attempts to find a lower cost insurer.
- o Loss of business by those Blue Cross and Blue Shield Plans that still use some form of community rating or that have high cost enrollments accumulated as a result of open enrollment policies or less rigorous screening policies.
- o Lower premiums available to a small employer plan willing to accept a new pre-existing exclusion clause or to exclude persons who have become very expensive to insure.

- Success of some insurers in selling services that appear to reduce outlays by more than is apparently actually achieved (especially some PPOs).

It is also still possible under some insurance arrangements to leave an insurer with a deficit accumulated under a participating contract, although these contracts are increasingly rare. (There has also been movement among larger groups to self insured arrangements, in many cases reflecting the success of third party administrators (copied by some insurers offering administrative services only policies and vendors of self administration support services) in selling employers on the very low first year cost that occurs when an insured group that has been paying premiums in advance becomes self insured, and gets a free ride for three or four months from the lag between when services are performed and payment for them is made.)

There are also some of the traditional economic gains expected from competitive markets, that is from gains by those insurers or administrators able to offer the insurance services more efficiently or effectively. This can occur through a lower cost provider network, lower administrative costs, more restrictive claim payment procedures, or a lower option plan.

By my observation, however, the returns to insurer managements from investing time and energy in offering more efficient management and administration is still too low compared to that from concentrating on sales, screening and rating. Consequently, the managers of the departments that deal with small groups devote their primary attention to the latter functions, since these are essential to survival in the market place. In addition, there also does not appear to be much capacity among employers to determine which vendors can really reduce the cost of health care. This may change dramatically in the future, as more administrative companies (including insurers) develop effective means of determining inefficient practice patterns and assemble cost effective PPOs and other methods to control utilization. In addition, employers will become more sophisticated in determining which vendors will be most effective in reducing their costs.

In summary, a large proportion of the administrative costs of private health insurance appears to be the result of a high rate of turnover among insurers of individuals and small groups. As I have explained elsewhere, the root causes of the turnover are market incentives that must be changed through regulation if these costs are to be reduced. Further, the other effects of turnover, on the insured persons particularly, are more adverse than the economic burden of turnover administrative costs. These expenditures benefit only those who draw compensation directly from them, especially those involved in the sales and administrative organizations.

6. Implications

Finding the remedies for the large and apparently unproductive expenditures by our society for health insurance administration is not as easy as diagnosing the causes. The potential solutions are as complex as the problems that must be solved, and many simplistic approaches may produce counterproductive results. Further, nearly all of these expenditures constitute the incomes of employed persons. In addition, premium taxes are an important source of income to the states, and insurers pay other federal and state taxes. The most productive solutions would be those that change the fundamental incentives given to the insurance business to direct their efforts more to reducing the cost of insurance and increasing the effectiveness of the care paid for.

It is still more important not to embrace apparent remedies that may not only fail to reduce our spending for health care, but might wind up increasing it. In this regard, it is especially important to identify correctly the causes of spending for administration of health insurance and to be sure that any proposed solutions actually attack the real problems. For example, there has been much discussion

in the media lately of adopting a Canadian like system, at least as far as certain features of the Canadian system are concerned such as paying for most acute health care from a single government program. In particular, the thesis has been advanced repeatedly that adoption of a "single payer system" would eliminate nearly all insurer expenses and a large proportion of provider administrative costs as well. But several proposals being advanced would actually increase the proportions of health care paid for by health insurance without reducing the number of payers. Further, if there are deductibles or copayments in a new program, these may be picked up by private supplemental health policies, with administrative costs almost as high as current spending. It should be considered that the administrative costs of Medicare supplement policies exceeds that spent to administer the Medicare program.

A National program funded in a manner similar to Medicare without any deductibles and coinsurance may well have unit administrative costs similar to those of the Medicare program, which are currently only a little over 2% of benefits paid. But the percentage would rise, since the average size of the bills paid would fall. The average might rise as high as 3% or 4%, and of course apply to all health spending, which would in turn rise as a result of increased demand.

The impact on the administrative costs of providers is more difficult to project. For one thing there is far less documentation of what proportions of the administrative costs of providers are really caused by collecting bills from a multitude of insurers, the Federal Government and from patients. Further, the relevant question is not what we spend compared to the Canadians, but what we would spend if we adopted a single national program.

There may be other causes of the higher level of spending for administration by providers in the U.S. than in Canada. To the extent that these causes persist under a single payer system, provider administrative costs will not fall as anticipated. Further, there are several aspects of the conditions under which our providers operate that are very different than those in Canada, that have not been adequately investigated. One is the impact of our legal system. Fear of malpractice suits has led most hospitals and physicians to change their procedures in radical ways. One aspect of this is to provide for documentation of all aspects of care, especially that for surgery and hospital services. The impact of such documentation on administrative costs has not been investigated.

Another major difference in how medicine is practiced between the U.S. and Canada is the demands for controls on utilization. Complying with utilization review increases provider costs by an unknown degree. It is not clear that the record keeping required to comply with utilization review are any less than those needed to bill multiple insurers. The Congress itself has been a leader in requiring utilization review and setting up peer review processes.

Other actions taken by the Congress have also increased health insurance administrative costs. Almost any reasonable estimate of the private cost to administer "Medicare secondary payer" programs exceed the amounts collected. But Congress adopted the employer payment responsibility to reduce its visible costs, without considering the impact on private employers and insurers. There is no reason to believe that the U.S. would be any less concerned over who got what services and why in a single payer system than with multiple payers, or would be less inclined to adopt laws and regulations that drive up unit costs of providers, patients and employers compared to what the Canadians would spend. For example, the multiple that the U.S. spends on health services research compared to Canada greatly exceeds the comparable multiple on any other aspect of our health care system. The reason is simple, the Congress believes such expenses are in the public interest, but the Canadian Parliament is not willing to pay for them.

Another plausible explanation for the higher cost of administration in the U.S. than in Canada is the cumulative effect of how we have paid hospitals and physicians for many decades. Especially from 1965 until recently, those hospitals that spent the most were paid the most, and nearly all health insurance programs based payment to physicians on whatever they charged collectively. Payment for outpatient services is still on a cost plus basis, and the cost is still increasing rapidly. It should be no surprise to anyone that we pay more for every aspect of health care than the Canadians do, including nurses and administrators' salaries, equipment, gift shops, cafeterias, etc. - and of course hospital libraries. The explanation of the level of cost would appear to lie more with Professor Parkinson's first law of bureaucratic growth than to multiple payers.

7. Compared to What?

The cost of administration, both for health insurance and for providers, is only relevant to health policy if their are alternative policies that can change them. Thus the relevant question is not what we spend but what we might spend under some alternative set of national laws that might conceivably be enacted. Further, it is the total spending for health care that is most relevant to the overall distribution of national resources, not what is spent for administration. Providing care more efficiently may be more important than administrative costs. Finally, as noted above, there are many apparently unnecessary expenditures under the present system, especially as relates to the cost of turnover of insurers and incentives given to insurers to concentrate on matters other than providing insurance efficiently. Many other inefficiencies can be identified and measures devised to improve performance of administrators. Correcting these perverse incentives could also achieve major reductions in the cost of administration under multiple payers. It should be noted that there are other countries (e.g. Holland and Germany) with multiple payer systems that do not result in administrative costs as high as we pay. Their examples may be as relevant for us as that of the Canadians.

Table 1

Estimated Ratios of Administrative Expenses to Benefits Incurred in Fully Insured Plans in 1984

Number of Employees Covered	Blue Cross/Blue Shield	Insurance Company
1-49	17.5%	36.4%
50-99	13.6%	16.8%
100-249	11.2%	14.9%
250-999	10.2%	12.2%
1000-4999	9.0%	10.3%
5000-19999	7.0%	8.0%
20000-49999	5.6%	6.9%
50000+	4.7%	7.1%

Table 2

Average Commissions and Other Sales Costs
by Type of Insurance and Size of Group

	Blue Cross/Blue Shield	Insurance Companies
I. Individual Policies	5.0%	40.0%
II. Group Insurance		
2-4	2.5%	25.0%
5-9	1.5%	20.0%
10-24	1.0%	17.5%
25-49	0.5%	7.5%
50-99	0.3%	5.0%
100-199	0.2%	3.0%
200-299	0.1%	2.5%
300-399		1.5%
400-499		1.0%

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Trapnell.

Next, we have Seymour Sternberg. Mr. Sternberg is Executive Vice President of the New York Life Insurance Company in charge of the Group Insurance Department. He is testifying on behalf of the Health Insurance Association of America. Before joining New York Life in 1989, Mr. Sternberg spent 13 years at the Massachusetts Mutual Life Insurance Company.

Please proceed, Mr. Sternberg, when you're ready.

STATEMENT OF SEYMOUR STERNBERG, EXECUTIVE VICE PRESIDENT, NEW YORK LIFE INSURANCE COMPANY, REPRESENTING THE HEALTH INSURANCE ASSOCIATION OF AMERICA

MR. STERNBERG. Thank you, Mr. Chairman.

The focus of my testimony is on U.S. insurer operating expenses, what these costs consist of, how and why these costs vary by the size of the group insured, what value insurers provide in exchange for these costs, and how these costs figure into the larger picture of health-care reform.

HIAA data show that insurer operating expense averaged 12.9 percent of premium. However, no one number accurately reflects insurer operating expenses, because operating expenses are a function of the size of the group covered.

As I will discuss in a moment, expenses associated with a particular group may be as low as 4-5 percent or as high as 25 percent, depending upon the size of the group.

Insurer operating expenses fall into five basic categories: taxes, plan administration, risk and profit, claims administration, which includes managed care and sales cost.

Taxes for group business average between 1-3 percent of premium and include state premium taxes, licensing fees, and federal income tax. As premiums have been rising, states have received increased revenues from insurers.

General administration expenses average about 4 percent of premium. This category includes the cost of underwriting a new case, collecting premiums, tracking enrollment, communicating with employers and employees, and maintaining and upgrading facilities in computer systems.

Risk and profit charges average less than 2 percent of premium. Between 1980-89, the average net operating gain for HIAA's 20 largest group and individual companies was 1.72 percent of total premiums. Claims administration expenses average 4 percent of premium.

Steps involved in processing claims include verifying the eligibility of claimants, implementing managed care provisions, providing information about claim processing decisions, and identifying fraudulent claims.

The final component of insurers' operating expenses is sales costs, including advertising by companies and agents and commissions paid to agents and brokers. Sales costs average 2 percent of premium across all group sizes and plan types.

I want to emphasize again that these percentages are industry-wide averages and that there are large variations in operating expenses across groups of different sizes.

To get a sense of how operating expenses vary as a percentage of premium, I would like us to look at three charts representing three groups of different sizes. And in our written testimony, these charts follow page 245. I apologize for the size of the print; it's a little small. But, I'll try to take you through the charts.

For the smallest size group plans up to 25 lives, operating expenses may be as high as 25 percent. The chart indicates this worst case scenario and illustrates the breakdown of operating costs among the components I discussed— federal taxes, 2 percent; state taxes, 3 percent; sales and commissions, 6 percent. Profit charge is 4 percent; plan administration is 6 percent; and claims administration is 4 percent. By comparison, for a group of between 100-499 lives, operating expenses average 14 percent.

The third chart illustrates the breakdown for a large group, over 2,500 lives. And you'll see at this point that operating expenses have fallen to only 6 percent of total premium.

Why is there such variation in operating expense ratios across different size groups?

The primary reason is that some expenses remain relatively fixed in absolute dollar terms, regardless of the size of the group insured. Consequently, as the percentage of premium paid, these costs are higher for smaller cases and lower for larger cases.

Sales cost and plan administration fall in this category. For example, an agent spends roughly the same amount of time selling a policy to a small employer as he does to a larger employer. It makes sense that he should receive roughly the same net compensation. Also, agents who sell group health policies to small employers usually provide continuing service to that employer, such as answering employees' questions and interacting with the insurance company. A large employer typically has an employee benefits manager to handle these matters. A small employer rarely can afford that luxury.

Agent compensation, when measured as a percentage of premium, is smaller for a large group than for a small group, both because it's measured in comparison to higher premium and because the agent often provides additional service to the smaller group.

In contrast, other types of operating expenses vary directly with the size of the groups, claims administration is an obvious example here.

Insurers work continually to find ways to operate more efficiently. The most important activity now underway to reduce operating costs of providers, as well as insurers, is the development of a uniform electronic claims-filing system. When effective, this system will reduce paperwork for everyone and facilitate more rapid payment to patients and providers.

The first phase of this project is now being pilot-tested. Medicare will begin testing in four states in October 1991. The HIAA is an active

participant in this effort, and we're confident that it will result in a more efficient, less costly claim system.

The uniform claim system and other issues will be discussed with Secretary Sullivan at the Summit meeting that he recently announced to discuss the issues of operating costs in the U.S. health-care system.

The HHS Summit is aimed at finding appropriate ways to reduce administrative expenses, and we look forward to participating in this effort.

Mr. Chairman, one of the things that disturbs me most about the current health-care reform debate is the assumption by many that the U.S. system can be improved by reducing or eliminating private health insurers. But the value of the private health insurance system cannot be determined merely by looking at operating expense to premium ratio. It involves balancing the costs incurred and the services provided in order to offer the best overall value to the public. Clearly, it costs the U.S. more to administrative our pluralistic health-care system than it costs the Canadians to run their unitary system. But competition and innovation in our private, free market insurance system results in real value to the American public. For example, the newest piece of claims administration function and the one that has the greatest potential for assuring best quality medical care at the lowest price is the implementation of managed care provisions in benefit plans.

Managed care has as its primary objective the delivery of effective, appropriate medical care. When experts agree that 25-40 percent of medical services provided yield no significant medical benefit and, in some cases, are actually harmful, it's clear that we need to focus administrative resources on making sure that the care received by the insured is appropriate and of high quality.

Competition among health insurers creates other significant benefits for the American public. For example, competition encourages positive technological innovation. This encouragement is lacking in a single-payer system and results in many non-U.S. citizens, including Canadians, coming to the U.S. for high-tech diagnostic and therapeutic treatment.

U.S. insurers also compete vigorously in the area of customer service. New York Life has recently made a substantial investment in new computer systems and is placing an increased emphasis on the quality of services provided to our customers.

This type of effort results in the system's innovation and improved quality of service in claims handling.

And, finally, as we consider whether competition in the insured's market is worthwhile, we must remember that the American public values choice, unlike any other consumer in the world.

A recent Harris Poll found that less than 20 percent of national leaders would prefer a health-care system with a single plan for everyone.

A competitive private health insurance system gives the American consumer a range of options to choose from and trade-offs to make.

It makes no sense in either a budget or health policy grounds to eliminate the competitive insurance industry that provides both choice and value in our health-care system.

Mr. Chairman, in conclusion, I know that today's hearing is primarily concerned with administrative costs. But please permit me to direct your attention to what we believe to be the more fundamental issue.

I would like to return to the charts that we used earlier. You'll note that, in each of these illustrations, the claims component of cost accounts for a far greater percentage of overall costs than do operating expenses, 75 percent for under 25 life groups to 94 percent in groups over 2,500 lives.

Furthermore, what's not shown on these charts is the rate of growth of each of these segments. At New York Life, for each of the past three years, the claims component—that's hospital and doctor's costs—has been growing at 20 percent per year; while most elements of the administrative piece, which are largely driven by salary increase, are only growing at 5 percent.

If we were to eliminate the private sector entirely and overnight bring administrative costs to zero, it would take less than 18 months for the cost of medical insurance for the 25 life group to return to its current level. And less than four months for us to be in the same boat for the 2,500 life group.

Mr. Chairman, while some might want to redirect the discussion to the easier administrative cost issue, it's important to this country that we focus our attention on the basic problem: the cost and utilization of medical care in the United States.

I can't emphasize this strongly enough.

The underlying reason that health insurance premiums are rising so quickly in the United States is not that the private insurers are inefficient or are reaping huge profits. The reason that health insurance premiums are rising at double-digit rates is that the cost of utilization of health care is rising at double-digit rates.

A constructive national debate predicated on a rational discussion of the dynamics of our health-care system can be found at only an approach that recognizes that each of the payers of our system—Federal Government, states, and the private sector—has a responsibility to meet.

The health insurance industry has developed its action plan with this concept as a cornerstone. We're prepared to work to achieve a responsible and affordable health-care system.

Mr. Chairman, thank you again for the opportunity to appear today. I would be happy to answer any questions after the prepared remarks.

[The prepared statement of Mr. Sternberg, together with attachments, follow:]

PREPARED STATEMENT OF SEYMOUR STERNBERG

Mr. Chairman and Members of the subcommittee, I am Seymour Sternberg, Executive Vice President, New York Life Insurance Company. I am here today representing the Health Insurance Association of America (HIAA) in response to your request for comments on the issue of the operating costs of the U.S. health insurance system. I offer these remarks as a member of a trade association of more than 300 member companies in the business of providing health insurance. HIAA's member companies insure 98 million people. In 1989, the latest year for which we have data, all private insurers, HIAA members plus the Blue Cross plans, covered 76 percent of the population or 189.0 million out of 249.9 million Americans. Persons covered either by private or public health insurance totalled 216.6 million.

Despite this impressive level of coverage, many individuals and employers are unable to afford health care and health insurance. Appropriate steps must be taken to assure availability and affordability of health care and health insurance. The HIAA's suggestions for comprehensive reform are outlined in Appendix A.

The focus of my testimony today is on insurer administrative costs or, more properly, operating expenses[1] and the role they play in overall health insurance costs. Lately, there has been a great deal of interest in the assertion that the problem of how to finance health care for currently uninsured Americans can be solved easily. "It's simple," the advocates say. "Just do away with private insurance. The administrative savings from having a single (government) payer run the system would be more than sufficient to provide full health care coverage for everyone."

This premise has no foundation in reality. The claims of enormous administrative or operating savings from moving to a single payer system are greatly exaggerated. No doubt a unitary government-run health insurance system would spend somewhat less on "overhead" than our current pluralistic system. But these small savings do not justify the other consequences that would flow from the adoption of a government-run system. The Canadian experience demonstrates that moving to a government-run system would produce other significant consequences -- consequences that Americans would find totally unacceptable. For example: limitations on the choice of benefit plan; long waiting periods for certain services and providers; and "rationing" high technology diagnostic and therapeutic equipment. A 1990 HIAA study shows clearly that Canada has not been more effective than the United States in controlling the growth of real health spending per capita.[2] A centrally controlled, universal system is unlikely to effectively implement the elements of the U.S. system that have proven most efficacious at controlling health care costs.

---

[1]I will use the term "operating expenses," rather than "administrative costs," when discussing the private health insurance system, since the term is more common in the insurance industry and technically more correct. In the insurance business, "administrative expenses" are often interpreted to mean only expenses directly related to administering a plan. Operating expenses include the full range of insurer overhead costs, including expenses directly related to administering a plan, as well as other expenses such as legal fees and the cost of complying with state laws. For our purposes today, "operating expenses" will also be understood to include taxes paid, as well as profit and/or loss.

[2]Edward Neuschler, Canadian Health Care: The Implications of Public Health Insurance, Washington, D.C.: Health Insurance Association of America, June 1990.

The value of the private health insurance industry cannot be determined merely by examining an operating expense-to-premium ratio. Rather, it also involves balancing costs incurred and services provided in order to offer the best overall value to the consumer. That is the genius of the American free market system, and no bureaucratically controlled system can match it. In calling for a "summit meeting" to discuss administrative costs in the U.S. health care system, Health and Human Services Secretary Sullivan recognized the complexity of this issue and the need to look for appropriate ways to reduce unnecessary administrative costs. The HIAA looks forward to participating in that effort with Dr. Sullivan.

Today I'd like to examine with you in greater depth the allegation that insurance companies spend too much on operating expenses -- broadly defined -- and not enough on benefit payments, as a percent of premiums received.

In 1990, according to the most recent figures available from the Health Care Financing Administration (HCFA), the operating cost[3] of our entire system of private third-party coverage for health care expenses was $30.7 billion, representing about 14.2 percent of total premiums paid (including premium equivalents for self-insured plans) and only about 4.6 percent of the total national health care bill. This figure tends to vary in a cyclical fashion depending on whether insurers are making or losing money in a particular year. Since 1960, operating cost has varied from a low of 9.3 percent of premium to a high of 15.1 percent, and has oscillated between those extremes a couple of times. (See Chart 1.) The average cost over the entire most recent cycle was about 13 percent, which is a better indication of the long-run average than any one-year figure.

The HCFA operating cost figure is an average, of course, and it masks considerable variation in the operating expense of various types of health care coverage arrangements. Self-insured health benefit plans have the lowest total operating cost for three main reasons. First, they do not have to pay state premium taxes. Second, by assuming the risk themselves, employers who self-insure avoid the costs associated with purchasing insurance to protect against that risk. Third, all large groups, whether insured or self-insured, benefit from economies of scale; and, self-insured employers tend to be larger, on average, than insured employers. (This is true because, for the most part, only large employers have the financial wherewithal to accept the risk of self-insurance.)

Self-insured plans have the lowest operating costs regardless of whether they are administered by the employer itself, by a Blue Cross plan, by a commercial insurer, or by an independent claims administrator. In fact, managing large self-insured health benefit plans is a major component of commercial health insurers' business. In 1989, fully self-insured plans accounted for one-third of commercial insurers' group health business, and partially self-insured plans -- also called "minimum premium plans" -- accounted for another 21 or 22 percent.

In contrast, fully insured health plans have higher operating expenses than self-insured health plans for three main reasons. First, fully insured plans must pay state premium taxes, which are typically set at 2 to 3 percent of premium for commercial insurers in most states. (In many states, Blue Cross/Blue Shield plans pay lower or no premium taxes.) Second, fully insured plans cover primarily small employers, and it is more expensive for an insurer to deal with, say, 100 groups with 10 employees each than to deal with one 1000-member group. (The reasons for this are discussed below.) Third, any business has to generate a positive return

---

[3]HCFA actually calls its estimate the "net cost" of the private health insurance system, which includes all operating expenses, taxes paid, and insurers' profit or loss. To avoid confusing the issue by using different terms for the same concept, I will use the term "operating cost" or "operating expense" to include all the components HCFA includes in its "net cost" concept.

on invested capital -- a profit -- if it wants to stay in business for very long, and insurers are no exception. Thus, the apparent operating cost of commercial health insurance in any given year is affected by whether the industry as a whole made or lost money in that year. If we made money, our operating expenses appear to go up; if we lost money, our expenses look lower.

I hasten to add that insurance company profits are not a very large portion of the operating cost of private health insurance. Between 1980 and 1989, the average net operating gain for HIAA's 20 largest group and individual companies was only 1.72 percent of total premiums. Profits ranged from a high of 5.25 percent of premium in 1985 to low of -1.56 percent (loss) in 1981. (See Chart 2.)

More generally, what do the operating expenses of insurers consist of? Let me take a few moments now to explain the kinds of expenses insurers incur in operating a health benefit plan. Then I'll talk about how these expenses vary depending on the size of the group being covered.

Oper. Cost of Private Health Insurance as a Percent of Total Premium Payments

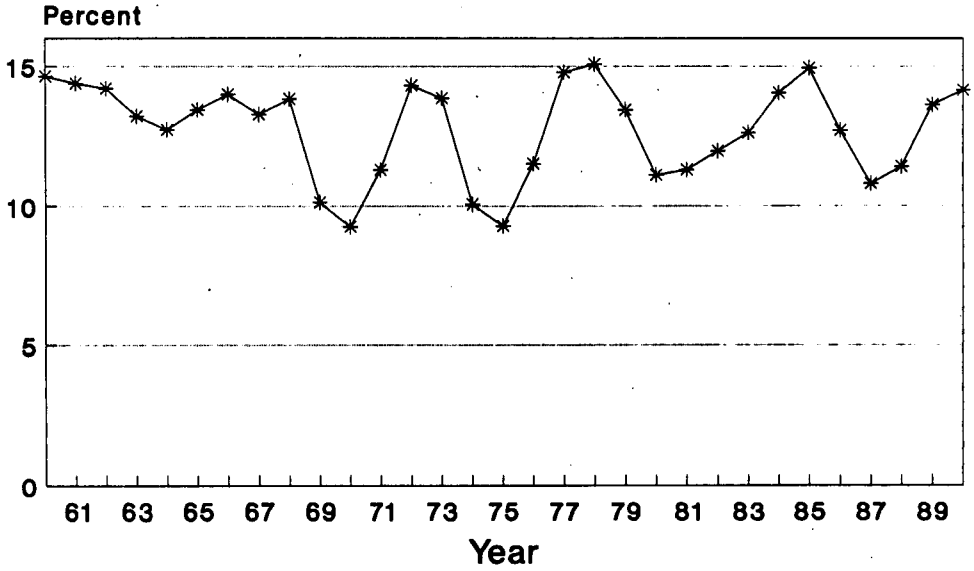


Chart 1

Source: HCFA Off of Nat'l Health Stats.
"Operating Cost" includes all operating expenses plus profit less int. income

Chart 2: Net Operating Gain as Percent of Premium for Group and Individual Business: 20 Largest HIAA Member Companies, 1980-1989

YEAR	PREMIUMS (Thousands)	NET OPERATING GAIN OR (LOSS) (Thousands)	GAIN OR (LOSS) AS A PERCENT OF PREMIUM
1980	$17,824,853	($27,096)	(0.15%)
1981	18,455,376	($228,456)	(1.56%)
1982	19,757,580	$250,685	1.27%
1983	21,896,368	$598,308	2.73%
1984	23,101,041	$913,934	3.96%
1985	22,869,946	$1,200,914	5.25%
1986	22,867,444	$732,903	3.21%
1987	25,603,810	($239,463)	(0.94%)
1988	28,480,682	$145,928	0.52%
1989	31,473,343	$698,149	2.22%
1980-89	**$232,330,443**	**$3,985,806**	**1.72%**

SOURCE: HIAA Annual Survey

There are five major types of expenses insurers incur to administer health benefit programs:

- Taxes
- General administration or plan administration
- Risk and profit
- Claims processing expenses (including managed care)
- Sales costs

These expenses are offset to some extent by

- Net investment income

For insured group business, taxes generally consume about 3 percent of total premium. They include state premium taxes, licenses and fees, federal and state income taxes, and other taxes such as corporate and property taxes. For self-insured group business, taxes are minimal.

"Plan administration" or "general administration" expenses include everything from collecting premiums and tracking enrollment to client education, auditing and regulatory compliance (and everything in between). The industry-wide average is roughly 4 percent of premium, although, again, there is considerable variation around this average. Insurers vary in how they categorize their various costs, and insured employers vary in the tasks other than claims processing that they ask their insurers to undertake.

As I noted, risk and profit charges average less than 2 percent of premium. Net investment income contributes an amount equal to roughly 2 percent of premium but, again, the amount varies considerably among companies and plan types.

The fourth component of insurer operating expenses is claims processing; these costs average 4 percent of premium but can vary between 2 and 6 percent, depending on factors such as the extent of claims review and the amount of reporting the client has requested. The many steps involved in accurately processing claims include: verifying that the claimant is an eligible insured; verifying that the services and providers are covered; coordinating benefits among multiple payers; identifying and pursuing possibly fraudulent claims; and informing claimants of decisions.

Implementing managed care provisions of benefit plans is a very important operating expense that has grown significantly in the last decade. This expense varies depending on the exact features included in each employer's plan. HIAA does not have a separate estimate of the cost of implementing managed care provisions. Some insurers include managed care in the claims processing category, while others consider it a part of plan administration.

The final component of insurer operating expenses is sales costs, including general marketing and advertising by companies and agents, as well as commissions and fees paid to agents and brokers. Sales costs average 2 percent of premium across all group sizes and plan types, but this is an area where the percentage varies greatly by size of group. (More on this in a moment.)

The percent-of-premium figures I have given for the various components of operating expenses should be taken as illustrative, rather than definitive. Different companies classify particular expenses under different headings, so the breakdown may vary considerably across companies.

Because operating expenses vary considerably, depending on the size of the group and the type of plan (self-insured v. fully insured, extent of utilization management activities, comprehensive v. special purpose coverage, etc.), calculating an industry-wide average is difficult and, in many ways, not particularly meaningful. Nevertheless, due to the extensive interest in this issue, HIAA has been examining this question, using data submitted by its member companies.

Preliminary results suggest that, on average across large and small groups, the operating cost of comprehensive group hospital and medical benefits coverage is in the range of 12 to 13 percent of premium. If average taxes paid are subtracted from operating expenses, the range would become 10 to 11 percent for comprehensive group coverage. HIAA is continuing its work in this area and should have more definitive results in a few months.

Let me give you a sense of how operating expenses vary as a percentage of premium revenue across groups of various sizes. For large, self-insured groups of 2500 or more employees, insurers' operating expenses can be as low as 4 percent.[4] By contrast, insurers' operating expenses for groups of fewer than 25 lives (almost all of which are fully insured) range up to 25 percent or so of premium. The charts on the following pages illustrate operating expenses as a percent of premium (or premium equivalent for self-insured groups) for five different group sizes.[5]

---

[4]Costs are higher for the relatively few large groups that choose to be fully or partially insured, due to the factors noted.

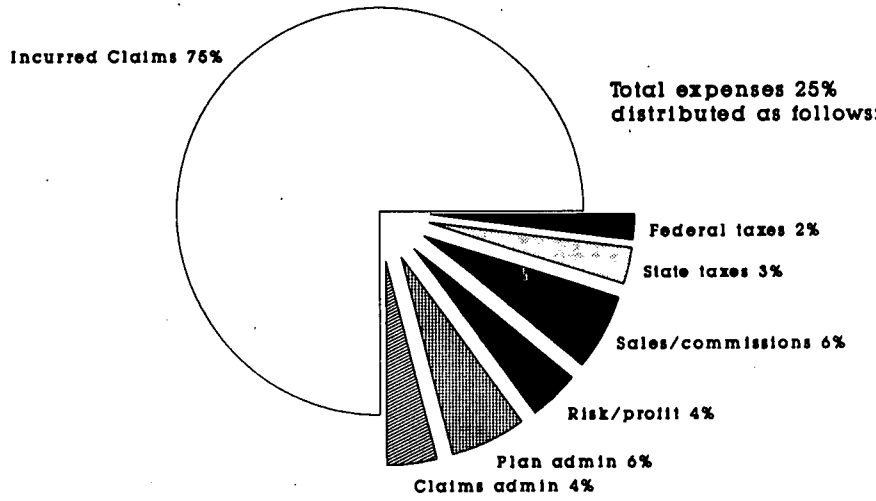
[5]These charts are the preliminary results of an actuarial study currently underway at HIAA but not yet fully complete; therefore, the figures remain subject to revision. Nevertheless, HIAA believes they accurately illustrate how operating expenses vary by size of insured group.

It should be noted that, for each group size, operating costs have been averaged across insured and self-insured groups, according to the actual distribution of insured v. self-insured business in that size category. Thus, in particular, the operating expenses shown for groups of 2500 or more employees are slightly higher than would be experienced by a self-insured group, because the higher operating costs of the relatively few insured groups of that size (largely due to premium taxes) have been averaged in.

Note also that figures have been rounded to the nearest percent to avoid false precision. Thus, the figure "4%" for an expense category in one chart may have been rounded up from 3.6 percent, while the same entry for another expense category or on another chart may have been rounded down from 4.4 percent.

Operating Cost for Group Health Coverage
(as a percent of earned premium)

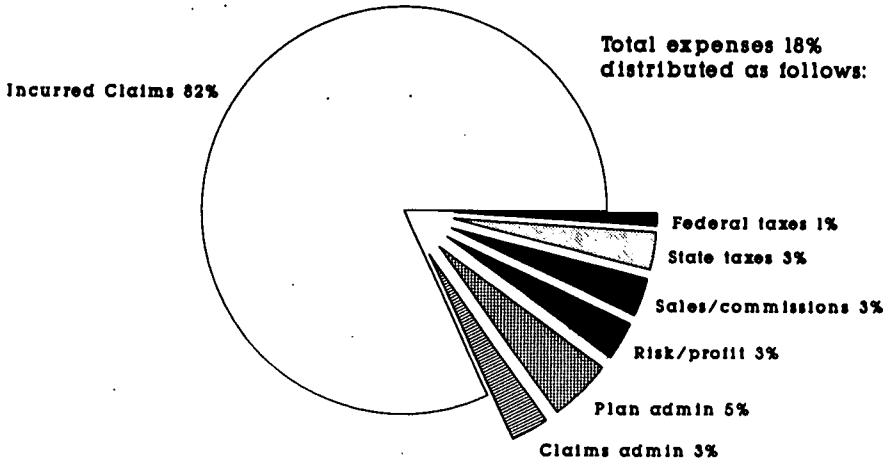
Groups with fewer than 25 Employees



Source: HIAA

Operating Cost for Group Health Coverage
(as a percent of earned premium)

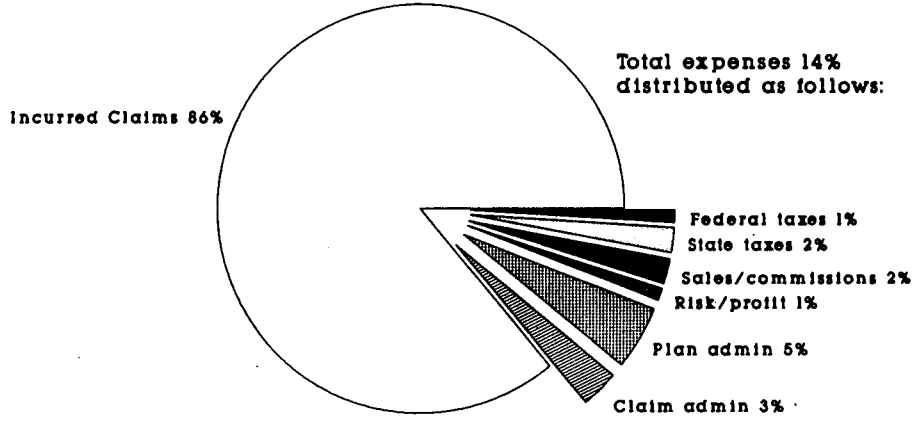
Groups with 25-99 Employees



Source: HIAA

Operating Cost for Group Health Coverage
(as a percent of earned premium)

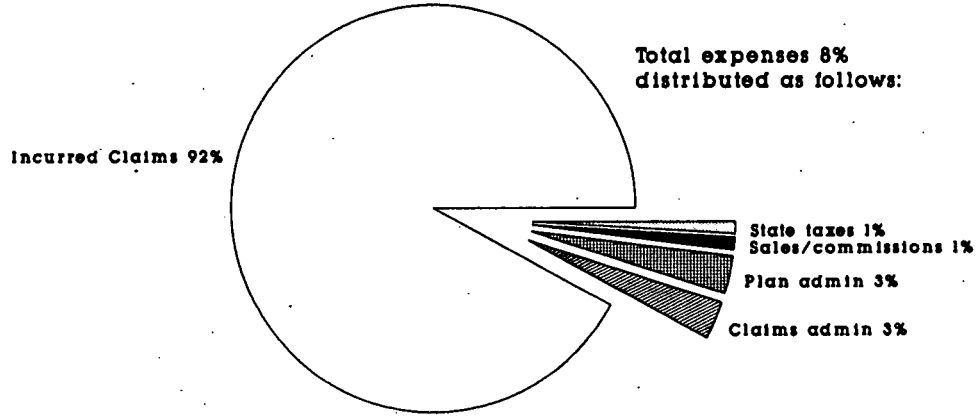
Groups with 100 to 499 Employees



Source: HIAA

Operating Cost for Group Health Coverage
(as a percent of earned premium)

Groups with 500-2499 Employees

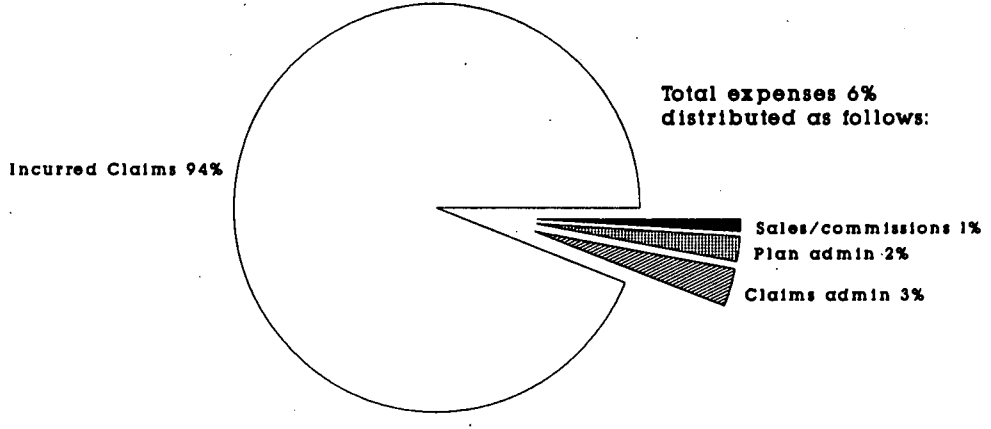


Source: HIAA

Federal taxes and risk/profit charges average less than 0.5 percent each.

Operating Cost for Group Health Coverage
(as a percent of earned premium)

Groups with 2500 or more Employees



Source: HIAA

Federal and state taxes and risk/profit charges average less than 0.5 percent.

Why is there such variation in operating expense ratios across different size groups? The primary reason is that some expenses remain relatively fixed in absolute dollar terms, regardless of the size of the group insured. Consequently, as a percentage of premium paid, these costs are higher for smaller cases and lower for larger cases. Sales costs and general administration expenses are the primary examples here.

For example, an agent or broker devotes roughly the same amount of time to selling a policy to a small employer as to a large employer. It makes sense that she should receive roughly the same net compensation. Moreover, agents who sell group health policies to small employers often provide continuing service to that employer, such as answering employees' questions and interacting with the insurance company. A large employer typically has an employee benefits manager or staff to handle these matters. A small employer rarely can afford that luxury, so he must rely on his agent for these functions. Thus, agent compensation -- when measured as a percent of premium -- is smaller for a large group than for a small group, both because it is measured in comparison to a higher premium and because the agent often provides additional services to the smaller group.

Other costs are proportionate. That is, they vary directly with the size of the group covered, so there is very little difference across group size when the cost is expressed as a percent of premium. Claims processing is the obvious example here (although there may be differences if some claims-processing-related costs, such as utilization management and managed care, are used more frequently by large groups than by small groups).

Finally, because some costs can be avoided by choosing self-insurance, some expenses that appear on the surface to be proportionate, primarily state premium taxes, are not. Because small employers cannot take the risk of self-insuring, they must pay state premium taxes. Large employers are better able to avoid these taxes by self-insuring.

Insurers work continually to find ways to operate more efficiently. Perhaps the most important activity now underway to directly reduce operating costs -- of providers as well as insurers -- is the development of a uniform format for filing claims electronically. The results of this project should include dramatically reduced paperwork for hospitals, physicians and other providers, and more rapid claims payment to patients and providers. No longer will hospitals have to worry about different claims formats for different insurers.

The development of these uniform electronic data interchange formats and standards is being coordinated by the American National Standards Institute (ANSI), a private, nonprofit organization serving both the private and public sectors. When fully effective, these standards will address not only claims filing and processing, but enrollment/eligibility information as well. The payment and remittance segment of this effort is now being pilot tested, and Medicare will begin testing it in four states in October 1991. By the end of 1992, ANSI hopes to have the claims segment of the project in operation. The HIAA is an active participant in this effort, and is confident that it will result in a more efficient, less costly claims system.

Let me turn now to the assertion that the United States could save large sums by moving to a single, government-run health insurance system. The advocates of such a national health insurance system assert that government-run health insurance would be cheaper than our current system, at least in part because operating expenses are lower in government-run systems. Canada and Medicare are the examples usually cited. There is a long list of reasons why the magnitude of the operating cost difference is nowhere near as large as usually claimed by national health insurance advocates. Nor is it as large as was recently suggested by the General Accounting Office. (The HIAA's comments regarding the GAO study are contained in Appendix B.) A major reason for the inaccuracy of most

estimates of the relative operating expenses of private U.S. insurers and government-run insurance programs is that government and private industry account for indirect costs -- such as space, depreciation, the cost of capital and reserves -- in different ways. Government incurs all of these costs; it just doesn't attribute them to particular government programs on its books.

Similarly, one of the major operating expenses incurred by insurers is the premium taxes they pay to state governments, and other taxes and fees, amounting to about 2 to 3 percent of total premium.[6] These tax revenues would be lost if a government-run system were to be put in place. It is clearly inappropriate to consider amounts paid in state and federal taxes as amounts added by insurers to the cost of our nation's health care system, nor are these taxes attributable to any alleged inefficiencies in our private insurance system.

In addition, we must put the issue of insurer operating expenses in proper perspective. Clearly, it costs the United States more to administer our pluralistic health care system than it costs the Canadians to run their unitary system, although the difference is not as great as the advocates claim. But, if the United States were to implement a unitary, government-run health insurance system, whatever savings there might be in insurers' operating expenses would be wiped out in less than a year by health care inflation.

For example, suppose for a moment that a government-run insurance system could reduce operating costs for insuring the under-age-65 population to the level currently enjoyed by very large, self-insured employers -- about 5 percent of claims.[7] In 1989, according to HCFA, the U.S. private health insurance system paid $169.6 billion in claims at a net or operating cost of $26.8 billion, of which HIAA estimates at least $2.2 billion represented taxes paid by insurers, leaving $24.6 billion in true operating costs plus insurers' profit. If operating expenses were reduced to 5 percent of claims, they would total only $8.5 billion, yielding a savings of $16.1 billion. But, again according to HCFA, total claims paid in the private insurance sector increased by $16.5 billion between 1989 and 1990, an amount more than sufficient to wipe out the savings in operating expenses in just a single year.

This little example serves to illustrate a very important point: The underlying reason why health insurance costs are rising so rapidly in the United States is not that private insurers are inefficient or are reaping huge profits. Rather, the reason why health insurance costs are out of control is that the cost and utilization of health care services are out of control.

It is important to keep this basic fact in mind when assessing the operating costs of our current insurance system. Many of those costs are aimed directly at assuring that only proper and necessary health care services are provided. Moreover, the American public receives other tangible benefits from our private insurance system.

At least three types of insurer operating expenses within the "claims processing" function result in direct benefits to the consumer. Two of these go directly to reduce the overall expense of the health care system. When claims are filed,

---

[6]In this case, premium equivalent for self-insured plans is not included in the term "premium."

[7]Advocates credit Medicare with operating expenses of about 3 percent of claims, but the true rate is higher because government does not count many expenses that must be included under private-sector accounting rules. Moreover, per capita claims are much higher for the Medicare population than the non-Medicare population; this allows fixed expenses to be spread over a larger claims base, lowering the apparent expense-to-claims ratio.

insurers verify not only the eligibility of the claimant for benefits; we also verify that the type of services provided and the individual or institution providing them are eligible for reimbursement under the benefit plan. A related "investment" by insurers is the detection of deliberate attempts to defraud insurers -- and thereby to defraud honest plan participants.

One of the most disturbing things about the current debate over health care reform is the assumption by many in Congress and elsewhere that our system can be improved by reducing the number of (or eliminating entirely) private health insurers in the United States. On the contrary, competition among health insurers serves the public well. Among the advantages of this competition is that it encourages positive technological innovation -- encouragement that is lacking in a single-payer system. In fact, other countries, including Canada, currently rely on and benefit from technological developments in the United States.

U.S. health insurers also compete vigorously in the area of customer service. This results in several positive developments, including systems innovation and quality service and claims handling.

Perhaps most importantly, competition encourages efficient quality care. Employers and employees demand the allocation of resources to effectively administer the system, including implementing managed care programs. This ensures that care is appropriate and of high quality, and that reimbursement is made only when consistent with the terms of the plan. Through these functions, the private sector collectively is working to control increases in health care costs. In contrast, government programs normally place a cap on expenditures without changing the way medical services are rendered.

The portion of premium invested in these efforts produces absolute savings for specific groups and for the health care system overall.

Perhaps the most important investment of premium funds is in the implementation of managed care features of a benefit plan. Managed care has as its primary objective the delivery of effective, appropriate medical care. When experts agree that 25 to perhaps 40 percent of medical services provided yield no significant medical benefit, and in some cases are actually harmful, it is clear that we need to focus administrative resources on making sure that the medical care received by our insureds is appropriate and of good quality. By working with patient and provider, managed care plans improve the delivery of health care by, among other things, reducing instances of unnecessary testing and procedures, and closely coordinating the delivery of care with the needs and desires of the patient.

Government-run systems are notoriously poor at this kind of individual judgment. The PROs and their predecessors have been at best marginally effective; and legal requirements make it impossible, for all practical purposes, for government to develop effective managed care systems based on selection of efficient physicians and hospitals, as private insurers are aggressively undertaking to do. Thus, government health insurance programs in most other countries, such as Canada, typically address cost control by simply limiting physician fees and putting a cap on hospital expenditures without changing the way medical services are rendered. Moreover, Canadians may claim that their system is not "socialized medicine," because providers are not directly employed by the government, but there is little doubt that the allocation of health care resources is centrally planned, just as it would be in a socialist state: In Canada, all major hospital decisions to invest in new technology or services must be approved by the provincial governments.

The consequences of this kind of approach are clear from the Canadian example. Appended to my remarks today are examples of inadequate access taken from recent Canadian press reports (Appendix C). GAO reports similar findings. It is quite clear that new, high-tech services simply are not adequately available in Canada, and therefore, patients who need them have to wait in line. This "rationing by queue" is the inevitable result of government attempts to control

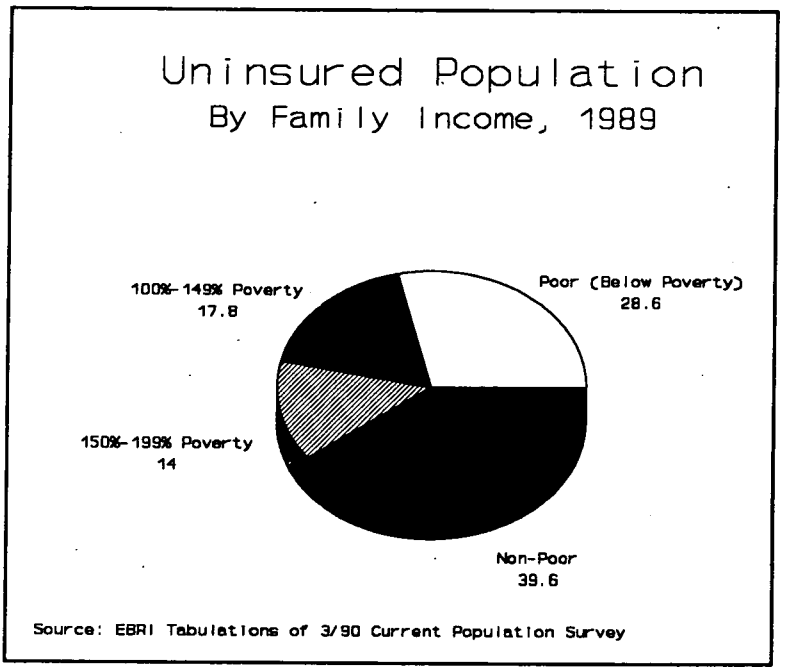
costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, a bureaucratic budgetary approach to cost control discourages innovation, perpetuates existing inefficiencies, and leads to creeping obsolescence. This is an outcome that we must strive to avoid as we seek a uniquely American solution to our cost and access problems.

Finally, as Congress and state legislators consider health care reform, it must be remembered that the American public values choice unlike any other consumers in the world. A recent Lou Harris poll found that less than 20% of national leaders would prefer a health care system with a single plan for everyone. Public opinion polls of consumers obtain similar results.

A pluralistic, private system gives the customer a range of options to choose from -- and tradeoffs to make. If a customer is unhappy, he can switch his coverage to another insurer. As noted, choice stimulates competitors to provide good, high quality care and service. In particular, private insurers have the ability and the incentive to mold benefit packages to meet the needs of the beneficiaries. These preferences reflect the makeup of the employer's work force, budget size, competition, regional variations, and the need for employers to retain their work force.

A constructive national debate, predicated on a rational discussion of the dynamics of our health care system, can be founded only on an approach which recognizes that each of the three players - the federal government, the states and the private sector - has a responsibility to meet. The health insurance industry has developed its action plan with this concept as its cornerstone. We are prepared to work with each of the other players to achieve a responsible and more affordable health care system for all.

APPENDIX A
HEALTH INSURANCE ASSOCIATION OF AMERICAN PROPOSAL ON PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS
(In Brief)



As the above chart shows, in 1989, approximately 28.6 percent of the uninsured were below the federal poverty level; 17.8 percent had incomes between 100 percent and 149 percent of poverty; 14 percent were between 150 and 199 percent; and 39.6 percent had incomes 200 percent or more above poverty. Of those with family incomes below the Federal poverty level, Medicaid reaches only 42 percent of them.

The Health Insurance Association of America developed its comprehensive proposal, announced last February, on access only after a very exhaustive analysis of the data just provided and collateral data on cost and industry practices. HIAA believes that only through a combination of efforts between the public (federal and state) and private sectors can we hope to stabilize the present and improve access into the future.

A detailed explanation of HIAA's proposal follows this summary outlining the actions we as industry can take, actions you as federal legislators can take and actions appropriate for state action. The three taken together will achieve the objective of access for all Americans.

INDUSTRY STEPS

For more than three years, HIAA wrestled with perhaps one of the most complex parts of the access equation -- the small employer market. Developing a proposal that would meet the needs of that market while at the same time making it possible for traditional providers of coverage to continue to participate in that market was difficult -- but not impossible. The Association adopted a set of precepts, which in brief are:

- Guaranteed access to coverage
- coverage of whole groups
- renewability of coverage
- continuity of coverage
- premium pricing limits
- market viability

Using these precepts as a base, we've developed model legislation that we believe state legislatures can and should adopt to implement small market reforms.

STATE STEPS

In addition to adoption of our model bill, we also believe states should repeal state statutes that are obstacles to managed care arrangements and that states should establish a reinsurance entity to permit carriers to spread losses for high-risk people equitably across the market.

For the medically uninsurable individuals who are not part of an employer group, we advocate the creation of state risk pools. State risk pools are designed to guarantee the availability of individual private health insurance to all Americans under age 65 who want to purchase protection but who are not considered to be insurable for health reasons. Losses should be financed by state general revenues or other broad based funding. At this time 33 states have enacted, or are considering, legislation establishing state risk pools.

The HIAA is aggressively pursuing legislation affecting small groups at the state level. Virtually all of the 49 states in session for 1991 are currently studying the problem of the uninsured or have introduced legislation targeted at the problem. The HIAA has testified in 41 states regarding possible solutions to the growing number of uninsured and has reported over 500 bills to its membership.

The National Association of Insurance Commissioners (NAIC) is also actively involved with legislation at the state level. Model legislation on small group rating and renewability has been adopted by the NAIC and has been enacted by, or passed at least one legislative body, in Arkansas, Indiana, Florida, North Dakota, New Mexico and South Dakota. At its June 1991 meeting, the NAIC exposed two drafts of model legislative aimed at assuring the availability of private insurance to all small employers and assuring the stability of the small employer health insurance market. Hearings are scheduled for the fall and final adoption is expected by year-end.

FEDERAL STEPS

We call on the federal government to take the following steps:

- ensure that the states have the authority to extend the market reforms to all plan administrators and insurers in the small employer market

- extend to all insured plans the same exemption from state mandated benefits enjoyed by large self-insured employers.

- help small business by extending to the self-employed the 100 percent tax deduction for health insurance.

- target new tax subsidies to financially vulnerable groups.

- restore the promise of Medicaid for the poor and near poor by expanding Medicaid to cover all those below the federal poverty level.

- extend the Medicaid "spend-down" program to all states and set eligibility thresholds so that no one is impoverished by medical expenses.

- allow low-income individuals above the poverty level to "buy into" an income-related package of primary and preventive care services.

COST CONTAINMENT

No one single step can achieve on its own the results we all seek. Just as we must take those steps necessary to improve and reform access to care, so too must we come to grips with perhaps one of the most significant components to the problem -- cost.

During the past five to ten years, the health care delivery and financing system in this country has evolved at an impressive pace. The most visible change has been the explosion of what are becoming known as managed care delivery systems, of which HMOs and PPOs are the best known.

Managed care embraces a variety of existing and developing structures. It may be defined as those systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;

- explicit criteria for the selection of health care providers;

- formal programs for ongoing quality assurance and utilization review; and

- significant financial incentives for members to use providers and procedures associated with the plan.

In 1989, one out of three employees had health coverage provided through an HMO or PPO. Enrollment in HMOs has more than doubled between 1983 and 1989. There were approximately 33 million Americans in HMOs in 1989 or approximately 13.2 percent of the population. When we calculate in point-of-service plans and managed fee for service, the number of Americans covered by some form of managed care would approach 75 million.

Continued growth and use of managed care arrangements is an essential tool for reigning in health care costs.

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 percent 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.

APPENDIX B

A Response to the General Accounting Office's Findings on Canadian Health Insurance

The General Accounting Office has drawn on faulty logic and inaccurate methods in Canadian Health Insurance: Lessons for the United States to announce that a uniform payment system is "worthy of consideration in a reformed United States [health-financing] system." (GAO, p. 7) The report's executive summary concludes that a single-payer system will solve America's health-financing problems, but there is no well-grounded evidence to support the conclusion. Further detracting from the report is its lack of defined parameters within which a similar system might be replicated here.

Canadian-style health insurance is fraught with negative features that, despite their inclusion in the report, were overshadowed by GAO's analysis of administrative savings under such an arrangement. In listing the system's shortcomings, GAO recognized that: insurance is rationed by politicians, there are long waiting lists for surgeries deemed to be elective by government boards, patients have died while awaiting "elective" surgeries, and Canadian citizens benefit from the proximity of the U.S. medical system, which also serves as a pressure valve for the government-run system north of the border. Although most forms of health insurance are illegal in Canada, private spending to enhance an austere government health plan still accounts for more than one-fourth of health expenditures.

It is difficult at best to compare health systems across international lines since common denominators aren't common. (GAO, p. 17) Nevertheless, GAO chose Canada, with the second-highest health spending in the world, as a model for comparison and emulation. The most nettlesome issues confronting American health policy analysts and policy makers -- overutilization, rational access to medical technology and real cost containment -- are not resolved in Canada, and therefore, would not be obviated by importing the Canadian system to this country.

GAO states that "savings [in administrative costs] would be realized only if the public payer succeeded in lowering payments to hospitals and physicians. . . ." Yet the report does not explain how the U.S. government's track record in controlling provider payments would improve under a Medicare approach to national health insurance.

HIAA's analysis of Canadian health care spending indicates that real per capita health expenditures are growing faster in Canada than in the United States. GAO disputes this finding. Per capita spending may or may not be a reliable indicator on which to base comparisons of health spending between nations, but it is clear that Canada's per capita health care costs grew at a rapid rate even after its medical insurance program became a public one in the 1960s. To avoid this result in the United States, GAO suggests the American version of national health insurance might include deductibles and cost-sharing to curb overutilization, but fails to describe how the government would process claims or manage a complex billing process more efficiently than the private sector.

The GAO report urges "a more flexible approach [than Canada's policy] on the acquisition of high-technology and other resources to avoid the development of future queues for high-technology procedures" that exist in Canada today. This country's policy toward physician investments in high-technology diagnostic centers has led to some flagrant excesses in utilization, self-referrals and attendant excessive outlays. Despite this climate, GAO offers no advice on how to curb physician profits from self-referral to diagnostic centers that they own, short of yet another excess -- government regulation. (GAO, p. 70)

Savings from a single-payer system would make most cost-control problems dissolve into global budgets, according to GAO. Unfortunately, the agency abandoned its practice of conducting primary, nonpartisan research and relied on sloppy methods to draw its conclusions on administrative cost savings. Here, GAO projects that the United States would save $67 billion if a Canadian system were adopted. The sole rationale for this figure is that it lies somewhere between the high-end estimate proffered by the Physicians for a National Health Plan organization and a more conservative figure prepared by the consulting firm of Lewin/ICF. (GAO, p. 65) Is this the calibre of research worthy of advocating government-run health care insurance?

Were Canadian-style central health planning adopted in the United States, it would undo two important steps taken to correct health financing deficiencies: prospective payment based on diagnosis-related groups and managed care. GAO specifies that "the [current U.S. Medicare] DRG system for hospital prospective payment gives hospitals the incentive to develop cost-based management information systems to determine whether a hospital is operating efficiently." On the other hand, a single-payer system implies that hospitals' administrative cost savings can be achieved only through global budgeting mechanisms, independent of incurred costs or consumed resources. Such a system would undermine the cornerstone of the DRG program necessitated by runaway hospital costs -- and that is accountability.

The report acknowledges how important HMOs and other managed care forms are in the United States and that Canada would like to imitate them. (GAO, p. 71-72) But folding managed care networks into a single-payer system is not addressed, whether that means establishing managed care in Canada's current system, or overlaying a single-payer system on managed care networks in this country.

The GAO report fails to analyze cultural variations between the United States and Canada and how these would transform a Canadian-style health-financing system if it were to be adopted here. It is not purported administrative excess and waste that drive up the costs of health care; genuine health needs and the nature of American society are the main causes. Litigiousness, an aging population, the AIDS epidemic, widespread substance abuse, unhealthful lifestyles and personal violence are not found to the same degree in Canada.

By focusing exclusively on the initial effects on health care expenditures and not on the rippling effects that a newly imposed system will induce, the "savings analysis" collapses of its own weight. State revenues from premium taxes would evaporate. Health insurers, some of the most stable and responsible private financial institutions in America, would be eradicated. Technological and research discoveries and developments sparked by market forces would fizzle. Government spending to administer the health system could go in one direction only -- up.

Methodological shortcomings and internal inconsistencies make a dim lesson of Canadian Health Insurance: Lessons for the United States. Buried deep in the GAO report, and certain to be missed by many, is this basic truth: America should "build on the strengths of the current U.S. system by encouraging greater emphasis on managed care and retaining its superior management information systems. Through this approach the United States may be able to develop new solutions compatible with unique American needs." (GAO, p. 72-73) We concur.

APPENDIX C

Consequences of Government-Run Health Insurance in Canada

There is growing evidence of access problems in the Canadian health care system, at least for high-technology specialty care, and growing concern over the continuing escalation of costs. The debate is raging in the popular press, as the headlines in Exhibit 1 suggest, making it clear that the Canadian health care system indeed suffers access problems and waiting lists at least for certain kinds of care in some parts of the country. Specific complaints about lack of access include the following:

- Long waits for certain surgical and diagnostic procedures. Examples cited include not only surgeries such as coronary artery bypass grafts, hip replacements and lens extraction (cataract surgery), but also preventive tests such as mammograms. Deaths have been reported among patients on waiting lists for heart surgery.

> In an effort to cut costs, most provincial governments have clamped down on hospital budgets at a time when many nurses are quitting their jobs to protest poor pay and working conditions. The result has been lengthening waiting lists and a toll of deaths among patients who cannot survive long enough to receive the surgery they need. In Manitoba, six heart patients died last year before they reached the operating room at Winnipeg's Health Sciences Centre. In Toronto--where an estimated 1,000 people are facing waits of as long as a year for bypass operations at three hospitals--two people have died since December. Last month, long waiting lists forced the city's highly regarded Hospital for Sick Children to send home 40 children who need heart surgery. (MacLean's, February 13, 1989, p. 32)

> St. Clare's [Hospital, Newfoundland] four-month wait for a first-time mammogram makes it almost impossible to do preventive breast cancer screening; the hospital can only handle women who need an immediate diagnosis. (The Globe and Mail, Toronto, May 28, 1988)

- Temporary closure of hospital beds to remain within budget, even though the beds are needed for patients on waiting lists.

> New Brunswick's hospitals, which were forced to take about 300 hospital beds out of service after Premier Frank McKenna's Liberal government tightened hospital budgets, are among the most seriously affected. At Moncton Hospital, some patients are kept in hallways and even in closets, while a total of 2,300 people were on waiting lists for surgery last month. . . . The situation in parts of the Prairies is equally alarming. (MacLean's, February 13, 1989, p. 33)

- Overcrowded emergency rooms and inability to admit patients in need of emergency care, due to overcrowding.

> Stella Lacroix's death started as a suicide. But most people here [Toronto] think it ended as something else. Moments after she swallowed a quart of cleaning fluid, she changed her mind and raced to the nearest emergency room. The hospital wasn't equipped to perform the surgery she needed to stop internal bleeding, so her doctor began a frantic search for an available bed elsewhere in the Toronto area. "She was turned away from 14 hospitals," the doctor . . . said after his three-hour search had failed. "There was no space anywhere and she just bled to death. This woman needed immediate care and we couldn't get it for her." (The Washington Post, December 18, 1989, p. 1)

In addition, the Fraser Institute of Vancouver, in cooperation with the British Columbia Medical Association, has surveyed a sample of physicians in the province to determine how long their patients have to wait for certain surgical procedures.[1] Responding ophthalmologists reported 882 patients had been waiting a average of 18.2 weeks for cataract removal. General surgeons reported 68 patients waiting for hernia repair, with an average wait of 24.6 weeks, and 39 patients waiting for cholecystectomies, with a average wait of 31.7 weeks. Cardiologists had 313 patients waiting for coronary artery bypass grafts, with an average wait of 23.7 weeks.[2]

The problem of waiting lists is real enough in Canada that at least two provincial health plans have felt it necessary to permit patients to seek care in the United States for certain conditions. Coronary bypass surgery and lithotripsy have been identified as areas in which Canada has significantly fewer resources available than the United States.[3] To reduce a waiting list of 700 patients needing cardiac surgery, the British Columbia Health Association contracted with at least two Seattle hospitals for up to 50 coronary bypass surgeries each (until a new cardiac service opened in Vancouver).[4]

In Ontario, a volunteer organization called "Heartbeat Windsor" has arranged for several Detroit hospitals to provide cardiac surgery to Canadian patients and accept the Ontario Health Insurance Plan rate as payment in full. In its first seven months of existence, the organization arranged 150 operations.[5] Alberta's health plan also has said it will pay if Albertans wish to travel to Detroit to avoid waiting for heart surgery.[6] With only one lithotripter in all of Ontario (a second one is scheduled), half of the lithotripsy patients at Buffalo General Hospital in nearby New York are Canadians.[7] (Extracorporeal shock wave lithotripsy breaks up kidney stones without surgery, greatly shortening hospital stays.)

Clearly, the Canadian system is no panacea.

Exhibit 1

Health Care Headlines in the Canadian Press

"Sick to Death: Caught between Rising Costs and More Restraints, Hospitals are Cutting Services."
-- MacLean's (Canada's national news magazine), February 13, 1989 (cover story)

"Soaring health costs a provincial headache."
-- The Ottawa Citizen, May 29, 1989

"Bed closings blasted: 91 left on backlog for urgent surgery."
-- The Winnipeg Free Press, July 5, 1989

"CO$T of LIVING: Clogged heart programs are just a symptom of a system needing adjustment."
-- The London (Ontario) Free Press, June 10, 1989

"Ontario's Health Care is in Critical Condition."
-- The London Free Press, May 27, 1989

"Health system ill in Quebec, says founder."
-- The Ottawa Citizen, January 25, 1990

"Need surgery, medical tests? Go to the end of the line."
-- The Globe and Mail, Toronto, Ontario, May 28, 1988

"Budget limit on MDs' services urged by major Ontario report."
-- The Globe and Mail, May 24, 1989

"N.S. Royal Commission recommends controls on doctors."
-- The Evening Telegram, St. John's, Newfoundland, December 9, 1989

"HSC staff denounce deplorable conditions in emergency ward."
-- The Winnipeg Free Press, November 24, 1989

NOTES

1. Steven Globerman with Lorna Hoye, "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Forum (May 1990), pp.5-38. (The Fraser Forum is published 12 times per year by The Fraser Institute of Vancouver, British Columbia.)

2. The questionnaire was sent to half (73) of the ophthalmologists in the province; 19 responded. One-third (83) of the general surgeons were surveyed; 10 responded. All (27) of the cardiologists were surveyed; 5 responded. The number of patients waiting is the raw total reported by those physicians who responded, not an attempt to project a figure for the entire province.

3. Dale A. Rublee, "Medical Technology in Canada, Germany, and the United States, Health Affairs 8:3 (Fall 1989), pp.178-181.

4. Washington State Hospital Association Weekly Report 15:8 (February 23, 1989). Howard Kim, "Canada Tabs Wash. Hospital," Modern Healthcare, March 26, 1990. "[For the Record] Second Seattle Hospital Gets Canadian Contract," Modern Healthcare, April 2, 1990, p.13.

5. Carol Goodwin, "U.S. 'Miracle Workers' Take Pay Cuts to Help Canadians," The Kitchener-Waterloo (Ontario) Record, February 15, 1990.

6. Karen Sherlock, "Detroit Offers Short Wait for Heart Surgery. Provincial Insurance Covers Bill," The Edmonton Journal, January 6, 1990.

7. Information for the first five months of 1989. (American Hospital Association, op.cit., p.16.) A U.S. physician at a treatment center associated with Buffalo General also reports that 40 percent to 45 percent of his patients are Canadians. (Suzanne Morrison, "Lack of Lithotripter Sends Health Cash to U.S.: Patient," The Hamilton (Ontario) Spectator, December 21, 1989.)

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Sternberg.

Our third witness is Mary Nell Lehnhard, Vice President in the Office of Government Relations of the Blue Cross and Blue Shield Association. Before joining the Blue Cross and Blue Shield Association, Ms. Lehnhard was a professional staff member for the Subcommittee on Health of the Committee on Ways and Means.

We're glad to welcome you back to your old haunts, Ms. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

MS. LEHNHARD. Thank you, Mr. Chairman.

We welcome this opportunity to address you on the challenge of assuring adequate health coverage while managing the cost of health care, including administrative costs.

Earlier this month, the board of directors of the Blue Cross and Blue Shield Association unanimously approved the Health Care Reform Strategy. It has three major goals. First of all, to assure universal coverage. Second, to make that coverage affordable. And, third, to assure the portability of those benefits as people move from job-to-job.

REPRESENTATIVE SCHEUER. It's universal. Is it comprehensive?

MS. LEHNHARD. Yes.

REPRESENTATIVE SCHEUER. Universal/comprehensive care.

MS. LEHNHARD. Yes.

REPRESENTATIVE SCHEUER. Thank you.

MS. LEHNHARD. Our affordability strategy relies on the dynamics of the competitive marketplace. However, this would be a marketplace that had new rules; for example, rules that would prohibit insurers from competing on the basis of selecting the best risks in the market in order to hold their costs down.

We would also reward insurers that are what we call qualified carriers. And these would be carriers that would compete on their ability to manage costs and to deliver services efficiently.

The key to controlling total health-care costs, as Canada is now recognizing, lies in managing the use of services. However, we are quick to say that we aren't ignoring the need to make sure that the administrative costs of our pluralistic system are reasonable and, in all cases, necessary.

We think that we have a good record of administrative costs at the Blue Cross and Blue Shield Plans. In 1990, our administrative costs were 9 percent of total premiums, when you exclude taxes. These figures compare extremely favorably with the administrative cost of any service industry.

Our administrative costs are higher than the 3 percent commonly reported for the Medicare Program, and this is essentially our single-payer

system in the United States. However, we think that there are a number of critical reasons for these differences.

First, obviously, Medicare doesn't buy the same services as private insurance. The most obvious difference is the uniformity in Medicare, as in Canada. However, we believe that——

REPRESENTATIVE SCHEUER. Wait a minute. I didn't get. The most obvious?

MS. LEHNHARD. Difference between Medicare and private insurance is Medicare is purchasing one set of benefits. So, your administrative costs are lower. However, we don't believe that, in trying to——

REPRESENTATIVE SCHEUER. I don't quite understand that. Medicare takes care of all of the health needs of the elderly, excluding long-term care, as I understand it.

MS. LEHNHARD. That's right. But it is one set of uniform benefits which has resulted in lower administrative costs for Medicare. However, when you look at whether the people over 65 think those benefits are adequate, they have, in turn, chosen, as Gordon Trapnell mentioned, to purchase additional benefits.

So, when you're comparing Medicare and the private sector, you have to realize that Medicare is just purchasing one set of benefits. If you move that point to the——

REPRESENTATIVE SCHEUER. It's universal for those over 65, but it is not comprehensive.

MS. LEHNHARD. Not comprehensive. The government has said, "we can't afford the comprehensive."

We think, in the under 65 population, the same principle would apply, that we wouldn't be able to provide a comprehensive set of benefits, and employees would want choice about how they're going to use essentially scarce resources.

A second point is that in the private sector I don't think you'd find employers willing to tolerate the level of funding under the Medicare program, the 3 percent, in terms of the level of claims review that it produces and the subscriber services.

We administer 90 percent of the Medicare program. We know that, in effect, what we're doing in reviewing claims is inadequate and that it would not be tolerated by our employer clients.

I'd also comment on the measurement method used when comparing public and private programs. Usually, efficiency is measured by the percent of premiums versus administration. The higher utilization of services by Medicare beneficiaries, however, essentially dilutes the administrative costs of Medicare. For example, someone 60 years of age may use four times the services than somebody who is aged 25. When we look at our own administrative costs on a per capita basis, we see that they're, in fact, less than Medicare on a per capita basis, and our testimony goes into that.

REPRESENTATIVE SCHEUER. Isn't that a major phenomenon? That we're concerned about the fact that the private insurance companies tend to cream. They tend to design policies that are attractive and are aimed at the young and the well, and because they know they're going to have a comparatively favorable experience with them?

MS. LEHNHARD. You're absolutely right.

REPRESENTATIVE SCHEUER. And they can offer a very competitive price, which pulls the young and the well out from the general pool. And so we're left then with people who can't afford private insurance because they aren't young and may have preexisting illnesses. They may be in a very small group. And so they're not at all attractive to private industry, and their rates are very high. And those that can't afford private-health insurance, then fall into the public sector, and the taxpayer ends up paying their bill.

MS. LEHNHARD. You're absolutely right.

REPRESENTATIVE SCHEUER. ——the young and the well. And, of course, that's one of the reasons that we're so concerned about the present insurance market. Empire Blue Cross/Blue in New York just dramatized that very vividly by their application for a large rate increase. And they're good people. But their application to raise their rates substantially by about 50 percent over a year or two, because they say they've been the victim of this phenomenon in the private insurance business, which is where they compete, whereby private insurers pull out of the general pot only those who are young and well, and they leave the rest with, in effect, Blue Cross and Blue Shield. And they're suffering.

MS. LEHNHARD. We have offered, as has the HIAA, a strategy to stop this competition based on risk selection. And you're exactly right about the effect of it. And we're saying, if we want to preserve our system—and we do—we have to stop this kind of competition.

REPRESENTATIVE SCHEUER. How are you going to stop it? We'd be interested in hearing it.

MS. LEHNHARD. We think that there are several different ways to do it, but you can essentially say that, as one example, every carrier has to take every group regardless of their health status. If a carrier wants to reinsure those claims through the private sector, it's appropriate. We would limit how much you would charge the sickest group compared to the healthiest group. And we would say that you can't drop the coverage. You can't drop a group just because they're sick. It's a three-legged stool and all these pieces need to be in place. I think both groups have come to recognize that, if we don't clean up these practices in the small group market, there is no value added for private insurance.

REPRESENTATIVE SCHEUER. And they're not involved in what most people conceive of when you say the word "insured". Insurance is spreading the risk.

MS. LEHNHARD. I think——

REPRESENTATIVE SCHEUER. If you're going to follow a policy of only selling an insurance product to people who demonstrably have very, very little risk and excluding those who have a greater risk, you're really not an insurer. You're something else.

Ms. LEHNHARD. We agree with you. And I would say that the other big area where we think that there is tremendous value added in our system is in the managed care area.

What we are seeing is that the Canadians are now coming to Blue Cross and Blue Shield—coming to the commercial companies—and saying:

> We have used global budgeting. We've used all payer systems to try to manage costs. We haven't questioned what we are paying, and we have to do what you're doing and manage those costs.

We are moving to do some of what Canada is trying to do, and Canada is trying to move to do what we are doing.

There are tremendous discrepancies in the questioning of the Canadian studies. What we have said is, step back. Take a closer look at those costs. We think that they re-overstated. Take a closer look at what both countries need to do. And don't fail to see the value added in our current system. Yes, it needs reform. Yes, it needs cleaning up, but there is tremendous value there that we think can be preserved.

REPRESENTATIVE SCHEUER. Well, Ms. Lehnhard, I couldn't agree with you more. And that's what we're all struggling with. And that is the purpose of this hearing, too, to distill what is useful and working in both health-care systems. There is no monopoly of wisdom and no monopoly of virtue, north or south of the border. Undoubtedly, we are doing some things with a very high level of excellence. Undoubtedly, there are lessons that the Canadians could learn from us. There are undoubtedly lessons we can learn from them. Neither country has achieved perfection. And what we're trying to do is to distill from their experience and our experience, and see if we can't create a whole that is better than the sum of the parts; see if we can't distill a superior wisdom that involves elements in both systems.

So, I appreciate your testimony very much. Are you finished now?

Ms. LEHNHARD. Those are the key points that I would make.

REPRESENTATIVE SCHEUER. Make them, because I interrupted you.

Ms. LEHNHARD. We cannot end on a point better than the fact that with adequate reforms of our system—the system of private, employer-based financing care—we can ensure universal coverage, affordability of benefits, and that those benefits are portable.

REPRESENTATIVE SCHEUER. What about comprehensive coverage?

Ms. LEHNHARD. The comprehensive question is one of how much the country wants to spend. We think the key thing is to put in place the framework, to make the coverage universal, the benefits portable so that you don't have job lock, and control total cost.

We have one idea about a set of benefits, and other people will have other ideas about a set of benefits. That is going to be a continuing debate

about how much this country can afford. The country has decided it cannot afford comprehensive benefits for Medicare.

REPRESENTATIVE SCHEUER. Yes, they did decide that, and I think it was a wrong decision. I voted against terminating the catastrophic care. It seems to me that we are faced with a very serious question and that is: The Canadians spend 9 percent. The average for the OECD countries is a little under 8 percent, and they all have universal care, and they all have comprehensive care. How do they do it?

And that is why I made a point of asking you that question. And if they can afford to provide universal and comprehensive care at 8 percent of their gross domestic product and we can't afford to provide either universal or comprehensive care when we are investing 12.4 percent of our gross domestic product, something is rotten in Denmark. And that is what we're trying to get to.

We have had various estimates of the savings to be achieved by seizing the pot of gold out there that is achievable by going to a single-payer system. And you can take your $50-55 billion, which is what Mr. Reischauer suggests, or the $67 billion that GAO suggests, or a figure in excess of $100 billion—Woolhandler and Himmelstein suggest $132 billion—whatever figure it is, it is a hell of a big figure. And if that can be saved, it is at least as large as the figure that the Pepper Commission estimates it would cost us to go to a full national health program, which would be both universal and comprehensive. One wonders why we don't seize that pot of gold and use the savings to finance a universal and comprehensive health-care system.

And then you are saying that we want to protect this industry that we have now. And if it doesn't provide long-term care like all of the other OECD countries do, that is a sacrifice that we are willing to make to preserve the present system. If it doesn't provide catastrophic care to anybody, we're willing to make that sacrifice. If it doesn't include 12-13 percent of the population, lose them totally, without formal access to the health-care system, we are willing to make that sacrifice.

But I think the country has to face up to the fact that there are real tradeoffs, that there is a real tradeoff here, and that we have to analyze that payoff and figure out what health coverage we are willing to sacrifice to achieve the goal of preserving the present system—the 1,500 payer system.

Do you think that is an unfair way for me to pose the problem to you?

MS. LEHNHARD. I think it overlooked several things. I think the cost of the two studies you cite are in question.

REPRESENTATIVE SCHEUER. The cost of what?

MS. LEHNHARD. The costs attributed by the two studies to our administrative overhead. It includes physicians' libraries and receptionists.

REPRESENTATIVE SCHEUER. Let's not diddle around the edges. We have a big figure out there. You can take any one of those three figures—$50 billion, $67 billion, $132 billion, yes. We can spend all day comparing what this figure includes, what that figure includes. And I will ask the

whole panel at the end: Can you agree at least on the fact that there is a major saving—probably in excess of $50 billion—to be achieved by going to a single-payer system that we could then allocate. We can reallocate those funds into providing health services now that we don't provide to many, many groups in our society.

Ms. LEHNHARD. I think you would end up reinventing the private sector to control costs. If you stop and consider that all the studies show that 40 percent of medical care provided is probably unnecessary, what you have to do is harness——

REPRESENTATIVE SCHEUER. That's probably true for both countries.

Ms. LEHNHARD. ——and what you have to do is harness the private sector to reduce that 40 percent of total health-care costs, which is an overwhelmingly larger number than the relatively small number of administrative dollars that we're talking about.

REPRESENTATIVE SCHEUER. Well, I think we ought to go after both. As you know, Congressman Henry Waxman has a piece of legislation that he's drafted to study health outcomes.

Ms. LEHNHARD. We're very supportive of that.

REPRESENTATIVE SCHEUER. Yes. And I think that's been done in Canada and in our country. And we haven't achieved perfection at all in health outcomes from all kinds of procedures—drugs, surgery, tests.

Ms. LEHNHARD. Technology.

REPRESENTATIVE SCHEUER. Technology, yes. We haven't. But we're moving, and hopefully that figure will shrink. There's no doubt about it, we have a lot to learn yet.

I appreciate your testimony very much, Ms. Lehnhard.

[The prepared statement of Ms. Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD

Mr. Chairman and Members of the Committee, I am Mary 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, labor unions, health care providers and government.

We welcome the opportunity to address the Committee on the challenges of securing access to health care for all Americans while managing health care costs, including administrative costs. We are committed to a program of increasing coverage and assuring affordability of health care. I will discuss our recently announced position on health care reform and how it fits with the issues of affordability and access to care. Three major goals guide the Blue Cross and Blue Shield system reform strategy: make coverage available to all Americans; make coverage more affordable; and assure portability of coverage.

I. AFFORDABILITY

Affordability primarily deals with the cost of delivery of health care services. I will discuss in my testimony today: 1) managing the benefits costs; 2) the role of reform of the insurance industry in limiting costs; and 3) the costs of administering health benefits. Specifically, I will address the inappropriate comparisons and the conclusions of the recent GAO report and the Woolhandler article in the New England Journal of Medicine. By placing the discussion of administrative costs in the larger context of health care reform, it

should become clear that while important, administrative costs are a relatively small component of the overall health care picture in the United States.

Managing Benefits Costs

Benefit costs are the driving force of health care cost increases and they comprise the overwhelming majority of costs for both public and private programs. Our affordability strategy relies on the dynamics of the competitive marketplace. Under our approach, we would stop rewarding insurance companies that are principally claims processors and medical underwriters and start rewarding "qualified carriers" who have demonstrated their ability to contract for high quality and efficiently provide services through managed care and selective contracting techniques.

These carriers would negotiate with providers for favorable prices, manage the cost and quality of care provided and measure the appropriateness of care. This will be accomplished through a reliance on outcome measures that evaluate services according to the improvements they make in patients' lives. Outmoded and unnecessary services would not be covered.

The concept of managed care is nothing new, but many who purport to offer it have not made full use of its potential. The development of cost-effectiveness and outcome measures is still in its early stages. Today, insurers have access to incredible amounts of data to help them evaluate the effectiveness, not only of individual procedures, but also, of the practice patterns of individual providers.

Carriers who add these new tools to the traditional managed care arsenal will make dramatic changes in the way we spend health care dollars. They will increase the value of care purchased and improve the quality of care provided to patients.

To be recognized as qualified carriers under our plan, insurers must demonstrate proven records of managing health care costs effectively. These qualifications include a capacity to perform utilization management, selective provider contracting and uniform billing and data collection. Corporate and individual purchasers of care would be offered incentives to choose such qualified carriers. Active competition among carriers would help control the current rate of cost growth, reduce administrative costs, and make health care coverage more affordable.

Insurance Market Reforms

A strategy to assure universal availability of coverage through a pluralistic system must include a well-functioning and competitive insurance market.

Eliminating the current imbalances between self-funded and insured benefit plans would be a valuable step toward improving the efficiency of the insurance market. Because ERISA protects self-funded employers from state regulation, these employers are not required to provide state mandated benefits -- nor do they pay state premium taxes or share in the costs of state-run high-risk pools for individuals. Legal imbalances shift these burdens onto insured employers, who tend to be the small and medium-sized companies that are least able to afford the additional costs.

Equal treatment of insured and self-funded plans would serve as an important step toward improved competition. However, we also recognize the need for reform of practices in the health insurance market.

In January of this year, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved recommendations to reform the small group insurance market at the state level. These reforms would replace competition based on ability to select risks with

competition based on ability to control costs. Specifically, the Blue Cross and Blue Shield system supports measures to assure:

- Small employers have access to private insurance, regardless of health status, occupation or geographic location;
- States have a range of options to choose from in providing for the availability of private insurance to small employers;
- Small group coverage is provided at fairly established rates;
- No small employer is dropped from coverage because of poor claims experience;
- all entities doing business in the small group market are subject to the requirements (including multiple employer welfare arrangements--MEWA's) and there is effective enforcement of all requirements.
- Adequate effective enforcement of all carrier requirements;
- Equitable sharing among carriers of both high-risk small employers and the losses associated with covering these high risks; and
- Availability of lower-cost products.

With respect to assuring small employers access to private insurance, BCBSA believes that states should have the flexibility to choose an approach that meets the needs of their environments. One approach that has received a lot of attention would require all carriers to offer coverage to small employers on a guaranteed issue basis and is dependent on a private reinsurance mechanism to help carriers spread the costs associated with high-risk groups.

While this approach may be appropriate in some states -- where participation in reinsurance is voluntary -- we believe it is equally important for states to be able to choose approaches that do not rely on guaranteed issue and a reinsurance mechanism.

We also support several alternative approaches. In general, these other approaches would assure that all small groups have access to private coverage and that all carriers comply with the requirements noted above.

These approaches would not rely on a reinsurance mechanism to spread the risk of a requirement that all carriers accept all groups.

Reinsurance has not been tested in any state. It may prove difficult to regulate, costly to administer and unfair to some insurers. In addition, the losses are unknown and could require additional funding. One alternative would identify at least one insurer that voluntarily provides coverage to all small employers and meets all other requirements. This approach recognizes that in some states at least one insurer already offers comprehensive coverage on a guaranteed issue, community rated basis to small employers. For example, in Pennsylvania, Blue Cross and Blue Shield Plans offer year-round "open enrollment" for all their small group products and charge a single rate for all small groups in an area.

Another approach would require all insurers in the small group market to accept otherwise uninsurable groups through placement of such groups by a state program. Under this "allocation" approach, uninsurable groups would select coverage under rules set up to assure fair distribution of such groups among all small group carriers in the state. This alternative has the advantages of providing incentives for insurers to manage high-risk cases, being easier and less expensive to administer and simpler to enforce than a reinsurance mechanism.

States also could develop other programs for assuring availability of private coverage for small employers, as long as the alternatives achieve the objective of assuring availability of all small employers at fairly established rates and met the other requirements described earlier.

Administrative Costs

Recently, considerable attention has been given to the role that the administrative costs of our pluralistic health care system may play in contributing to the current cost pressures. As we discuss administrative costs, I think it is important to understand that without question, a pluralistic system has higher administrative costs.

However, we agree that these costs deserve close examination. I would like to share our own experience with insurers' administrative costs, discuss some of the shortcomings of the current understanding of this issue and offer some suggestions for improving both the efficiency and the measurement of our health care system's performance.

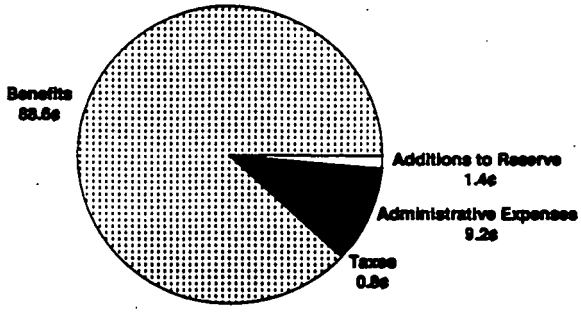
Blue Cross and Blue Shield Experience

As the largest provider of private health insurance coverage in the United States, Blue Cross and Blue Shield Plans have a major interest in working to reduce administrative costs to assure the most effective use of limited health care resources.

We are proud of our performance on administrative costs. In 1990, Blue Cross and Blue Shield Plan administrative costs were 10.0 percent of total premium. As illustrated in Table I, when government taxes are excluded, our administrative costs were 9.2 percent of premium.

TABLE I

Blue Cross Blue Shield 1990 premium dollars



Source: BCBSA, NAIC Insurance Blanks

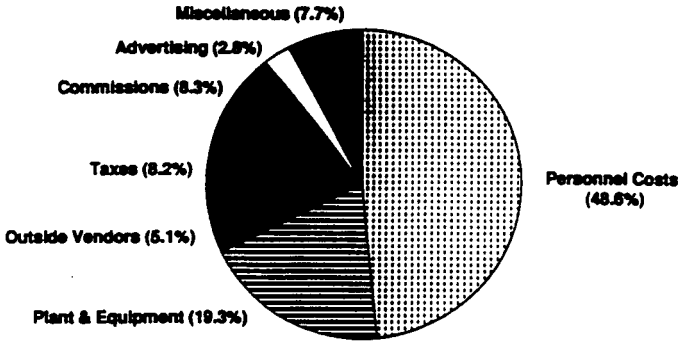
A study issued last fall by Citizens Action examined only the administrative costs of underwritten (insured) business of commercial insurers. However, our data includes the administrative costs associated with all our health-related insurance products, including fully underwritten and administrative services only (ASO) arrangements. We believe it is essential to capture data from all financing arrangements to describe accurately the costs of private health insurance. In addition, we have included all product lines, including traditional and managed care coverage, as well as supplementary policies such as Medigap, vision and dental coverages. While the latter policies tend to have higher administrative costs as a percentage of premium — because they have a large number of small dollar claims -- we believe their inclusion is important because they reflect the diversity of coverage choices available in a private system.

Table II provides a breakdown of our administrative expenses by major categories. Like most financial service industries, our largest administrative expense is personnel, representing about half of administrative expenses. An examination of salaries in other companies of comparable size shows that our compensation is in line with other industries.

TABLE II

Personnel costs represent the largest portion of costs while taxes represent approximately 8 percent of administrative expenses.

Distribution of Administrative Costs
Blue Cross and Blue Shield Plans 1990



Source: NAIC Insurance Blanks, BCBSA

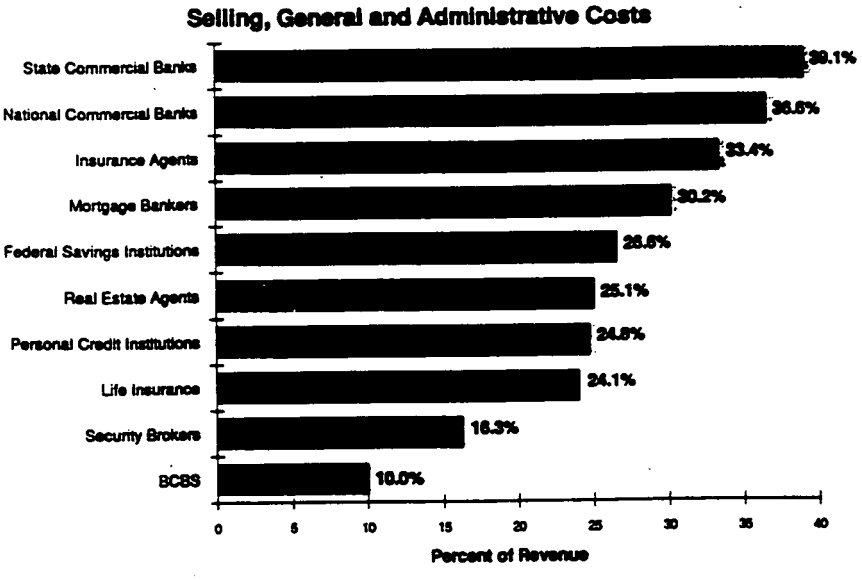
Another component of overhead that has attracted considerable attention is sales commissions paid to brokers. Blue Cross and Blue Shield Plans paid only .8 percent of total premiums in broker commissions during 1990 (equal to 8.3 percent of administrative costs).

Administrative Costs of Government Programs

When the administrative costs of other industries are examined, our costs compare favorably. I have included for your review the selling, general and administrative (SG and A) expenses as a percent of net sales for several other American industries. Table III demonstrates that Blue Cross and Blue Shield Plans' administrative costs are well below the SG and A costs of other financial services sectors.

TABLE III

Not only are Blue Cross and Blue Shield's administrative costs lower than other commercial carriers but they are also less than the administrative costs of other financial services firms.



Source: BCBSA, Lotusone On-Line Data Retrieval System, Second Quarter 1991 Edition

While the relative expenditure for administrative costs is important, the data do not support the contention that the health insurance industry is grossly inefficient. When we examine our performance against that of public insurance programs, our administrative cost ratio is higher than the three percent commonly reported for the Medicare program. However, there are a number of critical reasons for these differences that deserve further exploration.

First, Medicare's administrative investment does not buy the same services as private insurance. Most obvious is the uniformity of Medicare's benefit design, which simplifies administration, but limits beneficiary flexibility and choice and does not respond to the diverse market needs of the population under age 65.

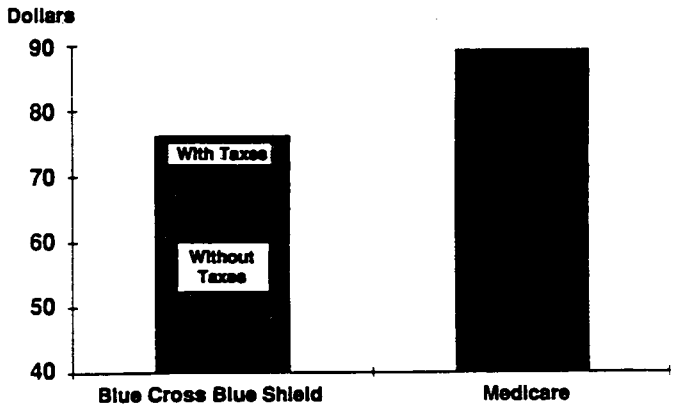
Second, the private sector would not tolerate the level of claims review and services that government funding accommodates. Over the last few years, the government repeatedly has under-funded the administrative costs of the Medicare program. Major reductions in the activities necessary to screen claims for medical necessity, appropriateness and fraud have resulted in billion of dollars in over-payments. These are the simpest of review procedures that are not being performed which employers who purchase private coverage would expect as a bare minimum.

In addition, services for beneficiaries are under-funded. The most recent example is the 1992 Medicare contractor budget, which has resulted in Medicare intermediaries being funded for fewer than one-third of expected inquiries from beneficiaries and providers. Furthermore, almost seven million mandatory hearings on disallowed Medicare payments -- about 70 percent of the total projected for next year -- will be backlogged for 250 days or longer. Clearly, these types of service reductions hold down administrative costs for the program in the current fiscal year, but can seriously jeopardize the integrity of insurance -- a result that would not be tolerated in the private sector.

Finally, the perceived efficiency of insurance programs is affected by the measurement method used. Frequently, efficiency is measured by the percentage of premiums spent on benefits versus administration. This approach can be useful in a number of ways. It is commonly accepted and easily understood; it facilitates comparisons across programs and countries; and it focuses our attention on the relationship to total health expenditures, our primary concern in the current environment. Nevertheless, there are biases associated with this measure which may be potentially significant. For example, this measure varies with differences in benefit design and utilization.

TABLE IV

Annual administrative costs per capita: Blue Cross Blue Shield and Medicare.



Source: BCBSA analysis, 1989 data

These measurement issues are readily apparent when we examine Medicare's administrative costs against our own on a per capita basis. As illustrated in Table IV, in 1989, Blue Cross and Blue Shield Plans generated administrative costs of $76.62 (With taxes), $71.16 (without taxes) per member while Medicare's administrative expense was slightly higher, at $88.71. Not surprisingly, Medicare's older, high-utilizing population requires significant administrative support for each beneficiary. We believe these statistics indicate that greater analysis should be given to the debate over the relative efficiency of private insurance.

Because considerable attention has been given in recent months to the Canadian health insurance system, we also have analyzed comparable costs for their national health insurance program. The most recent data on the administrative costs associated with the public insurance program in Canada have been reported by Woolhandler and Himmelstein and the U.S. General Accounting Office. Based on personal communications with officials from Health and Welfare Canada, Woolhandler and Himmelstein estimated that just under one percent of total benefit costs were absorbed by administration of the public health insurance program in 1987.

Much has been made of these study results as policymakers regularly cite the study as support for proposals to move to a Canadian-style system. Thus, we believe it is important to respond to this work. We do not believe that the assumptions and data used to support these findings stand up to careful scrutiny. For example, in developing their estimates of administrative costs in the U.S. system, the authors not only included overhead costs directly attributable to dealing with multiple payers, but all overhead -- everything from the receptionist in a doctor's office to library facilities to rent. Most of these costs would not be eliminated by moving to a single-payer system.

Finally, the higher administrative costs in the U.S. system are not due exclusively to having multiple payers. For example, both insurers and entities that administer self-funded programs in the United States make significant expenditures to control the use of services. These activities are meant to reduce total health care costs by reviewing the medical necessity of services provided, the excessive use of services and the outcomes of clinical treatments. Payers in the United States also expend considerable amounts to assure the quality of services, including support of provider utilization review programs and their own quality assessment activities.

In contrast, Canada's efforts to control costs have focused almost entirely on budgetary tools such as expenditures caps, with little scrutiny regarding the appropriateness of services delivered. Canada is just beginning to realize that it has to make the same type of investment in managing costs that we have and, in fact, they are looking to our system for ideas.

Moreover, other factors, such as the vastly higher rate of malpractice litigation in the U.S. (five times that of our northern neighbors), also contribute to underlying differences in administrative cost structure by requiring physicians and hospitals to spend more money on legal fees, risk management and documentation.

For these reasons, we urge decision makers to exercise extreme caution in using the Woolhandler and Himmelstein study and the GAO study to draw conclusions or make decisions about our health care system.

Efforts to Reduce Administrative Costs

While we are proud of our performance in limiting administrative costs, there are steps we believe should be taken to reduce these costs further. Blue Cross and Blue Shield Plans are on the cutting edge of information technology and we are moving aggressively to a paper free environment.

We have been involved for quite some time in industry-wide efforts to limit administrative costs. For example, we have been working with others in the health industry to establish common data standards to facilitate electronic provider payment and billing. Within the Blue Cross and Blue Shield system, we have developed a streamlined system for processing our multiple-state accounts and further reducing our own administrative costs for managing these accounts.

We also are experimenting with ways to assure the most effective use of services and the best clinical outcomes for subscribers while eliminating provider costs that frequently accompany managed care techniques, thus reducing administrative burdens on providers. Our goal is to strengthen both our own efficiency as well as the value of the pluralistic system.

- For example, Blue Cross and Blue Shield of the National Capital Area has developed an analytic system called "Pro/File^{R}" for evaluating practice patterns of providers. This system, which has been in use since 1988, can compare, in detail, individual physicians' practice patterns with other physicians in similar specialties. It uses statistical techniques to adjust the data to account for physician differences such as more complex mixes of patients.

  The information is used to: 1) provide feedback to physicians; 2) select and recruit physicians for participation in managed care networks; 3) select physicians whose practice patterns indicate that they are efficient at providing a range of primary care services to act as "gatekeepers;" and 4) target utilization and quality management programs toward problem areas. In this way, physicians who meet specified criteria have the added benefit of reduced utilization review.

- Blue Cross and Blue Shield of Arizona began implementing the Medical Office Review (MORE) program in 1987. This program is used to evaluate the administrative and operating procedures of physicians participating in managed care networks. Review teams use a specially developed protocol to evaluate the full range of office activities, including accuracy of claims coding and billing procedures. This information, along with recommendations for improvements, and comparisons with the performance of other network providers are shared with individual physicians. As of September 13, 1991, 2,000 physician offices were reviewed.

Provider Benefit Costs

While the administrative costs associated with our pluralistic health care system are not insignificant, the much larger component of health care costs are provider benefit costs. Cost increases in this area are caused primarily by the intensity and volume of services provided, which are driven by factors such as an aging population and advances in medical technology.

Making health care more affordable will mean addressing these increasing demands for health care services by managing both the price and the utilization of services.

The Blue Cross and Blue Shield System has a long history of undertaking initiatives to limit the cost of medical services, and we have expanded cost management efforts in recent years. In addition to controlling costs through contract arrangements with hospitals and physicians, Blue Cross and Blue Shield Plans have made great progress in expanding managed care arrangements. Blue Cross and Blue Shield Plans now operate 164 managed care programs in 47 states. These HMOs, PPOs and point-of-service (POS) arrangements cover 17.5 million of our subscribers. We operate the largest PPO network and the second-largest HMO network in the country. Overall, close to half of Blue Cross and Blue Shield subscribers participate in HMO, PPO or managed traditional arrangements and the proportion continues to increase.

Blue Cross and Blue Shield Plans are devoting increasing levels of resources to cost management and health care quality initiatives. These efforts contribute to administrative costs but also result in major net savings. Cost management efforts by 27 Plans in 1989 resulted in overall savings of $303 million -- more than four dollars saved for each dollar spent.

Although we have made progress in making affordable health care services available to our subscribers, certain cost factors are beyond

our control. We are limited in our ability to prevent the over abundance of costly medical equipment and devices, which often leads to induced demand. State governments and the courts often order insurers to pay for certain medical services for which their is no clinical evidence of efficacy.

In light of these factors, we recognize that we need to work in partnership with providers and government to affect major changes in health care costs and assure affordability of coverage. All of the parties involved must participate in developing solutions.

One important step in this direction would be to provide incentives for employers and individuals to choose carriers that have proven records of managing care effectively.

II. AVAILABILITY

The employer-based health care system has served us well for more than 60 years. Because most of the uninsured are connected to the workplace, we believe that initiatives to increase coverage should be based on that system.

Under our proposal, large employers would continue the practices most already follow -- offering health insurance and making a financial contribution to the costs of coverage for their employees. Today, more than 90 percent of the firms with at least 25 employees offer coverage; nearly all firms of more than 500 employees offer coverage and contribute to employee premiums.

We would ask small employers to offer coverage but we would not require them to contribute to employee and dependent premiums. We would, however, develop subsidies and tax incentives that would encourage the employer to make those contributions. Those employers that do not fund their employees' coverage would be subject to an assessment, which would be significantly less than the cost of contributing to coverage. These funds would be used to assist their employees' purchase of private coverage.

In developing subsidies and incentives, we would pay particular attention to firms with fewer than 10 employees; today 54 percent of them do not offer coverage.

The role of the individual employee is critical in this equation. Again we face a question of balancing responsibilities - in this case between the small employer and the employee. The small employer must offer coverage and the individual would have to accept it. Most employees would continue to have the major share of their premium paid by their employer. All employees working for small employers who only offer coverage would have a significant share of their premium subsidized. Funding for this subsidy would come primarily from the assessment paid by their employer. In addition, substantial tax subsidies would be provided to low-income employees to assist them in purchasing coverage for themselves and their families.

Individuals not connected to the work force should have incentives to purchase private insurance, and government subsidies should be available to those who cannot afford the cost of private coverage.

Those who cannot afford private insurance, even with this assistance, should be covered under an expanded Medicaid program. Medicaid eligibility should include all individuals and families below the federal poverty level, regardless of age or family structure.

PORTABLE COVERAGE

We believe that reforms are needed to assure that coverage is continued as individuals move from job to job or between public and private programs. "Job lock" has become a serious problem in America. More and more Americans are afraid to change jobs because they will lose coverage of preexisting conditions for a period that can range from months to a year.

As employers and employees take responsibility for offering and accepting health care coverage, there will be no need for such practices as preexisting condition exclusions and waiting periods. Insurers need these only to prevent people from buying coverage only when they need it.

The Blue Cross and Blue Shield system also is exploring private market alternatives to reduce the administrative burden on employers resulting from the current COBRA continuation of coverage requirements.

III. CONCLUSION

In conclusion, we acknowledge that the problem of the uninsured population is very serious, and that it demands a concerted effort by the private sector and government. At the same time, the problem of the uninsured should not be viewed as an indictment of the private system of health care financing. The private system is meeting the health care financing needs of an overwhelming majority of Americans.

The Blue Cross and Blue Shield System is continuing its efforts to assure more efficient administration of private insurance programs, and more efficient and appropriate use of services. We stand ready to work with government to develop a series of well-planned, coordinated steps that will help assure access and control the increases in health care costs that have made access the serious problem it is today.

3901C

REPRESENTATIVE SCHEUER. Next, we'll hear from James F. Doherty, President and CEO of the Group Health Association of America, Inc. (GHAA). Mr. Doherty joined the GHAA staff in 1970, following several years as counsel to the Committee on Banking and Currency of the U.S. House of Representatives.

We're happy to welcome you back to your old haunts, Mr. Doherty. Please proceed.

STATEMENT OF JAMES F. DOHERTY, PRESIDENT AND CEO, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

MR. DOHERTY. Thank you, Mr. Chairman. And I'll try to shorten my short statement in the interest of time.

In our testimony this morning, we've been asked to testify on administrative costs and on our health-care delivery systems.

Our track record for holding down costs is pretty well unquestioned. A recent Foster-Higgins survey showed that our health-care costs per employee are some 16 percent less than the normal indemnity fee-for-service sector. There's a number of reasons for this. We provide care for patients on a fixed prepayment, and we developed incentive arrangements, which I think are rather important, with providers designed to promote the efficient delivery of health-care services with due regard for quality. We are also carriers and providers of health care at the same time, so we integrate delivery of financing systems to reduce the need for complicated claims processing. And furthermore, we do not use extensive deductibles or significant co-payments, and that further reduces our administrative costs.

Now, to get to the numbers. According to our surveys, a weighted average, the data shows that the mean total expense per member per month in an HMO is around $92.33. Of this, 35 percent is spent on hospitalization, 56 percent for medical costs, and 9.4 percent on nonmedical administrative costs.

However, because of the economies of scale, the average weighted aggregate administrative cost across larger HMOs—that means those with more than 100,000 enrolles—was only 8 percent of expenses. Costs are likely to be even lower for the very largest HMOs. For example, the Health Insurance Plan of Greater New York—and I cite this only through an amazing coincidence—a large nonprofit group model HMO with 900,000 members in the New York City area, had administrative costs of 5 percent. Group Co-Op of Puget Sound, with 460,000 members, 5.1 percent. And when, as you see, they grow larger, the administrative costs go down. Kaiser Permanente, with 6.2 million individuals enrolled, have spent 2.5 percent of total expenses on administrative costs.

It's important to realize that HMOs, as we know them in the United States, do not exist in Canada. A major reason is that the Canadian system has made it difficult, if not impossible, for HMOs to survive or

prosper. Despite the focus on private delivery of care, the Canadian system creates barriers to HMO development.

First, in Canada, federal requirements for universal coverage and access have been interpreted to exclude all but very minor rare user charges and guarantee open access to any provider in the area.

For an HMO to function, its enrolled population must be clearly defined and have the ability to manage the care of that population within its delivery system. This is hard to achieve in Canada, because enrolles always have the option to use any provider at no additional expense to them. Therefore, HMO-like organizations are open to fee-for-service patients, with no incentives for these patients to comply with the managed care guidelines.

Indeed, in the late sixties and early seventies, there were three very fine HMOs—our members in Canada—and they've all gone out of business as HMOs, although they are still delivery systems under the Canadian system.

HMOs have been traditionally able to negotiate discounts with providers because they can provide volume and steady business for the providers. It's through such negotiated discounts that HMOs are able to offset the costs of providing comprehensive benefits.

Implementing a mandatory single-payer rate for hospitals and providers can well remove the incentive and ability of an HMO to offset costs and provide comprehensive benefit packages. This agrees with the testimony of the two previous witnesses in their emphasis on managed care.

HMO design in the United States is based on an integrated system which rewards cost-effective delivery of quality care. The Canadian system, on the other hand, relies on a variety of regulatory provider controls, with no focus on the appropriateness of the overall allocation of resources.

REPRESENTATIVE SCHEUER. Excuse me. Doesn't the pressure resulting from the global setting of expenditures focus the attention of the hospitals and other health-care institutions, within the geographical area in which they are involved, on making sure that only necessary and appropriate health-care methods are used? Now, they may have a lesser level of technology than we have, but leaving out the question of high-tech, doesn't the principle of global budgeting in health care assure that somebody in the office of the hospital administrator is going to be watching carefully, screening out, and preventing inappropriate and unnecessarily costly levels of health-care expenditures in that hospital? They have a budget that they have to live with.

MR. DOHERTY. I don't think that's necessarily true. If it were true, then we wouldn't be getting the requests in our organization, and as Mary Nell has and the insurers have, from very sophisticated socialized systems, such as the Swedes, the West Germans, the French. They've all been in to see us. The British are extremely sensitive to the cost-containment things. And, indeed, one of the imminent American policy analysts, Dr.

Alain Enthoven, had a lot to do with some recent changes that were brought in the British system.

I think what we're talking about is that in the managed care aspect of things, if you have a system which is simply cost-reimbursed and you do not provide incentives in that system for the kind of competition, pluralism, and what not, then that is going to be lost. The whole idea of private-sector competition is going to be lost in terms of bringing about what you see as the objective, which is universal access to comprehensive services.

I think that these countries are beginning to have some thought about trying to inject competitiveness. There's a great irony here.

We have a very inefficient health-care delivery system in the United States, a very high-cost system. We've all admitted that. Mr. Steinberg admitted that. But the irony is that we do manage care better than anybody else in the world, and they're coming over to look at our managed care things. I think all we're suggesting is that—I don't know about the other witnesses—you ought to look at how we can make the managed care component of our system more efficient and universal.

REPRESENTATIVE SCHEUER. I find it hard to understand how you can say that we have the most efficient system of managing health care in the world. Is that more or less a paraphrase of what you said, or have I unjustly——

MR. DOHERTY. No, sir. I said we are the most inefficient health-care delivery system in the world. However, the managed care component is more efficient than anywhere else in the world. There are 36.5 million people in this country who belong to managed care systems. But it's that small component that leads other nations to take a look at us. And there's a lot more to be learned—it seems to me—by taking a hard look at managed care.

Some of the things that Dr. Welch has recently published, in terms of a tremendous ripple or halo effect in the communities themselves, is that this competitive aspect of the HMOs and managed care systems does have a tendency to depress hospital costs overall, or hospital stays overall, in the community. So, all we're saying is that if you want to go to a single-payer system, that may be well and good, but before you get there, you ought to look at some of the single-payer systems, and particularly at those that do not have pluralism or competitive systems built in.

REPRESENTATIVE SCHEUER. Well, presumably, they may not have a competitive system, but by establishing a budgeted, maximum level of health expenditures, don't they get the same effect of concentrating people's minds on making economies where they can?

MR. DOHERTY. That's an aspect. The idea of prospective budgeting has even been adopted in this country with your DRG legislation. Prospective budgeting is a key component of managed care organization.

REPRESENTATIVE SCHEUER. Yes.

MR. DOHERTY. So, these efficiencies are not peculiar simply to the single-payer systems.

I'm not arguing against the single-payer system. It just seems to me there's a lot of things to be looked at before that rather drastic and time-consuming step is taken.

You know, the Canadian national health system began in the late forties in Saskatchewan, and it's going to take you a long time to get from here to there. It seems to me that there are a lot of components of health-care delivery and health-care policy that you ought to look at before you take this rather drastic step. One of those components is how do you get the benefits and advantages of competition and incentives toward efficiency?

REPRESENTATIVE SCHEUER. Can you get incentives toward efficiency without competition by the basic underlying principles of global budgeting?

MR. DOHERTY. You can get some benefit through global budgeting, but it seems to me that there ought to be sort of winners and losers within that game.

REPRESENTATIVE SCHEUER. Oh, there definitely are.

MR. DOHERTY. And that this is what——

REPRESENTATIVE SCHEUER. I'm sure the Canadian doctors and hospitals would be happy to enlarge on that. Of course, there are winners and losers. There have to be.

MR. DOHERTY. I'm not familiar with the details of what happened in Great Britain, but I do know that they have inculcated a system——

REPRESENTATIVE SCHEUER. We have a doctor on the next panel who has extensive experience in Canada. I will ask him this question.

MR. DOHERTY. ——hospital area.

REPRESENTATIVE SCHEUER. Pardon?

MR. DOHERTY. Question him about what Great Britain has done in the hospital area, in terms of trying to put some competition into the system, so that the more cost-efficient hospitals are rewarded.

REPRESENTATIVE SCHEUER. I don't think anybody is advocating that we adopt major portions of the British system. Some of their concepts of health rationing would be totally unacceptable in this country. For example, if you're over 55, you cannot get kidney dialysis under their system. I'd be drawn and quartered if I suggested such an approach to my people in New York. And maybe some other atrocities would take place before I was drawn and quartered. [Laughter.]

MR. DOHERTY. I'm sadly amused at the GAO report that says that there are long queues in Canada for incidental things. And then one of the incidental things are heart bypass operations. There's a problem in all of these systems.

REPRESENTATIVE SCHEUER. It is true. And there's also evidence from recent studies that we do too many heart bypass operations. I hope somebody will comment on that, either in this panel or in the next panel.

You could say they don't do enough hysterectomies in, say, England. We do a heck of a lot more in this country than are done overseas per hundred thousand in population, and the evidence is rather clear that our rate of hysterectomies does not improve the health of American women in any clearly definable way over the British rate, which I think is about half of ours.

So, the question is: What proportion of these quadruple heart bypass operations are medically justifiable and appropriate?

MR. DOHERTY. Absolutely right.

REPRESENTATIVE SCHEUER. Now, you mentioned that we have the most ineffective, wasteful health-care system in the world—something to that effect. Can you tell us with a surgeon's scalpel what elements in our health-care system are clearly inefficient and wasteful and uneconomic?

MR. DOHERTY. Most of the studies that I've seen is in the area of unneeded and unnecessary services.

REPRESENTATIVE SCHEUER. That's this 40 percent that we're all talking about.

MR. DOHERTY. Right. And then we have a number of things in the managed care area that concerns us that are very wasteful. Mandated benefits at the state level. You've heard often about the case of wigs in Minneapolis being a mandated benefit for certain diseases, skin diseases.

REPRESENTATIVE SCHEUER. Did you say wigs?

MR. DOHERTY. Wigs.

But any willing provider legislation where an HMO or a managed care system in a state has a closed set of providers, then we hear from the pharmacists and others that they've been excluded. And so the state will pass a law saying that we have to use these systems, regardless of what they do or don't do for our efficiency. We have to go to all providers in the state or anybody that wants to join.

So, there's a lot of things. It's unnecessary services. It's state laws that impose benefits that are neither necessary nor desirable, or in a way that aren't necessary.

[The prepared statement of Mr. Doherty follows:]

PREPARED STATEMENT OF JAMES F. DOHERTY

Good morning Mr. Chairman and members of the Subcommittee. My name is James Doherty and I am President and CEO of the Group Health Association of America, Inc. (GHAA). GHAA is the nation's oldest and largest trade association representing health maintenance organizations (HMOs). GHAA members account for 75 percent of the people enrolled nationwide in 569 HMOs.

I have been asked to testify today on the administrative costs of HMOs in the United States and the impact of imposing a Canadian-like national health care system on prepaid health care organizations such as HMOs. Before I begin, I would like to offer a brief overview of some of the industry trends among HMOs.

HMO INDUSTRY TRENDS

HMOs provide cost effective, quality, comprehensive health care services to members in exchange for a pre-determined, fixed monthly premium. Emphasis is on early access to care in order to keep people healthy and to detect serious illness as early as possible.

Since their development, HMOs have emerged to provide organized, prepaid, quality health care to over 36.5 million Americans nationwide. In many areas of the country, HMOs have a significant share of the market. For example, in the San

Francisco Bay-Sacramento area, 46 percent of the population are enrolled in an HMO. Similarly, HMOs in the Minneapolis-St. Paul area have 44 percent of the market. In total, 22 percent of the population in the 30 largest U.S. metropolitan areas were enrolled in an HMO in 1989.

In 1973, Congress passed the Federal HMO Act to encourage the growth of HMOs. This Act set forth standards for HMOs wishing to be "federally qualified." A federally qualified HMO must meet specific standards that assure the HMO provides a comprehensive benefit package with limited cost-sharing, that services are community rated and available and accessible, that the plan is fiscally sound, and importantly, that there is a quality assurance system in place.

Specifically, federally qualified HMOs are required to provide a number of basic benefits. These include: inpatient and outpatient physician and hospital services, emergency services, diagnostic laboratory and therapeutic services, preventive health services, short-term rehabilitation and physical therapy services, outpatient mental health services, and substance abuse services.

Copayments are restricted and deductibles for basic benefits are prohibited except for a limited point of service option permitted in 1988. Further, federally qualified HMOs are not permitted to have waiting periods or pre-existing condition exclusions for their group accounts.

By year end 1990, about half of all the HMOs in the country were federally qualified. However, enrollment in these HMOs represented 74 percent of total HMO enrollment.

Now let me highlight some of the HMO industry trends as they relate to rating.

Rating Trends. Prior to 1988, HMOs which were federally qualified were only permitted to use two types of rating methods -- standard community rating (CR) and community rating by class (CRC). The HMO Act Amendments of 1988 added a new type of rating, adjusted community rating (ACR). ACR, while still a prospective rate, allows some adjustment in rates for anticipated group-specific experience. HMOs need the flexibility of ACR to respond to employer demands and remain competitive in the changing marketplace.

Briefly, CR, the "traditional" method of rating used by HMOs, involves setting prospective rates for all enrollees in a particular class of business, such as group or non-group. Within that class there are separate rates for "single" and "family" coverage.

CRC involves adjusting the community rate based on certain demographic characteristics of the group, such as age and sex. This allows younger, healthier groups within the class to get better rates since they are expected to have lower utilization. In turn, high risk groups will pay more.

ACR is a prospectively determined rate based on the expected experience of a particular group in a class of business. No retrospective adjustment is permitted, in contrast to true experience rating. To assure that federally qualified HMOs using ACR would still offer premiums affordable to small groups, the 1988 amendments limited the use of ACR for individuals and families in groups of 100 persons or less to 110 percent of the community rate.

Despite the use of ACR, HMO rating methods continue to differ considerably from those commonly used in writing indemnity insurance. Almost all rating within the HMO industry continues to be prospectively based. According to the GHAA Annual HMO Industry Survey, less than 10 percent of all established HMOs (those three years old and older) used any retrospective adjustment in setting rates in 1990. Most HMOs - 69 percent - used only community rating methods permissible under the HMO Act, regardless of federal qualification.

In 1990, 44 percent of all HMOs used only CR or CRC in rate setting but GHAA data show that an increasing number of HMOs are making some explicit adjustment for group experience in setting rates. We expect to see a greater use of ACR in the future in the large group market. Since 1989 was the first full year that ACR was available as a rating method for federally qualified HMOs, many are still developing the data systems necessary to use this method of rating.

Benefits. HMO benefit packages reflect HMO commitment to access to comprehensive coverage that encourages preventive care and early treatment. Despite fiscal pressures to increase cost sharing and reduce benefits, the GHAA data show that HMO benefit packages, on the whole, continue to be comprehensive even for those HMOs that are not federally qualified. For example:

- 77 percent of all established plans covered hospitalization without patient payment in 1990; virtually all (99 percent) covered primary care with no limit on the number of visits.

- 72 percent of plans required a payment for primary care visits, almost always in the form of a fixed dollar copayment. The most common copayment was $5. Generally, no extra charges were required for laboratory or radiology services.

- While over 99 percent of plans covered prenatal and well baby care, only 50 percent and 57 percent respectively charged copayments for these services.

- Also, 96 percent of HMOs covered prescription drugs in their best selling package. Although 90 percent offered this benefit with some patient cost sharing, the typical copayment was $3-$5 per prescription. Further, only 9 percent applied a dollar limit to this benefit.

In addition, data shows that 81 percent of plans report that their benefit package was basically the same in 1990 and 1991; only 2 percent made major changes. While increased cost sharing was reported in 1988, 1989, and 1990, 32 percent of HMOs reporting in all three years had no increase in cost sharing over the entire time period.

As you know by now, availability of health coverage is only one part of the problem plaguing the American health care system. Affordability is another.

HMO COST CONTAINMENT

HMOs have a track record of holding down costs -- for government, private employers, and individual and family HMO members. A recent employer survey by A. Foster-Higgens showed that in 1990, employers paid 16 percent per employee per year less for HMO coverage than for traditional health insurance. HMO coverage averaged $2,683 per worker, a savings of $531 over the $3,214 paid for indemnity insurance.

Further, studies show that between 1987 and 1990, premium increases for HMOs -- group, staff and IPA models, were below that of traditional indemnity products, including those with cost containment features. HMOs do this in a number of ways.

First, HMOs provide care for patients for a preset fixed payment and have developed appropriate incentive arrangements with providers designed to promote efficient delivery of health care services.

The goal of each HMO is to preserve quality care and eliminate unnecessary services. In this way, HMOs are able to achieve continued cost savings over the long run, not just one time cost-savings as reported in some other "managed care" systems.

This means that it is important to have monitoring systems to assure the quality of care is not jeopardized. All HMOs are required by law to have internal quality assurance systems to measure the quality and outcomes of care being delivered through the HMO. HMOs are also subject to external review of their quality. For example, those HMOs which contract with HCFA to provide Medicare services are subject to peer review organization (PRO) review of both ambulatory and hospital care. This type of oversight of HMO quality has no counterpart in the fee-for-service sector.

Second, by having integrated delivery and financing systems, HMOs are able to save on administrative expenses. Since HMOs are both carriers and providers of care they are able to integrate their delivery and financing systems to reduce the need for complicated claims processing systems.

Further, because HMOs tend not to use deductibles and significant copayments, their needs for complicated administering and tracking systems are reduced. This integrated and coordinated system of managed care serves to lower overall health care costs and allows the HMO to provide their enrollees with a more comprehensive benefit package.

ADMINISTRATIVE COSTS

While HMO administrative costs are typically less than those of indemnity carriers, it should be noted that within HMOs as well as indemnity insurers there is considerable variation in the way that administrative costs are calculated and what these numbers reflect. Further, because HMOs combine delivery and financing systems, it is misleading to compare the administrative costs of HMOs with those of tradition insurance which does not have delivery responsibilities.

Even among HMOs, definitions of what is included in the plan administrative costs vary. For my purposes today, I will be referring to non-medical administrative costs - that is, the costs incurred by HMOs in organizing the managed care system, marketing benefits, enrolling individuals, processing benefits/claims and complying with government regulation.

In 1989 GHAA data shows that the mean total expense per member per month in an HMOs was $92.33. Of this approximately 35 percent was spent on hospitalizations, approximately 56 percent was for medical costs and 9.4 percent for non-medical administrative costs. However, because of economies of scale,

the average costs for plans with 100,000 enrollees or more was only 8 percent of expenses; and costs are likely to be considerably lower for the largest plans.

For example, the Health Insurance Plan of Greater New York (HIP), a large non-profit group model HMO with 900,000 members operating in all five boroughs in New York City, Westchester, Nassau and Suffolk counties, in 1990 had administrative costs of 5 percent. Group Health Cooperative of Puget Sound, a staff and network model HMO enrolling over 460,000 members in Washington state spent approximately 5.1 percent of total expenditures on administrative costs in 1990.

Kaiser Permanente, on the other hand, the largest group model HMO, enrolling some 6.2 million individuals nationwide, spent 2.5 percent of total expenses on administrative costs in 1990. This is comparable to administrative expenses incurred by Medicare.

Further, for older plans, those in existence for over 16 years, the average administrative costs amounted to 6.1 percent of administrative costs. This shows that administrative costs decrease as the HMO matures and achieves substantial membership.

In a June 1991 report by the General Accounting Office, (GAO) titled "Canadian Health Insurance: Lessons for the United States," GAO asserts that if the universal coverage and

single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for millions of Americans who are currently uninsured and possibly eliminate copayments and deductibles, if appropriate.

While adopting a Canadian health care system might reduce some administrative costs such as marketing and possible coordination of benefit expenses, on the whole we doubt that it would achieve administrative cost savings alleged by GAO, especially in HMOs where there are already low administrative costs.

Now let me turn to the Canadian Health Care system.

CANADIAN HEALTH CARE SYSTEM

In recent years, U.S. health policy makers, providers, purchasers and researchers have looked to the Canadian health system as a possible model for the U.S. to adopt when reforming our health care system. However, during this examination, very little attention has focused on the implications of the Canadian system on prepaid, organized health care delivery.

It is important to realize that HMOs, as we know them in the United States, do not exist in Canada. A major reason is that the Canadian system has made it difficult, if not impossible, for plans of this type to survive and prosper.

Although the U.S. has not done nearly as well in providing universal access to care or in controlling health care costs, the U.S. has - in contrast to Canada - actively encouraged innovation in health care delivery and finance. As the United States pursues the debate over how best to encourage universal coverage, it is important to understand the problems that a Canadian-like model poses to organized delivery systems like HMOs and other forms of managed care that currently exist and are developing in the U.S.

As you know, the Canadian health system came into being through a series of enactments originating with the Hospital Insurance and Diagnostic Services Act in 1957 and culminating with the Canada Health Act of 1984. Under this system, costs are shared by the provinces and the federal government, which established the structure for the system by defining its basic principles.

Under the Canadian system, each provincial government essentially administers a single insurance plan. While financing is largely public, health care delivery is private; generally it is provided through nonprofit community based institutional services and physicians in private practice. Hospitals are paid on global budgets, with separate approval for capital projects and equipment. Physicians are paid largely through negotiated fees.

Despite the focus on private delivery of care, the Canadian system creates certain barriers to HMO development by

eliminating the incentives needed for physicians, institutions, and patients to support the existence and development of HMO-like plans. Let me briefly discuss some of these barriers.

1. **Lack of Ability to Create a True Closed Panel and Lock-In**

In Canada, federal requirements for universal coverage and access have been interpreted to exclude all but very minor, rare user charges and to guarantee open access to any provider in the system.

For an HMO to function, its enrolled population must be clearly defined, and the plan must have an ability to manage the care of that population within its delivery system. This is hard to achieve in Canada because enrollees always have the option to use any provider -- at no additional expense to them. Therefore "HMO-like" organizations are open to fee-for-service patients with little plan loyalty and no incentives for the fee-for-service patients to comply with managed care guidelines such as gatekeeper referral.

2. **All Payer Rate Systems**

All payer rate systems, such as those used in Canada, may also be problematic for HMOs. HMOs have traditionally been able to negotiate discounts with providers, e.g. hospitals, and physicians, because they can provide volume and steady business for the providers. It is through such negotiated discounts that HMOs are able to offset the costs of providing such comprehensive benefits with first dollar coverage.

Overlaying a single payer rate for hospitals and providers may remove the incentive and ability of an HMO to offset costs and provide comprehensive benefit packages. The best approach instead, may be to permit HMOs the option of participating in such a rate setting system, similar to how Medicare and HMO Medicare risk contractors relate now. For example, Medicare has given Medicare risk HMOs the option of using the DRG rate as a limit on what the hospital can charge the HMO, or allow the HMO to negotiate a lower rate - if possible. This has a positive impact on the HMO's costs and therefore benefits the HMO member -- in this case a Medicare beneficiary and the government.

3. Failure to Put Plans at Risk for All Services

HMO design in the United States is based on an integrated system which rewards cost-effective delivery of quality care and comprehensive benefits. HMO delivery systems use savings achieved from prudent hospital and ambulatory utilization to fund expanded benefit packages which are appealing to consumers.

In Canada, this system of integrated private sector incentives is lacking. Instead, the Canadian system relies on a variety of regulatory provider controls with no focus on the appropriateness of the overall allocation of resources or service mix.

For example, in Ontario, between three and four percent of the population is enrolled in HMO-like organizations. However,

the majority of these plans are capitated for primary care services only, not capitated for hospitalizations or, in general, for specialty referrals. They do receive an incentive payment for savings in hospital days, but at only approximately one-third of the actual savings.

Thus, these providers may not be sufficiently at risk financially for health care services, are not "penalized" for unnecessary care, and are not appropriately rewarded for reducing high cost hospitalizations. As a result, these incentives do not financially reward integrated, cost-effective care, and would not produce the savings necessary to fund the expanded benefit packages and limited out-of-pocket costs that attract enrollment here in the United States.

4. Difficulty in Developing Attractive Benefit Packages

Research has consistently shown that comprehensive benefits, low out-of-pocket costs, and competitive premiums compared to indemnity insurance, provide the strongest motivations for individuals to enroll in an HMO. Because Canada's system provides universal access at virtually no direct expense, the incentive to join an HMO would be limited even if HMOs had full access to the savings they achieved and offered uncovered services such as outpatient pharmacy benefits or eyeglasses. In Canada, an HMO-like organization is placed in the position of touting relative intangibles such as improved quality, flexible providers, and coordination of services in a delivery system.

HMO-like organizations are not allowed to market their product and thus are limited in their ability to educate the public in order to seek additional enrollment.

In addition to those barriers just mentioned, Canada has certain characteristics that distinguish them from the U.S. These include but are not limited to:

- The domination of hospitals in the Canadian system, (attributable in part to the 10-year lag between the introduction of hospital and medical insurance) has lessened the ability to encourage non-hospital based alternatives.

- The fragmentation of Canada's system into hospital and physician components resulted in multiple provincial bureaucratic agencies, each with vested interests and limited scopes of concern, a situation not conducive to system-wide innovation or aggregate risk arrangements.

Canadian Concerns and Future Initiatives. Mounting fiscal pressures on the provinces have accentuated the provincial interest in initiatives that encourage greater cost-effectiveness and reallocations. Despite consensus in Canada that major change is not desirable, pressures are building for some modification in the system.

Recently there was widespread attention given to increased management of health resources, including alternatives to

fee-for-service practice. Concerns in Canada include: the institutional focus and heavy use of inpatient days, the need to redirect resources toward prevention and improve coordination of services, increases in ambulatory volume which have led to the use of physician expenditure targets in several provinces, and the limited ability to encourage the use of alternative providers such as nurse practitioners and non-hospital based alternatives such as ambulatory surgery centers.

It is important to note that these concerns, are addressed in the basic tenets of HMO-like arrangements.

In Ontario, small developmental grants are being offered to Comprehensive Health Organizations (CHOs) which would be fully capitated and allowed to advertise but would still permit individuals the right to seek care from any provider. A similar, but more limited approach, was proposed in Quebec last year. Other provinces are considering a variety of initiatives. Despite these modest changes, however, the constraints in the current Canadian system limit the likelihood of any widespread introduction of HMOs in Canada in the foreseeable future.

An unanticipated side-effect of national health systems, regardless of whether care is publicly or privately organized, is that they have tended to perpetuate fee-for-service systems and result in institutional rigidity. In other words, absent concerted efforts to the contrary, national health systems

unless carefully developed may reinforce the status quo fee-for-service system and deter other cost-efficient pluralistic approaches such as HMOs. For Canada, this is unfortunate; some of the limitations being experienced there could have been avoided had there been specific provisions designed to spur innovation in alternative delivery and financing systems.

One critical lesson we can learn from Canada is to avoid the natural inclination to construct a system entirely around a predominant fee-for-service mode which clearly isn't working in the areas of access, cost and quality. Rather, GHAA would recommend that any reform approach used in the U.S. have an integral role for HMOs and other comprehensive managed care systems from the start.

Unless this integral role is planned from the outset, inevitable conflicts stemming from the fundamental differences and inconsistencies between fee-for-service practice and prepaid organized delivery systems will preclude HMOs from participating fully in this new system. Creating a more consciously pluralistic system up front would enable the U.S. to avoid repeating the mistakes made by Canada and may provide the best opportunity to build on the strengths of both the U.S. and the Canadian systems.

Finally, I would like to point out that the June GAO report also concludes that "a reformed U.S. system should also retain and build upon the unique strengths of the existing

54-863 O—92——11

structure of U.S. health care. The strong U.S. research establishment, the continuing development of medical technology, and the capacity to evolve new and potentially more efficient service delivery mechanisms, such as health maintenance organizations, are characteristics of the U.S. system that should be preserved, even as we search for models elsewhere that would help us overcome our recognized problems."

CONCLUSION

In conclusion, GHAA believes the HMO industry serves as an example that quality, comprehensive health care services can be provided for an affordable price. In fact, many in the U.S. health care marketplace have copied HMO techniques in their "managed care" products in order to be more cost effective. Further, other nations like Canada are looking to HMOs as models for reforming their systems when they look at greater cost-effectiveness.

GHAA strongly believes that managed care has a role to play in any plan to address the needs of the uninsured. We are, however, concerned about the impact that a poorly devised Canadian-like health care system would have on the future of prepaid organized health care systems.

We look forward to working with you Mr. Chairman and members of the Committee as you continue to discuss these issues and try and arrive at an effective and equitable solution so that every person has access to health care.

REPRESENTATIVE SCHEUER. All right, Mr. Doherty. Thank you very much for your testimony.

Now, we'll hear from W. Pete Welch, who is a Senior Research Associate at the Urban Institute in Washington. He's a distinguished graduate of Swarthmore College in Swarthmore, Pennsylvania—I hasten to add. Prior to joining the staff of the Urban Institute, Mr. Welch served as a health economist in the Office of Management and Budget.

Please proceed, Mr. Welch.

STATEMENT OF W. PETE WELCH,
SENIOR RESEARCH ASSOCIATE,
THE URBAN INSTITUTE

MR. WELCH. Thank you very much, Mr. Chairman.

REPRESENTATIVE SCHEUER. If you wish to comment on anything that I've said or anything that anybody in the panel has said, please do so. I'll extend the same opportunity to any of you to react to anything you've heard this morning.

MR. WELCH. Because there's a time constraint, I think I'll focus on my prepared remarks. My basic point is, on the one hand, academic; on the other hand, I think crucial to the debate that compares Canada to the United States. In such international comparisons, two measures of cost containment are used; the first being real health-care costs per capita; the second being the percentage of GNP going into health.

My basic point is that the first measure—real health-care costs—is biased and heavily biased against nations experiencing economic growth. Whereas, the second measure—percentage of GNP—is a reasonable measure of cost containment.

But let me first give you the theoretical argument for this. Consider a nation that is experiencing economic growth. That means that real GNP per capita is increasing. When that occurs, necessarily, real wages increase in general, because most income is in terms of wages.

Now, when wages are increasing across the economy, wages have to increase in the health-care sector because that sector has to attract and retain labor from other sectors of the economy. And when real wages go up in the health-care sector, real health-care costs per capita necessarily rise.

So, economic growth necessarily increases real health-care costs per capita. Note that in such a situation nothing has changed in the health-care sector in real terms. Rather, the state of the entire economy has changed. And, therefore, when you're trying to measure what's happening, to the cost of care in the health-care sector, you are actually measuring what's happening in the economy, as a whole.

Hence, if one uses real health-care costs per capita as your measure of cost containment, some nations will appear unsuccessful in cost containment simply because they are successful in terms of economic growth. That's the basic theoretical argument.

Let me present some of the empirical evidence in support of it.

REPRESENTATIVE SCHEUER. Are you stating that when a country is enjoying prosperity, the percentage of their GNP that goes to health increases, because health-care workers make more than the average wage in that country?

MR. WELCH. No. That's not the argument. I'm not speaking to the level of wages in the health-care sector versus the rest of the economy, I'm speaking to the growth. When the economy grows, wages throughout the economy must grow, including in the health-care sector. I haven't really spoken to GNP—per se—I'm simply saying that if you——

REPRESENTATIVE SCHEUER. Excuse me. If wages in the economy grow at the same rate as wages grow in the health-care sector, there won't be any change in the percentage of gross domestic product that goes to health, is there?

MR. WELCH. Yes. In essence, that's what I'm getting at. But the insurance industry does point to dollars per capita spent on health. Right now, I'm abusing us of that concept, as a useful measure of cost containment, because dollars per capita will go up, whereas the percentage of the GNP going into health probably isn't going to change. At any rate, there's been considerable scholarly work on the relationship between health-care expenditures and GNP. In general, or I should say all the——

REPRESENTATIVE SCHEUER. I'm going to suspend this hearing in a few minutes. There's a roll-call vote on.

Excuse me. Please proceed, Mr. Welch.

MR. WELCH. Sure. I'll try to shorten this a little bit.

There have been a number of econometric studies of the relationship between health-care costs and GNP per capita. And, in general, when the GNP goes up by 10 percent, health-care costs per capita in real terms also go up by 10 percent. But as you've already alluded to, the percentage of GNP doesn't change, in essence, because the numerator and the denominator wash out. Hence, I find the percentage of GNP to be a fair measure of cost containment in nations that are experiencing economic growth, as Canada has over the last two decades. This brings us back to using percentage of GNP; the Americans, of course, being at roughly 12 percent and the Canadians at 9 percent, and so forth.

Let me focus in very briefly on administrative costs. My friend Morris Barer from British Columbia and I tried to put together comparable figures for the United States and Canada over a period of time. We don't have figures on all components of administrative costs. We have figures only on the insurance overhead. The American figures come from HCFA, and these are the figures that Gordon Trapnell started off talking about. Our comparable figures go from 1971 to 1989. As a percentage of GNP, insurance overhead in the United States went up 3 percent per year.

Now, keep in mind, because we're speaking in terms of the percentage of GNP, we've already deflated for prices. We've already adjusted for population growth, and so forth. And, in spite of this, the U.S. figure went

up 3 percent. Over the same time period, the Canadian comparable figure dropped by 1 percent per year. Cumulatively, over the 16-year period starting in 1971, the Americans were well above Canada and, as a percentage of GNP——

REPRESENTATIVE SCHEUER. Above Canada, in what?

MR. WELCH. In terms of the percentage of GNP going to the insurance overhead, starting from a high point, they went up. And they went up over a 16-year period by 72 percent. The Canadians, starting low, went down by about 15 percent.

REPRESENTATIVE SCHEUER. All right. I'm going to suspend that and make this roll-call vote. And when I come back, Mr. Welch, I'm going to ask you to explain that to me in very simple layman's language.

[Laughter.]

MR. WELCH. Thank you for the forewarning.

REPRESENTATIVE SCHEUER. I was an honor student in economics.

[Brief Recess]

REPRESENTATIVE SCHEUER. On page 25 of today's *Washington Post*, there's an article by Spencer Rich, who is quite an experienced health-care reporter for the *Washington Post*, in which he interviews Otis R. Bowen, who was former Secretary of Health and Human Services, and his former Chief of Staff, Thomas R. Burke. And they say that the continuing incredible growth in U.S. health outlays stems from a huge advantage that doctors and hospitals bring to the marketplace. They can generate demand and sell services simply by telling sick people they need them.

If anybody wants to read it, we have the original here and, I think, a couple of copies. I'll pass them out to anybody who wants to read them.

All right. Mr. Welch, you were getting to the heart of the matter. Why don't you sum up and tell us from the mountain top—from the point of view of a pure health economist—where are the targets of opportunity for saving large amounts of money from the health-care system; meanwhile, hopefully, providing for universal access and comprehensive care, assuring quality standards?

MR. WELCH. You're, I think, broadening the issue considerably from——

REPRESENTATIVE SCHEUER. Well, why don't you narrow it for me. [Laughter.]

MR. WELCH. Well, when we had the recess, I think you had one or two questions from my oral testimony. It's unclear to me whether the questions were limited to my figures on insurance overhead, or pertain to the more general and theoretical argument.

REPRESENTATIVE SCHEUER. Why don't you take off and respond to the direction of the questions as you see them?

MR. WELCH. Well, I was just coming to the end of my testimony, and talking about insurance overhead as a percentage of GNP.

Previously, I have argued that when you make international comparisons, particularly in terms of changes over time, you should use percent-

age of GNP. Since this hearing is focused on administrative costs, I tried to look at the percentage of GNP going into administrative costs.

REPRESENTATIVE SCHEUER. Let's focus it a bit. Canada spends 9 percent of its gross domestic product on health care. The United States spends a little in excess of 12 percent. Would queues for health care exist in Canada if they increased their spending from 9 percent——

MR. WELCH. Presumably, their queues would go away pretty quickly.

REPRESENTATIVE SCHEUER. Yes.

MR. WELCH. Long before you got to 12 percent.

REPRESENTATIVE SCHEUER. Right. Around what point? Ten percent? Ten and a half?

MR. WELCH. I really don't have any idea. I think that, as I concluded in my written testimony that you quoted, we really don't know very much about waiting times and quality of care when we compare these two systems. What I think we do know is that one system is much more expensive than the other.

REPRESENTATIVE SCHEUER. And do we know why? Is it because the Canadians, through their global budgeting, are able to effect economies and more cost-conscious decision-making by doctors than our present system of managed care? Is it attributable to that? Is it attributable to something else?

MR. WELCH. You're now raising a comparison between U.S. managed care—as represented by the HMOs and Mr. Doherty—and the Canadian system.

One quick question, which is of interest and I certainly can't answer right now, is how well do American HMOs do relative to the Canadian system in terms of cost? We're forever comparing them to fee-for-service. Against Fat City, they do pretty well. Against Canada, it remains to be seen.

[The prepared statement of Mr. Welch follows:]

PREPARED STATEMENT OF W. PETE WELCH[1]

In international comparisons of health care expenditures, there is debate over the appropriate measure of cost containment. Analysts use both real per capita health care costs and the percentage of GNP going to health care. In particular, an assessment of Canada's experience is heavily dependent on the choice of measure. Canada's critics in this country point to the fact that real per capita health care costs have increased in Canada. In contrast, if the percentage of GNP is the measure, Canada has controlled its costs much better than the U.S.

The most important conclusion of this presentation is that real per capita health care costs is an unfair measure for a nation experiencing real economic growth, as Canada has over the last two decades. In the long run, rising real GNP per capita increases real wages in the health care sector, causing health care costs per capita to rise. In judging the comparative international performance of one sector of the economy, such as health care, it is inappropriate to use a measure that is heavily influenced by the comparative performance of entire economies. Health care costs as a percentage of GNP, in contrast, is a reasonable measure.

Theory. Consider this simple example. Suppose that the real wages of all workers in the economy increase by 10 percent; that labor is the only factor of production; and that wages are the only source of income.[2] Even if health care use is unchanged, real health care costs per capita will still increase by 10 percent. Yet only an unusual definition of health care cost containment could lead one to conclude that this increase in real expenditure was evidence of a country's failure to contain its health care costs.[3]

In this example, real GNP per capita would increase by 10 percent, as would real health care costs per capita. Health care costs as a percentage of GNP would not change, because increases in its denominator (GNP per capita) would cancel out those in its numerator (health care costs per capita). Given that nothing has occurred in the health care sector per se, an appropriate measure of cost containment would typically not change in this situation. Hence, health care costs as a percentage of GNP is conceptually a more appropriate measure for comparison.

While GNP can be thought of as the value of all final goods and services, it can also be thought of as the sum of the incomes of all factors of production, including labor. In the long run, increases in real output per capita raise wages in all sectors of the economy. The mechanism by which this occurs can be illustrated most

---

[1] This testimony draws heavily from Morris L. Barer, W. Pete Welch, Laurie Antioch, "Canadian/U.S. health Care: Reflections on the HIAA's Analysis," Health Affairs (Fall 1991): 229-236.

[2] In the United States, three-quarters of income is received as wages, a ratio that has remained constant since 1970. A minor assumption here is that the number of wage earners per capita remains constant or at least is the same in the two countries. In 1971, civilian employment as a percentage of the population was 38.2 in the United States and 37.6 in Canada. In 1987 (the latest year for which data are available), this percentage was 46.1 in the United States and 46.7 in Canada. See Organization for Economic Cooperation and Development, Labor Force Statistics, 1967-1987 (Paris: OECD, 1989). Relaxing these assumptions does not substantially alter the story.

[3] Analogously, one should not use unadjusted expenditures to evaluate the efficiency of hospitals, some of which are in high-wage areas and some in low-wage areas. Just as each hospital must take the areawide wage levels as given, each sector of the economy must, to a large extent, take economywide wage levels as given. Recognizing this, the U.S. Medicare system varies its payment to hospitals according to area wages.

simply by positing otherwise--that wages increase in some sectors of the economy but not in the health care sector.

In the short run, workers in the health care sector--physicians, nurses, administrators, and so forth--would find that their wages, relative to those in other employment opportunities, had fallen. This would cause some of these personnel to switch sectors, forcing the health care sector to raise the wages it pays. This "employment adjustment" would not occur at the same rate for all occupational groups. In the long run, however, the wages of all occupational groups in the health care sector would be expected to rise at the same rate as those in the rest of the economy. Note that in real terms, nothing has changed in the health care sector. There are no new labor or capital inputs in the sector, no new technology has been introduced, and there have been no improvements in health outcomes. The only change is that the opportunity costs of the sector's inputs have increased.

In sum, nations that are successful in terms of economic growth will appear unsuccessful in terms of cost containment if real per capita health care costs is used.

Empirical evidence. Several analysts have investigated the relationship between health care costs and GNP.[4] In principle, such investigations capture both input price effects and changes in health care use as a function of changes in national income. Relying primarily on a microeconomic framework and downplaying the input price effects, analysts have labeled this relationship the "income elasticity" of health care expenditure. Empirical analyses incorporate the impact of returns to nonlabor inputs as well as labor income. Hence, they relax the assumptions of the theoretical analysis above.

An income elasticity of, say, 0.5 would indicate that an increase of 10 percent in GNP per capita would be associated with (result in) an increase of 5 percent in health costs per capita. An elasticity of one would imply equal percentage increases in GNP and health care costs per capita and would be associated with an unchanged ratio of health costs to GNP. An elasticity of zero would indicate that a 10 percent increase in GNP per capita would typically have no effect on health costs.

An income elasticity near zero would suggest that general macroeconomic activity has no systematic impact on health care, in which case one reasonably could use trends in real per capita costs to compare cost containment. On the other hand, an elasticity closer to one would lend support to use of the health care share of GNP to compare cost containment experiences.

Most of these analyses have involved simple, cross-sectional regressions, involving as many as twenty developed nations. To my knowledge, no one has seriously suggested that income elasticity is close to zero. Rather, the issue is whether health care has an income elasticity a little less than one or a little greater than one. This body of research supports the argument that real health care costs per capita is a poor measure of relative cost containment performance.

Short run versus long run. Even if the long-run elasticity is in the neighborhood of one, in the short run, the share of GNP devoted to health care might rise or fall as a result of sharp turns in general economic fortunes. If, for example, health care

---

[4] See, for example, D. Parkin, A. McGuire, and B. Yule, "Aggregate Health Care Expenditures and National Income: Is Health Care a Luxury Good?" Journal of Health Economics 6 (1987): 109-127; J.P. Newhouse, "Cross National Differences in Health Spending: What Do They Mean?" Journal of Health Economics 6 (1987): 159-162; D. Parkin, A. McGuire, and B. Yule, "What Do International Comparisons of Health Expenditures Really Show?" Community Medicine 11 (1989): 116-123; G.J. Schieber and J. Poullier, "International Health Care Expenditure Trends: 1987," Health Affairs (Fall 1989): 169-177; and U. Gardtham, Essays on International Comparisons of Health Care Expenditure, Linkoping Studies in Arts and Science 66 (Linkoping, Sweden: Department of Health and Society, Linkoping University, 1991).

prices, wages, and use are relatively insulated from the early effects of broader business cycles, then the share might increase at points of economic downturn and decrease in the early growth phases of the cycles. For example, in the early 1980s the share jumped sharply in both Canada and the United States as a result of the onset of the common recession.

But these are short-run phenomena. Several analysts have argued implicitly that the numerator is not a function of the denominator, that factor prices in health care (for example) are not a function of real GNP per capita.[5] Such an argument inappropriately uses a short-run model to explain a long-run phenomenon.[6]

Measurement problems. It is also noteworthy that international comparisons of real per capita costs require an explicit analytic effort to make the figures in each country comparable. Costs in each country must first be converted to "constant (base) year" values through the use of general expenditure (for example, GNP) deflators, comparably constructed for international comparisons. Furthermore, to compare absolute levels of cost per capita at particular points in time, figures from each country must be made commensurable through the use of a purchasing power parity (PPP) conversion for the base year. The accuracy of such statistical adjustments is a consideration not encountered with the use of the ratio of health care costs to GNP in each country.[7]

Data. I close this discussion on the use of percentage of GNP by presenting the figures of the U.S. and Canada, although the general pattern is well known. In 1989 the percentage of GNP (or more precisely, gross domestic product) going to health care was 11.8 in the U.S., 8.8 in Sweden, 8.7 in Canada and France, and lower in other developed nations.[8] By this measure of cost containment, the U.S. not only has the most expensive health care system, but one that is much more expensive than any other nation. The difference between the U.S. and Canada is 3 percent of the GNP, or roughly $165 billion. To paraphrase the late Senator Dirksen, "That's real money."

Of particular interest to this hearing are the administrative costs in the two countries. I have comparative data over time on only one component of administrative costs--namely, insurance overhead. Thus, my figures exclude the administra-

---

[5] For instance, E. Neuschler, Canadian Health Care: The Implications of Public Health Insurance (Washington, DC: Health Insurance Association of America, 1990).

[6] It is understandable that analysts focus on health care costs, whether or not adjusted for population and price level. In the short term, the public policy problem is how to control those expenditures. Expenditures appear in public budgets and must be compared to available revenues, whereas health care expenditures as a percentage of GNP do not appear in those budgets. Whether it is a provincial parliament or the U.S. Congress, the immediate focus is necessarily on expenditures (costs). The same holds for an American firm that offers health insurance to its employees. As often is the case in macroeconomics, the perspective of one component of the economy is different from the perspective of the economy as a whole.

[7] On the problems with attempting such comparisons using exchange rates in each year, see R.G. Evans, "Split Vision: Interpreting Cross-Border Differences in Health Spending," Health Affairs (Winter 1988): 17-24.

[8] G. J. Schieber and J. Poullier, "International Health Spending: Issues and Trends," Health Affairs 10 (Spring 1991): 106-116.

tive costs for physicians and hospitals, which are the other two components in the well-discussed GAO figures.[9]

The data are from 1971, when the Canadian system was implemented in full, to 1987, the latest year for which comparative data are available.[10]

	Insurance overhead as a percentage of GNP		Annualized growth rate, 1971-1987
	1971	1987	
U. S.	.308%	.529%	3.4%
Canada	.128%	.108%	-1.1%

In the U.S., health insurance overhead increased from about one-third of a percent of GNP to about one-half of a percent, more precisely, from .308 to .529 percent. Over this time period, the share of GNP going to insurance overhead increased 3.4 percent per year in the U. S. In Canada, however, insurance overhead as a share of GNP started from a lower base but still fell--at a rate of 1.1 percent per year. Cumulatively over this sixteen-year period, insurance overhead as a share of GNP increased 72 percent in the U.S. and decreased 16 percent in Canada. Clearly, Canada is controlling its insurance overhead and the U.S. is not.

Conclusion. A major "natural" experiment on health care financing has been conducted in North America. Canada has had a single-payer system for health care, while the U.S. has had a multipayer system. The results on cost containment are available, although the results on access (including waiting lines) and quality of care are not. The North American experiment demonstrates conclusively that the Canadian single-payer system has contained costs more effectively than has the U.S. multipayer system. Although this fact alone does not mean that the Canadian system is superior, it would be unfortunate for Americans to ignore the cost-containment results from the North American experiment.

[9] Government Accounting Office (1991) Canadian Health Insurance: Lessons for the United States, Washington, DC, HRD-91-90.

[10] Health and Welfare Canada (1990) National Health Expenditures in Canada 1975- 1987, Ottawa; and Lazenby, H. C., and S. W. Letsch (1990) "National Health Expenditures, 1989," Health Care Financing Review 12 (Winter 1990): 15. Additional data were obtained from the Health Information Division, Health and Welfare Canada and from the Office of National Health Statistics, Health Care Financing Administration.

REPRESENTATIVE SCHEUER. All right. Let's open up questioning for the whole panel.

MR. STERNBERG. Mr. Chairman, could I have a chance to respond to some of the questions? If I could, I'd just like to make some comments relative to some of the questions that you've raised with some of the other panelists.

REPRESENTATIVE SCHEUER. Yes, indeed.

MR. STERNBERG. I know you expressed an interest in, first, the universality of CAT and the whole question of insurance carriers selecting risk and only taking the insurable and leaving the uninsurable out. I just want to make sure that we put on the record now that the HIAA has changed significantly their position in the last 12 months. We are now supporting guaranteed issue of coverage for small groups, with an acceptable re-insurance mechanism. We recognize that we have to guarantee renewability. We recognize that we can no longer exclude an individual within an employer group if, in fact, that individual has high claims. So, I think that there's been a major change in policy relative to the universality issue. I think even relative to universal coverage, universality.

REPRESENTATIVE SCHEUER. Is this actually the situation in the marketplace now?

MR. STERNBERG. That is the situation. We are working with states now, including New York State, putting forward our position, and also working with the NAIC to establish overall procedures.

And one law, for example, in Connecticut—as you know, Connecticut now has a re-insurance mechanism—guaranteed issue for all employer groups. They come forward, we must provide coverage. We're supporting that. So, there's been a big change in terms of universal access. In terms of the comprehensive nature of coverage, again, as my colleagues have said, the word "comprehensive" is in the eyes of the beholder. The whole question is what you can afford. There's judgment. I think the issue on the table is to have a basic benefit plan available, a no-frills plan, as it's called.

REPRESENTATIVE SCHEUER. That's what they have in Canada.

MR. STERNBERG. And provide that kind of coverage. And I think, again, you'll find the insurance industry would be supportive of that.

REPRESENTATIVE SCHEUER. Let's just review the bidding there.

MR. STERNBERG. Yes.

REPRESENTATIVE SCHEUER. You say that we'll have the health care that we can afford. In Canada, they have universal/comprehensive health care. All appropriate health care.

MR. STERNBERG. Right.

REPRESENTATIVE SCHEUER. And necessary health care. I think they exclude cosmetic surgery, and there maybe a few other things that they exclude that are obviously not needed.

Now, how would you decide what elements of necessary and appropriate health care, excluding cosmetic surgery, we can't afford? If they can afford it in Canada, if they can afford it elsewhere in the developed world, we should be able to afford it here. How are we going to come to the conclusion that there are other major elements of health care that all other developed countries consider comprehensive, but we can't afford in this country? What would those be?

MR. STERNBERG. Well, you know, Mr. Chairman, nothing in life is free. There's a trade-off. And the real trade-off, the Canadian trade-off—the English trade-off, to a much greater extent—is the willingness to cap physician and hospital costs; the willingness to do some degree of rationing.

REPRESENTATIVE SCHEUER. Well, we do a hell of a lot of rationing in this country, but we don't call it rationing. When you exclude 34 million people from health care, you're rationing.

MR. STERNBERG. But, if you want——

REPRESENTATIVE SCHEUER. When you tell elderly people they have no assured access to long-term care or catastrophic care, you are rationing with a vengeance. And the same thing goes with all of the other groups that aren't served.

MR. STERNBERG. Well, we——

REPRESENTATIVE SCHEUER. Ten percent of our kids have no access to health care at all. Isn't that rationing? In all of those events?

MR. STERNBERG. Even the poor who are counted within the 37 million of uninsured, if an emergency arises, those individuals are handled and the costs are then passed on through bad-debt pools and the like.

REPRESENTATIVE SCHEUER. So, in an emergency, they're handled. But what gives rise to their poor health is that they have no formal access to health care, as compared to sickness care.

MR. STERNBERG. Sure.

REPRESENTATIVE SCHEUER. Ten percent of American kids have no regular access to health care and don't see a doctor from one year to another. It seems to me that's rationing.

MR. STERNBERG. Right.

REPRESENTATIVE SCHEUER. We do a heck of a lot of rationing in this country.

MR. STERNBERG. We are prepared to support, and we are supporting, full universal access. We do not want 35 million Americans unsupported by some sort of medical coverage.

REPRESENTATIVE SCHEUER. Would you be prepared to provide comprehensive coverage? Tell us to what degree your coverage would fall short of what you and I understand to be comprehensive coverage. That's all necessary and appropriate health care, excluding cosmetic care of various kinds.

MR. STERNBERG. We can provide a full-benefit plan. The question is whether or not the buyer can afford it. We are a private-sector institution,

so we, unlike the government, are not really providing a level of coverage because we're not paying for it. We act as an agent. We collect money and pass on a service. The question is, if we represent, for example, an employer, we have to say to that employer, "Mr. Employer, how much would you be willing to spend? We are prepared to give you any sort of benefit plan that you want to provide your employees."

So, I can't really respond directly to your question, because we are an intermediary. We are collecting dollars from our customer—our customer being the employer—and providing a service to his employees. If he wants to buy a $100 deductible plan, we are prepared to provide that level of comprehensive coverage. If he says, "I can only afford a $500 deductible plan," we are prepared to provide that level of benefit. And we are prepared to provide any level of coverage that our customer is willing to fund. In some cases, the small employer may find that they cannot afford a certain level of coverage.

REPRESENTATIVE SCHEUER. That is the current situation.

MR. STERNBERG. That is the current situation. And now the issue is to what extent are we willing to get, or willing to have, federal subsidies support that small employer. Again, that will be determined on how much that small employer can afford. And based upon on how much they can afford, we will provide that level of coverage.

REPRESENTATIVE SCHEUER. What I am suggesting is that almost every other developed country in the world manages to make a national decision on what is appropriate and necessary health care. They don't leave that determination to small employers, and they seem to be able to do it at a total cost of health care far less than ours.

Now, I am trying to have us look at the various components of health care and find out where our window of opportunity may be, to help us do what every other developed country in the world does, which is to provide comprehensive/universal health care at a far smaller cost to their societies than we accept in providing noncomprehensive and nonuniversal health care.

And how is it that they can do that at a cost one-third less? The average for the OECD countries is around 8 percent. And we pay 12 percent. And how come we pay 50 percent more for a standard of health care that is not universal and comprehensive? This is what we're searching for.

MR. STERNBERG. A study was completed that shows that the doctors in Canada earn about two-thirds of what they earn in the United States. The GAO states that savings in administrative costs would be realized only if the public succeeded in lowering payments to hospitals and physicians. We're not suggesting that.

The issue is, are we really prepared to do something like that? Because that pot of gold out there is only available if you are willing to take some major reductions on the major part of that chart that I showed, which is the claims cost component, not the administrative cost component. As my colleague Mr. Trapnell showed, the administrative component is only $25

billion. If you reduce that to zero, you only have $25 billion. Unless you're willing to deal with the other sector, you don't have the pot of gold to spread to the other levels of coverage. And I'm not sure that we are prepared to make that kind of a choice here in the states. And I think that is the issue.

REPRESENTATIVE SCHEUER. I'm not sure either. And I think it depends largely on the development of a consciousness among the American public of the tradeoffs of the balancing act that they have to do.

And if you are picking, on the one hand, the big gaps in what our country offers people in terms of services less than universal, less than comprehensive, and if you said that we can only move to a comprehensive/universal system if doctors' salaries move from an average of several hundred thousand to $150,000, you are proposing a tradeoff.

Now, I don't want anybody in this room to go into cardiac arrest at the idea that the assurance of income to doctors and other health professionals in the hundreds of thousands of dollars is not written in the stars. As you very properly point out, these are some very basic decisions that we have to make, balancing off the need for the perceived national wish to move to a universal and comprehensive health care versus the desire on the part of many powerful groups in this country—and I'm not judging one way or the other—both to maintain the present pay system, which seems to be bloated and wasteful to many, and perhaps also the level of doctors' salaries.

Now, I don't know if, in the Canadian system, when they go to global budgets, does that require hospitals and health administrators to set, in effect, a cap on wages to doctors and other health-care personnel? Anesthesiologists and so forth. Is that one way that they manage it in Canada by their global budgets? Are the pressures on doctors and hospitals and the negotiations every year with doctors and hospitals so tough that there is great pressure on the medical and hospital association to keep down hospital costs and doctors' fees? Can anybody answer that?

We have been joined by Senator Bryan. You're very welcome Senator. We're just in the questioning of the first panel. Do you have any statement that you would like to make?

SENATOR BRYAN. Let me withhold that and offer it for the record, subject to unanimous consent.

I'm delighted to hear the witness and the colloquy that has begun, and I will join in at the appropriate time.

REPRESENTATIVE SCHEUER. Let me just say that I would ask unanimous consent for the Senator's statement to be included in the record at this point in the hearing record.

[The written opening statement of Senator Bryan follows:]

WRITTEN OPENING STATEMENT OF SENATOR BRYAN

I am pleased to have the opportunity to participate in these hearings, and commend Representative Scheuer for focusing on an in depth comparison of administrative costs in the United States and Canadian health care systems.

The theme of these hearings, "How to push less paper and treat more patients" says it all. We must investigate the options that are out there, that are actually being used, that are truly containing costs, and that are still allowing quality health care to be provided. Then we can rationally determine whether they are the best options to reform our American health care system.

Ensuring quality health care for all Americans is the goal of all of us -- but in a cost effective way that will bring this nation's health care costs under control. All of us talk about the need for health care reform, and many of us talk about the Canadian system as the panacea to our problems. The focus of these hearings on delving into the Canadian system, and evaluating its administrative cost savings is a most necessary step to take in our search for the best health care system reform for America. These hearings will help us decide if the Canadian system is really the best way to go; if it results in significant administrative costs savings; if its premises will work in our country.

On a very personal level, I am most concerned about increasing health care costs. My State of Nevada is nationally among the very top few states with the highest of health care costs. As Governor, I worked hard to successfully place cost containment measures on my state's hospitals. Although these efforts helped slow the rise of hospital care costs, the overall cost of health care in Nevada has continued to rise. Some thing must be done for my state, and for this country to control these costs.

These hearings will help get us further toward our goal of ensuring cost effective health care for all Americans. I look forward to hearing the panels' testimony, and appreciate the opportunity to participate in these proceedings.

SENATOR BRYAN. Please continue.

REPRESENTATIVE SCHEUER. Please feel free to break in at any point. We are conducting quite an informal hearing here, and we're delighted to have you.

Does anybody else have any comments to make about the way the discussion has gone? About the comments or conclusions of any of the other witnesses?

MR. TRAPNELL. Congressman Scheuer.

REPRESENTATIVE SCHEUER. Yes, indeed.

MR. TRAPNELL. I would like to suggest that it is important to understand or to assess correctly the willingness of the American public to limit what they spend on hospital and physician care. I note that when the DRG system was adopted it was not set at a cost-saving level, but at a level that represented an increase in income to the providers. And when, through a quirk in the law, the level of the resource-based fee scale was going to be implemented in a way in which it would produce a significant reduction in overall fees, the Congress itself took the lead in demanding that the implementation be changed so as to raise fees to provide the same level of income to physicians; that is, "budget neutral."

So, if we do adopt a Canadian system, are you sure that we won't substitute the pork barrel as a manner of allocating expenditures for medical care, rather than some more objective system?

REPRESENTATIVE SCHEUER. I'm not sure of anything. If I were sure of anything, I'd write a book and retire. But, I'm not. I'm conducting a hearing. This is for the purpose of educating me and other members of the House and Senate.

Can the benefits of managed care, which I think some of you feel is a very useful approach, be combined with a cost-containment feature of global budgets as they are used in Canada and in other OECD countries? Can we have the best of both worlds? Can we have global budgets which put some pressure through the negotiation process on both hospitals and doctors and other medical professionals? It does put some pressure on them to contain costs, and at the same time, gradually introduce the benefits of managed care. Is that what the Canadians, whom you've talked to, have in mind?

MR. WELCH. Mr. Chairman, if I might take a shot at some of your questions.

I don't think one necessarily needs global budgets to control facility costs—hospital costs. We do, of course, have DRGs in this country. I believe that they would be more effective in controlling hospital costs in this country if we used them in an all-payer system.

REPRESENTATIVE SCHEUER. In a single-payer system.

MR. WELCH. In a single-payer system.

A major issue is, once you have a payment system like that—as Gordon is really alluding to—what level do you set the payment? Every year, Medicare and the Administration fights to keep the payment levels

down for Medicare, and through Medicare, to these hospitals. Certainly, some of the people who are in favor of the Canadian system are more willing than the conservatives to allow those costs to go up. So, that——

REPRESENTATIVE SCHEUER. Allow the costs to go up?

MR. WELCH. The rate at which we pay hospitals through Medicare.

REPRESENTATIVE SCHEUER. And doctors, I presume?

MR. WELCH. And doctors, too. So, you need not only a better payment mechanism than the status quo, you also need the political will, which is what Gordon is alluding to. Given that, we certainly have under Medicare both HMOs and prospective payments for hospitals.

So, I see the opportunity for prospective payments to control costs—as global budgets do in Canada—and for us to still have HMOs.

MR. DOHERTY. I think you've asked the crucial question as far as we are concerned, and it is one that people have given a great deal of thought and study to over the years and haven't really answered. The question is, is under a global budget, with a comprehensive set of benefits required, can a managed care system work?

The logic says that there is a serious question as to whether or not it can work, because for a managed care system to work efficiently and well, you have to have some benefits. Benefits for government, who is paying everything. You have benefits for the providers who have agreed to practice within that framework. And you have to have, above all, benefits for the consumers who belong. And if you are providing universal health coverage with comprehensive benefits, why would a consumer want to belong?

REPRESENTATIVE SCHEUER. Consumers go to an HMO to reduce their out-of-pocket costs.

MR. DOHERTY. Right. If you have a choice between a Blue Cross plan or an insured plan with co-payments and deductibles, then he can get a benefit by belonging to the HMO. He may give up something in terms of limiting himself or herself to the particular panel of providers. But there have to be incentives across the board. And this is one of the questions that we have about the Canadian system. I'm not opposed to the Canadian system, but where are the incentives?

If it is simply a cost-reimbursed system by the government and all you have done is transfer all of those ills of the private sector that you see now over to a government responsibility, you haven't done anything about containing costs, determining which procedures are best, or prioritizing the nature of care.

REPRESENTATIVE SCHEUER. I guess that you are transferring those tough decisions under the global budgeting process to the folks who are representing the hospitals and the doctors.

MR. DOHERTY. But you're not giving them any reward under a global budget system. Essentially, as I understand in Canada, the physicians and hospitals negotiated a price. And all of those elements go in there.

But it isn't that you're paying this hospital more because it is more efficient or paying it less because it is less efficient. And those kinds of things. For example, the citation here that the doctors of Canada are paid two-thirds of what they get in the United States to me is meaningless. Physicians only account for 15 percent of the direct medical costs in this country. It is their behavior that accounts for the rest of it.

The question is, can you get them in an organized system where they can be required to practice more efficiently, or they can't practice more efficiently because most physicians in this country want to do that.

REPRESENTATIVE SCHEUER. In this newspaper article that I cited from the *Washington Post*, Otis R. Bowen, the former Secretary of Health and Human Services argues that:

> Hospitals and doctors can generate demand and sell services simply by telling sick people that they need them.
>
> The nature of the problem is that health care has become a lucrative business in this country, and, because of the nature of the product it is selling, it has been allowed to ignore economic principles that restrain virtually every type of industry in this country. Health-care providers can generate their own demand and increase their revenues and profits despite declines in the demand for their services.
>
> As evidence that health-care providers have been relatively free to generate their own demand, Secretary Bowen and former Chief of Staff, Thomas Burke, cite what happened in 1983-86 when Medicare froze doctors' fees under the program and did not update them for inflation. The number of procedures on patients' eyes increased more than 50 percent, total knee replacements increased about 40 percent, colonoscopy increased 121 percent, sigmoidoscopy increased 216 percent, and cardiac catherizations by 85 percent.

Ms. LEHNHARD. Congressman Scheuer, I think that is precisely our point. And people are coming from Canada to say that the same thing is happening in Canada. They're trying to ratchet down on the prices, and physicians can make up for that by doing more in volume. In fact, they can increase their income by doing more discrete services and ultimately get paid more.

I think that what we are trying to say is that the private sector is just beginning to learn how to not pay for everything indiscriminately. For example, here in the District——

REPRESENTATIVE SCHEUER. That is terribly important to learn that.

Ms. LEHNHARD. We have said that we're not going to pay for every physician. We are tracking the services they ordered. What they do when they're in the hospital, what they do in their office. For example, they have package deals by types of delivery—Caesarian versus normal delivery. For Caesarians, we pay more, but when we track what they do once they're in the hospital and everything else, they turned out to be equal.

So, what we are doing is saying that we are only going to pay the physicians who are really effective in how they practice. If other physicians want to learn to practice that way, we will start to pay them

in these networks. We're not going to pay everybody the same way. And what we are saying is, when the government——

REPRESENTATIVE SCHEUER. When you say "we"——

MS. LEHNHARD. Blue Cross and Blue Shield.

REPRESENTATIVE SCHEUER. The insurers.

MS. LEHNHARD. Yes.

REPRESENTATIVE SCHEUER. When you have 1,500 insurers, do any one of them have the clout really to affect physician behavior and hospitals?

MS. LEHNHARD. Absolutely. A tiny little HMO can do the same as Blue Cross with 30 percent market share. In fact, they can do it a lot better than we do it.

But what we said in our strategy that we just approved is, unless you are an insurer that can do those kinds of things, can make that investment and analyze the physician data, the hospital data, you shouldn't have the same benefits in the marketplace, like the employer deduction for doing business with that insurer.

An insurer can make that investment and a managed care program, much like a Kaiser-type or an HMO-type arrangement. And Canada is coming to us to say, "Teach us how to do that. We need to learn to do that in Canada."

REPRESENTATIVE SCHEUER. Is anybody in the United States asking Canadians to help them adopt a particular global budget concept?

MS. LEHNHARD. We think that somewhere down the road, if you want to measure in total what we spend, you still have to put in place a framework underneath that says how you're going to limit what we spend. And we're saying don't use price controls, like under a government program. Give the private sector incentives to go make these investments. Pick out the best hospitals, pick out the best physicians. Eventually, what we have found is the most surprising thing and that is that the other physicians want to learn to practice like those best physicians.

REPRESENTATIVE SCHEUER. Isn't that more or less the situation they have in Canada?

MS. LEHNHARD. No.

REPRESENTATIVE SCHEUER. Once they establish a global budget, can an individual choose a hospital and a doctor?

MS. LEHNHARD. They don't do anything under the budget. They leave the physicians free to practice like they always have. The hospital is free to spend like they always have. And there are no incentives to change how they deliver care to get rid of the 40 percent of unnecessary care. And that is what they're coming to ask us how to do.

MR. STERNBERG. We are seeing this work, Mr. Chairman, in Southern California. I was at a board meeting of one of our PPOs several weeks ago. And a doctor, who is executive director of a large 200-physician group practice in Los Angeles was there. And we had some opportunity to talk to him about controlling costs. He was indicating that in his HMO

managed care business he is operating at a point where he is making a profit. And I said, "Are you making a profit?"

REPRESENTATIVE SCHEUER. He is operating.

MR. STERNBERG. His group practice is able to make a profit. And I said, "Are you able to make a profit because you're shifting your costs into indemnity or nonmanaged care, or have you changed your practice patterns?"

And he said, "We have changed our practice patterns. We are right now down to 158 admissions per thousand, where indemnity may be at 300." They have learned how to make a profit in a managed care environment, and the overall cost levels have, in fact, started to come down and be reduced.

You are seeing some positive results come from managed care. Obviously, we do not have that nationwide. We are still in the infancy. We are seeing some successes now in certain areas of the country that have had managed care for a long time—Southern California being one.

REPRESENTATIVE SCHEUER. Is there anything inconsistent in encouraging the utilization of managed care, while also adopting some kind of a global budgeting formula by states or regions and attempting to get the benefit of the private negotiations between hospitals and the doctors?

MR. STERNBERG. That is a very good question. I am right now chairing a committee at HIAA that was commissioned about eight weeks ago to look at just that issue. Is managed care and rate regulation of some sort compatible? We have had two meetings.

REPRESENTATIVE SCHEUER. Compatible with what?

MR. STERNBERG. Compatible with each other. Can you have a managed care system and price regulation, a DRG system?

HIAA is now working on developing a position on just that question. It is a very complex question. You have two schools. One school says that if you put a regulatory umbrella around managed care, you remove the incentive, and, therefore, managed care can no longer operate in a free market kind of an environment. There are those who suggest that managed care without some form of global rationing, or some sort of global budgeting, just can't work. And that's the issue, and we don't quite have an answer now.

REPRESENTATIVE SCHEUER. Senator.

SENATOR BRYAN. Thank you very much, Mr. Chairman.

If this has been addressed previously, I will get your response in the record.

What does our experience tell us with our effort to control the utilization, the prescreening, as it consists of a condition precedent to being admitted to a hospital for certain types of procedures.

There are those who have contended, although I have not seen any statistical evidence to support it, that that is a very elaborate structure that really hasn't saved anything in terms of medical dollar expenditures.

Do we have any data at all to indicate how effective that has been, if at all?

I tender that question to anyone of the panel.

Ms. LEHNHARD. We have some of those programs that you just described. All of the bells and whistles on managed care. We don't have good data. We can show some savings, company by company. But I think that we would be very quick to say that that is managed care as we now know it.

I think what all of us are excited about is that we are just beginning to understand what we can do. I go back again to what they're doing here in the District with Blue Cross and Blue Shield. We are doing this in Arizona also.

We are going out and looking at how the physicians practice; what they do once they start ordering tests in the hospital; what they do in their offices. We pick out the most efficient physicians, create incentives for people to use those physicians, and we leave them alone. We don't say that you need a second opinion. We don't require pre-admission certification. We say that you are the example in the community of how you should practice. We're going to leave you alone. And what we are finding is that other physicians are coming to us and saying, "How are they practicing that they got in this network?" And we are beginning to show really major savings by how these physicians practice.

SENATOR BRYAN. Ms. Lehnhard, if I could play the Devil's Advocate for a moment in making the judgment, the physician X and Y are doing all of the things that you're making the evaluation on, and saying that they are indeed efficient, and that we ought to reward them by participation in the program and not require all of the pre-certifications and all of that sort of thing. Critics or cynics might say that perhaps you're really driving it into the lowest common denominator, and quality may suffer.

Can you respond to that allegation? I am not suggesting that is the case. But clearly, that does suggest itself as a possible concern.

Ms. LEHNHARD. In fact, it is the opposite. These programs are identifying physicians that don't provide enough services. And we are using them to identify practice problems, both in these networks and in our fee-for-service business, generally.

We have gone in and looked at where those physicians aren't providing the services. We have found that what appears to be problems are only semiretired physicians who are doing camp physicals, and things like that. There are nurses who are looking at this and are very quick to point out that they can find underutilization just as quick as they can find overutilization problems.

MR. WELCH. If I might respond?

REPRESENTATIVE SCHEUER. Please, Mr. Welch. Subject to the Chairman's time schedule, continue.

MR. WELCH. You were asking about savings through utilization review and so forth. The tricky issue here, where you have to keep your eye on

the ball, is it "savings compared to what"? Is it savings compared to Canada, or is it savings compared to American fee-for-service?

I think, when we talk about savings due to UR, the savings are always relative to fee-for-service. That leaves open the question of, once you have driven down American fee-for-service and made it more efficient than it is at present, where do you stand relative to Canada? I don't know the answer to that, but I suspect that you are still well above Canadian cost figures.

REPRESENTATIVE SCHEUER. And what are the component parts of that increased cost?

MR. WELCH. Do you mean between the United States and Canada?

REPRESENTATIVE SCHEUER. Is it that we're doing more? Is it that we're doing the same, but charging more, spending more?

MR. WELCH. I don't have all of the figures in front of me, but roughly Canadians are hospitalized at the same rate. But the dollars—cost per admission—are much higher in American hospitals.

REPRESENTATIVE SCHEUER. Is that because we use more high-tech procedures, or because we pay our doctors much more?

MR. WELCH. Right now, I'm talking about hospital facility costs. I would assume that it means we're using a lot more high-tech. In terms of physician spending, the Canadians, if anything, have more physician visits. Scholarly work needs to be done on this. Canada is paying its physicians less per visit or whatever, and has lower physician incomes.

REPRESENTATIVE SCHEUER. They have lower physician income because they pay them less. They also use less high-tech, right?

MR. WELCH. That's right.

REPRESENTATIVE SCHEUER. Is there any comparison that you can make between the quality of health care that the Canadians deliver, which involves less high-tech, and the quality of care that the Americans give, which involves more high-tech? In other words, putting it a different way, how much of that high-tech usage in America belongs in that 40 percent black hole, as we have been discussing?

MR. WELCH. I think, if you talk about quality, you have to keep in mind that there are several conceptual measures of quality, one being process and another outcome. Outcome being the much more relevant, but also the more difficult one. And the short answer is we don't know.

I think that is where scholars should be focusing their efforts in the international comparisons. In my mind, the cost issue is pretty straightforward. It has been resolved.

REPRESENTATIVE SCHEUER. I yield back to you, Senator.

SENATOR BRYAN. I think Mr. Trapnell was about ready to offer a thought.

MR. TRAPNELL. Thank you. I would like to offer a comment on that. The words "managed care" have been used to describe so many different activities in so many different situations that they've become almost meaningless words.

To try to be more precise about it, they can attempt to control prices, control utilization, or both together—separately and/or in combination. And a lot of what is called managed care is really price control. For example, there are many PPO networks that advertise mostly the discounts they have from providers or their negotiated fees. The term itself suggests efforts to control utilization; that is, to try to persuade or require patients to use fewer services or more cost-effective services, thereby reducing the bill without necessarily changing any compensation.

Here, again, there is a vast difference in different insurance arrangements and, for that matter, in the skill and capacity of the people who are applying it. For example, even within the HMO industry, you have a number of distinct forms of organization in which the capacity to control cost varies very substantially. And it probably varies even more by the skill of the people who are applying the principles. For example, the most effective forms are those where all the doctors are employed by one plan. In some cases, the doctors are on salary and in others they organize themselves into a separate unit that negotiates with the HMO to provide the services. But the effect is largely the same. You have a staff that is dedicated to the HMO's patients and are living within the HMO's per capita income.

Kaiser, Puget Sound, and HIP in New York are typical examples. The incentives are internalized within the physicians' group itself to figure out how to lower their costs by operating more efficiently. Lower costs mean that there will be more money left for them and that their enrollments will grow. Both doctors and the HMO prosper because their prices will be low.

At the other extreme, there are HMOs that pay physicians for working in their own offices. Some of these can be operated very effectively, but you can also set up an HMO without changing anything. I have been personally associated with attempts to organize HMOs by physician groups—hospitals or both—in which the physicians expected to get their full fees while continuing to practice fee-for-service medicine. The hospitals expected the HMO to fill up their beds. They went through all of the steps and procedures that an HMO is supposed to go through. It is sort of like believing that if you do the right dances it will rain. But frequently, there are no savings, since there was no change in practices. To reduce utilization, someone has to identify excess utilization and figure out how they're going to set standards that will reduce it and get their providers to meet these standards. That requires hard work, and some providers must wind up with less income. It requires coordination between a lot of parties.

I'm sorry I'm going on too long. I just hear——

REPRESENTATIVE SCHEUER. You haven't gone on too long. And I'm going to yield back to the Senator. I want to give him all the time he needs.

But you are indicating to me that we have a situation on our hands. With all of these incomprehensible, extremely difficult thrusts at

controlling costs, why do we need it? Why do we need all of these incredibly complicated systems? And can the Canadian system, in effect, the global budgeting system in a very much more understandable system, can it accomplish most or all of these separate and distinct thrusts that we are making to control costs? Isn't there a simpler way to do it?

MR. DOHERTY. It's a transitional thing, starting in 1973 with the HMO Act, DRG, and all the other things that government has done to either encourage alternative systems or to put restraints on the current system. Tremendous changes have taken place in this country.

Hospital utilization is down. Maybe lengths of stay are a bit longer because of the number of people going to the hospital. Out-patient utilization is up. You can say that it's complex.

Obviously, as I said earlier, I think that our current delivery system is a mess. But if you are a CIGNA Corporation and you decided to get away from the indemnity business and get into the HMO business, does it make sense for you to spend $150 per foot just to build facilities to put everybody in a group or staff model HMO? Or, as CIGNA has indicated, do you try to organize the physicians, contract with them, and then to a degree that you can influence their behavior, slowly but surely, get them into the same kind of model that Mr. Trapnell talks about?

One other thing about this article. I think that my friend Tom Burke has painted a bit with the Irish brush, and we should not apply this—you see the ads. Tom sees the ads. We all see the ads about if your French poodle doesn't like you, come to our hospital. But I think to say that that is a uniform thing throughout the American medical care system is kind of nonsensical.

REPRESENTATIVE SCHEUER. You just said our health-care delivery system is in a mess.

MR. DOHERTY. Sure.

REPRESENTATIVE SCHEUER. Do you have some simple ways that you can describe some windows of opportunity to rationalize this messy health-care system, as you have described it?

MR. DOHERTY. Look, I'm not opposed and I'm not for a Canadian national insurance system. I agree with my friend, Pete, there is an awful lot that we have to look at and discover before we go into that radical direction. But there are some promising things happening.

REPRESENTATIVE SCHEUER. We wouldn't have to do it all overnight. We can phase it in over a five-year period, a single-payer system. We can phase it in by types of treatment. We can phase it in by populations. We can do this in a comfortable way over a 5- or even a 10-year period if that seems indicated. We are not eager to give a traumatic shock to half a million health-care personnel.

MR. DOHERTY. I don't think you can do it anyhow. I think there are an awful lot of things that you need to look at that are going on in Canada and in the more advanced social systems before you make a decision that that is where you want to go.

You asked a question, Senator, about second-opinion surgeries and some of the other cost-containment mechanisms. Many American hospitals have gone far beyond that. They are now taking the DRGs and processing expenses and shaving those DRGs. Is it really necessary for DRG 462, or whatever, to have that previously as hospitalization, or can the patient be left at home? So, what they are doing is, they are now contracting within the DRGs because Congress has set that kind of an incentive program. And you were one of its supporters.

So, I think that we have to look at the systems that you put in place now, see where they are taking us before you go on to talk about this broad-brush approach and say that we have to have a single-payer system. If you want to take care of the people that you're talking about, then do what the Pepper Commission says and put up $65 billion, and we take care of the kids that don't have health care. There has to be a better way of doing it.

REPRESENTATIVE SCHEUER. I'm greatly intrigued by the fact that there seems to be a consensus that there are $65 billion of savings that are sitting there ready to be seized, to apply to the $65 billion bill that we would get for moving into a comprehensive/universal system, which is our goal.

MR. DOHERTY. You mentioned cosmetic surgery. I assume you're talking about nose jobs and that sort of thing. Not the real traumatic kinds of things that require cosmetic surgery?

REPRESENTATIVE SCHEUER. That's true.

MR. DOHERTY. The Federal Government subsidizes the medical students and the sorts of students who do that sort of thing. I don't know if that's right or wrong, but you ought to look at it.

REPRESENTATIVE SCHEUER. I totally agree.

Senator Bryan, please proceed.

SENATOR BRYAN. One other question. Now, I don't want to get this off the focus, Mr. Chairman, that you had in mind. We have continually, at least since I have been part of the discussion, used a Canadian system as the baseline, as if that is the ultimate goal that we are seeking to accomplish. Could I ask very briefly without detracting the focus of the discussion: Is the Canadian system, in advanced industrial and social societies, viewed as the finest of the alternatives that we might look to? Or is there a good bit of diversion opinion on that? What do the Germans have, for example?

MR. STERNBERG. I would like to speak to that. We do not believe that the Canadian system is necessarily a point of comparison that we ought to be aiming for. There have now been issues raised about the German system as being a better benchmark. But each of these systems comes with a tradeoff. A tradeoff in the expectation of the U.S. public, expectation in terms of the importance of competition. There is no question that there are savings if you look at it cleanly and say there is

no tradeoff. But then how much of the dollars come back because you lose the competitive element in the system?

We know right now that there is built into the system controls to control our administrative costs. Right now, we compete against Aetna, Hancock, the Blue Cross in two ways. We compete in quality service, providing high-quality customer service at the lowest cost.

I spend six weeks, eight weeks every year working on budgets. And that is happening in every other insurance company. We really are ratcheting down our expenses in order to provide the lowest cost for customer service. And the other area that we make our investment is controlling the overall claims cost, starting out with utilization review, which was a 10-year old program, and now into PPOs and HMO evolution, managed care.

We're putting in a lot of our capital before we get returns on it. We are investing our capital to do that because, again, we are trying to compete. We're trying to do a better job than Aetna or John Hancock, another carrier.

I don't know what the dynamics of pulling that competitive element out of the system does. I don't know whether you get a $55 million savings on day 1. And then, on day 365, you lose half of it because you've lost the competitive element. That is a very complex issue.

So, I don't understand the dynamics. I personally believe that there is a lot of value in our competitive system. And I get very nervous when I see proposals coming forward to try to move us into a socialized kind of environment. But we recognize that there have to be steps taken. The current situation is not an acceptable situation, and we are working on that. We have put some suggestions forward.

REPRESENTATIVE SCHEUER. Mr. Welch, would you like to react to the statement that implies that competition and competitiveness achieves either a better quality of care in our society or cheaper care in our society?

Am I putting the question correctly, Mr. Sternberg?

MR. STERNBERG. I accept that question.

REPRESENTATIVE SCHEUER. Can you improve on it?

MR. STERNBERG. No, sir.

REPRESENTATIVE SCHEUER. What is the role of competition in either improving access to care, quality of the care, or cost of the care? What is the role of competition in improving the likelihood that we are going to achieve universality any time in the foreseeable future, or that we are going to achieve a comprehensive model of health care in our country? I think those two things are very much desired out there.

I am not aware of any tremendous thirst on the part of the American people for a competitive health-care system. I am aware of the fact that they are very dissatisfied with what they have now, compared to the Canadians who seem much happier. But the question of whether there is or is there not competition does not seem to be a major factor with them.

Now, if you could tell me that competition is going to improve quality, improve accessibility, improve comprehensiveness, then I would say, well, I am a little more sophisticated than the American people, maybe. I think that injecting assured competition and protecting it between 1,500 insurance companies, or between hospitals, or HMOs, if that is all going to improve access, improve quality of care, decrease costs, I am going to be for it, without any reference to whether the American people want it.

If I am convinced that it is going to be a way-station, that competition is going to help move us swiftly toward these goals, which I think are the real goals of the American People, then I am going to be for that, and I will do everything that I can through legislation and regulation to ensure that we have competition, if it is likely to play a major role in achieving these three or four goals.

MR. WELCH. I think your question is, to what extent does competition lead to universality, quality, cost containment, and so forth.

REPRESENTATIVE SCHEUER. Yes.

MR. WELCH. The short answer is to look at the "facts," if you will, of the Canadian-American comparison. One system has a lot of competition in insurance, and the Canadians have no competition in insurance, even though they certainly have competition among physicians.

REPRESENTATIVE SCHEUER. And among hospitals.

MR. WELCH. And among hospitals. And, as we all know, the Canadians have contained their costs a lot better. We are not so sure about quality of care.

So, the simplest response is to compare the two nations, and then competition obviously has not performed as well. The longer question would go along the lines of how can you structure competition so that it is more effective? We might have, say, a universal system, government-run, in which households are enrolled in HMOs versus fee-for-service, an Enthoven-type of plan, but with a universal component. There you could have competition. I think, with a more active government role, competition could have a much more beneficial effect.

REPRESENTATIVE SCHEUER. A beneficial effect in achieving what? Quality?

MR. WELCH. In achieving a combination of quality and cost containment and meeting the universality goal.

REPRESENTATIVE SCHEUER. Does anybody have any legislative suggestions? Do any of you have an idea of legislation that would enhance the role of competition and the potential of competition to improve access, universality, quality, cost? Anybody?

Because we would be very much interested from any of these five brilliant witnesses in anything that we can do to enhance the role of competition and its potential to improve the situation, which we are concerned about with the lack of universality, the rapidly increasing costs. If you show us how we can unleash competition to achieve these things, we would be very much interested in hearing that.

Ms. LEHNHARD. Mr. Chairman, I had mentioned that we approved, not two weeks ago, a strong measure that would say we want universal coverage, not just access. We want everyone covered under a set of benefits. I will not go into the details that treats large employers different than smaller employers and employees that take the coverage, but again a key—we can send you that proposal.

REPRESENTATIVE SCHEUER. I wish you would.

[The following proposal was subsequently supplied for the record:]

Assuring Universal, Portable and Affordable Coverage

A position of the Blue Cross and Blue Shield Association adopted by its Board of Directors on October 3, 1991.

Overview

America's pluralistic health care system is in the spotlight.

As health care reform rises to the top of the national agenda, legislators, policymakers, and consumers are taking a critical look at the employer-based health insurance system and the public/private partnership that has provided the framework for delivering and financing health care in America.

Many leading policymakers know that over the years the partnership between the private sector and government has increased the health security of millions of Americans; today over 200 million Americans, representing more than 85 percent of the American public, are protected through health insurance provided by employers, government, and the private sector.

These policymakers also recognize the values our system has fostered: an unrivaled quality of care, freedom of choice, technological innovation, and a broad range of providers.

And they know that over the last 50 years the system has helped transform American health care from relatively unsophisticated practices — based on simple technologies, a limited research base, and a limited number of providers — to a vast, complex, and sophisticated system that provides state-of-the-art care to millions of Americans.

However, these same decision makers are concerned that the very advances that distinguish our system also have fueled health care cost inflation. The system is expensive — with costs in 1990 exceeding $650 billion a year and representing more than 12 percent of the gross national product.

And, while medical advances promise more and better care for Americans, this cost escalation has made worse an already unequal distribution of those benefits. The high cost of medical care has contributed to the growing number of uninsured citizens — including many who work. It has made it more and more difficult for employers to provide coverage, especially for workers' dependents, for government to honor its obligations, and for individuals to purchase coverage on their own.

Today health care policymakers are faced with decisions that will impact the future health care of millions of Americans. Should we dismantle the system or renovate it? Should we adopt a new, untested

national system or adapt the system that has served us well for more than half a century?

The challenge before us is to maintain the very important strengths of our pluralistic health care system while altering the incentives that have inflated health care costs and exacerbated problems of access.

For more than 60 years, Blue Cross and Blue Shield Plans have worked successfully in the employer-based health financing system — providing affordable coverage to millions of Americans and working with consumers, providers, employers, unions, and government to develop responsive benefit packages, enhance quality, and manage costs.

Operating as a nationwide network of affiliated organizations, Blue Cross and Blue Shield Plans have a national perspective on the health care system's promise and its problems. Because we are deeply rooted in the structures of the communities we serve, we understand local views and individual and employer needs.

Based on this understanding of national and local needs and resources, the Blue Cross and Blue Shield Association and its 73 Plans are offering a strategy that would restructure the incentives driving our health care system yet preserve those aspects that remain most important to America's consumers, employers, and providers. Firmly rooted in the public/private partnership, our strategy is intended to increase access to care for the uninsured and to manage the cost, quality, and value of coverage. It calls on all players — insurers, providers, employers, consumers, unions, and government — to make the changes needed to improve the system.

Blue Cross and Blue Shield System Recommended Goals

Three major goals guide the Blue Cross and Blue Shield System's reform strategy:

- Universal Coverage

  Reforms that offer universal coverage and access to basic benefits will help us share the nation's medical skill and technological bounty with all its citizens, protect the health of future generations, and stabilize a health care economy burdened by the costs of uncompensated care.

  Because 75 percent of the non-elderly population currently is covered through employer-sponsored plans and more than 80 percent of the uninsured are either workers or their dependents, we believe that building on the employment base is the best way to assure high quality health care for workers and their families. Government subsidies would help ease the way for marginal businesses and low-income employees.

  The private sector also can and should play a major role in serving the uninsured who do not work. Under our strategy, federal subsidies would help low-income uninsured people purchase

private health insurance. Those unable to afford private coverage would be covered by an expanded Medicaid program.

- Portable Coverage
  It is not enough to guarantee coverage. We must safeguard the insured by eliminating concern that they will have gaps in coverage if they change jobs or move between public and private programs.
- Affordable Coverage
  Access cannot be achieved unless we also assure affordability. We must find ways to moderate health care cost increases to assure the promise of universal access.

  Assuring affordability means more than controlling the absolute level of health care expenditures. It also means getting the most possible value from health expenditures by (1) focusing on the outcomes of care rather than the number of services provided, (2) seeking to cover the most appropriate service in the most appropriate setting, (3) setting benefit packages with an eye towards balancing comprehensiveness of coverage with affordability, and (4) using government subsidies both to enhance the capacity of the private sector to serve the uninsured and to cover individuals whose needs exceed those the private sector can meet.

  Insurers — and all entities that underwrite and administer health benefits — have another role to play by eliminating market practices that inflate costs and avoid risk.

Underlying Principles

The methods for achieving these goals are complex and will require redefining the partnership between the public and private sectors. Our agenda for developing this reform strategy is based on six basic principles:

1. Cost, access, and value are linked and must be addressed together. Health care must be affordable, and all Americans should receive a fair return for their investment in health care.
2. All players share responsibility for promoting access to and the value of basic health benefits, and all must contribute to change.
3. The financial, political, and social incentives driving our health care system must be adjusted to assure that they promote cost-effective behavior.
4. National policies developed to effect these changes should guide, not dictate. They should set a framework for assuring fairness and equal access, while allowing for the maximum role possible for state implementation.
5. Competition in the provision and financing of health care should be based on cost-effectiveness rather than the ability to avoid or shift financial responsibility.

6. The complexity of the health care system, the diversity of the American people, and the nature of our political process call for phasing in reform and multiple, reinforcing solutions. The overall strategy is based on providing broad federal guidelines with implementation and regulation at the state level. Where possible, experimentation, on a state basis, of elements of the proposed national reform strategy should be considered.

In developing our strategy, we have focused heavily on the contributions that the insurance industry can make through market reforms. These reforms would

- increase incentives to manage risk;
- reduce unnecessary health care services that inflate costs and may pose a risk to the health of those who receive them;
- provide for efficient mechanisms to assure the diffusion of needed new technologies and eliminate those of questionable value;
- help consumers become wise purchasers of care; and
- eliminate insurance practices that unnecessarily add to administrative costs.

We believe that true competition in the insurance marketplace should be based on the ability to control costs rather than the ability to avoid risks. We believe that to more effectively address the cost problem we must not simply hold down costs but increase the ability to evaluate quality and assure value.

With these goals and principles in mind, the Blue Cross and Blue Shield System offers the following strategies.

Strategies to Achieve Reform

Universal

Universal Coverage: Reforms should be enacted to assure that as many Americans as possible have private health care coverage. For those unable to purchase private coverage, public programs should be available. To assure the adequacy of coverage, all individuals should have access to at least basic benefits.

The Blue Cross and Blue Shield System's strategy for universal access relies on both the public and private sectors. One part of the strategy addresses the needs of the uninsured who work or are dependents of workers; the other focuses on the uninsured who would not have access to employer-based coverage.

Employer Responsibilities

Employers should assume responsibility for providing coverage for working Americans and their families. Allowance should be made for differences in employers' abilities to contribute to employee coverage.

Because 73 percent of the uninsured are full- or part-time workers and their dependents — and another 15 percent are actively seeking work — the most effective and least disruptive way of extending coverage to the uninsured is to expand employer-based coverage.

The challenge in establishing employer responsibilities is to balance employers' resources with employees' needs. If employers were required to meet excessively expensive financial obligations or complex administrative requirements, this strategy would not succeed. Requirements that firms contribute to employee benefits have the advantage of making coverage more affordable to employees but may represent burdens too severe for small employers. On the other hand, requiring employers to offer coverage without contributing to employee expenses would eliminate the burden for all employers but might price coverage out of range for employees.

The Blue Cross and Blue Shield oganization's reform strategy offers a compromise on this issue. The obligation would vary for large and small employers because of the differences in their economic viability.

Large employers — who generally provide coverage for their employees — would be required to provide coverage directly to their employees and their dependents and contribute to its cost.

Small employers would be required to offer their employees group coverage with at least basic benefits. While small employers would not be required to make a premium contribution, incentives would be

made available to encourage a full contribution for employees and dependents. All small employers would be entitled to the same tax incentives that large employers have. In addition, federal subsidies would be made available to encourage marginally profitable small employers to contribute to coverage. Those employers that did not contribute to coverage would be subject to an assessment, which would be less than the cost of coverage. This assessment would be used to assist their employees' purchase of coverage.

Under this approach, the private sector would serve as the source of coverage for all employees. In contrast, some proposals would establish large public insurance pools to provide coverage for employees whose employers did not offer coverage. We are concerned that reliance on public pools would encourage employers to drop private insurance in favor of the public pools and, as a result, these pools soon would evolve into a massive federal program. We believe that private coverage that is affordable and available regardless of medical condition will serve the needs of employees better than a public program.

Employee Responsibilities

Employees — and their families — should have some level of responsibility to accept employment-based coverage.

It is not enough to ask employers to provide coverage to their employees. Employees should have strong incentives to accept such coverage. Expanding coverage to all employees will result in a more equitable distribution of health care costs and a reduction in both providers' bad debt burdens and the cost shifting that unfairly penalizes those employers willing to provide health insurance.

Government Responsibilities

Government subsidies should be available through the tax system for individuals and — where appropriate — for employers, to help finance private coverage.

The key to the success of this approach is whether the employee's own contribution is affordable. Subsidies must be provided to help low-income households meet their premium contribution requirements. Individuals and families below the federal poverty level should be fully subsidized. Those with incomes above the poverty line would receive assistance on a graduated basis.

Because a meaningful contribution to their employees' health benefits often represents a greater financial burden to small businesses, subsidies would be available to encourage them to contribute to coverage.

In considering how best to finance this assistance, all current tax subsidies for private health insurance benefits should be examined to assure they are used as efficiently and effectively as possible and are serving the objective of extending coverage to as many people as possible. The assessments on small employers who do not contribute to premiums would be used as a source of employee subsidies.

Non-Workers Responsibilities

A dual strategy is needed for individuals and families not connected to the work force.

Individuals not connected to the work force should have incentives to purchase private insurance, and government subsidies should be available to those who cannot afford the cost of private coverage on their own.

Those who cannot afford private insurance, even with this assistance, should be covered under an expanded Medicaid program. Medicaid eligibility should include all individuals and families below the federal poverty level, regardless of age or family structure.

Basic Benefits

To assure the adequacy of coverage, all individuals should have access to basic benefits that emphasize services of proven value.

Basic benefits should emphasize services of proven value and should include medically necessary inpatient hospital services, outpatient physician services, effective preventive services — such as prenatal and well-baby care — and other effective screening services.

In designing this package, it will be critical to balance the goals of affordability and adequacy of coverage. Employers could vary the benefits to better meet the needs of their employees as long as the benefit package were actuarially equivalent to the basic benefits.

Portable

Portable Coverage: Reforms should be enacted to assure continuity of coverage when changing from one private health plan to another or between public programs and private health plans.

A primary weakness of the existing pluralistic health care system is the lapse in coverage that can occur as a consequence of events such as a change in job or employment status, divorce, or relocation. Portability problems also exist for those whose coverage excludes pre-existing conditions and for those leaving group coverage who cannot obtain individual coverage.

Many of the practices that contribute to the current problems are a direct result of insurers needing to protect against the practices of some individuals and small employers who purchase protection only when they have an expected need for services. Waiting periods primarily are designed to deter participation in the insurance system only when there is a need. This practice only serves to drive up the cost of insurance and reduce the ability of insurers to spread costs across as broad a base as possible.

Adoption of a health care reform strategy to assure universal coverage would enable insurers to eliminate the practices that have caused breaks in health insurance protection. Further, universal coverage would create opportunities for the private sector to develop products that assure continuity of coverage, for example, private sector products to replace COBRA coverage.

Affordable

Affordable Coverage: To achieve affordable coverage, a number of reform strategies will be needed.

These strategies should rely on a mix of public and private sector programs to assure access to coverage. This will underscore the mutual responsibility of both sectors to develop and coordinate cost management programs.

Qualified Carriers

Insurers — and self-funded programs — should have incentives for meeting criteria to assure that they are "qualified" to contract for services that are efficiently provided and of high quality.

To be truly effective for the long term, cost management programs must alter the incentives underlying provider behavior — rewarding behavior that uses services efficiently, assures good patient outcomes, and increases patient satisfaction.

To this end, the Blue Cross and Blue Shield System proposes a strategy to strengthen incentives for employers to choose carriers that have proven records of managing the price, utilization, and quality of services — in other words, carriers that manage health care costs effectively.

These "qualified carriers" would be defined using specified criteria — including the ability to manage risk and operate efficiently through selective contracting and utilization management.

Under this strategy:

- Selective contracting criteria would require carriers to contract with high-quality, cost-effective providers to assure that patients receive the best care for the best price.
- Utilization management criteria would require carriers to use methods to assure that patients receive medically necessary care in the most appropriate setting.
- Data collection criteria would require carriers to develop systems for assuring uniformity in billing and data collection to increase operational efficiency, reduce administrative burdens on providers, and enhance our ability to analyze the quality and outcomes of care.

Our proposed strategy envisions incentives for carriers structured on a graduated basis. At a minimum, qualified carriers would be required to have or develop the capacity to contract with physicians and hospitals to negotiate favorable prices, establish terms for utilization review, assure quality, and protect subscribers against balance billing. Incentives would be offered to carriers that expand their operations beyond provider contracting and data analysis to outcomes management and practice pattern evaluation and education.

These new strategies offer the best promise for increasing the value of our health care expenditures because they offer ways to alter the incentives that generate the use of excess or unnecessary services — replacing them with incentives that promote the most effective practices for improving patient care and satisfaction.

Market Reforms

Insurers and self-funded programs also should be required to meet market conduct standards to eliminate competition based on risk selection and maximize competition based on ability to manage costs.

These standards, which would apply to all carriers and self-funded entities, should assure that

- small employers have access to private insurance, regardless of employees' health status, occupation, or geographic location;

- states have a range of options to choose from in making available private insurance to small employers;
- small group coverage is provided at fairly established rates;
- no small employer is dropped from coverage because of poor claims experience;
- all entities doing business in the small group market are subject to the requirements (including multiple employer welfare arrangements — MEWAs) and there is effective enforcement of all requirements;
- there is equitable sharing among insurers of high-risk small employers and the losses associated with covering these high risks; and
- lower-cost products are available.

To meet these objectives, states should have the flexibility to develop approaches that best meet the needs of their environments. There should be broad federal guidelines with maximum flexibility for states to meet their own unique needs. 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.

Government Program Responsibilities

Government must fund public programs adequately and must manage costs in its own health care programs.

Government must live up to the promises it has made. Funding for public programs, such as Medicare and Medicaid, must be increased to a responsible level and these programs must be managed efficiently to avoid continued cost shifting to private programs.

Public/Private Initiatives

The public and private sectors must work together to manage overall health care costs.

Government and private sector participation also is needed to

- reform our medical liability system, to decrease the need for defensive medicine and its associated costs;
- assure the efficacy and appropriate supply and distribution of capital-intensive technologies; and
- develop methods of measuring outcomes of medical interventions to support development of qualified carrier criteria and guide capital and technological investment decisions.

Provider Responsibilities

Providers should be responsible for assuring the effective delivery of quality health care services.

Provider participation in managing costs and assuring quality should include:

- Development and use of clinical practice parameters that define the range of acceptable medical practice. These parameters could be used to improve clinical decision making, help reduce unnecessary care, and guide payment decisions.
- Collection of provider cost and treatment results to improve our ability to measure and analyze the quality and outcomes of care.

- Coordination of care to assure continuity, use of the most appropriate level of care, and quality.
- Work constructively with qualified carriers to assure that care is delivered on an efficient basis and is of high quality.

Consumer Responsibilities

Consumers should accept greater responsibility for using services appropriately and for adopting healthy lifestyles.

Consumers also have a role to play. As useful information about cost-effective, quality health care services becomes widely available, consumers should take more responsibility in making appropriate coverage decisions. They also should assume an active role in their community, working with insurers and providers to address local issues of access, cost, and quality.

Conclusion

Today, this nation stands ready to embark on a major new policy direction that will have a far-reaching impact on the future of the health care system.

Action on reform has been complicated by the difficulty in identifying what should be done and getting all the players to agree to do it.

If we are to construct a strategy that will work, we must look to our experience — building on structures that have endured — and over time create mechanisms for balancing the competing interests of the key players. If we stray too far from our basic values, we will have difficulty building a consensus for reform, generating the political will to support it, and fostering the cooperation needed for implementation.

The Blue Cross and Blue Shield Association and its 73 Plans offer a strategy that is realistic, that takes the best the pluralistic health care system has to offer, and finds ways to share its resources with the American people.

But, change will not be easy. It will require enormous efforts to change consumer buying habits, insurer market practices, government financing methods, and provider practice patterns. But the task must be accomplished. With all the participants willing to play a role, we will find ways to control costs while retaining the freedom of choice, personal responsibility, quality, and innovation that will be at the heart of an effective health care system for America.

REPRESENTATIVE SCHEUER. Does anybody else have any contribution to make on the role——

MR. DOHERTY. I got in trouble 18 years ago on this, and I will do it again. The most sensitive competitive proposal that I have seen was the Nixon proposal in 1972, many of the elements of which Senator Kennedy has endorsed today, but it called for a uniform benefits package, uniformly applied throughout the community, with equal payment to the various payers and providers, external quality assurance systems that were very strict, and there would have to be some actuarial adjustments. But it was a good proposal then. It was developed by Dr. Altman, and I think it is a good proposal now, if you want to look at a competitive approach.

MR. STERNBERG. Mr. Chairman, HIAA prposals, both on the state and the federal level, are appended to my prepared statement.

REPRESENTATIVE SCHEUER. Terrific. I am going to leave now and ask the Senator to take the gavel and let him conduct the hearing for the next five or six minutes.

SENATOR BRYAN. That could be dangerous, Mr. Chairman.

REPRESENTATIVE SCHEUER. I want to express my personal appreciation to this panel. It was a marvelously stimulating and instructive panel, and I thank you all very much.

SENATOR BRYAN. Let me ask a couple of questions, since the Chairman is leaving.

We have discussed, I think, a concern which the Chairman has articulated, which I think does have a universal concern, and that is access, quality, and cost. It is my sense that this is no longer an issue that is confined to any socioeconomic strata in America. Clearly, in the last half-dozen years, it is my sense that that has embraced almost the complete spectrum of American society.

When one talks about cost containment, you get into the issue that Oregon has been dealing with, and that is rationing. I do not know how much of that has been discussed previously. It raises the legal, ethical, and moral dilemmas that people in public life, as well as professionals who are implementing the systems, have been very loathe to deal with. They are highly sensitive, and I am not suggesting that they should not be.

Discuss with me for a moment the implication of systems that put some constraints on cost. Does that lead to the inevitable consequence that you have to make some finite determinations that we do not provide certain types of medical care for certain types of people because it is simply too expensive and we cannot justify it, in the sense that we do a heart transplant for an 85-year-old individual? That it is something that society cannot afford to pay?

Those are things that I think are becoming much more apparent on the radar screen as we discuss this issue, and I invite your comments.

MS. LEHNHARD. I think what several of us are saying is, if you try tc impose the Canadian system in this country without fundamentally changing the way we deliver services, that is exactly what you would

have. You would have situations where you were literally running out of money. You hit your budget cap, and we continue to practice medicine and admit patients into the hospitals just like we always have.

What we are saying is that there is now clearly some hope for changing the way that you deliver services, in a way that does not negatively affect quality and, in fact, increases quality. Sometimes less is better. It captures both the price and utilization side of the equation of the total health-care costs. That is exactly what Canada has not been able to do.

SENATOR BRYAN. So, you are saying that it is possible to have it both ways.

I am not being confrontational with you, but there has been almost an implicit premise in a lot of the dialogue out there, not necessarily by people like yourself who have levels of expertise far greater than most of the people with whom we visit at town hall meetings and informal gatherings, as we return to our states or Congressional districts—as the case may be—that in order to put some type of brake on the costs—which we know the numbers; I think $675 billion is a fairly accepted number these days—it will go beyond a trillion dollars by the turn of the Century. You are saying that we can indeed provide some type of brake on this escalating and spiraling price and the kind of quality that Americans have come to expect, to my sense, that we enjoy the world's finest quality of medical care. I think most people accept that. I certainly do. That is not based on any study or survey. That is my own intuitive judgment, that we have the very finest. And yet, we can do all of that, quality, be comprehensive, and yet still not see the costs run completely off the chart. If that is true, those of us in the political process, who find it very difficult to make these difficult judgments, certainly embrace those kinds of suggestions. Tell us how we do that.

I want to give you, Ms. Lehnhard, a chance.

Ms. LEHNHARD. Let me begin, and Jim can speak to this, by saying we believe that you have to have federal regulation to do that. That is the big change we have made in the last two weeks, that we have to have federal regulation to clean up insurance practices in the health insurance market, and you have got to have federal regulation to make sure that we do not just continue paying on a fee-for-service basis, regardless of whether those services are needed. We have to begin to shape insurers so that they look more like the Kaisers, the closed-panel HMOs. You have to give the insurance industry those incentives. If they do not want to change that way, maybe they should sell life insurance or disability insurance, not health insurance.

SENATOR BRYAN. Mr. Doherty?

MR. DOHERTY. I do not envy you. It is in your ballpark. I think you have a responsibility to see to it that those who cannot afford medical care get it, period, particularly the kids and whatnot.

SENATOR BRYAN. It is pretty hard to argue against that proposition.

MR. DOHERTY. But when you talk about rationing, you get into quality of life.

There is a fellow in my church who is 92 years old and had a quadruple bypass. We all thought it was criminal that they would do this. I saw the guy last Sunday. He is as peppy as he can be. He is driving around the block. He is sharp, and he is still working.

My point is that that is a qualitative judgment. I do not think you can do that in a legislature, and I do not think you can do that in Oregon, or any place else.

That is the reason why Mr. Talon in New York and Dr. Aaron over at Brookings have some serious questions about the quality of life and how that is shortcutted when one goes to rationing.

I do not envy you. Your question is what leads me not to run for office. [Laughter.]

I would rather lobby you.

SENATOR BRYAN. We are looking for the life raft.

Ms. Lehnhard seems to be saying—and I do not want to inappropriately cast her response—look, if we change the way in which we practice medicine in America, and that requires federal regulation, we can indeed provide for this comprehensive system. And Mr. Doherty, I agree with you. I do not know how we can say——

MR. DOHERTY. I do not think she is saying that. I think what she is saying—I do not want to put words in her mouth—is how do we deal with the affordability issue. That is different than changing the practice of medicine. We can go to practice standards and try to do these external kinds of things to make sure that the medicine that is paid for is necessary medicine.

I will let Mary Nell speak for herself on that.

SENATOR BRYAN. Mr. Doherty, let me ask you that and rely on your expertise.

Is it possible for us to structure a system that provides the comprehensive care that we are talking about, but puts some type of constraint so that we are not escalating these costs beyond our ability? What is it, 12 percent of our gross national product today? It is roughly double what it was 20 years ago. And still not have to come to that ethical and moral twilight zone in which we are saying to the 92-year-old, we do not provide that kind of medical care for you? Is it possible for us to do that? Or are we simply kidding ourselves in saying that we cannot have it both ways? We cannot be comprehensive and universal and contain the costs without at least making some finite judgments that have some moral implications, I think, for a lot of us.

MR. DOHERTY. You have some very tough, economic judgments and decisions to make.

All of us are saying we would like to see you try. We think it is more efficient now that you try to develop what we have in the private sector. Hold all of us to our promises, except for Pete. He is an economist and he has license. But hold all of us. Deal with the affordability. If you do

not like the HIAA thing on small group reform to try to alleviate that segment, then say so, and make HIAA or the insurance companies do something more, and apply the same thing to us.

I think that we have a $680 billion system here. With $680 billion, if we cannot afford health care as a right for everybody in this society, something is wrong with us.

SENATOR BRYAN. Mr. Sternberg, it looks like you are eager to wade into this and supply the answer.

MR. STERNBERG. Well, you know we have various potencies of medicine that we can give for this problem.

I think the managed care brings with it the least negative side effects. That is why our position is, let us try and see how much we can constrain cost escalation using the managed care, which is still is in its very early stages of development. The next stage might be some level of price control. We do not, at this particular point, like that at all. The third level of potency is rationing, which we like even less.

The issue is, I think we have to give time for the managed care to work, because the other two medicines bring with it consequences that I do not think we want to deal with at the present time.

SENATOR BRYAN. What is a reasonable time for us to determine into the first level of medication, if it solves the problem?

MR. STERNBERG. I think you will find some positive results in the next 24 to 36 months.

SENATOR BRYAN. Are we going to see the rate of increase reduced?

MR. STERNBERG. Yes.

SENATOR BRYAN. Will we see a bubbling off, a reduction?

MR. STERNBERG. Right now, we are dealing with increases of both utilization and cost that is in the high double-digit range. I would hope that managed care can bring that down to the high single-digit level. I still think we are going to be dealing with cost levels that are greater than the CPI.

First of all, we have a demographic issue here in the United States with the aging of the population, which is going to be driving costs up independent of what steps we take. I think that we have to recognize that. The aging of the population is going to cause some escalation. But I would hope that we would be able to show, probably not in all areas of the country, but in enough areas of the country, that that escalation is reduced to the 9 or 10 percent range.

Then the issue that is going to be faced by you and your colleagues is, okay, do we want to take the penalty? Do we want to take the negative consequences of the rationing and the cost control to get anything better than that? That is going to be a judgment call that one Senator might go in one direction, and the other might go in the other direction.

It is a key judgment call. But I think it is too early to deal with those issues, because we do have something to work with that I think is going to provide some positive results.

SENATOR BRYAN. Are you suggesting that we can get into the single digit in some parts of the country—to paraphrase your response—in say 36 months? And are we saying that at that point, from thereafter, we are still going to see the high, single-digit increases? Or are we going to see further improvement as we get out to 48 months, or 60 months? Or is that just too far?

MR. STERNBERG. I just do not know. I really do not know the answer to that question, because you are dealing with—and Ms. Lehnhard indicated this—the issue that managed care is going to force a change, hopefully, in the practice patterns of physicians. How well they respond to those changes, and what they then do to constrain themselves, because if they see, for example, that we do not do business with doctors that are outlyers and are using medical care inappropriately, maybe we can see a change in overall practice patterns.Maybe that will cause some constraining in overall escalation. I do not know. It is hard to predict. But it is going to take 24 to 36 months to see what the effect is of some of the steps we are taking today.

SENATOR BRYAN. Mr. Doherty, I see you are less enthusiastic and sanguine about the process.

MR. DOHERTY. There are kids in the neonatal ward at Washington Hospital Center right now that cost about $1,400 a day to take care of. They would have been dead five years ago. You are dealing in an area of technology where demand is unlimited and the supply is limited.

I think you will control the inflation a little bit, and you will have a little more focus and responsibility, but I do not think you are going to do much about controlling overall costs. The demand is out there.

We are all politicians in the sense that you have to respond to the demand of the public. They want this high-tech care that you talk about. Look at the AIDS controversy. Now, the demand is for medicines that have not even been approved by FDA, that they want in an expedited way to get these things to market. It all costs money. All of that stuff costs money. And I cannot say "no," and I do not think you can say "no," either.

So, the question is whether or not you are going to be able to have control factors over the inflation by knowing what is causing the inflation, and seeing where you can economize and where you can perfect the system a bit better to make it a bit better.

MR. WELCH. To respond to the insurance industry a little bit—even though I am an economist—I never feel very comfortable with theory alone. I like to find what hard facts are out there to discipline our theories, if you will.

You asked about rationing. The example, of course, comes from this country, not from Canada. Canada has been able to keep its costs way below the United States without the explicit rationing that Oregon is considering.

It is strange to talk about it being necessary for us to ration in order to keep costs down further. My sense is that costs are going to continue

to go up and up. There is nothing in the system right now that is going to slow it down. People have been talking about competition since Ronald Reagan came to this town, so I would not use today as a starting point. I might use 1981 or something earlier as a starting point. If you do that, then competition has a track record. It is not a very good one.

SENATOR BRYAN. On the one hand, you say that the Canadians have not had to cross that threshold to get into rationing, and perhaps we ought not to make the assumption that we have to. Then you build into the system the kind of situations and problems that Mr. Doherty talks about, the demographic changes that all of us are aware of in society, which themselves under any system are going to require greater utilization that tends to drive the force. Then you have the American insistence or expectation, if you will, that we want the best.

This 92-year-old gentleman that you talked about, Mr. Doherty, gosh, if he were my father, you know, there would be no question in my judgment as to, you bet, that he should have that. On the other hand, if I am the taxpayer who has no personal relationship, then I can be much more objective and say, no, I do not know whether we ought to commit ourselves to that kind of expenditure.

Can we, Mr. Welch, with these demographic changes, with the technology demands, with the societal problems that Mr. Doherty talks about with AIDS patients, crack babies, fetal alcohol syndrome—all of which are tragically a part of our society—can we do it?

MR. WELCH. Let me speak initially to the demographic question. The change in demographics is widely understood, and therefore it is often raised in this context. I think its impact on cost growth is greatly exaggerated. It is very easy to calculate the impact of demographics. Typically—I do not have the figures—it explains 5 percent of the cost growth.

MR. TRAPNELL. That is too high. It is closer to 1 percent per year. We used to struggle with that when I was in the Office of the Actuary for the Medicare programs. We were always disappointed when we went through the age and sex projections. It was only adding something less than 1 percent to the cost of the program each year.

MR. WELCH. Thank you very much, Gordon.

Another way to make the very same point, the demographic changes that we are seeing in this country were seen throughout the developed world. Those nations are doing a much better job of controlling their health-care costs.

SENATOR BRYAN. Mr. Trapnell, is there anything you would like to add by way of comment?

I did not mean to ignore you, Ms. Lehnhard. You were somewhat interrupted earlier during the colloquy.

MR. TRAPNELL. I would like to react a little bit to the descriptions of competition in the insurance business. I was in the insurance business myself for eight years, and I would agree with the description that it is

murderously competitive. The difficulty I see is that a lot of what they are competing to do are the wrong things; that is, things that do not help the general public. This is especially true in the markets for individual insurance and very small groups, that is those under 25 employees. For these, the competition is to see who can determine best exactly how much to raise the rate for some group of 5 to 15 people, because somebody in that group has developed or will develop an expensive condition. It is also to figure out a way to reward the agents who bring in groups that are very healthy, and to develop high-tech systems for figuring out what it is going to cost to charge that group the next year.

The rules of the competition need to be changed if we are going to get these administrative costs down and have more people have a type of insurance that they can rely on, and not one that disappears when they need it.

I want to add that there are some insurance companies that are very aggressively following methods that undermine the value of insurance, and are forcing other companies to follow to avoid being forced out of business, and my colleague Mr. Sternberg is working with one of the responsible companies being pushed, not one of those causing the problems.

SENATOR BRYAN. Mr. Sternberg, I will give you equal-time response.

MR. STERNBERG. I think Mr. Trapnell's history lesson is correct. I do not think there is any question that our industry, in order to achieve their profitability, has attempted to select the best business through underwriting selection, which is part of the insurance business, and was certainly prevalent in the small group market. However, I think that this industry has matured and that is why we now have come forward in the past 12 months with a proposal for universal access. We recognize that we do have to provide insurance for all small groups and that the game is no longer a game of who can take the good risk and leave the bad risk to the Federal Government and the states. We now recognize that we have a responsibility, and as long as we can have a re-insurance mechanism that we would sponsor that spreads this risk across all of the carriers, we can support that, and we are moving in the right direction. So, that is my comment.

SENATOR BRYAN. On that elevated note, let me express my appreciation on behalf of the Chairman and all of the members of the Joint Economic Committee for your testimony.

All of these proceedings will be part of the record, and I am sure that we will leave the time open for any questions that any member of the Committee, who could not join us today, might have.

Mr. Welch, Mr. Doherty, Ms. Lehnhard, Mr. Sternberg, and Mr. Trapnell, thank you.

The Subcommittee will stand in recess for five minutes.

[Recess.]

REPRESENTATIVE SCHEUER. The Subcommittee will reconvene.

I apologize for the roll call vote.

Our panel of health-care providers and representatives of health-care provider organizations for this panel includes Donald T. Lewers, Eugene Hildreth, Laurens Sartoris, and Vickery Stoughton.

We will begin this panel with Dr. Donald T. Lewers. Dr. Lewers is Vice Chairman of the American Medical Association's Council on Legislation. He is a physician from Easton, Maryland with an active practice in internal medicine and nephrology. Dr. Lewis is accompanied by David Heidorn of the AMA's Division of Federal Legislation.

Dr. Lewers, please proceed for six or seven minutes and sum up your testimony. And I want to say to the whole panel, while we would like you to summarize in six or seven minutes, be assured that your prepared testimony will be reproduced, in full, at the point at which you testify. So, when you feel comfortable, please proceed.

STATEMENT OF DONALD T. LEWERS, M.D.
VICE CHAIRMAN, COUNCIL ON LEGISLATION
AMERICAN MEDICAL ASSOCIATION;
ACCOMPANIED BY DAVID L. HEIDORN, J.D.
DIVISION OF FEDERAL LEGISLATION, AMA

DR. LEWERS. It is a pleasure to be here with you. As stated, I am a practicing physician from Easton, Maryland. I practice both nephrology and internal medicine, which later on may come into some of your questioning.

It is a pleasure to represent the AMA here today, because the AMA agrees that the health-care system needs to be reformed. We have outlined that in our proposal, "Health Access America," which has been shortened to "HAA." We also agree that administrative reform is needed and required. The problem is: How do we do it? That is what we are here to discuss today.

My formal comments have been submitted to you, Mr. Chairman. As a result, I have written some brief notes to add on and hopefully cover some of the issues that have been covered earlier.

We would like to talk a bit about the Canadian system, since the purpose of the hearing is the Canadian administrative system. There are things that Canada does better than we do in the United States; mainly, providing access of primary care to its citizens. However, adoption of a single-payor system, such as the Canadian system, is not realistic for the United States for a variety of reasons that we will discuss.

In comparing the two systems, one major problem—and the one that we have talked about here today that I heard you discuss—is a lack of information about the administrative approach of both systems, not just the Canadian system. Even the GAO reports that the economic impact estimates that they have given are high ballpark figures.

One of the problems with health-care reform is that we simply do not have accurate information on cost factors.

For example, the AMA has estimated that liability reform alone will save $20 billion per year. Yet, in discussions that I have been around in this country, I have heard it quoted as high as $40 billion a year.

REPRESENTATIVE SCHEUER. You are talking about malpractice?

DR. LEWERS. Yes, sir. Liability reform. Yes, sir. Malpractice. "Defensive medicine" is also a term that we use. Those costs vary all over the map. I have heard them even higher than the $40 billion, but it is somewhere between $20 and $40 billion dollars a year.

REPRESENTATIVE SCHEUER. Between $40?

DR. LEWERS. Between $20 and $40 billion a year.

The GAO report on the Canadian system raises several questions to us. Is it appropriate to extrapolate savings to the entire Canadian system, based only on Ontario data? Factors that were utilized in projecting the savings on physicians' administrative costs were simply wrong. Technical and clinical personnel were included in administrative costs. They are not part of administration, and that cost would not go away even if we introduced that program. Inclusion of second-opinion programs, which they included as an administrative cost, are not administrative costs and are clearly inappropriate to be included.

Is it appropriate to compare the Canadian system in which ten provinces have less than a million population to a country where seven HMOs alone have in excess of a million members? Can an adequate comparison of the two systems ever be made without inclusion of social and cultural differences? In the United States, we have an older population. We have more violence. We have more AIDS victims. And we have a greater drug problem. It is difficult to measure because Americans are more individualistic, demanding more. As Alan Nelson, former president of the American Medical Association, liked to put it, Americans would rather sue than queue.

Another factor in the discussion is that the successes of the Canadian system have been at a cost that Americans would not be willing to accept. Americans will not queue. The lack of technical advances in Canada, which we enjoy in this country, is something Americans have grown to expect and do expect. The lack of capital investments in hospitals and similar facilities do not exist in this country, and Americans would not be ready to accept it. Americans do not want to adopt the problems of any system, but prefer to improve the system that already provides the best health care in the world.

We believe that this improvement can be achieved through our proposal, "Health Access America." In this proposal, we have proposed reforms that will achieve the same successes of the other systems, while building on and retaining the unparalleled quality of health care our system delivers to a large majority of Americans. Just to touch base on a few of HAA's proposals.

Liability reform is a key issue. The first panel mentioned it once. When we talk about the cost of health care in this country—the cost of insurance—you cannot get rid of defensive medicine and liability by

simply mentioning it only one time. Improved administration should be achieved, but that needs to be improved through the uniform payment form and through the electronic submissions that were mentioned in the first panel. Reduce physician hassles. We can talk about that for a long time, but I will not for the sake of time. Physician payment reform, which if implemented correctly, will improve our primary care availability. Small business insurance reforms and practice parameters. You have talked about unnecessary health care. One of the goals of practice parameters is to reduce that.

In conclusion, the AMA is committed to health-care reform. We are committed to looking at other ideas as demonstrated by our publication of the multiple proposals in the May issue of JAMA. Most important, we are committed to continuing an ongoing dialogue on health-care reform. However, the result must be a solution that is tailored to America and Americans. Thank you, Mr. Chairman.

[The prepared statement of Dr. Lewers, together with attachments, follows:]

PREPARED STATEMENT OF DR. LEWERS

Mr. Chairman and Members of the Committee:

My name is Donald T. Lewers, MD. I am a physician from Easton, Maryland with an active practice in Internal Medicine and Nephrology. In addition, I am the Vice Chairman of the American Medical Association's Council on Legislation. Accompanying me is David L. Heidorn, JD, of the Association's Division of Federal Legislation.

The American Medical Association (AMA) appreciates this opportunity to testify today concerning cost differences between the United States (US) and Canadian health care systems, especially as they relate to the single-payor Canadian model, and to share with the Joint Economic Committee our goals for improving the American health care system.

As the June 1991 report of the General Accounting Office (GAO) -- Canadian Health Insurance: Lessons for the United States -- indicates, the Canadian system has successfully provided all Canadians with access to primary health care for the last 20 years. When measured as a portion of gross national product (GNP), the Canadian system appears to consume fewer resources than the United States (US) system. The majority of Canadians report fierce pride in the health care they receive.

With these successes, it is understandable why the Canadian system has been a focus of attention in the debate on how to reform our own system. From south of the border, the way Canada goes about providing health care appears attractive for its assumed simplicity, seeming lack of bureaucratic hassle, and relative cost-effectiveness. The GAO goes as far as stating that, if Canada's single-payor system were applied in the US, the savings in administrative costs alone would exceed the costs of providing health care coverage for America's uninsured.

If such a grand promise could result from such a simple solution, we would be here today asking this Committee to work with us to adopt the Canadian system. Physicians share their patients' frustrations with the complexities of the US system and, more importantly, with the inability of far too many Americans to obtain coverage for their basic health care needs and with the increasing costs of our system. The AMA, too, is calling for change.

However, after careful examination, we do not believe that the Canadian system would be either a simple or an acceptable solution for the people

of this nation. Not only can the AMA not agree with some of the GAO's assumptions about the Canadian system, we do not believe that the choices Canada has made to achieve its successes would be acceptable to the American people, or to Congress.

Administrative Costs

The AMA's first concern is that GAO's bold assertion that adoption of Canada's single-payor system in the US would provide administrative savings that could provide coverage to all the uninsured, and then some, is not substantiated in the report. The study is obviously limited by the assumption that Ontario administrative cost experiences are representative of Canada overall, an assumption we do not believe can be made.

As a result of these assumptions, however, the GAO estimated that administration consumes 9.5 percent of Canadian health spending, versus 19.0 percent of US health spending. Savings associated with physicians' administrative costs alone were estimated at $15 billion, or $26,000 per physician, an estimate based on three factors: greater US expenditures for nonphysician salaries and benefits, the amount spent on specific billing services, and the difference in the value of physicians' time spent by filing insurance claims and providing second opinions. The estimate is not correct. The first component overestimates its part of physicians' administrative costs, since nonphysician salaries and benefits include spending on technical personnel, many of whom have nothing to do with billing or clerical work. The inclusion of time spent providing second opinions is similarly inappropriate.

Generally, little credible information is available on Canada's direct administrative costs. Administrative costs are absorbed into general, federal, and provincial government expenditures. The government system collects the revenue and administers the program, but the costs of doing so do not appear in general government figures for administration.

In comparison, figures supplied by the Health Insurance Association of America (HIAA) indicate average commercial insurance administrative costs of 11 percent of total premiums collected, an average of costs for groups of different sizes. Overhead costs related to administration and claims processing of public programs are very low -- 2.2 percent of benefit payments for Medicare and 4.8 percent for Medicaid. The share of administrative costs for Blue Cross and Blue Shield is 9.3 percent of premiums. American Hospital Association data indicates that billing costs (patient accounting, admitting, and data processing) were less than 4 percent of total hospital costs. Adequate data on the administrative costs of physicians do not exist. Nonetheless, these percentages, taken as a whole, do not seem substantially different than the administrative percentages for Canada presented by the GAO.

Besides the GAO, the only other study to compare the Canadian and US administrative costs is contained in an article by Woolhandler and Himmelstein in the May 2, 1991, issue of the New England Journal of Medicine. Substituting for the inadequacy of data in this area, the authors frequently generalize from the opinions or casual observations of "personal communications" to both the US and Canada as a whole. Of 60

references cited in the study, 22 are "personal communications" or "unpublished data."

Before comparisons between health care systems can be made, adequate information must be available. The information available on the cost of administering the US and Canadian systems is not adequate, so any comparison is speculative at best.

Intangible Costs

Although Canada's single-payor budget-driven approach is credited with controlling expenditure growth somewhat better than in the US, the Canadian system imposes other less noticeable, or intangible costs on patients and providers. Canada is excellent at providing primary care services, but it has chosen this result by creating severe limitations, or rationing, of health care services in other areas. The Canadian health care system suffers from: limited research and development; limited availability of technology; deterioration of the health system infrastructure as a result of limited capital investment; and reduced incentives for providers to seek efficiencies in health delivery.

These costs result in another type of access problem -- one in which patients must wait for tests, treatments, and hospital beds. The GAO report itself documents the rationing of certain, highly technological medical services such as cardiac bypass surgery, lens implants, and magnetic resonance imaging. An August 28, 1991 article in the Journal of the American Medical Association (accompanying this statement) supports

the GAO's findings in its study of patients from British Columbia being sent to Seattle, Washington, for coronary artery surgery, which is inadequately available in Canada because of global hospital budgets and restrictions on capital expansion for hospitals. We find this type of access problem as unacceptable as the access problems experienced in this nation.

Social and Cultural Differences

The unique characteristics of American medicine and society indicate that the savings enjoyed by Canada would not necessarily be attained if the US adopted a Canadian-style system. We have many costs that are unique to the US, such as the costs associated with our tort system; the high rate of physician specialists; societal and health problems such as AIDS, violence, and the difficult problems found along our border with Mexico; and our investment in research and development.

Converting to a single-payor system would not likely reduce these costs. In fact, our system's unique present expenditures in areas such as data collection are actually being used to bring about a reduction in costs by identifying inappropriate expenditures. As the GAO study notes, Canada's underdeveloped information systems provide few incentives for hospitals to track per patient or per diem costs.

Building on Our Current System

On balance, the AMA prefers seeking administrative savings through insurance market reform and claims administration reform -- and leaving

intact the competitive system of health delivery. Monopolies, including those of the government, become inefficient over time because of the lack of competition. In fact, our experience with a single-payor type of program -- the US Medicare program -- has been that, as the program is driven more and more by its budget, it imposes more and more bureaucratic burdens on patients, physicians, and providers. Rather than establish another government bureaucracy, efficiencies through reform of our competitive market should be sought.

Our health care system, at its best, offers unrivaled quality, choice, and technology. The AMA's proposal for reform, Health Access America (HAA), (which accompanies this testimony) would retain the best and address the worst by building on the existing private/public partnership that is the foundation of our health system. HAA would expand access to the over 20 million working uninsured by requiring employment-based insurance. This requirement would be phased-in over time, and significant incentives would be provided to assist small and new businesses. HAA would also reform Medicaid to ensure that everyone below the federal poverty level receives uniform basic coverage.

Cost Containment

Any reform proposal would be incomplete if it did not address costs. Our health system is costly, continuing to demand more and more of our resources. However, we do not believe that Canada's health system necessarily is less costly than the US system. While the growth in health shares of gross national product (GNP) has been slower in Canada

than in the US in the period between 1980-1989, growth in health care spending as measured per capita was actually faster in Canada during the same period. Between 1980 and 1989, the average annual per capita growth in health care expenditures was 10.6 percent in Canada and 10.3 percent in the US.

A more careful understanding of the factors driving up health costs in both nations is necessary. In the US, costs are being driven by a variety of complex factors, including new and expensive technology, aggregate population growth, more health-conscious consumers who utilize more services and technology, inflation, and the health consequences associated with increasing societal problems such as AIDS, drug abuse, and violence.

HAA addresses the cost dimension of health reform by responding to these factors through development of practice parameters; technology assessment and outcomes research; preemption of state mandates to allow employers to offer an essential benefits package such as the one the AMA has developed; medical liability reform; amendment of federal antitrust laws to allow the profession to review excessive fees; health promotion and disease prevention; encouraging appropriate utilization of health resources through tax incentives and through cost sharing; and supporting state demonstrations of alternative health delivery structures.

Conclusion

Canada's system of health care delivery certainly has considerable positive aspects. However, it is not a system that is transferable

to the US. Some of its attributes, which are attractive on the surface, would not be as positive as many critics of our current system aver. Its rationing of health care is no less pernicious than the indirect rationing that occurs in the US. While this nation needs to commit itself, like Canada, to providing better primary care to all Americans, certainly, without the availability of certain advanced technologies in the US, some Canadians urgently in need of medical care would still be waiting in lines.

We do not believe the choice between these two extremes is what the American public expect when they express dissatisfaction with the current health care system. They are largely satisfied with the medical care they receive. They simply want the kind of care already available to most Americans to be affordable and to be available to all Americans.

Special Communication

British Columbia Sends Patients to Seattle for Coronary Artery Surgery

Bypassing the Queue in Canada

Steven J. Katz, MD, MPH; Henry F. Mizgala, MD, FRCPC; H. Gilbert Welch, MD, MPH

Concern about waiting lists for elective procedures has become a highly visible challenge to the universal health insurance program in Canada. In response to lengthening queues for patients waiting for cardiac surgery, British Columbia made contracts with four Seattle hospitals to send a total of 200 patients for coronary artery bypass surgery. This article examines the cause of the queue for cardiac surgery in British Columbia and the events that led to outside contracting. Global hospital budgets and restrictions on capital expansion have limited hospital capacity for cardiac surgery. This constrained supply, combined with periodic shortages in critical care nurses and cardiac perfusion technologists, has resulted in a rapid increase in the waiting list. Reducing wide variations in the lengths of queues for individual surgeons may afford an opportunity to reduce long waits. While the patient queue for cardiac surgery has sparked a public debate about budget limits and health care needs, its clinical impact remains uncertain.

(*JAMA*. 1991;266:1108-1111)

ON February 16, 1990, the Ministry of Health of the province of British Columbia announced that an agreement had been reached with a US medical center to help serve over 700 patients waiting for cardiac surgery. Of these patients, approximately 70% were scheduled for coronary artery bypass surgery. By making the announcement, the Ministry of Health was publicly admitting that the province was unable to provide this service to all for whom it had been recommended. Minister John Jansen acknowledged the agreement in a news release on February 16, 1990:

> By negotiating contracts with Washington State [hospitals] for open heart surgery, [the Ministry] clearly recognizes the problems and issues associated with the programs in British Columbia and has adopted a responsible patient care response by arranging for service to be provided while addressing the local problems.

Queuing, meaning "to form or wait in line," has become a frequent criticism of the national health programs of Canada and Great Britain. Stressing the detrimental effects of queuing for cardiovascular services on patients in Canada, the American Medical Association recently initiated a high-profile publicity campaign, including a mailing to physicians, against proposals for a comparable system in this country. Canadian medical organizations have characterized queuing as rationing caused by inadequate government funding' (Times Colonist. February 16, 1990:B1) This article chronicles the events in British Columbia that led to outside contracting for coronary artery bypass surgery. In addition, we discuss several lessons about queuing drawn from the experience in British Columbia.

THE ORGANIZATION OF HEALTH CARE IN BRITISH COLUMBIA

British Columbia administers a universal health insurance program providing comprehensive benefits to all residents. Financed through individual monthly premiums, provincial tax revenue, and a federal subsidy, health care services are "free" to the patient at the time of service. For the most part, physicians are paid on a fee-for-service basis using a fee schedule negotiated annually. Private insurance for payment of physician services covered under the provincial health care plan is illegal, and physicians are prohibited from billing patients directly for insured services. Hospitals are financed by a global grant negotiated annually with the Ministry of Health. All hospital services including salaried personnel, pharmacy, and equipment are covered under this yearly grant. New capital expenditures for upgrading, expanding, or introducing new services are applied for separately. In the case of cardiac surgery, angioplasty, and other highly specialized services, the province's program funding scheme reimburses hospitals on a per-case basis but limits the total number of procedures. These funds cover the en-

From the Department of Internal Medicine, Division of General Medicine, University of Michigan Medical Center, Ann Arbor (Dr Katz); the Division of Cardiology, University of British Columbia, Vancouver, and Vancouver (British Columbia) General Hospital (Dr Mizgala); and the Departments of Medicine and Community and Family Medicine, Dartmouth Medical School, Hanover, NH, and the Department of Veterans Affairs Medical Center, White River Junction, Vt (Dr Welch). At the time of the study, Dr Katz was a Robert Wood Johnson clinical scholar at the University of Washington, Seattle.

Reprint requests to the Department of Internal Medicine, University of Michigan Medical Center, 3116 Taubman, Box 0376, Ann Arbor, MI 48109-0376 (Dr Katz).

tire hospital cost generated by patients undergoing these procedures. The goal of program funding is to control costs while ensuring that expensive medical procedures are provided without compromising other hospital services.

A provincial single payer coexists uneasily with physicians in private practice who have full authority over patterns and levels of health care services.[2,10] This system tends to create tension between physicians, who seek to expand services, and the government, which seeks to control utilization. The debate over queuing for certain high-profile procedures has become one manifestation of this tension in several provinces of Canada, including British Columbia.

THE PHASES OF THE QUEUE: 1986-1990

Two variables were acquired from the Ministry of Health to delineate the pattern of the queue over time. The first is the length of the queue itself, calculated by summing the number of patients scheduled for cardiac surgery by each surgeon. The second is the number of procedures performed each quarter, which constitutes the supply of the procedures. A third variable, demand, cannot be measured directly, but can be imputed by the number of patients referred for surgery each quarter. This number was calculated by adding the change in the number of patients waiting for surgery since the previous quarter (ΔQ) to the number of procedures performed during the quarter (S): so demand = $\Delta Q + S$. Thus, when demand exceeds supply, the queue lengthens, and when it is less than supply, the queue shortens.

These three variables are plotted over time in Fig 1. The top portion of Fig 1 demonstrates that the increase in the waiting list during 1986 through 1990 was not consistent. The lower portion of Fig 1 shows the variability in both supply (the number of procedures performed each quarter) and demand (the number of patients referred for surgery each quarter) during this period. The variability in supply predominates. To explain the effect of supply and demand on the lengthening queue, we describe four distinct phases.

During phase 1 (1986 through 1987), a relatively stable supply (averaging 450 procedures per quarter) did not meet demand, resulting in a moderate rise in the number of patients awaiting surgery (from 200 to 450). During phase 2 (1988), a marginal increase in supply (averaging 520 procedures per quarter) matched or slightly exceeded a steady demand for service, resulting in a slight decrease in the waiting list.

Phase 3 began in January 1989, when a marked drop in surgical volume fell far below demand. This resulted in an abrupt increase in the number of patients on the waiting list. There were two principal causes of the drop in surgical volume. First, a chronic critical care nursing shortage was made worse by a period of intermittent work slowdowns, followed in June by a 17-day nurses' strike. Second, a worsening shortage of cardiac perfusion technologists reduced operating room time. These conditions reduced surgical volume and further idled cardiovascular surgeons. During phase 3, the waiting list doubled from 400 to nearly 800 patients.

The fourth phase, beginning in early 1990, was marked by a slow return to prestrike nursing levels. While supply gradually increased to prestrike levels, the waiting list did not shorten, but plateaued at nearly 800 patients. Limits in the ability to increase the number of procedures performed meant that supply could not respond to the rising waiting list backlog.

Why couldn't surgeons perform more cardiac surgery? It was not because of program funding limits. Despite excess demand, the total number of cardiac surgical procedures performed annually met targets set under program funding in British Columbia in only 1 year. Except for 1988, the number of procedures performed fell short of targets by an average of 200 patients annually. The bottleneck was somewhere in the hospital.

Two hospital factors were particularly important in creating this bottleneck. First, global hospital budget constraints resulted in little excess capacity for technically complex services. At Vancouver (British Columbia) General Hospital, cardiac surgical intensive care and recovery beds have always been virtually full. Competition for these resources occurs among surgical services. For example, the inception of a new heart and heart-lung transplantation program in December 1988 at Vancouver General Hospital reduced the availability of these resources to routine cardiac surgery.

A chronic shortage of critical care nurses and cardiac perfusion technologists is a second hospital factor that has limited service capacity in British Columbia. Work arrangements and wages and benefits for critical care nurses and cardiac perfusion technologists are far superior in the United States. Because hospital employee unions in British Columbia do not base differential pay on job role, wages provide no additional incentives to work in critical care areas.

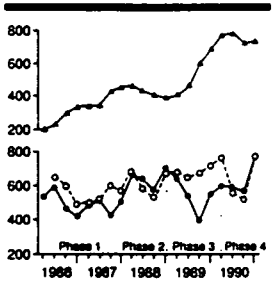


Fig 1.—Trends in the queue against the supply and demand for cardiac surgery in British Columbia, 1986 through 1990. The number of patients on the waiting list is shown at the top. The number of patients referred and the number of procedures performed per quarter is shown at the bottom.

Scheduling of cardiac surgical cases is usually reduced on Thursdays and Fridays because of the unavailability of cardiac surgical nurses on weekends. These hospital factors created a ceiling on the number of procedures performed despite the availability of program funds and surgeons.

DISPARITIES IN THE QUEUE: HOSPITALS AND SURGEONS

The number of patients awaiting surgery varied by hospital and by surgeon. Two hospitals in Vancouver and one nearby in Victoria, British Columbia, provided cardiac surgery services for the province. Figure 2 shows the distribution of waiting times for patients operated on at the three hospitals from April through November 1990. Almost half of the patients referred to surgeons at St Paul's Hospital in Vancouver waited more than 4 months (shown in gray) while less than 10% did so at Greater Victoria Hospital Society. Intermediate waiting times were experienced by patients at Vancouver General Hospital.

Disparity in the waiting list among the 14 surgeons performing cardiac surgery in the province was even more pronounced (Fig 3). Three surgeons (two at St Paul's Hospital and one at Vancouver General Hospital) accounted for two thirds of the waiting list. Thus, the length of a hospital waiting list is primarily a function of isolated queues for a few popular surgeons. This maldistribu-

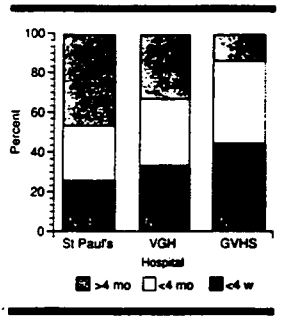


Fig 2.—The distribution of waiting times for patients operated on from April through November 1990 at three hospitals in British Columbia, Vancouver General Hospital (VGH); Greater Victoria Hospital Society (GVHS), Victoria; and St Paul's Hospital, Vancouver. N equals the number of patients operated on at each facility during the observation period.

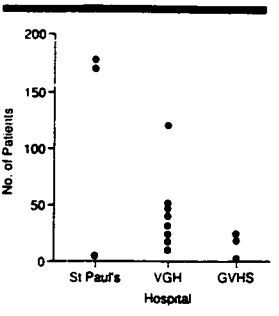


Fig 3.—The cardiac waiting list for 14 surgeons in British Columbia by hospital as of November 1990. (For explanation of abbreviations, see legend for Figure 2.)

tion is the result of traditional community referral patterns and a relatively fixed number of operating room slots per hospital and surgeon. Because operating room slots are only partly allocated on the basis of the length of a surgeons' waiting list, popular surgeons do not have sufficient additional opportunities to reduce long waits. The maldistribution of patients among surgeons and hospitals suggests an impressive lack of coordinated referral.

PUBLIC REACTION AND THE GOVERNMENT RESPONSE

During 1989 the Ministry of Health received many compiaints of long delays from physicians and their patients. Media stories appeared documenting the frustrations and experiences of patients awaiting heart surgery. Organized medicine characterized the queuing problem as a failure of the government to allocate adequate funds for surgery. The British Columbia Medical Association, which represents practicing physicians and negotiates physician fees, placed advertisements in newspapers blaming long waits for heart surgery on "government cutbacks" (Vancouver Sun. February 9, 1990:A10). A physician-spokesman for the British Columbia Cardiac Society claimed that 12 to 20 patients had died while awaiting surgery in 1989 (Toronto Globe and Mail. February 2, 1990:A10).

One event in particular prompted the provincial government to look beyond its borders for solutions to the growing problem. On January 8, 1990, George Yetman, a 35-year-old housing insulation worker from British Columbia, underwent quadruple bypass surgery in Detroit, Mich, at his own expense after waiting 10 months for surgery. This event received wide press attention (The Province. January 8, 1990:5). Provincial officials were concerned about the effect of covering the costs of patient services provided in the United States. However, after several months of negotiation with the Ministry of Health, Mr Yetman was reimbursed for his operation.

Despite plans to open a new open heart surgical facility, growing public concerns and the Yetman case prompted the Ministry of Health to go beyond its provincial borders for providers willing to perform the procedures. Initially, other Canadian provinces were approached. Neighboring Alberta had available beds, but because of funding problems could not eliminate its own waiting list. Taking patients from British Columbia would have had unacceptable political repercussions. Ontario had already arranged for heart surgery services in Detroit hospitals to handle a growing waiting list, and Saskatchewan faced similar problems.

Subsequently, James Nell, president of the Seattle (Wash) Area Hospital Council, was contacted by a Vancouver newspaper reporter and was asked whether Seattle hospitals might assist. Nell was quoted as favoring negotiation with the province for overflow patients:

> It's a very, very interesting concept. Our hospitals are in a competitive market here. If there are beds, it can mean extra income. We want to go through the proper channels on this, but it's possible it could be worked out (*The Province*. January 12, 1990:11).

If British Columbia was to export patients outside of Canada, Washington State was the obvious choice. Two thirds of the provincial population lives within 200 miles of Seattle. This proximity meant little additional travel for patients and their families. Surgical services were available within a competitive market environment; of the 12 hospitals performing coronary artery bypass surgery, 11 submitted bids for patients from British Columbia. Apparently, administrators viewed a contract with British Columbia as an important entree into a potentially large referral base.

Contracts were negotiated prospectively with four hospitals to perform 200 procedures at a discounted price. The hospital charge, approximately $12 500 (US dollars), was comparable to costs in British Columbia, but lower than third-party reimbursement to hospitals in Washington State ($14 000 to $17 000). The surgeon's fee of $4500 (US dollars) was significantly more than the reimbursement in British Columbia ($2500, US dollars) but lower than that in Washington ($6000). To decrease variability in costs to Seattle hospitals, it was agreed that only patients with low surgical risk would be accepted into the program. On March 13, 1990, the first patient from British Columbia underwent bypass surgery at the University of Washington, Seattle.

The Ministry of Health viewed these contracts as a short-term remedial measure while local solutions were implemented. Prompted by the growing waiting list in 1987 and a report by outside consultants,[2] the Ministry of Health began plans to increase capacity by opening an additional facility at the Royal Columbian Hospital outside Vancouver. A computerized registry of patients awaiting heart surgery was to be put in place in 1991. Finally, the Ministry of Health appointed a Provincial Advisory Panel on Cardiac Care made up of cardiac surgeons and cardiologists to review the waiting list on an ongoing basis, to create consensus indications for surgery, and to evaluate the appropriateness, urgency, and distribution of patients awaiting surgery.

The impact of the Seattle contracts has been modest. Ironically, despite the rapid rise in the waiting list, the rate of referral to the Seattle program has been surprisingly slow. As of February 1991, 1 year into the program, 185 patients had been approved for surgery. However, the indirect effects of the Seattle

contracts go beyond the provision of service to 185 patients. Although proposed as a short-term measure, in the long term, it may prove to be both an economic and political advantage. The Ministry of Health found hospitals with excess capacity willing to provide services at a marginal cost, less than that of providing those services with new facilities in British Columbia. In addition, though billed only as a patient care issue, the action sent a strong message to physicians: the Ministry of Health could find alternatives to expansion of capacity to solve the queuing problem. In fact, British Columbia has already begun negotiating contracts for radiation oncology services with Washington State facilities.

COMMENT

Queuing for certain services may be an inevitable result of a system that has successfully constrained health care costs while eliminating financial barriers to patients. Indeed, the scenario described for cardiac surgery in British Columbia is being repeated for other procedures and in other provinces. Physician and public concern about waiting lists for elective procedures has become the most visible challenge to Canada's universal health insurance program. Three lessons drawn from the British Columbia experience deserve scrutiny.

First, constrained supply is slow to respond to changing conditions. The supply constraint is the result of the successful cost-containment strategies of the Canadian health insurance program. While Seattle hospitals easily accommodated additional patients requiring coronary bypass surgery, little excess capacity exists in British Columbia. Cardiovascular surgery services are constrained by global hospital budgeting and restrictions on capital expansion and technology; intensive care resources are limited. The inability of the system to "gear up" after the personnel crisis demonstrates its vulnerability to a disruption in supply. Despite the availability of additional funds and surgeons, hospitals could not accommodate more patients. Thus, the new surge in patients on the waiting list could not be served in existing facilities and stabilized at a higher plateau.

Second, disparities in the length of the queue for different surgeons offer opportunities to reduce delays for surgery. Isolated queues for surgeons in British Columbia have created widely divergent waiting times for patients. Well-publicized instances of long waits (such as the Yetman case) have a strong negative impact on the public's perception of the availability of cardiac surgical care. This situation is the result of deeply entrenched community referral patterns and a relatively fixed number of operating room slots for each surgeon. Several mechanisms could reduce waiting times without expanding to additional facilities. One is the creation of a single central queue, from which patients would be parceled out to the next available slot based on urgency, regardless of which hospital or surgeon was preferred. However, the experience with a central queue for cardiac surgery in Ontario suggests that few patients and physicians are willing to forgo choice. Alternative mechanisms could be devised to reduce the uneven waiting times while acknowledging patient and physician preferences. The process of peer review established through the Provincial Advisory Panel on Cardiac Care may provide some degree of prioritization. Urgent cases could be distributed among all surgeons on a priority basis. Patients waiting for elective surgery would be given a choice of surgeons with shorter waiting times or the opportunity to wait longer for their preferred surgeon. Any of these mechanisms would reduce the extreme waiting times and, because of their skewed distribution, would lower the average wait as well.

Third, the debate about queues is a debate about needs. The rapid increase in the queue in British Columbia heightened the tension between physicians and those who pay them—a tension created by conflicting perspectives about need. Because physicians place high value on their services, they equate utilization with need. Thus, they perceive queuing as a measure of unmet need. In contrast, the government places high value on fiscal restraint and perceives the queue as a manifestation of the tendency for physicians to expand services and push against any budgetary constraint. Robert Evans, an economist at the University of British Columbia, suggests that this debate over queues is predictable:

> The periodic uproar over queues is nothing more than political theater involved in trying to get funds from the government and does not correspond to a shortage of capacity relative to needs. Rather, professional criteria for testing and intervention adjust to available facilities.[7, p.1688]

While waiting means frustration and anxiety for patients in the queue, its clinical impact remains uncertain. Highly publicized anecdotal accounts of sudden death while awaiting surgery in British Columbia provide little insight into this question because they fail to consider outcomes in patients who have had surgery. Media features elevating bypass surgery to a "lifesaving" therapy sharply contrast with the data demonstrating only a marginal effect on mortality in selected patients.[4-7] Broad disagreement among expert physicians about the appropriateness and urgency of the procedure adds to the uncertainty.[7] The fact that provincial patients and their physicians were slow to join the Seattle program suggests that the growing waiting list for cardiac surgery in British Columbia may not reflect an urgent need for surgery. The decision to send patients to Seattle seems less a response to a scientific understanding of need than a reaction to emotionally charged public and physician concern about access to a highly visible form of treatment. Using provincial funds for contracts with facilities in the United States may encourage physicians in Canada to scrutinize much more carefully who is on these waiting lists and why.

The preparation of this article was assisted by a grant from The Robert Wood Johnson Foundation, Princeton, NJ. The opinions and conclusions are those of the authors and do not necessarily represent the views of The Robert Wood Johnson Foundation.

We thank Neil A. Fatin MB, FRACP, for data and useful comments.

References

1. Le Bourdais E. Will the BC contract wrangle ever end? *Can Med Assoc J.* 1990;143:306-308.
2. Evans RG. The fiscal management of medical technology: the case of Canada. In: Banta HD, ed. *Resources for Health: Technology Assessment for Policy Making.* New York, NY: Praeger Publishers; 1982.
3. *Report to the Ministry of Health of British Columbia: Study of Cardiac Services of Open Heart Surgery, Percutaneous Transluminal Coronary Angioplasty and Coronary Angiography Provided in British Columbia.* Toronto, Ontario: Keon & Menzies Inc; 1988.
4. Alderman EL, Bourassa MG, Cohen LS, et al. Ten-year follow-up of survival and myocardial infarction in the randomized Coronary Artery Surgery Study. *Circulation.* 1990;82:1629-1646.
5. The Veterans Administration Coronary Artery Bypass Surgery Cooperative Study Group. Eleven year survival in the Veterans Administration randomized trial of coronary bypass surgery for stable angina. *N Engl J Med.* 1984;311:1333-1339.
6. Passamani E, Davis KB, Gillespie MJ, Killip T. A randomized trial of coronary artery bypass surgery: survival of patients with low ejection fraction. *N Engl J Med.* 1985;312:1665-1671.
7. Whalen R, Harrell FE Jr, Lee KL, Rosati RA. Survival of coronary artery disease patients with stable pain and normal left ventricular function treated medically or surgically at Duke University. *Circulation.* 1982;65:49-52.
8. Naylor CD, Basinski A, Baigrie RS, Goldman BS, Lomas J. Placing patients in the queue for coronary revascularization: evidence for practice variations from an expert panel process. *Am J Public Health.* 1990;80:1246-1252.

Health Access America

The AMA proposal to improve access to affordable, quality health care

Backgrounder

After several decades of scientific and technological advance, the United States has become the premier nation in providing high quality, comprehensive medical care and education. No health care system in the world can match the high caliber of medicine practiced throughout this country, nor the widespread availability of medical procedures and technology now considered common in the U.S.

However, the outstanding level of care found in our system has not provided solutions to serious problems that leave millions of Americans without health insurance coverage. Despite national spending of over $500 billion and 11 percent of the U.S. gross national product on health care each year, 33 million Americans do not have access to affordable medical insurance for themselves and their families. Public opinion polls find Americans are discontented with this inequity despite the very high level of satisfaction with the quality of medical care practiced in the United States.

Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. Public opinion polls show that Americans favor a system of employer-provided health care insurance that would slow rising costs, improve access for the poor and elderly, and remove the bureaucratic paperwork that serves only to complicate and stretch the resources of the system.

Who are the uninsured? Approximately 213 million or 87 percent of Americans today enjoy access to fine health care services through private or public insurance. Unfortunately, that leaves about 13 percent or 33 million without adequate access to care because they can not afford private insurance and public assistance is unavailable. About 70 percent of the uninsured, around 24 million, are working Americans and their families. About three million persons, some of whom are employed, are considered "medically uninsurable" by private companies due to health conditions. The Medicaid system, designed to aid those below poverty levels, assists only about 40 percent of our poor, many of whom are children.

While many in our society lack sufficient access to the system, an overwhelming percentage of Americans who do have proper access are satisfied with the level of care they receive. However, this country's system allows many persons to remain uninsured.

American physicians, who are represented through the American Medical Association, share the view that improvements need to be made promptly to our health care system, especially addressing the access and cost problems. In basic terms, certain principles should underscore the national discussion on improving our health care system:

-- **Strength.** Improvements to the American health care system should preserve the strengths of our present system.

-- **Access.** Affordable coverage for appropriate health care should be available to all Americans, regardless of income.

-- **Freedom.** The right to determine the manner in which health care benefits are delivered.

-- **Affordability.** Health care services delivered at appropriate cost and without excessive liability costs and paperwork interference.

-- **Security.** Continued access to health care for the elderly.

-- **Quality.** Access to care through physicians who are committed to the highest ethical standards.

Strengthening America's health care system

After an extensive review of the strengths and weaknesses of the American system, the AMA has developed a 16-point proposal to expand access to health care coverage to all Americans, while controlling inappropriate cost increases, and reducing paperwork and bureaucracy. Many of the elements contained in the AMA plan have already taken legislative form, such as the Medicare Reform package introduced by Rep. Charles Rose (D-N.C.). Other elements are part of a legislative approach calling for additional action to bring about needed reforms.

Primary to the AMA proposal is the belief that improving our system of health care must be based upon the strengths and successes of our present system. These strengths include:

-- The vast majority of Amercans are satisfied with their physicians and the health care services they receive.

-- Most patients have the ability to freely choose their physician, hospital and system of care.

-- Technology is widely available and science remains free to conduct research in the best interests of the patient.

-- The medical education system continues to produce highly trained, competent physicians.

54-863 O—92——13

-- Medical professionals remain free to act as patient advocates rather than agents of the government or other interests.

These strengths are the foundation on which the American Medical Association has based its proposal for reform. The individual's freedom of choice, combined with a free and independent medical profession, remain as the cornerstones of our system -- a system that does not allow government to dictate choices to patients.

Clearly, our health care system needs substantive revision to provide access to every American, but it would be counterproductive to "fix" aspects of the system that work well. And so, the AMA has selected to begin a process that will ask for the participation of all interested parties -- government, the insurance industry, other health care providers, and the public -- to contribute to the dialogue on improving the U.S. health care system.

The sixteen-point proposal

The AMA proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. It is summarized as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.

2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.

3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.

4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.

5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.

6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.

7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.

8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.

9. Develop proposals which encourage cost-conscious decisions by patients.

10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.

11. Urge expanded federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.

12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.

13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.

14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.

15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.

16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

Strengthening the American health care system through the elements contained in this proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts, as well as encouraging every interested party to join in the dialogue toward this goal. Our common objective will continue to be providing high quality care at reasonable cost, and access for every American.

DR. LEWERS. There are comments from the first panel I would like to make, but I will save those, as I have a feeling you might bring them up.

SENATOR BRYAN. Mr. Chairman, can I ask a question about the liability reform package?

REPRESENTATIVE SCHEUER. By all means, Senator.

SENATOR BRYAN. Do you have that outlined in your prepared testimony, the $40 billion savings?

DR. LEWERS. We have past testimony that we can give you. Senator Hatch basically has introduced the liability reform package that we are concerned about, which we have endorsed.

SENATOR BRYAN. And who has quantified the dollar savings? I will obviously take a look at that.

DR. LEWERS. Well, Senator, this is one of the problems that we have. That is the point I wanted to make. Those are estimates. They are ballpark figures. It is exceedingly difficult to come up with and say this is exact.

I practice medicine. I can tell you right now that I practice defensive medicine. I also serve on a Claims Committee of a liability insurance company, and I can tell you that physicians are doing this. We have to order tests. I was talking just recently with an individual about——

REPRESENTATIVE SCHEUER. You mean because of the fear——

DR. LEWERS. Because of the fear of liability.

REPRESENTATIVE SCHEUER. Yes.

DR. LEWERS. And I talked recently with an emergency room physician, and we were talking about waiting. In this country, of course, an American does not have to wait for emergency care. It is available. It is immediately there. The waiting lines are for those people who should not be there in the first place. They ought to be somewhere in the primary system, which is what we would like to see developed, and have worked toward through the physician payment reform package. But one of the problems that you see in emergency rooms——

REPRESENTATIVE SCHEUER. Excuse me.

DR. LEWERS. Sir?

REPRESENTATIVE SCHEUER. It is my understanding that you do not wait in Canada for emergency care.

DR. LEWERS. No. You can go in and get emergency care.

REPRESENTATIVE SCHEUER. Okay.

DR. LEWERS. What I am saying is, the people who are frequently waiting don't belong there, in the first place; but second, in emergency care, there are so many things you have to do defensively that require so much time. You have only so much room in an emergency room. If you have somebody who has a bump on the head and you not do a CAT scan, or they come in with a headache and you do not do a CAT scan, you are leaving yourself wide open for a lawsuit.

You can put down, "I don't think a CAT scan is necessary," but that is a judgment call. But the liability problem—the malpractice problem—Mr. Chairman, has taken that decision away from the clinical judgment

of the physician in this country, and we must reform the liability program if we are to get a handle on the cost and delivery of health care in this country.

SENATOR BRYAN. Thank you, Mr. Chairman.

REPRESENTATIVE SCHEUER. Okay. Our next witness will be Dr. Eugene Hildreth who serves as President of the American College of Physicians. He is Professor of Clinical Medicine at the Reading Hospital and Medical Center in Pennsylvania.

Dr. Hildreth, please proceed.

STATEMENT OF EUGENE A. HILDRETH, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS AND PROFESSOR OF CLINICAL MEDICINE, READING HOSPITAL AND MEDICAL CENTER

DR. HILDRETH. Thank you, Mr. Chairman, Congressman Bryan.

I am very grateful to be here, and I appreciate and the College appreciates this opportunity.

The written statement has been submitted, and I too would like to take my time making some additional comments.

REPRESENTATIVE SCHEUER. Very good.

DR. HILDRETH. As I read the title, "Health Care Reform: How to Push Less Paper and Treat More Patients," I thought that was the key issue. For 18 months, the College has been developing a position and publishing their attitudes toward the issue of reform. I think it is essential to recognize that we agree totally with your position; that access to health care has forced us to look at the issues of how health care in this country is delivered by its current nonsystem, and that in order to provide access to universal health-care coverage, and we believe still comprehensive coverage, we are going to have to have major reform of the health-care system. That is a long story, as you know very well, and I do not have to elaborate on it.

REPRESENTATIVE SCHEUER. Well, are you going to elaborate on it?

DR. HILDRETH. I can.

REPRESENTATIVE SCHEUER. We would very much like you to.

DR. HILDRETH. The complexity of it and the first issue in our proposal is that we should not have to ration health care at this point in time. Now, that does not say what is going to happen 10 years from now. Rationing is defined as limited available resources equitably distributed. We are not rationing health care now. They are not "equitably distributed." We are doing worse than rationing at the present time. The College does not feel that is acceptable to continue.

Where can we get the funds, then, to provide access in all the things we are desiring to produce and, at the same time, not get into rationing and within a limited budget? The only way we can visualize that as possible at the present time is to deal with the waste in the present

system. The waste in the present system, in part, is paper-pushing administrative costs.

REPRESENTATIVE SCHEUER. Plus, Dr. Lewers' estimate of $40 billion wasted on malpractice.

DR. HILDRETH. In a paper I have just written, we have 10 different areas that we would consider targets for waste control.

Administrative costs higher than necessary to provide good care, whatever that is, 20 to 30 percent.

Medically unnecessary costs, and this is not only costs on procedures that are not appropriate, but also may not be for that particular patient.

Inefficient medical care delivery.

Over-priced services.

Delay of health care, which when the patient eventually seeks care does so at increased expense.

Incentives that in fact have produced expensive insurance coverage.

Inadequate cost controls.

Insurance inefficiency—I enjoyed listening to the previous panel describe the activities of their interests, and they are obviously a far-sighted group of individuals—but there are 1,500 insurance companies dealing with health in this country, and I am pessimistic enough to believe that they are not all in there for altruism. That is a significant cost issue. The inefficiency there is tremendous.

Defensive medicine, we agree, is a major problem that will have to be addressed.

And, the mounting bureaucracy and paperwork in physicians' offices. As you read in the paper by Himmelstein, when they looked at the insurance and office inefficiencies, hospitals, and nursing homes, they came up with a guesstimate of $150 to $160 billion in that area alone.

I do not know whether those are correct figures any better than anyone else, but they are reasonable.

There is a pot of money out there, as you have implied in your discussion, that we are wasting.

To go to the specific topic of this particular session——

REPRESENTATIVE SCHEUER. You said you had written a paper outlining these points.

DR. HILDRETH. Yes, sir. It is right here. It is coming out in the *American College of Physicians'* publication in October.

REPRESENTATIVE SCHEUER. I would like to ask unanimous consent that you submit that for the record, and we will print it after your testimony.

DR. HILDRETH. I would be most happy.

REPRESENTATIVE SCHEUER. Okay. Please proceed.

DR. HILDRETH. Thank you very much.

I am in the practice of general internal medicine—the so-called "primary care" discipline. So, these issues of administrative costs and paperwork shuffling that you have addressed are particularly important to us.

In Canada, the primary care physician—internal medicine, pediatrics, and family physician—constitute a little over 52 percent of the population of physicians. In this country, it is about 38 percent and dropping, and we will get into that, and it is going to drop even worse to a dangerous point of no return if we do not do something about it.

We have in the estimate of costs in a physician's office of $20,000 to $30,000 administrative overhead for just doing administration of billing, and things of that sort, per physician in the country per year. Forty-eight percent of the gross income of physicians is spent on that element. In a 450-bed hospital in the past 10 years, they have been obliged because of new regulations' administrative needs to hire 144 new people for that function alone.

REPRESENTATIVE SCHEUER. Describe the function.

DR. HILDRETH. Administration of the system of collecting data for insurance forms, and billing, and carrying out the whole process of the economic administration of that hospital.

REPRESENTATIVE SCHEUER. Thank you.

DR. HILDRETH. In 10 years, 144 new people. That is a lot of people when numbered around the country with all of the hospitals.

In a primary-care physician's office, it becomes a bit more of a problem. It becomes a bit more of a problem than in almost any other office. The reason is that their basic income is considerably less than if they were doing cataract surgery. So, when you talk about a heavy overhead, it becomes a significant problem.

I would like to give you two examples, if I may, that happened last week when I had a young physician in my office as a student.

He went to my secretary, who was at that time attempting to deal with an insurance company about a bill that had been returned stamped across it "incomplete." No suggestion of what was missing. She called for 20 minutes on a multibusy line phone, got the person at the other end, who then, after due duress, said the problem is she wrote out "single patient." I had seen a single patient in a nursing home. She wrote out single patient, and she should have put "SP" there, instead.

This took considerable time. I became involved in the discussion in the middle of office hours. Eventually, we asked, "Would you just erase "single patient" and put "SP" down for us? Of course not. We had to retype the whole thing and resubmit it. That was the first experience this young patient had with the administration of health care in the private office.

The second one, we had to admit an elderly man who was confused—found confused by his family, looked like he may well have had a stroke, but was not totally unconscious. When we called for preadmission permission, we met with a person who, following a protocol that she had been given—and I can understand her decision—decided that that could be handled as an outpatient.

One needed to evaluate a head injury. One could get a CAT scan on outpatient procedure, etc.

I asked her what her educational level was. She admitted she was a high school graduate, following a protocol that she was assigned. She did her job quite well.

I then had to ask for a physician that was a second-level of consideration, and eventually got him, explained to him what was going on, and he okayed the admission of the patient. A significant amount of time.

Those also reflect the false use of money that could be applied for patient care. That is not only hassle, that is inefficiency, and it cost money to the payers.

When this young man, who was thinking of going into primary care, witnessed this particular exciting day that we were having—and it was not an unusual day—I must stress that I think he was puzzled.

I do not know what specialty he is going to end up in yet, but I am still working on him because he is a good person. But it reminded me of a study the college did in which they looked at internists in practice in this country, and 39 percent would not do it again. They would not go into medicine again, mainly because of the hassles and restrictions of practice that are going on.

Forty percent actively discourage others from going into medicine. Interestingly enough, one-third of them said, "We would take a significant reduction in income if we could get rid of the hassle and administrative foolishness and get on with taking care of patients."Instead of having micromanagement on every pro-thrombin time, we would welcome having the opportunity to be profile-evaluated and look at the outlyers. Let people in the middle, who are doing their job alone, take care of patients. There is a significant wish among practicing physicians to get more time for dealing with patients.

This hearing, in our opinion, is a welcome hearing. We support it and encourage you.

Thank you, very much.

[The prepared statement of Dr. Hildreth, together with attachment, follows.]

PREPARED STATEMENT OF EUGENE A. HILDRETH, M.D.

Comprehensive Reform of the Health Care System

The American College of Physicians (ACP) is pleased to have this opportunity to present our views on the need for comprehensive health care reform. With more than 72,000 members practicing internal medicine and its subspecialties, the College is the nation's largest medical specialty society. I am Dr. Eugene A. Hildreth, ACP President and Professor of Clinical Medicine at the Reading Hospital and Medical Center in Pennsylvania.

Our comments today will focus on the need for comprehensive reform to assure universal access to care. We will highlight the issue of administrative overhead costs and discuss how incentives in the current system must be restructured, regardless of the changes made in the financing system.

The debate in Congress on health care reform has focused largely on how to finance health care, whether through a play-or-pay or a single-payer approach. This critical discussion, however, should also include how to restructure the basic incentives of the system. Also, it is

important to bear in mind that administrative efficiencies can be achieved in a variety of financing reforms.

It is our view that the administrative requirements and costs of the current system are excessive and must be minimized. But even if this is accomplished, other fundamental changes in the system must be made. Without these changes, essentially a one-time savings in administrative costs would be realized, while other costs related to physician over-specialization and untethered technology, for example, continue to skyrocket.

Universal Access to Care and Comprehensive Reform

In May, 1990 the College published an editorial in the Annals of Internal Medicine that called universal access to health care a "medical and moral imperative." The late Nick Davies, MD who was to become President of ACP wrote in that editorial "We must reaffirm the sanctity of humankind, the primacy of the patient, and the importance of good health for all our citizens, not just those who can afford it." He said "...nothing short of universal access to a level of basic health care will be fair in the long run." We can delay no further the inclusion of all Americans into our health care system. We urge this Committee and the Congress to adopt that goal.

In a position paper accompanying that editorial, the College examined our health system and concluded that it has become, basically, dysfunctional. It is certainly not serving the 32 million uninsured Americans, nor is it working well for insured patients, physicians,

employers or government. We must work for comprehensive and coordinated reforms that address not only access to care, but cost, quality, administrative burdens and waste, liability, and other issues.

Like others, our initial motivation for developing our policy was the 32 million or more Americans who have no public or private health coverage. We were also struck by the Census Bureau finding that more than 60 million people have inadequate coverage or gaps in their coverage. That means that one in four Americans may be exposed to the risk of catastrophic illness with little or no coverage.

We also would argue with those who claim that people without insurance manage to get care through public hospitals, community health centers, or other means. Researchers at Georgetown University recently put that myth to rest in a study that found that the uninsured are up to three times as likely to die in the hospital, and are provided significantly lower rates of expensive procedures such as hip replacements.

On top of these problems with coverage, of course, is the mounting evidence that the health care system is headed for fiscal collapse. You are all familiar with the numbers: Health care spending is expected to reach $756 billion this year, having already passed the $650 billion mark, more than 12 percent of GNP, and headed towards annual spending of one trillion dollars and 17.3 percent of GNP by the turn of the century.

The alarming increases in the share of GNP consumed mean less money available for other social needs--education, housing, job training, fighting drugs and crime, and so on.

Developing successful strategies to address these problems will also have a major positive impact on health status for many Americans, especially the disadvantaged.

A study published last month in the *Journal of the American Medical Association* found that neo-natal cocaine exposure added over $500 million in 1990 to the costs associated with hospital costs and length of stay. This figure does not include neo-natal exposure to other commonly used drugs and is limited to very specific hospital costs. The lifetime costs to the individual, the health care system and society are incalculable. Societal resources must be used to prevent those conditions such as poverty, drug abuse, and violence that lead to health care costs. The research of panelist Leroy L. Schwartz, MD will help us understand the relationship between social problems and their medical consequence.

We concluded in our position paper that piecemeal solutions to the access problem would run the risk of aggravating other problems. Major reform of the entire system is necessary. We developed a set of 16 criteria to evaluate proposals for reform and guide development of our own recommendations, a process in which we are now engaged.

Administrative Overhead Expenses

One of the 16 criteria included in the ACP statement addresses the need to achieve administrative savings so that a high proportion of program outlays are devoted to delivery of health care services. Not only are we wasting resources that are needed for patient care, the burdensome nature of administrative requirements of the current system is a drain on both

patients and providers. Health care providers are subjected to complicated and differing rules and requirements from a multitude of insurers and other third-party payers. As a result, hospitals, physicians and other health care providers must hire costly administrative staff and professional consulting firms just to prepare and process their bills. Money and resources that are directly reflected in health care costs, but which yield nothing to patient care.

Patients frequently have difficulty understanding their insurance coverage and can be deterred from filling claim forms that are complex, time-consuming, and confusing. Patients too are now utilizing the services of professional health insurance claims consultants. These kinds of administrative costs are intolerable, especially at a time when employers, consumers, and government are seeking to curtail health care spending. Consequently, the College looked very hard at the Canadian health care system in developing our position paper on Access to Health Care. We concluded that there is much to be learned from the Canadian experience as we explore how to achieve universal access. While we envision a uniquely American system and do not believe we can simply transplant the Canadian system, we were particularly impressed by the relatively low administrative overhead of the Canadian health insurance financing mechanism, the administrative savings that are achieved, and the lack of interference in clinical decision-making.

The recent General Accounting Office study on Canadian health insurance highlights the differences in administrative overhead and administrative costs between Canada and the United States. The report reinforces our assessment that savings in paperwork, billing, claims

processing, responding to payment review, and other administrative overhead could more than offset the additional costs of expanding access to health care for all Americans.

Our Canadian members and colleagues are appalled by the financial obstacles, reporting requirements, and questioning of clinical judgement that U.S. physicians must endure. Administrative hassles and increasing interference in clinical decision-making are not an effective means of cost containment or quality assurance. ACP research revealed that internists are so frustrated that a substantial segment (30 percent) would be willing to forego a portion of their income if it would lessen the burden of administrative requirements and interference in clinical decision-making.

The need to address the administrative overhead, therefore, is based on two compelling arguments. One is that the savings that can be achieved--$67 billion according to the GAO--can be used to expand access. The second is that apart from the drain on resources, the resulting administrative burden on physicians is taking a heavy toll on the profession. In fact, it can be argued that the micro-management of clinical decision-making is a major factor in growth of dissatisfaction among physicians which in turn jeopardizes the nation's ability to maintain an appropriate supply and specialty distribution of practitioners.

Examining Insurance Practices

American health insurance practices are administratively complex and lack features that are essential to ensuring continuous health insurance coverage. Ever increasing health care

costs have led to fierce competition among health insurers, having the untoward effect of cost-shifting within the industry, administrative cost increases, and limitations on availability of insurance.

Increasing competition in the health insurance industry has resulted in the virtual elimination of community-rated health insurance. As the means to identify insurance risks have improved and been refined, both not-for-profit and commercial insurers have proceeded to segment the insurance market, offering lower-cost policies to healthy, low-risk groups and increasing premium rates for high risk groups and those with high claims experience. Consequently, individuals, small groups, and others identified as being at high risk typically find that health insurance is either unavailable or unaffordable. Instead of spreading insurance risks widely among a large population, risks are isolated for each employer group. Fierce competition for the healthy groups produces low initial rates, but uncompensated health care for the uninsured causes cost-shifting as hospitals and physicians seek to recoup their costs and ultimately all insurance premiums are raised. Exclusions for pre-existing conditions result in disallowances of claims for needed services and cause hardships for employees who change jobs or otherwise change insurance plans.

Meanwhile, the administrative, marketing, and overhead costs of insurance continue to increase and these costs are also passed on in the form of higher health insurance premiums. Attempts to curtail inappropriate and unnecessary health care services generate greater requirements for billing and claims processing, prior approvals, responses to utilization and

other reviews and audits, and increasing interference in clinical decision-making. Efforts to determine eligibility, ascertain copayment and deductible obligations, avoid duplication of benefits, and determine secondary and other payers add to the administrative costs and burdens. Clearly, it is time to examine insurance practices and develop substantial reforms in the industry.

Strategies for Administrative Savings

Strategies to achieve administrative savings include a variety of reforms that range from significant restructuring to relatively simple changes in current practices. There are a number of ways to decrease administrative costs that are being discussed and proposed in legislation that the Committee might examine:

--an all-payor system to minimize accounting within institutions for different rates from different buyers;

--a single negotiated fee-for-service rate within a geographic area to eliminate multiple rates for the same service;

--pattern monitoring of provider performance, replacing the inefficiency of case-by-case review;

--a single electronic billing and data form;

--a single administrative point of contact for payment.

The option of a single administrative point of contact is based on the "smart card"

concept, in which the provider (hospital, physician, or other health professional) is blind to the source of payment for any individual, and bills the point of contact who pays the established rate. The point of contact then bills the original source of payment (government, insurer, employer, managed care system). A combination of these strategies could result in substantial administrative savings.

Restructuring the Incentives of the Current System

Proposals to guarantee universal access and control costs must take into account, and change, the structure and incentives of our current system. Our best efforts will be compromised, and our goals unmet, if we do not make sure that deeply entrenched incentives of the financing and delivery system are modified. Even if administrative costs are reduced to minimal levels, there still would be elements in the system that would have to change. These include: the payment system, the manpower system, investment incentives, the liability system, utilization review, and the role of the patient.

Payment System: We have long recognized that the current health care payment system promotes overutilization. When revenue is determined principally by the number of units of service provided, the response of some - not all - is to provide more procedures and services than are necessary. This is accentuated when malpractice concerns are added.

What chance do cost control efforts have in the face of this powerful economic

incentive? Unless the financing system is changed from one that is driven by volume to one that provides incentives for more discriminating and coordinated use of resources, our efforts to define and promote appropriate levels of service are likely to fail.

We have to explore ways of closing the open-ended, volume-driven nature of the payment system. We have to ask how we can determine an upper bound, and then use our practice guidelines and research on effectiveness and outcomes to allocate resources across services and providers to maximize the effectiveness of our spending. In this way, practice guidelines are placed at the service of the payment system, and not at cross-purposes.

Manpower System: There is abundant data showing that the number and mix of physicians has direct impact on the utilization of health services. Yet, we continue to provide increasing numbers of physicians without regard to national geographic or specialty needs. A hands-off approach to manpower policy has resulted in excessive health services in some communities, while other communities have difficulty in providing primary care. Again, the incentives are to super-specialize, to locate where the highest volume of services can be achieved, and to perform the most high-tech, high-cost procedures.

We must develop a manpower policy that utilizes the tools at our command - and creates new ones - to begin to influence the mix and distribution of physicians in accord with the nation's needs. Our existing tools include medical school class size, the number and distribution of residency training slots, and government financing programs. The goals of

manpower policy must be not only to reduce the excessive use of high-cost services created by uncontrolled physician supply/distribution, but also to encourage minorities to enter medical professions, promote primary care, and enhance ambulatory care training.

Investment Incentives: Our system has placed few controls on capital investment, particularly in the non-hospital setting. In the spirit of American free enterprise, we have opened up investment opportunities to anyone. The result has been the generation of excess capacity, particularly in the form of freestanding diagnostic and treatment centers. Our system provides incentives to maximize volume in order to realize profits on the investments. With few constraints on who can be served, and a third-party payor ready to foot the bill, the opportunities for unnecessary services are greatly increased.

We suggest that regulatory controls on capacity have some role to play in resolving this problem. It will be useful to study why earlier attempts to establish health planning mechanisms failed politically. Are we facing a different environment now in which receptivity to notions of regulating investments and setting other planning goals is enhanced?

Liability System: Efforts to restrain spending are likely to be undercut by our liability system. Defensive medicine is acknowledged to be a major concern, costing billions of dollars in unneeded tests and treatments. In the face of our litigious society, asking good clinicians to change practice patterns in accordance with guidelines, however scientifically valid they may

be, may be asking them to risk exposure to a damaging lawsuit. Changes in the liability system will be necessary as an underpinning for proposals to increase access and control costs.

Significant reforms have been introduced by Senator Hatch and Representative Johnson, and proposed by President Bush. We agree with them that it is time to set national standards for tort reform, to address a major national problem. These standards have been proven effective in California and elsewhere. This legislation also would encourage pilot tests of alternatives to the tort system, such as the administrative dispute resolution process proposed by a large group of medical organizations. Passage of this legislation is a concrete step that Congress could take this year to begin reform of our health system. It will take a major re-thinking of old habits to move away from defensive medical practices, but this is a necessary first step.

Utilization Review: A fifth element of our current system that must be reformed is the way in which utilization review is conducted. Nothing accounts more for the disaffection of physicians than the intrusion into clinical decision-making and the doctor-patient relationship that results from retrospective case review by people who have not seen the patient and may have inadequate medical training or none at all.

Utilization review must be completely restructured. Our current system sanctions physicians who are more resource-intensive, but provides no reward to those who are less resource-intensive. As an alternative, practice patterns of physicians could be profiled, to

determine those who are outliers. The utilization review system then becomes an educational tool to bring the outliers into the norm. This would exclude most physicians from case review. Most physicians would be subject to profiling - a less expensive and far less intrusive approach. With this kind of information on practice patterns, and the use of guidelines to set the norm, it should not be difficult to change behavior of the outliers. Evidence from the Maine Medical Assessment studies, for example, shows that physicians want to practice in the norm.

Role of the patient: The patient has largely been overlooked in our efforts to achieve appropriate levels of resource use. For lack of any other direction, and supported by the media spotlight on medical miracles and by doctors nervous about liability exposure, the patient's mindset is one of trying anything and everything because "it might work".

We suggest that the role of the patient is a component of systemic change that must be considered as well. Attempts to control costs are as dependent on changes in patient behavior as they are on the other reforms we have discussed. Research on effectiveness and outcomes gives us, for the first time, an informed basis for bringing the patient into decision-making on the use of resources. We must explore means of helping patients apply their values to assess the possible outcomes and, with the physician, make decisions on treatment. We suggest that this is a critical component of moving from the excesses of a "try anything" system to a system in which thoughtful calculations are made on the value and costs of intervention.

The question is often heard of how we can achieve a consensus on the level of care and

spending acceptable to our society. This kind of approach, where the patient is brought into decision-making and makes an informed judgment on possible outcomes, in light of his or her values, may provide the means for building that consensus.

Conclusion

This is an extensive agenda for change. But we must not be daunted by the size of the task. In some areas, good ideas are already on the table, and must be further developed. In other areas, we need to learn from others as to what might work, with appropriate modification, in this country. We commend the Committee for holding hearings on health care system reform and believe that the administrative overhead issue is central to these discussions.

ACP OBSERVER/OCT
HILDRETH Col. 4/Hildreth
RS: 9-24
PK: 9-24
JC: 9/18

From the President:
Rationing Health Care Can be Deferred--For Now

Does the United States need health care rationing now? No one participating in the debate has an ironclad answer. I think we should redirect the flow of health care dollars instead of cutting back services to some patients. By tackling the obvious waste in today's "non-system" of health care and then establishing a creative health care plan and health care financing we might be able to defer rationing.

Estimating waste is difficult, and the projections here are rough. Regardless, it appears that the nation wastes $100 billion to $200 billion yearly under the current system. Clearly, critically needed money is being siphoned off from health care services. Examples of waste include:

1. Administrative costs higher than what is necessary to provide good care. These costs account for perhaps as much as 20%-30% of the total health care bill in the United States, and are substantially higher than in other nations.

2. Medically unnecessary costs. Money is wasted on care that is either ineffective or inappropriate for a particular patient, or both.

3. Inefficient medical care delivery. In some situations highly paid individuals do tasks that could be performed by less costly personnel.

4. Overpriced services. These are generally procedures paid at an inflated rate.

5. Delayed care. This is care that could have been less extensive and less costly had it been delivered when it first became medically appropriate.

6. Legislative misincentives. Tax laws encourage unnecessarily expansive and expensive insurance coverage.

7. Inadequate cost controls. The result is that many materials, equipment and drugs are overpriced.

8. Insurance inefficiency. The more than 1,500 health insurance companies all have different ways of collecting data, and charging and paying for services.

9. Defensive medicine. This is stimulated by the rising costs of medical malpractice and fears of litigation.

10. Mounting bureaucracy and paperwork in the physician's office. This cost of handling these materials is difficult to estimate, but ranges as high as $20,000-$25,000 yearly per physician in the United States.

Another problem is that unrelated costs may overlap with health care costs and distort them. Capital expenses, manpower, medical education and research in some instances are separated, but often these costs blur with health care costs.

As these examples show, waste in the U.S. health care system is indefensibly high. We should trim this fat before we consider rationing services. Even if we face the issue of rationing again later, we may be able to defer it if we deal with waste and design an efficient health care system now.

No one group--government, physicians, insurers--can be responsible for cleaning up this overwhelming list of waste. We each need to deal with the issues that are pertinent to our particular field and work cooperatively with others. Only then can we move from the current, unacceptable system of health care to a better one.

Eugene A. Hildreth, FACP

artquote

We should trim the fat in the health care system before we consider rationing services.

REPRESENTATIVE SCHEUER. Well, thank you very much for your excellent testimony, Dr. Hildreth.

We will hear now from Laurens Sartoris, who is President of the Virginia Hospital Association, and testifies on behalf of the American Hospital Association. Mr. Sartoris is also President of the Virginia Hospital Research and Education Foundation.

When you feel comfortable, please proceed, Mr. Sartoris.

STATEMENT OF LAURENS SARTORIS, PRESIDENT, VIRGINIA HOSPITAL ASSOCIATION, REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

MR. SARTORIS. Thank you very much, Mr. Chairman. It is a pleasure to be here today.

I think the tone that has been set today both by the Chair and Congressman Bryan, and certainly by all the panelists to date, suggest that we are all engaged in what I would characterize as a mutual enterprise.

While we recognize that there are problems in the system, our enterprise is one to continue to ensure access to quality and affordable health care for all Americans. I think we are all, in a sense—the Chair, of course—to be applauded for that; we are in the same "Amen" corner.

We have been engaged on the hospital side, Mr. Chairman, for a year in a process or a debate to try to develop principles and ideas for reform. I can say that over a year's work in this area has not produced a final product, but it has led us to adopt a number of principles that I think are consistent with where the work of this Subcommittee is going.

We have imposed a burden in our document on all sectors, or all stakeholders in the process, including providers, to eliminate unnecessary services, and to eliminate the duplication of costly technology and excess capacity, where appropriate. Individuals themselves need to accept greater responsibility for healthy lifestyles, and the use, appropriately, of our health-care system. Insurers need to focus on risk management rather than risk avoidance, and on keeping program administration costs to a minimum. I think a line of questions that you pursued this morning very much dealt with that area, Mr. Chairman. Two observations on that.

Interestingly enough, in reviewing yesterday some polls on the American public's attitude toward our health-care system, the polls showed two things: A very high level of dissatisfaction with the way we finance our health-care system in this country; but at the same time, a very high level of satisfaction with the underlying service or product.

So, the enterprise we are engaged in is to make sure that we do not lose the pieces of our system that do make it—as I think these two excellent physicians have pointed out to you—the finest in the world, while at the same time building economies and efficiencies into the system.

The polls basically show, Mr. Chairman, that what Americans are most afraid of is losing their health insurance. They are afraid of either not

having it, or if they have it—for example, if they go from one place of employment to another—finding themselves without it, or with benefits that are substantially reduced.

REPRESENTATIVE SCHEUER. Or with benefits at a tremendous increase in the cost of the policy.

MR. SARTORIS. Absolutely, Mr. Chairman.

It does not do you much good to go onto the next job if you already have cancer, if you already have a heart condition, to find that type of coverage is excluded.

Listening to some of your questions this morning—

REPRESENTATIVE SCHEUER. Or is prohibitively expensive.

MR. SARTORIS. Absolutely, sir.

REPRESENTATIVE SCHEUER. So, that a family cannot afford it.

MR. SARTORIS. No way, Mr. Chairman.

Listening to your questions this morning, I thought of something that has come to my mind over the past few years, Mr. Chairman, on more than one occasion. That is, maybe what we are trying to do, in a certain sense, not directly, is to reinvent the Blue Cross movement of 1929 and the 1930s, which, in fact, was a social movement that dealt with the problems of the middle-income Americans on the assumption that those who were poor would be provided care in some way. The rich would have their care, but it was so many of those middle Americans who would fall through, and that is the notion on which we started what we now know as health insurance. But that is more an aside.

With regard to financing and payment systems, Mr. Chairman, I think we agree that they need to be overhauled and to have incentives to support both disease prevention and care in the least costly setting.

Now, a good portion of today's focus certainly is on the Canadian system and administrative waste and duplication in this country. I was almost smitten, Mr. Chairman, with the notion developed in one of the papers of bureaucratic profligacy, and we all join each other in suggesting that that is an evil to be stamped out. I guess our question largely revolves today around the fact of what is the size—if there is one—of the pot of gold at the end of that rainbow, assuming that we could step in and eliminate that bureaucratic profligacy.

Some quick observations, and thinking more along the lines of what the GAO has rendered to you, the GAO report, which in large measure cleared up a lot of my thinking on the Canadian system—better than anything else I have read to date—also promotes the notion that there need to be compromises in what our northern neighbors provide.

These include: Ensuring immediate access to care and cutting-edge technology, which you all have reviewed this morning; and making provisions for the collection and monitoring of health utilization data, which is currently derived from billing systems in the United States.

Mr. Chairman, on another matter, I was meeting with a major U.S. health-care consultant yesterday, who advised me that he had just been

retained by the Province of Manitoba to help them to implement a DRG-type system that would not only make their payment system more efficient, but which would allow them to capture the type of data that their system currently does not collect.

And finally, the GAO suggests retaining some degree of cost sharing to prevent unnecessary overutilization, co-pays, deductibles, and such, and that would force an American system, modeled on the Canadian system, to maintain some type of billing.

The question that has come up several times today, Mr. Chairman, is global budgeting elements. Will they save costs? Possibly, yes, but I would turn your attention to the notion, as well, that taking any of the elements of cost, and availability, and quality separately may not lead to the most desirable result.

The Canadian system does not, for example, examine the causes of rising hospital expenses, some of which are beyond hospital control, which may include labor, drugs, supplies and equipment. By itself, it does not reduce unnecessary care. It does not look at the medical liability environment which drives up costs through reliance on defensive medicine. You heard testimony along those lines just a moment ago. It does not develop a list of appropriate limits of treatment.

What works? What does not work? The measuring of results that was one of the themes of this morning. It does not address unrealistic patient expectations, which I think we have come to believe that Americans themselves expect when they go into the system. And I do not think it addresses the deep-seated social problems like malnutrition, AIDS, homelessness, substance abuse, and crime present in many areas of this country, which are present to a lesser extent in some other countries, including Canada—something a colleague of mine has labeled the "social pathologies" in our system.

By way merely of example, Mr. Chairman, these figures on our male homicide rate is four times that of Canada. It is 12 times that of Germany. The incidence of AIDS in this country is more than three times that of Canada, and there are roughly 375,000 drug-exposed babies in the United States, and for Canada that is a negligible problem. So, some of those things clearly drive our costs.

Mr. Chairman, I still have a green light, but in the interests of time I would be happy to conclude.

[The prepared statement of Mr. Sartoris, together with attachments, follows:]

PREPARED STATEMENT OF LAURENS SARTORIS

Summary

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. Hospitals can and should exert leadership in these issues working at the local level with their communities to attack our serious health care 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. 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.

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. Two recent studies, one by the General Accounting Office (GAO) and the other by researchers Woolhandler and Himmelstein, suggest that billions of dollars in administrative costs could be saved by fully adopting the major elements of the Canadian health care system. We agree that certain aspects of the Canadian system are worth consideration. Other aspects of the Canadian system, however, would have to be modified significantly in order to respond to the distinct political and cultural environment of the United States. Needed modifications such as these call into question the likelihood of significant administrative cost savings if a single payer system such as Canada's were adopted in the U.S.

For example, GAO concluded that retaining some degree of cost-sharing is important to limiting the costs associated with increased demand for health care services stimulated by universal access. More importantly, waiving cost-sharing is an important incentive for the promotion of innovative delivery arrangements that better manage care. Maintaining copayments and deductibles, however, implies that much of the administrative savings associated with the Canadian system would be lost. Similarly, GAO also concluded that it would be prudent to retain and even expand the health care information available in this country so that we would not suffer from the information deficit experienced by Canada and other countries with national health programs. Much of the information we get about the distribution and use of health care services, however, is derived from billing systems. In fact, much less would be saved if the U.S. wants to continue to collect the kind of information we currently have available. Moreover, our nation's current focus on treatment outcomes and research on the effectiveness of health care services suggest that even more resources will be devoted to data collection in the future as we increase the quantity of clinical data reported.

This is not to say, however, that administrative costs in the U.S. system could not be reduced. In the area of utilization review, hospital administrative costs could be reduced by establishing more uniform and efficient procedures for review by insurers and private review firms, focusing utilization review on identified problem areas, rather than reviewing every admission and continued stay in a hospital past the average length of stay, and establishing medical practice parameters and translating them into screening criteria that can be used to evaluate the appropriateness of care. We also need to explore more cost effective ways of controlling utilization which rely not on extensive case-by-case external monitoring, but on implicit provider incentives that would have physicians and hospitals share the financial risks associated with inappropriate health care utilization. In the area of billing, full adoption and proper use of a uniform bill by all payers would reduce the quantity of paperwork involved for both providers and insurers, thereby streamlining the claims and payment processes.

We need to try to reduce administrative costs in our health care system where possible, but the adoption of a single-payer system is not the only solution to our health care cost problems. The success of a single-payer system depends heavily on whether that single entity makes sensible decisions about critical health care issues. A pluralistic health care system, much like our pluralistic political system, allows for more interests to be heard in the health policy debate and policy making process. Consensus may be more difficult -- but is not impossible -- to achieve. We believe that a pluralistic rather than a single-payer approach provides a more realistic road to health care reform.

Mr. Chairman, my name is. On behalf of AHA's nearly 5,500 member hospitals, I am pleased to have this opportunity to testify on national health reform and, specifically, on administrative costs within the U.S. and Canadian systems of health care. 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 ways to reform the American health care system. We appreciate the opportunity to testify on the administrative costs issue, but we think it is necessary to underscore the importance of addressing all of the health care reform issues -- cost, quality, and access -- simultaneously. To address only the issue of administrative costs and cost reduction in general ignores an important goal of health care reform: assuring access to high-quality, affordable 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. Reducing administrative costs is one step we can take toward keeping our health care system affordable. But we believe the key to successful reform is striking an acceptable balance among these often competing concerns.

AHA's Proposal

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. 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, which lead to more unsponsored care. Noncoverage and inadequate coverage lead to delayed care, which is also more costly.

Hospitals can and should exert leadership in these issues, working at the local level with their communities to attack our serious health care 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 consolidated 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.

54-863 O—92——14

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; sometimes these mechanisms actually increase health care costs by adding to administrative costs. 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, by a strategy that is systematic and comprehensive.

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.

We are pleased to see your subcommittee's interest in the issue of national health reform. As members of the Joint Economic Committee, you add animportant perspective to the debate: economics suggests we should seek

health care reform initiatives that realign the incentives of health care providers, payers, and patients and change the way in which health care services are delivered and consumed. Economics suggests we should seek initiatives that encourage the efficient delivery and use of health care services -- not simply limit overall health care spending or payment rates.

Administrative Costs in the U.S. and Canadian Health Care System

As more attention has been focused on health care problems in the U.S. and options for reforming our health care system, some policy makers and analysts have looked to the Canadian system of health care as a possible solution. Two recent studies, one by the General Accounting Office (GAO)[1] and one by researchers Woolhandler and Himmelstein,[2] suggest that billions of dollars in administrative costs could be saved by fully adopting the major elements of the Canadian health care system -- negotiated physician fee schedules and the setting of global hospital budget ceilings in Canada mean no patient billing at the point of service and virtually no copayments or deductibles.

But as recognized by GAO and others, the Canadian system would have to be modified significantly to respond to the political and cultural environment of the United States. For example, because there is no billing system in Canada, very little information is collected on health care utilization. In addition,

---

[1] United States General Accounting Office, Canadian Health Insurance: Lessons for the United States, June 4, 1991.

[2] Woolhandler S. and Himmelstein, D., "The Deteriorating Administrative Efficiency of the U.S. Health Care System" The New England Journal of Medicine Vol. 324, No. 18, pp. 1253-1258.

almost no external monitoring of the quality of care is conducted. These features of the system have severely limited Canada's ability to study the effectiveness of different medical technologies and their effect on the outcomes of care -- studies which we have established as a national priority in the U.S. Needed modifications such as these call into question the likelihood of significant administrative cost savings if a single payer system such as Canada's were adopted in the U.S.

GAO's report on this issue entitled "Canadian Health Insurance: Lessons for the United States" did an admirable job of compiling useful information regarding the Canadian health care system and comparing the characteristics of the pluralistic health care financing system in the United States with the single-payer system in Canada. The focus of GAO's report, however, is on financing rather than on the delivery of health care services in Canada and the U.S. Consequently, important issues of quality of care, distribution of facilities and physician specialties, and availability of specialized services and treatment were not directly or significantly addressed.

GAO notes that in terms of financing, health insurance in the two countries differ primarily in the proportion of the population covered by insurance, in system administration, and in the use of copayments and deductibles. The principle findings of their report regarding the Canadian health care system include the following:

* *Universal coverage*. All Canadian residents have health care coverage for necessary physician and hospital services, as determined by each province.

* *Controlled Physician and Hospital Spending.* Annual increases in physician reimbursement rates are controlled through annual negotiations between provincial governments and physician professional associations. Hospital spending is controlled through fixed global budgets that are negotiated by the provincial governments and individual hospitals. In addition, technology acquisition and diffusion are controlled by the governments.

* *No patient Copayments or Deductibles.* Care to patients is free at the point of services, so there are no copayments or deductibles. Providers are required to accept payment from the federal and provincial governments as payment in full.

* *Limited Spending on Insurance.* Private Insurance coverage is prohibited in Canada for any service that is provided through the national health system. Private health insurance is used primarily to upgrade inpatient care from ward to semi-private or private hospital accommodations. GAO estimates that by eliminating the need for private insurance, the U.S. could save $34 billion in insurance operation and marketing costs.

* *Lower Administrative Costs.* In addition to the $34 billion in insurance savings, GAO estimates that the U.S. could save another $33 billion in hospital and physician administrative costs, because a single payer system would reduce billing and clerical requirements. This brings the total GAO estimate of savings to $67 billion if the U.S. would fully adopt the major elements of the Canadian health care system.

We agree that certain aspects of the Canadian system are worth consideration. As I described earlier, universal coverage is one of the pillars of the AHA's proposed national health care strategy, which would be assured through a combination of employment-based plans and a new single public program consolidating and expanding Medicare and Medicaid. In our proposal for health care reform, the AHA also has incorporated reliance on negotiations between purchasers and providers as a means of controlling physician and hospital costs, although we would leave substantial latitude to develop new payment approaches rather than adopt a single approach as Canada did. In our proposal, purchasing agents would negotiate with providers and practitioners to determine what care would be delivered, at what price, and under what conditions, and how quality would be monitored and assured.

Other aspects of the Canadian system, however, would have to be modified significantly in order to respond to the distinct political and cultural environment of the United States. Because of this, we believe that the Canadian model offers some useful suggestions for the future, but that their system is not a panacea for the U.S. Canadians, in fact, have recently looked to our health care system as a model in search of answers to cost, quality, and access problems that still persist in their country, despite the availability of national health insurance. Health care in the U.S. is beset by major problems, yes, but there are some things we have done right within our pluralistic system and these aspects should be maintained in a reformed system. For example:

* *Retain Utilization Controls.* As GAO concluded, retaining some degree of cost-sharing is important to limiting the costs associated with increased demand for health care services stimulated by universal access. Copayments and deductibles have been shown to be an effective means of preventing the unnecessary overutilization of health care services. More importantly, waiving cost-sharing is an important incentive for the promotion of innovative delivery arrangements that better manage care. Maintaining copayments and deductibles, however, implies that much of the administrative savings associated with the Canadian system would be lost. Even with more limited use of copayments and deductibles, billing systems, clerical staff, and collection processes still would be needed.

In addition, utilization and quality review likely will remain an important component of American health care delivery. One reason administrative costs are lower in Canada than in the U.S. is that the quality and appropriateness of medical care are not significantly monitored or analyzed in Canada, while the excessive amount of external utilization review that takes place in this country adds significantly to our administrative costs. Because we expect only the best, our health care system is held to higher standards of scrutiny when it comes to quality and appropriateness of care. While utilization and quality reviews should be continued, we need to explore more cost effective ways of achieving these goals. Administrative savings in this area are possible but not to the extent achieved in Canada, since some level of quality monitoring is clearly necessary and desirable.

* *Increase Health Care Information Collection and Dissemination.* GAO also concluded that it would be prudent to retain and even expand the health care information available in this country so that we would not suffer from the information deficit experienced by Canada and other countries with national health programs. The U.S. is the envy of many nations because of our quantity of health care information, which allows us to better understand how we use health care services and how the delivery of health care services can be improved. Much of the information we get about the distribution and use of health care services, however, is derived from billing systems.

While it is true that a Canadian-style health care system could save money by reducing billing costs, those costs would only be saved if we downsized the billing systems themselves. Some estimates, like those made by Woolhandler and Himmelstein, exaggerate the potential administrative savings associated with moving to a single-payer Canadian-style health care system because they assume that all administrative costs, not just billing costs, would be reduced. While some reductions in billing and other costs might be expected, there is no reason to expect that all general administrative costs (costs associated with purchasing departments, medical libraries, auxiliary groups, etc.) would be reduced, unless specific budgetary cutbacks were made in these areas.

In fact, much less would be saved if the U.S. wants to continue to collect the kind of information we currently have available. Data that

would otherwise be collected through the billing process would have to be collected and processed through some other means, offsetting much of the savings attributable to reduced administrative effort. Moreover, our nation's current focus on treatment outcomes and research on the effectiveness of health care services suggest that even more resources will be devoted to data collection in the future as we increase the quantity of clinical data reported.

Given these modifications, it is likely that adoption of a Canadian-style health care system will not yield the tremendous level of savings estimated byGAO, and by Woolhandler and Himmelstein. In contrast to the $100 billion savings estimates advanced by Woolhandler and Himmelstein, the Congressional Budget Office estimates that the U.S. would only save some $25 billion in administrative costs by converting to a Canadian-style system if information systems developed by hospitals to better evaluate patient care are retained. Karen Davis, director of the Johns Hopkins School of Hygiene and Public Health estimates savings of only $17 billion. As I stated above, additional modifications of the Canadian system beyond added data collection would be necessary, reducing even more the level of anticipated administrative savings.

This is not to say, however, that administrative costs in the U.S. system could not be reduced. In the area of utilization review, hospital costs could be reduced by establishing more uniform and efficient procedures for review by insurers and private review firms. Such procedures could reduce administrative costs by reducing hospital staff time involved in responding to a variety of different questions and requests for clinical information from

the myriad of utilization review firms. In an effort to stimulate these efficiencies, a coalition of AHA, the American Medical Association, the Health Insurance Association of America, the Blue Cross/Blue Shield Association, and American Managed Care and Review Association last year completed a set of Guidelines for Health Benefits Administration covering general administrative procedures and concurrent review. Administrative costs could also be reduced by focusing utilization review on identified problem areas, rather than reviewing every admission and continued stay in a hospital past the average length of stay. Establishing medical practice parameters and, more importantly, translating them into screening criteria that can be used to evaluate the appropriateness of care are key to addressing this issue. Where the appropriateness of care is clearly defined, the need for utilization review is minimized. We also need to explore more cost effective ways of controlling utilization which rely not on extensive case-by-case external monitoring, but on implicit provider incentives that would have physicians and hospitals share the financial risks associated with inappropriate health care utilization.

In addition, the administrative costs associated with billing could be further reduced. The AHA has for many years worked with provider and payer organizations through the National Uniform Billing Committee to develop a uniform bill, commonly referred to as the UB-82. We sought its voluntary adoption by payers and continue to work to improve and update the uniform bill and processing systems (such as the current work on electronic claims submission). Although the UB-82 is currently used by Medicare, many state

Medicaid programs, CHAMPUS, and many commercial payers, commercial payers often use it inefficiently by requiring various attachments. Full adoption and proper use of a uniform bill by all payers would reduce the quantity of paperwork involved for both providers and insurers, thereby streamlining the claims and payment processes.

Conclusion

We need to try to reduce administrative costs in our health care system where possible, but the adoption of a single-payer system is not the only solution to our health care cost problems. The success of a single-payer system depends heavily on whether that single entity makes sensible decisions about critical health care issues. A pluralistic health care system, much like our pluralistic political system, allows for more interests to be heard in the health policy debate and policy making process. Consensus may be more difficult, but not impossible to achieve. We believe that a pluralistic rather than a single-payer approach provides a more realistic road to health care reform.

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

AHA

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.

- 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

[Note: This section will be further revised to reflect revisions in the cost estimates under development at Lewin/ICF. Revisions can be expected to yield slightly higher cost savings estimates attached to the delivery reforms, and perhaps some breakdown of the savings attached to specific reforms (e.g., tort reform).]

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 $60.2 billion increase in public program spending, offset by the $2.9 billion reduction in overall private insurance spending by employers, the $13.0 billion reduction in state and local government spending, and the $13.4 billion reduction in direct household spending, resulting in a net national health spending increase of about 5 percent ($30.9 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 $2.9 billion, the result of offsetting new spending of $7.7 billion by employers who do not currently insure their employees and dependents with spending reductions of $10.6 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 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 expanded use of managed care will result in an estimated net savings of $140 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 $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.

Government spending for public programs would increase by about $60.2 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 largely offset by expanded use of managed care in public programs and other offsets to Federal programs for a net increase in government costs of $2.9 billion.

Household spending would be reduced by about $13.4 billion, with reductions of $47.1 billion in out-of-pocket spending offset by an increase of $33.7 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 effective. The estimates of savings due to effective management of care that are included are dependent upon and reflect somewhat the implementation of the other reforms described, such as better practice parameters. However, while 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, there is little or no 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.

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 is expected to result in savings of $21.5 billion from reduced utilization at varying rates for different populations, dependent on their current form of coverage, ranging from additional savings of 1.5 percent for current HMO enrollees, to 10 percent for individuals currently enrolled in conventional plans.

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.

54-863 O—92——15

REPRESENTATIVE SCHEUER. All right. We will come back to your testimony later, Mr. Sartoris.

MR. SARTORIS. Thank you, Mr. Chairman.

REPRESENTATIVE SCHEUER. Our final witness today is W. Vickery Stoughton, Vice Chancellor of Health Affairs and Chief Executive Officer, Duke University Medical Center.

Interestingly, prior to coming to Duke, Mr. Stoughton was President and CEO of the Toronto General Hospital in Toronto, Canada.

So, I am sure we will hear your views, Mr. Stoughton, on a comparative evaluation of efforts to engage in cost control, and efforts to squeeze the fat out of the two systems.

Please proceed when you are comfortable, Mr. Stoughton.

STATEMENT OF W. VICKERY STOUGHTON, VICE CHANCELLOR OF HEALTH AFFAIRS AND CHIEF EXECUTIVE OFFICER DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NORTH CAROLINA

MR. STOUGHTON. Mr. Chairman, thank you very much. It is a pleasure to be here.

I have submitted written testimony, and I will make some comments based on that testimony.

I find it ironical that in recognizing the purpose of the health-care system is to meet health-care needs of the public—and that is the entire public—that we can call the U.S. system the best health-care system in the world. In my opinion, having been here before I went to Canada, and having come back for three months, the U.S. health-care system is inefficient, it is too costly, and in fact it is not serving the public.

As we strive for reforms, I think there are many lessons from other countries that we need to take a look at.

I would suggest to you that, if you looked at the Canadian system back in the late 1960s, at the same time Medicare and Medicaid was being introduced in the United States—and it was at that point in time in which Canada was introducing a universal insurance system—you would find that Canada had a system that was pretty much parallel to the structure and components that the U.S. system was based on: Multiple payers; fee-for-service physician and hospitals; basically, a relative lack of government involvement.

In the early 1970s and the late 1960s, both countries were spending a little more than 6 percent of GNP on health care.

REPRESENTATIVE SCHEUER. Both in Canada and the United States?

MR. STOUGHTON. Both in Canada and in the United States.

What has happened over a 20-year period, then, is that the increased percentage of GNP attributed to health care has risen much quicker in the United States than it has in Canada, and there are real differences in per capita payments on an individual basis between the United States and Canada.

Now, what is it that has enabled Canada to provide universal insurance for every citizen in Canada, while at the same time keeping its costs at a lower growth rate than the United States?

REPRESENTATIVE SCHEUER. Universal and comprehensive.

MR. STOUGHTON. And comprehensive.

Basically, there are four fundamental macro-control issues over the system that are well documented in the GAO report. Those four macro-control components have to do with lower administrative costs; that is, a single entity controls the finances of the system, global budgeting, much more specific control over technology distribution, and, finally, a different approach and control of the number of physician training positions and eventual fees a physician earns. So, it is really those four components that interact with each other in unique ways.

It is important to understand the interaction to understand the success Canada has had in keeping costs lower. But as has been pointed out, there are also some fundamental problems with the Canadian health-care system. Those fundamental problems primarily are waiting times. I can assure you that in 1970, when universal insurance was introduced in Canada, there were no waiting times in the Canadian system. In other words, the Canadian public was not sold universal health insurance on the basis of we are going to give you waiting times. It was sold on the basis of creating universality and equity, equal access on the part of every Canadian citizen. What has happened over the 20-year period has been, as cost control efforts have been achieved and been made operational, this has increased the waiting times.

People who have studied waiting times can find anecdotal evidence that an individual patient or family has suffered unduly because of the issue of waiting times. But when studies have been done of outcome indicators, particularly morbidity and mortality, there is no evidence that waiting times have had a negative effect on the overall health status of Canadians.

You are aware of the evidence that cardiac surgery, as an example, is done three times less frequently in Canada; that there are waiting times for cardiac surgery; and yet again, when you look at morbidity and mortality indicators, there is no evidence that these factors have had a negative impact on deaths from heart disease or on the health status of individual Canadians.

Now, I am not going to claim that because Canadians experience heart surgery less frequently that they die less frequently from heart disease, but I can tell you that the fact that they get it less frequently has not had a negative impact on morbidity and mortality rates in heart disease.

So, what does all this mean for the United States? Well, basically if you think about it, it means that the United States has to make a decision. Is the decision going to be that we are going to create universal access to everybody? Or is the decision going to be that we are going to continue to tinker with the system, using managed care as the vehicle in an effort to control costs?

The answer is that managed care will never control costs, because it will not eliminate unnecessary duplication of services.

Competition is a component of managed care and, as long as there are incentives in the system for the kind of competition that currently exists, costs will go up, technology will be distributed inappropriately, utilization will take place inappropriately, and you couple all that with the administrative overhead, in terms of the way the system is structured, and basically any effort to continue in the direction that we are is only going to further increase the cost of the system.

What Canada and other European countries demonstrate is that you can provide universal care. You can provide universal insurance. You can, in a sense, provide equity of access across the system. You have to be careful about waiting times, but you can do it, and spend a lot less money than the United States is current spending, provided you introduce different forms of cost control.

I would contend——

REPRESENTATIVE SCHEUER. I take it you would include, among those things that you can achieve, comprehensive care, in addition to universal care?

MR. STOUGHTON. Yes. The Canadian system provides comprehensive care.

Now, what you want to avoid—what we all want to avoid—is the issue of waiting times, and the negative impact on waiting times on the public. But with the hundreds of billions of dollars that are in that 3 percent differential, it would seem to me that there is more than enough money to make sure that waiting times do not become a factor.

Let me give you some examples of why the system is not as costly. I ran a teaching hospital in Canada that had all the technology that Duke Hospital has. It did not have it in the magnitude that Duke Hospital has. We had one MRI for a 1000-bed hospital. Duke has four MRIs for a 1000-bed hospital. That is an example.

REPRESENTATIVE SCHEUER. Let me ask you there, was there a waiting period for things that you thought could use MRI?

MR. STOUGHTON. Yes, there was definitely an inappropriate waiting time. And I can tell you that that particular technology was over-constrained, and it was a fault in the system that should have been more resourced. But I am not sure it was a fault in our own hospital, but there was not enough MRIs in other provider institutions. There were waiting periods.

REPRESENTATIVE SCHEUER. Has that been remedied?

MR. STOUGHTON. No, it has not been remedied.

I am not going to tell you that the system is perfect by any way, shape, or form. However, in Ontario there were three lithotriptors, another technology which is used to treat kidney stone disease. Now, the incidence of stone disease in a population group was evaluated and studied, and it was concluded that in order to treat stone disease, three

lithotriptors were needed, and three lithotriptors were placed throughout Ontario.

That was a process that involved provider/government interaction, debate, and decision. It was not something that was based on the marketplace. It was an example of how the Canadian system works well, whereas the MRI example is one in which it did not work so well.

Again, I think the United States should be smart enough to be able to put intelligent providers and financiers together, in the public interest, and make decisions. Lord knows, you have 3 percent to play with to make sure waiting times do not become acute.

So, I think there are some real lessons from the Canadian system.

As I have said to you, in the three-and-a-half months that I have been back here, I think the United States has some real fundamental problems, and nobody wants to address the biggest problem. That is, universal access to health care. If you are going to do it, you can increase the debt, but there are ways—

REPRESENTATIVE SCHEUER. Universal and comprehensive.

MR. STOUGHTON. And comprehensive.

REPRESENTATIVE SCHEUER. I do not want to sound like a broken record, but to me those two are inextricably intertwined.

MR. STOUGHTON. So, if you are going to do it, you want to make sure you do it in a way that you do not further increase costs, because that is not tolerable either.

As I said, whether it be Canada or Germany or Japan or wherever, there are lessons in these other countries, and we ought to wake up and recognize them.

Thank you.

[The prepared statement of Mr. Stoughton follows:]

PREPARED STATEMENT OF W. VICKERY STOUGHTON

Mr. Chairman, Ladies and Gentlemen,

Thank you for inviting me to comment on health care reform in the United States. As a bit of background, for the past 10 years ending June 30, 1991, I was the Chief Executive Office of the largest teaching hospital in Canada located in Toronto, Ontario. I moved to that position in 1981 from a teaching hospital associated with Harvard University. I am an American by birth and always felt that at some point in my career I would return to the health care system in the United States.

Since July 1, 1991, I have been the Chief Executive Officer at Duke University Hospital and Vice Chancellor for Health Affairs for Duke University.

During my period in Canada I became absolutely convinced that the Canadian health care system served the Canadian public in ways that far exceed the current ability of the U.S. health care system to serve the American public.

Since returning to the United States just three short months ago I have become even more convinced that this is the fact. In fact I am very concerned about the manner in which the current U.S. health care system works. I remember 10 years ago debating with the medical staff over the limited resources and having the physicians be the advocate of the patients that they were attempting to serve. In 10 years this has been lost from the health care system in the United States. Too many physicians are more concerned over whether patients can pay than whether there is a real need for health care services. Something is wrong with a system that fundamentally drives the providers away from their primary purpose. The United States health care system is inefficient, it is too costly, and it is not serving the public. This summarizes my impressions in the 3 months that I have been back.

Providers respond to the current incentives. The current incentives are focused on minimizing the cost per case but in no way lead to lowering the cost of the overall system let alone dealing with the issue of appropriateness within the delivery of services to particular patients. So much money is spent on administration that the system is so confused, so complex, and so burdensome to provider and patient alike that it is literally a jungle for patients to work their way through the system let alone for the providers who have to deal with the intricacies of multiple reimbursement processes and continual monitoring of the services they provide. There is a message that is continually promoted to the patients being served and that is that providers need to be watched, monitored, and regulated. Hence it is no wonder that the public has no confidence or very little confidence in the system and there is no question that the structure of the system itself contributes to the lack of trust as well as the malpractice situation which further drives up the cost of the system.

After having re-entered this system three months ago I already have serious concerns about the health care system. I have to question where the leadership is to make change happen. Having said all this, I would like to talk a little bit about why I feel the Canadian system responds so positively to the Canadian public and what lessons the United States may learn from the Canadian experience.

I should point out at the onset that I am not a proponent of bringing the Canadian system to the United States. Canada is a different country, its culture is different, its approach to services, to taxation, to government, to a whole host of areas is different than the U.S., yet it is a country that shares many commonalities with the United States. It is a country in which Canadians, like Americans, are concerned about world events, about employment, crime, environment, poverty, education, health and social justice, and even taxes. Canadians tend to be more conservative. They tend to be more tolerant of government intervention. They tend

to be more expectant that government will resolve certain social as well as economic problems. Canadian health care providers would never use the courts to settle issues over payment with government or issues over technology allocations or anything else. Canadian health care providers are in partnership with government and Canadian health care consumers (i.e. Canadian citizens) feel much more of a partnership relationship with government than current attitudes which are prevalent in the United States. That is not to say that health care reform in this country cannot take place, but in the absence of a nationally recognized crisis with evidence of voter dissatisfaction, no health care reform is going to take place without leadership.

The message I am giving you today, in my opinion, will not be heard until there is an absolute commitment on the part of the executive branch of this government, as well as the legislative branch, which you people represent, to do something about health care reform. When and if it is done, I would suggest that you look at some of the components of the Canadian system that have enabled Canada to insure everyone at a much lower cost.

First of all Canada has said that the primary and most important objective of the Canadian approach to health care is to provide national insurance and equal access to everyone. Recognizing this as the primary objective, Canada determined some time ago that in order to make universal health insurance affordable, control of costs would have to be simultaneously built into the system.

Hence, the Canadian health insurance system is structured around controls and incentives which reinforce the objectives of universal coverage, quality, affordability, and equity. Recently the Government Accounting Office identified four areas which the Canadian health care system has effectively used to control costs. The way these four areas interact with each other is fundamental to understanding how the Canadian system works. In Canada, by law, everyone has insurance. Cost control efforts then are focused on the four areas identified in the GAO report. These areas are single payor, hospital global budgeting, the rationalization of technology, and much more control over medical manpower, specifically the number of physicians and distribution across specialties as well as professional fees. The effect of these efforts has been to insure universal health insurance at lower costs with the downside being a growing problem with waiting times. The data shows that the cost control efforts have been effective in slowing the growth of health care costs in Canada. The effect of these controls has led to a situation in which the volume of treatment and diagnostic technologies is much lower per population ratios in Canada than in the U.S. For example, Ontario has fewer cardiac surgery programs per population than the U.S. and in fact Canadians have cardiac surgery three times less frequently than their counterparts in the U.S. There are similar examples involving many other diagnostic and treatment technologies. I should point out that whenever studies are done comparing the impact of this control strategy on the health of Canadians no evidence can be found that there is a negative impact other than waiting times. In so far as maintaining quality and innovation I did not find any difference in quality but to the extent there is a difference; it is my opinion that the Canadian system performs overall at a higher level. I can't site specific studies to prove this but I can offer the following facts for consideration.

Complex medical services are offered in the Canadian health care system in teaching hospitals almost exclusively. While this does create waiting times, studies of complex treatment services (for example, cardiovascular services, transplant, cancer services, etc.) have consistently shown that the number of patients treated annually impacts on quality and patient outcomes because larger numbers of patients lead to greater experience and improved care. There are no complex medical programs or services in the Canadian health care system with low numbers of patients. Outcome indicators show Canadian centers achieve appropriate

outcomes when compared with international outcome criteria. The same thing can not be said of all programs in the United States because many of these programs have been put into place for the sake of competition and they suffer from low volumes of services. In some cases volumes in U.S. centers are high but appropriateness of the procedure is questionable. Hence I believe if a major study was done, the result would demonstrate that overall Canadians are better served by programs and services in these complex health treatments than Americans are served in spite of waiting times.

What about waiting times? When I went to Canada in 1981, waiting times were not much of a problem. By 1983 in Ontario, waiting times averaged about five weeks for routine elective procedures. When the national system started there were no waiting times. Over a 12 year period average waiting times for elective procedures increased to 5 weeks. In 1990 a British Columbia study found waiting times to average 19 weeks for elective surgery. In Ontario they have also grown longer. My experience with this as a provider is that they can be a problem; yet I remind the Committee that there is no evidence that they have negatively affected the health of Canadians. However, I readily admit individual Canadians have experienced both anxiety and deteriorating health during the waiting period. I also remind the Committee that the waits have not changed public opinion about their satisfaction with the system. Canadians would rather face the anxiety of waiting than the anxiety of financial burdens or potential denial of access due to economic status.

I mentioned global budgeting as a cost control strategy. Let me tell it from my perspective. First, global budgeting cannot be viewed out of context with the impact of other cost controls (i.e. technology, medical manpower, and lower administrative costs through single payor). In the early seventies governments began to fund hospitals annually as part of global budget at a rate less than inflation. Canadian hospitals found that initially they had sufficient funds that could be reallocated for the purpose of acquiring modern medical capabilities. Billing offices were no longer needed. Cost control and the management of expenses quickly replaced the management of revenue. Finance and accounting offices found they had a work force 66% larger than they needed. This was also true in physician private practices. The system became unencumbered administratively. Over the period 1970-75, hospitals stayed current by reallocating resources from administrative overhead to patient care services. In the late seventies most of these redundant costs had been reallocated to patient care services. Funds were never taken out of hospital budgets. At the same time fewer specialists in training programs meant less pressure on community hospitals to open up costly tertiary services. Specialists gravitated to teaching centers and provincial governments provided special allocations to accommodate developing and expanding programs - sometimes before the program started, sometimes after it started and had received media attention and public support. Reallocation of resources was left up to hospital boards but they too were, and continue to be, subject to media attention and public accountability for their actions. There is no question in my mind that global budgeting has had a major impact on cost control. Canadian community hospital budgets are much lower than similar sized community hospitals in the states. They don't try to compete for high cost programs and services. They have no incentive to do so. They don't have any reason to add surgical specialists nor is there pressure from such people because their numbers are more controlled. Teaching hospitals run leaner. They don't have to track charges. They provide services of the same complexity of U.S. tertiary centers but do so with less staff. Canadian hospitals are more cost efficient. It is true that hospitals don't fail in Canada as this would be seen by the public as both a failure of the board of the hospital and also of the local provincial government.

Examples of cost differences: Employees per bed in Canadian community hospitals - 2 - 2.5 versus 3.0 to 4.5 and higher in U.S.; in Canadian tertiary centers 4 - 4.5 versus 5.5 to more than 7.0 in U.S. Another example, in 1989 a California teaching hospital operated with a budget of $230 million supporting 600 acute beds with an occupancy rate of about 85%. The 1,000 bed Toronto General Hospital with an occupancy of 81% had an operating budget of $220 million in Canadian dollars.

In the Canadian system there are no hassles with patients over payment, no justification to third parties over appropriateness. While Canadian providers are constrained in the quantity of services and technology they can provide, the providers are the sole determinants of appropriateness. The system does not use a third party to monitor and judge appropriateness of admissions, length of stay, etc.

Finally I would offer the following comments. The current federal position is that the solution to the health care problem is managed care. Managed care represents a continued approach that deals with the microcomponents of the health care system (i.e. how specific disease problems are diagnosed, treated, and funded). Managed care will not eliminate inappropriate competition. It will not discourage provider groups from acquiring high cost technologies and offering them to patients. Managed care may assure that the services provided are provided at an appropriate cost but it will not deal with the issue of appropriateness. It will not minimize the distribution of technology to appropriate levels and it will not lower the administrative costs of the system.

Hence managed care extended throughout the health care system coupled with universal insurance for the uninsured public will have the net effect of significantly increasing health care costs. What must be done is to maintain the information flow stemming from managed care processes and couple this micro level approach with the macro approaches which are components of the Canadian health care system and which are identified in the GAO report.

In Canada these macro approaches over a 20 year period have lead to increased waiting times. I submit that given the current level of spending on health care in the U.S., coupled with the information capabilities that now exist in the U.S. system; the U.S. could incorporate some or all of the Canadian cost control techniques without experiencing the waiting time problem for many, many years if ever, and also solve the problem of universal insurance.

As you are aware, the American public is very dissatisfied with the current health care system. As a provider who sees it from the inside I can tell you that they have every right to be dissatisfied. The incentives are wrong. There has been so much tinkering in the name of cost control we have lost sight of the purpose.

Is the courage to correct these problems here in Washington? Is the partnership needed between all branches of the government ready to move on this? Regrettably that's not my impression. I think the challenge before you is to reexamine this issue from the standpoint of the patient and then identify and ignite the necessary leadership.

The message from Canada is all too clear. The message is very simple. You can provide health insurance to everyone. You can do so without spending any more money. In fact you can do so by spending significantly less of the GNP than you currently spend. The wisdom that needs to be applied to the Canadian lesson is how to take this 3% GNP differential and insure that the U.S. citizenry has access on a more timely basis to a better health care system than exists anywhere else in the world.

That's the challenge before us. Thank you for the opportunity to testify.

REPRESENTATIVE SCHEUER. Thank you very much.

My first question, tell me what some of the lessons are from Canada, Germany, and Japan.

MR. STOUGHTON. The biggest thing that I noticed in Canada is, first of all, there has to be a single payer. There is a significant difference in administrative overhead. The comments that were made by the physicians here about the bureaucracy that they confront is absolutely correct, and it is absolutely nonexistent in Canada.

REPRESENTATIVE SCHEUER. How about Germany, or Japan?

MR. STOUGHTON. I cannot comment. I just do not know. But I can tell you that it does not exist. And it does not hurt the public, the fact that there is not this overhead and bureaucracy, and monitoring and second opinions, and telling people when to admit and not to admit, and kicking back insurance forms, and all this other stuff.

When I went to Canada from Boston, in a 700-bed hospital in Boston, there were 200 people working in the finance department at that point in time. I went to a 1,000-bed hospital, and there were 90 people working in the finance department. That is an example.

Duke University Hospital employs about 6.1 people per bed. The hospital I was in in Canada employed 4.3 people per bed. The case mix was the same. The overhead was vastly different.

When you get into community hospitals in the Canadian system, which have no incentive to compete in high-cost technology areas, they do not do the cardiac surgery. They do not do the neurosurgery. They do not do the complex orthopedic surgery. The cost base of those hospitals in comparison with community hospitals in the United States is significantly different. The number of employees is more like 3 per bed versus in excess of 4 in U.S. community hospitals. The difference is the marketplace phenomena of physicians in community hospitals competing with the tertiary centers for the same high-cost technology.

In the Canadian system, because few centers do this high-cost technology, one detriment is waiting times, but a very positive aspect of it is that there is an experience factor that permeates the health-care team that leads to very good outcomes. So, the patients that do get access generally experience outcome standards that are equivalent to the best anywhere in the world.

The reality is that you cannot say the same thing about the United States, because studies have clearly shown that centers doing complex procedures in low volumes experience outcomes below acceptable standards. There are many centers in the United States that are competing for the sake of competition, experiencing low volumes, and achieving outcomes that are below acceptable standards, let alone the issue of appropriateness.

So, in a sense, what Canada has done is lower its administrative costs, eliminate its competition, and have better control of its technology. And then again, as has been pointed out earlier, Canada trains 52 percent of its doctors in primary care services. It trains less doctors. The other

physicians that go into specialty care services obviously earn a higher fee than the primary care services, except there are less of them. Furthermore, the fees that are earned are lower on average than they are in the United States. So, when you put all of these combinations together, it keeps the cost down.

In the interest of patients, physicians are paid fees-for-service. I think it is a very fundamental and important part of the Canadian system. So, if the hospital wanted to keep a patient in because it was a low-cost patient, a doctor who controls admission and discharge has no incentive to do that because the physician fees are based on per-patient. So, the physician and the hospital have to, in a sense, work together in the interest of the patient.

Given the resources they have, the doctor earns more money as more treatment is provided. As more treatment is provided, the hospital theoretically would run out of money. So, it is very important that the hospital work closely with the doctors so that the treatment process is very cost-efficient.

In the Canadian institutions, cost management is much more a fundamental component of day-to-day life than anything that exists in U.S. hospitals, in spite of comments made by the previous panel, in terms of lack of information systems.

I am going on too long, so I will quit.

REPRESENTATIVE SCHEUER. You are not going on too long at all.

You seem to leap at the conclusion that if you are going to do anything constructive in moving toward squeezing the fat and the waste and the silliness out of our system, that a single-payer system is the obvious first place to start.

Now, I do not want to put words in your mouth.

MR. STOUGHTON. No, you are not.

I am a believer in incentives. I think what is going on in the U.S. system is a response to the current structure and incentives in the system. I think if you are going to change the incentives, the biggest single incentive in the system is economics, dollars. So, if you are going to change the structure of the system, you are going to have to control the dollars.

Now, you could have multiple insurance companies and still have some authority stating what to do with the dollars. Germany, in a sense, has done that. Hence, the interest lately in the German system. Everybody wants to avoid taking on any particular constituencies, so let us try to make everybody happy. So, Germany is a case in point. There are lessons in Germany, in terms of multiple insurers. But again, the way the money gets rooted in the distribution and the payment of it and the amount of payment and so on, that is very centrally controlled in the German system.

REPRESENTATIVE SCHEUER. Well, who would like to comment on this line of questioning?

Dr. Hildreth, you mentioned that this was a very wasteful system.

Scanning your 8 or 10 points, there is hardly a thing I could disagree with. Administrative costs are higher than necessary to provide good care, constituting 20 to 30 percent of the total health-care bill, substantially higher than other nations. You put administrative costs up there as the first of ten. The first among equals, perhaps.

Do you feel that our administrative costs should be the first target in our efforts? If so, how?

DR. HILDRETH. I think, as has been pointed out, there is remarkable agreement, I would imagine, among most of us around here. I think to deal with just any one particular thing is missing an opportunity to make a more important contribution. I would like to see us deal with all of those issues.

There is another aspect——

REPRESENTATIVE SCHEUER. Just tick off the issues you want to see us deal with.

DR. HILDRETH. In the waste——

REPRESENTATIVE SCHEUER. All right, the ones——

DR. HILDRETH. The ten of them are there.

REPRESENTATIVE SCHEUER. Yes.

DR. HILDRETH. This is a summary description. If you would look at number seven, for example, if you need equipment and have to buy it through the traditional—

REPRESENTATIVE SCHEUER. For the benefit of the West Coast audience, number seven is "inadequate cost controls." Correct?

DR. HILDRETH. Yes.

REPRESENTATIVE SCHEUER. Okay. Go ahead.

DR. HILDRETH. There are three issues that are just listed as one word, and they are a whole volume of interests: material, equipment, and pharmaceutical supplies. We have no real control over those, except the competitive purchasing arrangement that people will implement. But the cost of a simple piece of equipment that can be purchased at K-Mart may be five times that high purchased through the usual health system. The only problem with that is that K-Mart does not give us everything we need, so we do have to purchase in a major way through a traditional system. So, in thinking of waste, I would hope that we would address all of these issues.

There is another aspect of our problem, and that is when we try to look at data that has been brought up by the Canadian system. I hope the speaker on my left will correct me if I am wrong, but when we visited Canada to analyze their system, they had discrete budget and commitments for research, education, and capital expenditures.

So, they could define those, and they could make a prospective decision on what they want to put into those particular pockets. They felt this enabled them to make a much better judgment and purify the actual funds that were used for patient care. I would think that we ought to be

looking at that as a possibility, as well. Right now, we bury all of those into a health-care system.

The research, education, and of a given institution, research, education, patient care, and capital expenditures are often very hard to separate out.

Interestingly enough, our Canadian colleagues when we talked to them about how that was working, they said, well, in all honesty, we do save money on research in this country. We do not put as much in per capita as you do in the United States, and the reason is we do not need to. There is a lot of research south of the border.

REPRESENTATIVE SCHEUER. They can rely on our research.

DR. HILDRETH. Absolutely. Which is not a particularly good approach.

REPRESENTATIVE SCHEUER. Why not? What is wrong with sharing?

DR. HILDRETH. There is nothing wrong with that, but if every nation took that approach nationally and internationally, we would have a problem.

REPRESENTATIVE SCHEUER. Nobody would do it. There probably ought to be more sharing of health services R&D throughout the world.

DR. HILDRETH. Absolutely.

REPRESENTATIVE SCHEUER. Maybe the Japanese have done something significant in the area of outcomes.

DR. HILDRETH. Yes.

REPRESENTATIVE SCHEUER. We ought to know about that.

Maybe in countries that have a free economy, they have come up with answers on the malpractice claims that make sense, which maybe we should have a look at.

Well, on all of these ten things, I just cannot believe that there is not an experience across the length and breadth of Europe, Japan, Australia, New Zealand, and Canada where there is not some experience that could teach us things if we just would listen.

DR. HILDRETH. Well, I think there are experiences that can teach us things, as you say, and has been mentioned.

It was interesting. In visiting Canada, I took a Greyline Tour of Montreal, and it was fascinating that the bus driver made a great point about the wonderful things in their health-care system. We stopped at every hospital. We stopped at monuments, but we stopped at hospitals. His thesis was, you do not have to do any more than give them your card. They stamp it. It is simple. We can get good, basic care by primary care physicians is what he was saying when you asked him about it. Very proud of that. That is an element we need to strive for. No question.

REPRESENTATIVE SCHEUER. Mr. Sartoris?

MR. SARTORIS. I think that, irrespective of the system approach that is taken, the comment that was made a moment ago about any system being based on incentives is very appropriate, Mr. Chairman. If we really review the history—and let us look at federal financing for just a minute—of our health care, and step back to the eve of the Canadians' adoption of its

system, what we find was cost-based reimbursement being adopted by Medicare and then later by Medicaid.

I think historically looking at that, what we engendered with our cost-based reimbursement system was a program to guarantee more spending so that the previously underserved populations—the elderly and the poor—would have the same access to mainstream health care as everyone else who could afford to pay for it, or for whom someone else was financing the care. That was a very laudable, social goal.

What we have discovered over time is that there was not enough money being printed at the Mint down the street to be able to finance it, so we came along with a different set of incentives in the early 1980s with the prospective payment system.

There we have the eve, and now the fact of the type of competition that some now view as destructive in the system.

But my point, Mr. Chairman, is that whatever the next iteration of payment may be, I think it should also have incentives, and hopefully the right incentives, for all the players in the program—the providers, the patients—assuming there are other categories of payers—those folks, as well—to spend the dollars wisely and utilize the services wisely.

REPRESENTATIVE SCHEUER. You mentioned the phrase, "the destructive effects of competition." Can you elaborate on what you mean by that?

MR. SARTORIS. Well, I think what we have seen—and this is the point that was made a moment ago—is that what we have done in this country—and this is very well accepted, I think, by people—is that, routinely available within every community in the United States, we now provide the level of sophistication, arguably, that 40 years ago was at the Mayo Clinic.

I can remember in my youth, my parents being amazed when one of our neighbors went to Rochester, Minnesota, for open-heart surgery. That is routinely available in communities around the country now. Not only available, but there is access to most Americans who need that type of care. Some would argue, too much, but it is still there for everybody who needs it or who is deemed to need it.

The example of——

REPRESENTATIVE SCHEUER. We apparently have not fine-tuned our thinking.

MR. SARTORIS. No, sir. You are absolutely right. Yes, sir, you are correct.

REPRESENTATIVE SCHEUER. We have it available for the people who need it, and we are apparently doing a good deal more open-heart surgery than outcomes' research would indicate is necessary and appropriate.

MR. SARTORIS. Yes, sir. And that is why I think we would argue that the type of information that leads to monitoring and reasonable evaluation is very appropriate to continue to build into our system, not the type of intrusive, and sometimes destructive, too, micromanagement utilization review that this gentleman just so eloquently described to you.

REPRESENTATIVE SCHEUER. Yes, he did.

MR. SARTORIS. And that is a tremendous burden on the system. But some type of focused approach that really gets at the heart of the problem and does not layer——

REPRESENTATIVE SCHEUER. Where should that focused approach come from?

MR. SARTORIS. I think it probably is going to come ... well, it should come, ideally, from several different areas. It should become an institutional objective. It should become an objective of the practitioner, and it should be an objective of the payer. It should be a partnership, I think, among the three working to deliver the ideal health-care service to the patient—in the ideal setting—with the right resources applied to it, and with the commitment that that patient will go home restored to health.

REPRESENTATIVE SCHEUER. Dr. Lewers, do you have anything that you want to contribute at this point in reaction to the other three witnesses?

DR. LEWERS. Yes, Mr. Chairman, there are several factors. I will try to summarize them, if I might.

I am concerned that we are talking about very, very complex issues when we talk about delivery of patient care——

REPRESENTATIVE SCHEUER. There is no question about that.

DR. LEWERS. ——as a very simple matter.

One of the problems that we talk about, and those of us who practice medicine continually think about, is that we have to talk about the patient. That is what we are all about. That is what the whole system is about: what we do for our patient.

The Senator said on the earlier panel, about giving a bypass to a 95-year-old man, "if it was my father, I would want it done." That is the issue. He would want it done.

REPRESENTATIVE SCHEUER. He would want it done, yes.

DR. LEWERS. That is the issue we are talking about. When you talk about the GAO reporting that in Ontario, at the time they did their study, I think, 271 patients had been waiting a year for urgent lithrotripsy! Now, if you have a kidney stone, sir, that is bothering you and hurting you—and as a nephrologist, I can tell you, probably threatening your kidney if it is doing that—to wait a year is not quality health care.

REPRESENTATIVE SCHEUER. All right, Mr. Stoughton, what is your reaction?

MR. STOUGHTON. I agree with him. Waiting a year is not quality health care.

REPRESENTATIVE SCHEUER. So, you feel on that particular incident that the——

MR. STOUGHTON. No, but when you introduce any——

REPRESENTATIVE SCHEUER. ——that the queues were destructive of quality health care.

MR. STOUGHTON. Yes. Canada introduced that technology too slowly. But once the backlog was taken care of, then the reality is that the waiting times have pretty well disappeared.

REPRESENTATIVE SCHEUER. And I think you said—I do not want to put words in your mouth again—that Canada spends 9 percent of gross domestic product on health care, and we spend in excess of 12 percent, and that a very modest investment of that difference in high technology in Canada would go a long way to eliminating or drastically reducing the queues?

MR. STOUGHTON. That is correct.

I think the real point here is that if one is going to use wisdom in how to address public needs, that one is going to get payers together with providers and plan this on a more rational basis.

Canada has demonstrated it makes mistakes in undersupply. I would argue that the United States has demonstrated very concisely that it has made mistakes in oversupply. Somewhere between these two examples, there is a point which is more in the public interest, and there ought to be a structure within a system that assures we stay at the point that is most in the public interest. Right now, this health-care system does not do that. Unfortunately, the Canadian system does not always do it, either.

So, I am not going to sit here and——

REPRESENTATIVE SCHEUER. The question is, what can we learn from Canada? And conversely, what lessons can they learn from us that would benefit both countries?

MR. STOUGHTON. That is right.

DR. LEWERS. Mr. Chairman, if I finish a point on this, if you do not mind?

REPRESENTATIVE SCHEUER. Please do.

DR. LEWERS. The data the GAO gave us was from October 1990. I think what we need to point out is that Canada—several years ago—made a decision. What we need to decide is, "Does the American public want to make that same decision"? And you, sir, are in a position to help make that decision.

REPRESENTATIVE SCHEUER. What is the decision?

DR. LEWERS. The decision is on whether we adopt a single-payer system, and if we go with the cost limits, the queuing, the technology advances, whether we can accept all of those issues in America and still have the system that we have now, as far as quality is concerned.

REPRESENTATIVE SCHEUER. Mr. Stoughton has said that we may have erred on the high side of high technology and provided a CAT scan for every modest little community hospital, instead of economizing on this expensive high technology. On the other hand, the Canadians may have low-balled their estimate of the amount of high technology that is a legitimate requirement of their people.

Apparently they made a mistake in the technology mentioned, the lithro—

DR. LEWERS. Lithotripsy.

REPRESENTATIVE SCHEUER. Yes, and they very quickly eliminated their backlog at not a very great capital expense.

So, what I think we should be thinking about are: What are the major thrusts that we in this country ought to be focusing on? Certainly we do not want to give a shock to the system. We do not want to impose a traumatic shock on our health care system. I suppose anything we do should be reasonably incremental and absorbable by the system.

Now, that having been said, it seems to me that there are three or four targets of opportunity with major, major savings.

You yourself said up to $40 billion in the malpractice area. That is a big piece of change. On health outcomes from all of these procedures, on outcomes' research, up to 40 percent of the total cost of health care. We are spending over $700 billion on health care; for 40 percent, we are talking about $250 to $300 billion. I do not know if there is that kind of a target of opportunity for a great deal more thinking on outcomes' research, but if it is not $250 to $300 billion, maybe it is $100 billion. Maybe it is another $40 billion. Who knows what it is? Apparently there is a real consensus here that that is a big number.

You take your $40 billion from malpractice achievable savings, and let us take a very low figure, and let us low-ball it for outcomes' research. That is another $40 billion. That is $80 billion.

You said yourself that there is probably $15 or $20 billion available to be saved in the administration area. Correct?

DR. LEWERS. I do not believe that I used those figures, sir.

REPRESENTATIVE SCHEUER. Maybe it was the first panel. Anyway, one of the more conservative approaches was that there was probably maybe not the $67 billion that the GAO described, and maybe not the $55 billion that the Congressional Budget Office described, and certainly not the $130 billion that the two doctors set forth for us, but maybe $15 or $20 billion. One of them said that.

You take all of them and you are up to $100 billion. This is certainly more than what would be required in this country to go to a universal, comprehensive system that is fair, equitable, and just.

Does anybody have any quarrel with that?

DR. LEWERS. Sir, that is what we feel in our opinion is open for discussion, and we hope our proposal, "Health Access America," will remain on the table. We feel you should start with incremental small business insurance reform. We need to get into that area. It is something that can be done. We must attack the liability issue. We must direct our attention to practice parameters. We have to be able to give some direction out there and make some decisions. Those are things that we feel need and can be done.

On the administrative side, I do electronic billing for almost all but maybe one or two insurance carriers in my office, and it has reduced the hassle dramatically in my office. Now, it costs me $172 a month just for

the privilege of doing it, but it has reduced the hassles to the extent that I am willing to pay for it.

So, these are issues that we think can be dealt with, and as you have said, can be incrementally begun.

REPRESENTATIVE SCHEUER. Let me just interrupt you.

One of the witnesses in one of these panels—and I get a little fuzzy with 10 witnesses; all of them very stimulating—one of them said that they thought the probable cost of bookkeeping per doctor's office was in the neighborhood of $25,000 a year. Was that in your paper, Dr. Hildreth?

DR. HILDRETH. Yes. And the other thing is 48 percent of gross for practice.

REPRESENTATIVE SCHEUER. So, it seems to me, when he talks about $25,000 a year and 48 percent of his gross expenses, if you can substantially reduce that to less than $2,000 a year, you have really hit the jackpot.

DR. LEWERS. It does not cost me 48 percent of my office to do collections.

REPRESENTATIVE SCHEUER. What does it cost you?

DR. LEWERS. I do not know the figure, because the newer electronic billing has only been in about six months. So, I do not have figures that I can give you accurately. But I can tell you, it is a lot less.

But I can tell you that if we went even with a single-payer system, or a Canadian system, as has been said in some of the articles, that I would be able to get rid of an employee. I would not. My employees would remain the same, which is where some of those cost features have been put forth in some of the articles, saying that the doctors would be able to get rid of an employee. I am not going to be able to do that.

REPRESENTATIVE SCHEUER. Well, as I understand it, you may have squeezed the fat out of your billing system——

DR. LEWERS. I hope I have.

REPRESENTATIVE SCHEUER.——or your operation, excellently; far better than the average doctor has done in this country. But as I understand it, taking the average doctor in Canada, and taking the average doctor in the United States, the average doctor in Canada may have a fraction of one person in his office handling billing; whereas, the average doctor in the United States may have a half a dozen people handling billing. Maybe the half a dozen should be three or four. I do not know.

DR. LEWERS. One, maybe two, in a busy practice, at the most. In a group practice, they should be able to get by with one or two to do the billing, I would think. Dr. Hildreth may comment on that. He has done some surveys on it.

REPRESENTATIVE SCHEUER. Please, you other gentlemen, comment on it.

DR. HILDRETH. There is no question that electronic billing is a big asset, but he does not electronically bill everybody. That is one of the things.

We have to standardize the system of getting information out on billing and back, which gets down to who is the payer. I would hope that that is a future important consideration.

REPRESENTATIVE SCHEUER. Would you elaborate on that?

DR. HILDRETH. I agree with the other comments that, where the money comes into the single-payer office, there may be more than one particular route; that ultimately there ought to be one connection for billing and payment to reduce the bureaucracy and the administrative waste.

REPRESENTATIVE SCHEUER. And you can do that with more than one insurer?

DR. HILDRETH. It should be across-the-board. It should be whatever the system of payment is into the system, whether it is in combined private and public system into that pot that pays the bill. Whatever that system is, the physician and the patient ought to have one point of entry into that system and one payment from that system to simplify the billing. Instead of saying he has electronic billing for almost all of his insurance companies, he would have it for all.

REPRESENTATIVE SCHEUER. And am I to understand that you feel that if we had electronic billing and a requirement that all of our 1,500 payers be included in that system of electronic billing, that we could achieve a great part of the savings that the GAO and the *New England Journal of Medicine* say are there as a potential pot of gold?

DR. HILDRETH. I think electronic billing saves money. I think if we had a single-payer system, regardless of how the money went into that bank, let us say, we would save a great deal of money.

REPRESENTATIVE SCHEUER. Would you save a great deal more money, or a modest additional increment?

DR. HILDRETH. A great deal more money. If you asked me to give you more specifics, I have to go to the same articles we have all read. Whether that data is accurate or not, I would not be able to swear to any of it, except that we are talking about large amounts of money. Most physicians are moving into electronic billing. I admire the efficiency of my colleague in his office.

I think if we went into a system where the billing was as simple as it is in Canada—and I am not saying that we ought to take the Canadian system whole-hog—but if we had a system that simple, I could easily get rid of one-office person. I think that is true of everybody in our area that I know, in how they run their offices. I think the savings would be phenomenal.

REPRESENTATIVE SCHEUER. From going to electronic billing, or from going to a single-payer system?

DR. HILDRETH. Going to a single-payer system is the biggest thing that would save money. Obviously, that facilitates electronic billing, which is also an important consideration.

REPRESENTATIVE SCHEUER. Apparently Dr. Lewers has electronic billing without a single-payer system.

DR. HILDRETH. I understand that.

REPRESENTATIVE SCHEUER. How many payers are you involved with, Dr. Lewers?

DR. LEWERS. The program that we utilize is offered through Blue Cross/Blue Shield of Maryland, in what they call the "Lifecard System." They have now worked it out so that I think I only have, at least in my area, one or two insurance companies that I "deal with," which I cannot electronically bill. There are a huge number of carriers out there that do not permit electronic billing.

REPRESENTATIVE SCHEUER. Why is that?

DR. LEWERS. Sir, I do not know. The first panel would have to answer that, I guess. I do not have that expertise there. But in my practice, the carriers that I have to deal with are basically included in the Lifecard system, and I only have one or two that I have to go to. I do not know the total number now that they have done with Lifecard. They have expanded it, so I do not know where it is.

REPRESENTATIVE SCHEUER. Now, the GAO, in their estimate of $67 billion of savings, estimated that half of the savings are from contracting the number of insurers, thus, reducing paperwork and eliminating selling expenses. In other words, when you have a universal system that is comprehensive so that everybody is entitled to all legitimate, appropriate health care, you do not need a lot of salesmen out there. You do not need to advertise in magazines and newspapers, so that is a clear savings.

Do you feel that there is some way we could contract the number of insurers nationally by consolidation—this, that, and the other thing—to the point where they are efficient, large-scale, electronically plugged in payers, which would provide the American economy with a major portion of the savings that are available, according to the *New England Journal* and the GAO?

Could we contract the number of payers, if not from 1,500 to 1, perhaps from 1,500 to 1, or a few per state, or 1 or a few per region, and get to a major part of our goal, squeezing the waste and fat out of the payment system?

MR. SARTORIS. Mr. Chairman, if I may, I am not certain that the number of carriers is altogether the issue. Probably, in Virginia there are 300, 350. But if they had common billing practices, if they followed and adhered to a common utilization, streamlined review process, and if the underlying products—assuming your universal and comprehensive product—were essentially the same so that you would not have all the questions of coverage that come up with every patient that comes into the hospital through the emergency room or otherwise, I think simple logic dictates there has to be a huge savings someplace in the system, both on the provider side and on the side of the insurance companies.

On the marketing piece, I guess the last panel would know a great deal more about that then I would have any notion.

MR. STOUGHTON. You heard from the last panel that the average administrative overhead was around 9 percent. The average administrative overhead of the insurance process in the Canadian health-care system, as an example, which is a single-payer system, is more in the neighborhood of 3 to 3.5 percent.

REPRESENTATIVE SCHEUER. All right. Now, let us say that we did what Mr. Sartoris just outlined as a possibility. Let us say we did that. How far down from 9 percent to 3 percent would that help us move?

I might ask you the same question, Dr. Lewers.

MR. STOUGHTON. If I might just make a clarification here, those numbers have nothing to do with the overhead in an individual physician's practice. This is the differential in the insurance industry component. So, any additional savings in hospital overhead costs, or practice overhead costs, would be on top of the numbers I just mentioned.

REPRESENTATIVE SCHEUER. All right, let us get both figures.

What would the figures be for a doctor's office, a prototypical doctor? And what would the savings be to the insurance system, as a system? Is that a feasible way of thinking about the savings? How do we get a large part of the benefit of the single-payer system without sending the whole insurance industry into cardiac arrest? Is there some way we can salvage much, if not most, of this savings at a cost of some compromise here?

DR. LEWERS. Mr. Chairman, I sympathize with your frustration on that. That is the point I wanted to make in my opening statement.I do not think that data is available. I think we are talking about numbers that may work in my office and may work in Dr. Hildreth's office, but I do not think that we know what that basic data is. I think it is an area that we would like to know about, but we do not know now.

I cannot comment on the insurance industry. The point I heard them say on the first panel was that they spent 2 percent on marketing and sales out of that total that they gave.

REPRESENTATIVE SCHEUER. $4 billion for marketing!

DR. LEWERS. That is what I heard them say, and it is on the record, I assume. Two percent of their premiums went to that. That is what I heard them say.

REPRESENTATIVE SCHEUER. I reject—and I am not talking about anyone personally here—the theory that says that you have to know everything to do anything. From the time we get up in the morning until the time we turn out the lights after the *Ted Koppel Show*—and I hope you all watch Ted Koppel—we make judgments based on insufficient evidence. We do not know everything. We do not know if we are going to slip on a banana peel when we leave our homes in the morning. We make judgments that involve calculated risks, that involve a lot of instinct, that involve a lot of judgment, but we never have perfect knowledge about anything. Why should we require perfect knowledge in the field of health-care reform? There ought to be enough judgment in this business to say

we do not want to do anything radical that is going to traumatize the health insurance industry.

On the other hand, we are paying a terrible, awful, inhumane price, in human terms, of excluding major portions of our population from access to health care. I do not have to repeat the litany. You are all familiar with it. That is an immoral and unacceptable price.

Something has to give somewhere. Where are the tradeoffs in terms of producing a more acceptable system of administration and rationalization of the health insurance industry? Where is the reasonable compromise where we can get a major portion of the savings at a modest pain and inconvenience to the industry?

I am thinking about your comments, Dr. Lewers, that almost all of your insurers are on electronic management. If you require them to have, as Dr. Hildreth or Mr. Sartoris was saying, common accounting practices, common forms, common packages, what percentage of the savings that the GAO and *New England Journal of Medicine* talk about are achievable?

How much could you achieve with an acceptable level of pain? A little pain, but not too much pain? They say "no pain, no gain."

What level of reorganization and restructuring of physicians' offices and insurance company billing practices would you recommend in a private meeting with the insurance company executives that you do business with? The doctors that you do business with?

Would you say that there is a real, strongly felt need out there that there is a lot of waste in the system?

What can we, as the medical profession and the insurance profession, contribute to this, contribute to a reasonable solution?

DR. LEWERS. Mr. Chairman, I mentioned HAA several times, and we have that. Our proposals for insurance market reform include the following: community rating of small groups; no preexisting condition limitation;guaranteed acceptance of all employees; preemption of expensive state mandates for benefit coverage; guaranteed renewability with limits on premium increases; and required offering by carriers of essential health benefits or health policies.

Those are the things that we think we can start with now.

Now, I was happy to hear earlier that one of the insurance individuals mention that they had gone to some of this.

REPRESENTATIVE SCHEUER. I think that is a very impressive list of moves that would radically improve things for the average American family, including people like me—old and decrepit.

There are a lot of people in this country who are not young, and who are not healthy, who have desperate concerns. You are familiar with this.

I think that the program that you have outlined would make an awful lot of those people feel very much better, and reduce the tension and the anguish and the fear and insecurity—I think very much so.

Would any one of you like to react to that list?

MR. STOUGHTON. I think you summarized it, using the language of comprehensive and universal.

REPRESENTATIVE SCHEUER. Would this mean "comprehensiveness and universality"?

DR. LEWERS. I am not sure that it would mean comprehensive care. I think that that is difficult to define. I think if we say whatever you want you get, I do not know that we can afford that.

REPRESENTATIVE SCHEUER. In Canada, they have a comprehensive system, but you do not get everything you want. You get what is medically appropriate. You do not get a lot of unnecessary frills, and you do not get cosmetic surgery, but you get what is appropriate for a civilized country.

Maybe, a 92-year-old would not get the quadruple by-pass. I can see some kind of standard there.

But I would like you to define how close. What is the gap between your package and comprehensive care? It is universal, but it is not comprehensive? Tell us what the gap is?

DR. LEWERS. Our program primarily deals at this point in assuring access to the system. It does not say that we need to provide everything that someone wants. It does not get into whether that 91-year-old individual should get a bypass.

We have supported outcomes' research on issues of this nature. We have also spent considerable time in agreement with practice parameters that also point to what is indeed reasonable and comprehensive care that should be performed. We do not include comprehensive in that term.

We are concerned about the access to the system for the major problems that an individual has to have without any delay and without any fear of not having insurance.

So, the "Health Access America" has not addressed, as you have suggested, the issue of total comprehensive care.

REPRESENTATIVE SCHEUER. Long-term care, for example.

DR. LEWERS. In a separate package, we have addressed long-term care. There was a bill introduced last year—the Kennelly bill—which we did endorse.

MR. HEIDORN. It is being tested now in Connecticut. HCFA gave it approval. It is a public/private approach.

DR. LEWERS. We have also recommended in our proposal that we have to take a look at an update for Medicaid. We have to do something in Medicaid, because we are only serving less than 50 percent of the people who are below the poverty line. That program has to be addressed. We cannot allow the discrepancies that go on from state-to-state to continue. So, we have to do something to bring that program up to date.

Part of that, if you have the insurance packages, some of those individuals are working. They are working individuals who, if they could get insurance that way, would be off the Medicaid rolls. So, Medicaid needs to be reformed, as well.

REPRESENTATIVE SCHEUER. If we tell states that they cannot mandate a package, what is going to substitute for that judgment?

DR. LEWERS. Mandate which package?

REPRESENTATIVE SCHEUER. What is the purpose of prohibiting state mandates?

DR. LEWERS. To lower the cost of insurance. Those packages are very expensive, as I think the first panel spoke to.

I come from a state that, I believe, is now the leader in mandates. We have mandates for everything.

REPRESENTATIVE SCHEUER. What state is that?

DR. LEWERS. Maryland.

REPRESENTATIVE SCHEUER. What are some of the things that you think should not be mandated?

DR. LEWERS. I do not think that there necessarily should be any mandates. I think it should be the quality and delivery of health care, and the judgment of the physician and the medical community in determining that. You need to work with your patient. I do not think we need to say that you have to do this, or you have to get that, as mentioned earlier.

That is a new one for me. We do not have that in Maryland. But there are talks about mandating breast implants. There are talks about mandating penile implants. I think that is ridiculous. I think that is something we need to deal with on a medical basis. That is between the physician and the patient, and I think we need to get into dealing with that.

Practice parameters will also help a lot of that. The idea of small-area variations will bring forth some of that. That is what the lady from Blue Cross, I think, was talking about, how the pressures of small-area variations bring certain physicians, who are outlyers in the system, into line.

I think in all of this that the practice of medicine is what we need to do. Not mandating, not legislating. I do not think you can legislate the practice of medicine.

REPRESENTATIVE SCHEUER. No, but you can legislate the level of health care that civilized countries around the world who can afford it deem necessary and appropriate.

Countries have done that all over the world—33, 34 countries. They have national health-care programs. They ensure necessary and appropriate health care.

There has to be an answer. It seems to me it is not acceptable to say that we are going to have universal health care, but we are not going to have any standards at all of what is going to be included in that health care—the assurance of that health care.

I do not say that you have to define every aspect of the health care that a person is entitled to within a gnat's eyelash, but certain broad strokes ought to make it pretty clear what you think ought to be included in the universal package.

Can you tell me what you think ought to be included, Dr. Lewers?

DR. LEWERS. We have addressed this through what we feel is a minimum that ought to be applied, and basically a minimum benefit package of what should be included.

We can make that available to you.

REPRESENTATIVE SCHEUER. I wish you would.

DR. LEWERS. It may already be part of our package, but if not, it will be. We have addressed that minimum benefit package, and we feel that this is the absolute minimum that people should have.

REPRESENTATIVE SCHEUER. Can you describe it?

DR. LEWERS. We have gone over the number of hospital days, the number of days for mental illness, what you do with substance abuse. It is just a basic package.

Sir, it has been so long since I looked it, I am having trouble bringing it back, but it is one that was drawn up by the house of delegates of the AMA after a great deal of debate.

I represented the AMA at the National Governors Conference. They were very interested in the package. They were going to draw up their own package. Maryland has drawn up its own minimum benefits' package, which is too minimum as far as I am concerned, and it does not address it.

So—by wonder of the electronic world—I have just been handed the Minimum Benefits Package. I will get it to you.

We talk about maternal and child care. Prenatal care. As a minimum benefit, physician services to provide the necessary medical services to an individual with up to 20 office visits per year. Diagnostic, therapeutic services.

I am just skimming through here, sir. I will see that you have this.

Dental services limited to the repair by injury to sound teeth. Outpatient facilities. I can go on for another two pages.

Things that we recommend not be covered in a minimum package would be routine physicals and screening tests, detoxification, primarily because of the cost. It is just prohibitively costly. Sterilization or reversal of sterilization. Artificial insemination. Cosmetic surgery. Things of this nature.

REPRESENTATIVE SCHEUER. Why would you not want to include preventive health care rather than just sickness care as a means of encouraging people to grab hold of their own health status and to accept responsibility for it, regarding themselves as the people who are basically responsible for their own health care?

It seems to me that an important problem in this country is that some people—too many people—feel that the availability of CAT scans, or open-heart surgery, or kidney dialysis is going to assure their health. When really what is going to assure their health is their own personal behavior in avoiding too much alcohol, avoiding drugs, avoiding tobacco, exercising, taking care of their basic nutritional needs.

It seems to me that the more we can shift the focus of our health-care system from sickness care to preventive health care, the more in the long run we are going to lower the total cost to society of our health-care system.

So, why would you not want to include preventive health care?

DR. LEWERS. I do not want to mislead you. Preventive health care is on our list as part of the minimum health-care package. "Routine physicals" are also not included.

REPRESENTATIVE SCHEUER. Is that not preventive health care?

DR. LEWERS. It can be preventive health care. That was debated extensively on the floor of the house.

REPRESENTATIVE SCHEUER. Not enough, in my opinion.

DR. LEWERS. And my opinion, as well. I practice a lot of preventive health care. I have a little business where I do that as part of my practice of medicine. So, I agree with that.

What we have talked about, and what we have tried to develop, is a minimum package that we can go out and, hopefully, the insurance industry in this country could afford to provide this in an incremental fashion to get started. That is our point.

We have to start somewhere. We did not feel that we could go and say that you have to give everything. There has to be at least a minimum. If you want more than this, you can get it through a rider on an insurance package, or something of that nature.

REPRESENTATIVE SCHEUER. I would certainly say that what you have suggested is a hell of a big improvement over what we have now. It may not be perfection, but perfection may be the enemy of the good. This may be a very significant, incremental protection move. Would you be ready to see the government take that minimum level of care, and put it in the law?

DR. LEWERS. That is the policy of the AMA. That is part of our Health Access America package. We would be very happy to provide it if for some reason you did not have it.

REPRESENTATIVE SCHEUER. Do any of you have anything to say about this initiative.

MR. SARTORIS. Only to echo what you said a moment ago. Without some baseline care being defined, the notion of universal coverage becomes illusory.

REPRESENTATIVE SCHEUER. I want Dr. Lewers to hear this. Please proceed.

MR. SARTORIS. Without the baseline coverage, universal coverage is illusory. You have to have some standard. Then you know you have provided it to everyone.

On the mandated benefits' issue, Mr. Chairman, and this is an observation, the insurance companies in Virginia, when they talk about "mandated benefits," are talking about two things. Not only the health services and medical services provided, but also the providers who are

mandated by statute to be included in the policy. So, presumably in Minneapolis, based on this morning's comments, cosmetologists or a wigmaker is included. I do not know.

REPRESENTATIVE SCHEUER. I guess reasonable people could disagree on whether cosmetologists and wigmakers are included.

MR. STOUGHTON. I do not think anybody would disagree that this is not an improvement. The problem is that it still does not address the cost issue. It is easy to discuss this part of the equation, which is added benefits, or more appropriate benefits, or however you cut it. If you are going to discuss that part of the equation, you might as well say all-comprehensive and all-universal, or some component that is a little bit less than that.

But the point is that whatever you do on that side of the equation is going to add costs. Is it tolerable to add more costs to the health-care system? That is, in a sense, why we are here.

What lessons are there in other environments that have demonstrated an ability to do a little bit more than the United States may be able to do right now, but have also demonstrated an ability to manage the cost side in a different way?

So, the real issue is, if you are going to manage the cost side in a different way, you are going to affect the insurers. You are going to affect the institutions. You are going to affect the physicians.

REPRESENTATIVE SCHEUER. You are absolutely right.

MR. STOUGHTON. All of us, if you are only going to add, it becomes easier. Let's just cut it at the point that was suggested. Let's add it comprehensively. That is my argument.

On the other hand, if you are going to hurt everybody a little bit for the sake of that comprehensiveness and universality, then hurt everybody a little bit—the insurers, the providers, etc.

Again, if you are going to do that in the absence of a crisis, that amounts to votes. It means leadership. I am the first one that is going to sit here and tell you that I do not believe it is going to happen.

So, in a sense, it is nice to have these discussions, but I do not think they are going to go anywhere, because right now there is not the committed leadership, unfortunately.

REPRESENTATIVE SCHEUER. You mean the leadership coming from the White House?

MR. STOUGHTON. In combination with you and your colleagues. I think it has to be joint leadership.

REPRESENTATIVE SCHEUER. That would be the ideal situation.

Dr. Hildreth?

DR. HILDRETH. I would like to echo the comments. The American College of Physicians feels that access is of overriding importance directly because it is important, but also because right now there are a whole host of people who do not get good care and do not get preventative care.

We need a reform of the whole health-care system if we are going to be able to afford it, and if we are going to be able to provide it in an intelligent fashion.

I share the feeling that we need leadership. I am delighted that you are interested in this, but I really feel that we have to look at the whole system. If we just add on, we are not going in the right direction.

REPRESENTATIVE SCHEUER. If we just add on and tinker around the edges.

Dr. Lewers has given us some interesting thoughts about requiring the payers to be hooked into an electronic system, and the doctors should be hooked into electronic systems, and that they have consistent ways of keeping cost records, consistent records of all kinds, and that is a good start.

The question is: Is shrinking the health insurance industry a legitimate part of this effort to achieve savings? To what extent can we shrink it—short of obliterating—that would achieve most of the gains to be achieved through a national single-payer system, which would impose, I think, a shock to the health insurance industry. No doubt about it.

Is there something less than going all the way to a single-payer system that would achieve all, or almost all, of the savings that you would get through a single-payer system?

MR. STOUGHTON. One thing that could clearly be done is to pay the same amount for the same procedure right across the country. Because right now, the way we itemize our charges in the private insurance industry, and outside of the DRG process, adds an enormous overhead to every provider, as well as to every insurer.

So, coming up with a uniform payment is a step that would lower costs. It would lower the overhead of the insurance companies, clearly.

REPRESENTATIVE SCHEUER. Mr. Stoughton, would you have the same charge for a community hospital in Biloxi, Mississippi, for a particular kind of treatment that you would have in a community hospital in New York or Boston?

MR. STOUGHTON. Sir, to say that a particular procedure is worth more in one community than another community has never made any sense to me.

REPRESENTATIVE SCHEUER. But you can see that it costs more?

MR. STOUGHTON. Maybe because of wage differences, and so on, you can say that. So, I think you can get data that would demonstrate some of those factors, and work that into the payment.

REPRESENTATIVE SCHEUER. Have some kind of an index, perhaps.

Any other thoughts?

DR. HILDRETH. I think Mr. Stoughton was saying something else in his first ... and I hope you do not mind me commenting on it. I think the thing to do would be to develop a goal for—if we are going to have a public and private component paying into a common source—a single-payer system.

For example, I think, if we move in that direction, you would have to set up certain criteria for what that private group would carry out as their part of that function. It gets into exactly how they function, what they cover, the portability issue, and a whole host of things. I do not think you would have to worry about how many companies would persist in that endeavor. That is not the point. The point is, what should they be doing? Then those that are willing and able to participate would be participants. I think a lot would probably drop out, if it were really set up the way Mr. Stoughton was just talking about.

MR. STOUGHTON. I absolutely agree with that. It is like the banking industry. We have 15,000 banks and maybe we need 400 or 500 in this country. The incentives in the marketplace are going to make that occur.

What is the difference with the insurance industry?

I sit on the board of a big insurance company. It happens to be a life insurance company, but a company that was in health care at one point in time, and they said, we want out of this crazy market.

Now, you know, Aetna is not going to get out, and Prudential is not going to get out, and Blue Cross/Blue Shield is not going to get out. Those companies will survive in whatever structure we set up, provided we make room for them. Unless the government totally takes over, those very effective, high-quality companies will survive. But they will conform to the new structure.

REPRESENTATIVE SCHEUER. Why is it then that the cost of competition has not shrunk the industry? With normal market forces, why is it that the normal market forces have worked?

MR. STOUGHTON. Because they just pass the cost on to the consumer. It is an open-ended system.

MR. SARTORIS. To some extent it may have shrunk the system over time, because you see, at least in Virginia, fewer companies are writing indemnity coverage. We had only one Virginia-based company that wrote accident and sickness insurance. They went out of business. They said it was not worth their while.

In the meantime, you have a whole host of new players coming along with new types of products—the would-be "managed care" products—some of which are real managed care, and some are the sort of thing that Mr. Trapnell referred to this morning. They are just discounting mechanisms, and they do not add any value in terms of more efficient delivery.

If you have a single rate—maybe one of the disadvantages built into it—you do not have an incentive approach that allows in the private market for someone to develop more innovative ways to combine care efficiently. If it is all the same rate, why do it?

MR. STOUGHTON. Again, I would argue that all the same payment does not really mean that you could not charge your customers a different rate. What you would be inclined to do then would be to put pressures, or work cooperatively with providers, to ensure that your customers got access to lower-cost health care, so your rates to your customer could be lower, recognizing that there was a set payment rate.

There are ways in which you can work this thing. We mentioned incentives. Just keep coming back to incentives. I do not think any of us has thought through totally how to reform the health-care system, but clearly if one is going to reform it, one wants to create incentives for providers and insurers and government to work in partnership on behalf of the primary purposes of the system, which is to get health care to those in need. Right now, those incentives do not exist in the U.S. system the way they should.

REPRESENTATIVE SCHEUER. The incentives do not exist to shrink the insurance industry and squeeze out marginal firms.

MR. STOUGHTON. Or to practice more appropriately, or to be more cost effective—a whole host of things—or to compete more appropriately and acquire more appropriate quantities of technology. All of that does not exist, given the current incentives.

REPRESENTATIVE SCHEUER. Any final comments?

DR. HILDRETH. I will echo one comment that you made. We will never have anything laid out exactly for us with the right data to make the right decisions. We are dealing with a complex set of issues, which has been illustrated by this discussion.

I would say, let's get on with it. Let's start somewhere. Let's start on some very obvious things that need to be done, and get the process into gear.

I would hope that the Congress could develop the leadership role in stimulating some serious movement. We know enough, as you pointed out, to get started. Let's get started. Let's, as soon as we can, develop a template of what we are attempting to aim for ultimately and fill in as quickly as we can. But I think that we need to get going.

REPRESENTATIVE SCHEUER. Nothing succeeds like success, even on a small scale, but perhaps not the whole entire length and breadth of the health-care system.

What would be the targets that you think the Congress ought to address first?

DR. HILDRETH. The first goal, I believe, is access. The second thing——

REPRESENTATIVE SCHEUER. Start off right away going to——

DR. HILDRETH. I did not say how to get there. I said the first goal is access. The second goal would be to include prevention into the health-care packages, which is hardly an issue at the present time. The third thing is to recognize that the uninsured and the nonaccessed persons by studies have been shown to have three times the mortality when admitted to a hospital as those who have insurance coverage and access to the health-care system.

We have to correct those issues.

Now, how do you do it?

You have to get some money from somewhere. I would start on all of the areas in which we are wasting money right now. That is a huge menu

from which to pick a step and begin movement. But I think we have to accept that we cannot tinker with the present system. We are going to have to aim for a major reform. If we know what our goals are, we can take steps that will move us in that direction.

REPRESENTATIVE SCHEUER. Major, structural changes, yes.

Mr. Sartoris?

MR. SARTORIS. I would only say "ditto," Mr. Chairman.

REPRESENTATIVE SCHEUER. Mr. Stoughton?

MR. STOUGHTON. Again, I would look to some of the lessons in Canada and in some of the other countries. You are going to have to control the dollars, which means that you have to control dollars. There is going to have to be a single authority, or a state authority, that ultimately controls dollars.

You are going to have to eliminate the intensity of the competition. One way to do that is to globalize institutional budgets.

You are going to have to control training physicians within medical schools, because that creates physicians' supply that puts the demand on the system, and make sure that those training physicians are absolutely in the needs of U.S. society. Right now——

REPRESENTATIVE SCHEUER. Family medicine.

MR. STOUGHTON. Absolutely. This country needs more primary care physicians and less specialists. The medical schools will never straighten that out themselves.

Then, finally, you are going to have to look at what happens as more and more care goes to ambulatory treatments and diagnosis, and how to control costs in that environment. So, as you eliminate competition between institutions, in a sense, you are going to have to institutionalize ambulatory care. Then also carefully control the amount of competition in those environments. Because if you do not, what will happen is the funnel will just spread out in this direction. And it is complex. There is no question about it. But it is absolutely essential that we reform the system to get health care to everybody and that we control costs to enable us to do it.

REPRESENTATIVE SCHEUER. This has been a marvelously interesting panel, and I am grateful to you all.

The hearing is adjourned at the call of the Chair.

[Whereupon, at 4:54 p.m., the Subcommittee adjourned, subject to the call of the Chair.]

HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS – NATIONAL AND LOCAL PROPOSALS

WEDNESDAY, OCOTOBER 30, 1991

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Subommittee met, pursuant to notice, at 9:35 a.m., in room 2359, Rayburn House Office Building, Honorable James Scheuer (chairman of the Subcommittee) presiding.

Present: Representatives Scheuer, Snowe and Fish.

Also present: David Podoff, professional staff member.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

REPRESENTATIVE SCHEUER. Good morning. This is the third in a series of crucial hearings entitled "Health Care Reform: How To Push Less Paper and Treat More Patients."

Today, we will focus on national and state proposals for reform of our health-care system. At the outset, let me say how pleased and delighted I am to see so many members of Congress show up and be willing to share their thoughts with this Committee. The fact that so many of you are here attests, I think, to the urgency and importance that all of you and we place on the need to provide access to quality health care that is comprehensive for all Americans.

I have a longer written statement that I would like to put in the record, and I ask unanimous consent to insert it in the record. There being no objection, so ordered.

REPRESENTATIVE SCHEUER. We have three panels, so we are going to get on with hearing the witnesses. We may be interrupted by roll call votes.

Let me say first that there is general agreement that our health-care system is ill. It provides too little at too high a cost. At the present time, there is no national consensus on what to do about it. This series of hearings is designed to help move the country toward a recognition that something has to be done about it and ought to be done now, and that the

54-863 O—92—16

way to go is pretty clear. There are some alternative approaches around the edges, but we must take drastic steps to contain costs.

The General Accounting Office tells us that we can save $67 billion by moving to a single-payer system. Two distinguished doctors wrote in the *New England Journal of Medicine* that the saving would be $130 billion. The Robert Wood Johnson Foundation released a report a couple of weeks ago that said that if we implemented a Canadian style single-payer system that the cumulative savings to the economy over a ten-year period will exceed three trillion dollars, and that the cumulative gain to employers over the decade is two and a half trillion dollars.

Lee Iacocca complained to me when I was in Detroit with a number of other congressmen that health-care costs comprise over $700 per car, and that for our competition in Europe and Japan, it is less than half of that. That puts our American industry at a terrific competitive disadvantage.

Despite all the evidence with respect to administrative waste in our health-care system, there is resistance to adopting a single-payer system. And what we're trying to do is achieve a consensus on what must be done. Part of the opposition to a single-payer system stems from concerns about the political implications of the budget and tax policy changes that are required to implement a single-payer system, even though the net savings to the economy over the next ten years could exceed three trillion dollars.

Part of the resistance also stems from a reluctance to transfer resources from the private to the public sector. It's often argued, or rather assumed, that the private sector is more efficient. But the evidence clearly indicates that with respect to health-care expenditures, this assumption is not valid in a number of very, very capitalistic countries, including Canada, France, Germany and Japan. Between 70 and 80 percent of health-care expenditures are allocated through the public sector in a number of very capitalistic countries, compared to only 40 percent in the United States. Yet those countries spend 30-60 percent less per capita on health care than the United States, and have demonstrably superior health outputs.

So, I am looking for my colleagues to address these political concerns. Perhaps, together, we can find a way to overcome these hurdles so that we can realize the enormous potential savings of a single-payer system.

You take any one of these estimates, any one from the $67 billion to the $130 billion—the $67 is the GAO; the $130 is the *New England Journal of Medicine*; the Robert Wood Johnson Report talks about a savings of three trillion dollars in a decade, which is three hundred million dollars a year. Whichever figure you take, those savings would pay for all of the health care that tragically we are not giving our people. We exclude 37 million of us. We do not provide catastrophic care for anybody. We do not provide long-term care for seniors. We grievously underserve our Nation's youth. Ten percent of them have no regular access to health care whatsoever. And the savings just from the bureaucratic mess—this absolutely irrational, chaotic, wasteful Rube

Goldberg-type of nonsystem that we have—the savings from eliminating this and going to a single-payer system would provide for all of the missing services for large and important sectors of our population.

[The written opening statement of Representative Scheuer follows:]

WRITTEN OPENING STATEMENT OF REPRESENTATIVE SCHUER

This is the third in a series of crucial hearings entitled *HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS.* Today we will focus on National and State Proposals for Reform. At the outset, let me say that I am honored and delighted that so many of my colleagues from the Congress have agreed to share their thoughts with this subcommittee. The fact that so many of you are here attests to the urgency and importance that all of us place on the need to provide universal access to comprehensive, quality health care for all Americans.

Nothing I have heard in our first two days of hearings has undermined my belief that our health care system is critically ill, and that there is a fully tested cure -- called a national single payer system -- awaiting implementation. Let me briefly summarize how I view the issues after hearing some outstanding testimony.

First, there is general agreement that our health care system is "ill" as it provides too little access at too high a cost.

Universal access is assured in all countries of the Organization for Economic Cooperation and Development (OECD) except in the United States where 37 million people have no health insurance. We rank 24th in the industrial world with respect to infant mortality, 26th in low birthweight and 18th with respect to life expectancy. These gaps exist despite the fact that we spend far more on health care than any other country in the world. In 1990 the United States spent 12.4 percent of Gross Domestic Product (GDP) on health care compared to an average of 7.6 percent for the countries of the OECD. On a per-capita basis the comparisons are more staggering. The United States spends over $2500 per-capita on health care compared to $1800 in Canada, $1300-1500 in Germany, France, Norway and Sweden and only $1100 in Japan.

Second, there is undisputable evidence that our neighbor to the north provides universal access to comprehensive, quality health care, at the same time that it contains costs. A study supported by the Robert Wood Johnson Foundation -- and released about two weeks ago -- concludes that if the United States "implements a Canadian-style health care system, and focuses its initial reform efforts on administrative costs only," that the cumulative savings to the economy, over a ten year period, would exceed $3 trillion. Furthermore, the report notes that the "cumulative ... gain to employers over the decade is $2.5 trillion."

The Robert Wood Johnson funded study, conducted by the Economic and Social Research Institute, adds additional support to the findings of the General Accounting Office and the study of Drs. Woolhandler and Himmelstein, published by the New England Journal of Medicine. This latest study also finds that we waste, each and every year, billions of dollars ($90 billion in 1991 according to the Robert Wood Johnson study) on paper pushing activities that contribute nothing to our health status.

In the second day of this series of hearings we had eloquent and convincing evidence to bolster these findings. As one witness put it, "The North American experiment demonstrates conclusively that the single-payer system has contained costs more effectively than has the U.S. multipayer system."

And because these cost containment efforts tend to eliminate wasteful expenditures on useless "paper pushing" activities, there appears to be little or no impact on the quality of health care in Canada. As another witness, who has served as a high level hospital administrator in both Canada and the United States, put it, "In so far as maintaining quality and innovation I did not find any difference in quality but to the extent there is a difference; it is my opinion that the Canadian system performs overall at a higher level."

Third, despite the evidence with respect to administrative waste in the U.S. health care system, there is resistance to adopting a single payer system. Part of

the opposition stems from concerns about the political implications of the budget and tax policy changes that are required to implement a single payer system, even though the net savings to the economy, over the next ten years, could exceed $3 trillion.

Part of the resistance also stems from a reluctance to transfer resources from the private to the public sector. It is often argued, or rather assumed, that the private sector is more efficient. But the evidence clearly indicates that, with respect to health care expenditures, this assumption is invalid. In a number of capitalistic countries -- Canada, France, Germany and Japan -- between 70 and 80 percent of health care expenditures are allocated through the public sector, compared to only 40 percent in the United States. And yet these countries spend 30-60 percent less per-capita on health care than the United States. But I am convinced that the American public is ready to seize this pot of gold, and is willing to replace our chaotic, bloated, and wasteful health care system with a more cost effective system. The polls support this view. The Canadian system is well accepted. A Lou Harris survey found that 56 percent of Canadians said their system worked "pretty well," while only 10 percent of Americans had this view. The poll also showed that Americans are fed up with their health care system and want corrective action. Eighty-nine percent felt our system needs fundamental changes or complete restructuring.

I know my colleagues will address the political concerns. Perhaps, together, we can find a way to overcome these hurdles so that we can realize the enormous potential savings of a single payer system. If we succeed the United States will have a cost-effective health care system that provides universal access to comprehensive, quality health care for all Americans.

REPRESENTATIVE SCHEUER. Let me turn now to the panel. I am delighted to welcome the following distinguished members of the House of Representatives. Congressman Sam Gibbons of Florida; Congressman Jon Kyl of Arizona; Congressman Marty Russo of Illinois, who is expected here momentarily; Congressman Pete Stark of California; and Congressman Henry Waxman also of California.

Let's start with Sam Gibbons. In his fifteenth term from Florida, he serves as vice-chairman of the Committee on Ways, Means and chairman of its Subcommittee on Trade. Mr. Gibbons is the sponsor of a major piece of health reform legislation, H.R. 1777, the Medicare Universal Coverage Expansion Act of 1991.

Sam, we are delighted to have you here. Please take such time as you may need, within reasonable limits, and give us your views.

STATEMENT OF THE HONORABLE SAM M. GIBBONS REPRESENTATIVE FROM FLORIDA

REPRESENTATIVE GIBBONS. I will be very brief, Mr. Chairman. I merely propose that we extend the Medicare program to all Americans. I mean, everybody that lives in the United States, whether they be 65 years old or still in the womb. All Americans should be covered and will be covered under Medicare. It would be the first-payer in all of this. It would be tax financed, and there are multiple ways in which we can do that. It would cost far less than the current system, and it still would provide the huge experience that we've accumulated over 26 years of administering this program. Medicare now covers about 36 million people, all of whom are over the age of 65, but there are about two million people that are covered by it because they are totally disabled.

It's a broadly based program. It is efficiently run. It can be more efficiently run. It needs some fine tuning. But any program that we have is going to need finetuning. It now covers about 18 percent of our population. We are not going to change that program for those people. We only need one program in America, and Medicare takes care of the basic health needs of the individual. It doesn't cover everything. There will still be some room there for people who want to buy private-health insurance, or pay for it out of their own pocket.

The hospitals know how to use it, the doctors know how to use it, the medical-care providers know how to use it. It is a sound program, and it would relieve the problems that we face in America by lack of coverage and the catastrophic bills that some people face during their lifetime.

It would also offer to all Americans the chance to become truly free and not be tied down by their health-insurance policy coverage as to where they work. The current system, as you have outlined, is chaotic; it's expensive; it doesn't cover those in the greatest amount of need; and it is a happenchance of wage and price controls from World War II. It developed as a result of a wage and price control where fringe benefits and

many other things were not covered by that kind of control. That's how we got the current system that we're in.

That, Mr. Chairman, is all I really have to say. I'll be glad to answer questions. Nothing magic about my proposal. It's just a simple expansion of the age limit on Medicare to include all Americans.

[The prepared statement of The Honorable Mr. Gibbons follows:]

PREPARED STATEMENT OF THE HONORABLE SAM GIBBONS

H. R. 1777, THE MEDICARE UNIVERSAL COVERAGE EXPANSION ACT OF 1991

Mr. Chairman, thank you for this opportunity to address the Subcommittee on my bill, H. R. 1777, legislation I introduced to improve health insurance coverage and contain health care costs.

I would like to give an historical perspective on how we got to where we are today and what I think is the solution to the problem.

Fifty years ago I went off to war as a soldier in the United States Army. At that time there was no health insurance in the United States. Except for a couple of union contracts, there was relatively no health care insurance. During World War II, in order to keep down inflation, wage and price controls were imposed upon the workers and businesses of this country. But, in imposing those controls, they left one door open and that was fringe benefits. And so, during World War II, a system of fringe benefits was developed in order to replace the dollars that the workers weren't getting because of inflation. They built up the private health care insurance system that we now have. It is an historic accident. We have let it go on, and it has brought disaster to our whole health care system.

We have not only the most expensive health care system, but also the most clumsily-administered system to work with.

But we do have one system that works in this country and one system for which we already have the laws in place. We already have the administrators and bureaucracy in place. We have all the regulations written, and the people who like it. That is Medicare.

My proposal to this Congress is that we extend Medicare to all people, regardless of age, regardless of their status in life.

Some of the characteristics that any health care program for the United States should have are, first of all, that it be transportable. It should not be job-dependent as our current system is. It should be open to all, regardless of their current health status or their future health status. And it should be paid for by all. It should be an insurance program just like Medicare is now.

Now why use Medicare? Medicare has 35 million participants already. It has been in existence for 26 years. It works. The hospitals know how to use it. The doctors know how to use it. The beneficiaries know how to use it. All the health care suppliers know how to use it. And, certainly on par with all of that is that we know how to control costs under Medicare.

Unfortunately, under Medicare we get the most ill people of our population. Therefore, the medical care costs are higher than they would be for the entire working population. If Medicare is extended to all people as I propose, then the cost of medical care would be far less in the United States than under the current system, and everybody would be assured that whenever they became sick or needed preventive health care or counseling, they could go to a doctor or to their provider and get that kind of health care.

It is not a radical program. It is not a new program. There would still be room for the private insurance industry if it wanted to sell Medigap insurance to cover optional procedures or, for example, a private room over a semi-private room that is now covered under Medicare. There are all kinds of options that make it attractive to Americans.

It is an American program. It is a proven program. It is one that will save money to the average consumer and taxpayer. It is one that will promote better health care for all Americans.

Unfortunately, most of the Americans who are now not covered by health insurance are children who really can do nothing about it, and most of them are in families where the father and mother are both working or at least one of them is working outside of their home. So we have a very vulnerable group of people in America who are not covered.

It is estimated that in a year's time, Mr. Chairman, about 60 million people are not covered by any kind of health care insurance in the United States, not just 35 million that we see in those snapshots of one time during the year. We have a terrible need in this country. We can solve it by extending Medicare to all. We should do it at once.

REPRESENTATIVE SCHEUER. Thank you very much, Sam. I hope you'll be hanging in there with us.

Next, we have the Honorable Pete Stark from California. He is Chairman of the Subcommittee on Health of the Committee on Ways and Means, and he is a member of the Joint Economic Committee.

Pete, I invite you to come up here and join me if you have the time.

Let me just say that Pete Stark is the sponsor of a major health-care reform bill, the MediPlan Health Care Act of 1991.

Please proceed.

I may say that we have been joined by Congresswoman Olympia Snow of Maine, a member of the Joint Economic Committee.

STATEMENT OF THE HONORABLE PETE STARK REPRESENTATIVE FROM CALIFORNIA

REPRESENTATIVE STARK. I like to associate myself with the remarks of my distinguished colleague, Mr. Gibbons, because what H.R. 650 does, very quickly, is in effect make Medicare the base system for all employed Americans.

I would just like to amplify his comments a little bit, and then I would like to review with the Committee where we are.

Right now there are at least seven plans by democratic members of the Congress and at least one by Republican members. Senators Mitchell, Kennedy, Rockefeller, and on down the line have bills, all of which try to provide universal care or access to the system, given time. Some cost more than others. The lowest priced one is Senator Mitchell's at around $30 billion. On the House side, there's chairman Rostenkowski; chairman Dingell; chairman Gibbons; and Representatives Stark, Waxman, and Russo who has probably the most comprehensive and, parenthetically, the most expensive.

The one Republican plan by our colleagues, Ms. Johnson and Mr. Chandler, is basically just a modest insurance company reform and arguably has very little cost implication.

The Administration plan, as evidenced by Dr. Sullivan, is unique. It is interesting. It basically says that with four steps this country can take care of its health problems. They would be universal abstinence, celibacy, exercise, and prayer.

[Laughter.]

I don't know about you, Mr. Chairman, but in my district, that plan is found wanting by a few of my constituents for one reason or another, and I have trouble selling it. So, in the absence of the Administration's willingness to come home from Madrid and deal with the health-care problem, we have a host of plans on the Democratic side. Even a few of my Republican colleagues who would like to do something are frustrated because we will do nothing until the Administration decides to offer a plan. We don't have a two-thirds vote on this side of the Capitol for any plan.

Having said that, what are we to do? I come to religion very late in life and with great temerity, but there is no Stark trilogy that takes care of what we ought to do. And it is very simple.

The first leg of the trilogy is that every American, as a matter of right, ought to have access to medical care. As a matter of fact, I intend to introduce today a constitutional amendment to that effect. We want to have constitutional amendments for everything else in the world, why not a constitutional amendment that says every American has a right to medical care.

I challenge the Chair to tell me which group of Americans under the Constitution have the right to medical care, if any? You don't know? My colleagues will say that it is members of Congress, Native Americans, the military. It is prisoners, Mr. Chairman.

Under the 8th Amendment, go to the slammer, and if they don't give you medical care, it is cruel and inhumane punishment. So, if you have constituents who don't have medical care, send them to Los Angeles and have them get in a traffic dispute. They will need more medical care than they ever dreamed possible, and they will get it courtesy of the County of Los Angeles. But no other American will get it.

The second part of my trilogy. Every provider of health services ought, as a matter of right, expect reasonable compensation, not necessarily desired but reasonable compensation.

And the third part is very simple. We all want to pay for it according to our ability to pay. Members of Congress who earn a hundred-and-twenty-odd-thousand bucks a year ought to pay a whole lot more than people at the $8,000 poverty level who ought to pay nothing. That is a pretty great American tradition.

Having given you my triology, I used to have seven deadly sins, but I called them silly shibboleths of things that won't work. I have seen people toy with them, and I know of no sound economist or politician who would suggest that any of these will work.

The first one is a political issue, don't deal with the provider system; it's okay. Don't try and shove everybody into an HMO that may be more efficient. That was Dr. Bowen's and Dr. Roper's plan. I am inclined to agree that HMOs are more efficient, but my mother won't go. My mother will sleep on a grate and humiliate me before she'll go to an HMO. She has her doctor. Now, her doctor doesn't really do much to her except shop her around town for referrals, but you're not going to change the American way by which she views the provider system, which is very good. So, let it alone.

Two, long-term care is not a medical issue. Eighty percent of the people who need nursing home care or home health care don't need any change in medication, doctors, nurses, or so forth. They just need money. Members of Congress, again, on our retirement, if you are here the twenty years that I've been, you have enough of a retirement to pay for the $3,000 a month in a nursing home without destituting your children or your spouse. Long-term care is merely an income transfer. It has to deal

with the impoverishment of 25-30 percent of our retired seniors. Give them the money, they have long-term care. It is not a medical problem. Put that aside. It is an income transfer problem.

Three, patient competition in the market doesn't exist. Don't believe it. None of us know with any certainty exactly what we have taken out of our paychecks for medical care and medical insurance each month. The public doesn't think we pay for it at all. And none of us really know with any accuracy—and we are all relatively expert—exactly what are the benefits that we get. We don't pay for them.

Fourth, if I told you all that this afternoon, if you hurry and run and get a PAP smear or a proctoscopic examination, you could get two for the price of one, you wouldn't move. We, as patients, don't want to go to the doctor. We like them all right, but we don't want to go to the hospital. We do what the doctor tells us. So, we don't drive in any economic sense the system of costs. We don't have anything to do with it. We are pawns in a very good medical delivery system.

Next, the employment-based system won't work. It was designed in the 1940s, as Chairman Gibbons indicated to you, at a time when most children grew up with two parents, one of whom worked and the other of which stayed home to care for the kids. Times are different today. A child who gets to its majority any more with more than six parents is not a unique child. Watching the parents go to court several times during the course of the child's growing years, fighting over which parent gets them on weekends, and which parent has to pay for the education, clothing, or housing is all to common. It's a different system. Most families have at least two working adults in it, and most employers are uncertain as to which employer pays. It is silly. It is not a reasonable way to allocate resources through an employment system which is no longer uniform and traditional. You have to socialize the way in which we distribute the benefits.

A single-payment system is my next issue, and it is the only way—absolutely the only way—that anybody can control the costs in the United States. We are the only industrialized nation in the world, with the exception of the Black part of South Africa, that does not have a single-payer or its clone—an all-payer system—which is really a subsection of single-payer. To prevent cost shifting, whether it is government shifting costs to the private sector or vice-versa, you cannot get from here to there without a single-payer system.

And no responsible medical economist or social economist has come up with any alternative, be it socialism, be it something else. You can't get there without it. Private insurance won't work. Why won't private insurance work? They are too good at what they do. We know and they know that 80 percent of the medical costs in this country are caused by 20 percent of the people. The actuarial science and profession today are so good that they can tell you to a gnat's eyebrow who the 20 percent of the people are who will cause 80 percent of the medical costs, and they won't insure them. And they are so good that they can begin to tell you

when you're born whether you're going to be in this 20 percent, or that 20 percent, and what side of the street you live on. And that's the only way they make any money. They leave for the public system—either charity or the Federal Government—those people that they know will increase the costs.

Unless you want to drastically change the way insurance is delivered and take medical underwriting out of the formula, they cannot do the job and expect to make money and survive. That is not a criticism. It again is an economic fact of life.

We should do away with Medicaid. I have a hunch—I can't put words in his mouth—but my distinguished colleague from California might suggest that he would agree that it should be either Medicare, as Sam and I would indicate, or a uniform federal program. The poor have no advocates and Medicaid underpays. Have one federal system so that the hospital and doctor are blind as to whether you are poor, or elderly, or white, and if you give them reasonable pay, as I said before, they will not discriminate. Basically that deals with my system and seven points.

Just one final thought. The only argument that really exists today between Republicans and Democrats, between liberals and conservatives, is how we pay. I am going to suggest to you that as Lewin and Associates will tell you, in almost all of these plans that are comprehensive, there is no net social cost. General Motors and Chrysler, etc. will save $40-50 Billion a year on a uniform plan like mine, or Mr. Gibbons', or Mr. Russo's. The problem is, we don't know how to extract that savings from them in taxes. Imagine the United Autoworker who has never paid anything for his or her health insurance, and we tell them, gee, guys, you are now going to have to pay forty cents an hour out of your pocket. They are going to look at those of us who support labor and not vote for us again. They won't pay. They think they already have what they need. I can't convince them that by putting them into a plan like Mr. Gibbons or Mr. Russo they don't have to worry about the plant closing, or the mergers, or the layoffs; they will always have health care as a matter of right. Don't tell them that, not if it's going to cost them anything. They don't want to hear it.

As for the National Federation of Independent Businesses, 63 percent of them have health insurance, and indicate in the polls that they wouldn't buy health insurance for their employees if we gave it to them for next to nothing. All they want is a 100 percent tax deduction, and they won't give anything to their employees. They don't want us to provide anything. They want their own health insurance, and they never have paid for health insurance for others and don't intend to if it costs them anything.

Financing is the issue in putting in a universal health plan. There will be shifts; there will be winners—the big corporations who support national health insurance. There will be losers—small business people and people who will now have to pay something out of their pockets, and they'll call that a tax, and rightly so. If you have to pay a little more somewhere, you can call it a tax if you want to. But until we face up to

the issue, it is going to have to be adjusted on how much people pay—$13 a month, maybe.

Now, you say $13 a month. Your constituents and Mr. Gibbons' constituents may say, I'll buy that, but don't tell them that that adds up to $50 billion a year because then they won't vote for you. There is a difference in how we present that to the world. That's our political problem. Once we have a leader in the White House who says you have to solve it, and I am not going to beat you over the head on a partisan basis, we'll figure out a way. I hope it will be a better way than we did with the catastrophic bill, but we will figure out a way to provide access to all, and pay for it, and get about our work. I hope you and I are both here to see that done before the next Congress ends.

I thank you very much for letting me be with you.

REPRESENTATIVE SCHEUER. Thank you very much for your fine testimony.

REPRESENTATIVE STARK. I have a prepared statement that makes much more sense than my off-the-cuff remarks.

REPRESENTATIVE SCHEUER. We will put your complete statement in the record. I ask unanimous consent.

[The prepared statement of The Honorable Mr. Stark follows:]

PREPARED STATEMENT OF THE HONORABLE PETE STARK

"The MediPlan Act of 1991"

The American health care system is currently right on track to achieve the dubious accomplishments of leaving fifty million Americans without health protection while ringing up costs in excess of $1.7 trillion by the year 2000.

We can stand back and do nothing, or we can act to assure that these outcomes do not come to pass.

Access to health care should be considered a basic right of every American. Unfortunately, it appears that we slip further away from assuring this right every year.

Almost thirty-four million Americans currently lack health insurance, and another seven to ten million Americans are covered by inadequate plans. As many as sixty-five million lack health insurance at some point during the year.

And while more and more Americans find themselves without health insurance, the system keeps spending more and more and more dollars, as if there were no limits. If we don't do something, we will bankrupt our industries and price our products out of the international marketplace.

A national strategy is necessary to provide all Americans basic and affordable health care. Unfortunately, other approaches, including the employment-based plan recommended by the Pepper Commission, would not be truly comprehensive. Only a single payer plan under public auspices can assure every American a basic level of health services.

For example, under an employment-based plan, children may be particularly vulnerable. Changing family patterns create equity problems with employer-based plans and often leave children or spouses without the coverage they need. Only a public plan can assure that all children are covered and that payment on their behalf is shared equitably.

Part-time and seasonal workers may also fall through the cracks in an employment-based system. It is unclear how such an employment-based system would help those individuals who change jobs, are employed by more than one employer, or are unemployed for some period during a year.

A national plan is also critical for cost containment. Through a single national plan, operated by the Federal government, it is possible to build upon the fiscal discipline that we have achieved in Medicare. An employer mandate approach would continue the ineffective patchwork approach to controlling costs of the current system.

Because I am convinced that a national strategy is necessary to provide all Americans basic health services and implement meaningful cost containment strategies, I have introduced the MediPlan Act of 1991 (H.R. 650) to provide publicly-financed health insurance to every American.

The MediPlan Act of 1991 will assure vital health insurance protection to every American. Its enactment would make real every American's basic right to high-quality health services and would control skyrocketing health care costs. All residents of the United States, rich or poor, would be enrolled in MediPlan and eligible for health benefits.

Enactment of MediPlan will achieve a priority goal of the American people -- universal access to health care. And it will do so in a responsible, cost-effective manner which builds upon the proven strategies of Medicare in order to control costs.

MediPlan's basic benefits would be similar to those currently provided to the elderly by Medicare. In addition, MediPlan would cover all children and all pregnant women without payment of a premium and without copayments or deductibles. Benefits would include needed pre-natal, labor and delivery, and preventive well-child care, including immunizations. MediPlan would also provide additional, essential benefits, such as prescription drug coverage, for low income Americans, who would also not pay premiums, copayments or deductibles.

MediPlan is not based upon ideas borrowed from another country. Its basic design was developed by the Congress and the Kennedy Administration in the early 1960s. In fact, at the time Medicare was developed, many believed that it would be expanded to phase in coverage of other groups.

It is also true that MediPlan does not require the design of a new system from scratch. All of the administrative mechanisms already exist.

MediPlan also provides for responsible, workable cost containment. Through the use of Medicare's DRG-based prospective payment system (PPS) for hospitals and through volume performance standards and resource-based relative value scale (RBRVS) for physicians, MediPlan builds its cost containment strategy on the only proven cost containment system. It is important to recognize that Medicare is the most successful health insurance program in this country.

This is somewhat different from our usual view of Medicare. The more common view, expressed frequently during reconciliation debates, casts Medicare in the role of a government program whose costs are out of control. The truth is that, when compared to other insurance plans, Medicare is a virtual model of effectiveness and efficiency.

We have done a better job of providing benefits, assuring access to care, and controlling costs than any other public or private health insurance plan in this country. This is a record that can, and should, be built upon as the basis of a program of universal access for all Americans, and that is what I propose to do through MediPlan.

MediPlan is budget-neutral; the proposed legislation raises the revenue necessary to cover its cost. Through a combination of employer and employee-paid premiums plus a new tax on gross income, MediPlan provides a blueprint of how comprehensive health benefits for every American could be financed.

To finance the basic health benefits, every person with income above the poverty line would pay their share of the MediPlan premium (the total premium would initially be about $1,000/person) through the income tax system. Every employer would pay eighty percent of the MediPlan premium on behalf of each working American through a payroll tax of about $.40 per hour to a maximum of $800/year per employee. Thus, each full-time worker would be responsible for $200 of the annual premium.

Low-income persons would not pay the individual's share of the MediPlan premium. Between $8,000 and $16,000 for individuals and $16,000 and $32,000 for married couples, the individual's share of the MediPlan premium would be phased in.

MediPlan requires $65 billion in revenues beyond the payment of the MediPlan premium to support health insurance for children, pregnant women, and low-income persons.

To cover the $65 billion in benefits, revenues would be raised under MediPlan through a two percent tax on gross income, including tax-exempt income, deferred income and other forms of income not currently subject to taxation. Individuals with incomes below 200 percent of the poverty level would be exempt from the tax. All revenues from the MediPlan income tax would be paid into the MediPlan Trust Fund.

MediPlan's health care benefits would provide a true health care safety net for every American. I suspect that most will embrace the benefits included in this bill, but not support the proposed taxes necessary to fund the benefits.

To talk about the benefits without considering the costs and how to pay for benefits is to mislead the American people. I would urge those who object to the financing proposal to offer one of their own, or suggest areas where benefits of the program should be reduced.

I hope that my plan will move the debate forward, so that the 102nd Congress can enact the major changes the country so desperately needs. I look forward to working with my colleagues on the Joint Economic Committee to achieve that goal.

REPRESENTATIVE SCHEUER. Sam, do you have a prepared statement?

REPRESENTATIVE GIBBONS. Yes, I do, very brief.

REPRESENTATIVE SCHEUER. We'll put all prepared statements in the record at the point at which you spoke.

Next, we have the Honorable Jon Kyl from Arizona. In his third term, he is a member of the Armed Services and Government Operations Committee. Mr. Kyl is the sponsor of a medical liability reform bill, H.R. 3516, the Medical Malpractice Tort Reform Act.

Thank you for being with us, Jon, and please proceed.

STATEMENT OF THE HONORABLE JON KYL REPRESENTATIVE FROM ARIZONA

REPRESENTATIVE KYL. Thank you, Mr. Chairman. I do have a prepared statement that I would like to put in the record. I am going to testify some from that statement. I appreciate the opportunity to be here.

This is a bill that's been co-sponsored by myself and Charlie Stenholm. It's a bipartisan bill with sponsorship on both sides of the aisle.

REPRESENTATIVE SCHEUER. How many members are on it?

REPRESENTATIVE KYL. There are something over 30 at the moment, and we are gaining sponsorships everyday.

REPRESENTATIVE SCHEUER. Can I ask for the record, Sam and Pete, how many co-sponsors do you have for your bills?

REPRESENTATIVE GIBBONS. I don't know.

REPRESENTATIVE STARK. I don't have any idea, Mr. Chairman, a dozen maybe. That would be spectacular.

REPRESENTATIVE KYL. I see that I have 32 so far, at least on the sheet, Mr. Chairman.

I'd like to start with a comment that Congressman Stark just made because I would like to respectfully disagree. Noting that, first of all, there is much that we do agree about among other things. The fact that there is a problem, and we have to do something about it, and the sooner the better. But he said that he didn't think we agreed—Republican or Democrat, liberal or conservative—about the fact that there is a problem. The only argument is the question of how we should pay for it. I address the problem differently. I do not assume that there is one answer on how to pay for everything, and that will solve the problems. But rather, I believe that we have to isolate the causes for the problems, that there are numerous causes, and that we must productively move forward by addressing each of those causes with reform.

The bill that Charlie Stenholm and I have introduced, H.R. 3516, is an attempt to address one of those causes, and I think it illustrates the fact that each cause can be addressed seriatim and that the end result will be a system that provides low-cost care, which is good care to all Americans. That, of course, is our ultimate goal, rather than a one-size-fits-all national program that attempts to address all aspects of the health-care problem. As I said, I think we have to try to isolate each of the causes and develop

programs to deal with them individually. In considering any kind of reform, we have to concentrate on preserving the high quality of care and the innovation that people have come to expect within our system. And, as I said, a series of reforms should then be adopted to achieve that end and reduce the cost and expand the accessibility that we seek.

Medical malpractice tort reform is one of the essential components of an overall program to actually lower costs without decreasing the quality of care.

Mr. Chairman, medical malpractice premiums are a big problem, and a one size fits all program, such as has been discussed here, doesn't address that at all because the legal system will still exist, and that is something which is unique in this country as compared with all the countries that you mentioned in your opening statement, incidentally. The medical malpractice premiums are the fastest growing cost expenditure facing physicians and medical institutions in this country, according to the AMA's socioeconomic monitoring system surveys. Premiums for physicians' fees in 1988 had increased 174 percent over 1982 premiums. In 1988 alone, medical-insurance premiums added $5.6 billion to the cost of health care in America. Indirect professional liability costs, such as redundant testing and defensive medicine, add another $15.1 billion, bringing total professional liability to $20.7 billion. That doesn't even get into the other providers, such as the hospitals. These costs are having a significant impact on the individual physician.

In my home state of Arizona, for example, obstetricians pay an average malpractice premium of $52,900 per year. And obviously they are either forced to pass this cost along to their patients, or to get into other specialties, or to leave the practice altogether. Institutions are also confronting the high cost of premiums. Community and migratory health-care centers which treat the majority of our poor and uninsured are confronted with $58 million per year malpractice premiums, even though only $3-8 million in claims have been filed against them on the average since 1982. This is money that they could be using to treat additional patients rather than paying for high-insurance premiums. Our current system also promotes the awarding of large sums of money to a few individuals which significantly increases health-care costs.

The Kyl-Stenholm Bill takes a multifaceted approach to dealing with all of these problems. The Medical Care Injury Compensation Reform Act of 1991, which is what it's called, first seeks changes in the handling of malpractice cases by giving states grants to establish alternative dispute-resolution systems. These systems would allow people to have their claims reviewed without having to go to court and pay large attorney's fees.

Title I of the bill requires the Secretary of HHS to provide grants to the states for the implementation and evaluation of innovative systems to settle medical liability disputes. States will have the ability to design systems tailored to their own needs. Each system will be examined and approved by the Secretary for a two-year grant, and after a two-year

period, the state will have the option of extending the grant for an additional two years. The Secretary will also collect and disseminate information regarding the outcomes of these various systems to the interested parties. States desiring to implement their own ADR or finetune their existing program will be able to examine programs from around the country and determine what is most effective.

The second section of the bill imposes federal tort reform. Although states could always have more stringent laws, our reform changes the standard of care in medical malpractice cases from reasonable and prudent to reasonable, but that's important because it used to be that 30 years ago reasonable and prudent was one standard. Today, it has become two standards. What is reasonable is not as much as what is prudent. And lawyers have turned that into a system that makes it easier for them to recover in these cases.

REPRESENTATIVE SCHEUER. Could you describe the difference between reasonable and prudent, other than describing prudent. Is prudent avoiding tort claims through a full variety of tests and procedures that we've left out on a reasonable standard?

REPRESENTATIVE KYL. Mr. Chairman, you put your finger right on it. Of course, it used to be that reasonable and prudent was essentially that which described a standard of care prevailing in that community, essentially that everybody else equally qualified did what was reasonable. But now the lawyers have done exactly what you said. They said, that might be what's reasonable, but wouldn't have been prudent to take this extra step and do this test or that procedure. That's what the physicians and hospitals have had to do, practice defensive medicine with the additional $20 billion in costs that I mentioned.

Another reform is delineation of a series of damage levels. These include limiting noneconomic losses to $250,000; requiring mandatory periodic payments for damages exceeding $100,000; limiting attorney's contingent fees to 25 percent for the first $150,000 and 15 percent to amounts greater than $150,000; requiring mandatory offsets for damages paid by a collateral source; requiring liability to be several only, and not joint, with the defendant being liable only for the amount of noneconomic damages proportional to the defendant's percentage of responsibility; and finally, limiting punitive damages to twice the compensatory damage award.

In addition, as I said, a state may develop its own standards which would be more stringent. The statute of limitations would be two years from the time the injury was or should have been discovered.

Fourth, and this is very important, regarding obstetric services, health-care practitioners who are seeing a woman for the first time during labor and/or delivery of a baby could not be held liable for problems resulting from the term of the pregnancy. Health-care practitioners could still be held negligent for their own actions during labor and delivery, but not for everything preceding that. And, of course, there is one thing that has

driven up the cost of these premiums and that is, with respect to product liability.

REPRESENTATIVE SCHEUER. That's the one thing that the rural practitioners have a problem with.

REPRESENTATIVE KYL. Mr. Chairman, again you are right on. In the rural parts of my district, it is hard to find Ob-Gyns any more, and one would have to go many miles to get it. Absolutely right.

With respect to product liability, if a health-care producer of medical services or drugs goes through the Food and Drug Administration approval process, then punitive damages could not be awarded in medical product liability claims. It sounds reasonable enough, but those punitive damages are killing these companies. If a company withholds information or misrepresents the product during the approval process, then, of course, punitive damages could be assessed.

Sixth, a nationwide insurance-risk pool would be created for community and migrant health centers. Since community and migrant health centers have such a low rate of medical malpractice cases against them, creating a risk pool specifically for those centers would reduce their medical malpractice insurance costs dramatically. As I said, this Kyl-Stenholm approach to tort reform includes many component parts, but deals with specific problems. It does not attempt to solve everything in one bill. I think that this is the best way to challenge this very complex problem.

Thank you, Mr. Chairman.

[The prepared statement of The Honorable Mr. Kyl follows:]

PREPARED STATEMENT THE HONORABLE JON KYL

Mr. Chairman, thank you for allowing me this opportunity to testify before the Joint Economic Subcommittee on Education and Health regarding the Kyl-Stenholm my medical malpractice tort reform bill, H.R. 3516. My colleagues and I are here today because we realize the importance of health care and the difficulties many Americans face in obtaining that care because of the prohibitive cost of insurance and treatment.

But we disagree about the solutions. Rather than a "one-size-fits-all" national program that attempts to address all aspects of the health care problem, I believe we must try to isolate each of the causes creating the problem and develop programs to deal with them individually. In considering any kind of reform, we must concentrate on preserving the high quality of care and innovation that people have come to expect within our system. In order to do so, a series of reforms must be adopted to reduce cost and expand accessibility. Medical malpractice tort reform is one of the essential components of an overall program to actually lower costs without decreasing the quality of care.

Medical malpractice premiums are the fastest growing cost expenditure facing physicians and medical institutions. According to American Medical Association (AMA) Socioeconomic Monitoring System surveys, premiums for physicians fees in 1988 had increased 174% over 1982 premiums. In 1989 alone, medical insurance premiums added $5.6 billion to the cost of health care in America. Indirect professional liability costs such as

redundant testing and defensive medicine added another $15.1 billion, bringing total professional liability to $20.7 billion.

These costs are having a significant impact on the individual physician. In my home state of Arizona, for example, obstetricians pay an average malpractice insurance premium of $52,900 per year. They are forced to either pass this cost along to their patients or to enter different specialties.

Institutions also are confronting the high cost of premiums. Community and Migratory Health Care Centers, which treat the majority of our poor and uninsured, are confronted with $58 million per year malpractice premiums even though only $3 million to $8 million in claims have been filed against them on average since 1982. This is money that they could be using to treat additional patients rather than paying for high insurance premiums.

Our current system also promotes the awarding of large sums of money to a few individuals, which significantly increases health care costs.

The Kyl/Stenholm bill takes a multifaceted approach in dealing with all of these problems. The Medical Care Injury Compensation Reform Act of 1991 first seeks changes in the handling of malpractice cases by giving states grants to establish alternative dispute resolution systems (ADRS). These ADRS will allow people to have their claims reviewed without having to go to court and pay large attorneys' fees.

Title I of the bill requires the Secretary of Health and Human Services to provide grants to states for the implementation

and evaluation of innovative systems to settle medical liability disputes. States will have the ability to design systems tailored to their needs. Each system will be examined and approved by the Secretary for a two year grant. After the two-year period, the state will have the option of extending the grant for an additional two years.

The Secretary also will collect and disseminate information regarding the outcomes of the various ADRS to interested parties. States desiring to implement their own ADR or fine tune their existing program will be able to examine programs from around the country and determine what is effective.

The second section of the bill imposes federal tort reform, although states could always have more stringent laws. Our reform changes the standard of care in medical malpractice cases from "reasonable and prudent" to "reasonable".

Another reform is delineation of a series of damage limits. These include: limiting noneconomic losses to $250,000; requiring mandatory periodic payments for damages exceeding $100,000; limiting attorney's contingency fees to 25% for the first $150,000 and 15% to amounts greater than $150,000; requiring mandatory offsets for damages paid by a collateral source; requiring liability to be several only and not joint, with the defendant being liable only for the amount of noneconomic damages proportional to the defendant's percentage of responsibility; and limiting punitive damages to twice the compensatory damage award.

In addition, a state may opt to develop its own standards

which exceed the federal minimum standards provided by the HHS/Federal guidelines. If more stringent guidelines developed, these would apply to all services provided in the state (both public and private.)

The statute of limitations would be two years from the time the injury was or should have reasonably been discovered.

Fourth, regarding obstetric services, health care practitioners who are seeing a woman for the first time during the labor and/or delivery of a baby could not be held liable for problems resulting from the term of the pregnancy. The health care practitioners could still be held negligent for their actions during labor and delivery.

Fifth, with respect to product liability, if a health care producer of medical devices or drugs goes through the Food and Drug Administration approval process, punitive damages could not be awarded in medical product liability claim. However, if a company withholds information or misrepresents the product during the approval process, punitive damages could be assessed.

Sixth, a nationwide insurance risk pool would be created for Community and Migrant Health Centers. Since Community and Migrant Health Centers have such a low rate of medical malpractice cases against them, creating a risk pool specifically for those centers would reduce their medical malpractice insurance costs.

As you can see, the Kyl/Stenholm approach to tort reform includes many component parts, but deals will specific problems. It does not attempt to solve everything in one bill. I think that is the best approach to this very complex challenge.

REPRESENTATIVE SCHEUER. Thank you very much, Jon.

I take it that your bill wouldn't be inconsistent with any of the other proposals and that no matter what we do, whether it's the Russo bill, or the Gibbons bill or the Stark bill, we're going to have to address the question of medical malpractice and estimates of up to $40 billion that it costs our economy.

REPRESENTATIVE KYL. Mr. Chairman, I totally agree with that last statement that you made. My approach may be inconsistent to this extent. I still believe that it might be possible to address each of these individual problems, and having done so, end up with a system which provides quality care for all Americans without the necessity of going to a single system or one-size-fits-all system. I am leery of those for the reasons that we found in the Catastrophic Health Care Reform to be wanting.

REPRESENTATIVE SCHEUER. Thank you very much. Now, we will hear from the Honorable Marty Russo of Illinois. He is in his ninth term, vice-chairman of the Subcommittee on Health of the Committee on Ways and Means. And he is the sponsor of a major health care reform bill, H.R. 1300, the Universal Health Care Act of 1990, a bill that has upwards of 60 sponsors, myself included.

Please proceed, Congressman Russo.

STATEMENT OF THE HONORABLE MARTY RUSSO REPRESENTATIVE FROM ILLINOIS

REPRESENTATIVE RUSSO. Mr. Chairman, thank you very much for giving me this opportunity to testify before the Joint Economic Committee on the Russo Bill, H.R. 1300.

As you mentioned in your comments, Mr. Chairman, since I've introduced this bill in March of this year, the bill has gained widespread support. It now has 61 cosponsors, including the distinguished chairman of the Joint Economic Committee, as well as the support of 11 major labor unions, citizen action and other consumer groups, the National Council of Senior Citizens, Physicians for National Health Program, and, more recently, the American Medical Students Association. Obviously, the future doctors of America think that this is an important bill to support. This is more support than any other health reform bill in either the House or the Senate.

The question you may ask, Mr. Chairman, is why is this bill so popular? It's popular because it does what the American people want it to do. It establishes a single-payer health-care system. A single-payer system guarantees comprehensive high-quality health care to all Americans while cutting the Nation's health-care costs. Ninety-five percent of Americans would spend less on health care under the Russo Bill than they do now and would still be able to choose their own doctor, their own hospital, their own provider.

A single-payer system would replace the multitude of health insurance plans now in place with a single, comprehensive publicly financed plan

which covers all Americans. Because there is only one plan and one payer, money is no longer wasted on determining who is eligible for benefits, or on billing 1,500 insurance agencies and millions of consumers, or on advertising, marketing and commissions. According to the General Accounting Office, the United States would save more than $67 billion a year in administrative costs alone under a single-payer system. This means that we could provide health care to the uninsured, improve coverage for the insured, and eliminate co-payments and deductibles for everyone.

Not only does single-payer reduce billions in administrative waste, Mr. Chairman, but it keeps costs down over the long run by imposing strict cost controls. This includes establishing national and state health-care budgets, establishing mandatory expenditure targets, reimbursing health-care providers according to fee schedules, and reimbursing hospitals based on annual budgets. Both the General Accounting Office and the Congressional Budget Office have testified that these provisions would significantly contain health-care costs if applied to the United States.

The Russo Bill, H.R. 1300, would also improve the quality of care by expanding practice guidelines to cover the entire health-care system, to reduce unnecessary care, and by encouraging preventive care. Under Canada's single-payer system, Canadians visit their physicians more than people do in the United States and receive much more prenatal care than we do, have better health-care statistics than we do, live longer than we do, have a better infant mortality rate than we do, and they do it for 40 percent less per person than the United States. And they have better health-care statistics and better quality care for all their citizens.

Above all, Mr. Chairman, H.R. 1300 will give Americans peace of mind. Everyone will be covered for comprehensive benefits; including hospital and physician care, long-term care, prescription drugs, mental health services, dental, vision, and preventive care. People could change jobs, move out of state, and never have to worry about health insurance. No one would lose coverage just because they got sick. There would be no paperwork, no gap in coverages, no worrying about high medical bills, and no haggling with private insurance companies over whether a procedure is covered. Employers would no longer have to worry about high insurance premiums. Under H.R. 1300, employers would pay a simple 7.5 percent of payroll for health care as compared to the average 12 percent they pay now in 1989.

Mr. Chairman, I get a little tired of the inside-the-beltway mentality that says that single-payer is the best system, but it's not politically feasible. Mr. Chairman, single-payer is the only politically feasible option because it's the only plan that benefits all Americans. The bill isn't about raising taxes, it's about giving people more services for less than they spend now. H.R. 1300 would cover everyone for comprehensive benefits, and 95 percent of Americans will pay less than they spend now on health care. All other health-care reform programs, Mr. Chairman, would cost Americans more money and give less benefits. The widespread support

behind this bill includes 69 percent of Americans who say they want single-payer and 60 percent of whom are conservatives. It cuts all lines of ideology. This Nation can't afford to do anything less than single payer.

According to the General Accounting Office, the only way that we'll ever slow health-care inflation in the United States is through comprehensive reform. And as the Congressional Budget Office has testified before this Committee, single-payer is the only system that can provide high-quality care to all Americans for less than we currently spend. No other health-care proposal can make this claim. Single-payer is not only the best system, it's the only politically feasible plan around.

Mr. Chairman, we are always told to remember what happened with catastrophic health care. Well, if you do anything but single-payer, you will have a repeat of catastrophic health care because you are going to be asking people under these other plans to pay more money and not get more benefits. Under single payer, they will pay less money and get comprehensive benefits because we save over $80 billion in administrative waste. It is simple, it is easy to administer, and it covers all Americans. And so, it ought to be the plan that we put forth, not some patchwork system that we talk about until we get the courage to do something more important.

Thank you, Mr. Chairman.

[The prepared statement of The Honorable Mr. Russo, together with attachment, follows:]

PREPARED STATEMENT OF THE HONORABLE MARTY RUSSO

I appreciate the opportunity to testify before my colleagues on the Joint Economic Committee on behalf of my proposal for health reform, H.R. 1300, the Universal Health Care Act of 1991.

Since I introduced H.R. 1300 in March, the bill has gained widespread support. It now has 61 cosponsors, including the distinguished chairman of this committee, as well as the support of 11 major labor unions, Citizen Action and other consumer groups, the National Council of Senior Citizens, the American Medical Student Association, and Physicians for a National Health Program. This is more support than any other health reform bill in either the House or the Senate.

Why is this bill so popular? Because it does what Americans want; it establishes a single-payer health care system. A single-payer system guarantees comprehensive, high-quality health care to all Americans while cutting the nation's health care costs. Ninety-five percent of Americans would spend less on health care under H.R. 1300 than they do now and would still choose their own doctors and hospitals.

A single-payer system would replace the multitude of health insurance plans now in place with a single, comprehensive, publicly financed plan which covers all Americans. Because there is only one plan and one payer, money is no longer wasted on determining who is eligible for benefits, or on billing 1,500 insurance agencies and millions of consumers or on advertising, marketing and commissions. According to the General Accounting Office, the United States would save more than $67 billion a year in administrative costs alone under a single-payer system. This means we could provide health care to the uninsured, improve coverage for the insured, and eliminate co-payments and deductibles for everyone.

Not only does single-payer reduce billions in administrative waste, but it keeps costs down over the long-run by imposing strict cost controls. This includes establishing national and state health care budgets, establishing mandatory expenditure targets, reimbursing health care providers according to fee schedules, and reimbursing hospitals based on annual budgets. Both the General Accounting Office and the Congressional Budget Office have testified that these provisions would significantly contain health care costs if applied to the United States.

H.R. 1300 would also improve the quality of care by expanding practice guidelines to cover the entire health system to reduce unnecessary care and by encouraging preventive care. Under Canada's single-payer system, Canadians visit their physician more often than people do in the United States and receive much more prenatal care than we do.

Above all, H.R. 1300 would give Americans peace of mind. Everyone would be covered for comprehensive benefits including hospital and physician care, long-term care, prescription drugs, mental health services, dental and vision care, and preventive care. People could change jobs or move out of state and never have to worry about health insurance. No one would lose coverage just because they got sick. There would be no paperwork, no gaps in coverage, no worrying about high medical bills, and no haggling with private insurance companies over whether a procedure is covered. Employers would no longer have to worry about high insurance company premiums. Under H.R. 1300, employers would pay a simple 7.5 percent of payroll for health care compared to the average 12 percent in 1989.

I'm tired of the inside the beltway mentality which says that single-payer is the best system, but it's not politically feasible. Single-payer is the ONLY politically feasible option because it's the only plan that benefits all Americans. This bill isn't about raising taxes, it's about giving people more services for less than they spend now on insurance company premiums. H.R. 1300 would cover everyone for comprehensive benefits and 95 percent of Americans would pay LESS than they spend now on health care. All other health reform plans would cost Americans more money and give less benefits. The widespread support behind this bill, including the fact that 69 percent of Americans say they want single-payer, 60 percent of conservatives, testifies that this is what the public wants.

This nation can't afford to do anything less than single-payer. According to the General Accounting Office, the only way we will ever slow health care inflation in the United States is through comprehensive reform. And, as the Congressional Budget Office has testified before this committee, single-payer is the only system that can provide high-quality care to all Americans for less than we currently spend on health. No other health care proposal can make this claim. Single-payer is not only the best system, but it's the only politically feasible plan around.

I would be happy to answer to answer any questions you have.

The Russo Bill
Highlights

Major Provisions

- ***Universal access to health care*** through a single, publicly-administered program.
- ***Comprehensive benefits for all Americans***, including hospital and physician care, dental services, long-term care, prescription drugs, mental health services, and preventive care.
- ***No financial obstacles to care*** -- no cost-sharing, no deductibles, no copayments.
- ***Freedom of choice*** so that everyone can choose their own physician or source of care.
- ***Cost savings*** through annual budgets and a national fee schedule so that health dollars are spent efficiently and effectively.
- ***Progressive financing*** to make health care affordable for all.
- ***Quality*** measures to improve the type of medical care we receive.
- ***Uniform federal standards*** to guarantee that all Americans receive full access to comprehensive, quality care coupled with state administration so that implementation decisions reflect local needs.

Major Benefits

- People get the health care they need, rather than the health care they can afford or their insurance company is willing to pay for.
- The nation saves $40 billion in health care costs (and those savings grow over time) by substituting a single, publicly-administered and publicly-accountable program for the more than 1500 private insurance plans now in place. A single plan gets rid of paperwork, marketing and advertising, and other costs caused by the insurance industry.
- Senior citizens save $33 billion -- one-third of their current health costs -- and get long-term care, prescription drug, preventive and other new benefits.
- The non-elderly save $25 billion and won't have to worry about rising insurance premiums, cost-shifting, paying for children's health [illegible], or losing health coverage if they change jobs.
- Businesses that provide health care benefits to their workers lower their costs, can compete more fairly in the world market, and have more funds available to improve their operations and create jobs.
- State and local governments save $7 billion and no longer face the devastating budget impacts of unexpected and skyrocketing health care costs.
- Physicians, nurses and other providers spend more time caring for patients instead of filling out insurance forms and justifying their medical judgments to insurance company bureaucrats.

Health Care Spending Goals By Sector
1989, Russo Bill ($ Billion)

Sector	Current	Russo Bill	Change	Notes
Business	**$178**	**$199**	**+$23**	
Employee Health Insurance	$129	$0	-$129	Eliminated
HI Payroll Taxes (Employer Share)	$31	$169	+$138	Increase by 6 percentage points; no wage cap
Workers Comp (Medical Costs Only)	$14	$0	-$14	Eliminated
In-plant Health Services	$2	$2	$0	Retained
Corporate Income Tax Increase	$0	$27	+$27	Top rate up from 34% to 38% for businesses with more than $75,000 profits; $15 billion in reforms
Non-Elderly	**$135**	**$111**	**-$25**	
Out of Pocket Payments	$71	$28	-$43	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
HI Taxes (Employee Share)	$37	$38	+$1	Current 1.45% tax retained, extended to all workers
Private Insurance for Covered Services	$28	$0	-$28	Eliminated
Personal Income Tax Increase	$0	$45	+$45	New 15%-30%-34%-38% rates; $8 billion in reform
Elderly	**$84**	**$51**	**-$33**	
Out of Pocket Payments	$54	$15	-$39	No out of pocket for covered services (including long term care); items like over the counter drugs not covered.
Private Insurance for Covered Services	$18	$0	-$18	Eliminated
Medicare Part B Premiums	$11	$18	+6	New long term care/health premium equal to Part B premium plus $25/month for those above 120% of poverty
Added Tax on Benefits	$0	$6	+$6	Part of Social Security benefits included as taxable income; includes low income protection
Personal Income Tax Increase	$0	$12	+$12	New 15%-30%-34%-38% rates; $6 billion in reforms
State and Local Government	**$83**	**$76**	**-$7**	
Medicaid & Other Public Programs	$62	$54	-$8	Maintain 85% of Medicaid effort; $85 per capita fee; maintenance of noncovered services
Employee Health Insurance	$17	$0	-$17	Eliminated
HI Taxes (Employer Share)	$4	$22	+$18	All workers covered; rate up 6 pct. points; no wage cap
Other Private (Charity etc)	**$16**	**$16**	**$0**	
Federal Government	**$96**	**$96**	**$0**	
Health Programs (Net)	$88	$96	+$8	Maintain current effort, including employee health costs
Employee Health Insurance	$8	$0	-$8	Eliminated
Total Health Spending	**$589**	**$549**	**-$40**	

The Russo Bill
Impact on Businesses that Now Provide Health Insurance

Major Provisions

- Replaces current employment/private insurance system with publicly-administered program.
- Replaces current business costs of providing employee health care -- including health insurance premiums for current workers and retirees, self-insurance costs, and workers compensation -- with a 7.5 percent payroll tax and an increase of 4 percentage points in the corporate income tax rate on the most profitable firms.

Major Benefits

- Eliminates competitive disadvantages -- domestic and international -- faced by companies providing health coverage for their employees.
- Allows businesses to hire whomever they want -- without worrying that hiring an older person or someone with a preexisting condition will raise insurance costs
- By controlling runaway medical inflation, eliminating waste and requiring that all businesses contribute their fair share, businesses now providing health benefits will save money, allowing them to improve their operations and expand job opportunities. (Currently, over 90% of after-tax profits are spent on health benefits, up from 74% in 1984 and 14% in 1965).

Average Health Benefit Costs and Savings as a Percent of Payroll for Companies Currently Providing Health Benefits, 1989

Industry	1989 Payroll Costs	Payroll Cost Savings	Industry	1989 Payroll Costs	Payroll Cost Savings
Total All Industries	11.6	4.1	Machinery	7.4	-0.1
Total, All Manufacturing	12.1	4.6	Elect. Mach., Equip & Supplies	11.2	3.7
Food, Beverages and Tobacco	9.1	1.8	Transportation Equipment	13.7	6.2
Textile Products and Apparel	9.4	1.9	Instruments and Misc	11.0	3.5
Pulp, Paper, Lumber, & Furn.	10.4	2.9	**Total all Non-manufacturing**	11.3	3.8
Printing and Publishing	8.0	0.5	Public Utilities	13.7	6.2
Chemicals and Allied Products	14.8	7.3	Department Stores	7.0	-0.5
Petroleum Industry	10.3	2.8	Trade (Wholes. & other Retail)	12.9	5.4
Rubber, Leather and Plastic	15.7	8.2	Banks, Finance, etc	7.7	0.2
Stone, Glass and Clay Products	10.6	3.1	Insurance	10.0	2.5
Primary Metal Industry	14.4	6.9	Hospitals	10.1	2.6
Fabricated Metal Products	19.3	11.8	Misc Nonmfg Industry	10.0	2.5

NOTE: Calculations based on 1989 survey of approximately 1,000 companies by U.S. Chamber Research Center, Employee Benefits, 1990 Edition. Includes employer HI tax liability and medical component of workers' compensation, but not corporate income tax liability data, for which data was not available.

The Russo Bill
Impact on a Family of Four

Major Provisions

- Provides families with full access to comprehensive medical care -- including preventive care, prescription drugs, and long-term care -- at the physician, hospital or provider of their choice.
- Prohibits deductibles and copayments for covered services.
- Eliminates private health insurance and out-of-pocket costs for covered services, retains the current 1.45% HI payroll tax, and increases personal income tax on top brackets

Major Benefits

- Non-elderly families and individuals save $25 billion in insurance and out-of-pocket costs.
- All families are guaranteed full health care, including annual checkups, dental care, immunizations and prescription drugs.
- Coverage cannot be lost or reduced because of changes in employment or health status.
- Families will no longer have to rely on private insurance companies to provide affordable coverage and approve their claims or face the threat of financial disaster if someone gets sick -- all costs are fully covered by the national health plan.

Changes in Personal Income Taxes and Average Health Care Savings for a Family of Four, 1990 Income Levels

Income Level	Personal Income Tax Increase	Average Out-of-Pocket Health Care Savings
Lowest 20 percent (Average income = $12,800)	$0	$930
Second 20 percent (Average income = $27,400)	$0	$1,440
Third 20 percent (Average income = $39,200)	$0	$1,590
Fourth 20 Percent (Average income = $54,000)	$50	$1,750
Next 15 percent (Average income = $81,600)	$460	$2,020
Next 5 percent (Average income = $273,100)	$12,290	$2,620

Note: These figures are for no-elderly families of four. Current health care costs covered by plan include covered out of pocket expenses (including insurance). Tax figures assume no special break for capital gains (treated as regular income) and additional personal income tax reforms affecting high income families.

The Russo Bill
Impact on Senior Citizens

Major Provisions

- Provides comprehensive coverage, including long-term care, home care, prescription drugs, and preventive services not now covered by Medicare. There are no copyaments or deductibles.
- Senior citizens contribute to the National Health Trust Fund through a monthly long-term care/health premium (equal to Part B premium plus $25/month), an increased personal income tax on those in the top income brackets, and a provision to increase the portion of Social Security benefits included as taxable income.
- Senior citizens with incomes below 120% of poverty do not pay the monthly premium and are not affected by the Social Security or personal income tax changes.

Major Benefits

- Saves senior citizens $33 billion in current health care costs.
- Eliminates out-of-pocket costs and balance billing for covered services; gets rid of Medicare deductibles and cost-sharing.
- Protects those now facing cutbacks in coverage and/or increased cost-sharing as businesses reduce retiree benefits.
- Protects retirees from losing health care benefits if their firm goes bankrupt.
- Eliminates the need for Medigap insurance.

Average Net Savings from Russo Bill
For Senior Citizens Not on Medicaid

	Single Households		Married Couples	
	Median Income	Net Savings	Median Income	Net Savings
Lowest Fifth	$5,370	$1,120	$11,958	$2,161
Second Fifth	$10,548	$1,131	$26,238	$2,159
Middle Fifth	$13,520	$1,424	$39,631	$2,165
Fourth Fifth	$22,843	$1,717	$55,603	$2,518
Highest Fifth	$62,801	$1,086	$133,414	$2,878

Note: Net savings are based on a comparison of average household spending for taxes, Medicare premiums, and out-of-pocket expenses.

The Washington Post

TUESDAY, SEPTEMBER 10, 1991

Marty Russo

Health Care: There Is a Plan That Works

Everyone agrees that this country needs to reform its health care system. Everyone also agrees that this reform should guarantee high-quality health care to all Americans without increasing current health care spending. Only a single-payer health care system can expand health care to every American while saving billions of dollars without causing rationing and without requiring cost sharing.

A single-payer system simply replaces the multitude of public and private health insurance programs now in place with a single, publicly financed plan that covers all Americans. Because there is only one plan and only one payer, money is no longer wasted on determining who is eligible for benefits, or on billing 1,500 insurance agencies and millions of consumers or on advertising, marketing and commissions. According to the General Accounting Office, the United States would save more than $67 billion a year in administrative costs alone under a single-payer system. This means we could provide health care to the uninsured, improve coverage for the insured, and eliminate co-payments and deductibles for everyone. And Americans would still be free to choose their own doctor, hospital or health care provider.

The most common misconception about a single-payer system is that it would lead to rationing. This view ignores our well-documented overcapacity in technology, equipment and physicians. Charles Bowsher, the comptroller general, and other experts have testified that this overcapacity would prevent health care rationing under a single-payer system, especially in the first 20 years. The high level of funding that created this overcapacity, 11.5 percent of GNP in 1989, would be maintained. Since a single-payer system requires budgeting, however, health care dollars would be allocated more efficiently, so that quality of care would be improved.

Critics cite waiting lines in Canada, which they say are caused by the Canadian single-payer system. In fact, Canada has few waiting lines; the Canadians never have to wait for emergency care. Waiting lines exist primarily for specialized high-tech procedures, such as heart bypass surgery. It's true that the United States provides more of these procedures than Canada, but it's unclear that our citizens are any healthier as a result. The Rand Corp. found that 40 percent of heart bypass operations performed in the United States were unnecessary. This means many Americans paid for an expensive procedure and were exposed to serious risks, yet received no health benefit.

Those who focus on rationing in Canada tend to ignore the rationing Americans face daily from their insurance companies. Unable to control runaway medical inflation, insurance companies protect their profit margins through rationing. Their tactics include denying care, even when prescribed by a physician, increasing cost sharing and refusing to cover preexisting conditions. The high co-payments and deductibles force hard-working families to wait months before they can afford to go to the doctor, while skyrocketing insurance company premiums are pricing more and more Americans out of the health care system. Americans dependent on private health insurance are only an illness or a job away from losing coverage. In 1990, more than 37 million Americans had no health insurance, and millions more were underinsured. Canadians, on the other hand, never worry about whether their medical bills will be covered or about losing their coverage when they get sick.

The truth is, Canada's health care system is more efficient than ours. Canada spends 40 percent less per person on health care than the United States, yet Canadians visit their physicians more often than people do in the United States. Furthermore, nearly all expectant mothers in Canada receive prenatal care. In the United States, only 76 percent of women who had live births in 1988 received prenatal care starting in the first trimester. As examples from other countries show, single-payer increases the quality of health care by promoting preventive care and the appropriate u of expensive high-tech procedures.

Critics of single-payer say the plan would or work if it imposed high cost-sharing to preve consumers from over-utilizing the system and dr ing up costs. But the United States already has t highest level of cost-sharing among all industrializ nations, yet it is the only country that has be completely unable to control costs. As the Congr sional Budget Office explains, cost-sharing is re tively ineffective at controlling costs because co sumers lack the medical knowledge abo alternative treatments and their efficacy and the fore will follow their doctor's recommendatio Cost sharing is inappropriate and unnecessary control costs under a single-payer system.

Polls show that Americans support a univers single-payer health plan more now than ever b fore. A recent Wall Street Journal/NBC News p found that 69 percent of voters support a sing payer health plan similar to Canada's. I ha introduced a single-payer bill in Congress, H. 1300, the Universal Health Care Act of 19 which already boasts more cosponsors and endors ments from outside organizations than any oth health reform bill in Congress.

We can't afford to do anything less than sing payer. According to the General Accounting Offi the only way we will ever slow health care inflati in the United States is through comprehensi reform. And, as the Congressional Budget Offi has testified before the Ways and Means Comm tee, single-payer is the only system that can provi high-quality care to all Americans for less than w currently spend on health. No other health ca proposal—neither mandated benefits or pay-c play—can make this claim. Single-payer is the be solution to our nation's health care crisis.

The writer is a Democratic representative fro Illinois and vice chairman of the Ways and Means subcommittee on health.

REPRESENTATIVE SCHEUER. Thank you very much, Mr. RUSSO.

Next we have the Honorable Henry A. Waxman from California in his ninth term, Chairman of the Subcommittee on Health and Environment of the Committee on Energy and Commerce. Congressman Waxman is the sponsor of a major health-care reform bill that puts forth the recommendations of the Pepper Commission, H.R. 2535, the Pepper Commission Health Care Access and Reform Act of 1991.

Henry, please proceed.

STATEMENT OF THE HONORABLE HENRY A. WAXMAN REPRESENTATIVE FROM CALIFORNIA

REPRESENTATIVE WAXMAN. Thank you very much, Mr. Chairman. I am pleased to appear before you today to discuss one of the most urgent issues facing our nation: health-care reform. I think that we can all agree that our current system is a disgrace. Health-care costs continue to rise more than twice the rate of inflation, pricing care beyond the reach of millions of Americans. Small employers find it increasingly difficult to provide health benefits and remain competitive, or even stay in business. Millions of Americans have no health benefits. Millions more risk losing what they have if they have a serious illness or change jobs. Medicaid covers less than half of all Americans living in poverty and is at risk for deeper cuts as our economy continues to stagnate.

Certainly, by any measure, we're facing a serious crisis. Only the Bush Administration doesn't seem to see the urgency of these problems. Health-care reform just isn't a high priority at the White House where they are too busy telling states how they can spend their own taxes; too busy keeping doctors from giving their best advice under gag rules to patients in public clinics; too busy cutting Medicare physician fees; and too busy outlining politically correct research projects. After almost three years of this Adminstration, we still have no clue as to what they're for other than personal responsibility and less malpractice litigation.

In my judgment, our health financing system is on a self-destructive path. Its structural problems are not self-correcting. If nothing is done, things will just get worse, and the cost of reform will be even greater. Fortunately, Mr. Chairman, many of our colleagues in Congress have seen the need to act. A number of thoughtful and comprehensive reform proposals have been introduced in the House, measures calling for a single public-payer program and bills—like my own—that build on our private employment-based system and that are under consideration.

My Committee, along with the Ways and Means, Education, and Labor Committees, are working with the House Democratic leadership to develop a reform package that incorporates the strengths of these approaches. I've been asked to outline the Pepper Commission recommendations which I've introduced in H.R. 2535. Under our bill, Americans would be covered for basic health benefits in one of three ways: through private plans provided by employers; through a new Medicare-like public

program; or, in the case of the elderly and disabled, through Medicare itself.

More than 150 million Americans currently have basic health benefits through their jobs. Our bill would build on this model by assuring that employees and their dependents have access to basic health-care coverage through their jobs. Employers would have a choice—purchase the coverage through a qualified private plan, or enroll their workers and dependents in the new public program for a premium set at a fixed percent of their payroll. Reforms in the private-health insurance market would include prohibitions against excluding or cancelling coverage on the basis of individual health status and requirements for community rating of insurance premiums. For Americans outside the work force, including those eligible for Medicaid, basic benefits would be provided through enrollment in the new public plan. Unlike Medicaid, the public plan would be administered by the Federal Government, using private intermediaries to process claims. It would not be tied to the welfare system.

To control private and public health-care spending, our bill does several things. First, it creates incentives for individuals to be cost conscious by requiring annual deductibles and co-insurance on basic health services, except for preventive, prenatal and well-child care. Low-income persons will be provided assistance in meeting these cost-sharing obligations.

Second, the bill gives employers and other private purchasers of services the option to use public-plan rates in paying for coverage of basic benefits. These payment rates will be based on current Medicare principles for hospitals and physician services.

Finally, the bill increases incentives for the use of managed care, preempts state mandated benefits, and expands efforts to develop and use clinical practice guidelines. In order to meet the requirements of last year's budget agreement, the bill would have to be financed on a pay-as-you-go basis. We would propose additional funding beyond that which is provided by employer and worker's premiums be based on a progressive tax, and we would recommend a surtax on personal and corporate income-tax liability.

I recognize that there are other potential revenue sources to support this new public program. In my view, the important point is that funding for this program must be broad-based and progressive in its incidence and must avoid the chronic underfunding that has plagued the Medicaid program.

Mr. Chairman, I recognize that health-care reform is an ambitious and controversial undertaking. Other members have sponsored bills that have much to recommend them. I have chosen this course because I believe that we should not disrupt existing private plans that are providing good health-benefit protection. I also believe that it is possible to achieve many of the efficiencies associated with single-payer models—simplified billing and payment forms and consolidated claims' administration—in a plan that permits multiple private plans.

In closing, let me make four summary points. First, our health financing system in this country is fundamentally flawed. It is broken and needs to be fixed. Doing nothing won't solve the problem. Instead, costs will continue to climb, and more Americans will become uninsured or underinsured.

Second, the longer we wait to begin to solve the problem, the more expensive the solution will be. Health-care costs are projected to grow at least 12 percent per year over the next few years. At this rate, a basic package of services will cost Americans 57 percent more in 1995 than it would cost today and 140 percent more in the year 2000.

Third, even with effective cost controls, health-care reform will not be budget neutral. No one disputes that there are substantial savings to be had from eliminating inappropriate care and reducing administrative overhead and other system reforms. But these savings will not be sufficient to supply all of the additional resources needed to assure that all Americans have coverage for basic health services. The numbers of uninsured and underinsured Americans are simply too large.

My final point is that if we are serious about giving all Americans coverage for basic health benefits, we must fashion a plan that incorporates effective cost containment for all purchasers, minimum standards for private benefit plans, a strong public plan, and maximum consolidation of administrative functions. After we've accomplished these reforms, we can consider whether it would be desirable to phase out private health-benefit plans.

The road we must avoid is the one that looks to each state to develop its own solution for paying for basic health services. The Medicaid program teaches us that state revenue growth cannot over time keep pace with the cost of providing basic health services. If states are given a major role in financing health services, the inevitable outcome will be limits on benefits, inadequate payment rates, and reduced eligibility.

I believe that all Americans, whether they live in California, New York, Illinois, or Texas, should be entitled to coverage for basic health services. I look forward to working with you and other members of this Committee to design and fund a program that will achieve this goal as soon as possible.

Thank you very much.

[The prepared statement of The Honorable Mr. Waxman follows:]

PREPARED STATEMENT OF THE HONORABLE HENRY A WAXMAN

Mr. Chairman and Members of the Subcommittee, I am pleased to appear before you today to discuss one of the most urgent issues facing our nation: health-care reform.

The Need for Comprehensive Reform

I think that we can all agree that our current system is a disgrace.

-- Health-care costs continue to rise more than twice the rate of inflation, pricing care beyond the reach of millions of Americans.

-- Small employers find it increasingly difficult to provide health benefits and remain competitive, or even stay in business.

-- Millions of Americans have no health benefits. Millions more risk losing what they have if they have a serious illness or change jobs.

-- Medicaid covers less than half of all Americans living in poverty and is at risk for deeper cuts as our economy continues to stagnate.

The Administration

Certainly, by any measure, we're facing a serious crisis. Only the Bush Administration doesn't seem to see the urgency of these problems.

Health-care reform just isn't a high priority at the White House, where they are are:

-- too busy telling states how they can spend their own taxes,

-- too busy keeping doctors from giving their best advice under gag rules to patients in public clinics,

-- too busy cutting Medicare physician fees; and

-- too busy outlining politically correct research projects.

After almost three years of this Adminstration, we still have no clue as to what they're for other than personal responsibility and less malpractice litigation.

In my judgment, our health financing system is on a self-destructive path. Its structural problems are not self-correcting. If nothing is done, things will just get worse, and the cost of reform will be even higher.

The Route to Reform

Fortunately, Mr. Chairman, many of our colleagues in Congress have seen the need to act. A number of thoughtful and comprehensive reform proposals have been introduced. In the House, measures calling for a single public-payer program and bills -- like my own -- that build on our private employment-based system and that are under consideration. My Committee, along with the Ways and Means, Education, and Labor Committees, is working with the House Democratic leadership to develop a reform package that incorporates the strengths of these approaches.

I've been asked to outline the Pepper Commission recommendations which I've introduced -- H.R. 2535 -- in June of this year.

Under our bill, Americans would be covered for basic health benefits in one of three ways:

-- through private plans provided by employers;

-- through a new Medicare-like public program; or

-- in the case of the elderly and disabled, through Medicare.

More than 150 million Americans currently have basic health benefits through their jobs. My bill would build on this model by assuring that employees and their dependents have access to basic health-care coverage through their jobs. Employers would have a choice: purchase the coverage through a qualified private plan, or enroll their workers and dependents in the new public program for a premium set at a fixed percent of their payroll.

Reforms in the private-health insurance market would include prohibitions against excluding or cancelling coverage on the basis of individual health status and requirements for community rating of insurance premiums.

For Americans outside the work force -- including those eligible for Medicaid -- basic benefits would be provided through enrollment in the new public plan. Unlike Medicaid, the public plan would be administered by the Federal Government, using private intermediaries to process claims. It would not be tied to the welfare system.

To control private and public health-care spending, our bill does several things.

First, it creates incentives for individuals to be cost conscious by requiring annual deductibles and co-insurance on basic health services, except for preventive, prenatal and well-child care. Low-income persons will be provided assistance in meeting these cost-sharing obligations.

Second, the bill gives employers and other private purchasers of services the option to use public-plan rates in paying for coverage of basic benefits. These payment rates will be based on current Medicare principles for hospitals and physician services.

Finally, the bill increases incentives for the use of managed care, preempts state mandated benefits, and expands efforts to develop and use clinical practice guidelines.

In order to meet the requirements of last year's budget agreement, the bill would have to be financed on a pay-as-you-go basis. We would propose additional funding beyond that which is provided by employer and worker's premiums be based on a progressive tax, and we would recommend a surtax on personal and corporate income-tax liability.

I recognize that there are other potential revenue sources to support this new public program. In my view, the important point is that funding for this program must be broad-based and progressive in its incidence and must avoid the chronic underfunding that has plagued the Medicaid program.

Concluding Observations

Mr. Chairman, I recognize that health-care reform is an ambitious and controversial undertaking. Other members have sponsored bills that have much to recommend them. I have chosen this course because I believe that we should not disrupt existing private plans that are providing good health-benefit protection. I also believe that it is possible to achieve many of the efficiencies associated with single-payer models -- simplified billing and payment forms and consolidated claims' administration -- in a plan that permits multiple private plans.

In closing, let me make four summary points.

First, our health financing system in this country is fundamentally flawed. It is broken and needs to be fixed. Doing nothing won't solve the problem. Instead, costs will continue to climb, and more Americans will become uninsured or underinsured.

Second, the longer we wait to begin to solve the problem, the more expensive the solution will be. Health-care costs are projected to grow at least 12 percent per year over the next few years. At this rate, a basic package of services will cost Americans 57 percent more in 1995 than it would cost today and 140 percent more in the year 2000.

Third, even with effective cost controls, health-care reform will not be budget neutral. No one disputes that there are substantial savings to be had from eliminating inappropriate care and reducing administrative overhead and other system reforms. But these savings will not be sufficient to supply all of the additional resources needed to assure that all Americans have coverage for basic health services. The numbers of uninsured and underinsured Americans are simply too large.

My final point is that if we are serious about giving all Americans coverage for basic health benefits, we must fashion a plan that incorporates effective cost containment for all purchasers, minimum standards for private benefit plans, a strong public plan, and maximum consolidation of administrative functions. After we've accomplished these reforms, we can consider whether it would be desirable to phase out private health-benefit plans.

The road we must avoid is the one that looks to each state to develop its own solution for paying for basic health services. The Medicaid program teaches us that state revenue growth cannot over time keep pace with the cost of providing basic health services. If states are given a major role in financing health services, the inevitable outcome will be limits on benefits, inadequate payment rates, and reduced eligibility.

I believe all Americans, whether they live in California, New York, Illinois, or Texas, should be entitled to coverage for basic health services.

I look forward to working with you and other members of this Committee to design and fund a program that will achieve this goal as soon as possible.

REPRESENTATIVE SCHEUER. Thank you very much.

I'd like to welcome Hamilton Fish, a distinguished member of the Joint Economic Committee. I am going to turn over the questioning to Olympia Snowe. But I first want to add just a paragraph or two to emphasize, outline, and symbolize the absolutely shameful level of health care that we give many Americans.

The United States, in terms of health results, ranks poorly compared to not only the developed world, but also compared to the developing world. We rank 18th in life expectancy, 22nd in infant mortality, and 26th in low-birth weight children; children who, because of their low-birth weight condition, are vulnerable to all kinds of ailments, mental and physical disabilities that plague them through life.

In New York State, 56 percent of our State's preschoolers get preventive innoculations, compared to 70 percent of Mexicans; 76 percent of El Salvadorians; 77 percent of Ugandans; and 89 percent of Algerians. That has to be a subject of national shame for us to be not only below developed country standards, but below many developing countries in the kind of care that is given to kids.

I'd like to recognize Olympia Snowe.

REPRESENTATIVE SNOWE. Thank you, Mr. Chairman. I thank all of you for your statements.

Obviously, you represent a multitude of approaches to a very significant problem that I think we all agree on, whether we're Republicans or Democrats. And I think the most contentious part of it is how we're going to finance it. But I think more importantly is how we're going to provide a system that meets all the concerns of all Americans and, at the same time, is something that we know is the best approach to take. I know Marty offered the single-payer approach as a way, as well, of reducing costs, but on the other hand, Henry, you mentioned the fact that you don't believe that we're going to be able to reduce health-care costs even through effective controls. Do you think that the single-payer system will work in terms of reducing costs?

REPRESENTATIVE WAXMAN. There is no question that a single-payer system would reduce costs. It would probably be the most effective way to reduce costs, but it's not the only way to reduce health-care costs.

What we proposed is that even if there are a number of payers, which would include private insurance, to change private insurance from what we now have, where private insurers seek to avoid insuring people that may get sick, but require them to cover people, require them to market on a community-based rate, then, even with multiple payers, we can get a number of these reforms in place that will help us hold down health-care costs. And that has to be an important goal in any reform.

REPRESENTATIVE RUSSO. If I may just comment. There is no question that there are ways of cutting costs. But what can guarantee the minimum amount of costs for the maximum amount of benefits? Both the General Accounting Office and the Congressional Budget Office have said that the provisions in my single-payer bill is the way to go to contain costs. When

you have national and state budgets, when you have global budgets for hospitals, when you have national expenditure cards and fee schedules for providers, you are going to contain costs. But at the same time, because you have a single-payer system, you are going to be able to give the high-quality care to all Americans for less money because you won't have a multipayer system. You will have no need for the amount of paperwork that you would have in any other system other than single-payer.

And Henry is right. It is the most efficient; it is the most effective. There are other ways of doing it, but there are none that does it better. So, my attitude is, if we have the best plan available, why settle for something less than the best plan?

REPRESENTATIVE SNOWE. Would the Federal Government be writing the insurance policies?

REPRESENTATIVE RUSSO. No. The Federal Government would not be running anything other than paying the check every month to the doctors and hospitals. What the Federal Government would be doing is setting up the national program that's comprehensive in nature. The only thing that would not be covered under the Russo bill would be plastic surgery that is not medically necessary, private beds that are not medically necessary. So, you're talking about all other medical services, long-term care for everybody in this country, mental health services, prescription drugs, and vision and dental care. We can cover all of that because we save so much by cutting administrative costs. You can give the best comprehensive care to all Americans for less money than we spend today. Every other plan will cost more money than we currently spend.

REPRESENTATIVE SNOWE. But we've never really done that in the Federal Government. About as close as we've come to it is in Medicare.

REPRESENTATIVE RUSSO. Like Medicare, you bet your bottom dollar they want more benefits, sure they do. So, basically when you look at Sam's approach and Pete's approach, they're building on a single-payer system that everybody loves. People love Medicare. Those who are on Medicare love it because they know that when they're sick it's there. All I'm doing is taking Medicare one step further. I am saying, why shouldn't every American get it, and get it with no deductibles and no co-pays. Once you eliminate the insurance industry's waste, that money goes back into the system, and then you give comprehensive care to all Americans.

REPRESENTATIVE SCHEUER. If my colleague will yield, aren't you endorsing Sam Gibbons' bill, which is simply to expand Medicare?

REPRESENTATIVE RUSSO. Mr. Chairman, I would prefer my bill, obviously.

[Laughter.]

It goes the farthest, but I support the concept of single-payer. And so, if I had to get it in stages, I would prefer Sam and Pete's over anything else because it sets in place single-payer. It is just a matter of moving and eliminating deductibles and co-payments, and covering more things. That is all. There won't be any eligiblity requirements under the Russo bill because everyone would be eligible to receive it.

REPRESENTATIVE STARK. There is excellent evidence that what Henry suggests does work. The State of Maryland has basically an all-payer system for its hospitals.

REPRESENTATIVE SCHEUER. Would you describe that?

REPRESENTATIVE STARK. They have a commission in Maryland that gets together and sets a rate, basically for each hospital in a community. Then, whoever you are, you pay that same rate, whether it's Blue Cross, Medicare, or Medicaid. A private person who's paying out of their pocket—all payers, in a sense—pays the same amount. And there's a bargaining process, and there's risk and reward if hospitals will merge to save overhead. It's a very complex system of negotiating a fixed set of rates.

What it does not do and what is basically at the heart of our country's problem—of all the industrialized nations of the world, we are unique in this—is that we have no budget. We are a supply-driven medical system. That is to say, even though we write a budget for Medicare or Medicaid each year, we have no cap. We say to the doctor, you get $10 a picture for an X-ray. You can take ten million pictures, and we will pay for them. We have gotten very good at estimating what that will be, but we have no lid. We don't bargain. We don't bargain the way you bargain in Maine for your school budgets, or the way you bargain for the police budget, or the way we bargain for the Defense Department's budget. We just say, we set rates, and then we pay whatever the system provides. And I am not accusing anybody. I am just saying that we don't have any system for saying, spend $700 billion in this country on all medical care—public and private. What if we just said, guys, all we are going to spend next year is $700 billion. In a sense, that's what Marty is saying, and put everybody in the system. There is only another 30-40 million people uncovered. You have a couple of hundred million dollars in there already, so just spread the uninsured in. Spread the frosting out to the edges of the cake. It may be a little thinner in the middle, but you could get there with an all-payer system. But then the private insurance companies, which the bills that are incremental suggest we continue with, would want us to set the rates. Otherwise, the private insurance companies couldn't exist. You have to get some control and some uniformity of rates, whether it's all-payer or single-payer.

If we want cost control and if we want access, the private companies can't do it as inexpensively as the Federal Government, only because of the issue of overhead and profit, and because we absorb some of the Health and Human Services overhead in our budget. The political issue still comes out: How do people perceive what they're going to pay? They are still going to pay it one way or another. The company is going to pay or the individuals will pay for health insurance on their income tax, and that's why we are all on dead center. We are all looking for ways to pay for it. The Pepper Commission asked, how do you pay for it? We still don't know.

REPRESENTATIVE RUSSO. Will the gentleman yield?

REPRESENTATIVE STARK. Certainly.

REPRESENTATIVE RUSSO. There is no question, no matter what poll you look at, 90 percent of Americans don't like the current system. They want fundamental change. The question then is, do you build on a system that is in a shambles, that is a disgrace, or do you scrap it? And some of the things in pay-or-play build on the current system which the American public has already repudiated.

I think that if you take the current system with all of its gaps and paperwork you have to perform, and the coverage that it doesn't give, and the people it alienates, and the people it leaves out of coverage, and you put it in bill form in the Congress, it wouldn't get one vote. So, if it's that bad then, we have to come up with a system that scraps that. So, my objection to pay or play—and I have great respect for Henry on this—is that it tends to keep those groups involved that have created a lot of the problem, and it basically is all the administrative burdens that we have to go through. Doctors want to be doctors. They want to spend time with their patients. They don't want to be billing clerks and bill collectors. And hospitals need to deliver care, not try to figure out how to balance their budget by the end of the year.

When you look at the amount of people that work in a big hospital in Canada, they have only 2 or 3 people in their billing department. The same comparable hospital in the United States takes 300 people. You understand the problem. So, when you can walk in with a little card and say, this is my health card, take care of me, they get taken care of. They don't wait for acute care. They don't have to wait and go to the emergency room because they are worried about deductibes and co-pays, and all of this idea that deductibles and co-pays are a means of containing costs just isn't true. In the real world, in the industrialized countries that we compete with who have single-payer, they have very low co-payments and very low deductibles. And all of them, every one of them, spend less on health care than we do. We have the highest co-pays and deductibles in the world, and we are still the most expensive system in the world.

REPRESENTATIVE SNOWE. Isn't it true, though, with the Canadian system, there are a lot of waits?

REPRESENTATIVE RUSSO. That's not true. The bottom line is that those myths have been destroyed when people look and analyze exactly what happens. They had a problem with some high-tech coronary bypass problems, which they have corrected and which were more a matter of management rather than procedure. Nobody in Canada waits for acute care. Nobody in Canada waits for preventive care. Nobody in Canada waits for the doctors. Now, there are a lot of stories going around that talk about the Canadian system, but let me tell you that I don't want to build a Canadian system. I think one of the problems with the Canadian system is that they want to rachet down health-care costs. That creates problems. The Canadians haven't had problems for 20 years, and they haven't had real waiting lines. But now the system is beginning to get tighter for them. Here's what happens. What happens under my bill is, I don't cut spending, I keep it at the same level of GNP, as on the date of

enactment. The General Accounting Office said, as a result of that 11½ percent of GNP that we have been spending over the last several years, we have an enormous overcapacity of physicians, and hospital beds, and equipment, and technology; so, we will not face waiting lines for at least 20 years, if ever. If we keep it at the current GNP, you won't even have waiting lines because, right now, it's 12½ percent of GNP. The Canadians are 8.7 percent. If we keep it at 12½ percent, there isn't going to be waiting lines. So, this myth, this story, that is always being told about rationing—which is the boogyman who is supposed to scare people from getting national health care that is good for every American—doesn't exist, but it ain't true. The facts don't support it. When you don't have the facts, you argue the law. When you don't have the law, argue the facts. No, even in the case of elective surgery, there are no waiting lines in Canada.

There are waiting lines for elective surgery, but who makes the decision. Is it the doctor or an insurance company, or do you have to get a second, third, fourth, or fifth opinion. The answer is, the doctor makes the decision. But again, if you are talking about 8.7 percent, now we're talking a different ballgame. Then, I would say that you would have waiting lines in the United States. The answer is, it is not going to happen in the United States because we are going to do it at 12 percent of GNP, which is 4 percentage points higher than Canada, which is 50 percent more. Even at that level, we won't have waiting lines. So, Americans aren't going to have to wait. All we are trying to do is say, with all of this overcapacity, let's put it to use, let's get Americans quality health care and spend less money.

REPRESENTATIVE SNOWE. Henry wanted to answer something.

REPRESENTATIVE WAXMAN. I just wanted to make a statement to you. I think we should avoid overpromising to the American people, because the health-care system is a lot more complex than what people would like to think, because it doesn't work like the other commodities and services in the economy. We do have a demand-driven system where the demand is created by the supplier of that service, and doctors are the ones we look to for these decisions.

In this country, we have a different orientation. We have a lot of specialists, and they provide higher priced care, more speciality care. In Canada, they emphasize more preventive care, keeping people well as a basis for their services. They do crunch down on the more highly priced technical kinds of services.

There is a wait in Canada. Now, they will argue that that wait is not unreasonable because some of those services are not needed immediately. Of course, the person who needs the service, who has to wait, may have a different point of view. I am afraid that if we overpromise we are going to be unfair to the American people. If we take a system and include 34 million people that are not now covered, and that system functions pretty much the way our health-care system functions now for those people who are insured, it is going to cost a lot of money. And I don't think we can

say that we're not going to have to pay any more money into that system. There can be savings, and I think single-payer achieves the savings far better than any other way. In fact, the best way to save dollars is the way they do it in Great Britain. Ask them what they do on cost-containment. They say, well, we just appropriate a certain amount, and that's all that goes into the system.

REPRESENTATIVE SCHEUER. If you're 55 years or older, you do not get kidney dialysis under the National Health Plan.

REPRESENTATIVE WAXMAN. If you only have a certain amount of money and that's it, then everybody can't get all the services he or she would seek, even if the doctor thought it was appropriate. So, some people are going to have to go without, some people are going to have to wait longer. I don't think we ought to kid ourselves about it, especially when we're going from a system in the United States that gives a premium to the higher priced services as opposed to the primary-care services. Eventually, we would like to change that, but it's not going to happen overnight. There could be a lot of disruptions. I am not arguing against moving in the direction of trying to bring rationality to our health-care system to cover everybody, but I just react a little hesitantly to the idea that anybody can have anything, and it is not going to cost anybody any more than what they now pay. I just don't think that's accurate. We are going to have to think through on how to be honest with people about how to get the kind of health-care system that would be most acceptable to this country.

What is not acceptable are the kinds of cost increases that we see now that are driving many people out of the ability to provide insurance or pay for insurance. What is not acceptable is to have so many uninsured. Those are the two big problems. And they both must be solved together. We can have differences of how to do it and how fast to do it, but those are the two problems we must solve.

REPRESENTATIVE KYL. Mr. Chairman, if I could respond briefly to Congresswoman Snowe's question. If enthusiasm would solve the problem, certainly, with Marty Russo's help, we could get it resolved, but I tend to think that the comments that Chairman Waxman just made are very, very important, and they do define the reality.

If I could just relate a little bit to some of the statistics that you quoted earlier, Mr. Chairman, because they do point out a very serious problem in this country—low-birth weight babies, infant mortality, and so on. There are specific causes for these problems that are quite unique to this country. The problem of crack babies, for example, relates directly to the low-birth weight. The problem of the homicides and other kinds of street crime in this country, which fill trauma centers every night in this country, contribute to those statistics.

The high technology that is demand driven, that Chairman Waxman talked about, does contribute to the cost of the services in this country. The tort system that I spoke of before, which is unique in the world, contributes significantly; twenty billion dollars, as I said, just on the

physician side of the equation. I was there. I was on the Government Operation Committee, as well, when Chuck Bowsher testified about the administrative savings from a single-payer-type system. He also qualified in several respects. He indicated that he did not know, for example, the impact of differences in the tort system.

REPRESENTATIVE SCHEUER. Congressman, we have a roll call vote that just went on.

REPRESENTATIVE KYL. If I could just make one final point.

REPRESENTATIVE RUSSO. I used a lot of his time.

REPRESENTATIVE KYL. I am sure we will continue this debate, but Marty made a point. He said that the Canadian system does want to ratchet down, and that says it all. Cost is becoming a factor there. Ultimately, when you try to have a system like this, you are going to have to constrain costs by reducing the amount of services. And I think that that is going to be unacceptable to the American people.

REPRESENTATIVE SCHEUER. Sam?

REPRESENTATIVE GIBBONS. I just want to say that we have a system. It is uniquely American. It works. People that are in it love it. There is no reason why we can't expand it to everyone. It would take care of the concern that everybody has about not being able to meet their health-care bills, and anything we start out trying to invent from new, we are going to take a long time to learn how the system works and everything else. We know how the Medicare system works. It works well. It has cost controls in it. It has access. It has transferability. It has got fairness in it. I don't want to have to reinvent a whole new system to go through that long tedious training period. You have all the people trained for Medicare.

REPRESENTATIVE SCHEUER. Are you aware of any criticism of the Medicare system that it's not an efficient and economical prompt payer?

REPRESENTATIVE GIBBONS. It needs some finetuning because it has to interface with a very bad system. For instance, a lot of time is spent in Medicare payment time to figure out whether Medicare pays the bill, or do the private insurance people pay the bill? There is an exorbitant amount of time spent.

Under my proposal, Medicare just pays all the bills. If there is any left over, either the patient pays it or the insurance company pays it, or it just doesn't get paid. We would get rid of all that. But any system that we come up with is going to require a lot of finetuning about how do you hire a doctor, how do you compensate a hospital, and what do you do about the other medical-care providers? Those are all finetuning questions. We can work them out. It will take a little while. But, you know, we start all over with a whole brand new system. We have 20 years of learning before we can make it work.

REPRESENTATIVE SCHEUER. Sam, over how long a period of time would you take to phase in all health services?

REPRESENTATIVE GIBBONS. If we enacted it this year, I'd put it into operation in two years. That would just give you time to go back and reappraise. You know, you are going to have to give up some private-

health insurance, or it would be desirable to give up some private-health insurance. We could probably put it in operation within a year. Two years would be an orderly amount of transition time from the current system to an all-Medicare system. Some private insurance would be preserved through union contracts, through desires for people to have extra coverage, as we do now in Medicare with Medigap insurance.

REPRESENTATIVE RUSSO. Mr. Chairman, I'd just like to respond to a couple of things. I don't think that we're overpromising on single-payer. I think what we're saying to the American people is that we believe health insurance and health care in this country is a right and not a privilege. If that's the case, how do we get it? It's not overpromising the money, is there? It's not a question of spending more money. We are spending almost $800 billion a year, and I'm saying that for the $800 billion a year why don't we put in a system that covers all Americans? It is not overpromising. That is another one of those statements. I don't think Henry is overpromising what he's doing. I am not trying to overpromise. I am trying to say that if you look at these periods, all the countries that we compete with, all the industrialized nations that do it, we can do it better than them. We are spending more money than them; 40 percent more than the Canadians; 87 percent more than the Germans; 132 percent more than the Japanese. Why can't we do it better? We have the money to do it. It's not a question of not being able to do it. We can do it. And Henry is right. Our reimbursement system is wrong. We reimburse on high-tech. That's why we have more coronary bypasses than anybody else. That's why we have more MRIs than anybody else. Not necessarily that we need them all. We reimburse on it. We don't do preventive care; that's why our infant mortality rate is horrible because the reimbursement system is set up in the wrong way. Under my proposal, it stresses preventive care and that is where we want to spend the money. And, you know, the proof of the pudding, Mr. Chairman, is the people who use the service. Ninety percent of Canadians, even knowing that they have some waiting for elective surgery, love their system; 90 percent of Americans don't. Who else knows better about the system than the people who use it? We are in a situation where the politicians are way behind the people. That is why the polls show how important health care is to them.

I need to deal with Jon's question about medical malpractice because I think that is very critical. There are two ways of dealing with that in our bill. I think taking on health care is tough enough, let alone dealing with tort reform. How do we deal with that? We apply practice guidelines to the entire health-care system. What we're saying by that is, we want to know what is appropriate care for a medical episode so that we can get rid of the $125 billion of unnecessary procedures that the Rand Corporation found. We need to do that. So, you are going to get rid of a lot of unnecessary care. This doesn't even factor that amount of money in. How do we deal with malpractice? We deal with it indirectly in this bill. Why? When you have a single-payer universal coverage, it means everybody is

covered. The biggest awards in medical malpractice suits are because the person who is injured needs medical services for the rest of their lives. They are usually paralyzed. Under my proposal, they are covered. There isn't the worry about medical expenses because they're covered, so we deal with it indirectly. That doesn't deal with tort reform as far as punitive damages. But one of the key factors—the most important factor—is future medical services. It's not a problem any more.

REPRESENTATIVE SCHEUER. Let me ask a question of the whole panel, and then I am going to recognize Congressman Fish.

I mentioned that in a number of very capitalistic countries—Canada, France, Germany, and Japan—about 70-80 percent of health-care expenditures are allocated through the public sector, compared to only 40 percent in our country. Let me ask you, why are these countries more successful in controlling health-care costs than the United States? It certainly can't be because they rely on the private sector because they don't rely on the private sector. But still, they function very efficiently and produce far superior health outputs for about a third less money.

REPRESENTATIVE KYL. Mr. Chairman, before Pete responds, may I excuse myself? But I want to thank you very much for hearing my views.

REPRESENTATIVE SCHEUER. Certainly. Thank you.

REPRESENTATIVE STARK. Just briefly, you're familiar with the Canadian system. The German system, for instance, is probably 85 percent paid by employees and their employers.

REPRESENTATIVE SCHEUER. The guilds.

REPRESENTATIVE STARK. The guilds there are actually insurance companies. There are about 1,100 of them. They are probably more like our credit unions. They all have pretty much the same premiums and the same costs. The Germans themselves said, "We wish we didn't have eleven hundred, we can get away with ten, but they go back a hundred and some odd years." So, historically you belong to the legal trade guild, or the tinker's guild, or the miner's, or a regional one. There is implicit in the German system a national bargaining system. So, what you really have is a mandated system by the government that requires everybody to be covered and a traditional structure of how that care is delivered. And I just suggest, as Marty or Sam does, that you couldn't change the Germans, and there is no way you could import that system to the United States unless you wanted to go back to 1883 and bring Bismark over here.

REPRESENTATIVE SCHEUER. Pete, what I am suggesting is that there is nothing inheritantly good about having private enterprise pay the bills and manage the system.

REPRESENTATIVE STARK. And it really doesn't. In Germany, that private enterprise isn't really private, it's enforced. It is like private enterprise that runs Medicare in this country. I mean, in every state, there is a private insurance company that pays the bills that interfaces between the Federal Government and the provider of services.

REPRESENTATIVE SCHEUER. Let's get away from Germany because that is unique.

REPRESENTATIVE STARK. Canada.

REPRESENTATIVE SCHEUER. Or England or Japan or France.

REPRESENTATIVE STARK. Of the systems that we see, England is probably the most federalized. They hire everybody on a salary and pay everybody's bills, and everybody pays for it through the tax system. It has a small private sector, as Mr. Russo indicated. In Japan you have a unique system in that the doctors who make huge incomes in Japan are also the pharmacists and are allowed to make a profit on the prescription drugs that they sell to their patients. Therefore, you have a little bit of a different system and a little bit different way of assessing how things are paid. You get much the same distortions, as Henry alluded to a minute ago, with many specialists in this country. We are apt to have more specialty procedures because we have more guys who want to do high-tech things.

REPRESENTATIVE RUSSO. But they do it for 132 percent cheaper than we do it, Pete.

REPRESENTATIVE STARK. There is no question. I am just saying that there is nothing inherent or unique in each system that says, gee, private here works better or government here works better. All of the systems do two things that we don't do. Every other country in the world—obviously, the second-world countries do it by fiat—but the third-world countries and the first-world countries—all of them—say that everybody has the right to medical care; that is, the king waves his wand, or the dictator waves his sword, and they all have medical care.

The second issue that's different in all of these countries is that they work through a budget. We are open-ended. We are the only country in the world that says we will pay for every nickle that anybody wants to charge. The only argument that we ever have is what the increments will be. Those two things have to change. We have to do guaranteed access, and then we have to say, we are going to have a budget.

REPRESENTATIVE SCHEUER. Congressman Fish.

REPRESENTATIVE FISH. Thank you. I compliment you, Mr. Chairman, for calling this meeting and your opening statment, and I want to congratulate our panel who recognizes—all of us do—that we are dealing here with one of the national issues that is foremost in the minds of our constituents, and our panel today consists of the leaders in the House of Representatives that are addressing this issue.

Your question was my question also, but since we only got an answer from one panelist, I'd like to keep with it.

Many of you have, as said in your prepared statements, observed the fact that it costs more in the United States than it does in countries that have far greater access and more comprehensive programs. I must hope that there's more to the cost than simply high-tech overuse or whatever.

Mr. Stark mentioned that other countries have a budget. Well, without knowing more about it, that could be fairly draconian in terms of limiting

access or rationing. So, I will ask again. I am sorry but we have lost a couple of panel members, but we have three of you. If you could address the question, why do these other countries, who have far more comprehensive models than we have, are their costs contained?

REPRESENTATIVE RUSSO. I will take a stab at that from my perspective. Number one, I think that the key reason is that they don't have the administrative costs that we have here. The GAO estimates that the administrative savings alone, if we did the Canadian system in the United States—this is the General Accounting Office, and I think a very conservative estimate—we could save $67 billion in administrative costs, $34 billion from insurance company's administrative cost savings, and $33 billion from hospitals and doctors. So, all of the other countries who basically have the single-payer system start off immediately saving all of these costs, and then they take that savings and plow it back. To cover all uninsured in America today would cost only $18 billion out of that $67 billion in savings. So, you could cover everybody. Thirty-seven million Americans could be covered. Then the question is, what do you do with the balance of the money? And what the GAO found is that if you pay all deductibles and cover everybody like the Canadians for a total of $64 billion, you save $3 billion under their mantle. They do it through that major savings. They do it because they have national and state budgets. They do it because they have expenditure targets. They do it because they have a fee for services, for providers. They do it because they set an overall global budget for hospitals. Those are all the key features of my bill that I have taken from other different countries—medical stuff—and I have improved on it. So, that's how they do it. They do it because they don't have the administrative costs that we have.

Medicare. One of the best selling points of Medicare is that it is the most efficient service that we have. It is 2½ percent of payroll. Private insurance companies are 12 percent. Overall, we spend 24 cents on every health-care dollar in the United States on administrative costs. The Canadians have spent 11 cents. So, if we just got with the Canadians, in terms of administrative costs, we would save about $100 billion.

Now, there are studies that say you can save $120 billion. I would say that that is as far to the extreme as you can get, and $67 billion is the most modest. So, somewhere in between $67-120 billion is what you can save in administrative costs alone. That's how they do it. And that's why access—this idea of well, you have to limit access—they don't limit access. If you're sick, you go in. That's why they have a healthier society. They don't discourage utilization because people in the long run are healthier if babies are not born with low-birth weights and don't have all these defects.

As we know in the WIC program, for every dollar we spend on pregnant women and infant children, we save the Federal Government $3.50 because we don't have to pay all this money through public aid to take care of a baby who is retarded or has major defects. So, the bottom line is, if we set up a system that reimburses on the front end, in terms

of better health care, you have a healthier society and you don't have to spend as much money on it. Plus, when you don't reimburse based on high-tech, you don't have to do all of these high-tech procedures. We lead the world in angioplasties and in coronary bypasses. That doesn't mean it's right. And the fact that the Canadians make people wait for it doesn't mean they are wrong because they don't want to do as much high-tech. What we have to do is adopt these ideas to be sure that we are getting the best bang for our buck. Other countries do, we don't.

I think Pete is right. We just say, whatever it is, we will pay 80 percent of reasonable costs, and just keep doing it under expenditure targets. They can't get away with the system. They won't be able to gain the system because there won't be a thing called uncompensated care.

One of the reasons that hospitals in my state, and probably in your state, are closing is because the Medicaid system doesn't pay. It doesn't do its job because it is not funded properly.

When you have a system that has to have so much indigent care compensated for, you then have to cost shift and cost share. Single-payer eliminates cost shifting and cost sharing. It takes care of that.

REPRESENTATIVE GIBBONS. Under Medicare, we have a lot more cost controls. Cost controls, when you put it in, brings grumbling, but it works. It works as well as almost anything that a human does. So, we have been able to contain costs in the elderly population just by good business practices. We know how to do it now. We don't know how to do it perfectly, but we know how to do it a lot better than we did when we started 26 years ago. And those same experiences and rules that we developed through all of this 26 years of trial and error are applicable to be expanded to everybody else in the population. Our benefit system is a paperwork jungle. It is horrible. One doctor keeping two paperworkers busy is what it amounts to. And that is just money thrown away.

I have got to go, Mr. Chairman.

REPRESENTATIVE RUSSO. We all have a markup.

REPRESENTATIVE SCHEUER. Thank you very much. We appreciate your time.

We are going to take a five-minute recess and come back in about five minutes.

[Recess.]

REPRESENTATIVE SCHEUER. All right, we will come to order again. I am delighted that three distinguished colleagues showed up to share their views with us on the problem of our National Health Care System.

Senator Kerrey sent a written statement to be submitted for the record, and I ask unanimous consent that we do that.

[The prepared statement of The Honorable Mr. Kerrey was subsequently supplied for the record:]

PREPARED STATEMENT OF THE HONORABLE BOB KERREY

Mr. Chairman, thank you for this opportunity to offer the Committee some of my thoughts about our nation's health care system and how to improve our system of financing health services in such a way as to extend access to necessary health and long-term care services to all Americans and stem the rapidly rising cost of health care.

As a businessman and partner in a chain of family restaurants and fitness clubs in Nebraska, a father, a patient , and a politican, I am deeply alarmed about what is occuring in our nation's system of financing health services.

Reforming our nation's health care system is no longer only a humanitarian issue, it's a vital economic issue. It's eroding our standard of living and threatening our ability to compete in an aggressive international marketplace.

It is important to distinguish between our systems of financing and delivering care. Our delivery system -- the quality of our health and medical personnel; the effectiveness of our hospitals; the sophistication of our technology -- is the envy of the world. This system of providing care has greatly enhanced the quality of life of many Americans, including myself.

Our system of financing care, however, is clearly a disaster in the making. We all know the adjectives used to describe this "system:" cumbersome, inefficient, bureaucratic, unaccountable, out-of-control. Health care consumes a growing portion of our gross national product -- now over 12 percent -- and we're expected to top 15 percent by 2000. Recently released OECD data clearly illustrates one reason why US industries face tough competition from our international competitors. These data indicate that, while national health expenditures have remained relatively stable in other nations, US expenditures have continued to rise. We now spend about five percent points more of our GNP on health care than do some of our key competitors (e.g., Japan). OMB Director Richard Darman hit the nail on the head when he said that US spending on health care is simply "unsustainable."

It's important to look at the impact of our health care system on American business. A well-educated, well-trained, healthy workforce is crucial to our national productivity and ability to compete. It is also critical that our nation's businesses are healthy too. Rising costs of health care are keeping American business from competing as aggressively as it

should. Health care costs have nearly quadrupled as a percentage of payroll since the 1960s and have grown from less than ten percent of business' pretax profits to over half of these profits today.

If these numbers aren't enough to cause alarm, look at the numbers showing a growing number of Americans lacking coverage altogether, lacking adequate coverage, staying in jobs because of a fear of losing health coverage, worrying about whether they will pay for their parents' long-term care needs or save for their child's education.

Access to affordable health care is moving beyond the reach of working American families. Health care costs are rising as incomes are falling. Individuals and families are spending more for health care at the same time they're earning lower wages. In the past ten years, the average hourly wage dropped by more than five percent, while health care costs for households jumped from six to nine percent of gross earnings.

Mr. Chairman, we can do better, and we must do better. We can spend less for health care and provide better care for all Americans.

Last July I introduced legislation to restructure how our nation pays for health care. The Health USA Act of 1991 reforms the way America pays for health care in a way that allows us to extend access to comprehensive package of benefits to all Americans, establish a much-needed long-term care program and contain health care spending. Health USA is not the Canadian, German or any other system -- it is an American system that relies heavily on the private sector, promotes innovation in the organized delivery of health care and provides Americans with complete choice among competing private and public health plans.

Health USA has three major goals:

- o **cost control**. Our system of financing health care must enable us to control costs reliably, while ensuring choice for consumers and clinical autonomy for providers.

- o **universal access**. Our health system must provide basic, quality medical care to all Americans regardless of age, health, employment or other factors.

- o **health benefits independent of employment**. Health benefits should be independent of employment so that Americans can start work, change jobs, or acquire new skills to move to a better occupation without the fear of losing health coverage. Businesses, likewise, should be freed of the burden of providing health coverage to employees.

How Americans will receive care. Under Health USA, all Americans will enjoy a right to covered health services. Eligibility will

not be dependent on your employment, health, income status or geographic location. Americans will choose to enroll in a plan -- either on an individual or family basis. They might select their plan based on physicians participating in that plan; the plan's reputation for service; the plan's record in managing and delivering medical care; and the like.

All plans will offer at least a federally-prescribed core package of benefits. These benefits include inpatient and outpatient, physician and other services, including preventive care and prescription drugs. Long-term care services, including nursing home, home health and respite care services will also be provided for persons meeting activities of daily living (ADL) criteria.

A variety of health care plans -- operated by private insurance firms, non-profit organizations, or others -- will operate in each state. The state will pay these plans a standard amount (adjusted for "risk" factors for use of health services such as age, gender and the like) for each enrollee in a plan. States will also operate a public fee-for-service plan. These plans, the public and private plans, will compete for enrollees in their state, not based on price, but rather on service, quality and other aspects that make them attractive to individual enrollees. Health USA changes the rules of the marketplace, but leaves a perhaps stronger marketplace in which competition and innovation will lead to improvements in the health care that Americans receive.

Private and public plans will operate on a level playing field. No plan may reject any applicant, and once a year there will be an "open enrollment" period during which Americans may change plans. If, for whatever reason, someone fails to enroll in any plan, he or she will be automatically enrolled in the state-operated plan. The state-operated will not, however, act as the "payer of last resort" in the sense that Medicaid is today. Rather, this plan will compete with private plans for enrollees.

Americans will pay for care in a different way under Health USA. Rather than individuals and firms paying insurance premiums, they will fund the program, based on their ability to pay, through federal and state payroll, income and other taxes. They will be financially encouraged to promote their own health care through a system of nominal copayments applied to some services (no copayments are required for preventive services or for very low income persons).

Many Nebraskans have expressed their concern with the role of government under Health USA to me. They fear too much of the wrong kind of government. Health USA carefully and precisely delineates the role of government in the proposed health system. Government is used for those things it does efficiently -- raising and dispensing money. It leaves the delivery of services

in the private sector where they would continue to be provided in a pluralistic and competitive private setting.

Cost Controls. Health USA will contain health care spending in the aggregate and on an individual basis through a system of national and state-level financal incentives on health care providers, plans and patients.

Health USA establishes a budgeted health care system. A "single payer" system through which all health care spending will flow. Funds are then distributed to states based on a formula. The formula takes into consideration the average per capita cost of providing health care to a state's resident population taking into account the age, sex, geographic distribution and other factors characterizing a state's population that affect health care utilization. State's then pay participating health plans the risk-adjusted payment discussed above.

Physician spending is controlled through state all payer systems. Under this system, state's will negotiate physician fee schedules and expenditure target levels. Fee-for-service physicians will be paid fees for each service, based on a national resource based relative value scale (similar to that being implemented under the Medicare program). State programs will provide physicians with profiles of their practice patterns to assist them in staying within their budgets.

Hospital capital spending will be separate from patient care spending. A process will be established for determining capital and patient care budgets for hospitals based on the needs of local populations.

Patient cost sharing, as noted above, will also be called upon to help contain total health spending.

Health USA will also sponsor the further development of medical effectiveness and practice guidelines and treatment protocol development.

Medical malpractice will also be addressed. Recommendations will be solicited for providing incentives or grants to states to establish a range of options for addressing the malpractice issue.

Costs and Financing. I contracted with Lewin/ICF, a local health care consulting firm, to estimate the costs of Health USA. The analysis found that if Health USA were implemented today, we would be able to extend coverage to all Americans, including long-term care coverage, and still reduce national health spending for 1991 by over $11 billion. Over its first five years (assuming those years were 1991-1995), Health USA would reduce national health spending by a total of over $150 billion.

Health USA would provide much needed economic relief to the middle class as it struggles to make ends meet. It actually puts money into the pockets of the average American. Under Health USA, over half of all families will pay less for health care than under the current system. For most Americans earning $40,000 or less a year, there would be a $500 a year savings in health care spending.

Businesses would also see some relief from the current system. In addition to being relieved of the burden of providing health benefits to employees, employers that currently provide coverage to their employees would save $77 per year on average across all firm sizes. Smaller businesses would save more: firms with less than ten employees would save on average $590 a year; firms with less than 100 employees would save an average of $120-150 per year.

Health USA is financed by a variety of revenue sources designed to be fair and equitable. It is important to remember that Health USA proposes a redistribution of how we pay for health care in a way that achieves our primary purposes: cost control and universal access. It does this by replacing premiums that we would pay anyway with a variety of taxes based on an individual's ability to pay.

Revenues include: current federal and state funds spent on Medicare, Medicaid and other health programs; a five percent payroll tax (4 percent on employers and one percent on employees); excise taxes (primarily on distilled spirits and cigarettes); an increase in the corporate income tax; a two percent tax on non-wage income; a new 33 percent top rate on federal income taxes; raise the amount of income subject to Social Security taxes to $125,000; increase the amount of Social Security benefits subject to taxation to 85 percent.

Health USA takes what is good in our current health care delivery system and, by encouraging innovation and competition, makes it better. By changing the financing of health care, it makes the entire system fairer and more cost-effective. It does all of this for less than we're currently spending on health care.

It is an economic imperative that we address the serious flaws in our current health care system. If we don't we will invariably see:

- o more and more Americans likely to be uninsured as employers continue to eliminate or significantly reduce health benefits to employees.

- o Americans continuing to live with the uncertainty of health care coverage, not knowing whether they and their families will be covered if they change or lose jobs.

- o national health care spending at an estimated $1.6 trillion -- 15 percent of GNP -- by the year 2000.

- o spending per person on health care at an estimated $5,515 by the year 2000, an increase of 443 percent over 1980.

Unless we take on this challenge, we will see our children faced with staggering health costs. The legacy we will leave for the next generation will be stagnant incomes, with home-ownership, college tuition and adequate medical care beyond the reach of all but the wealthiest people. Our children will be forced to work more hours for less take-home pay, with less time for their children.

Thank you for this opportunity.

REPRESENTATIVE SCHEUER. We'll go ahead and hear from the second panel. We'll proceed by seniority, so we'll hear first from The Honorable Mary Rose Oakar, now in her eighth term. She chairs the Subcommittee on International Development, Finance, Trade and Monetary Policy of the Committee on Banking, Finance and Urban Affairs. She is the sponsor of a major health reform bill, H.R. 8, the Comprehensive Health Care for All Americans Act.

Please proceed Mary Rose.

STATEMENT OF THE HONORABLE MARY ROSE OAKAR REPRESENATIVE FROM OHIO

REPRESENTATIVE OAKAR. Mr. Chairman, I think it's just wonderful that you're having these hearings, particularly in your role with respect to this Joint Economic Committee, because health care is not only a necessity in this country—because of the crisis, we have with 77 million people who are not insured or underinsured, and eight million more who have no long-term care services, and families who need those services—but health care is also an economic issue, and I want to get into that in a second.

I was a member of the Pepper Commission—15 members on the Pepper Commission—and I might add that I was the only woman on that Commission. And I suspect that I brought a perspective to some of the ideas there because women are in the work force and are among those, along with children, who are the most underinsured.

Let me just say this, and I am going to be a little bit repetitive. I know you know this better than anybody, because you are outstanding in your own views on this issue, but it is very, very important to say that while we have this crisis with all these people who are non- and underinsured, Americans also pay more—12.5 percent of our GNP, compared to Canada's 8.5, Japan's 6.7 percent. We have a 100 percent higher infant mortality rate than Japan. That has something to do with not only the state of those children, but it inhibits our competetiveness when we have all of these problems.

What do I think we should do? I think we should, first of all, change the standard of coverage. It is not enough to say that we want universal health care for everyone. I think that's a given in terms of what I feel, and I feel this very, very strongly, but I want to change the standard of coverage. I want every American to have acute care that we traditionally think of with respect to health care, surgery, etc.

REPRESENTATIVE SCHEUER. Comprehensive care.

REPRESENTATIVE OAKAR. That's right. But second, preventive health care. A lot of people talk about comprehensive health care, but they do not include programs that relate to early detection.

As you know, Mr. Chairman, I have been a strong advocate in some of the areas with respect to breast cancer and other issues, that have been underfinanced and not on the front burner of the agenda, even though there's a crisis. But I want to change the type of care. I want to have

prevention in it. I want every child to have, as part of a policy, immunization. I want every woman to have access to a mammogram, every man to have access to prostate screening. I want every American to be able to get treatment for alcoholic and drug addiction problems.

REPRESENTATIVE SCHEUER. It's a national outrage that when a young kid, who is desperate to get the monkey off his back and get rid of addiction, calls up a hotline to get into a treatment program, and he's told that we don't have a slot now, come on back in eight months, ten months, or a year. What kind of people are we who would permit that to go on in our society? Please continue.

REPRESENTATIVE OAKAR. That's right. Betty Ford testified about the fact that many policies are dropping health coverage for alcoholism, and how are people going to be treated? Should we just give up on people with a drinking problem? They, in turn, will cost us more if they retain their alcohol problem because they will get diseases like cirrhosis of the liver and other more catastrophic diseases that cost more. So, I want that as part of the prevention.

I also want to see—as a policy—and this is in my bill, H.R. 8—a billion dollars more for research. I want to find cures for diseases like Alzheimer's. And here is an economic issue for you. We'll invest a couple of hundred million dollars to find a cure for Alzheimer's, and they're on the cutting edge. Yet, Alzheimer's disease costs Americans $89 billion—about $90 billion every year. Americans pay $90 billion or more for Alzheimer's disease. The contrast is really remarkable. I want to find a cure for breast cancer. I want to find a cure for prostate cancer. We can do it, and we have the resources to do it in my judgment. But we have not invested in that area, and most research is government financed. You ought to really take a look at this because NIH—the National Institutes of Health—gives 90 percent of the research dollars for finding and taking a look at diseases, and has an eight and a half billion dollar budget, compared to the military budget for research, which is $34-35 billion, in how to find more creative ways to have weapons and Star Wars and god knows what. So, they are way off balance.

You ask the American people if they would rather have a cure for cancer or have Star Wars research. I can bet that most of them will say, let's find some cures for these terrible diseases. So, we are not doing that either. We are not investing in research, and we have shifted gears in the last decade, in terms of our priorities and research. And I think the American people are saying now, we want health as a priority.

Finally, I want to see long-term care included, and that includes homemaker services. Why should men and women, who are family members, who have children with chronic diseases, have to institutionalize their child when, if they had congregate home services that would be cheaper, they could take care of that child? Why should 70-year old kids be taking care of 90-year old parents at home, and they don't have the resources to take care of those people? So, home, health care—which, as you know, was Claude Pepper's great advocacy, and he didn't live to see

that happen—we have to make it happen. And we ought to include nursing-home care for at least six months that the government would finance. Let me tell you why. The average annual stay—in the Pepper Commission, we found that for a person in a nursing home is not a lifetime—is four months. If a person has a broken hip, they go in that nursing home and get the kind of quality care that they need, and then they want to go home. What do they have to go home to if we take away most of their financial resources? We demean these people who have made this country the greatest country in the world by taking everything away from them. So, I think nursing home care, at least up to six months, ought to be part of it, and then people ought to be able to buy a policy from the government for that.

The question is, if you have this high standard of coverage, how are you going to pay for it? The answer is, and this is the economic end, we already pay for it. Americans spend $700 billion on health care in this country. We spend out of the $700 billion about $400 billion; about half of that, or a little more than half, is for government programs—Medicare, Medicaid, veterans' benefits, CHAMPUS, public health programs in various states, local progams, and so on. Why not recapture all of that money, put it into a trust fund? That's a big start in terms of financing. We also spend $209 billion for private-health insurance. So, out of the $700 billion, only two hundred and nine billion is for private-health insurance because so many people don't even have access.

Let me just comment on that briefly, Mr. Chairman, because I know you have this hearing going on all day long. But this is, I think, very significant to the economic part of this. When I was growing up in Cleveland, Ohio, all of the insurance companies that delivered health-care benefits were not for profit. Today, that is not true. We don't have any that are not for profit. Health providers and some of the famous ones were not for profit, and now they're for profit. Nothing is wrong with making a profit, but you see, here's what happens when we switch this.

Take a look at the $209 billion that we spend for private insurance. Out of that we asked the question in the Pepper Commission, how much does it cost to administer for people who think that the government costs more and don't do it as well. The government spends under 10 percent to administer their programs. Private insurance companies spend over 20 percent to administer their programs. That does not include all of the advertising and all of the other stuff that goes into it. So, that has nothing to do with consumer advocacy or consumer needs. We asked the question about reimbursement. We had so many complaints from people who said, "you know, we don't get reimbursed. Here, we thought our policy covered this and we can't get reimbursed."

We took a look at government policies; we took a look at private policies. Private policies, if you take the losers and the winners, and some of the losers are the ones most advertised—I might mention—if you add them all up, the average policy in this country that is private reimburses

60 percent of the time. Medicare, for all of its faults, and it has some faults, reimburses consumers 98 percent of the time.

REPRESENTATIVE SCHEUER. Ninety-eight?

REPRESENTATIVE OAKAR. Ninety-eight percent of the time. And 2 percent if they call a congressman and say that they haven't gotten their reimbursement; sometimes they make mistakes, and so on. We can become, in an impartial way, advocates if the consumer has a legitimate complaint. So, the fact is, if you take Medicare, it does it better and reimburses more often.

Mr. Chairman, I am for a single-payer approach with a little bit different twist. A single-payer approach saves the consumers anywhere between $68 billion, to now there are new organizations that have come out and said that you can save up to $200 billion. If we saved $200 billion and subtract that from $700 billion, you know, you don't need to spend any more money on the issue.

REPRESENTATIVE SCHEUER. The Robert Wood Johnson Company funded a survey on the benefits of going to a single-payer system. They said the savings to our society over a decade would be $3 trillion. That is $300 billion a year.

Do you want to proceed?

REPRESENTATIVE OAKAR. Sure.

REPRESENTATIVE SCHEUER. Have you finished your testimony?

REPRESENTATIVE OAKAR. Just one last point, Mr. Chairman. I would have a single payer do it—the Federal Government—but I would have a little bit different twist, and I would model it after some of the programs that we have as federal employees. I would have this high standard of coverage—acute care, preventive health care, long-term care, and research—and I would let nonprofit organizations or companies bid state-by-state on this high standard. The Federal Government would reimburse; they would be able to bid. So, you'd have a little competition involved so that you and I and the American people could choose from, maybe, three or four different policies.

When you have that competition, you do have people trying to outbid each other and even adding more benefits than the bill might provide. So, I would tell you to look at that. It's a different tact, but it is very, very similar to the fact that federal employees can choose from 21 different policies, and they are all major policies. But in order to get in the loop, they have to get a certain standard of coverage.

Believe me when I tell you, we can do it better than Canada, England, and all of the other countries that have ... I don't call it socialized medicine, I call it civilized. It is civilized to take care of your people.

Thank you, Mr. Chairman.

[The prepared statement of The Honorable Ms. Oakar follows:]

PREPARED STATEMENT OF THE HONORABLE MARY ROSE OAKAR

CHAIRMAN SCHEUER, MEMBERS OF THE SUBCOMMITTEE, I WOULD LIKE TO EXTEND MY DEEP APPRECIATION FOR THE OPPORTUNITY TO TESTIFY BEFORE THIS DISTINGUISHED SUBCOMMITTEE OF THE JOINT ECONOMIC COMMITTEE. CHAIRMAN SCHEUER, I COMMEND YOU FOR YOUR LEADERSHIP IN ADDRESSING THE ISSUE OF NATIONAL HEALTH CARE BEFORE THIS SUBCOMMITTEE. THE LACK OF AFFORDABLE HEALTH CARE IN OUR NATION IS NOT ONLY A DISGRACE IN HUMAN TERMS. IT IS ALSO AN ECONOMIC BURDEN AND A DRAG ON OUR NATION'S ABILITY TO REMAIN COMPETITIVE. OUR CURRENT HEALTH CARE SYSTEM HAS NOT ONLY SPAWNED A CRISIS IN HUMAN TERMS, IT EXACERBATES OUR CURRENT ECONOMIC SITUATION, AND WE MUST TURN THIS AROUND. MR. CHAIRMAN, YOU HAVE BEEN A STRONG VOICE IN THE CONGRESS ON BEHALF OF QUALITY HEALTH CARE FOR ALL AMERICANS AND I APPRECIATE THE FACT THAT, THROUGH THIS HEARING, YOU CONTINUE IN THAT DIRECTION.

AS AN ACTIVE FORMER MEMBER OF THE BI-PARTISAN PEPPER COMMISSION, LET ME RESTATE MY CONVICTION THAT UNIVERSAL COVERAGE OF ALL AMERICANS FOR COMPREHENSIVE HEALTH CARE AND LONG TERM CARE WILL BE AN ANCHOR ISSUE IN THE 1990's. ACCESS TO A HIGH MINIMUM STANDARD OF HEALTH CARE SHOULD BE A BASIC GUARANTEED RIGHT FOR AMERICAN CITIZENS. YET IN OUR NATION, WE TREAT HEALTH CARE MUCH THE SAME AS WE TREAT ANY OTHER COMMODITY.

I'M FOR WHATEVER WE CAN DO TO ADDRESS THE FACTS THAT 37 MILLION AMERICANS HAVE NO ACCESS TO HEALTH INSURANCE, ANOTHER 40 MILLION AMERICANS HAVE INADEQUATE INSURANCE, AND ALMOST 250 MILLION AMERICANS CANNOT GET AFFORDABLE OR ADEQUATE LONG-TERM CARE PROTECTION. WE ARE THE ONLY INDUSTRIALIZED NATION THAT DOES NOT PROVIDE EVEN THE MOST BASIC HEALTH CARE GUARANTEES FOR ALL OF ITS PEOPLE. CURRENTLY, OVER 1.3 MILLION OHIOANS HAVE NO ACCESS TO HEALTH INSURANCE. EIGHTY-EIGHT PERCENT OF THESE UNINSURED ARE WORKERS OR COME FROM WORKING HOUSE HOLDS. SENIORS HAVE THE HIGHEST ANNUAL OUT-OF-POCKET HEALTH COSTS OF ANY SEGMENT OF OUR SOCIETY, YET, SO MANY LIVE ON FIXED INCOMES AND ARE FORCED INTO POVERTY BY THEIR HEALTH CARE NEEDS. I BELIEVE THAT OLDER AMERICANS SHOULD BE HONORED AND REVERED IN OUR SOCIETY. THESE ARE THE PEOPLE THAT BUILT OUR GREAT NATION AND PROVIDED THE STANDARD OF LIVING THAT SO MANY OF US ENJOY.

I AM FOR WHATEVER WE CAN DO, BUT I HOPE THAT THIS WILL INVOLVE FIXING OUR HEALTH CARE SYSTEM CORRECTLY AND COMPREHENSIVELY THE FIRST TIME AROUND. I HAVE PUT A GREAT DEAL OF THOUGHT INTO MY LEGISLATION, H.R. 8, THE UNIVERSAL HEALTH CARE FOR ALL AMERICANS ACT -- I AM CONVINCED THAT IT IS THE BEST WAY FOR OUR NATION TO PROCEED. UNLIKE MOST OF THE PLANS ON THE TABLE TODAY, MY PLAN AND THE PEPPER COMMISSION PLAN INCORPORATE MY THREE MOST FUNDAMENTAL REQUIREMENTS FOR NATIONAL HEALTH CARE REFORM. FIRST, ACCESS MUST

54-863 O—92——18

BE UNIVERSAL. EVERY AMERICAN CITIZEN AND LEGAL RESIDENT ALIEN MUST BE COVERED FROM THE CRADLE TO THE GRAVE. THERE MUST BE NO EXCLUSIONS BASED ON PRE-EXISTING CONDITIONS OR ABILITY TO PAY. SECOND, THE COVERAGE MUST BE COMPREHENSIVE. I CONSIDER MYSELF AS HAVING BEEN THE SWING VOTE ON THE 8-7 PEPPER COMMISSION VOTE. THE CHAIRMAN GOT MY VOTE ONLY AFTER HE INCLUDED COMPREHENSIVE COVERAGE FOR PRENATAL CARE, NUTRITION SCREENING AND SERVICES, CANCER SCREENINGS, WELLNESS PROGRAMS, REGULAR IMMUNIZATIONS AND PHYSICAL CHECK-UPS, HOME HEALTH CARE, ALCOHOL AND DRUG ABUSE TREATMENT, ETC. THIS TYPE OF FRONT ENDED TREATMENT MAKES SENSE, AND A GROWING NUMBER OF EXPERTS ARE BEGINNING TO REALIZE THAT PREVENTION IS NOT ONLY MORE HUMANE -- IN THE LONG RUN IT CAN SAVE US A GREAT DEAL OF MONEY. IT IS ABSURD THAT MEDICARE WILL NOT PAY FOR A ROUTINE BLOOD PRESSURE CHECK TO AVOID A STROKE, YET MEDICARE WILL PAY FOR COSTS RELATED TO A STROKE. OF COURSE MEDICARE SHOULD PAY COSTS ASSOCIATED WITH ANY ILLNESS WHEN IT OCCURS, BUT SHOULDN'T WE TRY TO PREVENT THESE CASES? AFTER EIGHT YEARS OF EFFORT, LAST YEAR I FINALLY CONVINCED THE CONGRESS TO PUT COVERAGE FOR SCREENING MAMMOGRAPHY IN THE MEDICARE PROGRAM. THIS BENEFIT WILL SAVE MANY LIVES IF WOMEN TAKE ADVANTAGE OF IT. EACH DAY THAT GOES BY AT LEAST ONE WOMAN IN OHIO DIES OF BREAST CANCER. THIS IS NATIONAL BREAST CANCER AWARENESS MONTH AND I URGE ALL WOMEN COVERED UNDER MEDICARE TO GET THEIR MAMMOGRAM. ASK YOUR PROVIDER IF THEY ARE MEDICARE CERTIFIED TO PROVIDE A SCREENING MAMMOGRAM.

MY THIRD REQUIREMENT FOR ANY NATIONAL HEALTH CARE PLAN THAT GETS MY SUPPORT -- COMPREHENSIVE COVERAGE FOR LONG-TERM CARE. THIS IS INCLUDED IN MY LEGISLATION, H.R. 8. THE AMERICAN PEOPLE EXPECT THIS FROM ANY NATIONAL PLAN. ANY PLAN THAT GOES THROUGH CONGRESS MUST HAVE SOMETHING IN IT FOR EVERYONE AND AFFORDABLE LONG-TERM CARE, WHILE ONE OF THE GREATEST NEEDS OF OUR AGING POPULATION, IS OF ENORMOUS IMPORTANCE TO AMERICANS OF ALL AGES. THIS WE SHOULD HAVE DONE LONG AGO, AND IF WE DO NOTHING ELSE IN THIS CONGRESS WE MUST MOVE FORWARD ON A NATIONAL PROGRAM FOR LONG-TERM CARE WHICH INCLUDES AN EMPHASIS ON HOME HEALTH CARE, RESPITE CARE, ADULT DAY CARE, HOMEMAKER SERVICES AND HEAVY CHORE SERVICES. THE GOAL IS TO HELP PATIENTS REMAIN AS INDEPENDENT AS POSSIBLE AND OUT OF INSTITUTIONAL SETTINGS AS LONG AS POSSIBLE. BUT THE BOTTOM LINE IS THAT AMERICANS SHOULD NOT HAVE TO FACE POVERTY IF THEY, OR A LOVED ONE NEEDS LONG-TERM CARE. ELIGIBILITY FOR THIS COVERAGE MAY BE BASED ON AN ACTIVITIES OF DAILY LIVING (ADL) TEST AS IN MY BILL, BUT I AM NOW CONVINCED THAT PATIENTS WITH COGNITIVE IMPAIRMENT (SUCH AS MANY ALZHEIMER'S PATIENTS) MUST ALSO BE COVERED. IN MANY CASES TODAY, IN MY STATE OF OHIO AND ACROSS THE COUNTRY, IT IS NOT UNCOMMON FOR SEVENTY YEAR OLD CHILDREN TO BE CARING FOR NINETY YEAR OLD PARENTS. IT IS GOOD NEWS THAT AMERICANS ARE LIVING LONGER. THE 85 YEAR OLD AND OLDER AGE GROUP IS THE FASTEST GROWING SEGMENT OF OUR SOCIETY. YET, OUR PUBLIC POLICY IS NOT KEEPING UP WITH THEIR NEEDS.

ANOTHER PREVENTIVE COMPONENT OF MY LEGISLATION, H.R. 8, IS RESEARCH. THIS COMPONENT, SEPARATELY ENTITLED "THE INDEPENDENCE FOR OLDER AMERICANS ACT" WOULD COMMIT AN ADDITIONAL $1 BILLION IN FEDERAL RESEARCH DOLLARS ON DISEASES AND HEALTH PROBLEMS COMMONLY ASSOCIATED WITH AGING LIKE ALZHEIMER'S, OSTEOPOROSIS, CANCER, STROKE, INCONTINENCE AND OTHER SUCH ILLNESSES THAT COMMONLY GIVE RISE TO THE NEED FOR LONG-TERM CARE. A PORTION OF THIS PROVISION WHICH WILL EVENTUALLY CREATE 15 "CLAUDE PEPPER GERIATRIC CENTERS" ACROSS THE NATION WAS ENACTED INTO LAW LAST YEAR. ALZHEIMER'S DISEASE, ASIDE FROM THE INCREDIBLE PERSONAL HARDSHIP IT HEAPS UPON AMERICAN FAMILIES, COSTS OUR NATION $90 BILLION IN DIRECT AND INDIRECT COSTS EACH YEAR -- BREAST CANCER COSTS OUR NATION OVER $8 BILLION IN DIRECT AND INDIRECT COSTS EACH YEAR AND TAKES THE LIVES OF 45,000 WOMEN EACH YEAR. HOWEVER, WE INVEST FAR TOO LITTLE ON EFFORTS TO CURE AND TREAT THESE DISEASES. IN THE PAST THREE YEARS OUR NATION HAS SPENT MORE MONEY ON DEFENSE RELATED RESEARCH THAN WE HAVE SPENT ON ALL BIO-MEDICAL RESEARCH CONDUCTED SINCE THE TURN OF THE CENTURY.

NO MATTER WHAT BEGINS THE PROCESS, I AM CONVINCED THAT WE WILL INEVITABLY ARRIVE AT A PLAN FOR HEALTH CARE REFORM SUCH AS MINE FOR OUR NATION. I'M FOR MOVING AHEAD -- THE SOONER THE BETTER. WE MUST ACT SWIFTLY AND RESPONSIBLY TO REMOVE THESE PRESSING BURDENS FROM AMERICAN FAMILIES. THESE ISSUES ARE FAMILY ISSUES. THEY AFFECT US ALL AND HIT MIDDLE INCOME AMERICANS THE HARDEST. IN ADDITION TO MY WORK ON THE SELECT AGING COMMITTEE, THE PEPPER COMMISSION, AND MY EXTENSIVE PUBLIC TESTIMONY ON H.R. 8 (FIVE TIMES BEFORE CONGRESS IN THE LAST YEAR ALONE), I HAVE CALLED ON ALL OF MY COLLEAGUES TO JOIN THE BI-PARTISAN CONGRESSIONAL CAUCUS FOR NATIONAL HEALTH CARE REFORM ESTABLISHED BY MYSELF AND MY OTHER AGING COMMITTEE COLLEAGUE FROM NEW JERSEY, MATTHEW RINALDO. WE MUST BEGIN THE PROCESS TO DEVELOP A CLEAR CONSENSUS ON STRATEGIES FOR REFORM. SUCH A CAUCUS COULD SERVE AS A RESOURCE TO HELP MEMBERS SORT THROUGH THE CONFUSION OF THIS COMPLEX ISSUE. SO FAR, THE RESPONSE HAS BEEN TREMENDOUS AND OUR EIGHTY MEMBERS SHOW WE ARE OFF TO A GOOD START. I AM PROUD TO NOTE YOUR MEMBERSHIP, MR. CHAIRMAN, IN THE BI-PARTISAN CAUCUS FOR NATIONAL HEALTH CARE REFORM.

AS A NATION, THE $670 BILLION WE ALREADY PAY FOR A GROSSLY INADEQUATE HEALTH CARE SYSTEM WOULD JUST AS WELL PAY FOR A PLAN SUCH AS MINE. THE TOTAL NEW GOVERNMENT COST OF THE PLAN HAS BEEN ESTIMATED BY THE PEPPER COMMISSION STAFF AT $234 BILLION. AN EQUIVALENT AMOUNT IN DIRECT OUT-OF-POCKET PAYMENTS BY INDIVIDUALS AND EMPLOYERS TO PRIVATE INSURERS WOULD BE ELIMINATED. THAT IS, AS I MENTIONED, NOT MUCH MORE THAN AMERICANS CURRENTLY SPEND ON INADEQUATE PRIVATE INSURANCE WHICH, FOR THE MOST PART, DOES NOT COVER LONG-TERM CARE.

A RECENT SURVEY INDICATES THAT 67% OF AMERICANS WOULD FAVOR A SINGLE-PAYER PLAN WHICH GUARANTEES UNIVERSAL HEALTH COVERAGE AND LONG-TERM CARE. A GROWING NUMBER OF AMERICANS WOULD PREFER TO PAY A REGULAR PREMIUM TO THE GOVERNMENT IN RETURN FOR A GUARANTEED STANDARD OF HEALTH AND LONG-TERM CARE COVERAGE. I DO NOT BELIEVE THAT THE CONGRESS WILL BE ABLE TO IGNORE THIS GROWING MANDATE MUCH LONGER. I WILL CONTINUE TO FIGHT FOR SUCH A PLAN. AGAIN, I THANK YOU FOR HOLDING THIS HEARING, AND I APPRECIATE THE OPPORTUNITY OFFER MY STATEMENT.

REPRESENTATIVE SCHEUER. Thank you very much, Mary Rose.

I am going to make two comments about your testimony right now. I'll have some questions later.

First, it has been estimated that there are three crippling and disabling diseases—mental disability—and that's your Alzheimer's, Mary Rose—rheumatism, and arthritis second; and the third, incontinence—that cause people to be institutionalized at enormous expense, as you have said.

Each one of them costs $50-100 billion a year, but, which according to the National Institute of Health, if we spent $200-300 million over a couple of years, they think we could have a real breakthrough in each of the three of them.

You mentioned the one. I am just adding the others.

REPRESENTATIVE OAKAR. Absolutely. Right on, Mr. Chairman.

REPRESENTATIVE SCHEUER. I also want to congratulate you on your statement that we should do better for kids and mothers. Let me just give you a couple of figures that I mentioned before. We rank 22nd in infant mortality instead of first or second. We rank 26th in low-birth weights—low-birth weights that plague children with mental and physical disabilities for the rest of their lives. In New York State, we give preventive innoculations to 56 percent of the preschoolers.

Now, let's think about the Third World. Seventy percent of Mexicans get these innoculations in preschool. Seventy-six percent of Salvadorians, 77 percent of Ugandans, 89 percent of Algerians.

REPRESENTATIVE OAKAR. They're doing better, is what you're saying.

REPRESENTATIVE SCHEUER. These pitifully poor third-world countries are doing better at allocating their resources in an intelligent and pro-health, rather than pro-sickness, modality. So, you are right on. I appreciate your testimony very much.

Now, we'll hear from the Honorable William Dannemeyer who is in his seventh term from the State of California. He is the ranking Republican on the Subcommittee on Health and the Environment of the Energy and Commerce Committee. He is the sponsor of a health reform bill, H.R. 3084, the Affordable Health Insurance Act of 1991.

Please proceed, Congressman.

STATEMENT OF THE HONORABLE WILLIAM E. DANNEMEYER REPRESENTATIVE FROM CALIFORNIA

REPRESENTATIVE DANNEMEYER.Thank you, Mr. Chairman.

In a totally free society—and I just made a list of things from the beginning of this experiment in self-government 200 years ago—we individually have the responsibility for paying for education, our retirement, our disability, our unemployment, our personal safety; we carried firearms; we were volunteer fireman to keep fire away from destroying our residences; we had horses to transport ourselves; and we were responsible for our own health care.

Now, 200 years later, you go down this list and find we pay taxes. That is to say, it is obligated by the government at some level that money come out of our earnings to provide for education, for retirement, for disability, for unemployment, for personal safety, for fire protection, and for transportation. But for health, we are struggling with a solution. And we have this convuluted system that has been built up at the senior end, with Medicare taking care of our seniors and Medicaid taking care of the medically indigent welfare population. And in between, the vast majority of us are paying premiums on health policies.

The plan that I'm going to suggest very briefly this morning does not really detail this, but I think it's appropriate for our society in America to begin discussing a missing ingredient; that is to say, in a system where we depend on individuals—all of us—to provide for coverage for our own health problems. Some of us have difficulty in resisting the temptation to postpone immediate consumption for the purpose of protecting ourselves from the problems of health. In other words, the pressure to consume health services in America is profound. Some people, because they don't have the money, I suspect, or because of the bad policy of the legislature, or because premiums are too high, are not buying health insurance. So, now we're stuck. How do we provide for these folks who either cannot or will not provide for their own coverage?

I think, as part of the debate, we should consider an option that I don't think anybody has talked about, but needs to be discussed. Have we reached the point in America where, because so many people are now saying health care is a right, when you enjoy the right, somebody has to pay the bill. And in my judgment, we should talk about deducting a portion of our income from our wages and depositing it in a health IRA for the purpose of giving the individual the ability to pay for his or her own health care.

In Singapore, they take 6 percent of the salary of the employee and put it into a health IRA. Out of that health IRA, the patient pays for all of his health-care costs. We don't have a mandatory health IRA in America, but I think it is appropriate for us to begin talking about it. On the downside of that, how much more can we stand in the way of deductions from our pay in this country, given federal and state income taxes and Lord knows what other deductions we have to pay? But in the meantime, until we resolve that question, the plan that I've introduced, when you look at coverage of people today for health care in this country and if you're fortunate enough to work for a large company or the government, at any level, you probably have a pretty good health package. In fact, you may have a gold-plated package. And one of the reasons that you have the gold-plated package is that there really is no incentive for controlling costs. Whatever the premium is the employer deducts it, and the labor union bargains as low a deductible as is achievable for obvious reasons. They don't want to put money out of their union members' pockets. None of us want to pay money if we can get somebody else to do it. We are all that way.

But as a result, this gold-plated coverage, because we're all subsidizing it, costs an enormous quantity of money. For example, if we limit the deductibility of what employers can deduct for the premium on employee health policies to $3,700 for family coverage and $1,500 for individual coverage, would you believe this will produce $86 billion of additional revenue to the Federal Government over the next five fiscal years. This is according to the analysis of the Joint Tax Committee. In 1992, it's nine billion dollars. I will say that again. Limiting the deductibility of the premium that the employer can deduct on the health premium paid, when you limit the deductibility of the premium on the health policy, then that probably means that the employer is no going to want to pay more than what the deductibility for the premium is; which forces that coverage down onto the employee, and the employee is not going to like that because nobody likes to have to pay for anything that we can get somebody else to pay for. So, that is one feature of this plan. It limits the deductibility on the employer side. Now, we spend that $86 billion over five years in two ways.

We give employees a tax credit for the premium on a health insurance policy, and that would consume about $8 billion of this $86 billion over the next five years. And we also provide a health IRA, whereby up to about a third of the money that an individual puts into a health IRA will be a tax credit, and the premium is also about a third, but it adjusts depending on the age of the individual. So, the health IRA consumes about $78 billion of that $86 billion that we save over five years. And the refundable tax credit for the health insurance premium is $8 billion. So, it's revenue neutral.

I emphasize this because I believe that we in Congress have reached the point where there simply is no money in the General Fund to pay for anything. We are broke. We are adding $448 billion to the national debt this year. And I admit that there's a convalescent care problem; there are problems about these 35 million who don't have health insurance. But as a legislator, I am not going to be a part of any solution that increases this massive deficit that we are passing on to the unborn generations.

There is one other feature of this plan that I think needs to be expressed. Over the years, we noticed that health specialties have come to state legislatures and have gotten laws passed at the state level which mandate that any health policy sold in the state has to provide coverage for their speciality. For example, these are the mandates, just a few of them: chiropractors, social workers, acupuncturists, dieticians, drug addition aides, mental illness, accidental ingestion of cocaine and other controlled substances. Those are all good things for which to have coverage. But if you have a law in a state that says that any policy sold in that state must include coverage for all of those specialties, the premium for that policy will increase to a level where the vast majority of these 35 million Americans who don't have it today can't afford it.

So, I would say that my proposal also bypasses all state mandates and would provide for the purchase of a bare-bones health insurance policy.

There have been some estimates that by bypassing the mandates we could reduce the premium costs by up to 50 percent, and that consumers would be better able to afford it. These state mandates have become so numerous and expensive that there are 15 state legislatures that have enacted measures to enable insurers to market those plans. I think that this provision should be a part of any solution that we develop here.

Mr. Chairman, I thank you very much.

[The prepared statement of The Honorable Mr. Dannemeyer follows:]

PREPARED STATEMENT OF THE HONORABLE WILLIAM E. DANNEMEYER

A FREE MARKET APPROACH TO AFFORDABLE HEALTH INSURANCE

Mr. Chairman, thank you for holding these hearings on one of the most pressing domestic issues of our time - the question of how to make quality health care affordable and available to the maximum number of Americans.

My main purpose in appearing before you and the other members of this committee is to alert you to my legislation - H.R. 3084, the Affordable Health Insurance Act - which to my knowledge is the first free market approach to make health insurance more widely available to working Americans who find themselves unable to afford even the most rudimentary health coverage.

I would like to submit a copy of H.R. 3084 and a brief outline of its provisions for the record.

In my opinion, counterproductive government regulation and interventions in the market are the primary reasons why so many millions of hard working Americans find themselves unable to afford health insurance for themselves and their families. Any comprehensive reform of the health care system must take this into account and give consumers more control over how they spend their health care dollars. H.R. 3084 does this without the need for enormous new federal taxes. In fact, the Joint Tax Committee has certified to me that the provisions in my bill are revenue neutral over the next five fiscal years.

Background

In 1950, national expenditures on health care comprised 4.4 percent of the Gross National Product (GNP). Since then, as the governmental role in providing health care has expanded, total health expenditures have absorbed an ever increasing share of GNP. In 1990, health spending consumed 12.2 percent of total GNP and, if current trends continue, experts project that by the year 2000 the share of our GNP devoted to health care will rise to the economically unsustainable level of 17 percent!

According to data collected by the Department of Health and Human Services, 37 million Americans cannot afford even the most basic health insurance. The vast majority of these individuals (78%) either work or live in families with a breadwinner and almost 60 percent work in businesses with fewer than 100 employees. Workers in small businesses with 25 or fewer employees are much more likely to be uninsured than employees in large firms.

That so many of the uninsured have a direct link to someone in the labor force suggests that the source of the problem lies in the health care marketplace itself. Full time workers and their families should be able to afford basic, no-frills health insurance policies. Unfortunately, it appears that these workers have been priced out of the market for health insurance by federal and state policies which provide tax incentives for some, but not all, workers and which require workers to pay for coverage that they may not want or need.

Many experts attribute the difficulty that small business employees encounter in obtaining health insurance to the proliferation of state mandates on consumers. Insurance mandates are nothing more than concessions to special interests looking to coerce consumers into purchasing coverage for specific

diseases or health services, whether they want that coverage or not. The National Center for Policy Analysis in Dallas found that the total number of mandates exploded from 30 in 1970 to more than 800 today.

Mandated services include those provided by chiropractors, social workers, acupuncturists, and dieticians. Other mandates require consumers to purchase coverage for drug addiction, AIDS, mental illness, and the "accidental ingestion" of cocaine and other controlled substances. Some states regulate the terms and conditions under which policies are sold. Of course, the more extensive the coverage and regulations, the more expensive the policy. One think tank estimates that up to one quarter of the uninsured - 9.3 million in all - would be able to afford basic, no frills health insurance if some or all of these mandates were repealed.

The states have begun to realize the enormous cost of this approach. Since the beginning of 1990, 15 state legislatures have enacted measures to enable insurers to market no-frills plans. Ten others are considering such plans. Sponsors of these reforms estimate that they would reduce the cost of health insurance by as much as 50 percent.

The federal tax code also contributes to the problem of the uninsured. Under current law, employers can offer employees an unlimited package of health benefits on a tax-free basis. Many companies provide their employees with complete, first dollar coverage for a wide array of benefits. The unlimited nature of the benefit, in fact, has seduced employees in many firms to shift compensation away from salary and toward enhanced health benefits plans. Employer contributions for group health insurance have risen from 0.8% of the employee's compensation in 1955 to 5.1% today.

Thus, employees in large firms receive generous tax subsidies for gold-plated insurance coverage while their counterparts in small firms must purchase coverage with after-tax dollars. Stuart M. Butler of the Heritage Foundation believes that this inequity "encourages the healthy and wealthy to demand excessive insurance, while leaving millions of others with no protection at all."

It is the obligation of the federal government to guarantee that all full-time workers, even those with earnings at or slightly above the minimum wage, can afford basic insurance coverage for themselves and their families. If governmental intrusions into the marketplace raise the cost of health care and insurance to an unacceptable and unaffordable level, as I believe they have, it is the obligation of the Congress to eliminate these distortions and restore the integrity of the free market.

The Affordable Health Insurance Act

H.R. 3084 would give health care consumers strong incentives to take responsibility for more of their health care expenditures, rather than relying entirely on third party payors. Its main provisions are:

1) **Preempt state insurance mandates:** The preemption would extend to over 800 separate mandates enacted by state legislatures in response to lobbying by special interest groups. Studies show that mandated coverage drives up the cost of health insurance by as much as 40 percent. My bill would allow consumers to choose the package of health

benefits that best suits their needs.

2) **Establish a generous 33% tax credit for the purchase of no-frills insurance policies:** The credit (refundable to low-income taxpayers) would be available to individuals who work for employers that do not provide health insurance. The amount of the credit would be set according to the age of the taxpayer, ranging from $350 to $2,000. Joint Tax estimates that this provision would cause a loss of $8.1 billion in revenues over five years.

3) **Create a medical IRA:** A health care savings account would enable consumers to self-insure for predictable out-of-pocket health expenses. The IRA in my bill would offer consumers a refundable 33% tax credit for up to $825 in contributions to an account which would grow on a tax-free basis, provided the taxpayer uses the proceeds for eligible medical expenses. Joint Tax places a five-year cost of $78 billion on this provision.

4) **Place a generous limit on the deduction for employer-provided health benefits:** My legislation would establish a ceiling on the extent to which employer-provided health benefits are deductible. This ceiling would be set at an annual amount of approximately $3,700 for family and $1,500 for individual coverage, more than enough to provide employees with adequate health coverage, especially when supplemented by a medical IRA. Joint Tax estimates that this limit would raise $86.1 billion in revenue over five years, enough to offset the revenue losses from the bill's other provisions.

According to the Joint Committee on Taxation, the provisions in H.R. 3084 carry the following revenue effects:

	Fiscal Years [Billions of Dollars]					
Provision	1992	1993	1994	1995	1996	Total 1992-96
Refundable tax credit for health insurance	-0.7	-1.6	-1.8	-1.9	-2.1	- 8.1
Refundable tax credit for deposits to medical care savings accounts	-3.2	-11.9	-16.3	-21.1	-25.5	-78.0
Cap on employer provided health benefits	+9.0	+14.8	+17.6	+20.7	+24.1	+86.1
TOTAL	+5.1	+ 1.3	-0.5	-2.3	-3.5	0.0

As you can see, my proposal is self-financing. I believe any comprehensive health reform proposal should adhere to the standard established in my bill. Twelve percent of our GNP is more than enough to devote to health care.

John Goodman, President of the National Center for Policy Analysis in Dallas, has observed:

> "Our health care system is dominated by large bureaucratic institutions, and individual patients have little control over the prices they pay or the quality of care they receive. We want to restore the patient as the principal buyer of health care and unleash an army of millions of informed shoppers into the medical marketplace."

Health care savings accounts and tax credits to enable the self-employed and employees of small businesses to purchase health insurance, combined with the preemption of state insurance mandates, will dramatically lower the cost of basic health insurance.

I urge the members of this committee to look long and hard at whatever market-oriented proposals come before it. We should not be leading the American people down a path that has been tried and rejected by virtually every nation on this planet. Free markets can and do work. They should be given a chance to succeed in the area of health care as well.

Thank you.

REPRESENTATIVE SCHEUER. Thank you very much, Congressman. We'll now hear from the Honorable Bernard Sanders from Vermont in his first term. He is a member of the Committee on Banking, Finance and Urban Affairs and is the sponsor of a major health care reform bill, H.R. 2530, the National Health Care and Cost Containment Act.

Bernie, will you proceed?

STATEMENT OF THE HONORABLE BERNARD SANDERS REPRESENTATIVE FROM VERMONT

REPRESENTATIVE SANDERS. Thank you very much, Mr. Chairman. I am delighted to be here and I want to congratulate you for doing something that I've not seen very often here, and that is attempting to bring cooperation between the House and the Senate. Sometimes we forget that we are part of the same government. We seem to be going in different directions. So, I think working together, especially in the area of health care, is a major concern.

Let me be very brief because I think the others—and I am sure you have heard testimony earlier—understand what the problem is. I will just touch on my views on that, and I will tell you what I think the solution is, and, perhaps, suggest why we have not gotten to where we should be going yet.

We all know what the problem is. The problem is that you have 35 million Americans who have no health insurance. Importantly, and not discussed enough, are the facts that we have 50 million Americans who are underinsured. What that means, Mr. Chairman, is that somebody who thinks they have insurance and ends up in the hospital for a major operation is under the illusion that they're covered. They come out and they have a huge bill. So, that is a very serious problem.

As was mentioned, we have Medicare for elderly people, of course we do. But I think we also understand that despite Medicare our elderly people are paying, especially those on limited incomes, a very high percentage of those limited incomes for medical procedures, for Medigap, for Medicomp—the rates of which are zooming up.

Furthermore, we have not even touched upon the whole horror story regarding prescription charges. I know that Senator Pryor has done some work on that. Many of our elderly people in this chaotic nonsystem that we exist in cannot afford the pharmaceuticals that they need to keep them alive or to ease their pain. That's a whole other story that we might want to touch upon.

What's the bottom line? The bottom line is that every industrialized nation in the world, except South Africa and the United States, has made a basic and simple philosophical statement, not very complicated. And the statement is, if you are a citizen of a country, are you or are you not entitled to all the health care that you need because of your citizenship? It is not a very complicated issue. In our country, we have decided that young people are entitled to education. Everybody agrees with that—most

everybody. We have not made that decision. Countries around the world have different plans. The Canadian plan is different than the Swedish plan, which is different than the French, different than the German, etc., etc. We could argue which is better or which is worse. But, basically, all countries have made that decision.

REPRESENTATIVE SCHEUER. What decision are you speaking about?

REPRESENTATIVE SANDERS. Providing health care for all people regardless of income as a right.

REPRESENTATIVE SCHEUER. Comprehensive, universal health care?

REPRESENTATIVE SANDERS. Comprehensive, universal. That is what we are talking about. My point is that the English system is different than the Canadian system—they're different. We can argue which system is better or worse, but we have to acknowledge that there is something wrong when our country and South Africa say, if you are a working class person and you don't have insurance, tough luck. If you get sick or your kid gets sick, good luck to you because you are not going to get the help that you need.

Furthermore, as has already been stated, you made the point in terms of infant mortality. The United States of America is number 1 in the Persian Gulf War and number 22 in terms of infant mortality. In terms of how long we live, we are 12th in the world. So, in terms of all of the social indices, in terms of our health care system, we are far, far behind most other countries.

Having said all that, maybe the anwer is that we are just tight with our money. We are not spending enough money. Maybe we just need to throw some more money into the current system; right? Well, I think not. We are now spending $750 billion a year on health care. The Canadians who have the a comprehensive, universal health-care system for all of their people spend, in terms of per capita expenditures, the second highest amount in the world. Mr. Chairman, we spend 40 percent more per capita than the Canadians who spend a lot more than the English and many other countries around the world. So, it is not a question of not spending enough money. We spend more than enough money.

Furthermore, the cost of health care is zooming up every single year, which is part of the crisis. Small business people are being asked to pay 15-20 percent more every year. Elderly people pay 25 percent more for Medigap. Basically, the bottom line, in my view, is that the current system is disintegrating. It is falling apart. We need to junk it. We don't need to put Band-Aids on the system. We don't need to play around with free enterprise medicine. We have to move toward an entirely new approach.

The good news is that if, along with South Africa, we are the last guys on the block to move toward national health there is one advantage, I suppose, in that. That is that we can see what other countries have done and can learn from their mistakes. We can do better than they can do.

Now, the program that I have brought forth, H.R. 2530, is a single-payer, comprehensive, universal, health-care system, which will guarantee

health care for all people. As Congressman Oakar has said, as you have said, as many other people have said, one of the scandals of the present system is that we are wasting tens and tens of billions of dollars a year in billing and administrative costs, in advertising, and in a variety of red-tape practices. You go to any hospital in the United States, you go down to the basement, and you have people sitting around filling out forms because Mary Rose has Blue Cross, and I have Connecticut General, and Mr. Dannemeyer has the Traveler's Insurance. We have 1,500 separate insurance companies advertising and competing with each other, resulting in a maze of bureaucracy and bureaucratic overlap.

So, as you indicated, the General Accounting Office—not a very radical organization of the U. S. Congress—estimated that if we moved to single-payer we would save $67 billion. The National Physicians for National Health Care estimated $100 billion—maybe there are newer numbers—which suggests that we can save more. And it is not mystical that the government does it better than the private sector. What it is is that if you all have the same form we can end the maze of paper pushing that is costing us a fortune, driving doctors and hospital administrators crazy, and driving consumers off the wall, as well.

The program that I have introduced, I think, has certain very exciting advantages. Number one, what it suggests as we move toward a single-payer system is that it is preferable to see this system administered at the statewide level rather than at the federal level. I think people make a good point when they say, hey, you have a bureaucracy in Washington, and we would rather have the administration done closer to home. So, our proposal rewards those states who are prepared to come forward and say the following: Number one, we are going to have a single-payer system because we are prepared to save our consumers.

REPRESENTATIVE SCHEUER. Just for your interest, the next panel is going to include representatives from states who are pointed toward a single-payer system.

REPRESENTATIVE SANDERS. Beautiful, I think that's great, I really do, and I'll tell you why. I think, everything being equal, I would rather have the program administered at the statewide level, and keep it closer to home. Now, we're not talking about, in my view, saying to the states, oh, you can do anything you want. What we are saying to the states is that if you move forward with a single-payer comprehensive—covering all basic health-care needs—universal—covering every man, woman and child, portable—if you get ill out of the state, the insurance policy has to cover it; if you are prepared to do that, we in the Federal Government are essentially prepared to bring together your Medicaid and Medicare payments, your other federal programs, and on top of that, give you additional aid. We are going to allow you to reap all the benefits of the single-payer system.

I think the point that Mary Rose and all of us are making is that it is not necessary to inject tens of billions of dollars more into the system. If you move toward single-payer, you save huge sums of money, get rid of

the paper-pushing and the bureaucracy, and then you put that money into the provision of health care for all of our people. I am not of the opinion, and I don't think others are, that we need to put more money into the system. We need to get rid of the bureaucracy and the paperwork. Let's provide that for health care.

Furthermore, in terms of the politics, what is going on? Let's be honest. You'll excuse me, Mr. Chairman, if I am frank, but let's be honest about what's going on. While there are many of us in this body who would like to see the U.S. Government move tomorrow on this crisis, we understand that the President is still "studying" the problem; right? We understand that if we pass a national health-care bill tomorrow, this President, in all likelihood, will veto it. And I am not at all sure that we have the votes to pass a federal national health-care-system bill. That is the political reality. I don't have to tell you, Mr. Chairman, that the concept of national health care is not a concept that was invented yesterday. In 1948, Harry Truman ran on the issue of a national health care. It has been discussed for 40-50 years. So, I am not optimistic for a variety of reasons that the Federal Government is going to do the right thing. I think we lack the political will. The pressure on the President by the insurance companies, drug companies, the AMA, and the medical equipment suppliers are very powerful. I don't think this Congress has the political will to do it.

What is the alternative? The alternative, at least, is to be honest and to say that if you can't do it here let's not keep talking about it for another 50 years. Let's ask the states. And I would agree with you on that. I am delighted that we are having representatives from state governments here. In my State of Vermont, there was a very serious discussion about a single-payer system. As they did in Canada, by the way, you will remember that Canada did not bring about their national health-care system as a national system. It started in Saskatchewan and moved east. My hope is that we will give encouragement and financial support to those states that are prepared to do it. And I predict the following: If you have the State of Vermont or the State of New York move forward in that direction, New Hampshire and California and Illinois and Ohio will not be far behind because people are going to be looking around and saying, wait a second, I have a relative in New York State that gets all of the health care that he needs without out-of-pocket expenses. I am paying 20 percent more every year. It doesn't make sense, Governor, and I want you to bring it about.

So, I think, from an administrative point of view, I like the idea that the program is administered at the statewide level. From a political point of view, though, the political reality is that we are not going to do it here in Washington. The legislation that we have proposed gives encouragement and financial support to those states that are prepared to go forward.

To me, from an administrative and political point of view, it is a good approach. I thank you very much for allowing me to be here.

[The prepared statement of The Honorable Mr. Sanders follows:]

PREPARED STATEMENT OF THE HONORABLE BERNARD SANDERS

HR 2530
The National Health Care and Cost Containment Act

Everywhere I go in Vermont, I hear the same message: The present health care system is failing. People tell me this at town meetings and union halls and senior citizen centers. Working people and small business people, people who are ill and the doctors who treat them, all say the same thing. "Bernie, you've got to get the people in Washington to do something about our health care system. It just isn't working."

The major crisis facing our nation today is the imminent collapse of our health care system.

Thirty-five million Americans have no health insurance. Fifty million Americans are underinsured. Our elderly, despite Medicare, are spending a significant part of their limited incomes on health-related needs.

Every industrialized nation except the United States and South Africa offers national health care to its citizens. Nevertheless, WE ARE CURRENTLY SPENDING FAR, FAR MORE PER CAPITA ON HEALTH CARE THAN ANY OTHER NATION.

Even though we spend more per capita on health care than any other nation, the United States ranks only 22nd in the industrialized world in preventing infant mortality. Another shocking statistic reveals that, despite all we spend, Americans do not live as long as the citizens of eleven other nations: we rank 12th in the world in terms of life expectancy.

Study after study has revealed a deep level of frustration and even anger among American voters. One of the main reasons Americans are so dissatisfied with politicians in general, and Congress in particular, is that Washington has done very little while the income of working Americans or elderly Americans, their home equities, their savings, are eaten up by the catastrophically high costs of health care--a cost which continues to zoom upward dramatically every year. And there is no end in sight to these cost increases. This year, once again, the cost of health care has risen far faster than the rate of inflation.

This is why I have introduced HR 2530, the National Health Care and Cost Containment Act. This legislation would establish a Canadian-style, single-payer, comprehensive, universal health care system in the United States. I would like to express my deep appreciation for the support that Chairman Scheuer has shown for this legislation in becoming one of its co-sponsors.

H.R. 2530 would establish a system to provide comprehensive health care to every American without out-of-pocket expense. It will assure that, when illness strikes, every American can go to a doctor or enter a hospital without pulling out a wallet or checkbook or reading the fine print on an insurance policy.

Let me tell you one reason why we should look to the example of our northern neighbor, Canada, for ideas about how to provide health care to our citizens.

In the United States, over eighty million Americans either have no health insurance or are only partially insured. We spend 40% more per person on health care than our neighbor, Canada, but while all Canadians are covered by comprehensive health care, almost a quarter of our population is uninsured or underinsured.

One of the main reasons our health care system is so inefficient is that we waste over $100 billion a year by paying for most health care through private health insurance companies. There are about 1500 health insurance companies in the United States, and their wasteful duplication of services in billing and administration, their profit-taking, their bureaucratic waste and inefficiency, costs over $100 billion more than a single payer, Canadian-style system would cost, according to the latest study by the Physicians for National Health Care. The General Accounting Office of the US Congress, using older data and more conservative assumptions, estimates savings of $67 billion would be realized through a single payer system.

In other words, if we got rid of all the private insurance companies, we could provide health care to all Americans, at a cost not one penny higher than we are now paying for health care for only some Americans!

What will the bill I have introduced, HR 2530, do? Let me outline its major provisions:

1. It will provide increased federal funding to any state which establishes a single payer, universal, comprehensive health care system.

2. It will not increase the federal bureaucracy. The system will provide for all the basic health care needs of all Americans without out-of-pocket expenses, but it will be administered by the states, not by Washington. Patients will have full freedom of choice about doctors and hospitals.

3. It will control the present runaway inflation of medical costs. As in Canada, physicians' fees will be determined by negotiations between the state and the doctors, and not set by doctors alone. Hospitals will receive their funds based on statewide global budget planning.

4. The system will be funded through the general tax base on both the federal and state level. HR 2530 calls for a 7.7% surtax on corporate and personal income taxes at the federal level, increasing taxes by from zero to two percent of income. Each state will have the freedom to come up with its own tax mechanism to replace insurance premiums and out-of-pocket expenses.

HR 2530 does what this country should have done long ago: it assures health care to all of our people as a right of citizenship, not as a privilege of wealth.

There is intense opposition to HR 2530. The insurance companies, the pharmaceutical companies, the medical equipment suppliers and certain physicians' groups support the present system because they are making billions of dollars in profit from it. These groups are extremely powerful. Their paid lobbyists will raise an outcry over any plan that puts people before profits. They are already selling the idea that the only way to provide health care is not to make it equally available to everyone, but to restrict access to many health procedures to those who can pay for them out of their own wealthy pockets.

But the tide is turning against the pharmaceutical companies, the giant insurance companies, the ever-expanding huge central hospitals. Tens of millions of Americans are standing up ready and willing to demand national health care. The momentum for national health care is growing in this country every day. My colleagues, we in the Congress need to all work together to establish a single-payer, comprehensive, universal health care system such as the one called for by HR 2530.

REPRESENTATIVE SCHEUER. We appreciate your testifying, as we appreciate the entire panel, Congressman Dannemeyer and Congresswoman Oakar.

Let me state that the examples of states moving forward where the Federal Government is not aware or not responding to a national need is growing and growing, and it's not only in the field of health care, it's in the field of environment, in the field of energy.

Representative Dannemeyer's state has set a tailpipe emissions standard that is higher than the federal standard, and higher than what was put in the Clean Air Act. And other states around the country are beginning to crank up and to adopt those standards for their own states. There was a lead story in the *Washington Post* yesterday, in the extreme left-hand column, that stated that Governors Schaefer and Wilder are both seriously contemplating adopting the California standard for tailpipe emissions, and then discussed a conference in Philadelphia that was going on at exactly that time where half a dozen other states were waiting to do the same thing. You have in the field of environment and energy, where there has been a total deficit in presidential leadership, a movement going on where enlightened state environment commissioners, and enlightened state energy commissioners, and enlightened state utility commissions and enlightened state utilities are forging ahead.

And in California, the Sacramento Municipal Utility District is encouraging utilities in Sacramento to engage in least-cost planning. That means, in the vernacular, that they encourage states to study where they need to get their next hunk of energy from, how they should meet rising demands for energy, and they encourage them to study whether they can do that through conservation, or whether they can do that through encouraging utilities to help their customers acquire state-of-the-art energy-efficient equipment like lighting, air conditioning, heating, motors, and windows. And SMUD, the Sacramento Municipal Utility District, is offering financing to corporations, manufacturers, homeowners, apartment owners, and office building owners; they are offering them financing to equip their buildings with state-of-the-art technology, and giving them 6 or 7 percent financing, spread over 15 years.

All of this indicates—and I am sure that Congressman Dannemeyer will be happy to hear this—that our federal system really is working as a federal system, and we're all conservatives on this matter. If there is a deficit of leadership at the federal level, by golly, why shouldn't states go ahead, and, by golly, they are. And I know how proud you are that the State of California is at the head of the line and encouraging very enlightened state policies.

REPRESENTATIVE DANNEMEYER. If I may make an observation here, Mr. Chairman——

REPRESENTATIVE SCHEUER. Let me finish my sentence, and then I will yield to you.

On energy, on devising a rational energy program that we do not have in this country, on a rational environmental policy that we do not have in

this country, on rational health programs that we do not have in this country, states are filling the vacuum and providing the leadership.

Now, I know how conservative you are, and I join you in this. We are all conservative. We want the federal system to work. And now we are showing that it can work as a federal system with the Federal Government having, perhaps, first opportunity, first crack, at coming up with rational answers to problems. But failing that, by golly, we are finding out that there is a lot of imagination and a lot of leadership at the state level—the governors, and the commissioners, too—and in private enterprise. We are finding that private enterprise—the utilities all over the State of California—are working closely with SMUD and coming up with very innovative answers to all of these problems, health not the least.

Did you want to respond?

REPRESENTATIVE DANNEMEYER. I just want to say, Mr. Chairman, I thank you for your comments about my state, but let me caution you a little bit. I believe that this country can have one EPA at a time, either the feds or the state. We don't need both. Let me tell you what is happening.

REPRESENTATIVE SCHEUER. Are you for federal preemption of Governors and state utilities in health and energy and environment? Do you want the Federal Government—that great big monolith—having a preemptive claim on all of these regulatory matters?

REPRESENTATIVE DANNEMEYER. Air currents do not recognize state boundaries. We all know that. We need a national program to protect the environment.

REPRESENTATIVE SCHEUER. I wish you would discuss this matter with your President. We would all be a lot happier with an enlightened, imaginative President. As a matter of fact, he has a damn good environment administrator in the form of Bill Reilly. But what happens, and this happened with his Energy Secretary too—Admiral Jim Watkins—they both sent down very enlightened programs in energy and environment to the White House. But a funny thing happened on the way to the White House. There was a mechanical engineer—and I forget his last name—who took the scalpel to these programs, and he degraded and demeaned them, and wrecked them. So, even though Mr. Watkins and Mr. Reilly have sent us very enlightened, thoughtful, well-conceived programs, they were destroyed at the White House. Thank God there's enough energy and can-do spirit at the state level—the governors, the utility commissioners, and the private sector itself—to fill this vacuum. And the remarks that Bernie Sanders made were right on point, not only for our health-care system, but for our environment and energy problems as well.

Now, I want to ask Congressman Sanders a question. I mentioned before that in a number of very capitalistic systems where the profit motive is alive and well, about 70-80 percent of the costs of health care are allocated through the public sector. It is only 40 percent in our country. The total expenditures for health are at least a third less than ours relying on public-sector delivery for almost all their health care; whereas,

in this country, we rely on private sector for delivery of 60 percent of it, but at a rapidly escalating cost, and far less efficient and far less cost effective than these other capitalistic countries. Why are these countries more successfully controlling health care costs than we are in the United States? Far more money expended per capita, far less desirable health effects, health results. Surely, it is not because they relied on the private sector because they don't rely on the private sector. What is the key to their success in providing better health care for less money, and much more successful in controlling health-care costs by relying on the public sector to do virtually all of the delivery, in comparison to our country, where we rely on the private health-care sector with outrageously increased costs?

REPRESENTATIVE SANDERS. I think, Mr. Chairman, as I indicated earlier, different countries have very different systems. Let's just talk about them.

REPRESENTATIVE SCHEUER. I want to know why their systems work better.

REPRESENTATIVE SANDERS. I'll tell you why, because they have made, in many instances, a very basic statement and that is, in the deepest sense, human illness and misery is not an area to be allowed to have people make huge profits off of. That is the bottom line.

In other words, if you want to go out and make a fancy car, that's fine. But what we are saying is that when somebody is ill, when a child is ill, a function of the whole approach toward the medical care of that child should not be such that we say, aahh, this is a good disease. We have a $100,000 disease here. We can make a lot of money rather than developing a system which says, this is a human being, and what sanity and civilization dictates is that we're going to treat all people in the most cost effective way. The answer to your question, I think, is that the goal of health care should not be to make as much money as possible off of human illness, but to treat people as best we can in a cost effective way.

Let me take your question and, if I may, stretch it a little bit.

REPRESENTATIVE SCHEUER. I want to ask the other two members of the panel——

REPRESENTATIVE SANDERS. I want to ask the same question that you're asking. How come, Mr. Chairman, that in this country the same drugs manufactured by U.S. pharmaceutical firms are sold for 50 percent less in Canada and in Europe? How does that happen? Same drug manufactured by a United States firm? Answer, in those countries where you have national health care, they say to the pharmaceutical companies, guess what, you want do business in our country, you're not going to make huge profits off your product. We'll sit down and we'll negotiate with you, make a profit, but you are not going to rip the system off.

Second of all—to answer your question—all of the systems have far more cost effective approaches. I think Mary Rose was talking about that in Canada that the savings of 50 percent administrative costs ... you don't need to have a person there doing the billing, and a person here doing the billing. Imagine running an elementary school in New York City where

you had 14 different insurance companies providing educational insurance. It would be a nightmare; right?

REPRESENTATIVE SCHEUER. Let's not use the school system of New York City.

[Laughter.]

REPRESENTATIVE SANDERS. But the point is, I think, that that's the answer when you have the public sector involved. And by the way, let's talk about "socialized medicine".

REPRESENTATIVE SCHEUER. I'm going to ask you to bring your answer to a close. Go ahead, though.

REPRESENTATIVE SANDERS. Understand that the Canadian system, as a matter of fact—which I advocate—is not socialized medicine. It is a national health-care system. Hospitals and doctors practice, by and large, exactly the way we practice here in the United States. Canada and Sweden are socialized systems——

REPRESENTATIVE OAKAR. Mr. Chairman, that is a really important question. Why can they do it cheaper and more comprehensively?

REPRESENTATIVE SCHEUER. With far better health outputs at a fraction of the cost.

REPRESENTATIVE OAKAR. I wouldn't trade, you know, having an American doctor do my surgey, but the point is, why do they do it cheaper and more comprehensively?

Let me just give you three or four elements that we looked at.

Number one, it's the single-payer issue. We have already mentioned that you save anywhere—depending on who you believe—the GAO said $67 billion. I sure believe that. Some are saying that we would save up to $200 billion to have a single-payer system.

REPRESENTATIVE SCHEUER. The Robert Wood Johnson Foundation Study indicated that we would save $3 trillion over ten years, which is $300 billion a year.

REPRESENTATIVE OAKAR. Add that up and, boy, would that reduce the cost of health care.

Second, they have preventive health care, and I didn't mention that. Unlike Congressman Dannemeyer, I believe firmly in mandating a top-notch system. Let me give you a quick example. If you mandate prevention and early detection—I know a little bit about breast cancer; take that as an example—it would apply to just about any disease. I asked the Pepper Commission staff—I put in all the amendments on prevention in the report—breast cancer, if you catch it at an early stage and you give the woman the opportunity to get a mammogram—that is part of her coverage—and you catch it in Stage 1, it costs $10,000 or less. If it's in an advanced stage, it costs between $65,000-125,000, and the person is at much higher risk.

REPRESENTATIVE SCHEUER. Yes, the statistics on a five-year survival rate are far greater if it's caught at an early time than it is when you catch it later on.

REPRESENTATIVE OAKAR. That is exactly right. At Stage 1, it's a 95 percent chance of cure, period. So, that is just an example.

All of the preventive measures that I have put in my bill, if you analyze it over a three-year period, will save $45 billion. If you give people free blood pressure checks, you don't have to pay for the stroke. If you give medication for that high-blood pressure problem, you don't have to pay for the ramifications of a more terrible disease. If you cover alcohol treatment, you don't have to pay for cirrhosis of the liver, or stroke, or heart disease, or kidney malfunction. We are just doing it backwards. We save money, we save lives. That is number two.

Number three, we have to have a team approach to health care. I was fairly close to Wilbur Cohen. I served on the Commission with him, who is the father, most people say, of Medicare. And I said, Wilbur, why did it take so long and why did you only reimburse doctors and the hospitals? He said, well, the lobbying effort—although I will say now that the American College of Physicians believes that we should have universal health care, and that's on the federal level, which I believe it should be for every American—you know, they are the highest expenses. But why do we mandate that a doctor must sign off for a nurse who gives a blood pressure check—I mean, she is just as capable of doing that, and I am giving a very simplistic example. But we don't have a team approach. One out of four elderly are anemic. We need a nutritionist to go in and talk to them about their diet because it changes when you get older. That is another area, a team approach, and there is a tremendous bias, Mr. Chairman, against female-dominated jobs like nurses, like nutritionists, like people that Congressman Dannemeyer mentioned, social workers. Let me tell you something, I want a psychiatric social worker to be part of a team approach in dealing with mental health disease, because they have the knowledge that will not only assist that person to be a productive individual, but they also will assist them in getting a job and other ramifications.

REPRESENTATIVE SCHEUER. Do you want to focus in your final remarks on how these capitalist countries overseas are able to provide a better level of service at far less cost when they're imbued on government for 70-80 percent of their care, compared to our country?

REPRESENTATIVE OAKAR. Because their care focuses on ambulatory care and your immediate needs.

REPRESENTATIVE SCHEUER. Preventive health care?

REPRESENTATIVE OAKAR. That's right. You know, day-to-day problems, you take care of, and it's covered. Now, they have said, well, what about all of the long lines in Canada. You know, who come to Cleveland, Ohio for open heart surgery? Let me tell you something—what is good about our education—the fact is that we're the pioneers of open-heart surgery and in all the very, very problematic areas, and we wouldn't have that problem because we have people who are trained. It is part of our training.

REPRESENTATIVE SCHEUER. We've already made the capital investment and infrastructure for all of this high-tech stuff that is life saving.

REPRESENTATIVE OAKAR. That is exactly the point. So, we have the trained people, and it is part of our tradition.

REPRESENTATIVE SCHEUER. And the equipment. We bought it, we probably have bought too many. There probably could be better sharing of MRIs and CAT scans and open-heart surgery centers. We probably could administer these programs far more economically than we do. But the fact is, we've already made the capital investments to set up this infrastructure across the country and it's there. We are not going to junk all of that.

REPRESENTATIVE OAKAR. Mr. Chairman, they also include in the Canadian plan long-term care. I don't know of any policy that gives comprehensive long-term care. Homemakers services—home care—that saves money, and most people are caregivers for their loved ones and they want to be the initial caregiver for the loved ones.

And finally, when you have a single-care system, which is in my bill, you really generate—and this is what the other countries do—effective cost containment. You have a state government approval of global hospital budgets; you would have negotiations for fare and adequate health-care-provider reimbursement levels. You streamline the claims, as we have already mentioned. You have the approval of capital high-tech equipment expenditures. You know, you don't have the advertising. It costs tons of money to do that, and you have extensive preventive health care mandated. I believe that we should mandate a high standard, and you'll save money and lives. And, Mr. Chairman, we can do it better and cheaper. I don't think it will cost the American people one penny more than what they're already paying, because the average person over 65 pays $2,000 or more in out-of-pocket expenses, plus all these other policies, because Medicare covers 45 percent of their needs. Then, they get Medigap and all of these other things, if they can afford it.

The average person under 65 pays $1,400 or $1,500 in out-of-pocket expenses that they wouldn't have to pay, and, believe me, we can do it and it will not cost any more. Honestly, we can. I am as concerned as he is about the deficit, but I know we can do it better and cheaper with a higher standard.

My bill, by the way, would cost five-sevenths of what we pay now, and everyone would be covered comprehensively and universally.

REPRESENTATIVE SCHEUER. Thank you very much, Congresswoman Oakar.

Congressman Dannemeyer, please proceed.

REPRESENTATIVE DANNEMEYER. Let me respond, Mr. Chairman, to your observations.

REPRESENTATIVE SCHEUER. I am asking you a question. How is it that these European governments that are capitalistic to their eyeballs, where they are very successful competitors in the global marketplace, where they're imbued with a profit system, how come our industrialized colleagues across the length and breadth of Europe and Asia, Japan,

Singapore, Hong Kong, are able . . . why have they made the decision to funnel most of their health-care expenditures through government, and why have they eschewed the private sector?

REPRESENTATIVE DANNEMEYER. Let me respond, if I may. In a seminar that I attended at Houston Medical Center a few years ago, I heard Dr. DeBakey talk about this point, and I don't think I will ever forget it. He said, you can ration by price or time, take your choice. And the countries that you've described, Mr. Chairman, where the money is all flowing through the government, they ration by time. We ration by price.

REPRESENTATIVE SCHEUER. I don't think there is any scientific evidence for that.

REPRESENTATIVE DANNEMEYER. On the contrary.

REPRESENTATIVE SCHEUER. Do you have to wait in France and Germany?

REPRESENTATIVE DANNEMEYER. This is the example he gave.

REPRESENTATIVE SCHEUER. In Canada, that's an absolute myth that you have to wait for critical care in Canada. It's an absolute myth that has been debunked time and time again.

REPRESENTATIVE DANNEMEYER. Now, listen to me, here's the example that he gave. He says, in a system that compensates a surgeon by price, the surgeon will provide six to eight procedures a day, and the consumer can get that surgery in a day or two. In a system whereby we are going to get that surgeon, we're not going to tolerate——

REPRESENTATIVE SCHEUER. Tell me which country you are talking about.

REPRESENTATIVE DANNEMEYER. Let me finish my example.

REPRESENTATIVE SCHEUER. I want you to tell me which country you are talking about.

REPRESENTATIVE DANNEMEYER. In those countries that have gone down the road of drafting those surgeons—those rascals charging high prices—into the service of the government to get them, he says, they will cut what they pay for their service down to a third or a fourth. Suddenly, instead of performing six or eight procedures a day, they will do two or three. They will come in at 10:00 a.m.; they'll perform one; they'll have tea and then lunch, and they'll do one in the afternoon.

REPRESENTATIVE SCHEUER. You are talking about a mythical country. I'd like you to tell me the countries where that prevails. I think it's a myth.

REPRESENTATIVE DANNEMEYER. Would you quarrel with the wisdom of Dr. DeBakey?

REPRESENTATIVE SCHEUER. Well, you're up here.

[Laughter.]

REPRESENTATIVE DANNEMEYER. This is what he said. You can ration it by price or time. This is why people in England today are developing a private-sector medical system. People are sick and tired of waiting in line in the failed national health-care system.

REPRESENTATIVE SANDERS. Will the gentlemen yield?

It is true that Margaret Thatcher underfunded and attempted to destroy the national health system of England, but one of the reasons that the

Labor Party is now ahead in the polls is precisely because they are attempting to rebuild the system after 12 years of Margaret Thatcher. She could not destroy the national health care because the people in England feel very strongly about that system.

REPRESENTATIVE SCHEUER. Okay. I appreciate this very interesting panel. You've been, for the most part, thoughtful and incisive.

[Laughter.]

We will now move on to the next panel.

[Pause.]

REPRESENTATIVE SCHEUER. We'll commence the third panel this morning. Dr. John C. Lewin, who is director of the Department of Health in the State of Hawaii; and then we'll hear from Richard Gottfried, Chairman of the Health Committee of the New York State Assembly; and the Honorable Janice Schakowsky from the State of Illinois, co-sponsor of legislation for a single payer health system. And our last witness will be Lee Tooman, Product Manager of the Golden Rule Insurance Company.

Senator Akaka will now say a word of introduction concerning the Director of Health for the State of Hawaii, John C. Lewin, who will be one of our witnesses. Mr. Akaka, we are honored to have you here. We are very pleased. Please take such time as you may need.

STATEMENT OF THE HONORABLE DANIEL K. AKAKA SENATOR FROM HAWAII

SENATOR AKAKA. Thank you very much, Mr. Chairman. I am certainly happy to be testifying before you and your Committee. I thank you for this opportunity to appear before the Subcommittee on Education and Health and to participate in this hearing on health-care reform.

As a co-sponsor of S-1227, HealthAmerica, I believe it is time for Congress to extend health-care coverage to the over 34 million Americans without health-care insurance today.

I will be joined by John C. Lewin, M.D., Director of Health in the State of Hawaii. Dr. Lewin was appointed by Governor John Waihee to head the Department of Health in 1986. Of Navajo, Irish, and Welsh descent, Dr. Lewin earlier served with the Indian Health Service. Prior to his current position, he was the Medical Director of Kula Hospital, a state community hospital. Dr. Lewin is the current President of the Association of State and Territorial Health Officers.

Mr. Chairman, you will hear from Dr. Lewin about Hawaii's long-standing commitment to make health care available to all citizens.

Mr. Chairman, I ask unanimous consent that his statement be placed in the appropriate place in the record as he has not arrived yet.

REPRESENTATIVE SCHEUER. We will have his statement appear in the record at the appropriate place.

SENATOR AKAKA. We have reached near universal access to health care in Hawaii. State officials estimate that 98 percent of the population is now

covered, and we have plans to provide coverage to the remaining 2 percent. Moreover, Hawaii ranks among the healthiest states, based on such indicators as low-infant mortality, low hospital utilization, and chronic disease rates. With 34 million Americans lacking health insurance, the Federal Government is clearly not fulfilling its responsibility of guaranteeing access to health care for all Americans. At the same time, however, the Federal Government is not doing enough to assist states like Hawaii that have not waited for Washington to act and have achieved universal health coverage through their own initiative.

The cornerstone of the health-care system in Hawaii is the Hawaii Prepaid Health Care Act of 1974. Nearly two decades ago, at a time when the Federal Government was only beginning to wake up to the problems with our health care system, the State of Hawaii was boldly moving forward by mandating that employers provide certain basic health-care benefits for their employees. The Hawaii statute is the first and only such mandate.

Over the years, the state has continued to refine and improve the system. Regrettably, the Federal Government has often been the greatest obstacle to allowing Hawaii to expand its system of universal health coverage.

Under the Employment Retirement Income Security Act—ERISA—states like Hawaii are precluded from imposing minimal health-care requirements on employers without a specific exemption from the act. Legislation, which I introduced to provide Hawaii such an exemption, was enacted by Congress in 1983. Unfortunately, Congress only permitted the state to require the specific health benefits set forth in the Hawaii Prepaid Health Care Act in 1974.

Consequently, this landmark law has been frozen in time. In order for the Hawaii Prepaid Health Care Act to retain its limited exception from ERISA, no substantive changes can be made in that act.

Seventeen years have passed since this legislation became law. There is an urgent need to bring it up to date. Dependent coverage, alcohol and substance abuse treatment, and the balance of premium contribution between employers and employees are major areas for revision. I have introduced a bill, S-590, which would exclude the Hawaii Prepaid Health Care Act from ERISA. Such an exemption would give Hawaii greater flexibility to improve both the quality and scope of health-care coverage to working men and women. It would also allow the state to address inconsistencies in its innovative approach to health care.

As a cosponsor of HealthAmerica, I have joined a coalition of enlightened members of Congress who recognize that the Federal Government has neglected the health of millions of Americans. However, while we pursue larger strategies to close the nation's health-care gap, we must not overlook more modest initiatives, such as S-590, which would allow states like Hawaii to expand innovative health-care programs that have proven themselves successful.

Mr. Chairman, Hawaii's experience has much to offer in this discussion on how to reform health care. We hope we can answer some questions and offer some solutions. I thank you very much for this time and would like to ask that Dr. Lewin be given time to present his statement when he arrives.

Thank you very much.

[The prepared statement of The Honorable Mr. Akaka follows:]

PREPARED STATEMENT OF THE HONORABLE DANIEL K. AKAKA

Mr. Chairman, thank you for the opportunity to appear before the Subcommittee on Education and Health and to participate in this hearing on health-care reform proposals. As a cosponsor of S-1227, "HealthAmerica," I believe it is time for Congress to extend health-care coverage to the over 34 million Americans without health-care insurance.

Today, I am joined by John C. Lewin, M.D., Director of Health in the State of Hawaii. Dr. Lewin was appointed by Governor John Waihee to head the Department of Health in 1986. Of Navajo, Irish, and Welsh descent, Dr. Lewin earlier served with the Indian Health Service. Prior to his current position, he was the Medical Director of Kula Hospital, a State community hospital. Dr. Lewin is the current President of the Association of State and Territorial Health Officers (ASTHO).

Mr. Chairman, you will hear from Dr. Lewin about Hawaii's longstanding commitment to make health care available to all citizens. We have reached near universal access -- state officials estimate that 98% of the population is covered. Moreover, Hawaii ranks among the healthiest states based on indicators such as low-infant mortality, low-hospital utilization, and chronic disease rates.

With 34 million Americans who lack health insurance, the Federal Government is not fulfilling its responsibility of guaranteeing access to health care for all Americans. At the same time, however, the Federal Government is not doing enough to assist states like Hawaii, which have not waited for Washington to act and have achieved universal health coverage through their own initiative.

The cornerstone of the health-care system in Hawaii is the Hawaii Prepaid Health Care Act of 1974. Nearly two decades ago, at a time when the Federal Government was only beginning to wake up to the problems with our health care system, the State of Hawaii was boldly moving forward by mandating that employers provide certain basic health-care benefits for their employees.

The Hawaii statute is the first and only such mandate. Over the years, the state has continued to refine and improve the system. Regrettably, the Federal Government has often been the greatest obstacle to allowing Hawaii to expand its system of universal health coverage.

Under the Employment Retirement Income Security Act (ERISA), states like Hawaii are precluded from imposing minimal health-care requirements on employers without a specific exemption from the act. Legislation, which I introduced to provide Hawaii such an exemption, was enacted by Congress in 1983. Unfortunately, Congress only permitted the state to require the specific health benefits set forth in its 1974 statute.

Consequently, this landmark law has been frozen in time. In order for the Hawaii Prepaid Health Care Act to retain its limited exception from ERISA, no substantive changes can be made in that act.

Seventeen years have passed since this legislation became law. There is an urgent need to bring it up to date. Dependent coverage, alcohol and substance abuse treatment, and the balance of premium contribution between employers and employees are major areas for revision. I have introduced a bill, S-590, which would exclude the Hawaii Prepaid Health Care Act from ERISA. Such an exemption would give Hawaii greater flexibility to improve both the quality and scope of health-care coverage to working men and women. It would also allow the state to address inconsistencies in its innovative approach to health care.

As a cosponsor of HealthAmerica, I have joined a coalition of enlightened members of Congress who recognize that the Federal Government has neglected the health of millions of Americans. However, while we pursue larger strategies to close the nation's health-care gap, we must not overlook more modest initiatives, such as S-590, which would allow states like Hawaii to expand innovative health-care programs that have proven themselves successful.

Mr. Chairman, Hawaii's experience has much to offer in this discussion on how to reform health care. We hope we can answer some questions and offer some solutions.

At this time, I would like to allow Dr. Lewin to make his remarks.

REPRESENTATIVE SCHEUER. He certainly will be, Senator, and we are very grateful to you for have taken the time and made the effort to come over here and join us. I can't ask you whether the citizens of the State of Hawaii approve of our current national health-care system, because they have something that is a considerable improvement due to the initiative and leadership of the officials out there.

Do you think the citizens of your state would like to see a single-payer system that is part of a full-blown national health-care system be made e to them, or do you think they're quite satisfied with the initiative and leadership that your folks have shown in creating a system that has approximately 98 percent access?

SENATOR AKAKA. I feel the people of Hawaii are satisfied with the system we have now, which has the potential of covering 100 percent. There is always that 2 percent of individuals who do not take advantage of the system. Therefore, we count it at 98 percent. Hawaii serves the gap group—those who fall through the cracks—wth a program that we call SHIP. The State Health Insurance Program covers students, uncovered dependents of covered workers, and others who are not covered by employer or public plans. This state health plan is subsidized by the state. This is a program that fills the final gap.

REPRESENTATIVE SCHEUER. And it exists side-by-side with private health-insurance programs that employers take advantage of.

SENATOR AKAKA. That's correct. We employ and use federal programs, as well as the private health-insurance programs in Hawaii. I should say that the reason why we are seeking a broader exemption is that when we received the 1983 exemption it froze our benefits as they were in 1974. We want to update the statute. To do that, we have to seek another exemption.

REPRESENTATIVE SCHEUER. Very good, and that will take congressional legislation?

SENATOR AKAKA. That is correct.

REPRESENTATIVE SCHEUER. I am sure that we in the House, we who support a broader role for the Federal Government and the concept of a single-payer system that, in effect, you have out there, will support your testimony and efforts. I appreciate very much your coming over here. We will place your health commissioner's testimony in the appropriate place in the record.

SENATOR AKAKA. I do appreciate that. Thank you very much, Mr. Chairman.

REPRESENTATIVE SCHEUER. Thank you very much.

We will now go to our next witness, the Honorable Richard Gottfried. Mr. Gottfried is Chairman of the Health Committee of the New York State Assembly and has introduced a single-payer bill, N.Y. Health, in the State Assembly. He has been a member of the Assembly since 1970. Previously, he has served as Deputy Majority Leader of the New York State Assembly. He is widely regarded as one of the more thoughtful and innovative leaders in the field of health-care reform in the country.

We are delighted to have you here, Assemblyman Gottfried, and we ask you to proceed when you feel comfortable. Take approximately seven or eight minutes to sum up your testimony.

STATEMENT OF THE HONORABLE RICHARD GOTTFRIED CHAIRMAN, HEALTH COMMITTEE OF THE NEW YORK STATE ASSEMBLY

SENATOR GOTTFRIED. Thank you. My name is Richard Gottfried, Chairman of the Committee on Health of the New York State Assembly. I commend you, Mr. Chairman, for your leadership in convening this hearing. Today, there are many issues in health-care reform that I could talk about, but I will focus on the question of universal health coverage. I believe that it is central to almost every other issue on the national and state health agenda.

America has the finest health care in the world, but millions are effectively denied access to it because they don't have health coverage. And businesses that provide coverage for their employees are being crippled by the costs.

America needs what almost every country in the world has, a universal health plan. Opinion polls show that most Americans agree, and I would certainly like to see this legislated at the federal level. But until and unless Congress acts, the states can and should do so. Historically, the states have often taken the lead in developing social policy.

That's why I've introduced the N.Y. Health bill in the New York State Assembly. The bill is very similar to H.R. 1300, introduced by Representative Russo. The Assembly bill now has 65 co-sponsors, out of 150 Assembly members, and they represent a broad spectrum, both geographically and politically across New York State.

The United States spends a higher percentage of its GNP on health care than almost any country, but some of our health statistics would embarrass many under-developed countries, from infant mortality to life expectancy.

Over 30 million Americans—over 2 million New Yorkers—have no health coverage. They don't have it at work; they can't afford it on their own and aren't poor enough for Medicaid or old enough for Medicare. Millions more have inadequate coverage.

As head of the State Assembly's Health Committee, I can tell you that almost every problem that I deal with is made worse by the large and growing number of uninsured New Yorkers.

Employers that provide coverage may spend about 15 percent of payroll to do it. They often see premiums go up over 20 percent a year. Small businesses have the hardest time finding affordable policies. And more and more employers are cutting back, or dropping coverage, or shifting more and more of the costs to their workers.

Insurance companies seek out so-called low-risk customers. Those who get labeled high risk are hit with exorbitant premiums or are rejected

entirely. Even Blue Cross in New York is trying to get approval to set rates like that, which is a radical departure for the Blues in New York.

Those who have coverage have problems too—deductibles, co-payments, insurers arbitrarily refusing to pay part of the bill or rejecting the claim.

It seems that everyone with coverage, or not, has a health-insurance horror story. As a state employee, I have a pretty good health plan. Even I have horror stories.

Hospitals and doctors waste time and money doing paperwork for hundreds of different health plans. Insurance companies spend enormous amounts on marketing, evaluating risk levels of customers, monitoring deductibles and co-payments, and deciding whether to reject claims. In New York State alone, it is estimated that the needless spending by providers and insurers wastes over $5 billion a year that could be spent on health care.

No health insurer has the power to effectively control health-care costs, and so they keep sky rocketing.

The problems, bad as they are, are getting worse everyday.

Here's how N.Y. Health would work:

Under N.Y. Health, every New Yorker would be covered automatically regardless of where they work, whether they work, their health condition, age, etc.

The coverage is comprehensive: inpatient hospital care, primary and preventive care, specialists, prescription drugs, dental and eye care, labs, X-rays, mental health, etc. N.Y. Health pays the bill. No deductibles, co-payments, or extra charges from providers.

Consumers would choose their own doctors, hospitals, and other practitioners and providers as they do now. Providers would get paid by N.Y. Health, not by the patient.

Hospitals would be paid on an annual budget negotiated with N.Y. Health. Instead of the wasted work and cost of billing and collecting, they would get steady funding from the plan.

Doctors and other providers would be paid fees set by the plan. Practitioners who choose to work for a hospital, neighborhood clinic, or HMO could be paid a salary. The clinic, or what have you, could be paid a set rate on the plan.

Employers who now provide coverage would no longer have to pay as much as 15 percent of payroll for premiums. N.Y. Health would be financed mainly by a 7½ percent premium paid by all employers, plus 1½ percent paid by employees, which the employer could and probably would pick up as a job benefit. Self-employed people would pay 9 percent of their earnings, up to the FICA income level. The funding of existing government health programs, including Medicaid and Medicare, would be merged into the N.Y. Health Trust Fund.

Senior citizens would continue to pay Part "B" premiums to N.Y. Health, but would no longer face co-payments, extra charges, or Medigap premiums.

The merger of Medicare and Medicaid revenues and coverage into N.Y. Health would not cost the Federal Government anything extra. It would, of course, be dependent on federal approval and, I note with some enthusiasm and excitement, Bernie Sanders' legislation in that regard. However, if this is not done, N.Y. Health would and could be structured as a wrap-around of those programs.

The plan, regretably, does not cover long-term care, although it directs the N.Y. Health Board once its established to develop a proposal. Existing Medicaid and Medicare long-term provisions would continue, however. I believe that the magnitude of the long-term care issue really requires federal action.

Many are skeptical about whether their government can do the job, but under N.Y. Health, the government would not be practicing medicine, it would simply be processing payments. And the present system to compare it to is an unmitigated nightmare.

The numbers work because we will save off the top about $5 billion in administrative and paperwork spending by hospitals, practitioners, and insurers. Also, the N.Y. Health plan will have for the first time comprehensive power to contain health-care costs. Premiums will be lowered, in part, because all employers will pay a fair share. And, finally, universal access to primary and preventive care will keep New Yorkers healthier and keep costs down.

There is some question as to whether a plan that is as comprehensive as N.Y. Health is politically viable. I believe enacting a health-care coverage plan at the national or state level requires two key ingredients.

The first is broad and enthusiastic public support. Other proposals, such as the so-called "pay or play" options, do not really bring any benefit to the vast majority that have some form of coverage now. They solve almost none of the problems of the current system. A universal single-payer system like the Russo bill or N.Y. Health offers real value to every American.

Second, a plan has to convince the business community that it will provide them relief and not an added burden. Again, I believe that the other options have little real attraction to the business community. Only a universal single-payer model can deliver relief by eliminating waste, spreading the cost fairly, and controlling the price of care. In short, a plan like N.Y. Health is the most practical option on the table, both as health policy and politically. It is not magic. I believe it is just common sense.

Thank you.

[The prepared statement of The Honorable Mr. Gottfried follows:]

PREPARED STATEMENT OF THE HONORABLE RICHARD N. GOTTFRIED

My name is Richard Gottfried. I am chairman of the Committee on Health of the New York State Assembly. I commend you, Mr. Chairman, for your leadership in convening this hearing. There are many issues in health-care reform that I could talk about, but I will focus on the question of universal health coverage. I believe that it is central to almost every other issue on the national and state health agenda.

America has the finest health care in the world. But millions are effectively denied access to it because they don't have health coverage. And businesses that provide coverage for their employees are being crippled by the costs.

America needs what almost every country in the world has -- a universal health plan. Opinion polls show that most Americans agree, and I would certainly like to see this legislated at the federal level. But until and unless Congress acts, the states can and should do so. Historically, the states have often taken the lead in developing social policy.

That's why I've introduced the "N.Y. Health" bill in the New York State Assembly. The bill is very similar to H.R. 1300, introduced by Representative Russo. The Assembly bill now has 65 co-sponsors (out of 150 Assembly Members). They represent a broad spectrum, both geographically and politically.

Over 30 million Americans -- over 2 million New Yorkers -- have no health coverage. They don't have it at work, can't afford it on their own, and aren't poor enough for Medicaid or old enough for Medicare. Millions more have inadequate coverage.

As head of the State Assembly's Health Committee, almost every problem that I deal with is made worse by the large -- and growing -- number of uninsured New Yorkers.

Employers that provide coverage may spend about 15 percent of payroll to do it. They often see premiums go up over 20 percent a year. Small businesses have the hardest time finding affordable policies. More and more employers are cutting back, or dropping coverage, or shifting more and more of the costs to their workers.

Insurance companies seek out "low risk" customers. Those who get labeled high risk are hit with exorbitant premiums or are rejected entirely. Even Blue Cross in New York is trying to get approval to set rates like that, which is a radical departure for the Blues in New York.

Those who have coverage have problems, too: deductibles, co-payments, insurers arbitrarily refusing to pay part of the bill, or rejecting the claim.

It seems that everyone -- with coverage or not -- has a health-insurance horror story. As a state employee, I have a pretty good health plan. Even I have horror stories.

Hospitals and doctors waste time and money doing paperwork for hundreds of different health plans. Insurance companies spend enormous amounts on marketing, evaluating risk levels of customers, monitoring deductibles and co-payments, and deciding whether to reject claims. In New York State alone, it is estimated that the needless spending by providers and insurers wastes over $5 billion a year that could be spent on health care.

No health insurer has the power to effectively control health-care costs, and so they keep sky rocketing.

The problems are getting worse everyday.

Here's how New York Health would work:

Under N.Y Health, every New Yorker would be covered automatically regardless of where they work, whether they work, their health condition, age, etc.

The coverage is comprehensive -- inpatient hospital care, primary and preventive care, specialists, prescription drugs, dental and eye care, labs, mental health,

etc. New York Health pays the bill -- no deductibles, co-payments, or extra charges from providers.

Consumers would choose their own doctors, hospitals, and other practitioners and providers as they do now. Providers would get paid by New York Health, not by the patient.

Hospitals would be paid on an annual budget negotiated with New York Health. Instead of the wasted work and cost of billing and collecting, they would get steady funding from the plan.

Doctors and other providers would be paid fees set by the plan. Practitioners who choose to work for a hospital, neighborhood clinic, or HMO could be paid a salary. The clinic, or what have you, could be paid a set rate on the plan.

Employers who now provide coverage would no longer have to pay as much as 15 percent of payroll for premiums. New York Health would be financed mainly by a 7.5 percent premium paid by all employers, plus 1.5 percent paid by employees (which the employer could and probably would pick up as a job benefit). Self-employed people would pay 9 percent of their earnings, up to the FICA income level. The funding of existing government health programs (including Medicaid and Medicare) would be merged into the New York Health Trust Fund.

Senior citizens would continue to pay Part "B" premiums to N.Y. Health, but would no longer face co-payments, extra charges, or Medigap premiums.

The merger of Medicare and Medicaid revenues and coverage into N.Y. Health would not cost the Federal Government anything extra. It would, of course, be dependent on federal approval and, I note with some enthusiasm and excitement, Bernie Sanders' legislation in that regard. However, if this is not done, New York Health would and could be structured as a wrap-around of those programs.

The plan, regretably, does not cover long-term care, although it directs the New York Health Board once its established to develop a proposal. (Existing Medicaid and Medicare long-term provisions would continue.) I believe that the magnitude of the long-term care issue really requires federal action.

Many are skeptical about whether their government can do the job, but under New York Health, the government would not be practicing medicine -- it would simply be processing payments. And the present system to compare it to is an unmitigated nightmare.

The numbers work because we will save off the top about $5 billion in administrative and paperwork spending by hospitals, practitioners, and insurers. Also, the N.Y. Health plan will, for the first time, have comprehensive power to contain health-care costs. Premiums will be lowered, in part, because all employers will pay a fair share. And, finally, universal access to primary and preventive care will keep New Yorkers healthier and keep costs down.

Some question to whether a plan that is as comprehensive as N.Y. Health is politically viable. I believe enacting a health-care coverage plan at the national or state level requires two key ingredients.

The first is broad and enthusiastic public support. Other proposals, such as the so-called "pay or play" options, do not really bring any benefit to the vast majority that have some form of coverage now. They solve almost none of the problems of the current system. A universal single-payer system like the Russo bill or N.Y. Health offers real value to every American.

Second, a plan has to convince the business community that it will provide them relief and not an added burden. Again, I believe that the other options have little real attraction to the business community. Only a universal single-payer model can deliver relief by eliminating waste, spreading the cost fairly, and controlling the price of care.

In short, a plan like N.Y. Health is the most practical option on the table, both as health policy and politically. It is not magic. I believe it is just common sense.

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Gottfried. We will now hear from Dr. John Lewin, Director of the State of Hawaii Department of Health.

As I said before, he is President of the Association of State and Territorial Health Officers, and prior to his current position, he was in private medical practice. You've been very eloquently introduced by Senator Akaka.

Please proceed and take seven or eight minutes.

STATEMENT OF JOHN LEWIN, DIRECTOR STATE OF HAWAII DEPARTMENT OF HEALTH

DR. LEWIN. Thank you very much, Mr. Chairman. I am grateful to be able to serve with Senator Akaka and our congressional delegation, and I appreciate their contribution to the health care system of Hawaii on an ongoing basis.

I am here not only representing the Hawaii State Department of Health and the State of Hawaii, but also Governor Waihee, and I bring you his greetings.

Hawaii is a state that, perhaps, because of its relative isolation from the rest of the country in terms of having more than 2,000 miles of ocean between us and the mainland, has proceeded with health-care reform over the last two decades. We may have embarked upon this effort partly because we didn't know that the things we were doing were allegedly impossible. And, in essence, some very opportune results have been forthcoming from the developments in Hawaii which relate to the national health-care reform agenda.

Hawaii committed itself to universal health-care access some years ago as a result of a legislative agenda that occurred in 1974 with the passage of the Hawaii Prepaid Health Care Act. Hawaii became the first of the American states to mandate that all employers buy health insurance for each and every employee. The only people exempted from the law were people who work less than 19 hours a week and certain federal and government employees who are covered in other ways. When that law happened, Hawaii reduced its gap group of about 17 percent, down to approximately 3-4 percent. Employees of small businesses constituted most of the people who became insured with the passage of this law. Family coverage was offered as an option to all employees by this law, and most of the families, in fact, more than 95 percent of the family members of the small business persons were also covered by this option. So, the gap group in Hawaii went from 17 percent, where most of America still remains today, down to something like 3 to 4 percent of the population in the mid-1970s as a result of this single piece of legislation.

Something else happened when that occurred. That is, the insurance companies through a market competition process gave up experience rating and underwriting of small businesses. That is, the competition of employers and union people through negotiation resulted in the emergence

of two insurance entities, Blue Cross/Blue Shield and Kaiser Permanente, who offer community ratings to businesses under 100. What happened is that Hawaiian small businesses are now community rated on the basis of a voluntary, nonlegislative approach that has resulted in small business health insurance rates being the lowest in the Nation. This is a significant part of the success that we have had and is a vital part of what small businesses across America need to understand about Hawaii. We have mandated universal health insurance for all employers, but we have the lowest rates for health insurance in the Nation. Our rates average something like $1,100 per year, or $90 per month for individual coverage and a little over $3,000 per year, or $250 per month, for family coverage, for small businesses. This is about a third of what many of the states are having to pay right now for small business communities. So, this is a tremendous outcome for small business in Hawaii. I hope that the Committee will take a good look at this aspect of Hawaii in the future.

Hawaii also has a Medicaid program consistent with the other states. And between the Prepaid Health Care Act and Medicare and Medicaid, 95 percent of Hawaii's public is presently covered.

A third and very vital insurance mechanism was developed during the last few years in Hawaii called the State Health Insurance Program, or "SHIP", by which we insure the remaining people who are left in the gap: students, the unemployed, part-time employed, persons who are the owners of small businesses, and any others who have fallen through the cracks. SHIP is funded as a split cost between the insurer and the State of Hawaii general fund. Persons under 100 percent of federal poverty are covered by the program at no expense to them other than the small co-payments that they make at the time of the visit. Others, up to 300 percent of the federal poverty level, pay on the basis of a sliding scale. The maximum beneficiary payment is $60/month for individuals, but $120/month for families.

With these three programs, Hawaii has achieved universal access in that 98 percent of our people are presently holding a health-insurance policy of some sort.

What are the outcomes of these programs in Hawaii? Many people think that Hawaii has achieved healthy outcomes because of either genetic predisposition of our population—the choice of healthier lifestyles than the rest of America—or perhaps because of great weather. None of those things, in terms of the data that we've gathered, are real reflections as to why our health status is high, or why our health insurance rates are low. We have poverty in Hawaii; we have the highest cost of living of just about anyplace in America; we have housing costs that are the highest in America today. Our families have to struggle. Almost every family has to have both husband and wife working full time and sometimes at more than one job to make it. It is a very difficult place for people to "get by." We have our share of the elderly and abject poverty, and certainly we have the problem of migration of Pacific islanders and people from all over the Pacific coming to Hawaii to seek solutions to their health-care

problems. The native Hawaiian people—20 percent of the population—have the poorest health status of any ethnic group in America, so we have achieved what we have done in Hawaii primarily because we offer primary care and prevention to nearly all of our citizens.

The result of that is that we have fewer hospitalizations, one-third as many as the national average; we enjoy a reduction of one-third for the hospital days per capita in our state, and that is the main source of our cost savings right there; we also enjoy a reduction by one-third of emergency rooms compared to America's national average. However, we experience an increased number of outpatient visits that are less expensive, obviously, and emphasize our reliance on primary care.

Health-statistics-wise, we have the greatest longevity in the Nation; the lowest premature morbidity and mortality for heart disease, cancer, and emphysema; the lowest in mortality, and really very good general health outcomes.

We'd like to point out that Hawaii got to where it is by a commitment to universal care for everybody. We still have a long way to go even though we are at a much lower base in terms of the health-care costs. We have all the technology and the glitz and over-utilization of health-care that characterizes the American health-care system. So, we are working with our small businesses and legislature to find ways to reform the system and reduce the costs and the inflation of health care in Hawaii.

Our cost containment has been very interestingly accomplished in a marketplace-kind-of-arrangement between competing insurance companies. What we'd like to do in the future is to get comprehensive health insurance data to consumers, businesses, and labor unions through some process of mandating that all health data, insurance data, and so forth become available to them for analysis and review so that the purchasers of health insurance become smarter shoppers, and a more cost conscious health-care marketplace results. The purchasers of insurance must be better informed and educated so as to become better shoppers and consumers of health care, not only to reduce costs, but also to reduce unnecessary expectations on their part.

In summary, we think that Hawaii has some important health-care lessons for the rest of the nation that we'd like to share. First, prevention and primary care <u>really work</u>. By giving everybody access, you actually reduce costs. We are the only place in America that you can actually observe a system that has had 17 years of experience in near-universal access. The results are that such access reduces overall cost and improves health outcomes. We've proven that.

Second, we know that employer health mandates <u>do</u> work. We feel that this mechanism of insurance is better than a taxation approach because it encourages employers to be smart shoppers and promotes competition and incentive in the workplace. It also promotes incentives for insurance companies to manage care at reduced prices as a result of negotiations with employers and labor unions.

Third, if employer mandates are to be developed, they have to be accompanied by community ratings for all small businesses to render affordable rates.

As Hawaii proceeds with further reform, I hope that we can work with this Committee and with the members of Congress to affect a national health policy that would offer the rest of America some of these same advantages.

Thank you very much.

[The prepared statement of Dr. Lewin follows:]

PREPARED STATEMENT OF JOHN C. LEWIN

Thank you for the opportunity to contribute to national health policy development by outlining Hawaii's innovations. We appreciate the opportunity and recognition you have given by inviting us here today.

Hawaii is often thought of as a tropical paradise. What isn't known is the fact that we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost. Despite our high cost of living, we emphasize early intervention and outpatient treatment but Hawaii enjoys high-tech tertiary care programs as advanced as any state or nation. This system has resulted in one of the lowest infant mortality rates in the nation. We have the lowest death rates from chronic illnesses such as cancer and heart disease.

The key to our success, I would hold, is our state's longstanding commitment to ensuring that basic health care is available to all our people. Our Governor, John Waihee, points out we have 100% access and 98% coverage. Another cornerstone is Hawaii's innovative health care community which experimented with short hospital stays, outpatient surgery, and preventive health programs some time before they became the norm on the mainland United States.

Our state has a mandated employer benefits program, the only one of its kind in the nation. Only two other states have implemented more Medicaid Section 2176 waivers than Hawaii. We offer coverage to those left in the gap between these other programs through our new, subsidized State Health Insurance Program (SHIP). We don't offer these programs as panaceas for the national crisis of the uninsured. But, they are applicable to the people of California, South Dakota, New Hampshire, or any other state. I've come 5,000 miles to bring you the message: We have something of value to share, as do our partner states, and together we can contribute to national policy in health care.

HAWAII PREPAID HEALTH CARE ACT

Let's start by exploring a few basics about the Hawaii system. The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for virtually all employees in the State. The Act is administered by the State's Department of Labor and Industrial Relations. This measure was passed after many years of study and policy development; passed in a time of moderate unemployment in an environment already strong in employment-based health care coverage.

The Prepaid Health Care Law is the nation's first and only state mandated benefits plan. Employers are required to provide health insurance to their employees. Dependent coverage is optional. Costs are shared. The employee pays up to 1.5% of monthly wages, up to half the premium cost. The employer pays the balance. Dependent coverage is optional. Under the law, employers may provide benefits through self-insurance as long as those basic services are provided. There are coverage alternatives, a fee-for-service plan and a health maintenance plan. The fee-for-service plan -- most used in Hawaii -- provides a good package of diagnostic and treatment services, using co-payments to reduce over utilization. The HMO provides a generous package of benefits.

Any employee who works over 20 hours a week and makes a minimum per month is eligible for Prepaid Health Care. Because the program is administered in conjunction with temporary disability and workers' compensation insurance, no large state bureaucracy was created to administer Prepaid Health Care. A Premium Supplementation Fund assists employers who cannot, because of economic limitations, provide the insurance, and to assist employees whose

employers have gone out of business or who have not provided for the insurance. This fund has had minimal use over the 17 years of the program.

Excluded from the provisions of the Act are government employees (who have their own plan), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Prepaid Health Care has been very successful in bringing about coverage without negatively affecting business. Effects on unemployment have been negligible; in fact, over the last 16 years our unemployment rate has fallen to the lowest in the nation (I make no claims about a cause-effect relationship in this regard, but this seems to at least cast some doubt on assertions that such mandates will cause unemployment).

In addition the Act does not appear to have an adverse effect on "start up" of new businesses. In 1989, for example, our small business incorporation rate increased 18.2%, making Hawaii the third fastest growing state in the nation for small business. Hawaii also ranks fairly low on company failures. These figures are particularly striking for Hawaii, a small business state. About 97% of our businesses employ less than 100 and 94% have 50 or fewer employees. As you can see, our employer mandate has not had an overall negative effect on small business in Hawaii.

ERISA AND PREPAID HEALTH CARE

The Prepaid Health Care Act was passed just months before the Federal government passed the Employee Retirement Income Security Act (ERISA), which among its detailed provisions preempted state employer mandates. After long court challenges, special Federal legislation was passed in 1983 which allowed the Hawaii mandate to continue. The exemption, however, used as its base the 1974 law. Since then Hawaii's health care environment has changed but the state lacks the ability under the exemption to amend the Act to reflect these changes.

While the 1974 Act still serves us well, we could benefit from change on coverage of dependents of workers, cost-share change between employer and employees (especially with respect to higher income employees) and benefits.

COMMUNITY RATING FOR HEALTH INSURANCE

Because virtually all employers must provide insurance, health care contractors maintain health insurance rates for small employers which are comparable to those enjoyed by large employers. This has happened because the two major health insurers in Hawaii (both non-profit) voluntarily use modified community rating for small businesses, which keeps rates for comparable coverage well below rates for small business elsewhere in the country.

The results have been extremely positive. Small business can purchase insurance at reasonable rates. Employees are covered with health insurance. Insurance companies cut administrative costs and can market to a large pool of businesses. Prepaid Health Care has provided a uniformly level field for competition in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

MEDICAID

Hawaii's Medicaid Program services over 80,000 persons with a budget of about $250 million. It is administered by the State's Department of Human Services.

Hawaii provides Medicaid to both categorically needy and medically needy people. The elderly and disabled with income up to 100% of the poverty level, and children under age 6 whose family income is up to 133% of the poverty level, are covered. We opted to provide coverage for pregnant women and infants with income up to the maximum allowed by statute (185% of poverty). We also

implemented the "presumptive eligibility" provision for pregnant women to encourage early prenatal care.

HAWAII POPULATION WITHOUT HEALTH CARE INSURANCE

The effects of these programs, particularly Prepaid Health Care, is evident. In 1971, a survey showed that those without hospital insurance were almost 12% of our population and those without physician insurance were more than 17% of the population. Implementation of Prepaid Health Care dramatically dropped those figures. Estimates of those enfranchised with health insurance range from 3,000 people to more than 46,000. Other people were provided better coverage. The Department of Health estimates that those figures have grown with the shrinking of Medicaid to approximately 5% in 1987-1988 when planning began for the State Health Insurance Program.

Gap Group

We have not included the entire uninsured population in our definition of Hawaii's "gap group." We focused on people who are not insured by public or private health care coverage programs and whose income is low enough that they cannot buy regular health care insurance. The number is estimated to be between 30,000 and 35,000 people.

Populations at risk in the gap group are those who, for one reason or another, lack access to Prepaid Health Care. A 1988 survey found the unemployed make up more than 30% of Oahu's uninsured. This is probably true of the neighbor islands, too. Dependents of low-income workers, particularly children, are another major gap group. Part-time workers, excluded from Prepaid Health Care, are another population at risk. Neighbor island residents, immigrants, seasonal workers and students are also at risk, although they are not formally excluded from Prepaid Health Care.

STATE HEALTH INSURANCE PROGRAM

The State Health Insurance Program was implemented to meet the needs of this gap group. The program provides universal access to basic health care services for all of Hawaii's people by building upon Hawaii's Prepaid Health Care Act and Medicaid.

SHIP subsidizes affordable health care coverage, encourages use of private insurance and Medicaid and discourages shift to SHIP from private coverage. This makes SHIP a partnership between government, individuals and families, and the private sector. Government subsidizes insurance premiums for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially the model adopted by the State of Washington in its pilot Basic Health program.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child coverage and accident coverage fully covered. Twelve physician visits are allowed with a $5 co-payment during the course of the year. An individual's hospitalization, however, has been limited to 5 days. Two days is allowed for maternity care. Elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will qualify for Medicaid after exercising "spend down" for these costly procedures.

Costs

The insured's share is based on a sliding fee scale where individuals pay a portion of the cost on a monthly basis and are billed directly by the insurance

company. This fee scale is based upon ability to pay. Persons below the poverty level pay no fee and the monthly charges for those above poverty increase with income level. Co-payment at the time of a non-prevention visit is $5 and is required for all subscribers.

SHIP CARRIERS

SHIP insurance is delivered through contracts with the State's two largest insurers -- Hawaii Medical Services Association (HMSA), which has about 60% of all health insurance in Hawaii and Kaiser Permanente, which has about 17%. Both have cooperated enthusiastically with us in this program.

The Hawaii Medical Service Association contract covers the bulk of SHIP's subscribers with a statewide fee-for-service plan, although we do propose HMO coverage be developed. Almost one-half (about 1,000 physicians) have signed on to participate in SHIP through HMSA. Only 20% of SHIP's funds can be used for in-patient hospitalization. The philosophy that we've adopted is that hospitals provide for care for this group already -- much of this is uncompensated. The additional funding, even if it does not cover the whole cost of care, will assist the hospitals in providing for their needs.

The Kaiser contract is limited to 2,000 subscribers on the island of Oahu. Kaiser subsidizes a portion of the costs of the coverage for their full health maintenance coverage for these people.

PROGRAM IMPLEMENTATION

SHIP was launched statewide on April 16, 1990. From the beginning, our objective has been to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

Our major task has been to bring people into SHIP, to target what would be in any state perhaps the most difficult to reach, those people who are outside of the system. We have emphasized the non-traditional, with shorter application forms, instant access for special groups (pregnant women), and special outreach efforts to hard-to-reach groups such as immigrants.

We also have developed a broad-based community outreach program. Over 200 volunteers have been trained to assist people filling out the SHIP application form. Our volunteers are enthusiastic -- drawn from both Department of Health, private social service agency and community organizations ranks. This effort has transcended our regular organizational structure and has brought a wide range of staff together in this exciting effort.

We have worked very closely with our public agency partners -- the Department of Human Services and the Department of Labor and Industrial Relations -- developing a referral system from these two major State agencies to provide clients for SHIP.

We're also part of a unique program which uses touchscreen computers to provide information and referral on state health and human services. This program, called Hawaii Access, is at five locations statewide. We also have developed a module which allows people to actually apply for SHIP through this publicly accessible computer touchscreen.

What has been the result of this effort? As of October 1, 1991, we have enrolled over 12,000 members aboard HMSA-SHIP and 2,000 in Kaiser-SHIP. Our first "SHIP baby" was born in Hilo, Hawaii on June 4, 1990. As expected, SHIP members are, in general, young (43% are under age 18). Outreach in rural areas appears to have been successful -- almost 48% of SHIP clientele is from the generally rural neighbor islands. Sixty-five percent (65%) of SHIP membership has family income below the Federal poverty level, with almost 85% of the membership below 150% of the poverty level. Our SHIP population mirrors the population of uninsured found in the Robert Wood Johnson demonstration project and in

Washington State's Basic Health Plan. It is young, healthy and a good risk for insurance. Program utilization, given our short experience, appears to be good.

HAWAII'S EXPERIENCE AND NATIONAL HEALTH POLICY

We believe our experience has real relevance to national health policies. Among the most important aspects of our state's program are:

1. Primary care works to contain health care costs:

   Historically, Hawaii's doctors emphasized outpatient care. Today's modern practice patterns reflect this orientation. Our Prepaid Health Care Act made it possible for most people living in Hawaii to finance this care. Today, our health indicators show the results of primary care:
   -- Lowest rates of premature mortality in the nation for:
      - Heart Disease
      - Lung Disease
      - Breast Cancer
   -- Lowest hospital bed rates in the nation (2/3 the national average)
   -- Lowest infant mortality (with Vermont) in the nation

   As you can see, early detection of potentially life threatening conditions results in low premature mortality and low hospitalization. Our people are healthier not because of unique genetics, healthy climate or high tech medicine, but because they have access to primary care.

2. Mandated employer coverage can be an effective tool for universal access:
   In Hawaii, we do not have a "pay or play" system with its tax. In Hawaii, "everybody plays." In our system, all employers are required to provide coverage -- and they are allowed the flexibility to determine how coverage is provided. Under this arrangement, business does what business does best in America -- it finds the best cost solution -- in this case, to provide health care. This program has brought the rate of people without medical coverage from over 17% in 1971 to about 5% in 1988 -- without negative effects on small business.

3. Some form of community rating by health insurance companies must accompany an employer mandate:
   It is only fair that a mandate be accompanied by affordable insurance rates, which are possible through community rating. In Hawaii, ours is done voluntarily by the two major insurers, both non-profit organizations -- HMSA and Kaiser. This voluntary modified community rating works in keeping our rates low.

4. Using an employer mandate to cover a large number who would be otherwise uninsured, states can develop affordable public coverage systems for the remainder:
   Hawaii's Medicaid program covers about 80,000 people. SHIP, with its subsidized insurance for 14,000 otherwise uninsured people fills the gap between employer coverage and Medicaid without breaking the state treasury. (Federal flexibility would allow us to work more closely with Medicaid to create an even better program for those who need help with their health care coverage).

5. Partnerships Work:
   Prepaid Health Care, SHIP, and particularly voluntary community rating has involved a large degree of private sector collaboration with government. Instead of arguing endlessly about potential problems, when the chips are down, the public and private sectors have pulled together to produce winning products. Hawaii proves that health care reform can happen, can be successful, and can help all involved.

6. The importance of states in effecting health care reform:
   Thanks to its ERISA waiver Hawaii, though a small state, has demonstrated that an employer mandate can be successful in reducing the numbers of uninsured. Even this small number has now been reached through our SHIP . Further, the voluntary efforts of its two major insurers have produced health care coverage at costs well below most, if not all, other areas of America. We have successfully pioneered a number of important mechanisms to address health care access and cost. Other states are taking action to deal with their problems of health care access and cost. Whether or not action can be taken at the national level in the near future, states should be given more tools to address their own internal health care problems -- tools such as ERISA waivers and Medicaid/Medicare flexibility. With these tools, state actions will not only respond to the immediate problems of individual states, but as Hawaii has, "test out" models for future adoption at the national level.

As a state, we are proud to be able to contribute what we can to this national forum. Rather than attempting to create a national health insurance or a national health delivery system, Hawaii strongly recommends a national health policy of benefits for all citizens to be implemented and organized by the fifty states. Costs should be shared by both Federal and State governments. Until consensus can be achieved on a national policy of universal access, we recommend four basic policies to enhance the roles that states play in policy development. These recommendations would alter current Federal policies or programs which tend to inhibit state capacity for experimentation. We propose such flexibility, mindful of the memorable words of Justice Brandeis: "To stay experimentation on things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." In this concept, we propose the following to enhance the respective state's capabilities to develop individual responses to the crisis of the uninsured:

1. Allow waivers or exemptions from ERISA restrictions on state-mandated employer coverage:
   ERISA freezes the Hawaii Prepaid Health Care Act at the 1974 level. This impedes the growth of innovative changes to our program. Allowing waivers or exemptions from the ERISA restriction, such as proposed in Senator Akaka's legislation (S 590), will allow Hawaii and other states to experiment with mandated benefits and closely evaluate the results. For example, a state might wish to mandate only large employers to cover their employees and compare itself with other states like Hawaii which cover most of the employed within their boundaries. Similarly, the effects of various benefits packages, the impact of different cost sharing arrangements, or the changes brought about by insurance market reform could all provide for more informed decisions at the national level.

2. Reform Medicaid:
The current Medicaid system is a patchwork of Federal mandates and options, linked together with heavy doses of administrative restrictions. States must sometimes wait years for waivers and changes in state plans to be approved by various HCFA offices. In order for Medicaid to be more responsive and flexible, we propose:
   A) Flexibility for greater state experimentation with Medicaid delivery systems. Such options as employer buy-ins and co-payments which have been outlined in the policies of the Bipartisan Senate Committee could be tried in various states. Alternatives not yet conceived nationally might find fertile ground in one state or another.
   B) Reduction in the administrative paperwork required for Medicaid. Many administrative requirements of Medicaid actually serve as barriers to the poor, be they working poor or indigent. If indeed Medicaid is to be a program for the poor, it must reach them. Major reforms which allow for state flexibility in this area should be enacted.
   C) Creation of incentives for managed care alternatives under Medicaid. Very few managed care programs exist in Medicaid programs, and none at a statewide level. Fiscal and administrative incentives to offer such alternatives would help the spread of a more cost effective and responsible methodology of care.

3. Create a fiscal base for reforms:
While large sums of Federal dollars for health care reform do not exist, minor shifts of funds and incremental increases could provide the base for experimentation. Such alternatives might be:
   A) Provide a Federal tax incentive for employers offering minimum benefit coverage.
   B) Increase Medicaid reimbursement levels for institutions and primary care providers, particularly those in areas where there is a high proportion of uninsured persons. This temporary measure could assist institutions impacted by large numbers of uninsured.
   C) Make available Medicaid funding for state innovations rather than enact Medicaid mandates.

4. Allow for significant state latitude in program development and implementation:
The states remain inventive and important actors in this process by developing new models and systems of delivery. By sharing this innovation, states contribute to policy development. For example, SHIP has greatly benefitted from working with Washington State's Basic Health plan. Even with implementation of Federal policies, the states should be given the flexibility to continue as major actors. Any future Federal health care legislation should be formulated on the basis that the Federal programs are safety nets and do not preempt state programs which seek to provide better benefits to their citizens. In fact, new Federal/State partnerships should be explored, such as possible joint projects for Medicare recipients. Through this principle, states can be encouraged to continue in the forefront of policy development in health care finance.

If implemented, over the next few years, these principles should provide important national experience with many different approaches to universal access or universal coverage. From this broad base, truly responsive and workable national policy can result, policy that will meet the important health care needs of America's uninsured without bankrupting America.

Thank you for the opportunity to contribute our thoughts on this vital national issue.

REPRESENTATIVE SCHEUER. Thank you, Dr. Lewin for your very thoughtful testimony.

Our next witness is the Honorable Janice Schakowsky, a member of the State Legislature in the State of Illinois. She is co-sponsor of legislation to create a single-payer health-care program in Illinois. She was first elected last year. Prior to her election to the Illinois Assembly, she was a consumer advocate for more than 20 years. So, you are a very durable product of the consumer movement. We are delighted that you are here. Please take seven or eight minutes, and give us the highlights of your presentation.

STATEMENT OF THE HONORABLE JANICE D. SCHAKOWSKY MEMBER OF THE ILLINOIS STATE LEGISLATURE

MS. SCHAKOWSKY. Thank you, Mr. Chairman. It is an honor to be here. I am Janice Schakowsky, legislative representative from Illinois's 4th House District, primarily a middle-class district that encompasses Evanston, Rogers Park, and Chicago. I worked for five years as director of the Illinois State Council of Senior Citizens, which dealt with a lot of issues regarding aging and health care.

I want to briefly outline what the rapidly increasing health-care costs have meant in Illinois, both to our state government and to our citizens, and why we are so impatient at what we believe to be an issue that should be dealt with comprehensively at the national level, isn't, and why we feel we have to move in Illinois.

Last year, Illinoisans spent an estimated $30 billion on health care, or $2,619 per capita. That is two and a half times as much as was spent in 1980. And at the current rate, it will double again to a projected $69 billion by the end of the decade. It impacts every sector of our economy.

I want to first mention the uninsured. We have one and a half million Illinoisans who are uninsured. Two-thirds of those are in families that are headed by a working person. Sixty percent of those are children or women of childbearing age. But I want to say that we would not have health-care reform if it were only a question of those who were at the bottom level of our economic scale.

The reason, we believe, that we can win on this issue is because it is an issue that is now affecting more and more of our population, more and more of the higher income people.

In the last two years, employer health-care benefits in Illinois, the cost of those benefits for employers rose 50 percent. They paid as much for medical coverage as they realized in profits. Employers dealt with the problem by shifting more of the burden onto their employees. Based on U.S. Department of Labor figures, Illinois workers paid an additional $500 million last year in higher premium costs for employer-provided coverage, and that doesn't count the hundreds of millions of additional dollars in co-payments and deductibes that are employee paid.

The AFL-CIO has estimated that about 80 percent of strikes and job actions are related to health-care issues. Illinois is no exception. We are now faced with the likelihood of a major strike at a Caterpillar Tractor, the state's largest major industrial employer, over health-care benefits.

I want to perhaps correct something that Congressman Stark said, with all due respect. At least in Illinois, and I believe nationally, the United Auto Workers and its members strongly support a single-payer system. He said it would be hard to sell this to UAW members. That is not the case, certainly not the case in Illinois. And as far as management, the health-benefits manager from Caterpillar testified at a hearing in Chicago held yesterday that single-payer is the only way to go.

As a state lawmaker, I am regularly called by constituents who have been victimized by our deteriorating health-care system. I got a call in the last couple of weeks from a couple of people who actually—the bottom line—were stuck in undesirable jobs because they were afraid to lose their health-care coverage if they switched employers, or someone found that their treatment is no longer covered because their employer got a new carrier and now it's a preexisting condition that isn't covered under the new policy.

I heard from, and hear regularly from, people who can't afford the cost of long-term care for their spouses or their parents. I heard from a woman whose child is disabled and will be for life and who is about to reach the maximum on what their insurance policy pays. But among those least protected is state government itself. State spending in Illinois on Medicaid, for example, more than doubled during the past decade, even though Illinois only pays 67 cents on the dollar required to provide Medicaid services. We are 50th in reimbursements to hospitals, and we are 39th in reimbursements to nursing homes. We owed to the end of the fiscal year $700 million in back-logged Medicaid claims.

And to close the revenue gap, what did we do? Two things. The governor proposed incredible reductions in his FY 1992 budget. Let me emphasize that our budget crisis in Illinois is largely health-care driven. There is a *Washington Post* article today that says that's true in many, many states now. So, we eliminated many health-care benefits for our citizens, particularly the poor citizens, and we also cut our pharmaceutical assistance program for the elderly. I am anxious to see now if many of those elderly don't end up in nursing homes now because they can't afford the pharmaceuticals that they need, and we'll end up paying more in Illinois for nursing home costs.

While a number of the proposals that were suggested by the governor were rejected by the General Assembly, others were incorporated. The main way that we saw out of our budget crisis was to come up with a provider tax to get Medicaid matching funds from the Federal Government, equal to about $650 million. Many other states have devised those programs. And now we understand that the Bush Administration has loudly announced its opposition to such matching fund efforts, throwing our entire budget into jeopardy.

If I could just urge you to support H.R. 3595, which would prohibit HCFA from implementing these new regulations, and allow us at least to capture some federal dollars to get us out of this health-care bind. Lacking federal direction and unwilling to wait, we have attempted to institute a variety of short-term solutions aimed at addressing the most pressing health-care problems, but I want to tell you that none of these Band-Aid proposals have met with significant success. We instituted an Illinois comprehensive insurance plan for those denied coverage from private carriers due to medical reasons. The beneficiaries pay 135 percent of a comparable individual policy from a private carrier and average over $3,000 a year in premiums, and still we pay $12 million in state subsidies for the 4,000 enrollees. But really what has happened is that it has now become a dumping ground for those excluded from their employer's plans due to a preexisting condition. Within one year, the waiting list is now over 1,200, and we are cutting the budget of the CHIP program.

We instituted in 1990 a no-frills health coverage for small employers unable to afford benefits for their workers, but these plans will not be required to pay for state-mandated services like substance abuse treatment and psychiatric services. Shortly after the legislation was enacted, Blue Cross/Blue Shield unveiled such a no-frills policy at 40 percent lower rates; yet, within six months, Blue Cross stopped offering those policies because so few appropriate employers could afford health-care coverage at reduced rates.

Let me sum up by saying that there was introduced in the legislature a pay-or-play plan. It was rejected whole-heartedly by business in our state and met with little enthusiasm by consumers, as well. So, I, along with 24 of my colleagues in the House, have introduced a single-payer plan very similar to H.R. 1300, very similar to New York. I could go through the details, but they are almost exactly the same. And we believe that in the end the only way to resolve our budget crisis—the crisis of American families, the crisis of Illinois employers, and those around the country—is to pass such a single-payer plan.

[The prepared statement of The Honorable Ms. Schakowsky, together with an attachment, follows:]

PREPARED STATEMENT OF THE HONORABLE JANICE D. SCHAKOWSKY

Mr. Chairman and members of the Committee, I am Janice D. Schakowsky, State Representative from Illinois' 4th House District. I am a member of the House Health Care Committee and a cosponsor of HB 300, the Illinois Universal Health Care Act.

Previous to my election as State Representative, I was Executive Director of the Illinois State Council of Senior Citizen Organizations, and before that Program Director of the state's largest consumer organization. In these capacities, I have worked on health care reform for the past two decades.

This morning I want to briefly outline what the rapidly increasing health care cost crisis has meant in Illinois, both to state government and the state's citizens, and what I and a growing number of Illinois lawmakers believe to be the only solution to effectively addressing that crisis.

Last year, Illinoisans spent an estimated $30 billion on health care, or $2619 per capita. That is an enormous sum and one that has continued to increase rapidly. Health care expenditures in 1990 were two and a half times those in 1980 and, at the current rate, will more than double again to a projected $69 billion by the end of this decade.

The impact of such sharply rising costs are many and varied:

* It is conservatively estimated that 1.5 million Illinoisans, or more than one in every seven non-elderly individuals, is without health coverage, forcing them to rely on increasingly limited uncompensated care or to forego care altogether, at least until then end up in the emergency room with severe and extremely costly ailments.

* Illinois employers, as elsewhere, have responded to soaring

costs by shifting more of the burden onto their employees. Based on U.S. Department of Labor figures, Illinois workers paid an additional $500 million last year in higher premium costs for employer-provided coverage. In addition, they paid hundreds of millions of dollars more in higher co-payments and deductibles.

* The AFL-CIO has estimated that 80% of all strikers in recent years went out over health care cost-related disputes at the bargaining table. Illinois is no exception to the rule, and we are now faced with the likelihood of a major strike at Caterpillar Tractor, the state's largest industrial employer (and 7th largest overall) over health care benefits.

* In Illinois, as elsewhere, the health care crisis has had a dramatic effect on the daily lives of middle class individuals. As a state lawmaker, I am regularly called by constituents who have been victimized by our deteriorating health care system -- people who find themselves stuck in an undesirable job because they are afraid to lose their coverage if they switch employers, or those in the later years of their working lives who contract cancer or another serious health problem, and suddenly find that their treatment is no longer covered because their employer has changed carriers and their illness is now a "pre-existing" condition.

I hear from families that find themselves losing their savings, their homes, and most debilitatingly, their dignity, in order to pay for long term care of a spouse or parent, and those who find that the cost of providing care to a child with a dis-

ability is reducing their middle class status to poverty.

Such examples of individuals who have "fallen through the cracks" are becoming more and more common as our rickety system disintegrates and the cracks grow wider and more numerous. Few in Illinois are safe from the grim reality of our nation's health care cost crisis.

As we have also been witnessing in Illinois, among those least protected from the ravages of this crisis are state governments. Through their role in funding and administering Medicaid and other assistance programs, the states are both major consumers of health care and safety nets for those who lose their employer or individual insurance coverage. State spending in Illinois on Medicaid, for example, more than doubled in the past decade, even though the Illinois now only pays 67 cents on the dollar required to provide Medicaid services.

The result has been an unsustainable burden on the state's budget. Illinois, like many other large states, is facing serious fiscal woes. For the current fiscal year, there will be a projected billion dollar shortfall in the revenues necessary to maintain current service levels.

To close that revenue gap, the Governor of Illinois proposed widespread reductions in state health care services. His FY 1992 budget would have:

* Eliminated the state program that provides Medicaid coverage to the working poor without insurance;

* Eliminated Medicaid coverage for all those on public as-

sistance without children;

* Eliminated state coverage of wheel chairs and medical appliances, as well as dental, optometric care and other services for almost all Medicaid beneficiaries;

* Reduced payments to hospitals and other providers by 5% across the board;

* Reduced state pharmaceutical assistance to senior citizens.

* Capped state contributions to state employee health insurance coverage;

* Eliminated state support for individuals with hemophilia, chronic renal disease and those needing organ transplants, as well as state support for cancer research.

While a number of these proposals were rejected by the General Assembly, others were incorporated and, most disturbingly, these reductions were only stemmed by seeking an estimated $600 million in new federal dollars through a Medicaid matching fund structure, as several other states have done.

As necessary as those dollars are to prevent devastating reductions in state health services -- reductions for those individuals who can afford them the least -- the Bush Administration has loudly announced its opposition to such matching fund efforts, throwing the entire State of Illinois budget into jeopardy.

As elsewhere, it is clear that the state government's attempt to shift health care expenditures is no more than a temporary solution, and that such a one time answer will do nothing to

solve the underlying problem of soaring health care costs.

Unfortunately, the White House seems to have no answer except "NO!" on the health care problems facing not only state governments, but business, labor and consumers -- no new money to meet current needs; no support for comprehensive restructuring of health care financing; and no leadership towards a long-term solution to the health cost crisis.

Lacking federal direction, Illinois, like many states, has attempted to institute a variety of short-term solutions aimed at addressing some of the most pressing health care problems. Yet none of these proposals have met with significant success, and the record of their failures is instructive for federal lawmakers:

* In 1989, Illinois initiated a public health insurance program, the Illinois Comprehensive Health Insurance Plan (CHIP) for those denied coverage from private carriers due to medical reasons. Although CHIP beneficiaries pay a very high premium to participate (set by law at 135% of a comparable individual policy from a private carrier and averaging over $3000 a year), the program still requires a hefty state subsidy -- $12 million for 4,000 enrollees last year.

Intended primarily to benefit those with costly disabilities considered "uninsurable", CHIP has now become a dumping ground for those excluded from their employer's plans due to pre-existing conditions, and with one year its waiting list had already exceeded enrollment by 1,200. The burgeoning cost of covering

even this restricted number of participants has already made the program a target for the Governor's budget cuts this year.

* In 1990, the Illinois legislature passed legislation allowing private insurers to offer "no-frills" health coverage to small employers unable to afford benefits for their workers. Such plans would not be required to pay for state mandated services like substance abuse treatments and psychiatric services, and could be offered at a lower costs to businesses.

Shortly after the legislation's enactment, Blue Cross/Blue Shield of Illinois unveiled such "no-frills" policies at 40% lower rates for qualified employers. Yet within six months Blue Cross stopped offering those policies because so few appropriate employers could afford health coverage even at reduced rates.

* For the last several years, there has been legislation pending in the Illinois General Assembly, strongly backed by the hospitals, medical society and other providers, to require all Illinois employers to provide health insurance for their workers. Just as on Capitol Hill, however, this employer-mandated strategy has met with vociferous business opposition, and has little chance of passage.

Given this experience, I am convinced that such half-measures are not the answer to our state's health cost crisis. Along with 24 of my House colleagues and another 7 members of the State Senate, I have joined in cosponsoring legislation to create an Illinois Universal Health Care Program.

Modeled after the Canadian single-payer public health insurance system, the program would cover all Illinoisans and provide comprehensive health benefits -- hospital and physician services, preventative care and pharmaceutical services, long-term care, dental and optometric coverage.

The program would be funded through the same sources as current health expenditures -- state and federal funds now spent on Medicare, Medicaid, public hospitals and other public benefits, employer benefit expenditures (captured through a payroll tax), and individual out-of-pocket expenses (captured through a mix of higher income taxes and tobacco and alcohol taxes.)

Although it would cover all Illinoisans, including those currently without insurance, the program would save substantial funds through administrative cost reductions. For example, the estimated administrative savings on the state's current $3.8 billion health bill alone would be more than $400 million -- two-thirds the amount sought from the federal government through the Medicaid matching fund.

Along with my colleagues, I strongly believe that such a single-payer system is the only workable solution to our state -- and our national -- health care crisis. And this belief is clearly shared by a growing number of lawmakers in Illinois. In the spring session, with the support of the Health Care Committee Chairman and the Speaker of the Illinois House, we received 52 votes on the universal health care legislation -- just eight shy of passage.

As the U.S. General Accounting Office's study this spring documented, only a single-payer universal health insurance program can control costs by eliminating administrative waste and negotiating with providers over fees and budgets.

And only a plan that controls costs will meet the needs of the business sector, will ensure that government can meet its obligations at the local, state and federal levels, will end the irrationality of allowing insurance bureaucrats to overrule doctors and decide which medical procedures are appropriate, and -- most fundamentally -- will assure that everyone in this country has access to quality health care at a cost our society can afford.

* * *

ILLINOIS UNIVERSAL HEALTH CARE PLAN (IUHCP)

The following are the major components of the Illinois Universal Health Care Plan:

COVERAGE: Universal access for everyone.

PREVENTION AND PRIMARY HEALTH: Health education and community based services will be expanded with a strong emphasis on preventive and primary health care services.

COMPREHENSIVE COVERAGE: All necessary health care services for maintaining health or for diagnosis or treatment or rehabilitation following an injury, disability or disease. Services covered: Inpatient and outpatient hospital care, physician and other health professional care, prescription drugs, substance abuse, long term/nursing home care, mental health and other community services.

FREEDOM OF CHOICE: Each person has the right/freedom to choose any health providers (hospital, physicians, nurse practitioner and others) they wish to utilize.

OVERSIGHT COMMITTEE: The creation of a 13 person Governing Board, consisting of five consumers, five health care representatives, the Director of Public Health, the Director of Mental Health and Development Disabilities, and the Director of Insurance. All members would be approved by the Illinois Senate. This Board shall develop an annual budget and list of service requirements to meet the health needs of the state.

COST CONTROL/EFFICIENCY: A Cost Control and Efficiency Task Force will be created to advise the Governing Board on programs to improve the timeliness and efficiency of health services, interventions and cost controls. IUHCP would provide significant cost savings by eliminating unnecessary administrative expense, physician overcharges, health care and insurance industry advertising costs, insurance premiums and profits, and duplication of services.

COST-SHARING: There are no cost-sharing requirements.

PROVIDER REIMBURSEMENT: Health care providers will be reimbursed on fee for service, salaried or capitation basis according to rates set by IUHCP. Excess charges are prohibited. Budgets for each hospital will be set by the IUHCP with retrospective adjustments allowed for unforeseeable circumstances. Capital budgets and acquisition of major equipment will be approved separately from their operating budget, based on health service delivery needs. Long-term care facility budgets will set by the IUHCP. Prescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids, oxygen and related services will be provided through uniform state contracting process. Out-of-state providers will be paid reasonable rates for provision or emergency or urgent care.

QUALITY: A Quality of Care Task Force will be created to advise the Board on methods to improve the quality of health care and to develop proposals for training, recruitment and retention of needed personnel.

PROHIBITIONS ON INSURERS: After 1994, no insurer may independently insure, contract or provide health services included in the IUHCP benefits package.

FINANCING: A reallocation of existing monies currently spent on health care would occur. The IUHCP would be financed through five sources of revenue. Each funding source percentage represents that percentage of the total amount of monies needed: 1) 29 percent from federal funds (existing expenditures for Medicare, Medicaid, and the Veterans' Administration); 2) 6 percent from existing state funds; 3) 38 percent from employer payroll taxes, with tax breaks for smaller businesses; 4) 1.5 percent from doubling tobacco and alcohol tax revenues; and 5) 25.5 percent from state income tax (based on a 5 percent state income tax).

SAVINGS: Overall, Illinois households would experience a savings of $540 per household over their current health care expenditures, no hassles with medical and insurance bills, and a piece of mind that health care needs will be met.

CURRENT ILLINOIS HEALTH CARE SPENDING

(Millions of dollars)	1980	1990	2000	% Incr. 1990-2000
Per Capita	$1,093	$2,619	$5,953	127%
Total Spending				
Out-of-Pocket*	3,401	8,209	18,025	120%
Employer Provided**	4,201	10,348	22,707	119%
Non-Group	906	1,807	3,975	120%
Other Private***	223	533	1,316	147%
Subtotal, Private	8,731	20,896	46,023	120%
Federal Medicaid	612	1,232	2,607	112%
State Medicaid	612	1,232	2,607	112%
Medicare	2,340	6,719	17,533	161%
Other Public	194	519	1,008	94%
Subtotal, Public	3,759	9,702	23,756	145%
Total Spending	$12,490	$30,598	$69,779	128%

* Out -of-pocket does not include employee contribution to employer provided plans or purchase of non-group policies.
** Employer provided includes contributions to employer provided plans made by employees.
*** Other private includes philanthropy.

Campaign for Better Health Care
44 Main Street, Suite 208
Champaign, IL 61820
(217) 352-6533

HEALTH CARE SPENDING IN ILLINOIS* (1990 dollars/millions)

		(% Total)
Individual		
Out of pocket	$ 8,209	
Non-group	1,807	
Other private	533	
	10,549	(35%)
Employer	10,348	(34%)
Federal Spending		
Medicaid	1,232	
Medicare	6,719	
	7,951	(26%)
State Spending		
Medicaid	1,232	
Other	519	
	1,751	(5%)
CURRENT TOTAL	$30,599	(100%)

* Source: Lewin/ICF (1990)

ILLINOIS UNIVERSAL HEALTH CARE FUNDING (1990 dollars/million)

		(% Total)
Individual		
Income tax[1]	7,098	
"Sin" taxes[2]	390	
	7,488	(27%)
Employer[3]	10,348	(38%)
Federal Spending	7,951	(29%)
State Spending	1,751	(6%)
CURRENT TOTAL[4]	$27,538	(100%)

Notes:

1 - Equivalent an across-the-board individual income tax of 5%
2 - Assumes doubling of current taxes on alcohol and tobacco
3 - Equivalent to 8.4% of current non-government payroll; U.S. Chamber of Commerce estimates employers now pay 10% of payroll for health benefits.
4 - Estimate based on reduction in costs for duplicative administration; increased costs for utilization and decreased costs for preventative and early detection care.

BRIEFING Illinois Public Action

April, 1990

UNIVERSAL HEALTH CARE: THE SOLUTION TO CUTS IN STATE HEALTH CARE SERVICES

Proposed 1992 Health Care Reductions

The 1992 state budget proposed by Governor Jim Edgar makes substantial reductions in the level of state health care services. Indeed, the overwhelming majority of all reduced services in the Edgar budget are related to health care, reflecting the continued dramatic rise in health care costs in recent years. Major health service reductions proposed for FY 1992, totaling $511.9 million, include:

Department of Public Aid

* **Eliminating the General Assistance Medical Program** ($52.4 million)
* **Eliminating Aid to the Medically Indigent** ($54.8 million)
* **Eliminating coverage for all optional medical services** such as dental, optometric, podiatric, chiropractic, hospices and medical appliances (except for children and pregnant women) ($82.4 million)
* **Eliminating a 7.1% increase in nursing home funding** ($45.5 million)
* **Decreasing funding for hospitals with a disproportionate share of Medicaid patients** ($20 million)
* **An across-the-board 5% reduction for all medical providers compared to FY 1991** ($181.7 million)
* **Eliminating the Quality Incentive Payment Program (QUIP) for long term care facilities** ($22.3 million)

-more-

1 Quincy Ct. Chicago, IL 60604 (312) 427-6262
221 E. State St. Rockford, IL 61104 (815) 965-9663
124 N. Neil Champaign, IL 61820 (217) 356-1604
199 N. Main Edwardsville, IL 62025 (618) 656-8920
333 - 15th St. Rock Island, IL 61201 (309) 786-1775

REDUCTIONS (cont.)

Department of Public Health

* **Eliminating medical care for persons with chronic renal disease** ($1.95 million)

* **Eliminating medical care for persons with hemophilia** ($1.47 million)

* **Eliminating medical care for persons needing organ transplants** ($.95 million)

* **Eliminating support for the Illinois Cancer Council's State Cancer Plan** ($1.5 million)

Comprehensive Health Care Insurance Plan Board

* **Reducing Comprehensive Health Insurance Plan (CHIP) support** ($.94 million)

Other

* **Capping pharmaceutical assistance to senior citizens** ($46 million reduction)

* **Capping state employee health insurance** (Increases for state employee group insurance would be eliminated, restricting appropriation to FY 1991 level.)

SOURCES: Illinois State Budget/Fiscal Year 1992, and Fiscal Year 1992 Budget for the State of Illinois

Administrative Savings Through Universal Health Care

SB 300 and HB 300 would establish the Illinois Universal Health Care Program. Modeled after Canada's publicly financed health care insurance system, the legislation would create a single insurance authority funded by the current sources of payment -- individuals, employers, state and federal government.

The IUHCP would hold the state's share of total health care spending constant. However the IUHCP would also realize substantial cost savings through administrative efficiency. The most authoritative estimates put such administrative savings at 10.8% of current health care spending.* (Other savings would also be realized through cost control and increased preventative care.)

Based on this estimate, the state's contribution to financing the IUHCP could deliver substantially more health services. **In fact, if the Illinois Universal Health Care Program was in place for FY 1992, the administrative savings on state health care expenditures alone would equal 82% of the proposed reductions in state health services.**

STATE HEALTH EXPENDITURES (FY1992/millions)

DPA Medical Services	$2,829.9
Other**	526.4
Proposed Total	$3,356.3
Administrative Savings under UIHCP (10.8%)	($362.5)
+ Eliminated Services	$511.9
Administrative Savings under UIHCP (10.8%)	($55.3)
Total Administrative Savings under UIHCP	**($417.8)**

In other words, the administrative savings, in and of themselves, on state-funded care under a universal health insurance system would be nearly enough to provide the full level of needed services at the proposed state expenditure level for FY 1992.

* SOURCE: David Himmelstein and Steffie Woolhandler, Free Care: A Quantitative Analysis of Health and Cost Effects of a National Health Program for the United States, 1990.

** Includes other state departments and state employee health insurance. SOURCE: Lewin/ICF EMERGENCY! Rising Health Costs in America 1980-2000, 1990.

54-863 O—92——20

State administrative savings may indeed be much greater. Because so many of the state health services are means-tested, significant additional administrative expenses are required in proportion to the services paid for. For example, the Aid to the Medically Indigent Program requires a monthly income and health expenditure analysis to determine eligibility for each person enrolled in the program. Under IUHCP, such expenditures would be completely unnecessary, and those funds would be available to provide care.

Other Savings Under Universal Health Care

In addition to administrative streamlining, there would be significant other cost savings under the IUHCP.

The most substantial would be the ability to control health care cost growth through global budgeting and negotiated provider fees. Such a provision would significantly reduce inflation in medical costs, which has risen at twice the consumer price index since 1980.

The ability of a single-payer system to control medical costs is seen in the comparable experience of the U.S. and Canadian systems. In 1971, when the Canadians fully initiated universal health insurance, the U.S. and Canada spent the same percentage of their Gross National Product on health care. By 1989, U.S. health expenditures were one-third higher than Canada's.

In fact, in 1990 the Province of Ontario, Canada's largest, most diverse and most expensive provincial insurance program, spent some $1,297 per person on health care, just one-half the $2,619 per capita expenditure in Illinois.

In addition, there would also be significant savings accrued from the increased availability of preventative and early detection care from a universal system. State efforts to combat infant mortality, for example, would be substantially more cost-effective: in 1987, Illinois infant mortality rate was 11.6 while Canada's was just 8.3.

Universal health care will not only ensure that all Illinoisans have access to quality care, but that such care is delivered efficiently and cost-effectively. Universal health care is the alternative to ever increasing health inflation and the resulting cuts in state-funded services.

* * *

REPRESENTATIVE SCHEUER. Thank you very much, Ms. Schakowsky.

We'll now hear from Mr. Lee Tooman, Product Manager of the Golden Rule Insurance Company. He's had extensive experience in the group health insurance market and was co-founder of the Benicorp Insurance Company.

Please proceed for your seven or eight minutes, Mr. TOOMAN..

STATEMENT OF LEE TOOMAN
PRODUCT MANAGER, GOLDEN RULE INSURANCE COMPANY

MR. TOOMAN. Thank you very much, Mr. Chairman. My name is Lee Tooman. I am with Golden Rule Insurance Company. Golden Rule Insurance Company has been in the health insurance business for 50 years. We are a national company and have hundreds of thousands of people insured under our plan. We provide excellent value to our customers.

Earlier this year, Golden Rule Insurance Company and the Heritage Foundation developed a model law at the request of and in conjunction with the American Legislative Exchange Council. The acronym for that is ALEC. ALEC is a national organization of state legislators throughout the country. It brings several important reforms to health insurance and, subsequently, ALEC adopted this model legislation into its legislative source book. I've included a copy of the draft legislation with my testimony.

I'd also like to ask that this letter, which I've made copies of, be included in my testimony. It is a letter from the President of the National Association of Life Insurance Companies, a trade organization representing over 500 life insurance companies. He says:

> I've had an opportunity to review this model, my reaction is very positive. It provides all types of group access to commercial health insurance and deals with the problem of job block, provides rate stabilization, and has built-in mechanisms to discourage people from waiting until they are sick before trying to purchase health insurance.
>
> Some members of the NALC Health Committee have expressed a great deal of interest in promoting those features in this model, and discussion of this model will be an agenda item at the next Committee meeting.

This is signed by the President of the NALC, Mr. Roy Woodall.

The thrust of this model can be summarized very briefly. It makes it possible for people to stay in the insurance system. Most of the uninsured have had insurance at a previous job. This enables them to keep their insurance and thus stay in the system. Therefore, this model has very powerful implications for stability, access, affordability, and the cost associated with health insurance. Unlike other models, it doesn't accomplish this with incremental costs to our society in the form of higher premiums, higher taxes, or higher unemployment.

I have this prepared in my testimony. I'd like, before getting into some of the details, to discuss some issues that have been touched on today and to which I've devoted a fair amount of time and effort to understand.

Let me put three of these in their proper context. First, we heard today that we have 34 million Americans without insurance, and that number seems to be believed by most people. Some people would have us believe that all of the uninsured are also uninsurable, and that frankly is not true. The uninsured are predominantly young; they're healthy and employed, or they're associated with full-time employees in the form of dependants. In truth, only about 1 percent of the nonelderly population is uninsurable.

There's a big difference between the uninsured and the uninsurable. The uninsured are not chronically uninsured, either. In fact, half of all uninsured spells end within four months—the real problem is affordability. Nearly half of the uninsureds are employed by small businesses with fewer than 25 employees. The small businesses cannot afford health insurance because they are simply too marginal, and our inequitable tax system requires that their employees purchase health insurance with after-tax dollars, while you and I and most of the people in this room get our share of the $60 billion tax subsidy.

The second thing that I'd like to comment on is that our administrative costs are somehow the source of our high health insurance premiums. The fact is, health-care costs and misguided legislation are the real causes. Between 1971 and 1989, the states in this country have enacted 778 health insurance mandates. Who bears the cost of these mandates? The uninsured do not because they do not have insurance; so, they don't bear the cost of these mandates. Large self-funded employees do not. ERISA exempts them from insurance laws and regulations. And, for the most part, Medicaid and Medicare recipients are also relieved of these responsibilities. It is the individual and the small employer who buy health insurance that bear the brunt of the cost of these mandates.

Basically, what has been done with these mandates is to heap the costs on about a third of the population, and most of these folks are people associated with small businesses; these individuals trying to buy it themselves are the least able to afford these mandates.

In addition to raising the costs, these mandates have also made insurance policies much more complex. I would say—I am guesstimating here—that the average health insurance policy today is roughly twice the size that it was ten years ago. This adds a great deal of complexity and cost to insurance administration. The irony is that many of the same groups that have actively lobbied for all of these mandates over the years are now saying that health insurance has become so complex and burdensome that it should be thrown out altogether and replaced with a single-payer system.

Let me cite a few more examples.

Government programs that reimburse providers at less than cost result in significant cost-shifting to the individual and to smaller employers. Here, I am talking about Medicare and Medicaid.

Malpractice liability: We heard about that today. Malpractice liability causes physicians to practice defensive medicine that some estimate will cost over $15 billion annually.

Finally, many want to make you believe that there are as many claim forms as there are insurance companies. Fifteen hundred insurance companies, 1,500 claim forms out there, and confusion adding all of these dollars to the insurance costs. It simply isn't true. Doctors and hospitals almost universally use HCFA forms, and virtually every doctor and insurer in the country uses the AMA's current professional terminology; the CPT coding system.

The third thing that I want to touch on is this: Many people who want to completely change the current system ignore the fact that many model laws already exist to enact in the states. They already guarantee access and equity in the insurance system. The discontinuance and replacement law is the law in more than half the states. It guarantees that small groups that are changing carriers are treated as whole groups. Carriers can't cherry-pick people. We can't carve people out or apply new preexisting condition limitations to them. We have to take them as a whole group or we don't take them at all.

The comprehensive health insurance plans have been enacted in about half of the states. And several states—Maine, Louisiana, Oregon, and Colorado—have also guaranteed that the cost of financing these risk-pools is broadly based on all of society in those states. People in those states do not go about without insurance. There is access to insurance in those states.

Therefore, the remaining issues before ALEC, the American Legislative Exchange Council, was to identify remaining problems in the health insurance system, as we have it today, that we can deal with. The model law that we helped them develop brings four important things to the health insurance market: stability in premiums and renewal practices, access to health insurance, portability of health insurance, and affordability.

On stability, this model makes small group insurance "collectively renewable." Small groups are forced into pools. It is no longer a contract that allows carriers to single small groups out for selective rate actions or selective nonrenewals. Groups are pooled together. It also makes it impossible for carriers to put abusive rate increases on small employer groups. It is not permissible to apply more than a 15 percent rate increase, based on experience, to any small group. And, in addition, it creates a floor and a ceiling for small group insurance. So, groups that buy-in today do not find themselves with low-ball rates and with gigantic rate increases later that result in them being unble to afford it over the long run.

On the access side, what this model does is say "no ineligible industries." There are many industries that have a great deal of difficulty buying insurance—nursing homes, long-haul truckers, hospitals, doctors, lawyers, off-shore drillers, and miners. This prohibits ineligible industries.

More importantly than that, I think, is that it says that any individual who has maintained continuous insurance for at least a year must be guaranteed issue coverage if that person is changing jobs, losing dependent status, a young adult entering the job market, or a divorced woman

finding herself a new job. People who have been continuously insured must be guaranteed issue as long as they have been insured for at least a year. The premise behind that is that people who have been insured for at least a year are not out to take advantage of the system. People are not postponing the purchase of insurance until they need it if they've been continuously insured for a year.

Portability is the third part of this model law. And what this model law says is that people who would otherwise fall out of the system are guaranteed to be able to keep their insurance at an affordable rate and with benefits that were the same as they had on their job-based insurance plan. They are guaranteed that if they have been insured by an employer and lose their coverage for whatever reason—if the small employer goes out of business, let's say, or it's the widow of an employee who loses her coverage because her husband, who is associated with that small firm, dies and, therefore, she has a problem buying health insurance because she has a health problem—people will not find themselves without insurance through no fault of their own in this model.

Finally, and I'll be very brief because I know my time is short, this model law calls for the repeal of anti-managed care laws. Several states have put barriers in the way of carriers and providers to establish for themselves a better payment system. This also calls for the allowing of small groups and individuals to buy insurance without all of the mandates that they neither want nor can pay for.

Now, I've attached the complete ALEC model act to the appendix of this statement. It has been introduced in Pennsylvania and it is being considered in several other states. As I mentioned to you, it is in the ALEC Legislative Source Book, along with a great many other laws for state legislators to consider adopting in their states.

Let me close by restating that this reform model closes the holes through which employers and individuals can lose their health insurance coverage, either through abuses like large punitive rate increases or simple circumstances like changing jobs. Nonetheless, we cannot make insurance truly more affordable and portable unless we also address the distortions caused by our tax system. Our tax system penalizes people who have insurance, but do not get a large corporate contribution and, therefore, a large government tax subsidy. How can we call a system fair that causes working people to go without their own insurance, while subsidizing rich employers that buy health insurance with corporate money for already well-paid employees. It is only fair and right to give the person who is between jobs and struggling to maintain health insurance the same tax help that most of us already get. This can be accomplished without completely throwing out the present system and replacing it with the false promises of single-payer or employer-mandated universal coverage.

Thank you very much.

[The prepared statement of Mr. Tooman, together with attachments, follows:]

PREPARED STATEMENT OF LEE TOOMAN

Ladies and gentlemen, my name is Lee Tooman, and I am with Golden Rule Insurance Company. Thank you for the opportunity to speak before you today.

Earlier this year, Golden Rule Insurance Company and the Heritage Foundation developed a model law at the request of and in conjunction with the American Legislative Exchange Council (ALEC). This model law brings several important reforms to health insurance. ALEC subsequently adopted this model law into its legislative source book.

The thrust of this model can be summarized very briefly:

> It makes it possible for people to stay in the insurance system.
>
> Most of the uninsured have had insurance on a previous job. This enables them to keep the insurance -- thus staying in the system.

This model has powerful and positive implications for stability, access, portability, and the costs associated with health insurance.

Unlike other proposals, the ALEC model act generates virtually no additional incremental costs to our society, either in the form of much higher health insurance premiums, much higher taxes, or much higher unemployment.

Before discussing the specifics of this model, I wish to state that it is critical that in building any reform proposal we understand as fully as possible the real problems that exist in the market today. Many stories are told and retold in an effort to build a case for sweeping changes to the current system, but many of these stories are simply not factual. Let me put some often discussed issues in the proper framework:

1. In the U.S., it is believed that 34 million people have no health insurance.[1] Some people would have us believe that these people have medical problems that prevent them from obtaining insurance.

   In fact, the uninsured are predominately young, healthy, and employed.[2] In truth, only 1 percent of the nonelderly population is uninsurable.[3] The uninsured are not chronically uninsured either; in fact,

half of all uninsured spells end within four months.[4]

The real problem is affordability. Nearly half the uninsureds are employed by small businesses (fewer than 25 employees).[5] These small businesses cannot afford health insurance because they are simply too marginal.[6] And, our inequitable tax system requires their employees to purchase health insurance with after-tax dollars, while you and I get our share of a $60 billion federal tax subsidy.

2. Administrative costs are not the cause of high health insurance premiums for individuals and small business. Health care costs and misguided legislation are the real causes.

For example, state legislatures have passed scores of health insurance mandates. Between 1971 and 1989,[7] the states have enacted 778 health insurance mandates. Who bears the costs of these mandates?

The uninsured obviously do not. Neither do large self-funded employers; ERISA exempts them from state health insurance legislation. Medicaid and Medicare recipients are also out of the picture in most cases.

It is the individual and the small employer who buy health insurance that bear the brunt of the costs of these mandates. You have effectively heaped the costs of these mandates on one-third of the population. And, these are the folks who are least able to afford them.

In addition to raising the cost, these mandates have also made health insurance policies much more complex, while adding complexity and cost to insurance administration.

The irony is that many of the same groups that actively lobbied for all these mandates are now saying that health insurance has become so complex and burdensome that it should be thrown out altogether and replaced with a single payer system.

Let me cite some more examples. For instance, government programs that reimburse providers at less than cost result in significant cost shifting to the

Used in conjunction with existing model laws, the model law adopted by ALEC addresses those problems and does the following:

1. Stability: By making small group insurance Collectively Renewable, no small group can be singled out for termination due to health, claim cost, or length of coverage (the only reasons for singular termination are for acceptable reasons like fraud, nonpayment of premiums, and the like). Thus, a small group knows for a fact that it will be pooled with many other small groups and that no amount of high claim cost can be used to terminate its coverage.

   By making small group insurance Collectively Renewable, no small group can be singled out for abusive rate increases. Again, the small business, by definition, will be pooled with many other small businesses. The maximum amount an insurer can raise rates for <u>any</u> given group due to its own claim cost -- no matter how high -- is 15 percent per year.

   Lastly, a floor and a ceiling are established for the rates that can be charged to two groups that are essentially the same except for when they bought their coverage or the claim costs they have generated. This eliminates the so-called "lowballing" or "bait-and-switch" practices.

   Thus, these concepts, when used together, mean that no small group would ever be forced out of the system.

2. Access: No small group can be denied coverage simply due to the nature of its business. This will have an immediate and significant impact on a large number of "high risk" industries, such as nursing homes, restaurants, hospitals, bars, barbers, hair dressers, off-shore drillers, miners, and long-haul truckers, to name just a few. To make sure that the spirit as well as the letter of the law are complied with, rating restrictions are included.

   Furthermore, the individual who has maintained coverage continuously for a year is guaranteed access to a new employer's group health insurance plan with full credit for the prior satisfaction of any preexisting

individual and small employer. And, malpractice liability causes physicians to practice defensive medicine that some estimate to cost $15.1 billion annually.[8]

Finally, many want to make you believe that there are as many claim forms and coding systems as there are insurance plans. That is simply not true. Doctors and hospitals almost universally use HCFA forms. Virtually every doctor and insurer uses the AMA's CPT coding system.

3. Many who want to completely change the current system ignore the fact that many model laws already exist. These model laws have been enacted in many states that already guarantee access to and fairness in health insurance. Let me discuss two of these.

   One is the Discontinuance and Replacement (D & R) Law. It guarantees that small groups that are changing carriers are treated as whole groups. "Cherry picking" is prohibited. Each employee and dependent is given credit for satisfying preexisting condition exclusions.

   The second is called Comprehensive Health Insurance Plans (CHIPs). These plans guarantee that uninsurable people have access to quality health insurance coverage. Several states (Maine, Louisiana, Oregon, and Colorado, to name just a few) have also guaranteed that the cost of financing the health care of these uninsurable people is broadly based.

Therefore, the issues before the American Legislative Exchange Council were to correctly identify remaining problem areas and to propose solutions.

The problems facing small employers and their employees and dependents today are fourfold:

1) Stability in Premiums and Renewal Practices

2) Access to Health Insurance

3) Portability of Health Insurance

4) Affordability

access feature, means that no one will, through no fault of their own, fall out of the health insurance system and be unable to reenter it because of health problems.

4. Affordability: This model calls for the repeal of anti-managed care laws and special interest mandated benefits.

With respect to anti-managed care laws, some states have put barriers in the way of insurers and providers that wish to form health care delivery and financing partnerships. This takes one of two forms: either the carrier cannot be selective with the providers it wishes to contract with or the carrier is limited in its ability to use strong incentives to encourage its insureds to use one provider over another. Either way, it limits a carrier's ability to forcefully affect health care costs.

With respect to mandated benefits, special-interest groups have forced carriers to build costly benefits into their plans. These take many forms, and range from mandating coverage for in-vitro fertilization to substance abuse counseling. In some states, Connecticut, for example, rates are estimated to be 25 percent higher than necessary for quality health insurance coverage.

But these have an even more onerous implication. Large groups typically self-fund. That means they are not insured by an insurance company. ERISA allows them to be exempted from all insurance laws.

Thus, the weight of anti-managed care and mandated benefits laws are carried by individuals and small businesses that have insurance company plans. It is a totally inequitable and unfair situation; the big corporations can simply ignore these laws.

I have attached the complete ALEC model act in the appendix to this statement. It has been introduced in Pennsylvania and is being considered in several other states.

Let me close by restating that this reform model closes the holes through which employers and individuals can lose

condition exclusion period.

This means that a person who wants to change jobs must be guaranteed issue coverage by the new carrier. Young people who are losing dependent status and entering the job market must be issued full coverage by the new employer's carrier.

Let me repeat this part of the model: no one who has maintained continuous coverage for at least a year can be denied access to a new employer's group health plan, regardless of the type of plan from which they are coming.

Thus, this model act significantly improves access for both individuals and whole groups.

3. Portability: This model guarantees that, once you enter the health insurance system, you can stay in. In other words, if you were to lose your employer-based coverage, you would be guaranteed the right to convert to a permanent individual health insurance plan. The benefits would be identical to those you had, and your premium would be a small surcharge over the rate you would have paid had you stayed with your group plan.

Think of this as permanent COBRA that would extend down to the very smallest of groups. With this, a person cannot lose coverage simply because he or she loses eligibility for coverage through the loss of employment.

This has powerful implications for many people in a variety of situations. The person who leaves employment to start a business can keep present coverage if a health problem prevents buying new private coverage.

So too can the young adult who loses dependent status but has difficulty finding employment. This protects the widow who has relied on her h band's group coverage all her life but now finds herself with only the proceeds of a small life insurance policy to live on, no employable skills, and a health problem that would otherwise prevent her from obtaining private coverage.

This portability feature, tied in with the guaranteed

their health insurance coverage -- either through abuses (large, punitive rate increase) or simple circumstances (changing jobs).

Nonetheless, we cannot make insurance truly more affordable and portable unless we also address the distortions caused by our tax system. Our tax system penalizes people who have insurance but do not get a large corporate contribution (and, therefore, a large government tax subsidy). How can we call a system fair that causes working people to go without their own insurance while subsidizing rich employers that buy health insurance with corporate money for already well-paid employees?

It is only fair and right to give the person who is between jobs and struggling to maintain health insurance the same tax help that most of us already get. This can be accomplished without completely throwing out the present system and replacing it with the false promises of single-payer or employer-mandated universal coverage.

FOOTNOTES

1. EBRI SR-10, April 1991

2. EBRI SR-10, April 1991. More than 60 percent of the uninsured are under the age of 30. 54 percent of the uninsured are in families where the family head is employed full time year around.

3. EBRI Issue brief 110, January 1991

4. Inquiry Fall 1990 "Spells Without Health Insurance: Distribution And Their Link To Point-In-Time Estimates Of The Uninsured"

5. EBRI SR-10, April 1991

6. HIAA Providing Employees Health Benefits: How Firms Differ, 1990

   Small businesses that do not provide employee benefits tend to be very small, have high turnover, and pay low wages.

7. EBRI Issue Brief 110, January 1991

8. American Medical Association 1989 survey

9. Small group insurance has traditionally been Optionally Renewable this means that employer units can be singled out for rate increases and even non-renewal.

APPENDIX

ALEC SUBCOMMITTEE FOR HEALTH INSURANCE REFORM

"THE HEALTH INSURANCE REFORM ACT
FOR SMALL BUSINESS COVERAGE"

Synopsis

This proposed model act would:

(1) make small group plans collectively renewable by state;

(2) limit premium increases charged to individual groups with high claims;

(3) limit rate differentials which may be charged to small groups with similar case characteristics to ratio of two to one;

(4) limit premium charged to employers engaged in higher risk businesses;

(5) require insurers to offer conversions identical to the group plan and limit charges for such conversions;

(6) enable employees who have maintained prior coverage for one year to obtain small group coverage on no-loss/no-gain basis;

(7) prevent insurers from refusing to offer group coverage to small employers based on the nature of the employer's business;

(8) exempt small employer plans from complying with mandated benefit and anti-managed care laws.

MODEL SMALL EMPLOYER GROUP INSURANCE ACT

1. **Definitions.** As used in this Act:

(a) The term "insurer" means any entity which provides health insurance in this state.

(b) The terms "small employer" and "employer" mean a business which, during the most recent calendar year, employed at least three and not more than twenty-five employees who are eligible for coverage under a health benefit plan on at least 50 percent of that business' working days.

(c) The term "employee welfare benefit plan" has the same meaning as that term is given by the Employee Retirement Income Security Act of 1974 (29 USC Section 1001 et seq.).

(d) The terms "health benefit plan" and "plan" mean any employee welfare benefit plan which is insured by an insurer and which provides medical, surgical, or hospital care or benefits to employees of a small employer and their dependents. The terms shall exclude any individual major medical policy which is renewable at the option of the insured except for reasons set forth in paragraphs 2(a) or 2(c) of this Act or if the insurer nonrenews all policies issued on the same policy form in this state. These terms also exclude any policy of group insurance which is not designed, administered, or marketed as a health benefit plan to be provided by an employer for its employees.

(e) The term similar plans" means plans which do not materially differ from one another in any of the following respects:

(1) The set of services covered;

(2) Utilization management provisions;

(3) Managed care network provisions;

(4) The criteria used by the insurer in underwriting coverage under a plan where variations in such criteria may reasonably be expected to produce substantial variation in the claims costs incurred under the plan.

(f) The term "case characteristics" means demographic and other relevant characteristics as determined by the insurer that are considered by the insurer in the determination of premium rates for a small employer but excluding:

(1) Claims experience;

(2) Health status; and

(3) Duration of coverage since date of issue.

2. Nonrenewal. (a) No insurer providing coverage under a small employer health benefit plan shall nonrenew such plan except for any of the following reasons:

(1) Nonpayment of required premium;

(2) Fraud or misrepresentation on the part of the employer;

(3) Noncompliance with provisions of the plan including provisions regarding minimum numbers of or percentages of insured employees;

(4) Nonrenewal upon ninety (90) days written notice with respect to all small employers in this state.

(b) An insurer that exercises its right of non-renewal as provided in paragraph 2(a)(4) may not accept any new small employer business for a period of five (5) years after it provides notice of such non-renewal;

(c) Nothing herein shall be deemed to prevent an insurer from rescinding or non-renewing the coverage of any individual employee or dependent of such employee for fraud or material misrepresentation to the extent allowed by the law of this state.

3. Experience Rating. (a) The premium rate charged in connection with a small employer health benefit plan shall be the same for all small employers with similar case characteristics covered under similar plans. Notwithstanding the foregoing, an insurer may adjust the premium charged to an employer in connection with the plan based upon that employer's claims experience, the health of persons covered under the plan, and the duration of coverage since the date of issue, provided that the total premium shall not exceed two times the lowest premium charged to an employer with similar case characteristics.

(b) Subject to the limitations set forth in paragraph 3(a), the percentage increase in the premium rate charged to a small employer may not exceed the sum of:

(1) the percentage change in the new business premium rate for employers with similar case characteristics as measured between the first day of the calendar year in which the new rates take effect and the first day of the prior calendar year; plus

(2) an adjustment not to exceed 15 percent annually based on claims experience, health status, or duration of coverage; plus

(3) any adjustment due to changes in the coverage provided or changes in the case characteristics of the employer.

4. No Excluded Occupations. No insurer may refuse to offer coverage under a health benefit plan to employees of a small employer based solely on the nature of the employer's business. An insurer may charge additional premium based on the nature of the employer's business, but the total premium may not exceed 150% of the lowest premium which would be charged to that employer under paragraph 3 of this Act without regard for the nature of the employer's business.

5. No Mandated Benefits. No statute or regulation of this state which mandates the provision of specified health insurance benefits or which prohibits or limits the use of managed care shall be construed to apply to any small employer health benefit plan or any conversion policy provided in accordance with paragraph 6 of this Act.

6. Conversion Privilege. (a) Any person who has been continuously covered for at least 90 days under a small employer health benefit plan and who thereafter loses such coverage by reason of:

(1) Termination of employment;

(2) Reduction of hours;

(3) Divorce;

(4) Attainment of any age specified in the plan;

(5) Expiration of any continuation of coverage available as required by state or federal law;

(6) Cancellation of the plan by the employer or nonrenewal thereof due to failure to pay required premium unless within 31 days thereafter the employer provides coverage to any employee under any employee welfare benefit plan which provides medical, surgical, or hospital care or benefits;

(7) Nonrenewal of the plan as set forth in paragraph 2(a)(4) of this Act;

shall, upon written request to the insurer, be entitled to receive an individual conversion policy. Such request shall be made within 31 days of loss of coverage. The premium for any given period shall not exceed 135% of the rate that would have been charged with respect to that person had the person been covered as an employee under the plan during the same period. When the plan under which such person was covered has been canceled or nonrenewed, the rates shall be based on the rate which would have been charged to such person had the plan continued in force as determined by the insurer in accordance with standard actuarial principles.

(b) Benefits provided under such conversion policy shall not be less than the benefits provided under the plan. The insurer may apply any benefits paid under the plan against the benefit limits of the conversion policy provided that if it does so, it shall also credit the insured with any waiting period, deductible and coinsurance to the extent credited under the plan.

7. [Version A] Unhealthy New Employees Who Were Previously Insured. This provision applies only to persons who first become employees of an employer following the date an insurer first insures any employee of such employer under a given plan. No insurer of a small employer health benefit plan shall refuse to accept for coverage, under the plan, any person, who on the date of application for such coverage would be eligible therefor, except for underwriting considerations relating to such person's health status, provided such person has, as of that date, been continuously covered under any employee welfare benefit plan or other health insurance policy (other than any policy issued by or in connection with any state high risk insurance pool) for a period of one year. Nothing

herein shall require such insurer to provide benefits greater than those provided to a person insured as a standard risk under the small employer health benefit plan or greater than those that would have been provided under such prior coverage had it remained in force. For purposes of this paragraph, a person shall be deemed to be continuously covered for a period of one year if such person is insured at the beginning and end of such period and has not had any breaks in coverage during such period totaling more than thirty-one (31) days.

7. [Version B] Unhealthy New Employees Who Were Previously Insured. This provision applies only to persons who first become employees of an employer following the date an insurer first insures any employee of such employer under a given plan. If an insurer of a small employer health benefit plan refuses to accept for standard coverage, under the plan, any person, who on the date of application for such coverage would be eligible therefor, except for underwriting considerations relating to such person's health status, and such person has, as of that date, been continuously covered under any employee welfare benefit plan or other health insurance policy for a period of one year, such employee may elect to continue and/or convert coverage under the prior plan or policy. In the event of such election, the employer shall reimburse the employee for monthly premiums paid thereafter by the employee under such plan or policy up to the lesser of the following amounts:

(a) the amount of such premiums; and

(b) the amount of premium the employer would have paid under its plan had the employee and his or her eligible dependent been covered under the employer's plan;

For purposes of this paragraph, a person shall be deemed to be continuously covered for a period of one year if such person is insured at the beginning and end of such period and has not had any breaks in coverage during such period totaling more than thirty-one (31) days.

THIS LEGISLATION SHOULD BE ACCOMPANIED BY DISCONTINUANCE AND REPLACEMENT MODEL ACT (SEE ATTACHED).

REPRESENTATIVE SCHEUER. Thank you very much.

What do you mean when you talk about the false promises of single-payer systems?

MR. TOOMAN. It is the opinion of my company, Golden Rule Insurance Company, and I think a great many other thoughtful people outside of the insurance industry and inside it as well, that the single-payer system is not going to alleviate the problems or solve the cost issues that we have in our country.

What I mean by the false promises is that we will not with a single-payer system find ourselves any more able to control costs than we are right now with the system we have. We have a system that has developed, in large part, through the federal tax system that rewards employers that can afford to buy insurance for their employees, and causes terrific disincentives for people to buy insurance with their own money, or for small employers who simply can't afford it, or the self-employed person who has difficulty buying insurance.

REPRESENTATIVE SCHEUER. Have you been here throughout the other panels?

MR. TOOMAN. Yes, sir.

REPRESENTATIVE SCHEUER. Well, you heard a cacophony of voices from the congressional experts and others testifying that there are hundreds of billions of dollars to be saved by going to a single-payer system. And that if we reinvested that money, if we deployed those savings back into the system, we could provide a universal, comprehensive system at no more, and probably less, cost than we have now.

What do you say to that tremendous volume of evidence? Do you contest the fact that there's anywhere from $67-130 billion a year to be saved by wiping out the bureaucratic and administrative nightmare that you have, in part, described, and really moving those dollars from pushing paper to serving patients, treating patients?

MR. TOOMAN. We believe that the proposals put forth by the Heritage Foundation and the National Center for Policy Analysis that call for tax equity, for medical IRAs used in conjunction with high deductible plans, would eliminate a lot of the administrative costs that you've talked about. Put people and doctors back on a one-on-one relationship, and make people understand what it is that they have in coverage, what they're paying for, and what they're getting for it.

REPRESENTATIVE SCHEUER. You have described a very complicated insurance system, inordinantly complicated with all of the mandates. What's wrong with replacing that with a single-payer system and achieving this pot of gold that everybody says is hanging out there, improving efficiency and eliminating the chaos, the duplication, and the waste that's inherent in our current health-care delivery system?

MR. TOOMAN. Much of the so-called waste, the administration, the underwriting, and so forth is brought on by the fact that we have a voluntary system that has an employer-based insurance program. People get their insurance predominantly through their employers. The vast

majority of them have no idea what it costs for that insurance. Companies that change carriers, individuals that change jobs and go to our private insurance, and between jobs, reenter and reenter and reenter the system. If people would buy their own permanent individual insurance policies with high deductibles, it would not cost very much at all to administer because only large claims would need to be administered. We can reduce those administrative costs that you're talking about. Medical IRAs are a way to bring people into an understanding of what insurance costs and into making insurance truly portable.

You, earlier today and during the course of the day, and others have spoken about the experience in Canada and France and Germany. I am no authority on the experience in other countries, but one of the countries that you failed to talk about was the experience of Singapore, which has mandated that employees and all citizens build up and maintain a medical IRA. They have accomplished many of the things that you talked about today in terms of much better outcomes and in terms of reducing the indigent and uncompensated care. They've accomplished a great many of those things with the same kind of program that the Heritage and the National Center for Policy Analysis are proposing. The fact is, you know, I've seen statistics, and I'm sure you've seen them too, that point to the fact that in all of the developed countries spending for health care in relationship to per capita income is on a continuum. We're getting what we want. We have the highest per capita income in the world, we have the highest per capita health spending, and you go right down the line, and it's all on a continuum.

REPRESENTATIVE SCHEUER. In terms of a proportion of our GNP that we're applying to health, it goes up about two and a half times the rate of inflation. You've heard many of the witnesses say that we're spending about 12.2 percent of our GNP on health, compared to an average for the industrialized world of about 8 percent, and we're going down to about 6 percent for Japan. How come we're spending so much more per capita and we're getting so much less?

MR. TOOMAN. We've seen and heard that gross national product, gross domestic product is not measured the same in each and every country. They are measured differently; they mean different things in different countries, and they were never, ever intended to be measures that you could relate international spending to. The fact is, we have a much higher incidence than Canada, for example, of teenage pregnancies, of AIDs, of drug abuse. These things all add up. And it isn't simply because we have this administrative duplication that is causing the spending to go up by 15-20 percent a year.

REPRESENTATIVE SCHEUER. It is quite true that we do have those forces that other industrialized countries don't have, but it is also true that we've had a number of reports from experts, including the General Accounting Office, including the Robert Wood Johnson Foundation, including the articles that I'm sure you're familiar with, that do show—the *New England Journal of Medicine*—that there's a pot of gold there that is

available if we will but grasp it. It ranges all the way from $67 billion from the GAO up to $300 billion of the Robert Wood Johnson Foundation. Perhaps, those savings, if we could really put them into the system, would help pay for the costs of large numbers of adolescents, unwed mothers, AIDS, and so forth.

Recognizing that we do have some costs that all these other countries don't, isn't that a reason to carve out of our health-care system the inefficiencies and the chaos and the waste resulting from 1,500 insurance companies falling all over themselves and advertising and competing to get patients, when a single-pay system would treat everybody equal, with no advertising, no commissions, no nothing. Why shouldn't we try and seize that pot of gold for the very reason that you talked about, that we do have some expenses—health care expenses—that other countries don't have.

MR. TOOMAN. Obviously, you've made that argument and others have.

REPRESENTATIVE SCHEUER. How can a rational society that cares about its people say on the one hand that we are paying 50 percent more than the OECD countries and getting far less. If you were here earlier, you heard about a much higher incidence of infant mortality and lower life expectancy at birth. Our painful experience in New York about innoculations; how can any rational society sit there and accept such a system? Thirty-seven million people without any health insurance, some of whom flood and overwhelm emergency rooms of our hospitals—high-tech facilities that were meant for trauma, that were meant for heart attack, stroke—and we fill them up with families of kids who have runny noses, intestinal problems because that is the only way they can get access to health care. I mean, if that isn't an outrageously stupid deployment of health-care resources, I'd be willing to eat my hat.

Let's move to other members. Did you want to answer anything that I've said?

You deny the fact that people are being squeezed out of insurance programs; they're being dropped out, squeezed out, and if they get sick, they're out on their tails? People with preexisting health conditions have an enormously difficult time getting coverage.

We had the experience in New York of the Empire Blue Cross/Blue Shield raising rates. I think they wanted to raise their rates 50 percent. Well, the commissioner turned them down, but that is endemic to the system. It's an irrational system. How can any rational society not want to make the surgical structural reforms that would cure this awful condition?

MR. TOOMAN. Perhaps they would and perhaps they wouldn't. The things that you've described are fixed with this model legislation. People are not going to get abusive rate increases.

REPRESENTATIVE SCHEUER. Has this model legislation been adopted anywhere?

MR. TOOMAN. It's been introduced, but not adopted.

REPRESENTATIVE SCHEUER. Now, look, you heard Ms. Schakowsky. She's introduced a single-payer system. You heard Mr. Gottfried, Chairman of the New York State Assembly Health Committee. He has introduced single-payer legislation. Why haven't they selected your model legislation?

MR. TOOMAN. This model was adopted in the Legislative Source Book of ALEC only this May. Most legislatures don't go back into session until this January. Believe me, it will be discussed and it will be brought up in other states legislatures.

SENATOR GOTTFRIED. I'd like to respond to that question.

REPRESENTATIVE SCHEUER. Please do, and then Ms. Schakowsky.

SENATOR GOTTFRIED. A couple of things. One, is that it is very rare that I find myself in agreement with proposals coming from ALEC, but I think there are several items in its proposal dealing with portability and what not that I think we will find very attractive in New York, or at least many of us will.

But I want to comment on this question of mandated benefits that has been raised and is often raised. When people talk about the hundreds of mandates, they always mention chiropractors and God knows what else, which in the scheme of things amount to pennies, less than that in health-care dollars.

In New York, we asked Blue Cross/Blue Shield to spell out for us what fraction of their payments go totally for coverage that is covered by New York's existing mandated benefits. It came out to less than 20 cents on the premium dollar. Almost all of that 20 cents was accounted for not by requirements for second opinions, which is a requirement under a New York law, but most companies do it anyway. Almost all of that 15-20 cents on the dollar is accounted for by maternity care, which is a mandate in New York. Yet, almost anybody who discusses doing away with mandates says, "Well, of course, I don't mean to get rid of the maternity coverage. "

And the second largest item behind maternity coverage was mammography, which is one of the only preventive services covered by insurance. And again, when people attack mandates, they almost always say, "Well, of course, I don't mean getting rid of mammography." When you take those two out of the pie, you're talking about on the order of a nickel out of the insurance dollar. And in a world where insurance premiums are going up to often 20-25 percent a year, and have been for a long time, at least in the New York package of mandates, I don't think you can fairly attribute much of that burden to mandates.

REPRESENTATIVE SCHEUER. Ms. Schakowsky.

MS. SCHAKOWSKY. There is an increased impression in Illinois, and I'm sure around the Nation, that insurance is for healthy people. The insurance people that I meet with regularly—I must be a masochist—are very happy for us to expand Medicaid. They love Medicare, they love the CHIPs program in Illinois for the so-called uninsurable. Think about that word "uninsurable". This is not a technical word. This means sick.

REPRESENTATIVE SCHEUER. What does insurance mean, if not spreading the risk?

MS. SCHAKOWSKY. Absolutely.

REPRESENTATIVE SCHEUER. If it means spreading the risk, theoretically, as a logical matter, it should take the sick with the well. That's what insurance means, creating a large pool and spreading the risk. And the idea of squeezing people out of the system for preexisting illnesses or problems, thereby making it difficult for these people to get coverage, or difficult for people working for small and not very profitable businesses to get coverage, to me that's intellectually anti-ethical to the concept of the true essence of insurance: that is spreading the risk.

MS. SCHAKOWSKY. Now, we are finding, with the technical expertise of insurance underwriters, they can pinpoint any individual or group and get rid of them. I am not suggesting that this new plan is, but I want to say that the fundamental reason why we do not embrace the notion of insurance reform is that it still does not get at the issue of cost controls, of our ability to negotiate rates, global budgets for hospitals, rates for procedures with doctors. If we keep in place the current system of a multiplicity of insurers, we are not going to be able to really rid ourselves of the escalating costs, and we are not going to be able to keep costs down.

REPRESENTATIVE SCHEUER. Mr. Tooman, how is it that insurance companies in Hawaii seem so much more cooperative than insurance companies on the mainland, and that they're willing to go along with community ratings, which is the true essence of what insurance is all about. Why has that been so successful in Hawaii? And, on the other hand, if it's rejected ... I take it that you would reject the concept of a broad application of community ratings.

MR. TOOMAN. Community rating in a voluntary market will not work. In an involuntary market, like Hawaii—Medicare—it will work.

REPRESENTATIVE SCHEUER. I guess what we're talking about is an involuntary market where society seeks to achieve a universal, comprehensive program. And if you accept that, it can't be voluntary.

Dr. Lewin, how would you answer my question?

DR. LEWIN. In Hawaii, I think as you pointed out, we don't have a pay-or-play system. Everybody plays in Hawaii; all employers have to come in. It is a mandate, although it isn't nickle/dime mandates of this benefit or that benefit. It is a comprehensive benefit package. What Hawaii is talking about, and has maintained, is that government has provided a comprehensive benefit package and quality assurance standards for everybody. Then, we let the marketplace go at it in terms of, within that framework, the benefit package that everyone needs to achieve. Then, we let competition go to work. And the community ratings forced the commercial insurers out of Hawaii because they couldn't give up their practices and underwriting. They were unable to play. They couldn't change. They had to play the mainland game that they're used to playing, and so they ended up being outcompeted by Blue Cross and Kaiser.

In Hawaii, Blue Cross and Kaiser end up having much more efficient systems, I believe, than they have in other states because of the fierce competition between these two companies to keep the rates lower and lower and lower. The commercial insurance companies have really just basically had to flee Hawaii, in terms of health insurance as a market. Small businesses in Hawaii, 97 percent of them, are less than 100 employees; 94 percent are less than 50 employees. We have the third, best small-business market in America today with more new businesses being created. Few are failing.

Fortunately, Senator Akaka has introduced the ERISA waiver bill for Hawaii, H.R. 5590. The idea of that bill is to give small businesses a bit of a better break in terms of looking at the percentage of contribution of employee to employer, which has changed over the years. And we strongly support that bill and add a few prevention benefits to reduce emergency hospital use even more in our state and reduce the rates.

I guess, the Hawaii model is different than single-payer. I tend to stand in support of Ms. Schakowsky and Mr. Gottfried and yourself, if we can't solve the problem of a complex health-care system, then single-payer makes sense. I do want to point out, though——

REPRESENTATIVE SCHEUER. Do you see any other way of solving the problem?

DR. LEWIN. Yes, because we have achieved it without a single-payer. We have a kind of modified single-payer. We only have two insurance companies, but there is nothing to stop a third or a fourth insurance company from coming into Hawaii and competing. That may very well happen someday. I don't think that our marketplace is closed. It's still in a sense open. The idea is, though, insurance companies are not willing to play a managed care game in which we really put everybody in one risk pool, and we develop an efficient system. Hawaii, though, looks to the future with an interesting twist that I think I need to add here. That is, we are not a single-payer plan, and we do not plan to develop that. We plan to develop a framework of government that doesn't get in as the coach, the team, or the player, but rather as a kind of referee of the system. Basically, setting up the standards and the basic benefit package that everyone must have—standard reimbursements, which include Medicaid, Medigap program, our SHIP. We want a single-reimbursement system, a single-benefit plan, and then let the insurance companies go at competition, giving labor, business, and consumers, by legislative mandate, access to all of the health information data, all of the claims form data so that they know exactly what the costs are, and then they can go out and be smart shoppers and force prices down.

In that situation, we think multiple insurance companies would actually create competition and force the rates down further than single-payer, which might reduce the extent of competition and even consumer choices in the long run. Imagine a single-payer is HCFA, for example, imagine that, because that's the kind of single-payer. It's a system that is not very user friendly to consumers. So, we'd like to make sure that consumer

choice is in there, and that the system is caring as well as cost-efficient. In that sense, we believe that we can create, in essence, what we're trying to achieve with the single-payer movement, and with more than one payer, and force insurance companies into a different game, out of the cherry picking game, out of the red-lining game, out of the game of rejecting people because they are sick and looking for people because they're healthy, and, instead, to really do what insurance is supposed to do, spread the risk over the whole population.

In Hawaii, if you lose your job today and you get another one tomorrow and you have AIDS, you are insured at the same low rate as anybody else coming in. If you have longstanding cardiovascular disease or diabetes and you are working, your insurance rate is the same as any other employee. That is really interesting because it is working in Hawaii. We are far away, but we hope that the rest of America takes a look at least at what we have before forcing us into a system that literally maybe inferior to what we have already. We hope that it is at least examined by the rest of the country before we all knee-jerk into a plan.

REPRESENTATIVE SCHEUER. Do you want to respond to Dr. Lewin? Please do. And when you're finished, I am going to ask both of you—you and Senator Gottfried—what you have learned from trying to pass a single-payer system in your state with reference to implementation. And are there things that we in the Federal Government could do to ease the way for states to adopt the single-payer system, in their discretion and wisdom, if they see that that is the right way to go, apart from any initiative on the part of the Federal Government to get into the admittedly complicated and anxiety-ridden businesses of rationalizing this health-care morass that we have on our hands?

MS. SCHAKOWSKY. First of all, the notion of user friendly. Nothing could be more user friendly, it seems to me, than a single-payer system. From the point of view of the health-care consumer, we are talking about one piece of paper, that's their health-care card. That's the card that they take to the doctor, to the hospital, to the pharmacy, and under the Illinois plan, even to the nursing home with you. There is no paperwork on the part of the consumer. There is some on the part of the provider, but a minimal amount.

REPRESENTATIVE SCHEUER. Because everything is automatically approved.

MS. SCHAKOWSKY. I think that this is the ultimate of user friendly. In terms of what we learned in Illinois, one, I think we shocked everyone when our legislation got 52 out of the 60 votes needed in the House of Representatives. The medical society, the insurance industry, and, in fact, even some of the proponents were surprised. We shouldn't have been. The reason is that they all heard from their constituents. People, as the vote was going up on the board, began to jump onto the legislation. They didn't want to go home without it. And so, I believe, that the political environment for this—and I mean this really in a bipartisan way—I think this is an issue that crosses partisan lines. People can no longer live under

this kind of health-care system. So, I am optimistic even though there are remands in Illinois that this is legislation that we will pass.

We would prefer the Federal Government to move ahead of us, to do this as a national plan, to pass H.R. 1300. We're proud of Marty Russo from Illinois and support his legislation. At the very least, we'd like the Federal Government to make it more easy for us to capture those federal Medicare and Medicaid dollars, and pass this plan so that we would put it into our single-payer plan in Illinois.

REPRESENTATIVE SCHEUER. Have you talked to Congressman Russo about federal legislation—a modest federal legislation—that would ease your way at the state level until such time as the Federal Government and the President would be ready to step in with a major drive and initiative?

MS. SCHAKOWSKY. Actually, we spent most of our time with Congressman Russo trying to mobilize support for his bill.

REPRESENTATIVE SCHEUER. Senator Gottfried.

SENATOR GOTTFRIED. Several things. One, as to what could help us from the federal level, I would certainly love to see national legislation enacted, although I think there is a lot to be said for that national legislation relying on state administration. I think, if hospitals are going to negotiate annual budgets and providers negotiating fees and what not, there is a lot to be said for them doing that with people who are closer to the local level than with the Federal Government. But I would also repeat, as I said in my testimony, my very enthusiastic reaction to Bernie Sanders' proposal for federal legislation that would both provide some seed money to state programs and also ease the way for the folding in of Medicaid and Medicare into state option programs. I think that that would be terrific.

I think the main thing that I've learned in this process so far is similar to what Ms. Schakowsky has said. I have just been stunned by the enthusiasm for a universal single-payer system. I've introduced zillions of bills in my time in the legislature. I have never had the kind of enthusiastic reaction from my colleagues, not only 65 of them coming on as sponsors, but coming up to me and thanking me for introducing this bill and giving them the opportunity to be sponsors of it, and telling me what a terrific idea it is. I just wish I had dreamed it up, but I am delighted to be the recipient of their thanks.

The other thing is that while this debate has been going on for a long time—and people usually refer back to Harry Truman—in the New York Legislature, we had a bill on this topic introduced by Al Smith in 1916. And I learned today, hearing descriptions of the German system going back to the 19th Century, how Smith's bill was essentially to import the German model. Even though this debate has been going on for an awful long time, I think that it has gotten really serious only in the last several months. I think it is much too early in the process for people to look at the single-payer plan and say, yeah, that's a great idea, but we really can't achieve it, so let's go to a fallback position. I think it's too early in this process to be going back to fallback positions.

What I would like to see is, if more people in this debate who carry credibility with them—certainly the 60 or so members of Congress who have come on the Russo Bill—if the AFL-CIO and some other groups like that could bite the bullet and say, yes, we're going to go with the plan that in our heart of hearts we know makes sense, I think a single-payer plan takes much more of the center stage and becomes an awful lot more realistic. As I said in my testimony, I think, on the merits and on the politics, it really is the only option that can develop the kind of political consensus among the general public and the business community. And I think more and more people have to wake up to that fact.

REPRESENTATIVE SCHEUER. Thank you, Senator Gottfried.

Dr. Lewin, any comments?

DR. LEWIN. I just need to point out, as we talk about this as the only option, I do want to just let everybody know that Hawaii does exist; we're there; it's real, and we're in the world today. And what we have achieved is that 98 percent of our public has an insurance policy with very broad coverage. And we have the outcomes. And it's not because of weather, genetics, or lifestyle. It's because we have provided primary care and prevention to everybody. We've got it; we're there. So, that's one thing that is a little frustrating for us because we continuously hear that what we have is not possible. So, I have to awaken people to know that what we have is possible, and, in fact, were we to have HCFA as our single-payer, which is what most other nations of the world have developed, as benevolent as it might be, it is not a system that induces competition and incentives. It is a system that may very well serve to cover everybody, and I am fully 100 percent behind that. Everyone should be covered; it's a right of citizenship. There should be no two classes. We should offer decent quality health care to every citizen now. And to do that is the cheapest possible thing that we can do to save our economy and to save business in the future.

But I think that Hawaii's system is the simplest of all models that you can imagine. It has almost no government regulation. We have no price fixing. We do no cost controls. We don't cap hospital costs. We don't cap doctor's fees. We allow that to market competition. We are going to tighten that competition even further and allow new groups, allow nurses to perform services that they can perform better, allow more team approaches, capitate the primary care services, and move toward more efficacious managed care. But we do not believe that we will achieve that at the present time if we go to single-payer, we think it will be a step backwards for us. It may not be for other states.

I don't want to argue in any way against this whole area, I just want to leave the notion there for people. Please don't set up some kind of a system in the nation that takes away something that already works, so we create something that is allegedly going to be better when we have something that we're quite satisfied with and now want to prove it. If New York doesn't want to look at it, that is fine. But we do want to point out the fact that we are here; we exist; we're in the world.

REPRESENTATIVE SCHEUER. You're alive and well.

DR. LEWIN. I think that if you could offer every person in your state an adequate health insurance policy for $1,000 for individual or $3,000 for a family and get 98 percent of the people covered, which we have done, then maybe that would be a goal worth achieving.

REPRESENTATIVE SCHEUER. Let me stop you there. Do you want to respond to that?

SENATOR GOTTFRIED. Only slightly tongue in cheek to say that I heartily concur with Dr. Lewin's suggestion that those of us, particularly in the Northeast, for the next several months ought to go look at the Hawaii system, probably for several weeks. [Laughter.]

MS. SCHAKOWSKY. Coming from Chicago, I dispute your disallowing weather as a reason.

DR. LEWIN. My daughter has convinced me that Chicago is the world's best place to live and the best place to go to college.

MS. SCHAKOWSKY. But I do want to say that my understanding of the Canadian system is, if it meets the qualification of affordability and all, there are some differences among the provinces in Canada, as well. And I think that we might want to certainly consider the option of letting Hawaii and others do their thing.

REPRESENTATIVE SCHEUER. One last question. In terms of controlling costs, do you believe that the global budget-setting process is a better means of controlling costs than managed care?

DR. LEWIN. I believe that we must have some global budgeting process. I think that's absolutely essential and necessary. And Hawaii's health-care reform process and visions, the means of doing that in a way that may be somewhat unique compared to how other states envision doing it, we plan to control costs by setting minimum standards and a benefit package that goes from prevention all the way through, including long-term care, and including dental health benefits, mental health and substance abuse benefits, and including the gamit of what we call the total health-care package for all citizens. And then to have the marketplace go about setting those prices. What we see as necessary to make that really work in the marketplace is to create an authority or commission that consists of business, labor, and consumer advocates who would have access to all of the health data from insurance companies and providers, whether it be Medicaid, Medicare—all that data to them by law. All of this information would be there. So, they would be able to look for efficiencies and demand them into contracting for care that is undertaken in Hawaii.

So, we would give the information to the purchasers of health care. We would also set a tax ceiling on the lowest benefit, whatever package provides the best preventive care for the lowest amount of money, the consumer satisfaction, the provider satisfaction, that would become the standard bearer. All business would have to buy or spend for that health-care policy, and that would be the limit of taxability. So, anything above that would become a boutique that the individuals would have to pay for on their own.

REPRESENTATIVE SCHEUER. Okay. I am only sorry that the full membership of the Committee wasn't here for this hearing. It was extremely interesting and informative, and I thank all four of you.

[Whereupon, at 1:50 p.m., the Committee adjourned, subject to the call of the Chair.]

HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS: LOCAL VIEWPOINT

MONDAY, DECEMBER 9, 1991

CONGRESS OF THE UNITED STATES,
SUBCOMMITTEE ON EDUCATION AND HEALTH
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:30 a.m., Center for Extended Care and Rehabilitation, North Shore University Hopsital, 300 Community Drive, Manhasset, New York, Honorable James H. Scheuer (chairman of the Subcommittee) presiding.

Present: Representative Scheuer.

Also present: David Podoff, professional staff member.

OPENING STATEMENT OF REPRESENTATIVE SCHEUER, CHAIRMAN

REPRESENTATIVE SCHEUER. I am Congressman Jim Scheuer and I am a senior member of the Joint Economic Committee of the House of Representatives. This is the thirteenth hearing that I have chaired for the Joint Economic Committee on the subject of how we get control of the galloping escalation in prices in our health-care system. Part of that implies a redeployment of resources. Part of it implies how do we start pushing less paper and treating more patients.

The fact of the matter is that is the title of this latest series of hearings "How to Push Less Paper and Treat More Patients." And we decided to have this hearing right in the district so that we could achieve a local prospective on the problems confronting our health-care system. I hope that many members of congress will do the same thing so that we can get the wisdom of people around the country in how we achieve a health-care system that provides for all of us and for all of our legitimate, serious health-care needs.

Well, this series of hearings is a logical extension of the comprehensive set of hearings that I chaired in 1988 on "The Future of Health Care Costs in America." In a report entitled "Medical Alert," I summarize some of the major themes that emerged from those hearings.

Let me read one brief quote from that report.

54-863 O—92—21

> Overhauling the health-care system by significantly modifying the existing system in the short run and by ultimately providing national health insurance in the long run will not only rationalize health-care delivery, but will also save hundreds of billions of dollars...

Nothing I have heard since those hearings started has undermined my belief that a fully tested cure for our critically ill health-care system —called a national single-payer system—is part of the overall treatment. A national single-payer system is an indispensable element in a package that will save us billions of dollars, while providing two underlying elements that are the intellectual underpinnings of any health-care system. The first is comprehensiveness and the second is universality.

Any health-care system that's worth its salt must provide for a human being's predictable health-care needs, and that includes normal health care, it includes dental care, it includes eye care. It includes the kind of care that I have benefited from—corsets, braces, crutches—all of the therapeutic devices that a polio patient would need in the course of a structured recovery program. I was the victim of polio in 1948. Thanks to a merciful God, I made a fantastic recovery, but I didn't do it by myself, I did it with a lot of aids and supports, and any person who falls prey to polio or any other catastrophic illness is, by definition, in a civilized and fair and just society, equally entitled to that. So, the system must be universal; it must cover everybody, and it must be comprehensive. It must provide for all of their legitimate health-care needs.

Now, we are not talking about cosmetic surgery, we're not talking about chin tucks and so forth, we are talking about legitimate health care, and there isn't a country in the developed world—not one of the advanced, developed countries—that does not have a universal health care system that provides comprehensive health care, and that should be our goal.

Universal access to health is assured in every single one of the European democracies, what we call the Organization for Economic Cooperation and Development. The United States is the only country where 37 million of our citizens are excluded from health care and have no formal access to the health-care system. And the elderly don't receive proper health care according to standards of developed countries. We don't have a long-term care program for the elderly, and we don't have a catastrophic program either for the elderly or for anybody else. We didn't have it for me when I got polio when I was 28 years old. Thank God, my family had the resources to manage it, but if they didn't, it would have been a very tragic situation.

Ten percent of our children from birth to age 10 have no formal access to the health-care system. Of all of the moral stigmas that I can imagine in the field of health care, none is worse than saying to 10 percent of our kids, "You're not going to have formalized access to a health-care system." It is a shame and a disgrace for our country, and until we solve

that problem, we shouldn't be able to look at ourselves in the mirror in the family of Nations.

We rank 24th in the industrial world with respect to infant mortality. We're 26th in low-birth rate. We're 18th in terms of life expectancy, and this gap prevails despite the fact that we pay far more than any other country in the world for health care. The fact is that we are paying the most and we are getting the least of any country in the developed world.

On a per capita basis, the comparisons are absolutely staggering. The United States spent over $2,500 per capita on health care, compared to $1,800 in Canada, $1,300-$1,500 in France, Germany, Norway and Sweden, and $1,100 in Japan. We pay significantly more than twice the per capita investment in health care than the Japanese pay, and they have substantially superior objective measures of health outcomes.

Next, there is undisputable evidence—and I will be happy to discuss this with any of the members of the medical community who appear here today—that our neighbor to the north, Canada, has provided universal access to comprehensive quality health care at the same time that it has successfully contained costs. The Robert Wood Johnson Foundation—that's the company that provides Band-Aids and so forth, a mega health products company—supported a study that concludes that:

> If the United States implements a Canadian style health-care system and focuses its initial reform efforts on administrative costs only, that the cumulative savings to our economy over a 10-year period would exceed $3 trillion.

That means we would save $300 billion a year, not from controlling the system for delivering health care itself, but from controlling the management, the billing, the paying, and all of the nuts and bolts aspects of management that don't really impinge on health care at all.

The report substantially adds additional support to the study of the General Accounting Office, which is the financial and technical watchdog agency for the Congress, and a study that was printed in the May issue of the *New England Journal of Medicine* by Drs. Woolhanler and Himmelstein, who substantially say the same thing, which I recommend to all of you who haven't read it. If you take these studies together, they indicate that there are savings of between $100 and $150 billion a year out there just from refining management of the system.

Despite the evidence with respect to administrative wastes in the United States health-care system, there is resistance from quite a few quarters from adopting a single-payer system. Now, part of this opposition stems from concerns about the political implications of the federal budget and tax policy changes that are required to implement a single-payer system, even though the net savings to our society and to our economy over the next ten years would exceed $3 trillion. Now, I'm not going to get in to how we pay for this system. The fact is, that after instituting the kind of reforms that I'm talking about, our society will have to pay somewhere between $100 and $200 billion less each year for the cost of our health service delivery system. How we effect that saving is a whole

other matter in itself. What I want to do is to seize that pot of gold ou there, to find the $100 to $200 billion to ingest that into the system, tc pay for the 37 million people that we now exclude, to pay for the cost ol giving health care to the 10 percent of our kids that we now exclude, to pay for catastrophic costs for everybody, and to pay for long-term costs for our seniors, which we know we can pay out of the savings.

How we arrange for society to pay for the new system at a rate $100 to $200 billion less than what we are spending now is a matter for another hearing, and, perhaps, even another set of experts. But that pot of gold, that great opportunity that reaches up ahead, is too good to be missed and we can fund all of the things that we need to support in order to produce a health-care system that we can be proud of.

We can indeed be proud of many aspects of our health-care system. For those who are able to pay out of their own pockets, or for those who have comprehensive health plans, we provide health care that is probably the best in the world; but for tens of millions of other people who are not as well situated, we provide a standard of health care that really doesn't even meet third world standards in many respects, and this is a blight on our health-care system that it doesn't deserve, that it doesn't merit; and if we have the sense to make the basic organizational changes, then we can have a system that is universal, that is comprehensive, that we can truly be proud of.

But the proliferation of more than 1,500 insurance companies to provide health insurance of a wildly differing variety, it is this factor that is primarily responsible for the chaos and administrative wastes that plague the system.

I'm convinced that an enlightened American public is light years ahead of its officials. Certainly, light years ahead of the Executive Branch and the President and, I think, well ahead of the politicians in the legislative branch, in the House and Senate, and in the State Legislatures. Now, it should be said that there are many members of the House and Senate who have been working actively for reform, and there are many leading members of State Legislatures who are quite aware of and are providing leadership in the need to reform the system. Here in New York State, Assemblyman Gottfried is providing pioneering leadership in moving this state to a rationalized health-care delivery and payment system. In the Congress, we have a proliferation of bills—60 members of the House, including myself, have joined in support of the Russo bill, HR 1300, that is designed to move us into a single-payer system. And this is what the American public wants as their right. In a recent *Wall Street Journal* NBC poll, 69 percent of the voters said that they would favor adoption of a Canadian-style universal health-care system; only 20 percent were opposed. And a Lou Harris survey showed that Americans are fed up with their health-care system and want corrective action. Eighty-nine percent felt that our system needs fundamental changes or complete restructuring.

Last week, I introduced with Senator Paul Simon a resolution expressing the sense of the Congress that the President of the United States

should submit to this Congress a proposal for reforming the health-care system of the United States.

Over 50 members of the House are supporting this proposal, and what it means is that the American people know something is wrong; everybody connected with the health-care system knows something is wrong. It's only the President who doesn't seem to know that something is wrong and hasn't lent his leadership to the move to achieve something a great deal better.

In the 40 years that have passed since President Harry Truman first proposed universal access to health care, time has passed and nothing has happened. The need for reform was clear 40 years ago, and it's just as clear today. Time has only increased the sense of urgency. The time for action is now.

[The written opening statement of Representative Scheuer follows:]

WRITTEN OPENING STATEMENT OF REPRESENTATIVE SCHEUER

I am delighted to bring this crucial series of hearings, entitled *HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS*, to the district so that we may obtain a local perspective on the problems confronting our health care system.

This series of hearings is a logical extension of the comprehensive set of hearings I chaired in 1988 on the *FUTURE OF HEALTH CARE IN AMERICA*. In a report, entitled *MEDICAL ALERT*, I summarized some of the major themes that emerged from those hearings.

Let me read one brief quote. "Overhauling the health care system by significantly modifying the existing system in the short run and by ultimately providing national health insurance will not only rationalize health care delivery but will also save billions of dollars...."

And nothing I have heard since 1988 has undermined my belief that a fully tested cure for our critically ill health care system -- called a national single payer system -- is awaiting adoption. A national single payer system is the only cure that will save us billions of dollars, while providing universal access to comprehensive health care. Let me briefly summarize how I view the issues, after listening to outstanding testimony, during three days of hearings I chaired in Washington, D.C. several weeks ago.

First, there is general agreement that our health care system is "ill" as it provides too little access at too high a cost.

Universal access is assured in all countries of the Organization for Economic Cooperation and Development (OECD) except in the United States where 37 million people -about 13 percent of the population -- have no health insurance. In addition, the elderly do not receive long-term care, 10 percent of our children do not have regular excess to medical care and no one is protected against the cost of catastrophic care. We rank 24th in the industrial world with respect to infant mortality, 26th in low birthweight and 18th with respect to life expectancy. These gaps exist despite the fact that we spend far more on health care than any other country in the world. In 1990 the United States spent 12.4 percent of Gross Domestic Product (GDP) on health care compared to an average of 7.6 percent for the countries of the OECD. On a per-capita basis the comparisons are more staggering. The United States spends over $2500 per-capita on health care compared to $1800 in Canada, $1300-1500 in Germany, France, Norway and Sweden and only $1100 in Japan.

Second, there is undisputable evidence that Canada, our neighbor to the north, has provided universal access to comprehensive, quality health care, at the same time that it has contained costs. A study supported by the Robert Wood Johnson Foundation -- and released in October -- concludes that if the United States "implements a Canadian-style health care system, and focuses its initial reform efforts on administrative costs only," that the cumulative savings to the economy, over a ten year period, would exceed $3 trillion. Furthermore, the report notes that the "cumulative ... gain to employers over the decade is $2.5 trillion." In addition, the Robert Wood Johnson study finds that each and every year we waste billions of dollars (an estimated $90 billion in 1991) on paper pushing activities that contribute nothing to our health status.

The Robert Wood Johnson funded study, conducted by the Economic and Social Research Institute, adds additional support to the findings of the United States General Accounting Office (GAO) and the study of Drs. Woolhandler and Himmelstein.

The GAO, after a thorough review of the single payer system in Canada, concluded that the adoption of a single payer system in the United States potentially could save $67 billion -- more than enough money in today's economy to provide quality health care for the uninsured and for the underinsured. And

based on their recent study in the New England Journal of Medicine, Drs. Woolhandler and Himmelstein estimate potential savings in 1991, from adopting a single payer system, to be $136 billion.

In the second day of this series of hearings we had eloquent and convincing evidence to bolster these findings from one of the witnesses. As Pete Welch, a Senior Research Associate at The Urban Institute put it, during his analysis comparing health care expenditures in Canada and the United States, "The North American experiment demonstrates conclusively that the single-payer system has contained costs more effectively than has the U.S. multipayer system."

And because these cost containment efforts tend to eliminate wasteful expenditures on useless "paper pushing" activities, there appears to be little or no impact on the quality of health care in Canada. A high level hospital administrator with experience in both Canada and the United States also testified at that hearing. Based on his experience Vickery Stoughton, Vice Chancellor of Health Affairs and Chief Executive Office, Duke University Medical Center, testified that "In so far as maintaining quality and innovation I did not find any difference in quality but to the extent there is a difference; it is my opinion that the Canadian system performs overall at a higher level."

Third, despite the evidence with respect to administrative waste in the U.S. health care system, there is resistance to adopting a single payer system. Part of the opposition stems from concerns about the political implications of the Federal budget and tax policy changes that are required to implement a single payer system, even though the net savings to the economy, over the next ten years, could exceed $3 trillion.

Part of the resistance stems from a reluctance to transfer resources from the private insurance industry to the government. It is often argued, or rather assumed, that the private sector is more efficient than the public sector. Yet it is the proliferation of more than 1500 insurance companies that is primarily responsible for the administrative waste in our health care system.

And based on the experience of other countries we know that, with respect to health care, government is more efficient than the private sector. In a number of capitalistic countries -- Canada, France, Germany and Japan -- between 70 and 80 percent of health care expenditures are allocated through the public sector, compared to only 40 percent in the United States. Yet these countries spend 30-60 percent less per-capita on health care than the United States. In part, these countries spend less because, as Ted Bernstein of the ILGWU argues cogently in his testimony to be presented later this morning, "In the health care arena, the marketplace cannot be more efficient than public planning and programs."

I am convinced that an enlightened American public, light years ahead of the politicians, is ready to seize a pot of gold, and is willing to replace our chaotic, bloated, and wasteful health care system with a more cost effective system. The polls support this view. In a recent Wall Street Journal/NBC News poll, 69 percent of voters said they would support adoption of a Canadian-style universal health care system; only 20 percent were opposed. And a Lou Harris survey showed that Americans are fed up with their health care system and want corrective action. Eighty-nine percent felt our system needs fundamental changes or complete restructuring.

As I indicated, I believe that a national single payer system is the solution to our health care crisis. Consequently, I am a proud co-sponsor of H.R. 1300 the Universal Health Care Act of 1991 introduced by Congressman Russo of Illinois. This legislation, with over 60 co-sponsors, provides for universal access through a simple single payer system.

The need for fundamental reform of our health care system is clearly recognized by my colleagues in the House of Representatives. In one of the hearings I conducted in Washington, members from both parties (and an independent),

suggested numerous alternative approaches to reforming our health care system.

However, fundamental changes in our health care system will require not only Congressional debate, but also the commitment of Presidential leadership. Therefore, I introduced, along with Senator Simon of Illinois, a resolution expressing the sense of Congress that the President should submit to this Congress "a proposal for reforming the health care system of the United States." Over 50 members of the House are co-sponsoring my resolution and Senator Simon has several co-sponsors for his resolution.

In today's hearing we will hear not only from policymakers, health care providers and consumers at the local level, but also have an opportunity to hear from people who have literally "fallen between the cracks" of our chaotic health care system.

It is more than 40 years since President Truman first proposed universal access to health care. The need for health care reform was clear 40 years ago; the passage of time has only increased the urgency.

The time for action is now!

REPRESENTATIVE SCHEUER. Now, let us go to the first panel.

I'm delighted to welcome three highly talented and experienced professionals in government who can be relied on to give leadership, knowledge and experience to the move to reform the health-care system.

We will hear from three knowledgeable government officials. First, The Honorable Claire Shulman, Borough President of Queens. Next, we will hear from Dr. Margaret Hamburg, Acting Commissioner of Health for New York City. Then, we will hear from Dr. George Pickett, Commissioner of Health for Nassau County.

We begin this panel with the Honorable Claire Shulman, Borough President of Queens. Mrs. Shulman was the first woman to be elected Queens Borough President. She began her professional career as a registered nurse at Queens General Hospital, so she has had great first-hand experience with our health-care system and comes to us this morning with a deep wealth of experience and professional training. We're delighted to welcome you here this morning, Claire.

Please take such time as you may need to give us your views. I'm going to suggest to all of the witnesses that they stick as close to 5 or 6 minutes as they possibly can. We have four major panels this morning. So, in deference to the other witnesses, we need to move reasonably rapidly through these panels. Borough President Shulman, we are delighted to have you here. Please proceed.

STATEMENT OF THE HONORABLE CLAIRE SHULMAN, BOROUGH PRESIDENT, QUEENS

Ms. SHULMAN. Thank you, Congressman Scheuer. Good morning, ladies and gentlemen. Thank you for this opportunity to share my comments on reforming the American health-care system.

Although the United States has the most expensive health-care system in the world, spending about $700 billion in 1991, which is about 12 percent of the gross national product, our health indicators rank with many of the poorest areas of the world. Straining the limits of our resources at both the local and national level is an increase in the number of AIDS cases, a growing elderly population, and an escalating substance abuse problem which impacts at almost every point along the health-care continuum.

In Queens, these conditions have placed our health-care delivery system in a precarious position as our existing, albeit limited health-care services struggle to keep pace with the steady and shifting demand for care.

In addition to a skyrocketing hospital bed utilization rate, our borough suffers from a lack of primary and tertiary care facilities.

What is incongruous about the unevenness of medical care and service in Queens is that we are a major metropolitan area and host to two of the Nation's largest airports, and home to 2 million residents and the foremost gateway to America for foreign visitors and emigres. Yet, similar to

considerably smaller localities around the Nation, we have difficulty attracting quality medical practitioners.

Witness the experience of many of our local hospitals which are experiencing severe difficulty in filling residency slots and attracting top-notch medical candidates. This is a result of a national health-care system that has created disincentives to either choose medicine as a career or practice in primary care areas.

These same disincentives have also made it difficult to encourage the citing of quality medical institutions in areas of the greatest need. Take, for example, the situation in Western Queens where there is absolutely no primary or tertiary medical care services to speak of. Despite this dire need for care and acute beds, New York Hospital is constructing or has applied to construct 970 acute care beds in Manhattan over the East River Drive. Even more unconscionable, the hospital is using Western Queens as its catchment area to justify its certificate of need. This suggests that the current structure of reimbursement favors the provision of health care in areas where there is less of a demand for need, without regard to the social and medical consequences to the larger community.

A further impact on the quality and provision of our medical care is a Nationwide nursing shortage, the likes of which we haven't experienced since World War II. Contributing to this shortage has been our inability to attract new candidates into the field, as evidenced by the decreased enrollment in nursing education programs. Since 1983 there has been a precipitous 50 percent drop in the number of students enrolling in nursing programs. Further compounding the situation has been the failure to retain existing RNs.

In the 1940s, the Federal Government addressed the problem by enacting the Bolton Act, which made it possible for many young people, including me, to attend nursing school. To address today's crisis, we need similar decisive action. Together, Congressman Ackerman and I have drafted the Emergency Nurse Shortage Relief Act, which was introduced by the Congressman 3 years ago. Since then, it has languished in committee, although it would encourage more people to enter the nursing fields by offering incentives, such as loans for continued nurse training and nursing scholarships. Passage of this legislation would acknowledge the magnitude and national scope of the nursing crisis and would improve the quality of health service in the borough, in the state, and in the country.

However, even with more nurses, more doctors and more medical facilities, many of our residents would still be faced with making choices between eating or obtaining medical care. In Queens this is no more apparent than in our senior community. Our borough has more than 400,000 seniors, the largest senior population in New York City , many of whom are barely surviving on fixed incomes. It is unacceptable that nearly 20 percent of the income of our elderly is paid out to cover the costs of health care. A popular misconception is that Medicare and Medicaid have addressed at least a part of this problem. However, the

truth is that the elderly pay more out-of-pocket today for health care than before these programs were enacted in 1965. This situation has been worsened by the action of some irresponsible segments of the legal community which have pushed the costs of practicing medicine through the ceiling, something that you did not mention that I mention.

The Russo bill has been suggested as an answer to the spiraling cost of health care in our country. I believe that the Russo bill is a first step in re-evaluating our national health-care needs; however, it is not the last step in our ultimately improving the quality of our health-care system and making it more accessible and affordable.

We need to balance the intent of the Russo bill with the practical implications of creating a one-source funding system in America. A single-payer system runs the risk of taking an element of independent judgment and choice away from the health services consumer. We need to examine whether it is a viable solution to totally eliminate the option of selecting medical providers and the ability to mold benefit plans to fit personal needs.

The private-sector insurance system—HMOs and other providers—can play a potentially valuable role in helping government forge a stronger and more productive partnership with the existing private health service delivery network. The crisis in health care in our country and the unstable economic climate dictate that our choices be made, but not short-sighted decisions. I am committed to build a health-care delivery system that meets our health needs, in terms of access, cost and quality, and I welcome the opportunity to continue to work with you toward our common goal.

Thank you.

[The prepared statement of The Honorable Ms. Schulman follows:]

PREPARED STATEMENT OF THE HONORABLE CLAIRE SHULMAN

Good morning.

Mr. Chairman and Members of the Subcommittee on Education and Health, thank you for this opportunity to share my comments on reforming the American Health Care System.

Although the United States has the most expensive health-care system in the world, spending about $700 billion in 1991 which is 12 percent of our GNP, our health indicators rank with many of the poorest areas of the world.

Straining the limits of our resources at both the local and national level is an increase in the number of Aids cases, a growing elderly population and an escalating substance abuse problem which impacts at almost every point along the health-care continuum.

In Queens, these conditions have placed our health-care delivery system in a precarious position, as our existing and albeit limited health-care services struggle to keep pace with the steady and shifting demand for care.

In addition to a skyrocketing hospital bed utilization rate, our borough suffers from a lack of adequate primary and tertiary care facilities.

What is incongruous about the unevenness of medical care and service in Queens is that we are major metropolitan area -- host to two of the Nation's largest airports, home to 2 million residents and the foremost gateway to America for foreign visitors and emigres.

Yet, similar to considerably smaller localities around the nation, we have difficulty attracting quality medical practitioners.

Witness the experience of many of our local hospitals, which are experiencing severe difficulty in filling residency slots and attracting top-notch medical candidates.

This is a result of a national health-care system that has created disincentives to either choose medicine as a career or practice in primary care areas.

These same disincentives have also made it difficult to encourage the siting of quality medical institutions in areas of greatest need. Take, for example, the situation in Western Queens where there are absolutely no primary or tertiary medical care services to speak of.

Despite this dire need for care and acute beds, New York Hospital is constructing a 970 acute bed hospital in Manhattan. Even more unconscionable, the hospital is using Western Queens residents to account for 30 percent of its catchment area and justify its certificate of need.

This suggests that the current structure of reimbursement favors the provision of health care in areas where there is less of a demand for need, without regard to the social and medical consequences to the larger community.

Of further impact on the quality and provision of our medical care is a nationwide nursing shortage -- the likes of which we haven't experienced since World War II.

Contributing to this shortage has been our inability to attract new candidates into the field, as evidenced by the decrease in enrollment in nursing education programs. Since 1983, there has been a precipitous 50 percent drop in the number of students enrolling in nursing programs.

Further compounding the situation has been the failure to retain existing Rns.

In the 1940s, the Federal Government addressed the problem by enacting the Bolton Act, which made it possible for many young people including me, to attend nursing school.

To address today's crisis, we need similar, decisive action. Together, Congressman Ackerman and I have drafted the Emergency Nurse Shortage Relief Act, which was introduced by the Congressman three years ago.

Since then, it has languished in Committee, although it would encourage more people to enter the nursing field by offering incentives such as loans for continued nurse training and nursing scholarships.

Passage of this legislation would acknowledge the magnitude and national scope of the nursing crisis and improve the quality of health service in the Borough and the State.

However, even with more nurses, more doctors and more medical facilities, many of our residents would still be faced with making choices between eating or obtaining medical care.

In Queens, this is no more apparent than in our senior community. Our Borough has more than 400,000 seniors -- the largest senior population in New York City, many of whom are barely surviving on fixed incomes.

It is unacceptable that nearly 20 percent of the income of our elderly is paid out to cover the costs of health care.

A popular misconception is that Medicare and Medicaid have addressed at least a part of this problem. However, the truth is that the elderly pay more out-of-pocket today for health care than before these programs were enacted in 1965.

This situation has been worsened by the actions of some irresponsible segments of the legal community which have pushed the costs of practicing medicine through the ceiling.

The Russo bill has been suggested as an answer to the spiraling cost of health care in our country.

I believe that the Russo bill is a first step in our reevaluating our national health-care needs. However, it is not the last step in our ultimately improving the quality of our health-care system and making it more accessible and more affordable.

We need to balanced the intent of the Russo bill with the practical implications of creating a one source funding system in America.

A single-payer system runs the risk of taking an element of independent judgment and choice away from the health services consumer. We need to examine whether it is a viable solution to totally eliminate the option of selecting medical providers and the ability to mold benefit plans to fit personal needs.

The private sector insurance system, HMOs and other providers can play a potentially valuable role in helping government forge a stronger and more productive partnership with the existing private health service delivery network.

The crisis in health care in our country and unstable economic climate dictate that hard choices be made, but not short-sighted decisions.

I am committed to helping build a health care delivery system that meets our health needs in terms of access, cost and quality. I welcome the opportunity to continue to work with you toward our common goal.

Thank you.

REPRESENTATIVE SCHEUER. Thank you very much, Ms. Shulman, for your fine remarks.

Let me correct a possible misunderstanding. A single-payer system has nothing to do with the quality of health-care delivery; it has nothing whatsoever to do with restricting choice on the part of a patient; it has nothing whatsoever to do with the quality of care; what it has to do with is efficiency in managing the business of paying for it, of pushing paper.

[Applause.]

Now, it's only one part of the total solution to our health-care problem. We have to implement some kind of global cost controls, similar to what is in place in most other countires. But that's a wholly different subject than creating a single-payer system simply to pay the bills, to push the paper. There's going to be a lot less paper. It is going to be a much faster, more expeditious process, and that's all the single-payer system is addressed to.

Ms. SHULMAN. If I might comment, Congressman.

REPRESENTATIVE SCHEUER. By all means.

Ms. SHULMAN. I agree with you that a solution has to be found, and I'm saying that a solution that accommodates a quality of health care plus the universality of delivering the service, I agree with that. But being a member of the bureaucracy, I am also familiar with the fact that government does not always operate in an efficient manner, and you are assuming that if the Federal Government manages the payment system for the entire country that that will be an efficient and effective way. Bureaucracy has an interesting way of violating its own mandate. For some reason, it just grows and grows, and sometimes the administration of the bureaucracy eats up your $250 billion. So, I am suggesting that we tread carefully with regard to government taking over lock, stock and barrel medical payment in the United States. You know, unless you are prepared to put all sorts of controls on this system, it will grow and eat up, in an administrative way, whatever resources should be available to the public, and that's my only criticism.

[Applause.]

REPRESENTATIVE SCHEUER. I don't think we should carry on this debate, but I will say, since I am the Chair, that the government knows how to pay bills very well. We pay Social Security payments, people get their Social Security checks very, very well. Medicaid and Medicare, the checks go out and that's all we're talking about, means of payment. All of the other things that you mentioned are other aspects of a health-care reform proposal and we can discuss them in good time.

I appreciate your testimony; and as the other legislator here, I would invite you to come up here and sit with me and help ask questions of the other witnesses.

Our next witness will be Dr. Margaret Hamburg, Acting Commissioner of Health for New York City. She served as Deputy Commissioner prior to her appointment. She has also worked a number of years at the

National Institute of Health in Washington D.C. and serves on a number of health advisory committees.

Welcome Dr. Hamburg. We await with pleasure your testimony. When you are comfortable and feel ready, please take such time as you may need.

STATEMENT OF MARGARET HAMBURG, M.D., ACTING COMMISSIONER OF HEALTH, NEW YORK CITY, DEPARTMENT OF HEALTH

DR. HAMBURG. Thank you very much. I appreciate the opportunity to appear before you today. As you know, the Mayor had hoped to be able to be here, but I am delighted to have the opportunity to serve in his stead.

REPRESENTATIVE SCHEUER. We welcome you.

DR. HAMBURG. We would like to have the opportunity to address our mutual concerns about our Nation's health-care system and to address particularly some of the problems facing New York City. While New York City's problems may appear more severe, they are in fact a microcosm of the problems facing our Nation's urban areas, and our suburbs and rural communities. The magnitude of New York's problems are greater, but they are not different. Our health-care system's success or failure in meeting its challenges reflects the general strengths and weaknesses of the Nation.

Americans, regardless of their age, gender, race, marital status, income and employment status—whether insured or uninsured, whether nursing an ill parent or caring for an injured child—are deeply concerned that our system is failing them, and if it is left to continue, it will also seriously fail their children and their grandchildren.

It is becoming clear to many Americans that fundamental reform is required. It makes no sense to prescribe aspirin for systemic infection. We must look deep into the workings of the system and employ remedies as profound as the problems we find. Americans, in the absence of leadership, look to Congress for meaningful health-care reform. In that respect, Congressman Scheuer, we certainly appreciate your leadership on this issue.

For reform to be meaningful, we must understand the chronic problems with the system. I want to take this opportunity in my testimony to speak broadly about some of the Nationwide issues that you know so well and also to focus on some specific New York City concerns. I want to identify a few of the most serious problems that we face, and you have mentioned them already today—health insurance coverage, health-care costs and access to primary care, and I want to conclude with some general principles that I believe should be reflected in any model of health-care reform that is enacted by Congress.

Insurance coverage is the key to health care in this country, and it has already been mentioned several times this morning that the United States

spends close to $700 billion on health care, representing more than 12 percent of our GNP. That is the highest per capita expenditure of any industrialized Nation, yet some 35 million Americans had no health insurance in 1990, and the number of Americans without insurance is increasing.

Without health insurance, a person who needs care quickly finds that affordable services are unavailable. Necessary, even critical care, is put off solely for want of the ability to pay; yet, without timely care and preventive treatment, health problems can become life-threatening crises. The uninsured hypertensive man receives no medication and suffers a crippling stroke. The uninsured diabetic woman faces blindness and loss of a limb. The asthmatic child suffocates. Our hospitals' overcrowded emergency rooms have become the physicians' offices of last resort. Each year New York City's public hospitals treat approximately 1.3 million uninsured patients. And poor patients with preventable illnesses require expensive and intensive medical interventions that could have been much less costly, in both financial resources and human misery, had they been provided earlier.

The health-care bill for the uninsured is immense and growing Nationwide. An estimated $8.9 billion was spent in 1989 by 6,270 hospitals on unreimbursed care. That represents 4.8 percent of all hospital expenses. This year New York State will spend an estimated $944 million on medical care for the uninsured and the underinsured.

These escalating costs are the second systemic problem I want to address today.

Health-care costs increase far faster than inflation every year, fueling a vicious cycle. The increased costs drive up insurance premiums, which, in turn force businesses to drop their coverage. While the available monies for the uninsured are stretched to pay for additional uninsured people, the percentage of costs reimbursed to health-care providers is also reduced. Financially strained providers then reduce services or lay off staff.

Currently, New York City spends $578 million on health benefits for its employees. This fiscal year alone expenses are expected to soar by 11 percent. And by fiscal year 1995, New York City expenses are expected to double to $1.1 billion. Our HMO costs increased 18.9 percent last year, and the costs are expected to increase 13 to 14 percent next year. These increases closely parallel the 17.9 percent national increase in 1989 to 1990. No individual, small enterprise, large business, small or large municipality, state or country can endure for very long such intense spiralling costs. Real, meaningful cost controls must be established if care is to remain affordable to anyone other than the wealthy.

Finally, I want to address the chronic lack of primary care in New York City; a problem that is particularly acute in many of our poorer neighborhoods. An important study recently completed by the Community Service Society of New York stated:

> The absence of accessible affordable quality primary care is a principal reason for much suffering and death among the poor minority residents of this city.

Their study found that there is an immediate need for almost 500 primary care physicians in economically disadvantaged inner-city neighborhoods.

Even when the doctors are available, barriers still exist to appropriate health care. Incredibly, the study I just mentioned found that 65 percent of the doctors providing prenatal care could not deliver babies due to their lack of hospital affiliations. So, even mothers who have had adequate prenatal care may be forced to use hospital emergency rooms for delivery and, sad to say, many more babies are born without the benefit of adequate prenatal care.

The consequences of our health-care crisis are readily apparent in a growing number of public health problems and a worsening profile of health in our city. And I'll just take a moment to mention a few critical areas.

First, infant mortality. As you mentioned, our Nation fares very poorly in terms of our infant mortality statistics. New York City does even worse. After decades of decline in New York City's infant mortality rate, the rate actually rose in the mid-1980s. This rise was associated with the appearance of crack cocaine on our streets and a marked increase in the use of cocaine by pregnant mothers. Last year's infant mortality rate was 12.6 per thousand live births, about one third higher than the national average. And in many areas in New York City, the infant mortality rate rivals that of third world Nations. Central Harlem, for example, had a rate of close to 28 per thousand live births.

We have heard mention already this morning about the problem of AIDS in New York City; and, of course, we are the center for the epidemic in the Nation. Approximately 36,000 New Yorkers have been reported with AIDS to date, and our city's caseload reflects about 20 percent of the Nation's total AIDS cases. We estimate that between 125,000 and 235,000 people are infected with the HIV virus in our city. Approximately one-eighth to one-quarter of the one million people who are HIV infected Nationwide live here in New York City.

Our best Department of Health statistics indicate that, over the next few years, we will see a doubling of the number of cases that we have witnessed in the first decade of the epidemic. I don't need to tell you that this is placing an enormous human and economic toll on the health-care system of our city.

Tuberculosis is another problem that we are all very acutely aware of at the moment, and that represents many of the problems in our health-care system. The current tuberculosis epidemic in New York City is one of emergency proportions. The TB incidence has increased more than 130 percent over the past decade and close to 40 percent from 1989 to 1990 alone. The city's TB case rate was 49.8 per hundred thousand last year, which is five times the national average, and accounts for 15 percent of the cases Nationwide.

A further concern is the fact that multiple drug-resistant tuberculosis has increased dramatically, and nearly one-quarter of New York City tuberculosis' patients have a germ resistant to one or more of the standard antituberculosis drugs. The emergence of such significant levels of drug-resistant tuberculosis reflects the fact that too many individuals with tuberculosis disease are not completing the necessary treatment regimen. Partial treatment leads to poorer health outcomes and more expensive treatment.

One last example that I would like to mention in this regard is New York City's problem with measles. As you know, measles is an easily preventable disease. We have a safe and effective vaccine, yet inadequate access to primary care means that large numbers of children, particularly the poor—often African-American and Latino youth—are not receiving timely immunizations. This has contributed to our escalating measles epidemic in New York City. In 1991 we had more than 3,600 cases; in 1990 we had some 2,500. So, the numbers are clearly going in the wrong direction.

For an increasingly large number of people, many, but by no means all of whom are poor, there is no question that our health-care system is not fairly or adequately distributing health services to those who need them, or it is not adequately using our available resources, knowledge or technologies to prevent and alleviate disease, or that it is failing to help each new generation to grow up as healthy as it can.

We believe that health-care reform is necessary and is, in fact, long overdue. We believe that several general principles should be the basis of health-care reform. While I am not here to enter into debate about the specific financing mechanism for this reform, I would like to briefly outline some of the more important principles that should guide that reform.

Health insurance coverage must be universal and include a mechanism to guarantee health care for the residual population of uninsured who will exist whatever plan is put into law. These at-risk populations include the undocumented, the mentally ill and the homeless. Primary care must be central to all aspects of public health policy, including medical education, and the citing and designing of facilities and reimbursement mechanisms.

Services must be high quality and readily accessible. Cost containment must be effective, covering all areas of health care, including rates, volume and administrative costs. Urban health facilities must be adequately funded to provide the special care needs of populations at particular risk.

And, finally, I must emphasize that localities cannot be asked to bear additional costs; these must be borne by the Federal Government.

How we address the heath care needs of our citizens mirrors our ethical and moral commitment to each other; it reflects our national soul. If we are to continue as a democracy, as a Nation pledged to fairness and equality, as a compassionate people, then we must structure a health-care

system that reflects these values. If you do less than that which is required, it would endanger our traditions, our integrity and our future.

Thank you very much.

[Applause.]

[The prepared statement of Dr. Hamburg follows:]

PREPARED STATEMENT OF MARGARET A. HAMBURG, M.D.

Good morning Congressman Scheuer, ladies and gentlemen. I am Dr. Margaret Hamburg, the Acting Commissioner of Health for the City of New York. I am very pleased to be here today to address our country's crisis in health care and particularly the problems facing New York City. While New York City's problems may appear more severe, they are in fact a microcosm of the problems facing all of our nation's urban areas, suburbs and rural communities. The magnitude of New York City's problems are greater, but they are not different, and our health care system's success or failure in meeting its challenges reflects the general strengths and weaknesses of the national health care system.

Americans, regardless of their age, gender, race, marital status, income, employment status -- whether insured or uninsured, whether nursing an ill parent or caring for an injured child -- are deeply concerned that our system is failing them, and if left to continue, will also seriously fail their children and grandchildren.

It is becoming clear to many Americans that fundamental reform is required. It makes no sense to prescribe aspirin for a systemic infection. We must look deep into the internal workings of the system and employ remedies as profound as the

problems we find. Americans, in the absence of leadership from the President, look to Congress for meaningful health care reform.

For reform to be meaningful, however, we must understand the chronic problems with the system. I want to identify a few of the more serious problems: health insurance coverage, health care costs and access to primary care. And I want to conclude with some general principles that I believe should be reflected in any model of health care reform that is enacted by Congress.

Insurance coverage is the key to health care in this country. It is ironic that, while the U.S. spent $668 billion [on health care] in 1990 -- more than 12% of our GNP and the highest per capita expenditure of any industrialized nation -- recent census figures indicate that 35 million Americans had no health insurance in 1990. And the number of Americans without insurance coverage is increasing.

Without health insurance, a person who needs care quickly finds that affordable services are unavailable. Necessary -- even critical -- care is put off, solely for want of the ability to pay. Yet without timely care and preventive treatment, health problems can become life-threatening crises. The uninsured hypertensive man receives no medication and suffers a crippling stroke. The uninsured diabetic woman faces blindness and loss of her legs. The asthmatic child suffocates.

Our hospitals' over-crowded emergency rooms become the family physicians' office of last resort. Each year, New York City's public hospitals treat approximately 1.3 million uninsured patients. And poor patients with preventable illnesses require

expensive and intensive medical interventions that could have been much less costly -- in both financial resources and human misery -- had they been provided earlier.

The health care bill for the uninsured is immense and growing. Nationwide, an estimated $8.9 billion was spent in 1989 by 6,270 hospitals on unreimbursed care. That represents 4.8 percent of all hospital expenses. This year New York State will spend an estimated $944 million on medical care for the uninsured and the under-insured.

These escalating costs are the second systemic problem I want to address today. Health care costs increase far faster than inflation every year, fueling a vicious cycle. The increased costs drive up insurance premiums which, in turn, force businesses to drop their coverage. While the available monies for the uninsured are stretched to pay for additional uninsured people, the percentage of cost reimbursed to health care providers is also reduced. Financially strained providers then reduce services or lay off staff.

Currently, New York City spends $578 million on health benefits for its employees. This fiscal year alone, expenses are expected to soar 11.4%, and by fiscal year 1995, New York City expenses are expected to double to $1.1 billion. Our HMO costs increased 18.9% last year, and the rate of growth is expected to increase 13 to 14% next year. These increases closely parallel the 17.9% national increase in 1989-1990. No individual, small enterprise, large business, small or large municipality, state or country can endure for very long such an intense cost spiral. Real, meaningful cost controls must be established if care is to remain affordable to anyone other than the wealthy.

Finally, I want to address the chronic lack of primary care in New York City, a problem that is particularly acute in many of our poorer neighborhoods. An important study by the Community Service Society of New York stated: "The absence of accessible, affordable, quality primary care is a principal reason for much suffering and death among the poor, minority residents of this city." Their study founds that there is an immediate need for 495 primary care physicians in economically disadvantaged inner city neighborhoods.

Even when the doctors are available, barriers still exist to health care. Incredibly, this study found that 65% of the doctors providing prenatal care could not deliver babies due to their lack of hospital affiliation. So even mothers who have had adequate prenatal care are forced to use hospital emergency rooms. And sad to say, many more babies are born without the benefit of their mothers' having had any early care.

The consequences of our health care crisis are readily apparent:

- Infant mortality

  NYC's infant mortality rate actually rose sharply earlier in this decade after the first appearance of crack, the insidious smokeable cocaine, to city mothers. Last year's IMR was 12.6 per 1000 live births, about one third higher than the national average.

  In many areas of New York City, the IMR rivals that of third world nations: Central Harlem, for example, had a rate of 27.5/1000 live births.

- AIDS

Approximately 36,000 New Yorkers currently meet existing clinical criteria for AIDS, and our city's caseload reflects about 20% of the nation's total population of 195,000 afflicted with this devastating disease. We estimate that there are between 125,000 - 235,000 people infected with the HIV virus in our city; approximately one-eighth - one-quarter of the 1 million people who are HIV infected nationally live here.

Our latest AIDS incidence projection figures, the most comprehensive to date, indicate that, between 1991 - 1995, an additional 36,000 New Yorkers will be diagnosed with AIDS. In the next five years, we will double the number of AIDS cases that we saw in the first ten years of the epidemic.

- Tuberculosis

The current tuberculosis epidemic in New York City is one of emergency proportions. Tb incidence jumped 38% from 1989 (2,545 cases) to 1990 (3,520 cases) alone.

The City's Tb case rate last year was 49.8 per 100,000, five times the national average of 9.5 per 100,000, and three times the level considered by the CDC to be epidemic.

Drug-resistant Tb has increased dramatically because patients are not taking their complete regimen of medication. Nearly one-quarter of NYC tuberculosis patients have a germ resistant to one or more anti-Tb

drugs.

- Measles

  Easy access to comprehensive primary health care is everyone's right. But our national failure to provide for that right is perhaps nowhere more shameful than with our children.

  Consider, for example, New York City's problem with measles. Measles is an easily preventable disease. Barriers to primary care's accessibility mean that large numbers of children, particularly the poor, particularly African-American and Latino youth, are not receiving timely immunizations.

  That has contributed to our escalating measles epidemic in New York City. In 1991, more than 3,600 cases have been reported; in 1990 more than 2,500 cases were reported; in 1989 only 135 cases were confirmed.

For increasingly large numbers of people, many, but by no means all of whom are poor, is there any question that our health care system is not fairly or adequately distributing health services to those who need them? Or that it is not adequately using our available resources, knowledge, or technologies to prevent and alleviate disease? Or that it is failing to help each new generation grow up as healthy as it can?

We believe that health care reform is necessary and is in fact long overdue. We believe that several general principles should be the basis of health care reform. I do not intend to enter the

debate about the financing mechanism for this reform. I only intend to outline some of the more important principles that should guide that reform:

1. Health insurance coverage must be universal and must include a mechanism to guarantee health care for the residual population of uninsured who will exist whatever plan is put into law. These at-risk populations include the undocumented, the mentally ill, and the homeless.

2. Primary care must be central to all aspects of public health policy, including medical education, siting and design of facilities, and reimbursement mechanisms.

3. Services must be high quality and readily accessible.

4. Cost-containment must be effective, covering all areas of the health care including: rates, volume and administrative costs.

5. Urban health facilities must be adequately funded to provide the special care needs for populations at particular risk.

6. Localities cannot bear additional costs; these must be borne by the federal government.

How we address the health care needs of our citizens mirrors our ethical and moral commitment to each other. It reflects our national soul. If we are to continue as a democracy, as a nation pledged to fairness and equality, as a compassionate people, then we must structure a health care system that reflects these values. Our national destiny is at stake. To do less than what is required would endanger our traditions, our integrity, and our future.

Thank you.

REPRESENTATIVE SCHEUER. Thank you very much, Dr. Hamburg.

We will now hear from Dr. George Pickett, Commissioner of Health for Nassau County.

Dr. Pickett has served as President of the American Public Health Association and has headed local health departments in several states, including Michigan and California.

We are delighted to have you serving Nassau County, Dr. Pickett. You bring a very distinguished record to the citizens of Nassau County, and we are very happy to welcome you here today. Please proceed and take as much time as you may need.

DR. PICKETT. Thank you, very much, Congressman Scheuer. I am very grateful for this opportunity and want to commend you for the leadership that you have shown in this regard.

If I may reverse a usual practice, I think I would like to have your permission to incorporate your opening remarks into mine, because I agree with them, and had I thought about talking about the things at the national level, I would have done so. I elected, however, to focus on unique problems that are oft-times left out of national health policy discussions, because they affect us at the local level, and we have a lot of concerns about what may happen at the national level as we move ever so slowly toward solving this very longstanding problem. It's interesting that this meeting is being held at the extended health-care facility. In 1965 we might have held it in the acute health-care facility, but by now, we book it in the extended health-care facility. So, it has taken us a very, very long time to view this problem.

REPRESENTATIVE SCHEUER. You are cognizant of the fact that the pace of things is picking up and, as I said before, the American public, in its concern and its focus on this problem, is light years ahead of the Administration, perhaps, not as far ahead of the Congress, but truly ahead of the Congress. The people are way ahead of the leadership of the Congress in both the House and Senate. And the people who are doing the most innovative work—the 60 members who have supported the Russo bill are members—they are not leaders, but they are way ahead of their own leadership, as well as being ahead of the Administration. And I suggest to you, Dr. Pickett, that you are going to see concerns about our health-care system at the head of the national agenda in 1992, not because the President wants it there, not even because the leadership of the House and Senate want it there, but because the people insist on it being there. And it's the younger, dynamic members of the Congress, like myself—I knew that would be a laugh line—but it truly is the younger, more junior members of the Congress who are picking up the banner and marching, because they know that they are listening to the people, whereas the President is totally disconnected. He is totally out of the universe of concerns of the people. His hearing aid has run dry.

Okay, I couldn't help make that small aside, that the pace of progress is quickening, and you can be sure that there is going to be major action next year.

REPRESENTATIVE SCHEUER. Please proceed, Dr. Pickett.

STATEMENT OF GEORGE PICKETT, M.D., COMMISSIONER OF HEALTH, NASSAU COUNTY DEPARTMENT OF HEALTH

DR. PICKETT. I sincerely hope you are right. I thought so in the 1960s; I thought so in the 1970s; I thought so in the 1980s; but by God, let's do it in the 1990s.

I am going to focus on a very few problems. They aren't necessarily the most important, they may even be mundane, but they happen to have been on my mind over this week. Next week, I might come up with a different plate of issues, but I'll try to focus on a few.

There was a time, just 25 short years ago really, when indigent health-care problems were largely local issues in this country and so were the solutions. Many local governments operated hospitals and extensive clinics, and local forms of general assistance were used to pay for the health-care needs of the poor. No longer. We count 113,000 medically indigent people in Nassau County, in addition to the 25,000 Medicaid beneficiaries. Both those groups have a very difficult time obtaining needed health-care services, and everybody is having an increasingly difficult time trying to pay for it.

In addition to the County's very heavy Medicaid cost burden, protecting those 113,000 medically indigent people would cost us another $406 million just for this one county. As you search for the best structure for what most people believe must be a national solution, we ask that you recognize a few of these local issues.

Number one, and first and foremost, we simply cannot pay for it at the local level. I am not an economist and I am not going to waste time belaboring the obvious, but it is clear that the local tax base cannot support the health-care system because of its size, and because it is not possible for local officials to make the necessary policy changes to control the system. In fact, I well recall a small county not too many years ago which was, according to state law, responsible for the care of those "not otherwise provided for" indigents—in the words, of the Elizabethan poor law. It would have had to consume 140 percent of its entire annual budget to pay for the cost of one baby burned in a house fire if it had had to pay for that cost. Many local jurisdictions are in the same position.

In the best of all national systems, some people will be uninsured for all services and all people will remain uninsured for some services; and when they are poor, they will turn to local government for assistance. If you can achieve, at the congressional level, 95 percent coverage of the population of the United States, a monumental accomplishment—that small remainder, that 5 percent would still cost a county such as Nassau $234 million annually to provide care at the present care-cost rates.

Second, the insanity of the present system of insurance—Medicare and Medicaid—cripples our efforts to be effective and efficient. I think you

have addressed this effectively in the Russo bill and in your opening comments.

Nassau County is presently facing the most serious fiscal period of its post-World War II history. We are losing staff. The question before us is, and I am really serious about this, should we eliminate those positions which determine client eligibility and process the bills, or should we keep them and drop the people who actually provide the medical care? Peculiar to the American system that has developed in this country is such that a case could really be made for preserving the billing clerks and cutting the physicians.

REPRESENTATIVE SCHEUER. That's exactly what we are doing.

DR. PICKETT. That's exactly what we are doing. Recently, while meeting with the staff in our Elmont Health Center, we discussed the frustrations that they have in trying to determine client eligibility. Our standards are such that if you have an income of $150 or more a week that that exposes you to some out-of-pocket charges for the health care that we provide. And the people know that, and when they are asked about their income level, they say $149. Now, the staff doubts that, at times, just on appearance, or the automobile, or whatever it is; but it is very difficult for them to pursue the issue, given our very slender staffing and, really, our lack of willingness to play tough in a clinical environment.

REPRESENTATIVE SCHEUER. Forgive the interruption, but why the hell should anybody have to play tough to decide whether a person is eligible for health care. That is precisely the point of the lesson. The system must be universal. Everybody must be covered.

DR. PICKETT. Another staff member complained about residency. Elmont is right near the Queens border. Many people in Queens are closer to our health center than to available sources in Queens and use our services, but we're so strapped now that we have had to move to exclusionary policies based on residency. Yet, the would-be care seekers tell our staff that they live in Nassau County, and they can produce addresses of friends and relatives, and it's very frustrating to our staff who feel they are being bamboozled in the process. But what is really frustrating is that we have to waste our time on such irrelevant issues. Why should it make any difference that you live in Queens when our health center is across the street? If you are sick or pregnant and think you have been exposed to tuberculosis or HIV, why, in a civilized society, should your address make any difference at all? And why should we have to consume valuable time and scarce human resources, all of which is ultimately paid for by those third-party payers who do, as you point out, trying to figure out whether you have $149 or $151 in your pocket? Shouldn't that worried, pregnant young woman be able to reach out to the nearest public health center for help without having to face such obstacles? Never mind the indignity of it all and the way it makes sick people and health professionals adversaries, just think of the waste involved in that process.

And the last of my three brief points, why focus on treating more patients, as the purpose of this hearing does, when we really ought to have fewer? Speaking as public health people, Dr. Hamburg and I have have some other interests and concerns in the national health policy.

None of the 30-plus bills proposed so far—including the Russo bill—deals effectively with prevention services and health promotion. Most of the money presently allocated for the AIDS battle goes for the provision of services, and virtually none of that money can be used for prevention.

So, long as attempts to reform the medical health-care system in the United States focus on insurance mechanisms, this probably is going to continue to be the case. Much of what we do at the local level has to do with the very unglamorous but rewarding work that was talked about by Dr. Hamburg, preventing diseases—measles, AIDS, tuberculosis hepatitis, breast and cervical cancer, developmental disabilities, lung cancer, deaths and disability based upon injuries, and a host of others problems which would otherwise increase the burden of dependency in society. And the techniques that we use have all been demonstrated to be technologically safe and effective, unlike those that are paid for in the Medical care system. These are programs that are not included in most health-care systems or plans. We think that a reasonable portion of the Nation's medical care bill should be allocated for health, not disease. We are justifiably worried that the present focus on access to and the cost of medical care may undermine the very limited fiscal support for prevention services and programs.

Those are just a few of the many issues which we hope will be considered by the Subcommittee. We can deliver effective and valuable services at the local level, but the power to determine the structure of that system and the authority to control its costs and the resources needed to pay for it reside at the national and state levels.

I want to thank you for the opportunity to appear before your Subcommittee, Congressman. I would be pleased to respond to any questions or suggestions, or to provide you or the members of the Subcommittee with any additional information, if that would be helpful.

[The prepared statement of Dr. Pickett follows:]

PREPARED STATEMENT OF GEORGE PICKETT, M.D.

HEALTH CARE REFORM: HOW TO PUSH LESS PAPER AND TREAT MORE PATIENTS*

As the folk-saying of local government officials goes, "It's at the local level that the rubber hits the road." That's quite true: the engine, the design and the fuel may be produced elsewhere, but the skid marks and pot-holes are here on the ground.

There was a time, just abut 25 years ago, when the health care problem was largely a local issue and so were the solutions. Many local governments operated hospitals and clinics and local forms of general assistance were used to pay the small costs of the medical care needed by the poor. No longer. We count 113,000 medically indigent people in Nassau County, in addition to Medicaid recipients. Both groups have a very difficult time obtaining needed health care services and all of us have a very difficult time paying for it.

In addition to the County's heavy Medicaid cost burden, protecting those 113,000 medically indigent people would cost another $406 million -- an increase of 21% in an unacceptably high tax bill.

This is not the time or the place to try to account for the enormous change in the nature of the problem during these past three decades, but rather to examine some of the special health care problems faced by local governments in the United States.

As you search for the best structure for what most people believe must be a national solution, we ask that you recognize these local issues.

1. We can't pay for it. I'm not an economist, nor will I waste time belaboring the obvious, but it is clear that the local tax base cannot support the health care system. One, because of its size and two, because it is not possible for local officials to make the necessary policy changes to control the system. I well recall a small county, which was, according to state law, responsible for the care of the medically indigent, which would have consumed more than 140% of its entire annual budget had that law been enforced for a young boy who had been badly burned in a house fire. Our Health Department budget is about $36 million.

   We provide primary care to 47,000 people for $10 million of those dollars. The impossibility of our assuming the costs of care for the remainder of the medically indigent is apparent. In the best of all national health insurance systems, some people will remain uninsured for all services and all people will remain uninsured for some services. When they are poor, they will turn to local government for assistance. If you can achieve 95% coverage in the United States, that small remainder would still cost Nassau county $234 million!

2. The insanity of the present system of insurance, Medicaid and Medicare cripples our efforts to be effective and efficient.

---

* Testimony prepared for The Subcommittee on Education, and Health of the Joint Economic Committee, the Honorable James H. Scheuer, Chair, by George Pickett, MD, MPH, Health Commissioner, Nassau County, New York, 9 December 1991.

Nassau County is presently facing the most serious fiscal period of its post-World War II history. We are losing positions. The question is: should we eliminate those positions which determine client eligibility and process bills, or should we retain them and drop the people who provide the medical care? The peculiarly American system which has developed in this country is such that a case could be made for preserving the billing clerks and cutting nurses and physicians.

Recently, while meeting with the staff in our Elmont Health Center, the discussion centered on the frustration they faces in trying to determine eligibility. Our standards are such that an income of $150 or more a week will expose you to paying some out-of-pocket charges. People know that, and, when asked about their income, respond, "$149 a week."

The staff may doubt that, but it is difficult to pursue the issue given our slender staffing and our lack of willingness to play tough.
Another staff member complained about residency: Elmont is close to the Queens border. Many people in Queens have used our services, but we are so strapped now that we have had to adopt an exclusionary policy. Yet the would-be care seekers tell our staff that they live in Nassau County, and can produce the addresses and phone numbers of friends and relatives to prove it. It is frustrating to our staff. But what is really frustrating is the fact that we have to waste time on such irrelevant issues. Why should it make any difference whether you live in Queens when our health center is across the street? If you are sick or pregnant or think you have been exposed to tuberculosis or HIV, why, in a civilized society, should your address make a difference?

And why should we have to consume valuable time and scarce human resources (all of which is paid for by those third-party payors who do pay us) trying to figure out whether you have $149 or $150 in your pocket? Shouldn't that worried, pregnant, young woman be able to reach out to the nearest public health center for help without having to face such obstacles? Never mind the indignity of it, and the way in which it makes sick people and health professionals adversaries, think of the waste.

Last of my three, brief points: why focus on treating more patients, as this hearing does, when we should have fewer? None of the 30 plus bills proposed so far deals effectively and efficiently with prevention services and health promotion. Most of the money presently allocated for the AIDS battle goes for the provision of services: virtually none of it can be used to prevent the disease.

So long as attempts to reform the medical care system in the United States focus on insurance mechanisms, this probably will continue to be the case. Much of what we do at the local level has to do with the un-glamorous but rewarding work of preventing diseases: measles, hepatitis, AIDS, tuberculosis, breast and cervical cancer, developmental disabilities, lung cancer, deaths and disabilities caused by injuries and a host of other problems which would otherwise increase the burden of dependency in society. And the techniques we use have all been demonstrated to be

technologically safe and effective. These are health services and programs which are not included in most medical care systems or plans. We think that a reasonable proportion of the nation's medical care bill should be allocated for health. We are, justifiably, worried that the present focus on access to and the cost of medical care may undermine the very limited fiscal support for prevention services and programs.

These are just a few of the many issues which we hope will be considered by the Subcommittee. We can deliver effective and valuable services at the local level. But the power to determine the structure of that system, the authority to control its cost and the resources needed to pay for it reside at the national and state levels.

Thank you for the opportunity to appear before the Subcommittee. I would be pleased to attempt to respond to any questions or sugggestions or to provide the Subcommittee with any additional information you may find helpful.

54-863 O—92—22

REPRESENTATIVE SCHEUER. Thank you very much, Dr. Pickett.

We are focusing this morning on the comparatively narrow issue of how do we improve the management of the system. There are all kinds of ways we can improve it, and not a one of them is more important than the focus that you have suggested. We should place more emphasis on preventive health care and wellness care rather than on sickness care. We have a great propensity in this country to inflate the advantages of open-heart surgery, organ transplants, and MRIs and so forth. Well, the average person's health outputs are going to depend far, far less on any and all of those than they are on what a person can do when they finally decide that, "We have met the enemy and he is us." When people decide to take their own health outputs under their own control, when they start thinking more seriously about avoidance of alcohol abuse, avoidance of drug abuse, avoidance of food abuse, and by that I mean proper diet, proper exercise, avoidance of predictable violent situations, when the American people finally make up their minds that their health outputs are their own responsibility, to a very large extent, we will find that we will have a radical increase in our positive health outputs at very, very little cost. And it seems to me that one of the things that we ought to be doing—and I've been talking about this for years—is to have not sickness places, but wellness places.

I would like to see a network of wellness clinics in every large place of employment, in every school, in every hospital, for the workers there to teach people how they can take charge of their own health and radically improve their own health, without, as I say, organ transplants, quadruple heart surgery, and MRIs and the like.

We are in charge of our own health and the greatest opportunity for improving the health of the American people is for each one of us to focus on what we can do to enhance and support our own health outputs.

DR. PICKETT. May I?

REPRESENTATIVE SCHEUER. Yes.

DR. PICKETT. I concur with you and I think most of the people, just as you have indicated before, are well informed and will do what they can to improve their own health. I'm very concerned about the fact that there are some 37 million people who are uninsured in this country, who are also the very people who find taking those positive steps well nigh impossible. Many, many social policies which emanate from our legislative bodies and from our executive leadership in these United States result in policies that directly and inadvertently effect the health status of the lowest income population groups. For many people, it is not enough to say that you should eat the right diet and should not smoke and exercise. There are many social policies that generate the very pathology which drives them into the dependency care system.

REPRESENTATIVE SCHEUER. Now, I would like to recognize, for questioning, The Honorable Claire Shulman.

MS. SHULMAN. I just have a couple of questions.

You spoke about regionalization and the fact that Queens people should be able to cross the border into Nassau. One of the reasons that we have discovered that medical care in Queens is poor is because we are locked into the New York City region and because of the cost-containment policies in New York State. The other boroughs had walked away with a lot of the quality part of medical care that we in Queens do not have. In a county of 2 million people--we would be the 5th largest city in the United States--and yet there is only one hospital that does cardiac surgery in the Borough of Queens, and we share it with your borough, your county, and that's LIJ. And if anyone has a heart attack in my borough, they have to wait for a bed in your county, or go over the Queensboro Bridge to Manhattan. That is very poor planing, and I think that if regionalization is something that is being proposed, in terms of primary care, certainly, how would you work it out so that you won't have all these big vacuums in a very large area like mine? I have 2 million people in my borough and very poor medical availability.

DR. PICKETT. I think, Madam President, my friend and colleague Dr. Hamburg might be the one to address the problems of distribution of health services in New York City, but I do think——

Ms. SHULMAN. Well regionalization was really the question, but I would be glad to hear from Dr. Hamburg.

DR. PICKETT. I personally think that the experiments we entertained in this country from 1966 to 1974 with health planning were very valuable, and I think what has happened, both at the national level and, I would say, at the state level, is people expressed their dissatisfaction with some of the structural problems in regional planning by abandoning the concept rather than by repairing the concept and implementing it in a more forceful fashion. It would be my hope that under national legislation that something akin to that regional comprehensive health planning program would be reinstated in the United States; I think we badly need it.

DR. HAMBURG. I might just add, in reference to your question, that I think that your own testimony pointed to the answer in some instances. You describe the situation in which New York Hospital is applying for a certificate of need—included in their identified catchment are those individuals in Western Queens. Well, I think that the question then needs to be asked, are the needs of those individuals in Western Queens being truly and most effectively met by the placement of a hospital across the bridge in Manhattan? Those questions are very difficult to ask and there are many, many complicated and vested interests involved in how many of these decisions get made. But I think the fundamental issue of where the need is and how best to address it has to be laid out very clearly and explicitly on the table.

Ms. SHULMAN. The medical politics puts the politicians' politics to shame.

The other question I wanted to ask both of you with regard to primary care, which is an essential part of the delivery system: What connection

does it have to the quality of primary care? Is it connected to tertiary care availability, the quality of primary care?

DR. PICKETT. The quality certainly is.

DR. HAMBURG. Again, I would like to turn in part to your testimony to get the answer, which is the problem with medical education and the lack of emphasis from the very beginning of medical training on the importance and role of primary care. I think that individuals in training need to learn about tertiary care and, essentially, in that way, quality primary care is linked to good training and understanding of tertiary care and experience in tertiary care.

Ms. SHULMAN. I am talking about the availability of tertiary care. The availability, is it plugged into primary care? Does it have any impact on the quality of primary care?

DR. PICKETT. I think it operates quite independently, unfortunately. I think the whole tertiary-care sector has isolated itself from primary care. In fact, it looks down upon the primary-care system and doesn't recognize it in many instances as being representative of the kind of progress that I would like to see in the major teaching hospitals. Most American medical schools de-emphasize primary-care residency training. And if you go into schools of medicine and look for departments of family practice and general medicine, you will find that they are the least popular with the deans and directors of the medical schools. It has not been treated well in our reimbursement systems historically, so I think primary care is disarticulated from the driving force in medical care in the United States. And I think the recent congressional action to take a look at how those reimbursement systems are set up under Medicare has been an attempt to reflect this and to reshape those forces and put more drive into the primary care system; but it is going to take more than that to restructure.

Ms. SHULMAN. I think it is certainly a topic that we all ought to discuss a little more fully, and what the relationships have been and are, I think, valuable to each other; and where do you draw your top-notch physicians from? We have virtually no medical education program in a county of two million people. When Governor Rockefeller built Stony Brook in Suffolk, he did us a great disservice. That medical school should have been built in Queens.

REPRESENTATIVE SCHEUER. Thank you very, very much for your extended testimony. We're grateful to you.

We will now welcome the second panel—Alice Martin, Katherine Halkin, Clive Chilton and Phil Rosenberg.

Let me say, while this next panel is assembling, that we are very grateful to the North Shore University Hospital Center for Extended Care and Rehabilitation for the splendid way in which they have organized this session and for the excellent set of directions. I admire the clear signs pointing us in the correct direction, so we all could get here without taking a half a dozen wrong turns. We are grateful for their kindness and

hospitality in providing the beverages and refreshments in the back of the room. So, thank you very much North Shore Hospital.

We will now commence the second panel in which we will hear consumer views. We will hear from representatives of the people.

Our first witness will be Alice A. Martin, Chairperson of the Long Island-Nassau Coalition for a national Health Plan. Ms. Martin is an educational therapist who has worked with both youth and senior citizens. She has written a column on the elderly for North Shore Long Island weekly newspapers.

Ms. Martin, your reputation for excellence and outstanding leadership has long preceded you, and we are delighted and honored to have you with us here today to give testimony. So, please, when you are ready and feel comfortable, take such time as you may need to give us your views.

STATEMENT OF ALICE A. MARTIN, CHAIR, LONG ISLAND-NASSAU COALITION FOR A NATIONAL HEALTH PLAN

Ms. MARTIN. Thank you for those kind words, Congressman Scheuer, but thank you even more for this presentation. You mentioned that the people are somewhat ahead of their elected representatives.

REPRESENTATIVE SCHEUER. You are misquoting me. You said that I said they are "somewhat ahead." I said they are "light years ahead."

Ms. MARTIN. We won't quibble about adjectives, but what I do want to talk about is the feeling that so many of us have that you are indeed providing the kind of leadership that is going to make the whole movement achieve its goal, and not in the sweet by and by, but in a reasonable length of time.

Speaking of time, let me get on with what I wanted to say.

REPRESENTATIVE SCHEUER. Very good, thank you.

Ms. MARTIN. It is very tempting to not refrain from responding to some of the things that were said earlier. I would just like to make one point and that is to Dr. Pickett's remark about there not being preventive care provided for in the Russo bill. This is an anomaly for Dr. Pickett, because ordinarily every word that comes out of his mouth is greatly respected by me. However, in this case, I think he is wrong. There is a provision for preventive care, both explicitly and implicitly.

Good morning and thank you for the privilege of presenting the views of my organization. My name is Alice Martin. I represent a grass roots organization of over 40 affiliates and several hundred individual members who educate and advocate for a national universal, comprehensive, single-payer health plan. My colleagues and I speak with and for thousands of Long Islanders every year. I put this in as a part of our bona fide. We also have a strong relationship with a sister organization—the Suffolk Coalition for national Health Plan. The title of this hearing emphasizes a local viewpoint, but it is hard to distinguish between a local and national viewpoint.

REPRESENTATIVE SCHEUER. No, we want local viewpoints on this most national of all problems. So, please, express yourself on any aspect of the national problem and challenge.

Ms. MARTIN. Good. Yesterday's *New York Times* included a piece on the Carnegie Foundation for the Advancement of Teaching in Children, a report in which they noted that children are burdened by poor health—something we do indeed know about.

REPRESENTATIVE SCHEUER. Actually they are burdened with neglect, cynical neglect, which produces that poor health. They aren't burdened by poor health per se, they are burdened by a society that doesn't seem to care about them.

Ms. MARTIN. Your language is far better than that reported in the files. Thank you.

The 1.5 million children under the age of six have no health insurance. One-quarter of pregnant women have no prenatal care, placing their children at risk even before they are born. In the words of a *New York Times* editorial—also of yesterday—it takes no expertise to know that $500 of prenatal health care is in every way superior to paying $500 a day to keep a low-birth weight baby in neonatal intensive care, which is comparable to things I have heard you, Congressman Scheuer, speak of.

The local counterpart to that, even in the affluent North Shore, there are pockets of poverty, but in Nassau County itself there are six designated poverty communities. In those communities, there is a standard of care that I believe few people in this room would recognize as existing in our own country, much less in the county.

This inevitably creates adults and children who not only receive inferior treatment, but who have further reinforced the image of themselves as people unworthy of care given to others and people who suffer and die from diseases that are treatable. It isn't the focus of your investigation, but one must inevitably make the connection between health care and the lack of health care and the social ills that play in our society, from crime to drug use, school dropouts, and the creation of what has been called "an underclass."

I would like to highlight conditions of some of the group most effected by the health-care inequities—women. On Long Island, 13.9 percent of women are without insurance. The implications of treatment and equally important preventive care are enormous. Recently, a physician doing a summer stint in a poor area commented on, and I quote, "Seeing for the first time in her professional life women who were going to die of cervical cancer." That is, women who didn't receive PAP tests regularly, as is routine for middle class women for whom early diagnosis and intervention is a successful and taken-for-granted procedure.

The majority of uninsured women are of child-bearing age, which implies they will either fail to receive any prenatal care or, if they are persistent, will become part of the patient load of our overburdened, understaffed County network that Dr. Pickett alluded to. Always understaffed, the Nassau County Department of Health now has 70

positions vacant, and believe me that's not a large department. From my personal experience as a member of the advisory board of one of the Nassau County health centers, let me tell you a very few facts.

In the poverty areas, twice as many infants are born with low weight than in nonpoverty areas. In the Freeport-Roosevelt Clinic, current patients applying to be seen in the general medicine department have to wait 15 weeks; new patients, 14 weeks. They get a break of a week. Children over a year in age have to wait 20 weeks. For dental treatment, people wait 15 weeks. The first visit, again, gets a break, 14 weeks. Yet, dedicated staff battles to ameliorate truly terrible conditions.

Medicaid, theoretically the safety net of the poor, almost 70 percent of Medicaid funds are applied to those in nursing homes who have, quote, "spent down," to virtual destitution. Again, theoretically, Medicaid offers coverage for many needed services. In actuality, since only 15 percent of physicians in this area will accept Medicaid patients, this is a hollow benefit.

There is, in fact, no dentist in all of Nassau County, except those in the County Department of Health network, who will accept Medicaid. We all know the reason why private physicians shun Medicaid. Reimbursement is woefully inadequate, about $11 a visit. Physicians will not beggar themselves in order to serve the poor, nor should we expect it of them. These are systemwide, not individual, areas of dysfunction.

The last group I would like to highlight is the elderly.

REPRESENTATIVE SCHEUER. Excuse me, let me just highlight that devastating point that you make, that we achieve neither universality nor comprehensiveness when we claim to offer a service where there isn't going to be a health-service professional to fill that slot.

Ms. MARTIN. Exactly.

REPRESENTATIVE SCHEUER. It is egregiously, intellectually dishonest, in my opinion, to say, "We are offering our population dental services," when, in effect, we aren't.

Ms. MARTIN. That's right. It's a mirage.

REPRESENTATIVE SCHEUER. It's a mirage and it's a very cynical, dishonest mirage that we are putting out there. And if any statistic could underscore the need to have a truly universal and truly comprehensive system, it is this cynical anomaly that you have just pointed out.

Ms. MARTIN. Thank you.

The last group I want to highlight is my own—the elderly. Those of us who are on Medicare know that we are paying, as has been alluded to, as much out-of-pocket now as we did before 1966—the year the program became law.

In addition to the burden of premiums, out-of-pocket payments and deductibles, almost 70 percent of those on Medicare pay additional premiums for Medi-gap insurance. Despite the high percentage of income that the elderly spent, many remain with a basic fear, the specter of long-term illness. Nine out of ten New Yorkers have no long-term

coverage should they require it. The long-term care policies being currently hyped in the press and in the media are inadequate and very expensive. The very notion of older people dealing with yet a third patchwork of insurance, with all its elaborate bureaucracy, administrative costs, paperwork and red tape, is downright repugnant.

One last note on the burdens of the elderly and the chronically ill is the exorbitant cost of necessary medications. The United States pays the world's highest prices for drugs; 54 percent more than Europeans for the 25 most commonly prescribed medications. Parkinson patients, for instance, pay $240 monthly for a supply of Eldepryl. The same amount costs $28 in Italy and $48 in Australia. Frequently, life-giving drugs will be diluted, halved or taken intermittently, because to buy the full dosage would mean a sacrifice of food. Prescription drugs are the largest single expense for three-quarters of the elderly. Medicare, of course, doesn't cover this.

With even the AMA acknowledging the crisis, the time is clearly here to talk solutions. Three alternatives are in the public arena: pay or play, a managed care, and single-payer bill. Of these only the Russo bill offers universal, comprehensive care and can be financed by controlling costs, not adding to them. This, of course, is a single-payer bill, and was alluded to earlier by Congressman Scheuer.

I would like to say a word or two about the other two alternatives. Would you rather I defer that, or do you think it is covered within the confines of your topic?

REPRESENTATIVE SCHEUER. Ms. Martin, if you would like to refer to those two other options, by all means do it.

Ms. MARTIN. Okay, good. A brief word on the pay-or-play proposals. They do little to control costs since they retain the role of the 1,500 private insurers, only adding yet another level of administrative bureaucracy. They continue the burden on employers that in the end undermines business and, hence, the general economy, and perpetuates inequities. Those who receive care under the benevolence of the pay part of the program will hardly be treated with the same care as other patients. The comparison with Medicaid is inevitable. And as with managed care—the newest Band-Aid to receive attention—this is a system where economies are made not through restraining red tape, but limiting treatment. It is the corporate advertising of health care; private HMO's are the hottest Wall Street item, proving to be silent moneymakers for Health Care USA, Humana and the dozens of companies competing for the health-care buck.

For the patient it is a different story. Primary-care physicians are pressured to limit care, sometimes by limiting laboratory tests or consultation with harmful effects to patients. Physicians whose paperwork load is increased manyfold are, in fact, rewarded financially by withholding care. Members are limited to treatment from within the system and utilizing specialists from within the roster. The appeal is largely to the young and healthy who can play Russian roulette with their future health-

care needs. In Long Island workers have resisted this option when they could by the largest majority.

Inherent in both solutions is the inability to deal with the heart of the matter. If costs are not contained through the abolition of private-health insurers—global budgeting and agreement on prior charges, they will simply bulge out at another part of the system. If one looks at the health-care problem as a large balloon, not a piece of cement that if you chip away something here, it's going to be chipped away, but instead that balloon, where if you tighten up one end, it bulges out in another place. I didn't put that in my statement.

REPRESENTATIVE SCHEUER. Very well said.

Ms. MARTIN. They will simply bulge out at another point in the system and end up excluding still more Americans from the entitlement they deserve—universal, comprehensive care within a fiscally responsible framework. Representing many who have thought long and hard about the alternatives to the crisis in health care in this Nation, our colleagues heartily support the single-payer bill—HR 1300—and thank you again.

[Applause.]

[The prepared statement of Ms. Martin follows:]

PREPARED STATEMENT OF ALICE A. MARTIN

Congressman Scheuer, ladies and gentlemen:

Good morning, and thank you for the privilege of sharing in this effort to present the local impact of current health care conditions, and to comment on reform proposals. I represent the Nassau Coalition for a National Health Plan, a grassroots organization with well over 40 mainstream organizations and several hundred individuals members. We educate and advocate in Long Island for a single payer health care system. My colleagues in the Coalition and I speak for and to thousands of Long Islanders in the course of a year. We also work closely with the Suffolk Coalition for a NHP.

What is a "Local Viewpoint" of health care?

Clearly it depends on who you're speaking to. In our area one will find some few individuals for whom there is no problem in paying for ever-rising health costs. Even they, however, suffer some of the negatives experienced by the rest of us, namely the built-in financial incentives for over-use of high-tech procedures, thirty percent of which have been described as unnecessary by the President's Leadership Commission on Health Care, and the Rand Corporation. And should even well-insured folks find themselves in an Emergency Room, they may endure a wait of unknown proportions, due to the over-load of uninsured patients using an ER for primary care, creating what's known as Emergency Room gridlock.

In the brief space and time allotted me I would like to highlight conditions of some of groups most affected by the inequities of our present irrational health care system.

Women: On Long Island 13.9% of women are without insurance. The implications for treatment, and perhaps equally importantly, for preventive care, are enormous. Recently a physician doing a summer stint in a poor area commented on "seeing for the first time in her professional life women who were going to die of cervical cancer" - women who had not the Pap test which is routine for middleclass women, for whom early intervention is a successful procedure. It should be noted also that those women (and men) who go to hospitals and cannot pay, contribute to the millions in uncompensated care which becomes part of the generalized rise in hospital costs for those who can pay. Nationally that sum is over $10 Billion annually.

The majority of uninsured women are of child-bearing age, which implies that if pregnant they will either fail to receive pre-natal care, or if they are persistent they will become part of the patient load of our over-burdened, understaffed County network. Always underfunded, Nassau County's Dep't of Health, has at present more than 70 positions vacant.

From my personal experience as a member of the Advisory Board of one of the Nassau County H.C. Centers I know of the delays in treatment, the shortage of equipment and space- the almost third-world conditions which dedicated staff battles to ameliorate. Let me tell you a few facts: in the 6 areas designated as "poverty" communities twice as many infants are born with low weight than in non-poverty areas, data connected with a lack of prenatal care. To quote from a NYTimes editorial of December 10,"It takes no expertise to know that $500 of prenatal health care is in every way superior to paying $500 a day to keep a low-birthweight baby in neonatal intensive care."

In the clinic I mentioned current patients applying to be seen in the general medicine department have to wait 15 weeks, new patients 14 weeks; children over a year wait 20 weeks,; dental treatment 16 weeks, 15 weeks.

MEDICAID: Theoretically the safety net of the poor, almost 70% of Medicaid funds are applied to those in nusrsing homes who have "spent down" to virtual destitution. Again, theoretically, Medicaid offers coverage for many services. In actuality, since only 15% of physicians in this area will treat Medicaid patients, this is a hollow benefit. There is in fact no dentist in Nassau County, outside the County Department of Health network, who will accept Medicaid.

We all know the reason why private physicians shun Medicaid. Reimbursement is woefully inadequate, about $11.00 per visit. Physicians will not beggar themselves in order to serve the poor, nor should we expect it of them.

The last group I would like to highlight is the elderly. Those of us who are on Medicare know that we are paying as much out-of-pocket for health care now as in 1966, the year the program became law. In addition to the burden of premiums, out-of-pocket and other payments, almost 70% of all Medicare recipients pay additional premiums for medigap insurance. This, it should be noted, is the insurance that pays out only 50% of its income in benefits.

Despite the high percentage of income elders spend on health care many of us remain with a basic fear, the spectre of longterm illness. Nine out of ten New Yorkers have no long termcare coverage should they require it, and the added insurance policies now being hyped at seniors are inadequate and very expensive. The very notion of older people dealing with yet a third patchwork of insurance, each with its own elaborate administrative costs,paperwork, and redtape, is downright repugnant.

One other among the burdens on the elderly, and chronically ill, is the exorbitant cost of neccessary medications. The U.S. pays the world's highest prices for prescription drugs, as noted in the NY Times of May 24. Americans pay 54% more than Europeans for 25 commonly prescribed drugs. Parkinson patients, for instance, pay $240 monthly for a supply of Eldepryl; the same amount costs $28

in Italy and $48 in Austria. Frequently, vital prescribed drugs will be diluted, halved, or taken intermittently, because to use the full dosage would mean a sacrifice of food.

I have not touched on the effects on the middleclass, but it should be noted that at a time of every-rising costs, and economic hard times, employers are divesting themselves of previously assumed responsibility for health coverage. Over 50% of employers are now setting up their own insurance structures, which are even less regulated than that of commercial insurers. The Courts have confirmed the right of an employer to cut guaranteed coverage - in this case an AIDS patient was limited to $5,000 instead of $1,000,000 - abrogating a contractual commitment. And what can be done with AIDS can be done with leukemia, cancer, multiple sclerosis and other catastrophic illnesses.

The middle class generally is experiencing greater costs: premiums and deductibles are rising, job lock - staying in a job for fear of losing health benefits, when the individual might well prefer another type of work - is widespread. And as the economy worsens, the threat of losing complete coverage haunts most employees. As every L.I. community sees shops and businesses close down, a first concern is loss of health coverage.

Often part of that sad process is actually linked to health insurance. Employers are paying out as much as 40% of their NET profits for this coverage. Understandably, health care costs are the first cause of small business bankruptcy.

Big business faces the same stress, with the added concern that if they produce a product sold internationally, they are at a disadvantage against their competitors in nations with a NHP, which includes every industrialized country except South Africa. Many have turned to the self-insurance cited above, in a cafeteria offering of managed care, which places a larger burden on workers, makes gatekeepers out of insurance company clerks, and restricts choice of providers. Its goal is to save money through restricting care, rather than addressing the 25% spent on health care administration. In addition to the paper-pushing targeted by Congressman Scheuer, money is spent for advertising, and for profits to shareholders. This is the phenomenon economist Uwe Reinhardt calls the "last hurrah" for our current non-system before we get down to a real solution.

With even the AMA acknowledging the crisis the time is clearly here to talk solutions. Three solutions are in the public arena: pay or play, managed care, and a single payer plan. Of the three only a single payer bill, such as HR 1300, the Russo Bill, is universal, comprehensive, and can be paid for by controlling costs, not adding to them.

A brief word on the pay-or-play proposals espoused by some members of Congress: These do almost nothing to contain costs, since P/P retains the role of the private insurer, only adding yet another

level of administrative costs; it continues the burden on employers that in the end undermines the business community, and perpetuates inequities. since those who receive care under the "benificence"of the government fund will hardly be treated with the same quality of care as private patients. The comparison with Medicaid, and its disastrous history is pertinent.

As for "managed care," the newest band-aid to receive attention: this is a system where economies are made not through restraining red-tape, but limiting treatment. It is the corporatizing of health care. Private HMOs are the hottest Wall St. item, proving to be excellent money-makers for Health Care USA, Humana and the dozens of companies competing for the health care buck. For the patient it is a different story. Primary care physicians are pressured to limit care,sometimes by limiting laboratory tests, or consultation, with harmful effects to patients. Physicians, whose paperwork load is increased manyfold, are in fact rewarded financially by withholding care. Members are limited to treatment from within the system, utilizing specialists from within their roster. The appeal is largely to the young and healthy, who can play Russian Roulette with their future health care needs. In L.I. workers have resisted this option when they could, by the largest majority.

Inherent in both "solutions" is the inability to deal with the heart of the matter: if costs are not contained through the abolition of private health insurers, global budgetting, and agreement on provider charges, they will simply bulge out at another point in the system, and end up excluding still more Americans from the entitlement they deserve: universal, comprehensive care., within a fiscally responsible framework.

Representing many who have thought long and hard about the alternatives to the crisis in health care in this nation, our Coalition heartily supports a single-payer bill, HR 1300.

Thank you.

REPRESENTATIVE SCHEUER. Thank you, Ms. Martin. Thank you for your excellent testimony and for what seems to me to be a life-long dedication toward moving toward a fair, decent and just health-care system for all Americans. I'm grateful to you.

Ms. MARTIN. Thank you, sir.

REPRESENTATIVE SCHEUER. Okay, our next witness will be Katherine Halkin, former executive director, Long Island Advocacy Center. Ms. Halkin has unfortunately experienced firsthand the devastating effect of the gaps in our health-care system. Like millions of Americans, she has discovered that when serious illness strikes, your health insurance often deserts you.

It's a pleasure to welcome you here, Ms. Halkin, and we are deeply grateful to you for the time, energy and commitment that you have displayed coming here to give us your wisdom.

When you are ready and feel comfortable, please proceed and take such time as you need.

STATEMENT OF KATHERINE HALKIN, FORMER EXECUTIVE DIRECTOR, LONG ISLAND ADVOCACY CENTER

Ms. HALKIN. Thank you, Congressman Scheuer.

Because of my spinal cord injury two years ago, I was initially paralyzed from the neck down. I was placed in a respirator and was unable even to speak for nearly six weeks. After two years of intensive physical therapy, I still have only partial use of my left side, and my right side is also moderately impaired. I will always need some help to perform most tasks of daily living. Obviously, the cost of my medical care has been and will continue to be extremely high.

At the onset of my injury, I was hospitalized for two months and spent an additional nine months as a patient in a residential rehabilitation center. I have lived at home for the past 15 months, assisted by a 24-hour-a-day personal-care aide. My medical treatment now includes the semiweekly services of a visiting nurse, six hours of physical and occupational therapy a week, and quarterly visits to my neurologist, family physician and podiatrist. In addition, I must make semiannual visits to my dentist and to the outpatient clinic of North Shore Hospital, where I am seen by other specialists, according to my needs, and where I receive a battery of tests to determine how my internal organs are functioning and the effects of the 12 medications on these organs that I must take on a daily basis.

I also need a number of over-the-counter items each month, including expensive catheterization and blood monitoring supplies. I have to be transported by ambulette whenever I go for therapy or medical care. The level of care that I require goes far beyond the coverage provided by even the most comprehensive health insurance policies. My own insurance paid for most, but not all, of the expenses incurred during the two months when I was being treated in a regular hospital setting, both in North Shore University Hospital and in the community hospital. However, once I

transferred to the inpatient rehabilitation institute, my troubles with the insurance company started.

Initially, representatives of this company had assured my family and the admitting office at the rehabilitation center, that I was covered at this facility—meaning the rehabilitation center—for 100 percent, up to $1 million. Unfortunately, this wasn't put in writing. After I had been there for seven weeks, we were informed that a mistake had been made and that I was not covered at all. This mistake was due to the fact that the rehabilitation institute is connected with the hospital, and the insurance carrier had somehow assumed that I was being admitted to the hospital. My policy stated it did not cover inpatient services in a facility that was solely for the purpose of rehabilitation. However, the bills that were sent to the carrier clearly indicated that nearly two-thirds of the services provided me were health-related. The bed was charged as a medical bed at a cost of $350 a day. I was also taking 13 different prescription drugs daily. The staff that cared for me when I was not receiving therapy consisted of doctors, nurses and other health-care personal. Because I had been discharged from North Shore Hospital while I was still so weak that I couldn't even sit up, I required intensive medical care and testing at the rehabilitation facility. These tests were actually done in the hospital but were billed through the rehabilitation institute. Therefore, the services provided by this facility were not exclusively for the purpose of rehabilitation.

I pleaded with the administrators of the hospital and the institute to assist me in trying to pressure the insurance company into changing their rule, but they weren't interested, even though they admitted that they had lost numerous potential clients because of this issue. I hired a lawyer who discovered that another rehabilitation facility in the state had forced a different insurance company to reverse their ruling, but the administrators still wouldn't get involved. I considered suing the insurance company, but my lawyer wanted $10,000 just for a retainer, and I had no way to pay it. It was imperative that I continue my rehabilitation therapy, as I only just started to benefit from my treatments. I couldn't be sent home to get therapy as an outpatient because I still required too much medical care. Therefore, I had no recourse but to apply for Medicaid. My medical insurance policy continued to cover doctors' fees that were billed to me directly, but I was responsible for co-payments. These approved bills included only the services of the various specialists from the hospital and of the senior physician from the rehabilitation institute who supervised my case.

It should be noted that, as Executive Director of my agency, I had personally selected this insurance policy and had fully believed it would meet my needs and those of my staff. I had previously dropped one policy which provided excellent coverage because it had become too expensive. Other good companies would not accept our group because two staff members were seriously disabled and others of us had pre-existing conditions.

Once I was accepted for Medicaid, all remaining bills were paid, except for $31,000 that I still owe the rehabilitation center. Needless to say, I am intensely grateful that a federal program like Medicaid exists, or I would never have been able to continue my treatment at the residential rehabilitation facility. Instead, I would have been left to vegetate in a nursing home until I died. However, once I left the institute after nine months, I had to find a way to continue to receive rehabililation services, home health care and medical treatment on an outpatient basis, or I still would have had to go to a nursing home. Since no private insurance policy would cover this level of care for an extended period of time, probably for the rest of my life—I had no recourse but to continue receiving Medicaid. I should explain that at this point that I no longer even have the health insurance that I started with. I had continued to receive coverage after I was terminated from my job through COBRA, which extends health insurance at the group rate for 27 months, if one is disabled.

REPRESENTATIVE SCHEUER. Can you spell out COBRA for the record?

Ms. HALKIN. I really don't know what the letters stand for, but basically it's federal legislation that ensures that individuals who leave their place of employment can continue with group coverage.

MR. PODOFF. It stands for Consolidated Omnibus Budget Reconciliation Act—C.O.B.R.A. It is a health insurance provision that Congress included in COBRA.

Ms. HALKIN. At any rate, COBRA would have allowed me to extend my health insurance at a group rate for 27 months since I was disabled. Other people have it extended for only 18 months. That would have taken care of at least some of my needs until I became eligible for Medicare, which starts two years after you begin receiving Social Security Disability Benefits.

However, the original insurance company had raised its rate so significantly after my illness that the Board of Directors of my agency decided to switch to another carrier. At that point, neither the old carrier nor the new one had any legal obligation to provide me with a policy, so I was left with nothing. The only policy I could get was Empire Blue Cross/Blue Shield at an individual rate, with $1,000 deductible and no coverage for pre-existing conditions until after 11 months.

I had to invest in a private insurance policy because almost no local doctors will accept Medicaid payment, and I needed a way to pay qualified specialists if I should require them before my Medicare starts next April. As much as Medicaid has done to make my present level of recovery possible, it is still a mixed blessing. I am allowed to have a monthly income of only $475 a month. The remainder of the big $757 Social Security Disability Check that I get must be used for medical expenses. Before Medicaid authorized my return home, my children had to sign a statement saying that they would pay for all my needs not covered by this $475. To help them out, I would like to be able to work part-time if I regain more of my strength, yet, if I were able to earn even

a part-time salary, I would no longer be eligible for Medicaid benefits. Furthermore, if I should ever be well enough to work, even if I don't choose to, I become ineligible for home care services, despite the fact that I must have such services and they would cost me a minimum of $700 a week if I had to pay for them myself.

What has happened to me can happen to anyone, at any age, at any time. It only takes a minute to become disabled for life because of an accident, a stroke, a difficult operation, or even a problem at birth. Under today's present health-care system, no private insurance policy is designed to cover the multiple expenses of long-term care. It is both ironic and pathetic that the only two groups now receiving such care are the very rich and the very poor, including people like me who had to become instantly poor in order to qualify for aid. This doesn't happen in any other western industrialized country. We already have excellent examples in Germany and Canada of universal coverage, programs that work effectively, using far less money than we are spending here on a health-care system that has become a disgrace for the entire Nation and a personal tragedy for all too many of us.

[Applause.]

[The prepared statement of Ms. Halkin follows:]

PREPARED STATEMENT OF KATHERINE R. HALKIN

Congressman Scheuer and members of the Subcommittee on Education, my name is Katharine Halkin and I am here today to discuss the need for a national health care plan in order to overcome the grave deficiencies in our present system of private health insurance. For over five years, in my capacity as executive director of a not-for-profit agency that protects the rights of handicapped individuals, I presented testimony to legislative bodies on the special needs of disabled people. However, this testimony will be different. I can now speak with first-hand authority since I myself became permanently disabled more than two years ago.

Because of a spinal cord injury, I was initially paralyzed from the neck down. I was placed in a respirator and was unable even to speak for nearly six weeks. After two years of intensive physical therapy, I still have only partial use of my left side and my right side is also moderately impaired. I will always need some degree of help to perform most tasks of daily living. Obviously, the cost of my medical care has been -- and will continue to be -- extremely high.

At the onset of my injury, I was hospitalized for two months and spent an additional nine months as a patient in a residential rehabilitation center. I have lived at home for the

past 15 months, assisted by a 24 hour-a-day personal care aide. My professional treatment now includes the semi-weekly services of a visiting nurse (to deal with my in-dwelling catheter), six hours of physical and occupational therapy a week and quarterly visits to my neurologist, family physician and podiatrist. In addition, I must make semi-annual visits to my dentist and to the out-patient clinic of a local hospital, where I am seen by other specialists (according to my needs) and receive a battery of tests to determine how my internal organs are functioning and the effects on these organs of the twelve medications that I must take on a daily basis. I also need a number of over-the-counter items each month, including expensive catheterization and blood monitoring supplies. I have to be transported by ambulette whenever I go for therapy or medical care.

The level of care that I require goes far beyond the coverage provided by even the most comprehensive health insurance policies. My own insurance paid for most, but not all, of the expenses incurred during the two months when I was being treated in a regular hospital setting. However, once I transferred to the in-patient rehabilitation institute, my troubles with the insurance company started. Initially, representatives of this company had assured my family and the admitting office of the rehabilitation center that I was covered at this facility at 100% for up to $1 million. Unfortunately, this was not put in writing. After I had been there for seven weeks, we were informed that a mistake had been made and that I was not covered at all.

This "mistake" was due to the fact that the rehabilitation institute is connected with a hospital, and the insurance carrier had somehow assumed that I was being admitted to the hospital. My policy stated that it did not cover in-patient services in a facility which was solely for the purpose of rehabilitation. However, the bills sent to the carrier clearly indicated that nearly two-thirds of the services provided to me were health related. The bed was charged as a medical bed, at a cost of $350 a day. I was also taking thirteen different prescription drugs daily. The staff that cared for me when I was not receiving therapy consisted of doctors, nurses and other health care personnel. Because I had been discharged from the hospital while I was still so weak that I couldn't even sit up, I required intensive medical care and testing. These tests were done in the hospital but billed through the rehabilitation institute. Therefore, the services provided by this facility were <u>not</u> exclusively for the purpose of rehabilitation.

I pleaded with the administrators of the hospital and the institute to assist me in trying to pressure the insurance company into changing their ruling, but they weren't interested, even though they admitted that they lost numerous potential clients because of this issue. I hired a lawyer, who discovered that another rehabilitation facility in the state had forced a different insurance company to reverse their ruling, but the administrators still wouldn't get involved. I considered suing the insurance company, but my lawyer wanted $10,000 just for a retainer, and I had no way to pay him.

It was imperative that I continue my rehabilitation therapy, as I had only just started to benefit from my treatments. I couldn't be sent home to get therapy as an out-patient, because I still required too much medical care. Therefore, I had no recourse but to apply for Medicaid. The Medicaid form is hard enough to complete if one is in reasonably good health and living at home. Imagine what it was like for a semi-paralyzed person trying to fill out this form from a hospital bed! Even with my family and staff from the institute helping me, I eventually had to pay a private social worker to review the application and submit it for me.

It took me three months to complete all the work necessary to become eligible for Medicaid. My major assets consisted of two annuities which had to be cashed in and spent down. Under new Medicaid regulations, I could have given this money to my family to help support me, but then the rehabilitation institute would not have been reimbursed. Instead, I had to use the money to pay off outstanding debts (including doctor bills) and to purchase equipment I would need once I returned home. Spending the money in this way was also time consuming.

My medical insurance policy continued to cover doctor's fees billed to me directly, but I was responsible for co-payments. These approved bills included only the services of the specialists that were trying to improve the functions of my various organs, and of the senior physician from the rehabilitation institute who supervised my case. (It should be noted

that, as executive director of my agency, I had personally selected this health insurance policy and had naively believed it would adequately serve my needs and those of my staff.)

Once I was accepted for Medicaid, all remaining bills were paid except for $31,000 which I still owe to the rehabilitation center (and have no way of repaying). Needless to say, I am intensely grateful that a Federal program like Medicaid exists, or I would never have been able to continue my treatment at the residential rehabilitation facility. Instead, I would have been left to vegetate in a nursing home until I died. However, once I left the institute, I had to find a way to continue to receive rehab services, home health care and medical treatment on an outpatient basis, or I still would have had to go to a nursing home. Since no private insurance policy would cover this level of care for an extended period of time, I had no recourse but to continue receiving Medicaid.

I should explain at this point that I no longer even have the health insurance I started with. I had continued to receive coverage after I was terminated from my job, through COBRA, which extends health insurance at the group rate for 27 months if one is disabled. This would have taken care of at least some of my needs until I became eligible for Medicare (two years after I began receiving Social Security Disability benefits). However, the original insurance company raised its rates so significantly after my illness that the Board of Directors of my agency decided to switch to another carrier. At that point, neither the old

carrier nor the new one had any legal obligation to provide me with a policy, so I was left with nothing. The only policy I could get was Empire Blue Cross/Blue Shield at an individual rate, with $1000 deductible and no coverage for pre-existing conditions until after eleven months. I have only now started being reimbursed through this policy for any out-of-pocket expenses. I invested in a private insurance policy because almost no local doctors will accept Medicaid payment, and I had to have a way to pay qualified specialists if I needed them before Medicare starts next April.

In September, New York State drastically reduced Medicaid benefits. Patients are now allowed just 14 doctor or clinic visits a year, including rehabilitative therapy. Chronically ill recipients can receive payment for only 60 prescriptions, refills and over-the-counter items a year. Doctors may appeal these restrictions for specific patients, but waivers are granted only for short periods of time, so that the doctor has to continuously reapply. In my case, I used up my allotted 14 initial visits in less than three weeks of physical therapy, and my basic drug allotment was exhausted in two months. Even as I speak, the State Legislature is considering additional Medicaid cutbacks, in order to balance the current budget.

As much as Medicaid has done to make my present level of recovery possible, it is still a mixed blessing. I am allowed to have a monthly income of only $475. The remainder of my $757 Social Security Disability check must be used for medical expenses. Before Medicaid would authorize my returning home, my

children had to sign a statement saying that they would pay for all my needs not covered by this $475. To help them out, I would like to be able to work part time if I regain more of my strength. Yet, if I were to earn even a part-time salary, I would no longer be eligible for any Medicaid benefits. Furthermore, if I should ever be well enough to work (even if I don't choose to), I become ineligible for home care services, despite the fact that such services would cost me a minimum of $700 a week and I cannot function without this help.

Most people are aware that homeowners who use Medicaid to cover nursing home care must relinquish their houses, but it is not common knowledge that this rule also applies to Medicaid recipients aged 65 and over who get home care services. So, under the present system, I will lose my last asset - my home - in five years. I'm not looking for a free ride, but it is very discouraging to realize that all the sacrifices I have made for years in order to remain self-supporting after retirement have now been to no avail, and that I will be a perpetual financial burden on my children for so long as I live. None of this would be necessary if this country had a national health care program.

What has happened to me can happen to anyone of any age at any time. It only takes a minute to become disabled for life because of an accident, a stroke, a difficult operation, or even a problem at birth. Under today's present health care system, no private insurance policy is designed to cover the multiple ex-

penses of long-term care. It is both ironic and pathetic that the only two groups now receiving such care are the very rich and the very poor (including people like me who had to become instantly poor in order to qualify for aid). This doesn't happen in any other Western industrialized country. We already have excellent examples in Germany and Canada of universal coverage programs that work effectively, using far less money than we are spending here on a health care system which has become a disgrace for the entire nation and a personal tragedy for all too many of us.

So many times in the past, we have seemed very close to enacting legislation to correct this injustice. But, in every instance, powerful pressure groups have intervened. A recent poll indicates that 85% of the population now favors some sort of national health care program. My concern is that Congress, in trying to appease the AMA and the insurance industry, will settle for a plan which serves only these interests, making universal coverage and comprehensive and long-term care so expensive that it is not feasible. With a cost-controlled program, however, it is possible to give quality coverage to all of America's residents. Please do not delay any longer the enactment of a universal and comprehensive National Health Care Program. Far too many people have already suffered unfairly for far too many years.

NYU Medical Center

560 First Avenue, New York, N.Y. 10016
Cable Address: NYUMEDIC

Finance Division
(212) 340-5857 212 340-5690

February 14, 1990

Mrs. Katherine Halkin
16 Bayview Place
Massapequa, New York 11758

Re: Serial: 77909
Rusk Adm: 12/22/89 - still confined

Dear Mrs. Halkin:

We regret to advise that we have been notified that there are no benefits available for your admission to Rusk Institute under your contracts through the United Welfare Fund. Neither the Blue Cross contract nor the Major Medical policy extends benefits for admissions for physical rehabilitation.

Inasmuch as this is the only coverage declared at the time of admission, we must now consider you to be a Self-Pay patient, responsible for all of the charges incurred. Enclosed is a statement which reflects the current status of your account.

Under the terms of the Financial Agreement executed by you, these charges are due and payable immediately, and weekly bills will be rendered.

We look forward to your cooperation.

Very truly yours,

PATIENTS ACCOUNTS

Thomas J. Dunne
Manager

7790901
NT DATE
2/13/90

NEW YORK UNIVERSITY MEDICAL CENTER
RUSK INSTITUTE OF REHAB. MEDICINE
400 EAST 34TH STREET
NEW YORK, N.Y. 10016
(212)340-6133

ADMITTED | DISCHARG
12/22/89 |

BILLING PERIOD
12/22/89-02/12/90

TYPE OF BILL
INTERIM

HALKIN, KATHERINE
#: 9002008608

JENNIFER, RUTH

1-1 3 pages of Bill

DETAIL CHARGES PAGE 1

CODE	DESCRIPTION		COVERAGE	COVERAGE	PATIEN RESPONSIB
MEDSP	MEDICAL SEMI-PRIVATE				
	4138 10 @ 350.00	3500.00			3500.0
12/31	TELEPHONE DIEM CHARGES	60.00			60.0
00640	CHOLESTEROL TOTAL	21.00			21.0
00510	BLOOD GLUCOSE	11.00			11.0
00800	TOT PROTEIN-ALBUMIN	13.00			13.0
00640	CHOLESTEROL TOTAL	21.00			21.0
01150	URINALYSIS ROUTINE	17.00			17.0
50410	URINE CULTURE	52.00			52.0
50420	URINE CULTURE SENSI	62.00			62.0
34020	PHYSICAL THERAPY SESS	72.00			72.0
34020	PHYSICAL THERAPY SESS	72.00			72.0
14600	ELECTROCARDIOGRAM	70.00			70.0
14580	ELECTROC[illegible]H STRI	70.00			70.0
34240	THERMAL MODALITY	44.00			44.0
34020	PHYSICAL THERAPY SESS	72.00			72.0
46110	IND. OT SESSION	72.00			72.0
34040	DOUBLE MODALITY	88.00			88.0
34020	PHYSICAL THERAPY SESS	72.00			72.0
34130	2 AMBULATION SESSIONS	88.00			88.0
46110	IND. OT SESSION	72.00			72.0
31140	EGG CRATE	9.00			9.0
09790	SPECIAL MED SUPPLIES	3.00			3.0
09790	SPECIAL MED SUPPLIES	12.00			12.0
34020	PHYSICAL THERAPY SESS	72.00			72.0
46110	IND. OT SESSION	72.00			72.0
46040	PSYCHOLOGICAL EVAL	400.00			400.0
02090	SMA-ELECTROLYTE GROUP	65.00			65.0
00510	BLOOD GLUCOSE	11.00			11.0
MEDSP	MEDICAL SEMI-PRIVATE				
	4138 31 @ 350.00	10850.00			10850.0
34240	THERMAL MODALITY	50.00			50.0
34030	PT DOUBLE SESSION	156.00			156.0
34020	PHYSICAL THERAPY SESS	78.00			78.0
01150	URINALYSIS ROUTINE	20.00			20.0
50410	URINE CULTURE	59.00			59.0
50420	URINE CULTURE SENSI	62.00			62.0
01/31	TELEPHONE DIEM CHARGES	186.00			186.0
34240	THERMAL MODALITY	50.00			50.0
34020	PHYSICAL THERAPY SESS	78.00			78.0
34130	2 AMBULATION SESSIONS	88.00			88.0

THIS BILL ARE EXCLUSIVELY FOR HOSPITAL SERVICES
CLUDED ARE PHYSICIAN AND CONSULTANT FEES FOR
ECEIVE SEPARATE BILLS

TOTALS

SUBJECT TO REVISION UPON RECEIPT OF ADDITIONAL HOSPITAL CHARGES AND/OR CHANGES IN BENEFITS AS ESTIMATED

90901
DATE
13/90

NEW YORK UNIVERSITY MEDICAL CENTER
RUSK INSTITUTE OF REHAB. MEDICINE
400 EAST 34TH STREET
NEW YORK, N.Y. 10016
(212)340-6133

ADMITTED 12/22/89 | DISCHARGED

BILLING PERIOD 12/22/89-02/12/90

TYPE OF BILL: INTERIM.

HALKIN, KATHERINE
900200BC08

JENNIFER, RUTH

DETAIL CHARGES PAGE 2

REVENUE CODE	DESCRIPTION	CHARGES	COVERAGE	SECONDARY COVERAGE	PATIENT RESPONSIBILITY
46110	INC. OT SESSION	78.00			78.00
46010	PSYCHOTHERAPY-I	72.00			72.00
34110	POOL SESSION	81.00			81.00
34240	THERMAL MODALITY	50.00			50.00
34020	PHYSICAL THERAPY SESS	78.00			78.00
46110	IND. OT SESSION	78.00			78.00
47340	CYSTOGRAM	190.00			190.00
01150	URINALYSIS ROUTINE	20.00			20.00
50410	URINE CULTURE	59.00			59.00
34040	DOUBLE MODALITY	99.00			99.00
34240	THERMAL MODALITY	50.00			50.00
46120	INC. OT DOUBL SESSION	156.00			156.00
34110	POOL SESSION	81.00			81.00
13410	CYSTO [illegible]	500.00			500.00
13400	CYSTO [illegible]	250.00			250.00
02090	SMA-6/BC/TROLYTE GROUP	73.00			73.00
50420	URINE CULTURE-SENSI	62.00			62.00
09640	SPECIAL MED SUPPLIES	29.00			29.00
09640	SPECIAL MED SUPPLIES	29.00			29.00
10260	SURG ELASTIC BINDER	18.00			18.00
34040	DOUBLE MODALITY	99.00			99.00
34020	PHYSICAL THERAPY SESS	78.00			78.00
34140	PROGRESSIVE RESISTANCE EXER	55.00			55.00
46120	INC. OT DOUBL SESSION	156.00			156.00
46010	PSYCHOTHERAPY I	72.00			72.00
10260	SURG ELASTIC BINDER	18.00			18.00
50410	URINE CULTURE	59.00			59.00
01150	URINALYSIS ROUTINE	20.00			20.00
34040	DOUBLE MODALITY	99.00			99.00
34020	PHYSICAL THERAPY SESS	78.00			78.00
34140	PROGRESSIVE RESISTANCE EXER	55.00			55.00
46110	INC. OT SESSION	78.00			78.00
14600	ELECTROCARDIOGRAM	79.00			79.00
55170	RENAL ECHOGRAM	207.00			207.00
59660	KIDNEYS SONO B-SC	400.00			400.00
04060	CHEST XR	131.00			131.00
06970	LUNG SCAN	376.00			376.00
07620	XENON VENT LUNG SCAN	365.00			365.00
31380	WATER BED	68.00			68.00
10970	ANTI-EMBOLIS STOCKING	8.00			8.00
10970	ANTI-EMBOLIS STOCKING	8.00			8.00
	TOTALS ▶				

*BILL ARE EXCLUSIVELY FOR HOSPITAL SERVICES
LISTED ARE PHYSICIAN AND CONSULTANT FEES FOR
ICEIVE SEPARATE BILLS

SUBJECT TO REVISION UPON RECEIPT OF ADDITIONAL HOSPITAL CHARGES AND/OR CHANGES IN BENEFITS AS ESTIMATED

ACCOUNT NO. 7790901
STMT DATE 02/13/90

NEW YORK UNIVERSITY MEDICAL CENTER
RUSK INSTITUTE OF REHAB. MEDICINE
400 EAST 34TH STREET
NEW YORK, N.Y. 10016
(212)340-6133

ADMITTED 12/22/89

PATIENT HALKIN, KATHERINE
REF #: 900200808

BILLING PERIOD 12/22/89-02/12/90

BILL TO
JENNIFER, RUTH

DETAIL CHARGES PAGE 3

DATE	TRANSIT		TOTAL	PRIMARY	SECONDARY
01/08/90	10970	ANTI-EMBOLIS STOCKING	8.00		
01/08/90	37710	INTER CATH DAILY	16.00		
01/09/90	46110	IND. OT SESSION	78.00		
01/09/90	34240	THERMAL MODALITY	50.00		
01/09/90	34030	PT DOUBLE SESSION	156.00		
01/09/90	34140	PROGRESSIVE RESISTANCE EXER	55.00		
01/09/90	37710	INTER CATH DAILY	16.00		
01/10/90	34040	DOUBLE MODALITY	99.00		
01/10/90	34240	THERMAL MODALITY	50.00		
01/10/90	34030	PT DOUBLE SESSION	156.00		
01/10/90	34140	PROGRESSIVE RESISTANCE EXER	55.00		
01/10/90	46120	IND. OT DOUBL SESSION	156.00		
01/10/90	37710	INTER CATH DAILY	16.00		
01/11/90	34110	POOL SESSION	81.00		
01/11/90	46110	IND. OT	78.00		
01/11/90	34040	DOUBLE MODALITY	99.00		
01/11/90	34030	PT DOUBLE SESSION	156.00		
01/11/90	34140	PROGRESSIVE RESISTANCE EXER	55.00		
01/11/90	37710	INTER CATH DAILY	16.00		
01/12/90	34240	THERMAL MODALITY	50.00		
01/12/90	34020	PHYSICAL THERAPY SESS	78.00		
01/12/90	46120	IND. OT DOUBL SESSION	156.00		
01/12/90	46120	IND. OT DOUBL SESSION	156.00		
01/12/90	37710	INTER CATH DAILY	16.00		
01/13/90	37710	INTER CATH DAILY	16.00		
01/14/90	37710	INTER CATH DAILY	16.00		
01/15/90	34020	PHYSICAL THERAPY SESS	78.00		
01/15/90	46130	GRP OT DOUBLE SESSION	110.00		
01/15/90	37710	INTER CATH DAILY	16.00		
01/16/90	34240	THERMAL MODALITY	50.00		
01/16/90	34030	PT DOUBLE SESSION	156.00		
01/16/90	46120	IND. OT DOUBL SESSION	156.00		
01/16/90	34110	POOL SESSION	81.00		
01/16/90	71130	MODULAR WATER BED	62.00		
01/16/90	10970	ANTI-EMBOLIS STOCKING	8.00		
01/16/90	10970	ANTI-EMBOLIS STOCKING	8.00		
01/16/90	31370	RESPIRATORY EXERCISER	8.00		
01/16/90	29600	GLYCOSULATED HEMOGLN	18.00		
01/16/90	01160	THYROXINE T4	23.00		
01/16/90	01980	T-3 RESIN UPTAKE	18.00		
01/16/90	01710	TSH-RIA	106.00		

THE CHARGES ON THIS BILL ARE EXCLUSIVELY FOR HOSPITAL SERVICES RENDERED. NOT INCLUDED ARE PHYSICIAN AND CONSULTANT FEES FOR

TOTALS

UNITED WELFARE FUND

138-50 Queens Boulevard
Briarwood, N.Y. 11435

718-658-4848 516-549-7940
Outside of N.Y. 800-527-5736
Fax 718-526-2879

Oct 10, 1990

HALKIN, KATHARINE
16 BAYVIEW PLACE
MASSAPEQUA, NY 11758
125 36 3215

Dear Member:

Under Internal Revenue Service regulations, the Trustees of the Fund have no obligation to offer COBRA continuation coverage to employees of an employer who ceases to maintain the Plan.

Your employer/former employer Long Island Obstetrics has ceased to maintain the Plan effective 10/1/90. The United Welfare Fund will not offer COBRA continuation coverage beyond this date. If you are currently being covered under COBRA, we cannot accept your monthly payments beyond this date. If you have already sent in your payment, it will be returned to you.

Once Blue Cross receives a record of your termination from our group, they will automatically offer you a conversion to continue your hospitalization with them on a direct payment basis.

Sincerely,

Charlotte Berg
COBRA DEPARTMENT
ext. 275

Harrieta Community Center
999 Harrieta Road, Room 108
New Hyde Park, NY 11040
(516) 248-2222

Linda Wain
Executive Director
Jeffrey Morris
Chairman

400 Town Line Road
Suite 125
Hauppauge, NY 11788
(516) 366-0140

St George's Church
319 Front Street, Rm 208
Hempstead, NY 11550
(516) 564-9006

November 19, 1990

Mr. Al Schubert, Director
HOLBROOK YOUTH DEVELOPMENT CORPORATION
96 Main Street
Holbrook, New York 11741

Dear Al:

This is to confirm our recent telephone conversation regarding the possibility of having our former employee, Katherine Halkin, join our new group health insurance plan with Suffolk County Youth Services Project Director's Association of which you are the President.

I appreciate your efforts in contacting the consultants, Joan and Rose at Karl Washwick, to clarify this matter since we have had several calls from Mrs. Halkin regarding this issue.

From your research, it has been determined that, as a former employee, Mrs. Halkin is not eligible for insurance with our new plan. Moreover, since our agency is under 25 employees, the Long Island Advocacy Center has no obligation to provide COBRA. Since Mrs. Halkin was a member of the Amalgamated Union 355 through United Welfare (from whom Mrs. Halkin continued to secure medical benefits after her termination of employment at the Long Island Advocacy Center), it is up to them to provide COBRA coverage. However, United Welfare's COBRA representative, Charlotte Berg, has informed me that per the original application signed by Mrs.Halkin, that continuing coverage would be terminated by United Welfare when our group plan ends which it did, as of October 1, 1990.

I have advised Mrs. Halkin of these findings which have determined that we have no further obligation to provide her with medical insurance. I have also suggested she get N.Y.State clarification from the Department of Insurance, as she seems to be caught in a Catch 22 situation.

Thank you for your assistance in this matter.

Sincerely,

Linda Wain
Executive Director

cc:Jeffrey Morris
Katherine Halkin

REPRESENTATIVE SCHEUER. We thank you, very much, Ms. Halkin for a genuinely touching and moving story of the truly immoral underpinnings of our national health-care nonsystem.

Next, we will hear from Clive Chilton, associate director of the Health and Welfare Council of Nassau County, a planning and advocacy organization made up of 300 public and private agencies serving the vulnerable in Nassau County. Mr. Chilton is also active in the campaign to achieve universal access to health care and is affiliated with the Nassau Coalition for a National Health Program.

We are delighted that you are here, Mr. Chilton, and when you feel comfortable and you are ready, please take such time as you may need.

MR. CHILTON. Thank you.

STATEMENT OF CLIVE CHILTON, ASSOCIATE DIRECTOR, HEALTH AND WELFARE COUNCIL OF NASSAU COUNTY

MR. CHILTON. Good morning. My name is Clive Chilton. I'm the Associate Director of the Health and Welfare Council of Nassau County, an organization made up of about 300 hundred public and voluntary human service agencies in Nassau County.

As part of my volunteering with Alice Martin's group, the Coalition for a national Health Plan, we have traveled to some 50 organizations in the last year and talked to them about health-care needs and health-care issues. Almost always after the presentation someone comes up and tells a horror story of how they were mistreated by their insurance company, and their stories are legion. But the one that strikes home most severely is the story of a woman who was fired because she had a cancer operation 2-to-3-years ago and her employer wanted to change insurance companies because the "powers that be" decided that if they paid less for health insurance they would have more profits and things would be better for the corporation. They brought in a number of insurance consultants who reviewed their employees' histories and what was going on, and the consultants said that the firm could save a considerable amount of money on their health insurance costs, but the woman who had the operation for breast cancer could not be covered.

About three months later, the company had a mysterious reorganization, her job was abolished, and she was let go. A month after that they changed insurance companies and saved a considerable amount of money.

A woman actually lost her job because she had a cancer operation, even though she was in remission.

It's perfectly legitimate that American business are concerned about the profit motive. The health insurance industry as a business needs to be concerned about profit as well. But somehow a system has to be developed that would divorce health-care coverage from employment. I don't know Mr. Rosenberg, but I've known Mrs. Halkin for years; she is one of the brightest, finest persons in human service, and in spite of her illness, has a tremendous amount to offer any potential employer. I dare

say, if she could overcome her problems with transportation and home care, she still would be unemployable because no employer would hire her if they were forced to put her on an insurance plan. I maintain that health insurance must be divorced from employment and pre-existing conditions.

Second, in Nassau County we have just come through some very, very difficult budget hearings on the county budget. Nassau County has a budget of about $1.8 billion. Of that budget, $590 million goes for the provision of Medicaid. Almost one-third of the county budget goes for Medicaid, and I know they used to say that Congress has a way of saying a billion here, a billion there and pretty soon you are starting to talk about money. But, in Nassau County, a county with a population of 1.5 million people, when you are talking about more than half a billion dollars going for Medicaid, you are really talking about money.

This is not the federal budget, this is the Nassau County budget, and that $590 million is only for Medicaid, and does not count Nassau County Medical Center and the Holly Patterson Home for the Aged; that does not count the expenses for the services that Dr. Pickett's Health Department provides. Nassau County obviously provides well over $600 million in health-care costs out of its annual budget. In Nassau County, half the cost of Medicaid is paid by the Federal Government and one-quarter is paid by the state. So, in actual Nassau County dollars, we are talking about $150 million being paid out of Nassau County's dollars for Medicaid for the year 1992. That amount, if my mathematics is correct, is $100 for every man, woman and child living in Nassau County, which just goes to pay for Medicaid.

Second, the county is also an employer and has to pay health insurance costs for its employees, as do school districts, towns, and villages. All these areas also engender a tremendous cost to the taxpayer for health-care costs. It is interesting that three organizations—Physicians for National Health Plan, the American Federation of State and County and Municipal Employees and the Public Citizen Health Research Group—have published a study issued last week, that talks about a single-payer national health insurance plan being the best cure for the state and local government's fiscal crisis. And this publication—this is the only copy I have, but I will share it with you and your staff—reports that if New York State had the Russo bill in place at this time, they would save $6.6 billion in the New York State budget. And it is a fact that $6.6 billion is the deficit that New York State is talking about in the fiscal year that we are presently in.

The Russo bill has implications not only for individuals, but also for those of us who are taxpayers.

The Council enthusiastically and wholeheartedly supports the principle of a single-payer bill, particularly as it is articulated in HR 1300—the Russo bill—and we appreciate your leadership in this area. We feel that sooner or later the leadership in Congress is going to hear the same message.

54-863 O—92—23

We support it because it is the simplest plan offered. People talk about government bureaucracy, but they haven't talked about insurance company bureaucracy, which drives patients, doctors and hospitals crazy. Another thing that people come up to us when we make presentations is stacks and stacks of paperwork from their insurance company that they have to deal with.

A physician came up to me after a presentation, and his hands were shaking, and he said, "I would support Russo in a minute if you would guarantee that I wouldn't have to fight with insurance companies over getting paid." When you are talking about bureaucracy, remember there is a tremendous bureaucracy out there in the insurance industry that is duplicative, wasteful and a tremendous problem to providers and consumers.

The second reason that we support the Russo bill is that we think it is the fairest. It is the fairest program for patients, physicians and hospitals, where no one group is—to use a colloquialism—"ripping off another group." It has the potential for being very fair to everyone concerned. And one of the things that we are terribly concerned about is that people are preserved the choice of a health-care provider.

I am sorry that Mrs. Shulman isn't still here. But she thought it was very important that people have a choice of insurance companies and a choice of possibilities. When we talk to the average people, they feel it is very important that they not be required to choose their physician from a list handed to them by an insurance company, but that they have some real choice in going with a provider that they know they feel comfortable with and that they feel is going to provide them with good care. It's interesting that I approach this from the patient's point of view, but I have also heard from physicians who are concerned about the same thing. When they get into these managed care programs, they often have to refer a patient to a specialist for surgery or other consultation, and often can't refer the patient to someone that they know because they are given a list of people that the person has to go to.

I want to make it clear that the Russo bill is not bringing the Canadian system to America. Canada has had their system for 25 years. It is not perfect. We are learning from their mistakes and, hopefully, as we implement Russo and HR-1300, we will pick up and learn from their 25 years of experience, and go ahead and make our system work. We can make the system work, and we feel that the Russo bill or a single-payer bill is the kind of bill that is going to meet the needs of the American people, the patients, and also will be fair to the physicians and hospitals and other health-care providers.

[The prepared statement of Mr. Chilton follows:]

PREPARED STATEMENT OF CLIVE R. CHILTON

Good Morning, My name is Clive Chilton. I am the Associate Director of the Health and Welfare Council of Nassau County, Inc. The Council, composed of more than 400 public and voluntary providers, is a private not-for-profit health and human services planning agency that has served the residents of Nassau County New York since 1947. Over the past decade the Council has focused its programmatic efforts on understanding and documenting the problems facing vulnerable families and individuals in Nassau County and on Long Island.

Nassau County, Long Island, New York borders New York city to the East and Suffolk County to the West. Nassau's population of more than 1.3 million persons accounts for nearly half of Long Island's 2.8 million residents.

Nassau has long been identified as one of the most wealthy regions in the nation. Nassau's median income is in excess of $54,000 per year, 80 percent of the 420,000 housing units are owner occupied and the median value of a Nassau home exceeds $200,000. Prior to the present recession both unemployment and poverty rates were substantially lower than the New York State-wide or national averages.

Unfortunately, a review of other data coupled with anecdotal information reveals another picture. A picture which includes some rather drastic health care problems. A 1989 Nassau County Department of Health Study reveals that the infant mortality rate in minority communities exceeds 30 per 1,000 births, a third world rate. The Centers for Disease Control reports that Long Island is the number one suburban community in numbers of persons with AIDS in the nation with 30,000 HIV positive/asymptomatic individuals and 2,500 with full blown AIDS. Information that demonstrates that Long Island is neither insulated nor isolated from national health issues.

Were I to come before you five years ago, I would have emphasized the results of a New York Statewide study, commis-

sioned by the Health and Welfare Council with similar organizations around New York State. The report described the situation of 2.4 million New Yorkers under the age of 65 not covered by private health insurance or Medicaid. It documented that 334,000 Long Islanders were without health benefits including more than 92,000 children and young adults under the age of 18.

While the issue of those with no health insurance remains critical and the numbers have certainly grown since 1987-88, there have been other equally serious issues uncovered since that study. Some of Council's member organizations have sponsored hearings over the past several years to determine the nature and scope of this crisis. Over the last year I have spoken about health care issues to over 50 Nassau and Suffolk organizations. Some of the information that I now share with you is from stories told to me by persons attending those meetings and some from the public hearings held by Council's members.

First, Long Island business, labor and government leaders continually report that they are financially hemorrhaging because of the exorbitant costs of for health insurance. In turn employers pass on the increased costs to employees in the form of co-payments and deductibles. Deductibles, which until recent years would be for $100-$250 per family individual now are in many cases in excess of $1000 per family member. This is not health care insurance - it is catastrophe insurance! The Long Island economy suffered a pre-recession blow as more than 15,000 Long Island NYNEX employees struck for more than 4 months in a bitter strike about employee contribution to the health plan.

The volatile situation surrounding the explosion in health insurance care has created bizarre situations. Persons are fearful of changing jobs, because the new job may not have health insurance or may not cover a preexisting condition.

At a hearing sponsored by the Long Island Progressive Coalition a Bellmore woman, who worked as a bookkeeper for a mid-sized Long Island Corporation for 19 years,came forth with this story. Her employer provided Health Insurance for its employees. During her employment, the woman was treated for Cancer, which went into remission. In an effort to reduce health care costs, the employer decided to change insurance carriers. The new insurance company required a review of employee health records before writing the coverage. They told the company that if the woman were covered the cost would be very high. The company "reorganized" and the woman who had cancer was let go. The company then signed on with the new carrier at a reduced rate. We have laws against discriminating in employment for race, religion, national origin, sex, and even sexual orientation, but we do not have laws against discrimination based on prior health condition.

Second, the present employer based health insurance system is geared toward full time employees. We at Council have heard

stories of firms who would rather employ two part time workers rather than one full time worker to avoid paying health benefits. The fastest, and only, area in which employment is growing on Long Island is in part time employment, which is up 75% in the last year.

The present recession is not merely a financial and employment crisis for the 41,000 Nassau County residents who have become unemployed over the last twelve months it is a health care disaster. Congress tried to ameliorate the situation by passing "COBRA" legislation providing that an employee who separated from his or her employment would be able to continue to purchase health insurance from his previous employer for a period of 18 months. However, very few unemployed persons can afford the premium on what they are receiving on unemployment benefits. An unemployed individual seeking health insurance continuity under COBRA reported being asked to pay as much as $750 per month to continue his family coverage. This forces families into the ranks of the uninsured.

A 31 year old married engineer with two children was layed off from a Long Island defense contractor. He was offered COBRA by his employer, but having just purchased a home, felt unable to afford the premiums. Several months later it was discovered he had cancer. After surgery, the cancer went into remission, but he was left with bills of over $10,000. When he was able to secure another job, they wouldn't cover him for health insurance because of his "pre-existing condition" and should he or another member of his family have a "health problem" they would be wiped out.

A small not-for-profit human service organization in Nassau employed 13 workers and covered them individually for health insurance at a cost of $111.50 per month in 1988. In 1989 one of the employees had a stroke and required three months of hospitalization followed by six months of care in a rehabilitation facility. When the not-for-profit's insurance was renewed for 1990, the premiums were increased to $700.00 per month per employee.

Long Island hospitals report to us the hidden costs of recession: the Emergency Rooms are overflowing with persons in need of routine medical care who use the emergency room for primary medical care because they do not have health insurance. The not-for-profit hospitals on Long Island reported an accumulated operating deficit of $110 Million Dollars, caused in large part by providing health care to uninsured individuals, while New York State reports spending over $400 million dollars from the Bad Debt and Charity pool to cover uninsured health care in the states hospitals.

While residents of Long Island and New York State feel the ever increasing burden of larger governmental deficits and program cuts, these same local governmental bodies feel the pressure as providers of health care through Medicaid, public hospitals

and clinics. They are also impacted as employers trying to pay for health coverage for their employees.

The Medicaid program, which was instituted as a health care for the poor, has become the principle provider of long term care for the middle class elderly. Today, almost 60% of Nassau's 100,000 poor and near-poor under age 65 are not participating in the Medicaid program. Simultaneously, Medicaid is the prime provider of Long Term Care for those of any income. Of Nassau's total Medicaid population of 19,991, 6,231 (or almost 1/3) are in Long Term Care institutions and another 2,234 are elderly with personal care aides. While middle income seniors make financial plans to shelter income and assets and become eligible for Medicaid should they have to enter a nursing home while State Officials and legislators reduce needed care for the poor to cut the costs of Medicaid.

Medicaid expenditures in Nassau County have increased from $295,882,925 in 1987 to a projected 590,593,000 for 1992 or a 99.6% increase in just five years. In 1991 Nassau County spent over half a BILLION dollars on Medicaid.

Finally, not for profit institutions, which play an ever increasingly significant role in the provision of basic services in local communities, are being crushed by excessive health insurance costs.

Discussions with its Agency Executive's Task Force reveals that Council's experience in this field is typical of the 300 plus not for profits in Nassau County.

Health insurance costs for the Council have risen from $137.02 per month for family coverage in 1981 to 497.50 per month in 1991 (a 263% increase) in spite of an increase in co-payments and deductibles. Many small not-for-profits human service agencies can not afford to provide health insurance for employees, or for their family members. Salaries in non-profit organizations tend to be lower so that employees can not afford to purchase on own.

The Health and Welfare Council joins with thousands of other individuals and organizations in demanding a change in the way the "business of health" is undertaken. We offer the following principles as the basis for the necessary restructuring of the system:

First, coverage should be universal. All Americans should be covered in the same program. Medicare, in spite of its known deficiencies, does not make a distinction, wherever you get sick, you get the same benefits. Long Island's public and voluntary providers of senior citizen programs report the vast numbers of senior who retire to southern states, only to return to New York

for health care when they get ill. They tell us that their new states just didn't have adequate health care systems.

Second, coverage should be comprehensive. A national health plan should include preventive care, prescription drugs, and Long Term Care at home and in nursing homes as well as the full range of medically necessary care. If long term care is not included as part of a National Health Care plan it will have to be provided for in some manner.

Third, the plan should provide a free choice of providers. Patients and doctors are not satisfied with having insurance companies choosing their health care providers. Long Islanders are reporting that some of their primary care providers are reluctant to make referrals to specialists that they do not know, and just present their patients with a list supplied by the insurance company.

Fourth, there should be no out of pocket costs such as deductibles and co-payments which tend only to create barriers to care and add to overhead costs when providers try to collect these relatively small payments.

Fifth, the program should operate under a single payer system for efficiency, reduction in paperwork and overhead, and for cost control.

For these reasons Council believes that the Universal Health Care Act of 1991 as introduced by Representative Russo comes closest to addressing the health care crisis as seen from Long Island.

I am sure that you do not underestimate the nature and scope of this problem. In the face of this crisis Americans are expressing their powerlessness. They tell us that they don't think that they'll ever see the day that such an equitable system will be put in place. They tell us that they believe the powerful forces of the health care industry will never permit such justice to occur and that public leaders don't have the courage to do what is necessary. On behalf of the many families and individuals at risk on Long Island I thank you for opening the door to constructive discussions on national health care.

I thank you for giving us the opportunity to raise our voices in hopes of resolving this national disgrace.

THE HEALTH AND WELFARE COUNCIL OF NASSAU COUNTY, INC.
773 Fulton Avenue, Uniondale New York 11553

Telephone (516) 483-1110

Health Issues Face Sheet # 2 August 1991

HWC Insurance Experience October 1981 - October 1991

Year	Single	Family	o/o Increase
1981	45.88	137.02	
1982	71.76	216.45	58%
1983	98.92	298.33	38%
1984	98.92	298.33	-
1985	98.92	298.33	-
1986	174.82	525.25	76%
1987	174.82	525.25	-
1988	249.99	751.27	43%
1989	111.50	277.50	
1990	181.50	402.50	45%
1991	225.00	497.50	24%

Percent Increase October 1981 - October 1991 263%

(With Higher Deductibles and Co-payments)

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Chilton, for your excellent testimony.

We'll conclude this panel with testimony from Mr. Phil Rosenberg, former sales representative of Grant Hardware. Mr. Rosenberg also, unfortunately, has experienced firsthand the devastating effects of the gaps in our health-care system. Like millions of other Americans he, too, has discovered that when serious illness strikes you, your health insurance may very well desert you.

So, Mr. Rosenberg, if you are ready, whenever you feel comfortable, please proceed with your testimony.

STATEMENT OF PHIL ROSENBERG, FORMER SALES REPRESENTATIVE, GRANT HARDWARE

MR. ROSENBERG. Thank you, Congressman Scheuer. I have a little statement to make about what happened to me with the health insurance plan that I had with my company.

In October 1990, the company who employed me for approximately 38 years moved to Hendersonville, Missouri, at which time they terminated my services as a sales representative. They gave me a severance package, which included six months of free medical insurance. In January 1991, they filed for bankruptcy and all arrangements were terminated, including the severance pay, the medical insurance and such. They offered me a COBRA policy which I would have to pay for myself, which I accepted, and they told me it would be good for approximately 18 to 36 months, depending upon the condition I had.

On November 2, 1991, I received a letter from the company's lawyers stating that as of October 31, 1991, they had sold the assets of the company and no longer had a medical plan for any employees because they had no more employees; they are now out of business. Now, this is two days after they went out of business, I received a letter telling me that I had no medical insurance at all. At that time, I started hunting around for a new medical policy. However, I had pre-existing conditions. I had a stroke in January 1991 and a second one in the beginning of October 1991, and trying to get insurance with other companies with pre-existing conditions is practically impossible. You can't find any company that will take you on.

I went back to the original insurance company that had the insurance policy, and they told me that they would take me with the pre-existing conditions; however, the premium for myself alone, not including my family, would be $15,000 per year just for me.

REPRESENTATIVE SCHEUER. My God.

MR. ROSENBERG. I applied for disability insurance, which I received; however, there's a two-year wait before you can get Medicare, which I don't think is the right thing to do really. If someone is on disability, they should be entitled to Medicare at the time that they get the Social Security insurance. I am receiving physical therapy three times a week and the

cost, even with the new policy that I had to take for $15,000 to keep up the therapy, is very expensive.

The bill that you are introducing would help quite a bit toward straightening out a lot of these problems.

Thank you.

[Applause.]

[The prepard statement of Mr. Rosenberg follows:]

PREPARED STATMENT OF PHIL ROSENBERG

Honorable James H. Scheuer
137-08 Northern Boulevard
Flushing, New York 11354

Dear Congressman Scheuer:

In October of 1990, the company who employed me for 38 years, Grant Hardware in West Nyack, New York, moved to Hendersonville, Missouri, at which time they terminated my services as a Sales Representative. They gave me a severance package which included six months of hospitalization insurance (major medical) which they paid for.

In January 1991, they filed for bankruptcy and all arrangements were terminated, including severance pay. At that time, they offered me COBRA insurance, which I took. On November 2, 1991, I received a letter from their lawyers saying that as of October 31, 1991, the assets of the company were sold and the new company would not pick up the COBRA participants and I would have to get my own insurance. The COBRA plan is only effective if the company that you work for remains solvent.

I had a stroke in January of 1991 and another stroke in October of this year. Obtaining insurance with pre-existing conditions is impossible. The only one who would cover me for the pre-existing conditions would be the insurance company that held the original policy. The premium is $15,000 per year. I am receiving physical therapy three times a week, and my medical bills are tremendous, even with this expensive coverage.

I applied for Social Security Disability Insurance, which I now receive, however, it will take two years for me to get Medicare. If I had Medicare, some of these problems would be easier.

Your truly,

Phil Rosenberg

REPRESENTATIVE SCHEUER. Well, thank you very much, Mr. Rosenberg.

Let me just hold up an article from yesterday's issue of the *Washington Post*, which illustrates how many Americans besides Mr. Rosenberg have been betrayed by the loss of their health benefits. Here it is: "When Health Benefits Die, Workers Feel Betrayal When Coverage Evaporates – Despite Law – As Firms Fail." That is from yesterday's *Washington Post*, precisely making the point that Mr. Rosenberg just made so eloquently.

All right, let me ask: Both Mrs. Halkin and Mr. Rosenberg are waiting to be eligible for Medicare. Now, Congressman Sam Gibbons, who is a senior member of the Ways and Means Committee, Florida—brilliant man—has proposed that the way to move into a national health-care program is simply to expand Medicare, and to apply all the principles of Medicare that now starts with age 65. You could go down to age 40, or you could start from birth and go up to 20 and gradually put the entire population under the principles and procedures of the Medicare program.

Let me ask Mr. Rosenberg and Ms. Halkin, would you have had better access and fewer financial problems if you had been eligible for Medicare immediately upon the on outset of your illness?

MS. HALKIN. I don't think Medicare would have done for me what Medicaid has done. There are co-payments involved. Medicare doesn't cover prescription drugs, which is a large part of my bill. It would not continue, I think, to pay for a 24-hour-a-day home health aide. It would not have picked up on my transportation to medical care and rehabilitation. Once I have Medicare along with Medicaid, then I will be able to drop my private health insurance; but I could not consider having only Medicare alone, and that is why people are buying Medi-gap insurance when they move into Medicare.

REPRESENTATIVE SCHEUER. Mr. Rosenberg?

MR. ROSENBERG. Well, when I got sick, I still had my old policy in effect, and they took care of most of the expenses that I incurred during the sickness. However, once the policy ran out, then it became a problem to me as to where to get a new policy. Nobody wanted to take my insurance and cover me for insurance with the pre-existing conditions, except the old company. Now, if I had Medicare at the time, possibly I could have gotten something less expensive on a wrap-around policy. So, it possibly could have helped me. But without the Medicare, I had to go to the more expensive policy to cover my expenses, or part of my expenses.

REPRESENTATIVE SCHEUER. Well, let me ask Ms. Martin and Mr. Chilton, is Medicare a good transitional vehicle to move gradually toward implementing a national health-care program?

MS. MARTIN. Can I comment first?

REPRESENTATIVE SCHEUER. Please.

Ms. MARTIN. I would say unequivocally no. The legislation that you mentioned, which I am somewhat familiar with, I was sent a copy of it, and as Kitty Halkin pointed out, the flaws in Medicare are many. It fails to give the average American what is needed in health care and what the Russo bill would, indeed, give. Plus, it would be a detour in terms of advocacy and political struggle to achieve a bill which would be a very small piece of patchwork, indeed, and be yet another patchwork.

So, I would say no. I would say, let's use our energies in the way that you have described and get HR 1300.

REPRESENTATIVE SCHEUER. Thank you Ms. Martin.

Mr. Chilton?

MR. CHILTON. In all the gripes that we have listened to, senior citizens have been very willing to share the weaknesses and problems with Medicare, but I don't think one of them would vote, if it were possible, to do away with Medicare. The problem with expanding Medicare to cover a larger population is that it would bring with it all the baggage and problems of the weaknesses in Medicare that exist now, such as Mrs. Halkin was talking about. And it seems to me that we have a unique opportunity at this time to really deal with the health-care crisis in this country and pass something that is not going to be a patchwork deal, and that we are going to have to come back within another 15 or 20 years, when the next generation of leadership is there, and try to put something together.

I think there is an opportunity to do it right now, and let's do it right now instead of these half-baked patchwork of solutions that really aren't going to work. Then, when HR 1300 or the Russo bill or something similar to it is implemented, then the energy can be spent on finetuning it in order to make sure that it really meets all of the needs, but not to immediately start talking about the next stage of the game in a half-baked manner.

REPRESENTATIVE SCHEUER. Actually, if I thought that the bill, which we have the knowledge and wisdom to put together next year, would last us pretty well for 15 or 20 years, I would say all right already. Let the Congress in the year 2015 or 2020 earn their salaries. They are underworked and overpaid anyway—everybody knows that. So, let them face those challenges.

The one thing that we know is that no matter what we do next year, no matter if Alice Martin and I were designated by the Congress to write that bill, in 15 or 20 years, there would be a lot of improvements that we would want to make, a lot of adjustments, a lot of tinkering around the edges, at the margins, and there will be plenty of work for the Congress 15 or 20 years from now. So, if we could get us an interim bill that would last us for a decade and a half or two decades, I would be very satisfied at my handiwork and the Congress's handiwork next year.

I take it that you don't feel that the current Medicare program provides the right transitional formula and basis for a national program that we

should tinker with. We should get down to basics and design the kind of bill that the American public needs and wants.

MR. CHILTON. Absolutely.

REPRESENTATIVE SCHEUER. Is there any other transitional mechanism that you would suggest that we could use to ease us into a national health-care program, and particularly into a single-payer system? We could move in, for example, by states or by regions. We could move in by addressing hospitals first and doctors second. There are many ways that we could move into a single-payer system.

Should we experiment by letting some states use financial incentives provided by the Federal Government? We have a significant leader in our own state legislature, Assemblyman Gottfried. Should we be talking to him about letting New York State and, perhaps, California and one or two other states be the bell weather states? How do we move into a single-payer system in an easy and comfortable transition? Alice Martin?

MS. MARTIN. Well, without having a crystal ball at my disposal, I would say that there is a strong possibility that that could, indeed, happen. In any event, what we've decided is that we should push to educate for both kinds of a solution, and that is not contradictory. Because when we educate for the kind of bill that Assemblyman Gottfried has proposed, we are also advocating for the essential core, indeed almost a replica, of what is covered in HR 1300. And every opportunity that we have to raise the consciousness of people about the need for a national health plan is important. The use of the word "national" is really a misnomer. It's a health-care bill that will cover all of the people in a given territory. If, as in some countries, this is done on a regional basis to begin with, there is no weakening of the effort. I would say that even your mentioning of it is supportive of a general thrust for a national health-care program and both bills are to be supported.

REPRESENTATIVE SCHEUER. Mr. Chilton?

MR. CHILTON. I would say, in principle, it sounded like a good idea. In fact, a group that I am part of—the Health Care for All Campaign in New York State—has worked with Assemblyman Gottfried in designing his bill, and certainly the idea that states be allowed to experiment has some merit. However, in practical terms, I would be concerned that any steps taken now be the initial steps toward a truly national health-care system. The way the system works now, in Nassau County, we have a situation where people move away to other states because the taxes are "so high" in Nassau County. They go to Florida, Arizona, places like that, where taxes are lower.

REPRESENTATIVE SCHEUER. Lower taxes and higher temperatures.

MR. CHILTON. Right, but then they get sick and find out that the medical benefits in those areas are not what they were used to in Nassau County, and it is a secret that is not advertised too widely, but there are numbers of people who actually return from those places back to Nassau County to get the medical care that they need, and it increases our costs.

REPRESENTATIVE SCHEUER. I think Dr. Pickett would swell with pride to hear your words. You would warm the cockles of his heart.

MR. CHILTON. The problem is not only the quality of the care, but also the funding of the care. The New York State's Medicaid program is much more friendly to the needs of people, compared with Florida's or certainly Arizona's and some other states. I think we have to be very careful that we are not designing a system that adequately meets the needs of the residents of New York State, and then find out that we become the nursing home haven for the whole United States as people flocked here because we were providing the kind of coverage that was needed and other states were not.

The ultimate solution has to be a national health-care system. If it is implemented in stages, it has to be made clear that those stages are the beginning stages of moving toward a national system, not something like Medicaid where you can have 50 different programs in 50 different states, and people are going to make decisions as to where they live based on what kind of care they get in a given state.

REPRESENTATIVE SCHEUER. Absolutely.

Well, this was a very wise and a very helpful and productive panel, as well as a panel that had the ability to move us. And, Ms. Halkin, and Mr. Rosenberg, you moved us deeply with your stories.

I thank this panel very much for their interest and concern and dedication. We are grateful to you for being here.

We will now take a three-minute break and we will then move on to the next panel.

[Brief recess taken.]

REPRESENTATIVE SCHEUER. All right, we will be commencing our third panel in about 20 seconds. So, please, all of you, take your seats.

Our third panel, with representatives of labor and the business community, gives us two witnesses with broad experience in the area of health benefits. This panel includes Theodore Bernstein, Director of Benefit Funds Department in the International Ladies' Garment Workers' Union; and Robert W. Bradshaw, Vice President for Human Resources and Secretary of the Grumann Corporation.

We are delighted to have you both here to give the prospective of business and labor.

Let me just interject a few thoughts before this panel starts. I had the pleasure of meeting with Mr. Lee Iacocca out in Detroit, Michigan a couple of months ago, and he told me that included in the cost of every Chrysler car that is purchased, there is a $700 per car charge for health services for Chrysler employees and the employees of the parts manufactures, whose parts go into Chrysler. He explained bitterly that that charge on the corporate world in general, and specifically on Chrysler, was a significant competitive disadvantage to Chrysler. Chrysler's competitors in Germany and Japan had about a third of that charge per car to pay for their employees' health benefits because, while they have just as good and perhaps better benefit packages, they are far more efficient and cost

effective in the way they pay for their health services. He is a very strong supporter of health-care reform and would much prefer to see a health-care delivery system paid for not by the corporations and not by a payroll tax and not by anything related to payroll.

He was very strongly in opposition to the pay-or-play program, which basically is corporate based. He made an interesting observation about that $700. He said that the much greater cost per worker, which had to be charged onto the car for health services, both hurt the corporation and labor because, he said, Chrysler has to be competitive in order to stay in business. If they can't somehow or other meet the competition and swallow whatever they have to swallow of their health-care cost per car, they are going to go out of business. So, part of it hurts Chrysler on the bottom line, and part of it hurts labor on the bottom line because, where there is a given price that they have to meet in international competition, that $700 bill has to be absorbed. It may be that Chrysler can afford to absorb part of it, but it may be that Chrysler can't afford to absorb all of it, and in that case, the workers have to take a hit at the negotiating table.

Corporate management can be very frank with the labor union and say: "Look we simply can't stay in existence if we have to take a $700 hit per car. We are going to have to tell you that unless we are going to close down, you are going to have to share it with us." And so the union leaders, the union negotiators swallow hard and pull in their belts a hitch and take part of the hit themselves.

So, this wasteful, extravagant and inefficient health-care system is a terrible burden for corporations. It is also a terrible burden for labor, and I have absolutely no doubt that is why both labor and a broad swath of corporate leadership across this country is in favor of fundamental reform of our health-care system, not to change benefits, not to reduce benefits, but to make the system itself a system and not a Rube Goldberg nonsystem.

So, with those words of welcome, let me say that we are very fortunate to have two such distinguished representatives.

We'll start this panel with the testimony from Theodore Bernstein, Director of Benefit Funds Department of the ILGWU. Mr. Bernstein has served the ILGWU and its benefit programs in various capacities since 1958. That gives you over 30 years of experience with benefits, and I dare say that there are aspects of Medicare and Medicaid and so forth that you don't fully understand after all these years, and, so, how can we be expected to understand them?

Mr. Bernstein also serves as director of the garment industry's major national multiemployer benefit programs.

REPRESENTATIVE SCHEUER. We are delighted to have you, Mr. Bernstein. When you feel comfortable and ready, please take such time as you may need and give us your wisdom.

STATEMENT OF THEODORE BERNSTEIN, DIRECTOR, BENEFIT FUNDS DEPARTMENT, INTERNATIONAL LADIES' GARMENT WORKERS' UNION (ILGWU)

MR. BERNSTEIN. Thank you, Congressman Scheuer.

It is especially pleasing to appear following the citizens group from which we have just heard. They give great credence to your opening statement that the public is light years ahead of the Nation's leaders.

I am testifying on behalf of our 175,000 members, 140,000 retirees and their families, in the interest of creating a rational, affordable and accessible health-care system for all. And the people on whose behalf I am testifying are not just union members, they are consumers, taxpayers and citizens. They are old; they are young; they are healthy; they are aging. They are married; they are single; they are overwhelmingly women. Eighty-five percent women, a high portion of minorities, and many new immigrants.

That the time is long overdue for major reform of our Nation's health-care system is evidenced by the plethora of legislative proposals before the Congress. The Chairman is rightfully taking note of the rising groundswell for action, as expressed in the polls, the letters and phone calls from all sectors of the populous. They say enough. We spend increasingly more than any other society on health care, yet, we lag in the major health indicators, such as life expectancy and infant mortality. We need a national health-care program now.

Tens of million Americans, including 19 million employed workers, and 10 million children have no health insurance. As costs escalate the numbers of uninsured rise each day, millions more are inadequately insured. Even the insureds are adversely affected as the increasing costs of the failing health-care system continually are passed onto them. Many must delay needed care because of the burden of mounting deductibles and copays.

The unabated increases in health-care costs take a further toll as many employers must remain competitive, must close their plants, or shift production to low-wage, low-benefit sources, frequently overseas. This is especially true in the labor-intensive industries of our Nation, such as the apparel industry. Ours is a highly competitive industry, composed of small businesses paying modest wages. Its low-wage base produces an oppressive health-cost burden, ranging from 12 to 15 percent of payroll. Elsewhere throughout the developed world to provide coverage, the cost of health care for all workers is in some part, if not all, financed by public funds rather than as a direct addition to wages.

Of our 15 multiemployer health benefit trust funds, 13 suffered cash deficits in 1990. Despite a declining base of covered workers, the

unabated increases in cost for the remaining participants continue to erode the financial condition of the funds. To maintain these funds in addition to negotiating still higher employer contributions, we have been compelled to shift more costs to our workers in the form of higher deductibles, increased out-of-pocket expenses, higher co-payments for family coverage, and stiffer eligibility requirements.

REPRESENTATIVE SCHEUER. In fact, isn't that a diminution of the wage structure?

MR. BERNSTEIN. Absolutely. We are being forced to pay-or-play.

In many cases, workers cannot afford to continue their family coverage, thus adding more to the roles of the uninsured. Without major changes in the existing system, the future survival of our existing benefit structure is problematical. The employment-based system of providing health care is no longer a viable approach to meeting today's needs. It contaminates labor management relations; it creates job-lock; it heightens inequities; it is used as a source on to which costs are shifted.

REPRESENTATIVE SCHEUER. I think you have to elaborate on what you mean by "job-lock."

MR. BERNSTEIN. Many workers cannot change jobs or relocate because they would lose their insurance and be forced into a new system that might have pre-existing condition requirements, higher co-pays and deductibles, not as extensive coverage. The COBRA continuation law also creates a problem because, even though people are eligible to continue at group rates, the group rates continually escalate, and many people are forced into COBRA at a time when they are unemployed.

We firmly believe, along with you, that legislation such as HR 1300 is the most promising prescription for our ailing health-care system. It is the single piece of legislation which embodies the key principles for effective health-care reform: Universal access, progressive financing, cost containment and quality care.

REPRESENTATIVE SCHEUER. And comprehensive care.

MR. BERNSTEIN. Yes.

REPRESENTATIVE SCHEUER. Comprehensive quality care.

MR. BERNSTEIN. This bill provides for a single-payer, single-system approach. Under such a route—as you cited—a recent GAO study projected that the savings in administrative costs alone would pay to cover all the uninsured, and for the rest of the population, eliminate all or part of the deductibles and co-payments.

Under such a route, no one will be involved in financing a plan from which only others receive benefits—one of the reasons for the failure of the catastrophic insurance. Under such a route, significant cost control and budget targets can be implemented, instead of continuing to meet ever increasing costs by limiting benefits or shifting costs.

It is our opinion that a pay-or-play situation is a false nostrum, an inefficient patchwork approach which would inexorably lead to the perpetuation of existing inequities and costly duplication of efforts. Pay-

or-play essentially continues the burdens that we are faced with under our current system of health care. The health-care system of our Nation is not a game to be played.

In the health-care arena, the marketplace cannot be more efficient than public planning and programs. Left uncontrolled, the private sector will inevitably concentrate on profitable paying patients and on money-making services, abandoning the less lucrative services, such as obstetrics and preventive care. They will bypass the less endowed and riskier patients, such as the unemployed and sick.

REPRESENTATIVE SCHEUER. And the elderly.

MR. BERNSTEIN. And the elderly.

One can expect wholesale dumping onto the public system of unprofitable services and those unable to pay. The cherry picking of good risks by private carriers will continue and the two-tier system will evolve with the public system saddled with the skyrocketing costs and inadequate financing for the riskier population.

A public-private split would engender a costly administrative nightmare, i.e., determining who and at what level there is coverage. You have to determine who is the sponsor, when and at what level? Are you employed with public or private coverage? Are you unemployed? Are you a part-timer with or without coverage? Are you an employee of a small business? Are you a low-wage worker? High paid resident? A resident? Nonresident? Working spouse? Dependent child? Medicaid eligible individual?

How does this system keep track of people shifting from one category to another, of employees changing employers, of persons and employers shifting between public and private plans or between carriers? How will the system ensure continuity of care and treatment and avoid expensive fragmentation and duplication?

We can no longer afford to continue to patch our deteriorating system piecemeal with Band-Aids and aspirin. We can no longer afford not to be bold. Our national health-care system must be transplanted with a national program—HR 1300 style—that benefits all Americans. Incremental changes—and we've been incrementalized to death—slogans about competition, the free market, managed care, along with voluntary efforts of the health-care industry by themselves will not halt the cost spiral nor provide affordable access to quality care. We urge the Congress to meet the challenge and act decisively to improve health and prevent disease.

A single-payer, single-plan approach is comprehensive and simple to administer efficiently. It is truly universal and equitable. There are no cracks to fall through, and no need for safety nets, no need for mountains of complex paperwork. And all, regardless of status, are treated equally with dignity. Most important, all Americans will be free to chose their own health-care providers and facilities. We urge your continued good work in this area.

[Applause.]

[The prepared statement of Mr. Bernstein follows:]

PREPARED STATEMENT OF THEORDORE BERNSTEIN

Mr. Chairman, Committee Members, I am testifying on behalf of our 175,000 members and 140,000 retirees and their families in the interest of creating a rational, affordable, accessible health care system for all.

That the time is ripe for long overdue major reform of our nation's health care system is evidenced by the plethora of legislative proposals before the Congress. The Chairman and the Congress are rightfully taking note of the rising groundswell for action as expressed in the polls, the letters and phone calls from all sectors of the populace. They say - Enough!, we spend increasingly more than any other society on health care, yet we lag in major health indicators, such as life expectancy and infant mortality. We need a national health care program now.

Tens of millions of Americans, including 19 million employed workers and 10 million children have no health insurance. As costs escalate, the numbers of uninsured rise each day. Millions more are inadequately insured. Even the insured are adversely affected, as the increasing costs of the failing system are passed on to them. Many must delay needed care, because of the burden of mounting deductibles and copays.

The unabated increases in health costs take a further toll as many employers must close their plants or shift production to low wage, low benefit sources, often overseas, to remain competitive. This is especially true in labor intensive industries such as the apparel industry. Ours is a highly competitive industry composed of small businesses paying modest wages. Its low wage base produces an oppressive health cost burden ranging from 12 to 15% of payroll for our unionized employers who are obligated to provide coverage. Elsewhere, throughout the developed world, the cost of health care for all workers is at least in some part financed by public funds rather than as a direct addition to wages.

Of our 15 multiemployer health benefit trust funds, 13 suffered cash deficits in 1990. Despite a declining base of covered workers, the unabated increased costs for the remaining

participants continue to erode the financial condition of the funds. To maintain these funds, in addition to negotiating still higher employer contributions, we have been compelled to shift more costs to our workers in the form of higher deductibles, increased out of pocket expenses, higher copayments for family coverage and stiffer eligibility requirements. In many cases, workers cannot afford to continue their family coverage, adding them to the rolls of uninsured. Without major change in the existing system, the future survival of our existing benefit structure is problematical. The employment based system of providing health care is no longer a viable approach to meeting today's needs. It contaminates labor-management relations, it creates job-lock, it heightens inequities and is used as a source to which costs are shifted.

We firmly believe that legislation such as HR 1300 is the most promising prescription for our ailing health care system. It is the one piece of legislation which embodies the key principles for effective health care reform - universal access, progressive financing, cost containment and quality care. This bill provides for a single payer, single system approach. Under such a route, a recent GAO study projected that the savings in administrative costs alone would pay for covering the uninsured and eliminate all or part of deductibles and copayments. Under such a route, no one will be involved in the financing of a plan from which only others are receiving benefits. Under such a route, significant cost control and budget targets can be implemented, instead of continuing to meet ever increasing costs by limiting benefits or shifting costs.

It is our opinion that a "play or pay" solution is a false nostrum - an inefficient patchwork approach which would inexorably lead to the perpetuation of existing inequities and costly duplication of efforts. "Pay or play" essentially continues the burdens we are faced with under our current scheme of health care. The health care system of our nation is not a game to be played.

In the health care arena, the marketplace cannot be more efficient than public planning and programs. Left uncontrolled, the private sector will inevitably concentrate on profitable paying patients and moneymaking services, abandoning the less lucrative services, such as obstetrics and preventive care, and bypass the less endowed or riskier patients, such as the unemployed and the sick. One can expect wholesale dumping on to the public system of unprofitable services and those unable to pay. The cherry picking of good risks by private carriers will continue and a two tier system will evolve with the public system saddled with sky rocketing costs and inadequate financing.

A public/private split would engender a costly administrative nightmare i.e. determining who is the sponsor, when and at what levels. Under many of the proposals, at least three separate programs would exist - public, private and Medicare - with a multitude of coverage categories. How will the system keep track

of people shifting from one category to another, of employees changing employers, of persons and employers shifting between public and private plans or between carriers? How will the system ensure continuity of care and treatment and avoid expensive fragmentation and duplication?

We can no longer afford to continue to patch our deteriorating system piecemeal with bandaids and aspirin. We can no longer afford not to be bold. Our failing health care system must be transplanted with a national program, H.R. 1300 style, that benefits all Americans. Incremental changes, slogans about "competition", "the free market" and "managed care" along with "voluntary efforts"of the health care industry by themselves will not halt the cost spiral nor provide affordable access to quality care. We urge the Congress to meet the challenge and act decisively to improve health and prevent disease.

A single payer, single plan approach is comprehensive and simple to administer efficiently. It is truly universal and equitable. There are no cracks to fall through, no need for safety nets, no need for mountains of complex paperwork and all, regardless of status, are treated equally with dignity. Most important, all Americans will be free to choose their own health care providers and facilities.

REPRESENTATIVE SCHEUER. I thank you very, very much for your excellent testimony.

We will conclude this panel by hearing from Robert W. Bradshaw, Vice President, Human Resources and Secretary of the Grumman Corporation. Mr. Bradshaw has been the Corporation Secretary since his election in 1974, and Director of Personnel at Grumman since 1974.

Mr. Bradshaw, it is particularly appropriate that we are hearing from you this morning, and considering the plight of labor in Nassau County, particularly your industry. The industry, through no fault of its own, is faced with a very real threat of being ratcheted down, as we, not so gradually, ratchet down our defense budget. The Soviet Union has disappeared, and we learned just in the last 24 hours that there is an informal confederation of Soviet republics taking its place. We hope that there will be a concentration of control over the nuclear weapons that are spread around the Soviet Union, in one of those states, presumably Russia or the Ukraine, but the threat of world war seems to have disappeared with the morning mist.

We are going to be faced with regional problems, such as we had with Saddam Hussein. There are a predictable group of nuts in the world other than Saddam Hussein. You name the area of the developing world, and I'll show you some dangerous mad men who are still chiefs of state. Thankfully, democracy is rearing its wonderful, beautiful head, and some of the old-time despots are being moved out of power. That just happened in the last week in Kenya, but nevertheless, the defense industries of which we have quite an establishment on Long Island are going to be under pressure to reduce costs and become competitive in nondefense sectors of the economy. They certainly will be under pressure to diversify, and to the extent that we can free them up from the onerous burden of excessive expenditures for their employees' health care, we will be removing a competitive disadvantage to your industry as you take a significant new role in global competition for whatever products you produce. Lee Iacocca is literally begging us to remove this competitive albatross around his neck and around the neck of the automobile industry, as they seek to compete in global competition.

So, it's extraordinarily appropriate that we have a representative from Grumman here, and I appreciate your coming. I'm grateful to you for your investment of time and effort, because it is so appropriate that you be here. And I ask you, when you are ready and comfortable, to take such time as you need to give us your wisdom.

STATEMENT OF ROBERT W. BRADSHAW, VICE PRESIDENT, HUMAN RESOURCES, AND SECRETARY OF GRUMMAN CORPORATION

MR. BRADSHAW. Thank you very much, Congressman Scheuer, and I do very much appreciate the opportunity to be here. I am going to give you a different view from some that you have heard, but one that we care very deeply about, and I know my fellow panelists will do the same. On one point, at least, we all agree, 37 million Americans without health insurance, with a population whose health is significantly poorer, and with costs spiraling out of control, something is terribly wrong, and we all know that.

As to solutions, I regret that I don't have any particular expertise with regards to those who are uninsured. I am very much impressed by the people we have heard here this morning, but as far as Grumman is concerned, I would be pleased to tell you our story.

We have been very fortunate in being able, through all the years of our existence, to provide a program of health insurance for our employees and their families, and we continue to be able to do that. But I must say, it gets increasingly difficult and obviously much more expensive. We pride ourselves as being a company that has a tradition about caring for each other, and there is no more meaningful way to be able to demonstrate that care than to be able to provide for our people when they need help. Five years ago, it cost us about $61 million a year to provide that kind of health insurance coverage. This year, it is going to cost more than $125 million.

REPRESENTATIVE SCHEUER. More than double.

MR. BRADSHAW. Indeed, and with no end in sight.

And this is in spite of the fact that we, like most other major employers, have done a lot of things to try and control that cost. One can only speculate what it might be had we not.

Clearly, the steps taken so far have helped, but not much. Clearly, just shifting the costs from the employer to the employee is not the way to solve this problem. And, clearly, the costs have to come down.

We believe that something has to be done to effect the cost drivers, and that goes inevitably to the way medicine is practiced in this country today. We do believe, therefore, that the managed care system ought to be given an opportunity to work. I can only tell you that if it doesn't, then what you are talking about, in terms of a comprehensive bill in Washington, is the only choice we will have. I regard it as the last, best and only hope for the existing system. If it cannot respond in a reasonably timely manner to these issues, we will indeed move in the direction that you are taking us with your leadership. I would regret that.

REPRESENTATIVE SCHEUER. Tell us why?

MR. BRADSHAW. Because I think we will have lost something. I think the system that is in place right now has done many good things and will continue to.

REPRESENTATIVE SCHEUER. Mr. Bradshaw, let me clear up any misunderstanding. We are not taking issue with the current means of delivering health care; we are taking issue with the current means of paying for health care. There are 500,000 people in this country who are involved in pushing paper. They ought to be involved in treating patients, and we intend to make extra special efforts to make sure that they have the chance to upgrade their skills and to apply their very considerable talents to treating patients rather than pushing papers around.

We are not talking about any basic change in the method of delivering health care. Although there will be global budgeting, that will be a move to address the problems of hospital costs that are soaring beyond control compared to other hospitals doing the same thing and treating the same patient group. But we are not really addressing any basic changes in the system of delivering health care; we are addressing the need for change in paying for health care and managing health care.

MR. BRADSHAW. Thank you. I understand that, and I guess my thesis is that unless we talk about changing the way health care is delivered, we are not going to solve the problem.

REPRESENTATIVE SCHEUER. That may be true in some respects, but basically that's not the focus of HR 1300, and is not my focus.

MR. BRADSHAW. I understand that, which is why I do not support the bill at this time; an honest difference of opinion, perhaps.

REPRESENTATIVE SCHEUER. Yes.

MR. BRADSHAW. Ten years ago, we wouldn't have dreamt of interfering in the relationship between a patient and physician. It was sacred; and look what that's gotten us. Today, we are very deeply involved and intend to remain so. We are involved because we don't see any other way of trying to refocus the delivery system. We are offering our employees today, as we speak, a network of quality health-care providers, who practice no more medicine than we need, and who do it for reduced fees, and who have an economic incentive to keep us well. I wish I could promise you that I think that's going to work. I do think it is going to work, but I can't promise. I do think, however, that it is worth a shot—our last best shot, as I have indicated.

There are some things that I think government can do to help, and we have heard a little of that this morning. I think we ought to do something about malpractice limits. I mean there's——

REPRESENTATIVE SCHEUER. No question about it.

MR. BRADSHAW. ——a problem that has been there for so long, and also to expose conflicts of interest within the system--physicians having economic interests in laboratories and hospitals and other providers of services. But I wish I had another way to tell you this, I don't think we are going to solve this problem without impacting the way health care is provided in this country. I agree with you that the inefficiencies in the administrative systems which support that clearly need to be improved, and it is hard to say just how much benefit that will produce. Some, I

hear, who are here today, would argue the savings would pay for the shortcomings in the system; I hope that's so. I doubt it, but certainly there are efficiencies to be gained there, but unless we get at the way medicine is practiced in this country, we are going to continue to have a problem. I recognize that that is a different view than what you have heard earlier. I do respect those. I do appreciate the opportunity of expressing this one here today, so I thank you.

[The prepared statement of Mr. Bradshaw follows:]

PREPARED STATEMENT OF ROBERT W. BRADSHAW

GOOD MORNING, MY NAME IS ROBERT W. BRADSHAW AND I AM VICE PRESIDENT FOR HUMAN RESOURCES AND SECRETARY OF THE GRUMMAN CORPORATION. I AM PLEASED TO HAVE THIS OPPORTUNITY TO APPEAR BEFORE YOU AND THE SUB-COMMITTEE ON EDUCATION AND HEALTH OF THE JOINT ECONOMIC COMMITTEE TO DESCRIBE THE EVOLUTION OF THE GRUMMAN HEALTH CARE PROGRAM OVER THE PAST SEVERAL YEARS.

GRUMMAN HAS HISTORICALLY PROVIDED MEDICAL INSURANCE TO ALL EMPLOYEES, AT NO COST TO THEM, FOR OVER 50 YEARS.

IN THE EARLY DAYS, THE NATION WAS EXPERIENCING HEALTH CARE COSTS OF 5 PERCENT OR LESS OF GNP AND GRUMMAN WAS ABLE TO PROVIDE THIS COVERAGE AS A PORTION OF OUR OVERALL EMPLOYEE BENEFIT PACKAGE.

TODAY NATIONAL HEALTH CARE COSTS HAVE SPIRALED TO 13 PERCENT OF GNP AND GRUMMAN NOT SURPRISINGLY HAS SEEN HEALTH CARE COSTS DOUBLE FROM $45 MILLION PER YEAR TO $108 MILLION PER YEAR DURING THE PAST FIVE YEARS ALONE. THIS YEAR 1991 IT IS ESTIMATED THAT GRUMMAN'S TOTAL MEDICAL COSTS WILL EXCEED $120 MILLION.

SEVERAL FACTORS ARE RESPONSIBLE FOR THE RISE IN HEALTH CARE COSTS. CERTAINLY INFLATION HAS PRODUCED AN INCREASE IN THE PRICE OF MEDICAL SERVICES. BUT INFLATION ALONE CANNOT EXPLAIN THE RECENT EXPLOSIVE TREND. COST SHIFTING FROM GOVERNMENT SPONSORED PROGRAMS SUCH AS MEDICARE TO GROUP AND PRIVATE MEDICAL INSURANCE POLICIES HAS CAUSED A PART OF THE INCREASE.

THE EMERGENCE OF NEW TECHNOLOGIES SUCH AS MAGNETIC RESONANCE IMAGING AND CAT SCANS, THE DEVELOPMENT OF NEW PROCEDURES SUCH AS HEART BY-PASSES AND TRANSPLANTS, THE RECOGNITION AND TREATMENT OF AIDS, DRUG PREVENTION PROGRAMS AND THE CARE GIVEN FOR PREMATURE BIRTHS ALL CONTRIBUTE TO THE INCREASE.

CAPPING THE LIST OF CONTRIBUTING FACTORS WE HAVE THE EXORBITANT COST OF MEDICAL MALPRACTICE INSURANCE AND THE PRACTICE OF DEFENSIVE MEDICINE.

AND TOGETHER WITH ALL OF THESE FACTORS, WE HAVE EXPERIENCED AN OVERALL INCREASE IN SERVICES RENDERED.

GRUMMAN LIKE MANY OTHER CORPORATIONS HAS MOVED RECENTLY TO CONTAIN THESE COSTS WHILE STILL PROVIDING WELL ROUNDED PROGRAM OPTIONS FOR OUR EMPLOYEES.

WE HAVE TAKEN THESE INITIATIVES IN A STEP-WISE MANNER. FIRST WE MODIFIED OUR EXISTING HEALTH CARE PLAN BY INTRODUCING SEVERAL COST CONTAINMENT MEASURES.

WE INTRODUCED THE REQUIREMENT OF A SECOND MEDICAL OPINION BEFORE APPROVING CERTAIN TYPES OF SURGERY. WE STRENGTHENED PRE-ADMISSION TESTING REQUIREMENTS AND PROVIDED INCENTIVES FOR OUTPATIENT TREATMENT. WE ENCOURAGED HOME HEALTH CARE AND INTRODUCED THE CONCEPT OF HMOS TO OUR INSURANCE PACKAGE.

WHILE THESE STEPS WERE INDEED PRODUCTIVE, WE NEVERTHELESS WERE REQUIRED TO MOVE FROM AN ENTIRELY COMPANY FUNDED PLAN TO ONE WHERE OUR EMPLOYEES SHARE TO A LIMITED DEGREE IN SUPPORTING PROGRAM COSTS.

TODAY AFTER MUCH STUDY AND PLANNING WE ARE MOVING TO INTRODUCE YET ANOTHER FEATURE IN 1992, A MANAGED HEALTH CARE PROGRAM. THIS PROGRAM WILL ALLOW GRUMMAN EMPLOYEES TO CHOOSE FROM THREE NEW PLANS, WHILE RETAINING THE EMPLOYEES OPTION TO JOIN A HEALTH MAINTENANCE ORGANIZATION (HMO).

THE FIRST OPTION IS A MANAGED INDEMNITY PLAN. IT PROVIDES BENEFITS FOR ANY ILLNESS OR INJURY FROM ANY PHYSICIAN OR HOSPITAL - THE TRADITIONAL FEE FOR SERVICE SYSTEM.

THE SECOND OPTION IS, THE POINT OF SERVICE PLAN WHICH ALLOWS THE USE OF PHYSICIANS OR HOSPITALS BOTH INSIDE AND OUTSIDE AN ESTABLISHED NETWORK. SAVINGS ARE OBTAINED BY NEGOTIATING REDUCED FEES FROM PHYSICIANS AND PROVIDERS OF ANCILLARY MEDICAL SERVICES AS PART OF A NETWORK. EMPLOYEES CAN OBTAIN SERVICES OUTSIDE OF THE NETWORK BUT AT A HIGHER COST TO THEMSELVES.

AND, FINALLY, A NETWORK PROVIDER PROGRAM WHICH USES ONLY NETWORK PHYSICIANS AND HOSPITALS. SERVICES OBTAINED OUTSIDE OF THE NETWORK ARE NOT REIMBURSED.

PROVISION EXISTS IN EACH OF THESE PLANS FOR MEDICAL CARE REVIEW BY A PATIENT ADVOCATE OR A PRIMARY CARE PHYSICIAN TO INSURE THAT OUR EMPLOYEES AND THEIR FAMILIES ARE RECEIVING APPROPRIATE MEDICAL CARE.

WE HOPE THAT THESE COST CONTAINMENT EFFORTS WILL REDUCE THE TOTAL GRUMMAN COST AND AT THE SAME TIME WILL PROVIDE OUR EMPLOYEES AND THEIR FAMILIES WITH A HEALTH CARE PROGRAM THAT SERVES THEIR NEEDS.

WHILE WE HAVE BEEN STRUGGLING WITH THE HEALTH CARE PROBLEM AT THE CORPORATE LEVEL, MANY PROPOSALS HAVE BEEN AND CONTINUE TO BE UNDER CONSIDERATION BY THE CONGRESS.

AFTER HAVING STUDIED THE SITUATION WE HAVE COME TO THE CONCLUSION THAT THERE IS NO ONE ANSWER TO THE HEALTH CARE CRISIS. RATHER IT LIES IN THE DOZENS OF ACTIONS THAT GOVERNMENT, CONSUMERS, INSURANCE AND HEALTH CARE PROVIDERS CAN TAKE TO GET AT THE ROOT CAUSES OF THE HEALTH CARE SPIRAL. INCREMENTALLY, THESE CHANGES COULD HAVE A SIGNIFICANT IMPACT ON COST, WHILE AT THE SAME TIME, PRESERVING OUR PLURALISTIC, MARKET BASED, HEALTH CARE SYSTEM.

CONSIDERATION OF THE FOLLOWING MIGHT PROVE HELPFUL:

- o MEDICAL LIABILITY
  - CAP AWARDS FOR PAIN AND SUFFERING
  - HIGH RISK SURGERY SHOULD BE LIMITED TO HOSPITALS AND DOCTORS THAT PERFORM SUCH PROCEDURES REGULARLY.

- o REGULATORY REFORM
  - STRESS REGULATIONS THAT HAVE SIGNIFICANT IMPACT ON THE QUALITY OF PATIENT CARE; REMOVE THOSE THAT DON'T;
  - CUT DOWN ON PAPERWORK AND ADMINISTRATIVE COSTS.

- o MANDATE REFORM
  - DO AWAY WITH MANDATES THAT DO NOT AFFECT PRIMARY COVERAGE AND PERMIT NEGOTIATIONS OF RATES WHERE THEY ARE ECONOMICALLY JUSTIFIABLE.

- LONG TERM CARE
  - FOCUS MORE RESOURCES ON LONG TERM CARE.
  - PROMOTE THE PURCHASE OF LONG TERM CARE INSURANCE.
  - PROMOTE THE DEVELOPMENT OF ADULT CARE COMMUNITIES.

- MEDICARE
  - INSTITUTE CO-PAYMENT FOR MEDICARE FOR THOSE WHO CAN AFFORD IT.

- MEDICAID
  - REQUIRE ALL MEDICAID RECIPIENTS TO ENTER MANAGED CARE PROGRAMS.

- DATA USAGE
  - EFFECTIVELY LINK HEALTH CARE DATA BASES OF BUSINESS GOVERNMENT AND INSURANCE.

- PREVENTION
  - STRENGTHEN PUBLIC HEALTH PROGRAMS THAT STRESS PREVENTION.

- INSURANCE
  - SET UP A HIGH RISK POOL FOR BAD HEALTH RISKS OR PREVENT INSURERS FROM DUMPING HIGH RISK CASES.

- COMMUNITY PLANNING
  - BUSINESS, PROVIDERS AND LOCAL OFFICIALS SHOULD WORK TOGETHER TO DEVELOP A PLAN THAT WORKS BEST FOR LOCAL REGIONS.

RECENTLY THE CANADIAN SYSTEM OF PROVIDING HEALTH CARE HAS RECEIVED WIDE ATTENTION. IN VIEW OF THE CURRENT STATE OF OUR ECONOMY, DIRECTLY SUBSTITUTING A BRAND NEW NATIONALIZED HEALTH CARE SYSTEM FOR OUR EXISTING SYSTEM SEEMS TO DRASTIC A CHANGE TO CONSIDER.

WE HAVE CONCLUDED THAT OUR CURRENT SYSTEM IS SO LARGE AND COMPLEX THAT A POLICY OF INCREMENTAL CHANGE SEEMS MORE MANAGEABLE.

BUILDING ON THE BASIS OF OUR EXISTING PRIVATE INSURANCE SYSTEM SHOULD PROVIDE FREEDOM OF CHOICE FOR CONSUMERS AND ACTIVE COMPETITION AMONG PROVIDERS.

REPRESENTATIVE SCHEUER. Thank you very much, Mr. Bradshaw. We are grateful to your coming.

There may very well be changes that we would want to make in the way we practice medicine, and certainly you alluded to the malpractice situation, which is a total waste of up to $40 billion, according to the General Accounting Office. Yes, there are some ways that we can improve the way that we practice medicine—removing the conflict of interest, which you discussed, yes. But, today, we are focusing mostly on management and converting a lot of that time, effort and dollars, expended on pushing papers around to serving patients. But there will be some changes undoubtedly in the way we practice medicine, and we will probably have some more hearings when we get around to that subject, and we would be very much interested in your views on that.

Let me just ask both of you, the AFL-CIO has urged adoption of pay-and-play as a transition to a single-payer system, as the ultimate goal.

Do you support such a strategy, Mr. Bernstein?

MR. BERNSTEIN. At this point, I believe the ultimate focus of the AFL-CIO is on a single-payer program; the question is what route do we take to get there? And I don't think there is any unanimity in the labor movement as to which is the best route.

REPRESENTATIVE SCHEUER. Which is the best transition route, you mean?

MR. BERNSTEIN. Transition route! Let me just comment on something Mr. Bradshaw said. Not all Americans are fortunate enough to work for Grumman, or to work under a contract with the ILGWU that provides health benefits, which we can finetune to have effective cost containment and control, whether it be through preferred providers or managed care or whatever. The health of our Nation is inextricably tied to one another. Workers who work for Grumman or union shops may be a little healthier than other workers because they have had health insurance for all these years. The costs for the one part of our population who need acute care or has unmet needs have inevitably been shifted to the Grummans, or to the union employers, or to other employers who provide protection. We need the cross subsidies of a broad group of employed, unemployed, young, old, etc.

REPRESENTATIVE SCHEUER. Isn't that what insurance is all about?

MR. BERNSTEIN. So, we need one national pool and we need the portability and cross subsidies. And let's face it, the way medicine is practiced in this Nation is controlled by the inadequacies of the system, which is dominated by 1,500 insurance carriers—mega companies buying hospitals and closing down the less efficient services. It really is a patchwork, and physicians practice defensive medicine. Most of the tests are unnecessary. We need to deal not only with the financing, but also the managing and maintenance of a system that's geared to all.

REPRESENTATIVE SCHEUER. Mr. Bradshaw, you discussed the need for changing the way we practice medicine or deliver health care. Would you

care to enumerate some specifics for us to think about, although that is not the main goal of this hearing. I would be interested in hearing any specific ideas that you may have as to how we ought to change the way we deliver health services.

MR. BRADSHAW. Well, thank you. I certainly don't disagree with your suggestions for reducing the administrative costs. I think that can be a very important change, but when it comes to the practice of health care, it seems to me that the physician is really the control point; that's where it all begins. And to the extent that that physician is driven by a concern, as Mr. Bernstein has suggested, practicing defensively, I think there is something government can do about that.

It is really awfully nice to see settings, and there are some in this country, where doctors practice medicine without being concerned about malpractice, without being concerned about having to generate income, and without being concerned about any number of economic incentives, but being concerned solely about patient care and being supported by their peers. Some of the better-run HMO's are able to do this; some of the poorer ones are not. There are places like the Mayo Clinic, for example, where you see the highest kind of medicine being practiced in a setting which also happens to be very economic. That's the direction I think we would like to take, to the extent that we can encourage that. And God love them, there are hundreds of thousands of physicians in this country who care most about their patients and about practicing medicine, and we have to encourage those people to do that.

MR. BERNSTEIN. The crying shame is that with our great advances and technical knowledge and the way the world looks to us in the field of health care and medicine, there are such failings and there are such gaps in the health care of our Nation, there should not be one Mayo Clinic and it should not be available to only to those who have insurance carriers who will cover the Mayo Clinic. The Nation should be replete with Mayo Clinics so that not only will we generate savings from less paperwork—nobody measures the savings that the system would have, the government or the employers, from the better health engendered by a comprehensive system with a universal access, and, you know, preventive medicine being the hallmark of the system.

REPRESENTATIVE SCHEUER. Well, I appreciate very much hearing you two gentlemen. I'm convinced that we can look in the long run and even in the immediate run to the wisdom and the counsel of the health-care profession itself. I am convinced that we can lean hard on the medical community for direction and guidance in where we ought to be going and how we can establish reasonable cost controls and reasonable global budgeting in our system, as every other developed country in the world has learned to do. They have had to learn to do that.

I refuse to believe that the medical community in this country is so avaricious, so greedy that they will not consider the interests of 250 million persons who are desperately searching for something better. I believe there is leadership, there is vision in the health-care community

itself, that is going to help guide us through this and help us make the kind of decision, Mr. Bradshaw, that you were talking about.

How do we eliminate the medical malpractice and the $40 billion that that costs our country? How do we eliminate defensive medicine and the variety of unnecessary tests, many of which don't hurt the patient, some of which do harm the patient? I believe we can look to our health-care community for wisdom and guidance in making these necessary changes so that we emerge with a sounder, more wholesome health-care community with increased integrity, increased public responsibility, that will maintain better health care for over 250 million Americans, at far lesser costs and not increase the bill.

My goal, and I think that Congress's goal ought to be, to maintain our spending for health care at approximately the same 12 percent that we are spending now. That is far higher than any other developed country in the world. We should be able to purchase for ourselves a superb health-care system. We should be able to pay for a universal system. We should be able to pay for a comprehensive system—a system that includes everybody and provides all necessary health care, omitting the frills of cosmetic surgery. We are not interested in the nips and tucks, but we are interested in providing basic health care, including dental care, including eye care, including prosthetic care.

MR. BERNSTEIN. Prescriptions?

REPRESENTATIVE SCHEUER. All prescription drugs. People don't buy drugs because they taste good; they buy drugs because they are necessary. And if we paid for prescription drugs, I can't believe we would be overstressing the system. And I believe that we have to involve the medical community in these basic decisions; and I believe they will be willingly involved.

I believe that there is evidence that the American Medical Association has been rethinking its traditional opposition to a national health-care program, and I think they are involved in some agonizing reappraisals, and some new and fine and imaginative leadership is emerging. I believe our Congress will be able to work with the leaders of the American health-care community to fashion and sculpt the kind of health-care system that the two of you have been describing.

So, I thank you very much for your splendid testimony and, Mr. Bradshaw, I will hope to be in touch with you as we move ahead, and you too, Mr. Bernstein, and get the advantage of your continuing advice and counsel on these very difficult, very perplexing problems.

MR. BRADSHAW. Thank you.

REPRESENTATIVE SCHEUER. Thank you both very very much.

All right. We will now move to the last panel, which will include three representatives of the health-care system. In our last panel, we are going to hear from three very knowledgeable representatives of the health-care industry as they discuss the problems that are facing our health-care system.

This panel includes Alan Schechter, Senior Vice President for Finance of the North Shore University Hospital Health Care System. We will then hear from Dr. Thomas Cardillo, Consultant, Harter, Secrest and Emery, representing the Medical Society of the State of New York. And then, finally, we will hear from Dr. Robert Padgug, Director of Health Policy of the Empire Blue Cross/Blue Shield Insurance Company.

We will start this panel with testimony from Alan Schechter, Senior Vice President for Finance of the North Shore University Hospital and Health Care System.

Mr. Schechter, before you start, I would like to repeat my thanks to you and the North Shore University Hospital for hosting this hearing on health care in a very appropriate setting, with gracious amenities and refreshments that have made it such a pleasant morning.

Mr. Schechter is currently serving as co-chairman of the New York State Health Care Reform Committee. We welcome you, and I invite you to take such time as you may need in expressing your views.

STATEMENT OF ALAN SCHECHTER, SENIOR VICE PRESIDENT FOR FINANCE, NORTH SHORE UNIVERSITY HOSPITAL AND HEALTH CARE SYSTEM

MR. SCHECHTER. Good afternoon, Congressman. Again, we appreciate the opportunity to host the hearing today, and it is nice seeing you again. I am happy to share some thoughts with you on our views on health-care reform, both in New York State and nationally.

My written testimony, as you have seen, covers a variety of topics. It covers an overview of the North Shore Health Care System, and it covered North Shore University Hospital-Cornell University Medical College, which is a cost-efficient hospital struggling to survive at a break-even point in a highly regulated and financially troubled New York State. It covers health-care policy in New York State that has caused severe financial stress to hospitals and long-term care facilities, and touches on the impact of health-care reform and our vision of the future.

North Shore's health-care network is a center of excellence. It consists of many pieces. At its hub is North Shore University Hospital-Cornell University Medical College, a 700 bed tertiary care regional recovery center; North Shore Hospital for Extended Care and Rehabilitation, a 250 bed long-term care facility; North Shore University Hospital of Glen Cove, a 265 bed acute community hospital.

Research and our clinical practice plan would consist of all of our physician services. North Shore has created a health-care continuum, which is a vertically integrated health-care system providing a health-care continuum of integrated patient care services. Patient care is provided in a cost effective and highly regulated fashion, where physicians and facilities work as partners in an approach that results in genuine managed care and not managed access to care.

Our approach, Congressman, is to talk a little bit about the expense side. You have heard a lot today about different proposals and suggestions that are out there in terms of reforming health care. Our approach is to talk a little bit about the expense side. Our whole focus is to provide quality health care in a highly efficient manner, and we think we have a story to tell, a story within. The story within New York State is that New York State hospital profitability is one of the lowest in the country. An indication of this is the number of FTE's per adjusted occupied bed.

REPRESENTATIVE SCHEUER. Number of what?

MR. SCHECHTER. Full-Time Equivalent Employees that work for us, and it is close to 6,000 employees that work here at North Shore, but in the State, we are at 3.36. This is an indication—one might say—that New York State is very efficient. Another theory may be that the hospitals have ratcheted down their costs so much that the quality has begun to suffer and this is something that is being debated within our system.

Our story basically involves a community hospital that has grown to be a regional tertiary care referral center. We have done many efficiencies here at North Shore University at Manhasset. These efficiencies covered items, such as offering extensive utilization management procedures, in terms of examining ourselves on the level of services that we provide, how we provide it. It has involved many efficiencies, such as cost containment, things within the hospital, materials management—the integration of major computer systems within the hospital. But in spite of all of this, we have had major problems in terms of operating at a breakeven point within New York State. Because of this and because of trends, we decided to develop the North Shore Health Care System, which, as I said, is a vertically integrated system.

We embarked on this by building a long-term care facility so that we can provide integrated services to the elderly as part of our system. We, then, also embarked on acquiring and merging with the community hospital. The community hospital is the Community Hospital of Glen Cove. A picture of Glen Cove before the merger would show that Glen Cove was losing large sums of money. They had significant underutilized capacity. Their staffing was high, relative to their census, and there was a significant out-migration of people, out of the Glen Cove area.

REPRESENTATIVE SCHEUER. Out-migration of your professional staff?

MR. SCHECHTER. Yes.

We at North Shore, as a strong provider, recognized that it was to our advantage to establish a multihospital system so that we could enhance program development, share resources and overhead, and extend market share. A weak provider like Glen Cove went into this multihospital system because they wanted to improve their financial position, improve access to capital, eliminate constraints on growth and the deterioration of their market share. So, with them, we joined in the merger.

The strategy of the merger was to first manage costs through sharing of services, sharing of staffing, nonsalary expenses and extensive length of stay management. Focusing on cost allows us time to build utilization.

We wanted to enhance medical services and finally add new programs and upgrade facilities. This service is a model throughout the country. And what I mean by that is, with all the proposals outstanding in how you pay for health care, what one has to examine first what is the proper cost of health care? And by focusing on what we did at Glen Cove, in terms of this strategy, this resulted in overwhelming support that saved the hospital, improved access to high-quality care, improved the financial position and allowed us to develop a broader health-care network.

We did such things at Glen Cove like closing their laundry. Their laundry was underutilized. We now serve their laundry out of Manhasset. We combined the financial and data processing system. We cut back on their lab services a little bit, and we provide the basic services over at Glen Cove, but some of the tertiary services out of our facility here, and with the combined administration and efficiencies this year, Glen Cove is going to break even—Glen Cove will break even. The merger at the hospital improved access to high quality care, improved their financial position, and allowed us to develop a broader health-care network.

REPRESENTATIVE SCHEUER. Did you make any progress on sharing high-tech equipment, like CAT scans or MRIs, and using them more cost effectively?

MR. SCHECHTER. Yes. What we did is the CON process in New York State. The Certificate of Need process has basically been a failure in terms of controlling the underutilization of certain services. By entering into an arrangement like this, you can more appropriately plan for what services should be at both facilities and how we should plan for them in the future.

The health-care reform debate that's going on nationally, in terms of what we can do as a national agenda and as a New York State agenda—the model of the system in New York State, where hospitals and long-term care facilities are very highly regulated—is really a lesson for us on a national basis. Hospitals and nursing homes comprise 50 percent of the health-care dollar in New York State and are very highly regulated. Yet, physicians, physician services, laboratories and imaging centers are not controlled, so the dichotomy of that is that hospitals as the largest provider, other than nursing homes, are being squeezed. An illustration is that for the last five years North Shore has fought with the State for a second MRI. During that period of time, within a mile radius of the hospital, five physician-owned MRI's have opened up. No approval was needed; the physicians could just go out and acquire them.

REPRESENTATIVE SCHEUER. Excuse me, did those five physician groups work out any plan among themselves for sharing a facility rather than having five facilities?

MR. SCHECHTER. No, these are five independently owned facilities out in the community.

Another example of the dichotomy is in terms of some of the high-tech drugs that are coming out. There's a drug Centoxin that is coming onto the market. It treats sepsis infections in the elderly. This drug will cost us

$4 million a year. Neither the State nor the Federal Government is prepared to pay for it, and it will save 30 lives a year. Where do the regulators expect us to get the money from to pay for this drug? What provision is there to control the drug companies in terms of passing on these very high—and I really wonder if it is warranted—costs to the hospital community? And these are two examples of the types of——

REPRESENTATIVE SCHEUER. Excuse me. What would be the cost per elderly patient of that drug?

MR. SCHECHTER. About $2,000 or $3,000 a dose for that drug.

REPRESENTATIVE SCHEUER. And how often would they need a dose?

MR. SCHECHTER. This is done up-front to these elderly patients. In other words, for every four patients that are treated with this drug, only one would have come down with the infection, and that is part of the problem. It's a preventive type of treatment rather than responding to somebody who needs the treatment.

REPRESENTATIVE SCHEUER. What is the per patient cost of that treatment?

MR. SCHECHTER. I'm not sure.

REPRESENTATIVE SCHEUER. You say it is $4,000?

MR. SCHECHTER. To actually provide the drug to the patient. So, the lesson basically to be learned in this is that if we are going to regulate health care, we should regulate all the pieces of health care. You cannot just regulate part of the provider community and not the entire community. You can go that route or you can go the route of deregulating everything and let the marketplace force its impact, as they are. But we believe that a vertically integrated health-care system that consists of the entire continuum of health care, with an integrated system with everybody working in partnership, is one way of trying to control and keep down the health-care costs within an environment that is either completely regulated or completely deregulated. I think there are a lot of efficiencies to be gotten out of the system where you link up the strong providers with the weak providers.

REPRESENTATIVE SCHEUER. Does that complete your testimony?

MR. SCHECHTER. Yes.

REPRESENTATIVE SCHEUER. Very good. Thank you very much, Mr. Schechter.

[The prepared statement of Mr. Schechter follows:]

PREPARED STATEMENT OF ALAN SCHECHTER

OVERVIEW OF THE NORTH SHORE HEALTH CARE SYSTEM

The North Shore University Hospital system is a vertically integrated health care delivery system which enables us to provide broad health care services in a high-quality, cost-efficient manner. At its core is North Shore University Hospital-Cornell University Medical College, a 720-bed tertiary care, regional referral center and teaching hospital. The North Shore University Hospital Center for Extended Care and Rehabilitation is a 250-bed skilled nursing facility. The Boas-Marks Biomedical Science Research Center, which conducts both basic and applied biomedical research, also is on this campus. A short drive from North Shore Cornell is North Shore University Hospital at Glen Cove, a 265-bed community teaching hospital we acquired in 1990. In our three patient care facilities, we have 1,235 beds, 985 of them acute care beds. (See Chart 1.)

Our mission is broad. We are committed to excellent patient care, and medical teaching through our affiliation as a clinical campus with Cornell University Medical College. We have major research efforts. We provide community education and outreach. We are committed to health care on Long Island. Our level of charity care is the island's highest at more than $20 million a year. We have more than 6,500 employees and our operating budget is over $400 million. We have nearly 400,000 patient days and nearly 375,000 outpatient visits for many kinds of services each year.

We could not have grown without the cooperation and support of the state Department of Health. We established the Center for Extended Care and Rehabilitation at the request of the department and it was instrumental in urging us to move forward with the merger with Glen Cove.

North Shore's health care delivery system provides a health care continuum of integrated patient care services. This includes inpatient acute care, specialized tertiary care, long term care, rehabilitative care, home care, ambulatory surgery, primary care, and outpatient care. (See Chart 2.)

The vertical integration of all these services into a health care continuum offers advantages. The patient care is more effective and economical. Physicians and facilities work as partners rather than as adversaries, providing the self-discipline and self-regulation needed for efficient and successful operation.

NORTH SHORE UNIVERSITY HOSPITAL-CORNELL UNIVERSITY MEDICAL COLLEGE IS A VERY COST EFFICIENT HOSPITAL STRUGGLING TO OPERATE AT A BREAK-EVEN IN A HIGHLY REGULATED FINANCIALLY TROUBLED NEW YORK STATE

North Shore-Cornell has had consistently high occupancy rates above 95 percent for the last 10 years. As a measure of our efficiency, we have 3.88 full-time equivalent employees per adjusted occupied bed a low number which ranks within the American Hospital Association's first quartile level,, its most efficient staffing ratio category. Our length of stay is under seven days and our days revenue in receivables are 57 days compared to a national median of 77 days for large urban hospitals.

Over the years in response to our high occupancy and financial pressures, we have incorporated many efficiencies and improvements into our system. These have included streamlining hospital operations to accommodate timely and appropriate discharge of patients; implementation of extensive utilization management programs to measure and evaluate the use of hospital resources; establishment of a comprehensive and fully automated hospital information system; the implementation of a materials management program to facilitate purchasing and monitoring of supply usage in a cost efficient manner. In addition, our hospital based preferred provider organization (PPO) allows us to provide employee health and medical services at substantial savings.

We also recognized that the role of the hospital was changing. Inpatient hospital beds increasingly are used for the sickest patients as simpler procedures were shifted from inpatient to outpatient settings. In response, we established a major role for North Shore-Cornell in ambulatory care to meet the dramatic increases in outpatient utilization. We have strong ambulatory care programs such as a free-standing ambulatory surgery center on campus which performs more than 10,000 surgeries each year.

HEALTH POLICY IN NEW YORK STATE HAS CAUSED SEVERE FINANCIAL STRESS TO HOSPITALS AND LONG-TERM CARE FACILITIES

The New York reimbursement system is highly regulated. The non-Medicare reimbursement system is based on 1981 costs with only certain minor adjustments for costs that have exceeded the update factor for inflation applied to hospital payment rates. This trend factor has not taken into account significant cost increases such as those for professional salaries and new technology. There also are built-in constraints on payments to hospitals such as the case mix increase limits, the blend of group average pricing with hospital-specific costs and charge control for self-pay patients. In essence, all non-Medicare rates are controlled under the State reimbursement system with limited opportunity to increase revenue. Because all other non-Medicare payors reimbursement rates are linked to Medicaid, every time the state cuts its Medicaid budget to save $1 to save money, hospitals lose $10 from all other payors. Furthermore, there have been historical limits on Medicaid payments for emergency room and clinic visits.

A recent report by Moody's Investor Service concluded the following about New York hospitals, "Consistent declines in the financial performance of New York hospitals--largely the result of a highly restrictive State reimbursement system--have contributed to weakened credit quality. Despite strong utilization trends, this poor financial performance has put stress on the health care system Statewide..." Furthermore, the Health Department has sought to radically constrain the supply of inpatient hospital and nursing home beds to moderate the rate of infusion of capital into the institutional sector and to limit institutional revenues. Through policy initiatives and regulatory incentives, rewards were reserved for those facilities that traded in inpatient capacity for new outpatient services, absorbed other facilities or served particularly needy communities.

Comparisons to national averages illustrate that the profitability of New York hospitals has declined until it is among the worst in the nation in terms of operating profit, return on assets and return on equity. (See Chart 3.) Hospital liquidity is also dangerously low. (See Chart 4.) To survive, New York hospitals have reduced their full-time equivalent employees per adjusted occupied bed to 3.36, the lowest in the nation. (See Chart 5.)

It is interesting to note why the Health Department has focused its efforts to control health care costs on hospitals and nursing homes. In the state as well as nationally, hospital and nursing home care amounts to almost 50 percent of each health care dollar. (See Chart 6.) The problem with this approach is that the other 50 percent, including physician services, drugs and other components of care, are uncontrolled, making the New York system of regulating only half of health care services unworkable.

Certain industry trends have become apparent to us. Despite North Shore-Cornell's internal management economies, full utilization and other efficiencies, the New York reimbursement system was becoming more and more financially restrictive. It was in this environment that we decided to set a clear direction for the reconfiguration of patient care services. We took major steps to balance them to allow us to service the region. In response, we decided to develop the North Shore health care system.

We continued to develop and expand our partnership with physicians within our system through our network of salaried and non-salaried physicians. Almost 300 salaried physicians in our clinical practice plan and 600 non-salaried voluntary attending staff make up a cooperative network of extensive physicians' services.

We expanded into long term care and the benefits were significant. The geriatric patient has increased access for inpatient and outpatient services, including day care and many community-based programs. The patient also benefits from continuity of care, or 'one stop shopping.' The hospital also experienced many benefits. It was able to reduce its length of stay by placing certain geriatric patients that had been hospitalized due to a shortage of beds in the more appropriate sub-acute setting. The Center for Extended Care and Rehabilitation and the hospital have extensive shared services with shared overhead, making the provision of these services very economical and cost efficient. The hospital's geriatric teaching program was expanded to the Center, a more appropriate setting for the students. Finally, it also allowed the hospital and the Center to more appropriately manage its resources and patient care.

We recognized that to provide regional care in a coordinated, cost-efficient manner, there has to be rational sharing and planning for the expenditure of resources within a region. Often, competing hospitals duplicate programs, causing inefficiencies and underutilization of certain services. The state, for all its good intentions, has not been able to control this through the certificate of need process.

Strong providers like North Shore-Cornell should consider developing multi-hospital systems to develop the medical staff, enhance program development, share resources and overhead and extend market share. Weak providers need to consider joining multi-hospital systems to improve their financial positions, improve access to capital, eliminate constraints on their growth or service development, and stop the deterioration of their market positions.

It is within this setting that North Shore-Cornell joined with Community Hospital at Glen Cove in a merger that saved the community hospital. Our objectives were to improve access to higher quality care, improve the hospital's financial and operating performance, achieve economies of scale and build a broader health care network.

When we began to discuss merging with the Community Hospital at Glen Cove in 1989, it was losing $5 million and expected to lose the same amount in 1990. It was in default on its long-term debt and the patient census was declining rapidly. Its decisions were being driven by financial constraints rather than medical needs. (See Chart 7.)

When we acquired Glen Cove the following year, we began a turnaround process that first focused on cost management, then on revenue management. Our cost management process, which was extensive, concentrated on sharing of services, managing operations, length of stay, and cash flow. After getting the cost structure under control, we focused on revenue management. Our process consisted of a program to enhance medical services, census building and expansion of marketing efforts.

The scope of the work was broad, with a sharing of services at a substantial savings in a dozen different departments ranging from laundry to laboratory to purchasing to engineering. In one example of savings, we were able to lower the prices paid for goods and services at North Shore at Glen Cove by approximately 12 percent through North Shore-Cornell's volume discounts. Another example was closing Glen Cove's obsolete and malfunctioning laundry and servicing the hospital out of North Shore-Cornell's underutilized laundry. One last example was the consolidation of both hospitals' finance, administration and data processing departments at a substantial savings.

In the first two years, the turnaround program has been very successful. The merger saved Glen Cove. It improved access to high quality care by expanding

physician coverage and medical services. It improved its financial and operating performance and achieved economies of scale. The hospital will show a profit in 1991. North Shore-Cornell and North Shore at Glen Cove are building a broader health care network in northern Nassau County and on Long Island. The merger has kept a community resource alive, enhancing the economic health of the Glen Cove community by doing so.

We believe very strongly that what we are doing in Manhasset and Glen Cove can be a model for other areas of the country. Our vertical system can be adapted to accommodate specific geographic areas' patient mixes and unique health needs. Although we are a suburban hospital, we believe our approach can work well in rural areas as well as urban ones. Even in states with different reimbursement systems, states where hospitals view Medicare patients as the worst payors and not the best payors, as they are in New York, a vertically integrated system with the kinds of programs and controls we developed can eliminate waste and promote efficiency.

There are many ways to structure multi-provider arrangements but we have found that the more the institutions are integrated, the more the benefits for both. A merger has worked best for both our hospitals.

HEALTH CARE REFORM AND OUR VISION OF THE FUTURE

Health care costs in the United States seem out of control. Health care spending, as a portion of the Gross National Product, has shown a continuing upward trend--9.1 percent in 1980, 10.4 percent in 1988, an estimated 13 percent in 1994, and as much as 15 percent by 2000. National health care spending totalled $540 billion in 1988 and is anticipated to reach $1.5 trillion by the year 2000. (See Chart 8.) Total health care costs doubled in the 1980s, and will triple in the 1990s.

Health care reform will require consensus building, not only within the provider community, but also among payors, and consumers. The crisis confronting our health care system has affected each of these groups differently. Providers must deal with the costs of caring for the uninsured and payor reimbursement that fails to keep pace with rising costs. Employers face spiraling health benefit expenditures for their workers. Both federal and state governments are searching for ways to contain public expenditures for health care service. Consumers worry about rising out-of-pocket expenses and many struggle for access to health care. Any reform plan must address each of these issues if a solution to all is to be reached.

From the perspective of the hospital providers, chief executive officers and physician executives alike identify providing care to an aging, sicker population as having a major impact on increasing their organizations' costs. According to a survey of hospital executives by Ernst & Young, they felt this was the most significant factor in cost increases. (See Chart 9.)

Another survey by Deloitte & Touche of hospital executives' views on limiting costs showed that 71 percent think health care provided in individual cases should be limited because of cost. (See Chart 10.)

The ultimate goal of health care reform will evolve from the national debate on the key components of the health care system of the future. The Hospital Association of New York State has concluded that the approach for achieving reform must include methods for broadening access to care and assuring continued improvement in quality within a governmental oversight framework which forces creativity and recognizes government's fair payment role. Their objectives are to reposition the patient and the community as the focus of health care decision making, optimize health care value, create and align health care system incentives, and move toward outcome-driven measurements of health care delivery performance. (See Chart 11.)

It is our conclusion that hospitals must provide a leadership role in the reform of the health care system. They must adopt and pursue a continuum of care within a system that encourages integration. The current system fosters groups of highly skilled providers pursuing separate objectives such as primary care, acute care, and long-term care. To maximize patient value, there should be an appropriately sized continuum. There should be incentives to establish appropriate volumes for each aspect of care. There also should be incentives for mergers or ventures contributing to the system's cost effectiveness.

We think that one method to achieve reform is to encourage vertical integration of health care systems in a manner that can combine financing, delivery, education, and research under one administrative structure.

The system's ability to own or provide the entire range of services is the measure of vertical integration. There should be coordinated relationships between the parts to make care more efficient, effective, and of higher quality than if care was given by separate entities. The result would be genuine managed care, not merely managed access to care.

During the national debate on health care reform, we will continue to develop the North Shore Health System. This system and others throughout the nation can possibly serve as models for the evolving health care system. However, there are lessons to be learned from our own experiences. We concluded that we needed to develop an integrated health care system as a result of our experiences in operating a highly regulated state. New York has failed to eliminate underutilization of services, respond to significant high-tech growth or stop the promulgation of costly, ineffective regulations. This has led to hospitals' and nursing homes' deteriorating financial performance. Many providers are in such poor financial condition that they have lost all their flexibility. Regionalization using the certificate of need process hasn't worked because it handicaps existing providers, such as hospitals, while allowing medical entrepreneurs a free hand. Nursing homes have bed shortages and reimbursement problems. The reimbursement system is complex and inefficient. And there are personnel shortages.

The time to repair this fragmented and fragile system has come. We must do it in two areas, nationally and statewide. Nationally, we must find ways to improve access to quality care for the uninsured at a reasonable cost. In the coming era of tight budgets, that means we must confront the issue of medical rationing. Over 50 percent of each person's health care expenditures are spent in the last two years of life. Nearly two-thirds of that in spent in the last six months. As a nation, we must ask ourselves how to decide the price we are willing to pay to keep people alive, for how long, and what the quality of that life should be. This is an issue that must be debated on a national level. Is the money better spent on the elderly at the end of their lives or on children at the beginning of theirs? We must ask similar questions about other kinds of sophisticated, high tech care. Obviously, this has to be done nationally by committed elected officials such as yourselves.

Until then, there are certain things we can do within the state. We must design an interim reimbursement solution that is fair and equitable. One formula for health care reform is to take strong providers, give them incentives to establish centers of excellence and establish an economic rationale for sharing in a partnership of physicians, hospitals and payors. More alliances, networks and mergers are the best way to bring greater efficiency to health care, lower costs and improve access. There must be a rational allocation of resources and regulatory reform. Taking these steps is not easy and it cannot happen overnight. But it can create the environment we need in New York to keep appropriate providers in an economically viable system.

I would like to make more specific recommendations in three areas: reimbursement, quality and efficiency. In reimbursement, we believe that partial regulation has been a failure. All the players must be regulated--hospitals, nursing homes and

physicians alike. Physicians in New York State can buy equipment without any state oversight; hospitals cannot. For the last five years, North Shore has fought with the state to get a much-needed second MRI. During that time, five physician-owned MRIs have opened within a mile radius of the hospital. Years ago physicians provided hands-on care. Now they are in the high tech business. In some practices, 60 percent of physicians' revenues are generated through lab services, X-ray services, ultrasound services--things that patients once went to the hospital for. This has meant competition between physicians and hospitals and puts a severe strain on hospitals. One party regulation doesn't work; you must regulate both physicians and hospitals.

Another example is the pharmaceutical industry, which is producing very expensive, high tech medications. The state and federal governments do not reimburse hospitals for these drugs. For example, Centoxin, which is manufactured by Centocor, is given to people over the age of 65 to treat sepsis, or systemic infections. We estimate it could save 30 lives a year at our hospital and cost $3 million. The state and federal government provide no additional reimbursement for this. Where are we supposed to get the money from? If we don't get the money, how can we offer the drug? Should drug company profits be regulated? One party regulation won't work here, either. The bottom line is this. Health care should either be completely regulated or completely deregulated. A hybrid system does not work.

Hospitals must form alliances and rationalize spending strategies to make sure they can provide appropriate levels of inpatient and ambulatory care. They must improve their credit worthiness if they are to grow. They must improve productivity. They must set clear direction for the future of their inpatient services, finding the appropriate balance between intensive and acute inpatient care and chronic, rehabilitative, and ambulatory services. We need to give potential patients the information they need to choose health services wisely. We need to respond to patients so they will want to return to us if they need health care services again.

We have great power to cure illness and are just beginning to explore our capacity to prevent disease. Unless we can find ways to use that power effectively and efficiently, it will be squandered and the price we pay in human suffering will escalate. Because no institution can do it alone, we welcome this opportunity to take part in this necessary dialogue. It is an important step towards solving these problems together.

APPENDIX OF CHARTS

A Center of Excellence ...
North Shore's Health Care Network

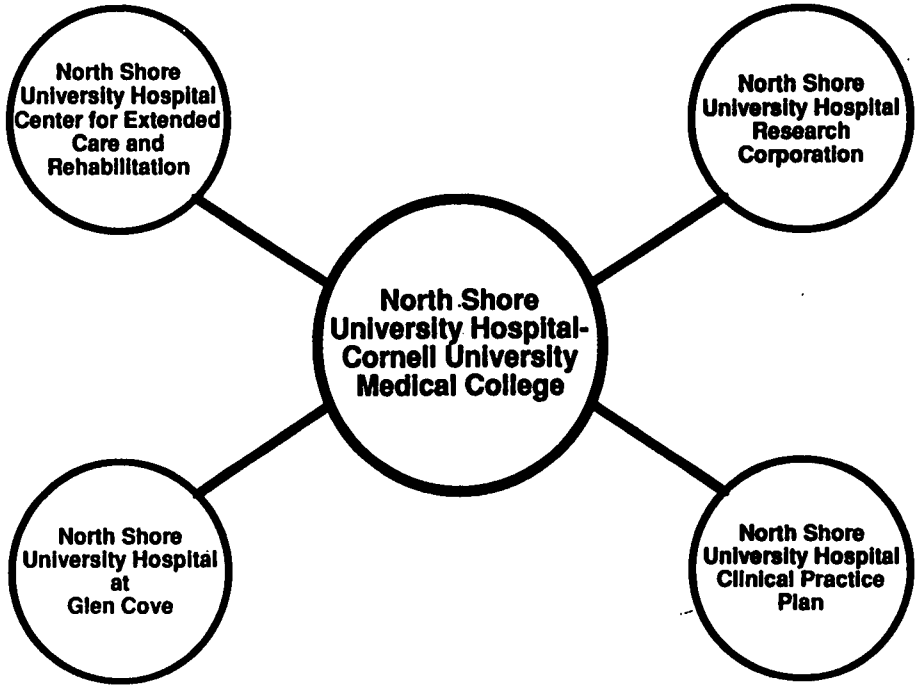
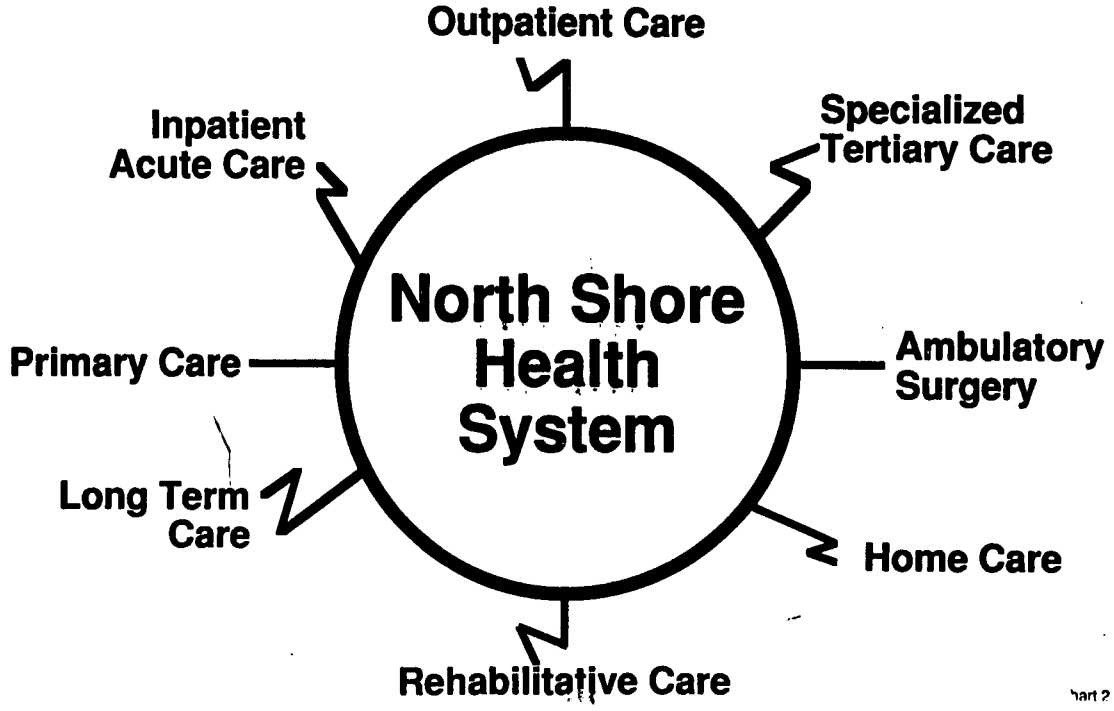
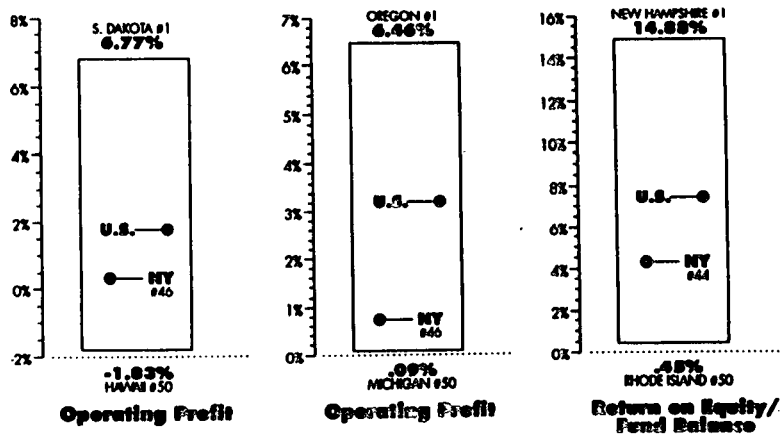


Chart 1

A Health Care Continuum of Integrated Patient Care Services



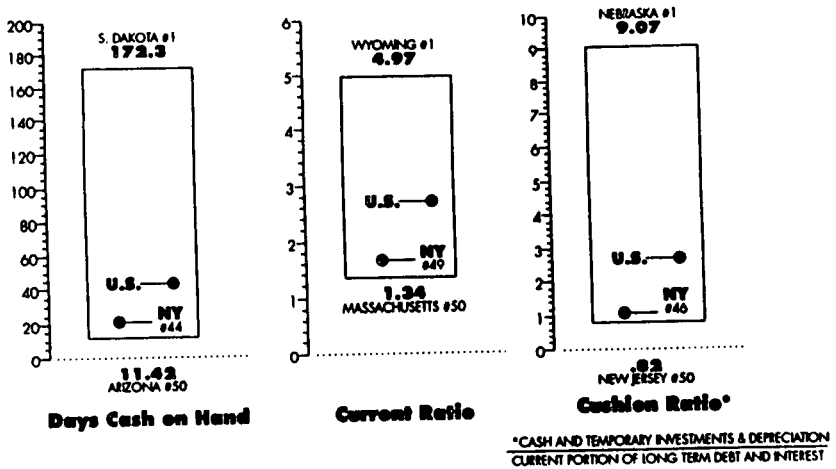
New York State Hospital Profitability



Source: Health Care Investment Analysts, Inc. and Deloitte & Touche

Chart 3

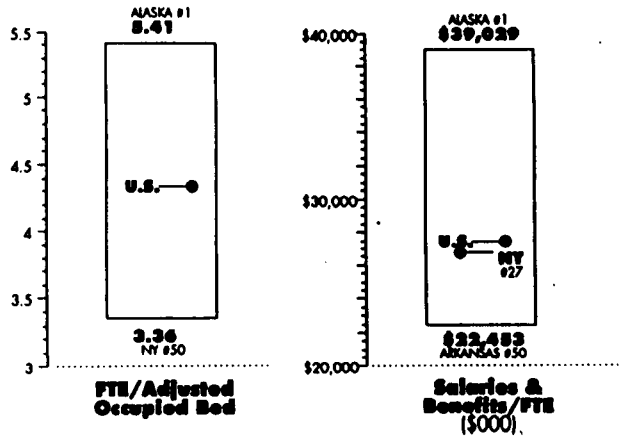
New York State Hospital Liquidity



Source: Health Care Investment Analysts, Inc. and Deloitte & Touche

Chart 4

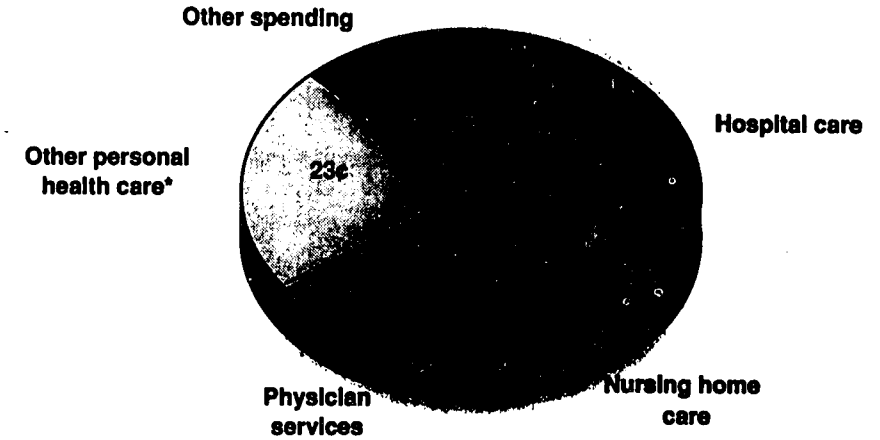
New York State Hospital Labor Efficiency and Expense



Source: Health Care Investment Analysts, Inc. and Deloitte & Touche

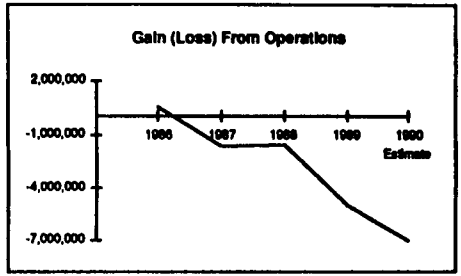
Chart 5

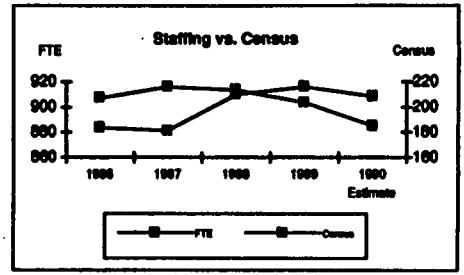
Where the health dollar went in 1990

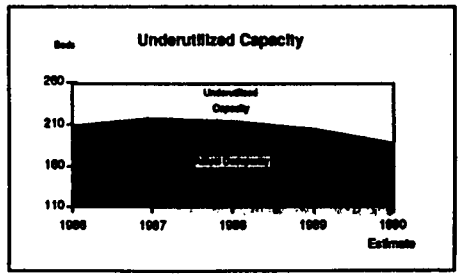


*Includes dental, other professional services, home healthcare, drugs and other nondurable medical products, vision products and other durable medical products.

Overview of Glen Cove Before the Merger





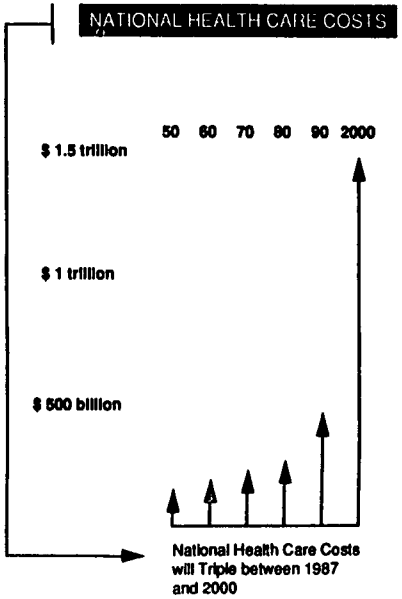


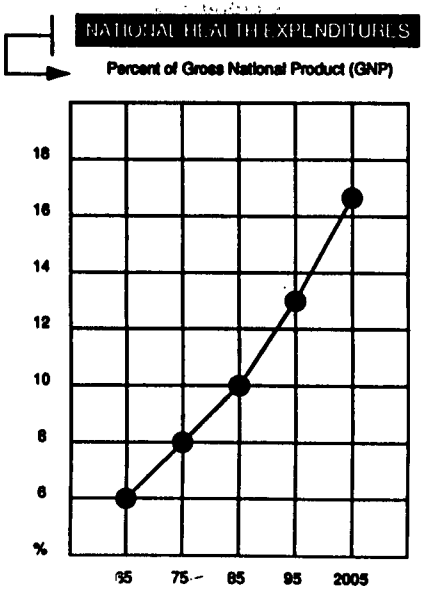
Admission to Other Area Hospitals

Service	Glen Cove Primary Market Share	Annual Outmigration
Medicine	69%	1,500
Surgery	67%	500
OB	51%	500
GYN	43%	200
Pediatrics	62%	150
		2,850

Chart 7

National Health Care Costs and Expenditures



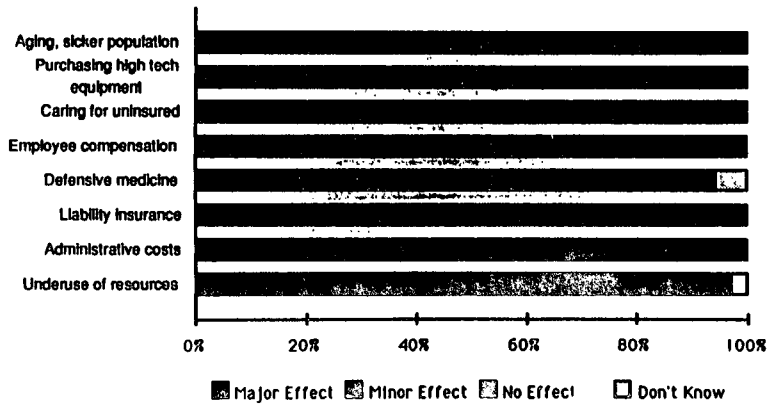


Source: Health Care Investment Analysts, Inc. and Deloitte & Touche

Hospital Executives Survey, Part 1

Rising Health Care Costs: Where are the Dollars Going:

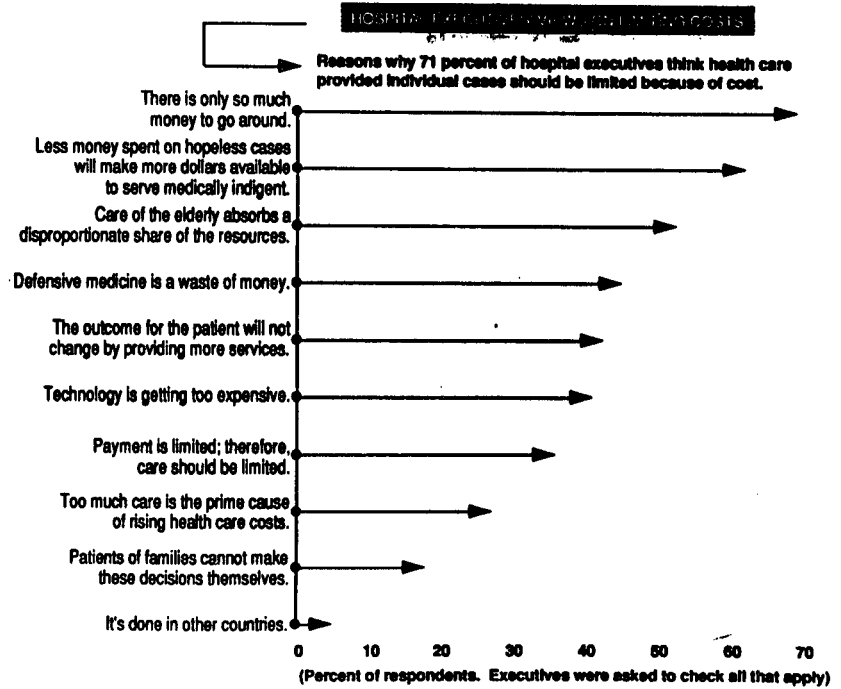
"What effect do the following factors have in increasing costs for your health care organization?



Source: A Provider Perspective, Survey Results Health Care System Reform, Ernst & Young

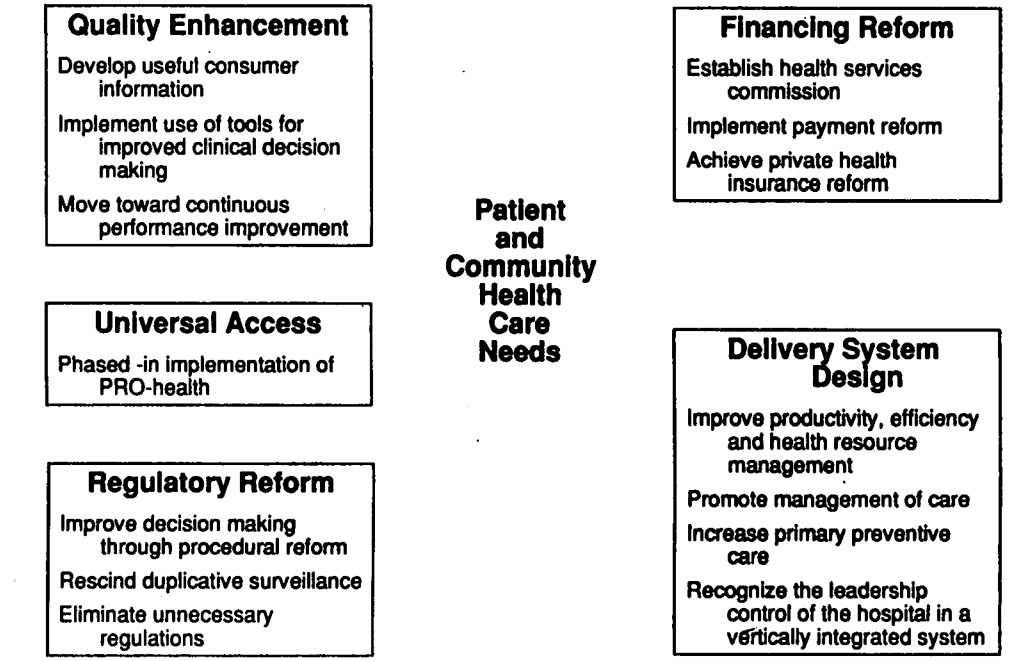
Chart 9

Hospital Executives Survey, Part 2



Source: Health Care Investment Analysts, Inc. and Deloitte & Touche

Health Care Reform



Source: Hospital Association of New York State

Chart 11

54-363 O—92—25

REPRESENTATIVE SCHEUER. Now, we will hear from Dr. Thomas Cardillo, a health consultant who is representing the Medical Society of the State of New York. Between 1975 and 1989, Dr. Cardillo was Executive Director of the Medical Society of Monroe County, and he currently serves on the New York State Medical Society's Ad Hoc Committee on Insuring the Uninsured.

We are delighted to have you here, Dr. Cardillo. Please take such time as you may need.

STATEMENT OF THOMAS E. CARDILLO, M.D., CONSULTANT, HARTER, SECREST AND EMERY, REPRESENTING THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

DR. CARDILLO. Thank you, Congressman Scheuer. I am pleased to be here today to give you the viewpoint of an outsider speaking to your prestigious panelists and yourself.

A few years ago, I was asked to serve on the State Medical Society's Committee to Insure the Uninsured. As a matter of fact, the true name was the Ad Hoc Committee to Insure the Uninsured. Despite this cumbersome name, at the first meeting it became obvious that I, as an internist, was to say, "Hey, wait a minute, in addition to covering the uninsured, we should talk about preventive medicine." The pediatrician on our committee immediately said, "Wait a minute, we have to do more for underprivileged children, particularly Medicaid," and then the obstetrician said, "And we have to do something about single pregnant females." And it seemed clear to all of us on the committee that covering the uninsured was only one aspect of the job that needed to be done. We went back to the State Medical Society and asked if they would increase the charge to the committee, and they did so. The charge was to develop a universal health insurance plan.

We met and discussed a basic benefit package, and we tried to make that take care of the uninsured, the near poor, the Medicaid children, the pregnant single females, etc. I am pleased that the Medical Society of the State of New York has come out in support of universal health planning, because I think it shows a great deal of vision on their part. I would agree with your statement that the public is light years ahead of others in terms of advocating and embracing a universal health plan, and I'm pleased that the Medical Society of the State of New York has taken that position.

We have been part of town meetings throughout the State, and I have had the pleasure of attending at least two of them and speaking on behalf of this planning, and it has been fairly well received in all of the areas of the State that I have participated in. There are some very good similarities between the Russo bill and the Medical Society of the State of New York's planning, and I'll go into detail later. What I want to do at this point is to say that I, as a physician, have always found great difficulty with categorizing my patients as being either Medicaid or Blue Cross/Blue Shield, or uninsured, or Medicare, or Champus, or Workers Compensa-

tion, or whatever. And it seems to me that this was a game in which you try to put round pegs into round holes and square pegs into square holes, or, anecdotally, different strokes for different folks. As a physician, I want only to see a patient in front of me who has sought my care, and I could care less about the reimbursement mechanism.

One of the things I like about what you are advocating is that we will be moving to a system that no longer discriminates against the poor, putting them all out on Medicaid, or the elderly put out on Medicare. That falls through the cracks, but what we will have is basically everything mandated by Congress and then purchased in different ways, whether you use the Russo bill or Medical Society of the State of New York bill.

We heard earlier from two ladies who expressed some of the problems with Medicaid and Medicare, and it seems obvious to me, as a physician, that they, as nonphysicians, foresaw the same problems in the two programs that I did. Medicaid and Medicare were necessary, important landmark legislations. Neither of them delivered to the poor or the elderly what was promised. The costs and the wastes in those programs far outshadow the costs and wastes in some of the other insuring mechanisms. That is what I realized.

I have seen a report recently that our health-care costs increased some 15 to 25 percent for Medicaid insurers and, yet, with Medicare it is more in the range of 30 to 35 percent. I think it is important to emphasize that while there are similarities between the Russo bill—and I am very comfortable about that—as we compare it to the State Medical Society, we are actually providing the same benefits, and it is comprehensive and is going to give Americans what they need.

I agree with the concept that we can do it by saving money under the present system. I think I take issue with you on a single government, single-payer system, and I rest my case by saying Medicaid and Medicare are examples of how governmental administration--ask this gentleman on the right--does certain things that are going to raise his administrative costs.

REPRESENTATIVE SCHEUER. Let me interrupt you. I never said I wanted a single-payer government system. Maybe Blue Cross/Blue Shield will be the single-payer. We probably should make that decision after a request for proposal.

DR. CARDILLO. I am glad you used those words because I am going to talk about an RFP.

REPRESENTATIVE SCHEUER. I welcome that concept, where competitive forces will produce a single state or county health plan rather than what the health insurance companies have produced in this incredibly chaotic arena in which they have become established. I would welcome a single-payer that was a normal insurance company, or Blue Cross/Blue Shield that may have excellent expertise.

DR. CARDILLO. Good. We are on the same wavelength.

REPRESENTATIVE SCHEUER. It could be national; it could be by the state, and it could be by cities of over a million, or it could be a consortium of states—the Rocky Mountain states could select theirs as a single-payer, and it could be one of the insurance companies, or the Federal Government, or it could be anything.

DR. CARDILLO. Congressman, I think we are on the same wavelength. I was with the space program for three years. I was the Medical Director of the Mars space flight in Huntsville, Alabama, and bureaucracy and other issues were new to me.

REPRESENTATIVE SCHEUER. You must have had a rude awakening.

DR. CARDILLO. Yes, except the NASA program was a government program and it achieved some very fine things. What I didn't understand was how they would use the request for proposal by which the Grummans and Boeing and RCA and aero jet engines—large corporate America—would have to respond as to how they were going to deliver the services and for what costs. And I came to have considerable respect for the system because the government was asking for a certain job to be done, and the private contractors, in responding to the proposal, were telling how they were going to do it and how much they were going to charge.

It seems to me that in our reform of the health-care system, we should consider something like this because I would like the opportunity to reject an insurance company that has an administrative overhead—and let me be ridiculous for a moment—of 35 percent, and, yet, I would like to encourage a health insurance company who has an administrative overhead of 8, 9 or 10 percent.

REPRESENTATIVE SCHEUER. Indeed.

DR. CARDILLO. So, that's sort of the position from which I am coming.

REPRESENTATIVE SCHEUER. Well, I respect that very much. You and I are in total agreement on that approach. Let them sharpen their pencils and compete for the right to carry on that single-payer function, removing the excess paper and paying the bills.

DR. CARDILLO. Now, earlier, many of our panelists gave you statistics. I am not going to go over them because I think we are all familiar with them, but I would like to conclude by simply saying the following:

I have good news and I have bad news. The good news is that the American health-care system is the finest that the world has ever known. We have all said that in this room today.

REPRESENTATIVE SCHEUER. For those people who have access to the system.

DR. CARDILLO. That is not what I said.

REPRESENTATIVE SCHEUER. But I think you have to——

DR. CARDILLO. The American health-care system is the best the world has ever known.

REPRESENTATIVE SCHEUER. For people who can enjoy it's benefits.

DR. CARDILLO. The bad is news is that it has not been available to everybody, and the health-care costs have reached the height that says we must reform the health-care system. So, I am agreeing that we need to reform it because the costs are unacceptable.

When premiums are going to rise at a rate of 15 to 20 percent, conservatively.

REPRESENTATIVE SCHEUER. A year?

DR. CARDILLO. Yes, sir. That's unacceptable. And I have been at major national meetings and I have heard government, labor, industry and business finally talking about a universal health insurance plan, and I am delighted to say that the Medical Society of the State of New York joins in recommending that we move to a universal health plan, with Congress passing a mandated benefits package.

I think to ask the State of New York to do it is wrong. I think to ask California to do it is wrong. And my reason is that this is not a local problem, it is a national problem, and I look to Congress to mandate, at the federal level, that we have this kind of program. I see no other solution to bringing quality health care to Americans and making it accessible, and I think it is going to be great when we can say that everyone will be treated equally.

Thank you.

REPRESENTATIVE SCHEUER. Well, that is a very terrific statement, Dr. Cardillo, and I am tremendously grateful to you and the rest of the panel for being here. But that was a most fascinating statement.

[The prepared statement of Dr. Cardillo follows:]

PREPARED STATEMENT OF THOMAS CARDILLO, M.D.

Good morning. I am Dr. Thomas Cardillo. I'm a physician from Rochester New York and I'm here as a member of the Medical Society of the State of New York, which represents 28,000 physicians in the state.

We are delighted to be of assistance to the Subcommittee on Education and Health of the Joint Economic Committee. I don't think anyone in this room can deny that there is a serious need to come to grips with the broad area of health care reform. As a medical society we have been involved in the issue of health care reform...including the issue of insuring the uninsured...since the early 1970s.

Beginning almost four years ago, we started the task of formulating a specific proposal to help insure that the 2.5 million New York state residents with no health insurance coverage were brought within the fold of adequate medical protection. This effort was launched at the same time that this Committee...under the leadership of Chairman Scheuer...held a series of highly enlightening hearings focused on the Future of Health Care in America. I think we can honestly attribute much of today's focus on health care reform to those efforts going back to 1988.

Undoubtedly, you are aware of the tremendous problems that providers of health care face here in the State of New York. The economic picture has cast a dark shadow on the State's ability to raise tax revenue and this...in turn...has now created cuts in health care funding that severely limit the ability of our provider institutions to care for those who most badly need medical assistance...our poor, our minorities, our homeless and our elderly. We believe that the time is long overdue that we as a nation came to grips with the necessity for creating a mechanism under which all Americans are assured that their basic health care needs are covered with some form of a national program.

The Medical Society of the State of New York has created a potential mechanism to assure that all citizens are fairly and adequately covered for their basic health care needs.

First, our plan calls for a federal law mandating that an appropriate health benefits package be made available by all health care insurance entities. The law would also mandate that such a package be purchased for each individual American citizen, either by the individual, or voluntarily by his or her employer. This basic package would be uniform across the country and would cover everyone, no matter what their age or income level. Competition between insurance companies would force competitive pricing of premiums.

Our program is based on the fact that the US has a large, superbly trained physician population, dedicated and skillful nurses, technicians, midwives, therapists and other health care professionals. Our hospitals are

first-rate, and our medical schools are well-equipped and superbly staffed. If we are to find a solution to the glaring weaknesses of the US health care system, we must maintain and build upon these systemic strengths.

But even with excellent facilities Americans who leave their current jobs, lose -- at least temporarily -- their health care coverage. Furthermore, so-called preexisting conditions may be excluded from any new policy provided by their next employer. Or they could find themselves in a position with an employer who does not provide health insurance at all. Rarely are employer-provided plans transportable to new jobs. Our program would assure that these individuals would have continuous coverage. Estimates are that 31 million Americans are without health care insurance, and an additional 70 million have inadequate insurance.

No American would be left out of the national basic benefits system. This means that even the high insurance risk patient would be covered. Under the Medical Society plan insurance companies would be required to cover these persons as part of their franchise to sell the basic benefits package. A risk-pooling formula would be established that would spread the risk equally among all insurers.

How would we pay for this care in a fair and equitable manner? The best method to accomplish that goal is to utilize the graduated income tax system. In our proposal, health care insurance would become a credit against taxes, dependent upon income.

Americans in the highest tax brackets would be considered able to afford the basic health care benefits package without public assistance.

Their tax credit would be zero. Americans in lower tax brackets, however, would gradually be given greater and greater aid in purchasing the basic package. Their tax credits would be determined on a sliding scale. They would be allowed to apply a larger and larger credit toward their income tax.

Employers would be encouraged to purchase the appropriate health benefit package for their employees as an inducement to attract high quality workers. The cost of the package, however, could be considered taxable income to each individual employee. The employee, thus, would retain the tax credit.

When the tax base reaches the truly indigent, who cannot and do not pay any tax at all, the health care insurance tax deduction is replaced with a non-transferable, one-use-only voucher usable solely to purchase the basic benefits health care package. The tax system gives the government a simple mechanism to determine who needs what help with the purchase of this insurance.

This system would mean that most Americans would pay some portion of their basic health care coverage, according to their ability to do so. In order to discourage frivolous overutilization of the system, a coinsurance and deductible would be required except for those Americans deemed truly indigent.

Quality would be assured in the new system, along with economy and efficiency. We envision two main safeguards to do this. First, the

establishment of appropriate medical review with the meaningful participation of qualified physicians at the state and local levels to assure the medical necessity and quality of all care rendered. Second, through the use of frequency of services parameters, arrived at in meaningful consultation with physicians and other providers.

We see no parallel for this approach anywhere in the world -- and that is how it should be. The United States is not Canada, not Great Britain, not France or Germany. An American Universal Health Care System must employ American strengths, American values. The technical wonders of health care in this nation have long been the envy of the world. By applying ourselves to curing the social ills that weaken our ability to deliver that best quality health care to all our citizens, we will once again light a path for other societies to follow.

We recognize that this Committee is challenged with analyzing and melding a wide variety of approaches to health care reform initiatives. The task is daunting, but in our minds crucial to the wellbeing of the nation. The Medical Society of the State of New York stands ready to provide this Committee with any assistance necessary to reach the goal of assuring decent health care for all Americans. Thank you.

I'm happy to answer any questions this Committee may have.

REPRESENTATIVE SCHEUER. Our final witness at today's hearing is Robert A. Padgug, Director of Health Policy for the Empire Blue Cross/Blue Shield Insurance Company.

Mr. Padgug has taught history at Rutgers University, and is presently a member of the University Seminar in Social Research in Preventive Medicine at Columbia University.

We are truly delighted to have you here as our wind-up witness, Mr. Padgug. Please take such time as you may need and give us your views.

STATEMENT OF ROBERT A. PADGUG, DIRECTOR OF HEALTH POLICY, EMPIRE BLUE CROSS BLUE SHIELD

MR. PADGUG. Thank you, Congressman Scheuer. I would like to thank you and the Subcommittee for affording me this opportunity to speak on behalf of Empire Blue Cross and Blue Shield about one of the most important issues facing our Nation at the present time—the reform of our health-care financing system. The problems inherent in our current system are easily identified. Voices are everywhere being raised to demand a system that can at once control costs, provide universal coverage, and retain the highest standards of care. Empire Blue Cross and Blue Shield fully agrees that those must be the aims of reform in the health-care financing arena.

But if the problems and goals seem obvious, the solutions are not quite so clear. That this is so can be seen in the welter of competing proposals for reform now before us. We have not yet agreed on the fundamental principles upon which to restructure our health-care financing system.

In itself, this lack of agreement is not necessarily to be deplored. Ours is an immensely complex system, and it is surely the aim of wise public policy to comprehend it better and reconstruct it in a more perfect form rather than to jettison it without adequate evaluation. Among those aspects of our current system that bear further consideration, three in particular stand out.

First, the role of private insurers. In recent years, the spread of private insurance has slowed considerably after decades of expansion. Many today have come to consider the private insurance industry inefficient and wasteful, and an obstacle to needed reform.

A closer look at the industry, however, would demonstrate that it is quite complex, with multiple sectors that vary greatly as to mode of operation and efficiency.

The not-for-profit insurance sector, for example, of which the Blue Cross and Blue Shield companies of New York State remain good models, has administrative costs that are much closer to those we find in Canada and elsewhere, and offers insurances to all who apply for it.

The not-for-profit insurance sector, including Empire, is undergoing difficulties in an environment in which commercial insurance companies have skimmed the best risks and avoided the poorer ones. It would unquestionably serve us better to restructure the market to

eliminate such practices and to nurture those companies that operate under a different set of principles rather than to simply abandon the entire insurance industry as it now exists. The experience of the not-for-profit sector, in fact, suggests that there is a major role available for private insurance in a universal health-care financing system, but only if the industry itself recognizes that its role is to provide coverage to as many Americans as possible and not merely to create profits. I would just simply point out that most countries of the world--Canada and England are exceptions to this—especially Continental Europe have systems which basically work through networks of private insurers that are not for profit—Germany, Netherlands and Switzerland are probably the most important in this respect.

REPRESENTATIVE SCHEUER. Do they have multiple insurers?

MR. PADGUG. Yes, throughout the country, not necessarily available to every single person. It varies from country to country, however, but Germany's system, which appears to be very efficient——

REPRESENTATIVE SCHEUER. That's a guild system that stems out of their medieval history, not something you would want to apply here. It works for them, but you wouldn't think of extracting any lessons from the German experience, the way you would extract some lessons from the Canadian experience.

MR. PADGUG. I believe many of the countries in Continental Europe do have lessons for us, for example, the Netherlands and Switzerland. We are only beginning. We are at the first stages of understanding those systems, I think.

REPRESENTATIVE SCHEUER. Correct.

MR. PADGUG. In any case, the second major area that demands better understanding involves risk pools—the means by which the risk of incurring costs for serious illness is shared among the healthy and the sick. Within our current system of health-care financing, risk pools have unfortunately been construed in an increasingly narrow manner. This is partly the result of narrowly competitive practices on the part of commercial insurers. But it is also the product of the desire of larger employers, who provide most of the funds for private insurance policies, to cover only the expenditures of members of their own groups, while sharing in none of the costs of health care generated by other members of society. The narrow risk pools that result are relatively fragile and are ill-designed to cover any but the healthiest members of society.

The increasing incapacity of our system to spread risk widely is at the root of our inability to provide coverage for all Americans. Any reform effort that does not acknowledge this fundamental reality, will inevitably fail to accomplish its aims.

Finally, but not least importantly, there is the question of local realities. In spite of the growing importance of the Federal Government in all aspects of health-care delivery and financing, most components of the health-care system that we encounter on a daily basis continue to have

their roots in local conditions, and are most directly affected by legislative and regulatory decisions made at the state level. It would certainly be imprudent to ignore the many lessons learned locally, just as it would undoubtedly be rash to move too hastily to a single national financing system that might not meet the needs of each state or region. Attention to the state and local level will allow us to avoid costly mistakes that will be difficult to correct on the larger terrain of the Nation at large.

Here in New York State, for example, longstanding legislation and regulation, taking into account the need for the broadest possible risk sharing, wide access to health care for all, and the important role of a not-for-profit insurance sector, has created a complex health-care financing system that has, in tandem with a relatively generous Medicaid program, afforded high-quality coverage to a very large portion of the population. Central to this system is the inpatient hospital differential, a mandated reimbursement methodology under which commercial insurers and self-insured companies pay hospitals at rates higher than those used by the not-for-profit sector. This allows the Blue Cross and Blue Shield companies to insure hundreds of thousands of poor risks without regard to health status, and to subsidize their cost through surplus gained from lower risk accounts.

While this system is also experiencing major problems, due to predatory commercial insurance practices, the solutions are not far to seek, including an inpatient differential set at a higher level than is currently the case, and a reform of the market for small groups and individuals that would eliminate the most antisocial practices of the commercial insurers. The New York system, in both its successes and its problems, has much importance to teach us about health-care financing.

Let me stress that in suggesting that there are important aspects of our system that we may be overlooking, I am not claiming that we do not need to make significant reforms. But what I am arguing is that we must explore the current system more carefully and attempt to comprehend better the likely consequences of major change in order to help our Nation reach basic agreement on the type of health-care financing plan that best suits it and that can be implemented with least disruption. In the meantime, I would suggest we also attend to the less glamorous but equally necessary work of shorter term reform in existing markets in order to render them as efficient as possible under present conditions.

Thank you.

[The prepared statement of Mr. Padgug follows:]

PREPARED STATEMENT OF ROBERT A. PADGUG

Dissatisfaction with the American health care financing system has risen to unprecedented levels. Innumerable proposals for reform have been presented to the public and placed on legislative agendas. The dramatic diversity of such proposals, however, demonstrates that we have not yet agreed on the fundamental principles upon which to reconstruct our financing system: plans for incremental reforms of selected aspects of the current system compete with strategies to achieve universal health care by systematically expanding the present combination of employer-provided insurance and governmental programs, which, in turn, vie with total reconstructions that would replace our private funding mechanisms with a purely governmental approach.

Empire Blue Cross and Blue Shield certainly agrees that fundamental problems are undermining our health care financing system. Among these, the most notable as well as the most often noted are constantly increasing costs and the closely connected lack of access to insurance and, ultimately, to health care itself for all too many Americans. We and other Blue Cross and Blue Shield companies have been in the forefront of efforts to deal with these problems through the implementation of innovative programs that provide affordable insurance policies for small groups, children, and other segments of the uninsured. We understand, of course, that much more remains to be done and that major reforms of the entire system are both necessary and inevitable.

At the same time, we would insist that the debate over restructuring of the health care financing system not be closed before all of its relevant elements are thoroughly explored and understood. Among the components of the system that have been dealt with in only a rudimentary fashion to date, but which are of truly fundamental importance if reform efforts are not to be undermined, three stand out:

1. **The Role of Private Insurers.** The private insurance industry, in partnership with the nation's employers, has for many decades played a crucial role in extending insurance for and access to health care to ever-larger numbers of Americans. Beginning in the late 1970s, however, the rate at which private insurance spread slowed considerably and the relatively high levels of coverage we had achieved even began to erode. The faltering of the insurance industry has led many to consider it inefficient, wasteful, and a major obstacle to needed reform. Nonetheless, in spite of what is often believed to be its relatively poor recent performance, a good case can be made that private insurance can continue to serve as the center-piece of our health care financing system. We can, under the right circumstances, build upon it in such a manner as to strengthen our entire system, offer universal coverage to all Americans, and help reduce the costs of health care--and do all of this without requiring massive infusions of new federal, state, and local tax dollars or creating major upheavals in the wider economy.

If private insurance *is* to play such a role in a reformed and expanded health care financing system, it can only do so on

condition that insurers recognize a fundamental truth: their role is to provide coverage to as many Americans as possible and not merely to create profits for their own companies. The endless search for profit and the increasingly more aggressive competitive practices to which it has led, especially on the part of commercial insurance companies, threatens to create an impasse for all American insurers: eventually, we may well insure only the healthy--and fewer and fewer even of these--while society's need to provide access to health care for all who need it will be ignored. Only if health insurers attend to the social side of their mission, the side they have tended to ignore for too long, can they expect to play a significant role in a reformed health care financing system.

2. **The Narrowing of Risk Pools.** Health insurance is protection against "risk," the risk of the financial loss associated with the use of health care services. It accomplishes that by spreading the losses of the relatively few who use significant amounts of health care among a larger pool of persons, most of whom will require relatively little or no care in any given year. It is obvious that the larger the pool within which risk is shared, the greater will be the number of persons, especially those at higher risk for ill health, who can be covered.

Within our current system of health care financing, risk pools have, unfortunately, been construed in an increasingly narrow manner. This is partly the result of competitive practices that lead commercial insurers to exclude as many of those at higher risk for disease as possible. But it is also the product of the desire of larger employers, who provide most of

the funds for private insurance coverage, to cover only the expenditures of members of their own groups, while sharing in none of the costs of health care generated by other members of society. The narrow risk pools that result are relatively fragile and are ill-designed--they are, indeed, largely unable--to cover any but the healthiest members of society.

The increasing incapacity of our system to spread risk widely, especially in a period of rapidly increasing health care costs, is at the root of our inability to provide coverage for all Americans. Any reform effort that does not acknowledge this fundamental reality will inevitably fail to accomplish its aims. Indeed, we would stress that all proposed reforms of the current health care financing system must be evaluated, at least in large measure, on the basis of whether they are both effective and equitable in their manner of spreading risk.

3. **Local Realities.** Finally, while the health care systems of all American states are basically similar in their general principles of operation, they differ considerably with respect to the specific manner in which those principles have been implemented. In spite of the growing importance of the federal government in all aspects of health care delivery and financing, most components of the health care system that we encounter on a daily basis continue to have their roots in local conditions and are most directly affected by legislative and regulatory decisions made at the state and local levels.

Given the significant variations in the manner in which each state has chosen to regulate its medical providers and its insur-

ance mechanisms, the local level has always presented a useful "laboratory" in which to test a wide assortment of approaches to the provision and financing of health care. This is especially true of the insurance world, traditionally within the sphere of state regulation and control.

It would certainly be imprudent to ignore the lessons learned locally, just as it would undoubtedly be rash to move too hastily to a single national financing system that might not meet the needs of each state or region. Attention to the state and local level will almost certainly allow us to avoid costly mistakes that will be difficult to correct on the larger terrain of the nation at large.

In order to explore these three points in greater detail and to see how they work in practice, it will be useful to turn to the experience of a single state--New York--in which the interplay of a substantial private insurance sector, a relatively successful attempt to spread risk widely, and a very distinctive state-implemented system of provider and insurer regulation offers important lessons for those engaged in reform of the health care financing system.

New York State has created what is possibly the most highly regulated health care system in the nation. In doing so it has consciously chosen to remove many aspects of health care from the unfettered operations of the pure market in the interest of creating an equitable system of provision of care accessible, at least in principle, to all residents of the state regardless of their health or employment status or their income level. It has thereby implicitly recognized that health care is a special kind

of "commodity," whose wide distribution is vital to the interests of all individuals as well as society at large and that ordinary market mechanisms, while quite efficient within their sphere, cannot by themselves accomplish the aim of universal distribution.

The state's major means of accomplishing this aim has been its support of, and creation of a true partnership with, voluntary institutions in both the provider and the financing spheres, in particular voluntary acute care hospitals and not-for-profit health insurers, most notably Blue Cross and Blue Shield companies. While the state's system is naturally complex and has many aims--including cost containment, the maintenance of hospital fiscal stability, and the assurance of services to all New Yorkers--we will concentrate here on its aims in the sphere of health care financing.

The major objective of the state with respect to its health care financing system is to ensure the widest possible sharing of risk in order to spread insurance as broadly as possible among the entire population. To accomplish this it basically relies on a number of private, not-for-profit insurance companies whose major purpose is not to create profits but precisely to provide insurance to as many New Yorkers as can afford it. The Blue Cross and Blue Shield Plans and those few other companies in this category offer insurance to all who apply on a year-round open-enrollment basis without regard to actual or projected health status. Not surprisingly, their pools contain the majority of those in poor health status or who are otherwise considered poor

insurance risks, and therefore incur significantly higher-than-average expenditures for medical care.

To offset these high expenditures, the not-for-profit insurers make use of several important risk-sharing mechanisms: community rating (through which those at highest risk--small groups and individuals--are placed in large pools that share risk broadly); cross-subsidies (mainly from surplus derived from operations in the larger and mid-size group markets); and the application of investment income to those lines of business least capable of supporting their own coverage at affordable rates. These devices ensure that individuals, small and large groups, the ill and the healthy, all share to some degree in the costs of the total system, thereby enabling a larger number of persons who would otherwise be without insurance to procure it at affordable rates.

Given the existence of numerous competitors in the insurance market, competitors who would, in the normal course of events, choose only the best risks and price their coverage at rates below the community rates charged by the Blue Cross and Blue Shield companies, thus undermining the ability of the community pools to spread risk widely, there must be additional offsetting factors built into the system. The state has, for example, not imposed premium taxes on the not-for-profit sector in an attempt to improve its competitive position. Its major effort in this respect, however, is the so-called hospital differential.

The hospital differential refers to a legislated rate level at which inpatient services are reimbursed by not-for-profit insurers that is lower than that at which their commercial com-

petitors pay. Not-for-profit insurers (as well as the state's Medicaid system) reimburse at cost-based rates, while all other insurers pay at rates above those levels. This payment differential recognizes the important social mission of the not-for-profit insurers in spreading insurance as widely as possible.

The differential in the amount paid for inpatient care allows the community pools of the not-for-profit sector to retain a larger proportion of good business and thus permits the insurers in this sector to spread risk--and therefore insurance itself--more widely. It also allows not-for-profit insurers to attract a larger share of the more profitable, larger groups, the operating surplus on whose business can then be used to cross-subsidize poorer risks. Finally, the differential in effect brings back into the wider risk-sharing pools, at least to some small extent, those better-risk groups that are either insured by commercial carriers or have become self-insured in order to avoid sharing risk with other members of society. It does this by forcing them to provide a larger proportion of hospital operating margins than would otherwise be the case and thus allowing hospitals to deliver more care to the medically indigent than they would normally be able to dispense. In addition, a small percentage is added to all hospital payments from private insurance coverage in order to enhance the hospitals' ability to absorb bad debt and charity care; here, too, the aim is to spread the costs of health care, in this case for the uninsured, as widely as possibly among the state's entire population.

When combined with a relatively generous state Medicaid

program and a highly regulated provider sector, New York State's financing system has historically been successful in providing access to health care for the vast majority of the citizens of New York and in spreading the costs of that health care as widely as possible among the entire population. It can teach us a great deal about how to ensure wide spreading of risk as well as the proper role of a not-for-profit insurance sector.

In spite of its achievements, however, New York State's system is scarcely ideal in its present form, and we can also learn a good deal from its problems. Above all, like all state and national financing systems, it is beset by problems of increasing costs for health services. While the state has one of the lowest rates of increase in the cost of hospital services in the nation, the rate of increases in its physician costs is among the highest. This is in large part due to the fact that it has been easier for the state to regulate the hospital sector rather than the far more diverse and complicated physician sector. Unfortunately it is in the latter sector that the largest proportion of health care costs in New York are now concentrated, in part due to the success of the state in restraining increases in hospital costs.

The inability of the state to address the non-hospital sectors adequately also means that while the costs of hospital care are widely and more or less equitably shared among the entire population, the costs of non-hospital care are not so shared to nearly the same extent. The state's Blue Cross and Blue Shield plans of course offer both hospital and major medical policies on an open-enrollment, community-rated basis, using the

same types of risk-sharing methodologies and cross-subsidization for both, but the means at their disposal are limited. They must utilize a payment differential that applies only to the hospital sphere to cover the medical sphere as well, with the result that the differential is too attenuated to be optimally effective.

Finally, and in some ways most importantly, the behavior of some participants in the financing system has not been controlled sufficiently to allow the system to operate at maximum efficiency. Rising costs and a stagnant market have led many commercial insurers to tighten their underwriting methods significantly and to intensify their competitive practices. They actively and aggressively seek to cover only the best risks (a category continually in process of narrower and narrower redefinition) and to avoid the poorer risks (a category in constant process of enlargement) through the redlining of "undesirable" geographic regions, the blacklisting of large numbers of industries, and the refusal to give insurance at all to those who are already ill or who are considered to be at greater risk for becoming so. By eschewing the poorer risks, commercial insurers can price their products at relatively low rates for the best risks and thus remove them from the Blue Cross and Blue Shield community pools. In doing so they undermine the ability of the latter to spread risk widely and to insure even the poorest risks, those with the worst health status. What from the point of view of the individual commercial company is a rational business practice is, from the point of view of society as a whole, an irrational practice that threatens to undermine the entire health care financing

system. Analogous processes are occurring in other states, as is well known, and are at the root of our current health care financing crisis.

In New York the inpatient hospital differential was intended to circumvent precisely this process. Unfortunately, it has been set at too low a level to remain a useful tool for this purpose. Its current legislated level is a mere 13%--only 11% if we take into account the 2% fast pay discount granted to commercials, which they appear to take in almost all circumstances--and, as we have noted, applies only to the hospital sector. In a world in which that sector accounts for only some 35% of total acute care costs, the differential really represents no more than a 4-5% advantage, an advantage easily overcome by competitors who insurer only low-risk groups.

As a consequence of all of these factors, New York's financing system is in obvious danger of becoming inadequate to its task. A solution to this threat is not, of course, difficult to find--it is implicit in the very methods by which the system accomplishes its goals. A substantial increase in the differential--expanded if possible to the non-hospital sector as well--coupled with the reform of the insurance market, especially for small groups and individuals, by eliminating the worst commercial insurer practices while reconstructing their pools on a community-rated, open-enrollment basis, would go far toward eliminating the immediate problem.

The wider lessons of both the successes and failings of New York's system are equally clear. They may be summarized as follows:

1. **Risk Sharing.** The widest possible sharing of the risk and consequent costs of illness must be part of any proposal meant to reform or replace the present health care financing system. This means that costs must be spread, to some degree at least, among *all* participants in the system, including individuals, small employer-sponsored groups, and large insured and self-insured employers. The larger experience-rated employer groups and those that have opted for self-insurance must be brought back within the overall system--as New York State has attempted to do to some degree--if universal health care coverage is to be achieved.

2. **Private Insurance.** Private insurers can make a significant contribution to a reformed health care financing system, but only, as we noted at the outset, if they are willing to spread insurance widely rather than contracting it in the interest of making a profit. This means that the insurance market must be significantly reformed and carefully regulated if it is to function appropriately.

3. **Role of Government.** While there are many possible roles for government in a reformed health care financing system, the experience of New York State as well as other cogent evidence suggests that the sphere in which government operates best is that of regulation of the market rather than the direct provision of services. Medicaid and other programs aimed at providing health care to the poor must be brought firmly within any reformed system. In the short run Medicaid should be expanded to deal with the near-poor, who cannot easily be covered by private

insurance as currently constituted. In the long run, methods must be found of reintegrating the poor and the near-poor within the private insurance system. A system of not-for-profit insurance funds of the sort already suggested should be able to do just that.

4. **Cost Containment.** Finally, no system will operate properly unless it contains effective cost containment measures. The widest spreading of the costs of ill health will be undermined if those costs become unacceptable and unbearable to our society. Rising costs have contributed to the aggressive competitive behavior of commercial insurers, to the attempts of larger employers to escape the system of wide risk sharing, and to the abandonment of insurance on the part of many of those in good health. Measures must be taken to ensure that a reformed system offers universal coverage at affordable cost, and such measures must begin to deal with the non-hospital sector in as thoroughgoing a manner as they have addressed the hospital sector.

Reforms of the sort suggested here will achieve the desired ends of universal, affordable coverage without large amounts of additional government spending and without massive intervention into the nation's economy of the sort that a fully governmental system would entail.

REPRESENTATIVE SCHEUER. Well, thank you for your very penetrating and thoughtful statement, which obviously comes after a great deal of hard thinking. I would like to have your suggestions for a reform of the health insurance industry. You referred to their predatory practices, and you referred to their tremendously competent efforts to engage in seeking out the young and healthy and defying every concept of insurance, which is to cover everybody, and let the different risks balance each other out. So, you have discussed the problem, and I would be very much interested in working with you to hear your view of how we can remove the predatory practices that you have discussed, or that you alluded to, and come down with a payment system that is lean and mean, competent and cost effective. If this can come through the health insurance company sector, so be it.

Maybe the approach should be to work with RFP's and get some real competition in the area. But I would like to hear your views. Do you have anything further?

MR. PADGUG. I think we would be happy to share those views at greater length, but at the moment I would stress there are two sides to this question.

One, are the practices I have called antisocial—and I really believe they are antisocial—of many companies, who are forced by their own competitive need to make profit, to use these means. Many of these have been redlining whole geographical areas that are unprofitable, and the things you have mentioned—carefully choosing only the young or the healthy and refusing to insure others, and some of the things we heard here today—groups being denied insurance because one or another member of their group is at higher risk for illness or is already ill—these things have to stop. That's the first side, to identify the full range of practices that we consider detrimental to the public welfare and prevent them from occurring.

The other side is a more positive side, however, and that is to—it's what I called nurturing the companies that, in fact, practice a different practice—provide insurance according to a different set of principles. As long as there is going to be competition between a for-profit and not-for-profit sector, the not-for-profit sector has to have certain offsetting conditions that allow it to continue to insure everybody who comes.

My company, for example, has insured more than 15,000 people—I am sure there are many more that we wouldn't be able to identify— who have AIDS, for example, and we are prepared to give insurance to people with AIDS and even after they have AIDS, but that's expensive. We must be able to offset that, and we can only offset that essentially if we have a sufficient number of healthy individuals and groups with fairly low utilization of health care so that we can spread that risk as widely as possible among the millions.

REPRESENTATIVE SCHEUER. That is the principle, absolutely, and it should be the principle underlying health insurance.

MR. PADGUG. And we would very much like to be able to continue to carry out that principle.

REPRESENTATIVE SCHEUER. Well, I would welcome the opportunity of picking your brains and learning more from you, Mr. Padgug, I have been fascinated by your testimony.

Let me just say to the three of you, this hearing never could have taken place ten years ago. I doubt if it could have taken place five years ago. The health industry, including the insurance industry, including the medical community, is showing, I think, more flexibility than most people give them credit for, and a hell of a lot more flexibility than I would have ever expected, certainly ten years ago and, perhaps, even five years ago. I think there is a lot of wisdom out there, and I think there is a lot of public spiritedness that is coming to the floor after all of these years that is really going to have an impact.

I think a whole new generation of doctors and leaders in the profession are going to change the way the medical profession thinks about these problems and makes them more relevant to the national process that we are all involved in, in seeking a universal comprehensive health-care system that is fair and equitable and doesn't egregiously exclude groups in our society. That makes us ashamed. I am ashamed as an American to have a health-care system that leaves over 10 percent of our kids in their most formative years beyond the reach of the health-care system. That is absolutely immoral. And I think there are real leaders in the health-care community that are concerned about the same thing that I am concerned about.

President Bush doesn't seem to be concerned about it. Dr. Sullivan doesn't seem to be concerned about it. But there are a lot of thoughtful people in the health-care community who are concerned about it, and I think this panel of health-care professionals tells worlds about what is going on out there in the field.

I would like to write a piece for the *New York Times* on the significance of what the three of you have had to say. This isn't the labor panel; this isn't a consumer panel; this isn't a panel of of tragically afflicted individuals who have been victims of the system—the small percent of the people who did fall through the cracks in very tragic ways—this is a centrist, mainstream panel representing the health-care community. To me, it is very exciting that you are showing the sensitivity that you have about the problems that real people feel out there, and that you are showing the enlightened, creative and thoughtful approach that you have. I think it offers great hope for the American people in their desperate search for something better than what they have now in terms of access to a universal and a comprehensive health-care system. And I can't think of a better way to close this hearing than having heard the three of you.

It fills me with great hope and great confidence that we are going to achieve a consensus out there involving the leadership of the health-care community, which is going to really help Congress craft a bill in a

consensus process, not in a confrontational process, that is going to meet the needs of the American people.

We know that confrontation really doesn't work very well. Just look at our history of confrontation in health care over the years. I hope it has passed, and I'm confident it has passed with the AMA having the reputation of adamant opposition to any change that might conceivably threaten the interest of their doctors. They are moving away from that, and it is very exciting. Of course, they want to protect the medical profession—we all do. We have, for the people who have access to it, the finest health-care community in the world. We all want to protect the integrity of the doctors, but I see a whole new openness on the part of the American Medical Association, on the part of all the groups, to think things through in the context of the realities out there, in the context of the problems that have arisen, in the context of an American people who really, urgently demand something better than what they have.

This has been a wonderful closing of today's hearing and a wonderful thirteenth hearing in our series of hearings. I don't want people to be misled by the number 13. I don't think it is unlucky at all. Thank God it isn't Friday; it's Monday, but it has been a very helpful, really an inspirational hearing, and I'm terribly grateful to the three of you and I hope that we will be in close contact from now on.

I have two announcements to make. After the hearing began, additional testimony of witnesses who appeared on the second, third, and fourth panel have been placed in the rear of the auditorium. I hope you will all feel free to take copies of the outstanding testimony that we have heard today. That's announcement number one.

Announcement number two. On January 14, the Congress is organizing a national Town Hall Meeting on Health Care, and these meetings will be held in individual districts. They are going to be coordinated by satellite from a hearing in Washington D.C. We will be having a hearing that I will chair at the Great Neck South Middle School on Lakeville Road in Great Neck at 6:30 p.m. on Tuesday, January 14. I invite any of you who are interested to attend.

Also, I wish to thank Carol Hauptman, from our host institution, North Shore University Hospital. She gave us tremendous assistance and helped in arranging this hearing. Ms. Hauptman, we are very grateful to you for your wonderful support.

We will leave the hearing record open for additional submissions.

[The prepared statement of Jean Christie, President, Reform Democractic Association of Great Neck, was subsequently submitted for the record:]

At this point, the meeting is adjourned at the call of the chair.

[Whereupon, at 2:00 p.m., the Committee adjourned, subject to the call of the Chair.]

PREPARED STATEMENT OF JEAN CHRISTIE

The Reform Democratic Association of Great Neck, the largest Democratic Club in Nassau County, New York, has long advocated "a genuine national health care program affording quality care, with efficient delivery and cost within the means of every American." Health care is not a privilege; it is a right of every person. We are pleased that Congressman James Scheuer and the Joint Economic Committee are holding these hearings, which will call attention to the increasingly urgent problems of health care in America and to possible ways to remedy the present disgraceful situation.

Today, wastefulness and inequity prevail. Individual out-of-pocket payments to providers, private insurance, employer-connected benefits, governmental programs for selected elements of the population, require consuming paperwork and yet leave millions with partial protection or with none. Among all the statistics, perhaps the most shameful is the infant mortality rate, highest of all industrialized countries; here in Nassau County, the rate in minority communities is over 30 per 1,000 births, a Third World rate. And yet the U.S. expenditure of almost 12% of the Gross National Product is the highest of the industrialized world. Only thoroughgoing reorganization can bring us a just and efficient health care system.

(continued)

. . . Statement by Jean Christie. . . continued:

In choosing among the various proposals currently set forth, the Congress should bear in mind certain basic principles.

To eliminate confusion and inequality and huge administrative costs, a single payer system is essential. The current multiplicity of policies and programs necessitates enormous waste of time and money as patients, physicians and hospitals fill out forms and process claims. Deductibles and copayments burden the patient and add to clerical work. Some proposals to mandate insurance coverage for various classifications of the population would add further layers and restrictions. Rather than complicate procedures, we should provide for one single payer for all health care. Government, clearly, must fulfill this duty.

To obviate the present partial and often capricious coverage, any plan should take in all health needs, including long-term care, preventive measures and prescription medications. It should, moreover, be universal in scope, covering all persons regardless of employment, age or financial condition. Rationing which sets a lower standard for the poor, thus establishing by law a two-tier system of medical care, is unacceptable. "Managed care" that restricts patients to a particular list of physicians is also undesirable; liberty to choose providers must be assured.

Several proposals before the Congress are based on these principles. The hearings by the Joint Committee will do much to stimulate both public discussion and consideration by Congress and, we hope, eventually to bring about legislation that will establish an equitable and effective system of health care for the people of the United States of America.

O