H.R. 3222, THE MANAGED COMPETITION ACT OF 1993

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 3, 1994

Serial No. 103–88

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H.R. 3222, THE MANAGED COMPETITION ACT OF 1993

THURSDAY, MARCH 3, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The committee met, pursuant to call, at 9:15 a.m., Room 2175, Rayburn House Office Building, Hon. William D. Ford, Chairman, presiding.

Members present: Representatives Ford, Williams, Martinez, Owens, Sawyer, Roemer, Becerra, Scott, Green, Romero-Barcelo, English, Goodling, Petri, Roukema, Gunderson, Armey, Fawell, Ballenger, Hoekstra, McKeon, Miller, and Castle.

Staff present: David Michaels, Alan Lopatin, Becky Franck, Karen Vagley, Phyllis Borzi, Apurva Desai, Ed Gilroy, Patrick Beers, and Russ Mueller.

Chairman FORD. Good morning. The committee meets today to take views on a prominent alternative to the President's health care reform bill. Congressmen Jim Cooper and Fred Grandy have sponsored H.R. 3222, the Managed Competition Act.

As my colleagues know, I am with a majority of the Democrats on this committee, cosponsors of the President's bill because we believe it is essential that the reform plan we adopt must provide for universal coverage. Only a system that covers all Americans can eliminate cost shifting and ensure that every one of us pays their fair share of the health care tab.

Frankly, the Cooper bill, from my first examination of it, struck a remarkable chord with me of similarity to my L. L. Bean catalog which I receive every year. With the L. L. Bean catalog, I have universal access to warm clothes, hunting equipment, boots and a lot of good things that I buy from time to time. But until I whip out my credit card and call the 800 number, I don't have coverage by any of those warm things. And the thing that is missing from the Cooper bill is the credit card.

Promising universal access has a nice ring to it, but I looked for it and couldn't find it anywhere, and I talked with my friends in the health insurance business, and even though they are very nervous about the President's plan, they couldn't find it either.

H.R. 3222 relies on Regional Health Plan Purchasing Cooperatives to cover a limited pool of Americans: workers in businesses employing no more than 100 people, those now covered by Medicaid and people with chronic illnesses. These are people with no better alternative and the bill would segregate them from the more fortunate among us: the unhealthy from the healthy, the high cost pa-

tients from the low cost, the have-nots from the haves, and the likely result would be continuing cost shifting, higher cost and fewer choices for an increasing proportion of American workers.

I look forward to our witnesses' presentation this morning, and recognize Mr. Goodling.

Mr. GOODLING. Thank you, Mr. Chairman. I am not sure they want to testify after that opening statement.

At any rate, I just had 14 town meetings, 7 senior meetings and 7 regular town meetings, and with the hundreds of people that attended, I had one gentleman in Carlisle who wants the President plan and one woman in Fairfield who wants the President's plan, and all the other hundreds don't want anything to do with the President's plan. They hissed those two people out of the room.

So at any rate, I thank you, Mr. Chairman, for holding this second in a series of hearings on alternative health care proposals to the President's Health Security Act.

I want to recognize the efforts that both Representatives Cooper and Grandy have put into developing an alternative to the President's health care reform plan. I welcome both congressmen to our committee this morning, and extend a special greeting to Representative Grandy, who is a former member of our Committee on Education and Labor.

Congressman Fred, having cut your teeth, so to speak, on ERISA under our committee's jurisdiction, we are relying on you to pass along your knowledge of employer plans and other important ERISA principles as your own committee proceeds to a markup of health care legislation.

In fact, it is my understanding that your Subcommittee on Health will soon consider a legislative beginning point that differs markedly from the President's plan. I suppose this comes about because of the concerns that many people have, the fears that many of them have from the disruption of their current health coverage.

I understand that the Cooper-Grandy approach does not include the premium and price controls contained in H.R. 3600. However, I look forward to hearing what features are included in H.R. 3222 which will address the problems many of our citizens have in obtaining and continuing health insurance coverage.

My own constituents have said their main concerns involve job-lock, eliminating preexisting conditions exclusions, obtaining more affordable health care rates, and so forth. As you know, these problems have also been addressed in the Affordable Health Care Act, H.R. 3080, of which I am a cosponsor.

Mr. Chairman, it is my hope that these hearings will help us focus on the common elements of agreement among the various plans such as cost containment, preexisting conditions, affordability, malpractice reform, reduction in paperwork. These are things that every plan, I believe, addresses, and these are things that all of my constituents seem to think are the areas that we should address.

So, I look forward to hearing from our colleagues and the other witnesses this morning.

Chairman FORD. The gentleman from Virginia?

Mr. SCOTT. Thank you, Mr. Chairman. I sincerely applaud your leadership in facilitating a comprehensive examination of the many proposals to effect change in our health care system.

Last month, we heard the debate on the American Health Security Act. Today, we are examining Mr. Cooper's plan, and later I understand there will be hearings on other major proposals. And of course, we have heard from many of the architects of the President's plan including the First Lady, Secretary Shalala and Secretary Reich.

I believe that it is critical that we spend whatever time is necessary to thoroughly examine all of the options to determine which one is best—which ones best meet the needs of our citizens. In my mind, the gaps in our current system are very clear.

I believe that it is unconscionable that in this the wealthiest and most powerful of all Nations too many of our citizens are unable to get the health care that they need. They either lack the insurance or the funds. And furthermore, I believe that it is indefensible that our health care system is still geared more to medical care once a problem has developed than to preventive care that will lead to a healthier citizenry.

Many health care plans cover bypass surgery, but they don't cover basic physicals or mammograms. So I believe that it is inexcusable that although we pay more per capita on health care than any other industrialized nation that we still trail other countries in our ability to immunize our children, and our infant mortality rates are, regrettably, still behind many other nations. I believe that a comprehensive health care reform package that can address these deficiencies is in our best interest.

Mr. Chairman, I believe that the single-payer plan and the President's plan actually provide comprehensive benefits, including preventive care and universal coverage that cannot be taken away. I am anxious to hear how Mr. Cooper and the other witnesses address these concerns with H.R. 3222, and I look forward to their testimony.

And again, Mr. Chairman, I want to congratulate you on your leadership on this issue.

Chairman FORD. Thank you.

Madge?

Mrs. ROUKEMA. Yes.

Chairman FORD. Mrs. Roukema?

Mrs. ROUKEMA. Thank you, Mr. Chairman. I want to welcome our witnesses here today and note that this is one of an extensive number of hearings we have held both at the full committee level as well as the Labor-Management Relations Subcommittee, where we have had field hearings as well as hearings here in Washington.

And during those hearings I think a number of you have heard me say in the past that it seems to me that everyone likes to talk about managed competition, but that there are as many different definitions of it as there are proponents, it seems to me.

It is especially timely at this point to remember that because as Congress has become more versed on the subject of health care reform and managed competition the American public is still significantly behind the learning curve and probably has demonstrated

more confusion on the subject, and they have more unanswered questions than ever before.

Support for health care reform may remain steady, but as the public learns the details and the real impact of many different plans, including your own, Mr. Cooper, and Mr. Grandy, their support for such radical overhaul drops off precipitously.

The Cooper bill has been called everything from pure managed competition to "Clinton Lite." I am hopeful that this morning will serve as an education for all the members of the committee here as to what we really mean by your definition of managed competition.

For example, one provision that certainly seems to be the linchpin or the litmus test for the Cooper proposal is the caps on tax preferences for health care benefits. Eliminating tax preferences, frankly, deeply troubles me. It would seem to me that we would be unwise to even tamper with the traditional tax preferences accorded health care benefits.

Under these proposals not only my constituents but 80 percent of the American public who currently enjoy good health care and insurance would be greatly disadvantaged. Many of the employees who currently receive extensive high-quality coverage will now see their tax deductions limited or eliminated or have their health care benefits taxed as income.

The impact of this to me is clear. The Federal Government would be sanctioning, if not actively encouraging, employers to cut back on the health care benefits they now provide. Once this is fully understood by the American people, I can confidently say that they will not accept such a proposition. Indeed, I think the poll released by the Washington Post yesterday indicated that.

Higher coverage for lower levels of care are not what the American people had in mind when they called for health care reform.

I have other questions regarding what managed care might mean when cost controls equate to rationing in specific terms, but I will keep them for the questioning period, Mr. Chairman. In any case, I think there have to be voices out there that go beyond just the characterization of Cadillac plans to actually talking about what is the quality of care that Americans will be enjoying under any health care reform.

Thank you, Mr. Chairman.

Chairman FORD. Thank you.

Without objection, the prepared statements of the people on the panel will be inserted in the record in full before the comments start. But I will continue taking opening statements as long as there are requests.

Governor?

Mr. ROMERO-BARCELO. Thank you very much, Mr. Chairman. I want to congratulate you on your interest and the efforts that this committee has done in trying to give everyone an opportunity to set forth their plans and their ideas of what the health care reform should be.

We also would like to acknowledge the job that Subcommittee Chairman Pat Williams has done and the number of hearings he has held in as far away places as Montana, California, and Hawaii

to discuss the health care reform plans and listen to the different options.

I myself also do favor the President's plan. I have subscribed also to the single-payer because the President's plan allows States to submit to the single-payer system if they so choose, so there is the option for the States for the single-payer.

I would like to be listening more about the Cooper plan, and I would like to have the opportunity today to just say some of the concerns I have had. One of the problems that we have seen with the insurer, insurance and the health care is that the insurers have found ways to discriminate against people and that way save the cost of their plan. The way they discriminate is by not insuring the poor health risks.

Whether this bill does enough to address those issues, I am not so sure. It seems that it falls short of the Clinton plan in addressing those issues.

And people with disabilities would be not as protected under this bill as they would under the Clinton bill. But I hope that today these issues will be discussed and perhaps my misgivings are misinformation, but so far this is the impression I get from the information that I have and the reading of the bill as far as I know now.

So, I look forward to listening to all of you. I congratulate you also on the interest that you have taken in coming forth with some plan. We do know that what we have is not what we need and that many injustices exist. Particularly people who lose their jobs, people who change jobs, people who have great difficulties with or problems with their health, and would then lose all of their savings in that interim of changing jobs or when they are unemployed or because of the health conditions they are not able to get insurance, they will lose perhaps everything that they have if someone in their family has a serious illness or that illness becomes serious and expenses become very high.

So, welcome here once again, and we look forward to hearing from you.

Chairman FORD. Mr. Gunderson?

Mr. GUNDERSON. Thank you, Mr. Chairman. And let me join my colleagues in thanking you for holding this hearing. It is obvious that this hearing is being held because you are willing to hear all sides, not because you are advocating a particular philosophy such as the bill in front of us, based on your opening comments.

But, Mr. Chairman, I want to suggest to you, and I want to suggest to Mrs. Roukema, and I want to suggest to the audience that the comments from the two of you indicate I think more clearly than ever that the Congress is at a critical point where we have got to decide do we want a political issue or do we want a bipartisan solution to the health care crisis that faces this country. That is why I think I was one of four Republicans who joined with four Democrats, Mr. Cooper being the leader, and Mr. Grandy being the leader on our side, to try to develop the only bipartisan solution that is out there today for consideration in either the House or Senate, and I think that that is the only hope we have of serving the public's general interest about resolving the desire to solve the health care problem amidst the budget crisis that faces us.

Mr. Chairman, it is in that regard, however, that I must as a member of this committee plead with you that in the future the staff of this committee does not send out the very biased and unobjective analysis of bills that they have sent to every member as their preconceived opinion of what H.R. 3222 does, because it is obvious that some of their notions are based on previous legislation, not H.R. 3222, and it is obvious that some of it is simply based on a desire to try to misrepresent this bill in hopes of defending a Clinton package.

I would point out to my colleagues that have looked at that summary that you can literally go down every point and suggest that the perception here does not meet the reality of the legislation. But I don't know of anyplace where that is more grossly obvious than in the section of older Americans where the staff have had the gall to suggest that older Americans would face higher Medicare premiums and a $40 billion cut in Medicare expenditures under this legislation.

I find that hard to believe when you have the President suggesting that he is going to fund the Clinton health care plan with $130 billion in cuts in Medicare, and then someone who is advocating that has the gall to suggest that somehow or another we are insensitive to senior citizens because rather than $130 billion we only make $40 billion in savings in Medicare.

Likewise, I would suggest, as one who has been a strong advocate for people with disabilities, to suggest that they would somehow see their medical cost rise dramatically under the Cooper-Grandy bill is proof that those individuals haven't read the legislation because this bill is absolutely premised on the condition that all people regardless of preexisting physical condition would be included, and if there is one group who stands to benefit significantly from this kind of legislation, which is aimed at getting passed, it is those very kind of communities.

I could go on at length with literally every point that is here, but I am one who traditionally hesitates from opening statements, Mr. Chairman. But I felt it incumbent to provide to the committee members and to others in attendance here today the gross inaccuracies of this kind of distortion which serves no one who is interested in truly resolving some kind of bipartisan solution to this crisis.

Thank you.

Chairman FORD. Well, I am disappointed in your disappointment in the ability of the professional staff of this committee to get it right because I am fighting with some people who don't want me to perfect that amendment for you yesterday, and the very people you are criticizing are trying to figure out how to take on the entire labor movement for a Gunderson amendment.

Mr. GUNDERSON. Mr. Chairman, that is why I commended you for holding the hearing and picked on the staff instead.

[Laughter.]

Chairman FORD. Well, you know it is a shot across the bow, Steve. I don't comment on the quality of the work of the Republican staff. This is one of the few committees in the House that lets both sides hire their own people and accept the responsibility. I will accept the responsibility for the qualifications and the ability of the

Democratic staff, and you accept the responsibility with Bill Goodling for the Republicans, and we will both consider where it comes from when various things go out from this committee. But don't try to intimidate my staff into not putting out statements that they clear with me.

Mr. FAWELL. Mr. Chairman?

Chairman FORD. Do we have any other requests on this side? Mr. Fawell?

Mr. FAWELL. Just very briefly. I want congratulate Mr. Cooper and Mr. Grandy. My district office tells me that we have had about 1,200 communications indicating that the Clinton plan is unacceptable and about 48 indicating it is acceptable.

Therefore I think to have an alternative out there, and especially one which is bipartisan in nature, is very helpful. I have looked at the Cooper plan, but I am not an expert, by any means, and I look forward to the opportunity of hearing from people who are living and dying with it. It is good to have those alternatives out there.

There are others, too. I laud the Chairman for having a hearing like this, and I hope that we can review the other measures which are out there also.

I do note that the Cooper plan does not mandate regional alliances, except in one instance, the small business people, and it doesn't appear to be the mandated price controls and employer mandate. So, it peaks my interest and I have some very positive feelings about it, and therefore look forward to the testimony.

Thank you, Mr. Chairman.

Chairman FORD. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman. I have no prepared remarks but I would just like to address some of the concerns that I have heard from my own district concerning all the plans. And I have not agreed to vote or cosponsor any of the proposals.

One of the concerns about the managed care plan, H.R. 3222, is the issue of the universal coverage and how you address the low wage worker whose employer does not provide health care coverage now, and also prescription medication for seniors that the President's plan provides for and some type of long-term care.

And I know this plan, the one we are having the hearing on today, has been characterized as a continuation of our current system, because having been a manager of a business we went through a managed care plan. We went from a typical health care insurance policy to a PPO and ultimately to an HMO, and without that significant reduction, except in the increases in our premiums from instead of 30 percent a year we saw the increases only going to 20 percent. And that was even tough on a small business. So that is the concern.

I would hope the testimony we have today would reflect how we can get that coverage to that worker who is what we call the low wage worker whose employer cannot provide it now because of the cost, and that is one of the concerns I have about this plan.

Thank you, Mr. Chairman.

Chairman FORD. Mr. Petri.

Mr. PETRI. Thank you, Mr. Chairman.

I would just like to commend all of our colleagues who are before us here today for the time and effort they have put in and attempt-

ing to provide some leadership, and I think that all their work is worthwhile. Because while their plans differ in various aspects, those differences help us to try to understand some of the trade-offs and some of the issues that are involved. It is hard enough to figure out a comprehensive reform of health care without having different options highlighted as is being done by the different plans that are before us.

I particularly want to thank our colleague and member of the other party, Jim Cooper, for the tremendous effort that he has put forward in bringing these options to our attention and to the attention of the American people.

I hope by the time we finish in this Congress we don't degenerate into finger pointing, but we do go through these different plans try to find out, if we can't agree on everything, what we can agree on, and do something this Congress that moves this forward at least a bit.

I think the American people expect that of us, and I think we can do it, because there are similar features in most of these plans. And let's not make the perfect, as we can't agree on the perfect, the enemy of the good. Let's do something for our country this Congress.

Thank you.

Chairman FORD. Mr. Williams?

Mr. WILLIAMS. Thank you, Mr. Chairman.

Mr. Cooper and my colleagues, I chair the subcommittee of this committee that has been having hearings and going to markup, along with the full committee, legislation. So we have spent a lot of time looking at the various proposals that are before us. Mr. Cooper, I want to commend you for adding significantly to the dialogue, discussion and debate that we have all been part of during the past couple of years.

I find things to change in every piece of legislation that is before us, including, of course, yours. But despite some of the controversy that has gone on in the past, particularly those portions which have been highlighted by the press which seem to enhance and sometimes create the debate between Mr. Cooper personally and the White House, despite that, which I think is more a figment of press reporting than it is the reality of which I am aware, despite that, I do think that Mr. Cooper has added value to this debate.

And I appreciate that you, Jim, as well as your colleagues, have come here to explain your legislation.

Thank you very much.

Chairman FORD. Are there further—Mr. Miller?

Mr. MILLER of Florida. Thank you, Mr. Chairman. Your analogy about using L. L. Bean makes me think about what a pleasure it is to have a choice where to buy my clothes. I am not sure under the health care system we'll have that kind of choice. I feel like L. L. Bean is saying everybody has to get their sweaters from that one source. I would rather be able to choose from the Land's End catalog, or as a kid going to jail, Hudson's, if it still exists up there. And I like the flexibility that we have in this country.

I also want to make a few comments, if I may. I am one of the core sponsors of the Cooper-Grandy bill, and I am very pleased about that because it is a real bipartisan approach to health care.

I feel very strongly it should be bipartisan. I also served on the task force with Mr. Grandy and several Republican members of this committee. We developed the Michel bill, which has the largest number of cosponsors. Unfortunately, there are no Democrats, and yet it turns out to be a partisan bill also.

Working on the task force and having had an opportunity to meet with Mr. Magaziner and Mrs. Clinton and the President on a number of occasions, they really conveyed the feeling that we should have a bipartisan approach to health care, and I think we all should have.

I was, unfortunately, very disappointed last September when the President presented his bill. It is so complex and so bureaucratic with the alliances, the mandatory programs and global caps that it was impossible for a Republican or on the Senate side to accept it. So it became a very partisan issue, and that is unfortunate.

What I like about the Cooper bill is that it does add flexibility. It is not all mandatory. It has a real strong malpractice program, it takes care of the problems of the low income, and it pays for it by capping the tax deductibility of health insurance.

While I am a sponsor of the bill, I have some concerns. I just want to briefly make those comments so that maybe you can address them. My concerns are several.

First, I don't like the mandatory nature of the alliances. Florida, as we know, started a program of managed competition, it is a voluntary system, and under the Cooper-Grandy bill there is up to 100 employees. I am a big believer that the States are the laboratory, and you let the States try out systems before applying them nationwide, especially if they are mandatory. I am anxious to see how the Florida Chipper system develops over this next year or so. So I still have a concern that we apply it nationwide. So that is one of my concerns.

Another of my concerns is the issue of long-term care, and there are several supporters of the Cooper-Grandy bill from Florida and several on the Republican side that support it. Under the Cooper-Grandy bill long-term care is shifted to the States.

We have a disproportionately high number of senior citizens in Florida, and my district has the largest number of senior citizens in the country. And I am concerned about the financial impact on our State on the long-term care, and I know we are working on that with Mr. Peterson, to come up with a solution to that.

A third concern I have is the alliances. We shift not only small business but the Medicaid population to think about. And the question is, is it going to raise the cost of insurance for small business by putting Medicaid and small business in the same pool? Hopefully, it doesn't and it will lower the cost, which is the goal, of course.

I agree with many of the concepts of Cooper-Grandy. I am very pleased with it. As several business groups said during the past month, this is a good starting point, unlike starting with the President's plan. I think it is much better to start with this plan.

I would like to see the plan shift to the right. I think some people on the other side of the aisle would like to shift the plan to the left, but it is a good plan to start. So, I congratulate you for putting the plan together, and especially the bipartisan aspect.

Thank you.

[The prepared statement of Mr. Miller follows:]

STATEMENT OF HON. DAN MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you Mr. Chairman. As a cosponsor of the Cooper-Grandy bill I welcome my colleagues to the committee and look forward to hearing their testimony. I believe health care reform must proceed on a bipartisan basis and I was extremely disappointed when President Clinton introduced a big-government plan that the White House had to know Republicans could not support. On the other hand, my colleagues here today worked in the true spirit of bipartisanship and developed a comprehensive plan that addresses many of the concerns Americans have expressed about the health care system.

There are many positive aspects of the Cooper-Grandy proposal. For example, the bill makes insurance portable and ends preexisting conditions practices. The bill provides assistance for low-income workers and contains real malpractice reforms that will help control the costs of health care. Additionally, the bill does not include costly employer mandates that would destroy jobs. The bill rejects the idea of global budgets and premium caps—and thereby avoids government-rationed health care.

At the same time, I do have concerns about several aspects of the bill as it is currently drafted. First, I do not believe a mandatory alliance structure is the way to go. My State of Florida has recently passed a major health care reform plan that has incorporated many aspects of the managed competition concept. But the Florida purchasing cooperatives—we call them CHPAs—are voluntary. I would prefer to see how these CHPAs operate before we force every small employer in the country into mandatory alliances. Next, as currently drafted, the Cooper-Grandy bill places all of the burden on the States to pay for long-term care. I represent a district with the second oldest population in the country. Quite frankly, I am worried about placing the entire financial burden for long-term care on the States. I know many of the cosponsors share this concern and are attempting to work something out.

One final concern is whether placing the entire Medicaid population into the mandatory alliances with the small business community is the right way to go. The concern I have is whether or not this would actually raise premiums for small businesses.

Mr. Chairman, let me just conclude by reiterating what several business groups have recently stated. The Clinton bill is far too complex and regulatory to be used as a starting point for health care reform. There is no reason and no excuse to proceed with a bill Republicans cannot support. Cooper-Grandy is a good, bipartisan place to start and let's proceed with the debate on that basis.

Chairman FORD. Mr. Roemer?

Mr. ROEMER. Thank you, Mr. Chairman.

I would like to extend a warm welcome to Jim Cooper and my colleagues who are testifying before us here at the Education and Labor Committee. I personally look forward to what you have to say and your comments and expertise in addition to solving what I think is a big problem in America today, our health care system.

I also want to say that I think President Clinton deserves a great deal of praise for what he has done in bringing the debate as far as he has and introducing this legislation and taking a great deal of criticism especially from radio and TV ads across the country, his being the most visible plan out there at this point.

And I am anxious to see, in terms of the President's very, very strong commitment to giving the poor and the indigent accessibility, portability, cost containment, to simplifying the bureaucracy, where we go with the Cooper plan in either adding to the President's very, very worthwhile and lofty goals or attempting to improve on what the President has even said is not a perfect plan.

I would like to welcome my good friend from Indiana as well too, Jill Long, for her testimony here today, and look forward to especially the colleagues in my class, Pete Peterson and Jim Moran and what they have to say.

I think you all have heard enough opening statements from us, we are anxious to hear from you and from the other good panels here today.

Thank you, Mr. Chairman.

Chairman FORD. Governor Castle.

Mr. CASTLE. Well, thank you very much, Mr. Chairman, and thank you for conducting these hearings. And I thank all the people for being here. The good news is I am the lowest ranked member of this committee, you should be testifying pretty soon.

[Laughter.]

Mr. CASTLE. But I would just like to take a minute or two, if I could, just to show you a couple of thoughts that I have.

I think we all—I know we all agree that the health care of Americans is more important than the politics of health care, what plan gets adopted here or whatever it may be. And I got to tell you, as one who has been involved in health care for a number of years at the State level, and also helped with the Michel plan here, that I am becoming increasingly concerned with this rush to judgment, that we need to have any one of these particular plans be the plan which passes in the Congress.

This affects all of us because we all have health concerns. It affects some 14 percent of the economy, I understand. It affects, I guess, about one out of seven or eight people who have jobs that relate to—who have jobs in country which do happen to relate to health care.

It is just a huge issue, and I am very concerned that the 535 of us down here in the Capitol building don't have all the wisdom in the world when it comes to health care. And I just hope that we can put our politics aside and try to reach whatever is a right answer.

And the more I look at it the more I think, and Mr. Petri alluded to this, the more I think perhaps we should do those things we agree upon this year, and agree that we will continue to look at it, and particularly agree to give flexibility to the States.

Your very States which are represented here are in some instances looking at universal health care plans and other things which are very interesting. And I know that in our little State of Delaware that we provided universal health care for children, started to do the things that need to be done. Perhaps this does not lend itself to a congressional solution all at once.

Having said that, it seems to me that you can really boil everything down to the question of universal coverage or cost, when you really look at it. And the cost, there is a million ways to adjust the cost, and I think managed competition does it as well as any other plan out there.

My concern is in this whole question of the universal coverage versus universal access or whatever, and I think the President makes his strongest point when he holds up that card and says, "This means everybody in America will have health care," although I don't think it quite means that for a variety of reasons.

But I would be very interested in your approach, from any of you, with respect to the issue of access to health care. I think there are a lot of underserved people. They get health care but they get it at the emergency rooms, as we all know.

I am not sure that Medicaid does all it can do to help people with health care. There is 15 percent of the population that doesn't have any access, except the emergency room, the tertiary care instead of the primary care that we would like to see them have, the preventative care, the things that go on that would make health care better for them.

On the other hand, you and some of the other plans talk about expanding some of the different concepts that help in this area, the clinics, the Medicaid plans that exist, or in your case merging the Medicaid plans into something else. I would be very interested in numbers and how we are chipping away at that not-served or very underserved population, because I think all these plans end up being a little bit closer than we understand and we tend to categorize them as either giving universal access or universal coverage and there seems to be nothing in between.

I think when you really analyze them it gets down to a much lesser percentage. So when you are testifying, not just today but in the future, and we are looking at this, I think we all have a responsibility to really understand who is going to receive coverage in this country and exactly what the extent of that coverage is, and I would appreciate your comments on that in the future.

Thank you.

Chairman FORD. Thank you. Mr. Castle, did I understand you to say that you are one of the architects of the Michel plan?

Mr. CASTLE. I am, sir.

Chairman FORD. The committee had scheduled a hearing at the request of the Republicans to hear about the Michel plan on Monday morning. I changed everything around so that I could be here at 10 o'clock on Monday morning and was then informed late Friday night that there was no witness available on Monday to speak for the Michel plan. Committee staff was instructed to try to reschedule it if there is any time left to this committee in this session of Congress. Could you give us a little help to get somebody to come up and explain it to us?

Mr. CASTLE. I was unaware of the problem. We want health care plans to work every day of the week, and I will do everything in my power, if we can get a rescheduling date, to make sure that we have the proper witnesses here. I happen to believe it is a plan that is not getting attention which should get attention.

Chairman FORD. The staff says that they are waiting for word from on high over here to reschedule Mr. Michel.

Mr. CASTLE. Well, you see, I am not on high. But I will try to help out with it because I can, sir.

Mrs. ROUKEMA. Will the gentleman yield?

Mr. Chairman, thank you. I do want my Republican colleagues as well as my colleagues on the other end of the aisle here to know that you and I spoke about this issue yesterday. I too was concerned after having changed my—made my arrangements to be here—and Mr. Goodling as well, I might add—as to why it had not happened.

I will pledge to you that as I have already contacted our House leadership since our conversation, I want our Republican members to know that we are in the process of trying to arrange that, and

I appreciate the fact that the Chairman is very willing to be flexible in terms of the scheduling arrangements.

But I think it is important for us to get Mr. Michel or someone representing the Michel proposal here, and I will work with Mr. Castle on that.

Chairman FORD. Thank you.

Mr. Sawyer?

Mr. SAWYER. Mr. Chairman, I would like to associate myself with the comments of the gentleman from Indiana who said we didn't need any more opening statements.

Chairman FORD. Thank you.

[The prepared statements of Mr. Owens follows:]

STATEMENT OF HON. MAJOR R. OWENS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

The bill which this committee considers today, H.R. 3222, is an *attempt* to expand access to health insurance. Unfortunately, thebill does not expand access in a meaningful or equitable way.

I have said it before in this committee room and I will say it again—the yardstick by which every health care reform plan must be measured is universal affordability. The guarantee of a standard benefits package is meaningless unless every American can afford to purchase health insurance which will provide coverage for the standard benefits package. Guaranteeing access to health insurance is not the same thing as guaranteeing that everyone will be able to afford health insurance. And if everyone cannot afford health insurance, then true universal coverage cannot be achieved. Neither H.R. 3222 nor the President's plan measure up to the yardstick of universal affordability. Only the single-payer bill [H.R. 1200] does.

H.R. 3222 benefits the private health insurance industry at the expense of many low-wage and middle-class families. The insurance industry would cash-in on the increase in the number of uninsured people and Medicaid recipients buying health insurance. Insurance carriers selectively selling to small, healthy groups also would flourish outside the confines of Health Plan Purchasing Cooperatives.

Meanwhile, currently insured middle-class families would face higher costs and shrinking health care choices. H.R. 3222 would tax as income the value of any health insurance plan an employee receives from his or her employer which exceeds the cost of the lowest cost plan. Therefore, every worker who currently is not enrolled in the lowest cost plan would pay new income taxes on the value of benefits received above the level provided by the lowest cost plan. Moreover, every worker would have to continue to pay various insurance premiums, copayments, and deductibles.

As for low-income families who currently do not have any health insurance, H.R. 3222 may not represent an improvement. Many of these families would be unable to afford copayments or deductibles, not to mention the premiums, even after being paid a government subsidy.

Three elements of H.R. 3222 also have the potential to inflict tremendous harm on individuals with disabilities. First, long-term care and prescription drugs are among the benefits most needed by individuals with disabilities. They are expensive and thus unlikely to be included as part of the cheapest health plan available. The result would be that individuals with disabilities would have to pay for these services out-of-pocket without taking any tax deductions. Second, the bill would allow for preexisting condition exclusion periods for up to six months. For an individual with a disability, that would mean the difference between life and death. Third, the bill would shift the cost of long-term care, now covered by Medicaid, to the States. However, the bill would not require States to offer long-term care to individuals with disabilities. As Chairman of the Subcommittee on Select Education and Civil Rights, which has jurisdiction over disability policy, I find these three characteristics of the bill to be deplorable.

This bill is a consumer's nightmare. It also amounts to a tax increase for which the middle class would have to pay dearly. I do not think that the citizens of this country are prepared to pay so much for so little in return. If a health care reform package does not include an unequivocal guarantee of universal coverage, then it is not worth its price tag.

[The prepared statement of Mr. Scott follows:]

STATEMENT OF HON. ROBERT C. SCOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Thank you, Mr. Chairman. I sincerely applaud your leadership in facilitating a comprehensive examination of the many proposals to affect change in our health care system. Last month, we heard the debate on the American Health Security Act, today we're examining Mr. Cooper's plan and later, I understand, that hearings will be held on other major proposals. And, of course, we have heard from many of the architects of the President's plan including the First Lady, Secretary Shalala, and Secretary Reich. I believe that it is critical that we spend whatever time is necessary to thoroughly examine all of the options to determine which one best meet the needs of all citizens.

In my mind, the gaps in our current system are very clear. I believe that it is unconscionable that in this the wealthiest and most powerful of all nations, too many of our citizens are unable to get the health care that they need. They either lack the insurance or the funds. I believe that it is indefensible that our health care system is still geared more to medical care once a problem has developed than to preventive care that will lead to a healthier citizenry. Many health care plans will cover bypass surgery, but they don't cover mammograms or basic physical. And, I believe that it is inexcusable that although we pay more per capita on health care than any other industrialized nation that we still trail other countries in our ability to immunize our children and our infant mortality rates are, regrettably, still behind many other nations. I believe that a comprehensive health care reform package can address these deficiencies in our current system.

I am anxious to hear from Mr. Cooper and other witnesses today as to how H.R. 3222 deals with these concerns. Thank you

[The prepared statement of Mr. Hobson follows:]

STATEMENT OF HON. DAVID L. HOBSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Chairman, thank you for providing this opportunity to discuss H.R. 3222, the Managed Competition Act. Congressmen Jim Cooper and Fred Grandy and others have, with the introduction of this bill, made an important contribution to the health reform debate. I am pleased to join them as one of the original 10 sponsors of the bill.

Much of the health reform debate has focused on working toward universal coverage of health services—and that should remain our central goal. But some plans overpromise when they say that most Americans will have the same health care or better for the same cost or less—CBO reminded us of this just a few weeks ago.

There are alternatives to false promises. We can guarantee health coverage to those Americans who are most in need. And we can pay for it.

Today there is a serious gap between all-or-nothing Medicaid eligibility and private insurance coverage. The people trapped in the middle—mainly the working poor—do not qualify for Medicaid and cannot afford insurance.

The Managed Competition Act is an important step toward bridging that gap. It replaces Medicaid with a new Federal program that provides health care premium and copayment assistance to individuals and families with income below 200 percent of their State's poverty level.

Low-income individuals and families [income below 200 percent of poverty] are free to choose from among health plans available in their area, and must be enrolled in a plan to receive Federal assistance. They are responsible for nominal copayments, and eligible for Federal cost-sharing assistance.

Very low-income individuals and families [income below 100 percent of poverty] are eligible to join a plan with no premium cost to them. They are eligible for assistance in obtaining types of health care that are now typically provided by Medicaid—like prescription drugs, eyeglasses, hearing aids—but may not be included in the uniform set of benefits.

Moderately low-income individuals and families [income between 100 percent and 200 percent of poverty] are responsible for paying a portion of the premium cost of the plan they choose. Their premium cost is based on a sliding scale related to income.

The approach taken by the Managed Competition Act has several clear benefits.

H.R. 3222 increases access to health benefits. Ten million Americans who have income below poverty and are uninsured would be guaranteed access to health coverage. Another 11 million Americans with income 100 and 200 percent of poverty would be eligible for a partial Federal subsidy.

H.R. 3222 controls medical inflation. The fee-for-service structure of Medicaid is highly inflationary—exceeding 12 percent growth annually. The Managed Competition Act allows individuals with low income to join private health plans that compete on the basis of cost and quality of services.

H.R. 3222 enacts effective welfare reform. Current Medicaid eligibility is linked to other public assistance programs so that welfare recipients who choose to work risk losing their health benefits. The Managed Competition Act preserves incentives to work by breaking the link between eligibility for health benefits and public assistance.

The Managed Competition Act bridges the gap between Medicaid eligibility and affordable health insurance along themes that have emerged as important to successful reform—increased access to care, cost effectiveness, and consistency with welfare reform.

Mr. Chairman, thank you again for facilitating this discussion on health care reform, particularly the Managed Competition Act. There are no easy answers to resolve the complicated issues of health care reform. But through careful deliberation—like this hearing today—we can avoid making false promises. We can identify alternatives that guarantee health coverage to those Americans who are most in need. And we can pay for it.

Chairman FORD. We had a number of requests from people to comment on the Cooper bill, and, as you can see, we have a full panel here and other panels following. We couldn't accommodate all of them, so they have submitted formal statements, and, without objection, we will insert them at this point in the record for your information.

[The prepared statements of Henry J. Aaron, Ph.D., Director, Economic Studies Program, The Brookings Institution and the Consortium for Citizens with Disabilities Health Task Force follow:]

Testimony of Henry J. Aaron*

before the

Committee on Education and Labor
U. S. House of Representatives

March 3, 1998

*Director of Economic Studies Program, The Brookings Institution. The views expressed in this statement do not necessarily reflect those of staff members, officers, or trustees of The Brookings Institution.

Mr. Chairman:

Thank you for the invitation to testify before your committee on H. R. 3222, The Managed Competition Act of 1993. In my comments today, I should like to emphasize two broad observations.

- H.R. 3222 embodies a number of principles that I believe must be in place before the United States can achieve universal coverage and cost control. These principles include the creation of regional alliances to supervise the sale and purchase of insurance, the requirement that members of groups smaller than some stipulated size purchase insurance from such groups or be denied tax advantages they would otherwise enjoy, and various limits on the practices of insurers.
- Despite these features, H.R. 3222 cannot be the starting point for drafting successful compromise legislation because of several design flaws and omissions. The design flaws include the absence of plausible mechanisms to significantly extend insurance coverage or control growth of spending and the use of the least costly plan in an area as the benchmark for subsidies and tax incentives. The omissions include a failure to specify just what benefits are to be covered.

Regional Alliances

H.R. 3222, along with the proposals of the Clinton administration and of Senator Chafee, calls for the creation of regionally based alliances that will perform various functions to oversee the sale and purchase of health insurance. Rules for membership in the alliances and the design and powers of the health alliances differ among these three proposals. I could spend my time listing the differences and indicating which features seem preferable to others, but I want to make a simpler point regarding the alliances.

Creation of regional alliances or health cooperatives is vital for the ultimate achievement of universal coverage and the creation of mechanisms capable of limiting growth of health care spending.

Alliances play a central part in three of the four major proposals now on the Congressional agenda. They play a central part in the competitive strategy of each of these three plans. But a deeper reason for the importance of health alliances makes them of equal importance to the supporters of a single-payer approach to universal coverage and cost control.

The United States is a large and exceedingly diverse country. Single states exceed major nations in size and population. The political, geographic, ethnic, religious, and political diversity of the United States is breathtaking. The organization and delivery of health care differs enormously within the United States. The idea that the same rules will be optimal for Iowa farm towns, East Los Angeles barrios, and Wyoming valleys, for the elderly in Miami and the Hopis and Navajos in Arizona and New Mexico; that the same rules will even work in states, such as California and Minnesota, where health maintenance organizations are widely accepted, and in Texas, where until recently physicians who practiced in health maintenance organizations were harassed by their professional colleagues; the idea that relatively liberal states, such as New York or Maryland will readily accept the same rules that will be embraced by conservative states, such as Montana or Arizona; the idea that the health systems of Massachusetts and Idaho, where per capita health spending differs by a factor of two, should be identically governed -- these ideas are, to be blunt, ridiculous.

A decent respect for the diversity of the United States demands that any national health plan accommodate considerable regional diversity in rules and administration. If such diversity is to exist, however, the rules governing health insurance will not be administered by federal agencies implementing a single set of Congressionally legislated rules, but by state or sub-state agencies implementing rules that reflect federal standards and requirements but differ based on the particular circumstances of various states and sub-state regions.

Unfortunately, no such organizations yet exist. They are coming gradually into existence in a few states. But they must be brought to reality everywhere if the objectives of insurance for everyone and a framework for cost control are to become realities. This statement is true whether you believe in a single-payer, Canadian approach to health care reform such as Representative McDermott's bill, an individual mandate such as Senator Chafee's, or a mixed employer and individual mandate such as President Clinton's. It is even true if you embrace the very limited reforms contained in Representative Cooper's bill. Nothing -- repeat, nothing -- of importance can take place without regional alliances or purchasing cooperatives.

Despite inclusion of some form of regional alliance in three of the major reform proposals, the very concept of regional alliances or health cooperatives is reported to be in political jeopardy. Many members of Congress look at the health markets that span state lines and say they could not support a plan, such as President Clinton's, that prohibits alliances that span state lines. Some find mandatory alliances unduly coercive,

while others are sure voluntary alliances will become homes for the very sick and collapse from high cost.

My primary purpose is not to enter into the specifics of alliance design, although I shall be glad to go into this issue further if you wish. Rather, it is to suggest to you that the most important strategic issue relating to health care reform that Congress will address this year is the creation and design of regional alliances. It is vital for the achievement of universal coverage and cost control that such alliances be created and become politically legitimated. It is vital that they collect information, that they learn to pay subsidies to individuals or to businesses, that they learn to supervise the sale of insurance, that they learn to deal with physicians, hospitals, and other providers. The exact set of tasks varies according to the particular plan. But nothing can happen unless politically legitimated sub-federal entities are created. If Congress deadlocks on every other aspect of health care reform this year, it will be a pity because much can and should be done. But if you do no more this year than bring regional health alliances into existence, 1994 will be remembered in history books as a landmark year and you can congratulate yourselves on having enacted one of the most important advances of American federalism in our history.

Shortcomings of H.R. 3222

H.R. 3222 is silent on what constitutes an acceptable benefit package. The task of defining such a benefit package is left to a Health Care Standards Commission, which would be brought into existence after passage of this bill. The bill contains some

guidelines that would govern the design of the benefit package, but as a practical matter, the bill asks Congress to mandate an unspecified package of benefits. The bill lists neither the content of the benefit package nor cost ceilings or floors.

If ever there were legislation veritably stamped: "Trust me; I am from the U.S. Congress and I am here to help you," this is it. The failure of H.R. 3222 to specify the core element of a health reform poses formidable technical and analytical problems. From the standpoint of Congressional procedure, it is not clear how the Congressional Budget Office can score this bill. To be sure, CBO presented estimates last year, but they stressed that they had to make assumptions regarding the benefit package on which the bill gave no guidance simply because it was impossible to make estimates on the basis of what the bill contained.

But there is an even deeper problem. As the Clinton administration discovered, specifying the services to be covered in a health plan is not enough to define the cost of the plan if the objective is to control growth of spending. The reason is subtle but simple. Nearly every medical service is of considerable value to some patients. For that reason, nearly every medical service should be available -- or covered -- by any approved plan. But if patients are insured and pay little or nothing for care when seriously ill -- and keep in mind that most health care spending occurs during episodes or periods that would easily exhaust even stiff cost sharing requirements -- they will tend to want those services in situations where the benefits are small to nil. Thus, some limit on total spending is necessary for cost control. But the bill contains none.

Tax Incentives

The fiscal discipline of H.R. 3222 comes from the provision that deductibility of insurance premiums is limited to the cost of the least expensive approved plan in a given purchasing cooperative area. This provision means that deductibility, at least at the outset, would vary enormously among and within states. Thus, H.R. 3222 doubly blinds members of Congress on what exactly they are being asked to approve. The content of the benefit package, which would be nationally uniform, is undefined. And the fiscal incentive from denial of deductibility for excess premiums, which would differ among and within states, will depend on how the boundaries of cooperatives are drawn and what plans happen to be offered within them. The scope for strategic behavior in drawing the boundaries of cooperatives is staggering, as is the scope for marketing strategy by individual insurance companies.

Even if someone happens to think that such rules are good policy, they are probably impossible to administer. What is deductible will depend on the marketing decisions of insurers in the various purchasing cooperatives. But federal tax laws do not usually vary across the states. H.R. 3222 would require separate tax rules for companies in every purchasing alliance because deductibility would be limited to the least costly plan in each alliance. Companies operating in different alliance areas would thus be subject to more than one set of rules. Since different alliances can set different size limits for the establishment of closed alliances, many companies operating in two alliances would be subject to diverse rules. Couples who both work outside the home and are

employed in different alliance areas would be subject to different ceilings above which deductibility of supplemental premiums would be denied. I doubt whether practicable solutions to these problems can be found, but attempts to make these rules work would give new meaning to complexity in tax administration and compliance.

Subsidies

For at least three decades, policy analysts have been aware of an inescapable dilemma in any program to provide subsidized benefits to the poor. Any such program, whether in cash or in kind, is defined by three variables: the amount of assistance, the rate at which benefits diminish as income rises, and the income level at which the subsidy ceases. Any two of these variables determines the third. The dilemma arises because high benefit reduction rates discourage work, but low benefit reduction rates increase the number of households that receive assistance and, hence, the cost of assistance. In the case of large benefits, the cost can be very high unless the benefits are withdrawn rapidly.

Providing health insurance to the poor presents this problem in stark form. All health plans now under discussion must face it and all do so in different ways. Thus, my comments on H.R. 3222 do not mean that other plans are free of similar problems, although I believe that the Clinton proposal handles the problems in ways that are generally superior to those of H.R. 3222.

Households with incomes not greater than the official poverty thresholds would receive subsidies sufficient to pay for the least cost plan in their alliance area. Once

again, it is important to recall that this provision means that the amount of subsidy will vary enormously among and within states. In general, residents of states where costs are high will receive much larger subsidies than do residents of low-cost states. But even within states, the resident of a relatively high-cost cooperative will receive subsidies worth much more than do neighbors across the street who happen to live in a low-cost cooperative. And there is no reason to think that service levels will be the same. Thus, one family may have to pay a considerable sum for the same service available free of charge to neighbors.

But even if these features do not bother one, the fact that millions of low income households will face nearly confiscatory taxes should be troubling. Family health insurance costs in President Clinton's plan, which provides benefits roughly at the median for corporate plans, considerably exceed $5,000 annually. Perhaps coverage under H.R. 3222 will be less generous or less costly. As I have noted, I do not know; and neither do you. H.R. 3222 provides full coverage of whatever benefit package happens to emerge at whatever cost happens to prevail in a particular community. Whatever that turns out to be, families with income not greater than official poverty thresholds will get it free. Families with incomes at least equal to twice poverty thresholds (or their employers) will have to pay for it in full. Thus, the full benefit will be removed over an income range that varies by family size. The following table illustrates the resulting tax rates:

Family Size	Income Range from 100 Percent to 200 Percent of Official Poverty Thresholds	Subsidy[1]	Implicit Tax Rate (percent)
One	$ 7,552	$2,100	28
Two	9,659	4,200	43
Three	11,832	5,565	47
Four	15,172	5,565	37
Five	17,929	5,565	31

[1] The subsidy is the cost of the Clinton health plan, as estimated by the Congressional Budget Office. For two-person units, I use the cost of the plan for a couple. For larger families, I use the cost of plan for a couple with children.

Were these the only taxes people face, one would probably not find the effects on work incentives excessively troubling. But most such households will face personal income tax rates of 15 percent and payroll taxes of 7.65 percent (15.3 percent if one takes account of both the employee and employer tax, both of which, according to most economic analyses are borne by workers). Many will face reductions in earned income tax credits at the rate of 17.63 percent. Those who are eligible for food stamps or housing assistance will face additional implicit taxes in the form of benefits that fall as income rises.

When a few households face such rates, one might well conclude that the results are undesirable, but tolerable as the price for extending health insurance coverage to all of the poor and many of the nonpoor. But these work disincentive effects would be pervasive and would be regarded by most people --correctly, I believe -- as intolerable. Only three avenues of escape are available.

The first is to retain the full subsidy for the poor, but sharply lower the rate at which benefits are withdrawn. Phasing out benefits at half the rate so that the implicit tax rates shown above were cut in half would extend benefits to all households with incomes of less than three times official poverty thresholds and would probably double program costs, since the range of income from 200 to 300 percent of poverty is the most heavily populated range of the income distribution. But even so costly a fix doesn't really solve the problem, as combined tax rates would still run to 60 percent or more and these rates would apply to a much increased share of the population. As a result, the total work disincentive impact would probably increase.

The second approach is to cut the amount of subsidy available even to the poor. Such a change would permit benefits to be phased out by the time incomes reach twice official poverty thresholds with lower benefit reduction rates. But such a change would render the claims of H.R. 3222 to significantly extend coverage transparently fraudulent. Households that are judged too poor to buy even the meager bundle of goods used to set the official poverty thresholds would be tantalized with the promise that they could buy insurance that was unaffordable but not quite so far beyond their grasp as it would be if they were not offered any subsidy at all.

Neither of these two escapes from the dilemma of assisting low-income households is acceptable, in my view. One is driven, therefore, to the third avenue of escape, abandoning altogether the framework of H.R. 3222 and extending coverage to low-income households in some other way. Let me be clear that I am not indicting the concept of subsidies paid directly to households; such subsidies are inescapable under

plans, such as Senator Chafee's or President Clinton's that establish an individual mandate, at least for households with no member connected to the labor force. Some such subsidies are essential, but the scope of high benefit reduction rates is significantly narrower in President Clinton's plan than in H.R. 3222. The scheme that President Clinton uses carries problems of its own, but I believe that these problems are far more manageable than those of H.R. 3222.

Conclusion

H.R. 3222 has been the primary legislative vehicle for those who believe that managed competition offers the best way to solve the problems of health care access and cost control. It is important to note that both President Clinton's and Senator Chafee's plans embrace key elements of managed competition. This debate should not be cast as a contest between true believers in managed competition, who embrace H.R. 3222, and the heathen, who embrace one of the other major plans. It is quite possible, for example, to embed powerful competitive incentives even within a single-payer plan that uses fixed budget controls on hospitals.[1] But even those of us who believe in using competitive markets to allocate resources wherever and whenever possible, need to recognize and acknowledge that H.R. 3222 simply won't work. Better plans are on the table. Congress needs to turn to them now.

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[1]Henry J. Aaron, "Budge Limits and Managed Competition: Allies, Not Antagonists," *Health Affairs*, 12:3, Fall 1993, pp. 132-136.

Consortium for Citizens with Disabilities

The Consortium for Citizens with Disabilities Health Task Force is a coalition of over 65 national organizations working to enact comprehensive health care reform that will meet the needs of persons with disabilities and chronic illnesses, and their families.

TESTIMONY ON BEHALF OF

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES

HEALTH TASK FORCE

RESPECTFULLY SUBMITTED TO

THE U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON EDUCATION AND LABOR

MARCH 3, 1994

ON BEHALF OF

Aids Action Council
American Academy of Physical Medicine and Rehabilitation
American Association on Mental Retardation
American Association for Respiratory Care
American Association of University Affiliated Programs for Persons with Developmental Disabilities
American Congress of Rehabilitation Medicine
American Council of the Blind
American Counseling Association
American Foundation for the Blind
American Network of Community Options and Resources
American Occupational Therapy Association
American Psychological Association
American Speech-Language-Hearing Association
American State of the Art Prosthetic Association
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Association for Education and Rehabilitation of the Blind and Visually Impaired
Association of Academic Physiatrists
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Autism National Center
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Learning Disabilities Association of America
National Association of Developmental Disabilities Councils
National Association of Medical Equipment Services
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National Association of the Deaf
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National Consortium for Physical Education and Recreation for Individuals with Disabilities
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National Head Injury Foundation
National Mental Health Association
National Multiple Sclerosis Society
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National Recreation and Park Association
National Rehabilitation Association
National Transplant Support Network
NISH - Creating Employment Opportunities for People with Severe Disabilities
Paralyzed Veterans of America
Research Institute for Independent Living
RESNA - An Interdisciplinary Association for the Advancement of Rehabilitation and Assistive Technologies
Spina Bifida Association of America
Task Force for Health Care Parity for the Environmentally Ill
The Arc
United Cerebral Palsy Associations, Inc.

For additional information, please contact the CCD Health Task Force Co-Chairs:

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The Consortium for Citizens with Disabilities (CCD) is a working coalition of over 100 national consumer, advocacy, provider and professional organizations, which advocates on behalf of people of all ages with physical and mental disabilities and their families. Since 1973, CCD has advocated for federal legislation, regulations, and funding to benefit people with disabilities. We appreciate this opportunity to present our views to the Committee.

For many persons with disabilities, lack of access to comprehensive health care undermines the promise of the Americans with Disabilities Act for inclusion, independence and empowerment. People with disabilities include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function. The 49 million Americans with disabilities have an enormous stake in the current health care reform debate. Lack of adequate health care coverage is a critical issue for many persons with disabilities and chronic illnesses, who have experienced first hand the myriad problems with the current system. Persons with disabilities and chronic illnesses are disproportionately represented among both the uninsured and the under-insured in the current system of private health insurance. As it operates today, the U.S. health insurance system fails persons with disabilities and chronic conditions in fundamental ways:

- It excludes many persons with disabilities and chronic conditions as "medically uninsurable" or only offers them insurance with pre-existing condition exclusions. In a recent Census Bureau survey, 43 percent of persons with severe disabilities reported that they did not have private health insurance.

- It often charges prohibitive rates to persons with ongoing health needs, making insurance unaffordable for many.

- It does not pay for many necessary health-related services, including adequate rehabilitation, assistive technology, and long-term services and supports.

- It places annual and life-time limits on health care services.

- It often fails to provide protection against catastrophic health care costs.

- It allows insurers to terminate insurance coverage when a person becomes ill.

For all these reasons, CCD strongly endorses the need for far-reaching and comprehensive reform of the American health care system.

When evaluating the adequacy of a health system reform proposal, whether the needs of persons with disabilities and chronic illnesses are met is an essential litmus test. It is our strong belief that a health care system that meets the needs of persons

with disabilities and chronic illnesses will meet the needs of all Americans. Accompanying this testimony is a document -- "The Cooper Health Plan Fails Persons with Disabilities and Chronic Illnesses" – which outlines in detail why Rep. Cooper's health plan does NOT meet the needs of persons with disabilities and chronic illnesses.

The remainder of our testimony provides a detailed analysis of the positive features of President Clinton's Health Security Act and the reasons we support them. The overwhelming majority of these positive features are NOT part of Rep. Cooper's bill. The testimony also includes recommendations for refining several provisions of the Health Security Act, which address specific concerns of the disability community. **It is important to note that while these recommendations relate specifically to the Health Security Act, many of the problems they address are not problems with the bill per se, but problems with the current health system that must be adequately addressed in any health reform legislation that the Congress enacts. The Cooper plan not only fails to address many of these problems with the current system, but in some instances would make them worse.**

POSITIVE FEATURES OF PRESIDENT CLINTON'S HEALTH SECURITY ACT

There are many positive features in the Health Security Act that address issues of concern to persons with disabilities. These features must be retained in any health reform legislation enacted by Congress. Legislative proposals that do not include these features do not constitute reform and will be vigorously opposed by the disability community. These fundamental features and the positive ways the Health Security Act addresses them are:

Universal Coverage. All legal residents of the United States will be covered by 1998 and health care coverage will not be dependent upon employment status, age, health, disability, or ability to pay.

Non-Discrimination. Federal civil rights laws, including Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, will govern all parts of the health care system, including health alliances, health plans, the National Health Board, and providers. These laws will provide important protections for persons with disabilities, including assurances that negative assumptions regarding the quality of life of individuals with disabilities will not be used to make determinations about the medical necessity and appropriateness of services. These protections are critical for persons with disabilities and must be retained in any health care reform legislation passed by the Congress.

Elimination of Pre-Existing Condition Exclusions. No one will be denied coverage for any health problem.

Equitable Financing and Mechanisms to Spread Risk as Broadly as Possible.

- **Mandatory community rating.** Community rating is the cornerstone of equitable financing. It eliminates the exorbitant premiums that people with disabilities and chronic illnesses have been forced to pay for inadequate coverage. Community rating will also help to increase employment opportunities and ensure retention of employees with disabilities. Currently, many employers are unable to afford or obtain health insurance for employees who have a disability, or who have a family member with a disability or chronic illness. This situation discourages the employment of persons with disabilities.

- **Mandatory Health Alliances.** Community rating in a multi-payer system requires that risk pools be structured to spread the costs of heath care as broadly as possible. Therefore, we strongly support the requirement that all employers with fewer than 5000 employees be required to participate in the alliance. Without this level of participation, the risk and costs of health care will not be spread widely enough. Regional health alliances will enable small and medium size employers, the self-employed, and for-profit and non-profit organizations that employ people with disabilities, to benefit from the negotiating power of a large pool to obtain affordable, comprehensive coverage for their employees.

  Exclusive, mandatory health alliances will require all residents in a geographic area to enroll in health plans offered through the alliance. This will assure portability of coverage. In our current system insurers pick and choose who they will cover, and employers often offer only one plan, which is not portable when people change their job. In marked contrast, requiring that everyone purchase insurance from a single alliance will assure that everyone can choose among a number of health plans, and keep their plan if they change or lose their job. Freedom of choice of health plans is particularly important for persons with disabilities and chronic illnesses who are Medicaid-eligible. Allowing persons who are Medicaid eligible to choose a health plan from those offered by the alliance will solve one of the major problems faced by Medicaid recipients in the current system: inadequate care due to a shortage of providers willing to accept Medicaid patients.

  There are proposed alternatives to exclusive alliances, including a proposal to allow multiple alliances in a geographic area and the option for consumers to purchase health insurance outside the alliance. **CCD strongly opposes this proposal because it would perpetuate the current segmented health insurance market that fails to spread risk adequately.** We are greatly concerned that allowing individuals and businesses to purchase insurance outside the alliance will allow insurers to continue skimming the low risks out

of the population; this will drive up costs for the plans that enroll a broader cross mix of the population, which would include a larger proportion of persons who are high users of health care. A voluntary and competing alliance approach will only continue the current system where too many insurance companies compete in a segmented market, making it impossible to adequately spread risk. Additionally, it will reduce the state's ability to provide stringent oversight of both marketing practices and quality of care.

- **Subsidies for Small Businesses and Persons With Low Incomes.** All businesses will be able to deduct 100 percent of the cost of insurance as a business expense. Additionally, small employers with low wage workers, and individuals and families with low incomes will be eligible for subsidies for the community-rated premiums. In addition, persons with low incomes will receive cost-sharing discounts.

The Elimination of Financial Barriers to Services.

- **Elimination of lifetime caps on medically necessary or appropriate covered services.** Persons with high ongoing health costs will be assured of coverage.

- **Protection against catastrophic out-of-pocket costs.** Deductibles and co-payments will be limited to $1500 annually for an individual and $3000 annually for a family. No balance billing will be allowed, i.e. providers will not be allowed to charge patients more than the amount negotiated with the health plan.

Comprehensive Benefits Package. Every American will have coverage for a specified, broad range of preventive, diagnostic, and treatment services. Many of these services are particularly important for persons with disabilities:

- Inpatient and outpatient rehabilitation services.

- Outpatient prescription drugs.

- Experimental treatments through approved clinical trials.

- Preventive services.

- Mental health and substance abuse treatment services.

- Durable medical equipment, orthotics (orthopedic braces) and prosthetics (artificial limbs), and prosthetic devices that replace all or part of the function of an internal body organ.

- Home health and extended care services.

Funding for Long-Term Services. The proposal recognizes that long-term services are crucial components of health care for persons of all ages with disabilities and chronic illnesses, and must be included in any plan to reform the nation's health care system. While long-term services and supports are not included in the mandated benefits package, the Administration has proposed to expand the availability of these services through a new program of home and community-based services, and to provide tax credits for personal assistance services for working persons with disabilities. Without these services, many individuals may be inappropriately institutionalized at a higher cost, both in economic and in human terms.

Chronic conditions account for 90 percent of all health problems. Chronic disease and illness are major causes of disability. The prevalence of functional impairments due to chronic illness, congenital conditions and trauma, has increased rapidly in the past decades and is expected to increase further in the coming years. This is due to advances in medical technology that save lives, but which often leave the survivor with significant disabilities. Yet, while treatment for acute episodes of care is covered, many persons with chronic illnesses cannot obtain the services they need to maintain their fragile margin of health. For these persons, it is not so easy to draw a clear line of distinction between acute and long-term services and the coordination of acute and long-term services is crucial.

Other people with disabilities need long-term services and supports to function independently. For many children and adults with disabilities, these services and supports can mean the difference between independence and dependence. CCD has several recommendations for refinements to the Long-Term Services provision of the Health Security Act, which we presented to the Committee in December 1993, and so we will not discuss them in this testimony.

The Incorporation of the Acute Portion of Medicaid into the New System. This step will eliminate the current two-tiered system of health care by providing every American with the same choice of health plans.

Cost Containment. The proposal includes measures to ensure that health insurance remains affordable. Without effective cost containment, increased costs will be shifted to consumers in the form of higher premiums, increased cost-sharing, and reduced benefits. Effective cost-containment measures include:

- Caps on premium increases.
- Competition among health plans in the regional health alliance.
- Standardization of health insurance forms to reduce administrative costs.

- Medicare prescription drug rebates.

Consumer Participation and Consumer Protections. The proposal includes a system of government and private oversight with enforcement procedures, including the appointment of an ombudsman at the regional alliance level. Other important provisions that will assure consumer involvement and protections are:

- A guarantee of due process rights with regard to benefit determinations, grievance procedures, and access to judicial review; provisions to protect the confidentiality of medical records and to assure access to regulatory proceedings.

- The establishment of regional health care alliances, which will increase the negotiating power of consumers, particularly small businesses and self-employed individuals. The mandated participation of consumers in the governance and administration of the health alliances will help assure accountability and responsiveness to consumer concerns.

- Consumer choice will be assured. Consumers will not be restricted to the plan their employer selects, but will be allowed to choose among a range of plans that they can keep if they change jobs. All managed care plans will have an out-of-network option. Consumers will be able to enroll in and disenroll from plans during "open season" and for "cause."

- Administrative simplification will make it easier for consumers to understand their health care coverage and their rights.

Consumer Protections During the Transition to the New System. There are a number of provisions designed to ensure maintenance of current health care coverage and benefits during the transition period. These include: requirements to help preserve current coverage, restrictions on premium increases, limits on the duration of pre-existing condition exclusions, and a national transitional health insurance risk pool. These protections are essential for persons with disabilities and chronic illnesses who may lose their coverage during the transition period as the insurance industry consolidates.

Research Initiatives. The HSA includes new funding for health research focused on prevention and outcomes research, which we strongly support. Priority areas include child and adolescent health, birth defects, chronic disease and conditions, mental health, environmental health, substance abuse, and the development of functional measures.

RECOMMENDED REFINEMENTS TO THE HEALTH SECURITY ACT

Legislation to address the major problems of access, cost, and quality for a large, heterogenous population will, of necessity, be complex and highly detailed. Provisions to reform financial, organizational, and service arrangements must take account of major variations in population density, ethnic composition, health infrastructure, and economic circumstances. In an undertaking of such enormous complexity and scope, there is a danger that the specialized needs of subgroups of persons with the most serious and disabling illnesses and conditions will not be understood and addressed.

To assure that a reformed health system will meet the specialized needs of persons with disabilities and chronic illnesses and conditions, CCD recommends several refinements to the provisions of the Administration's Health Security Act. It is important to note that while these recommendations relate specifically to the Health Security Act, *many of the problems they address are not problems with the bill per se, but problems with the current health system that must be adequately addressed in any health reform legislation that the Congress enacts. At the same time, the positive aspects of the current system must be retained.*

I. Reducing Financial Incentives to Underserve

The continuation of a multi-payer system of health insurance as proposed in the Health Security Act will reduce the extent to which risk and associated health care costs are spread. Therefore, individual health insurance plans will continue to be at risk for insolvency if they incur catastrophic costs. This situation and the need to contain costs generally create a variety of financial incentives to underserve persons with extensive or special health care needs. These incentives exist throughout our current health care system but are particularly problematic in capitated managed care plans.

As an example, certain types of managed care plans place individual physicians at financial risk when they serve persons with a need for intensive, ongoing services. This is a problem particularly for non-salaried physicians who receive a capitated payment for each person enrolled. In one such plan, a family whose child was born with multiple disabilities had great difficulty finding a pediatrician in their health plan who was willing to accept the child as a patient, because the physicians stated they would lose money if they accepted responsibility for the child, because he would require too much care. Other managed care plans pose similar problems of access and under-service. Some managed care plans attempt to pass on risk to providers in the form of financial incentives that seem especially likely to lead to underservice. These include bonuses or penalties to providers related to meeting or exceeding utilization limits and policies requiring physicians to assume the cost of out-of-plan specialty care. A recent GAO report concluded that the more risk is

shifted to physicians, the greater the potential for inappropriate reductions in services. *Therefore, CCD RECOMMENDS:*

1. *Contractual provisions in managed care plans that shift financial risk to physicians and other health care providers should be strictly prohibited.*

A. The Need for Risk Adjustment

The risk adjustment formula is critical in determining how much the alliance will pay to each plan. Plans that serve a higher number of high cost enrolees should receive more resources. While the Health Security Act includes provisions for risk-adjustment of premiums and capitated payments, it is the consensus of experts that current risk adjustment data and methodology do not permit accurate estimates of risk based on factors other than age. *Therefore, CCD recommends:*

1. *There must be increased funding for research on the factors associated with high levels of health care utilization. The findings of this research will greatly assist in the development of a risk adjustment formula. This research could be conducted by the National Health Board, the Agency for Health Care Policy and Research and the National Institute on Disability and Rehabilitation Research.*

2. *Different methods of risk adjustment should be considered. Given the nascent state of the risk adjustment field, it may be more appropriate to provide half of the risk adjustment payment at the time of enrollment, and the remainder only if the health plan documents higher utilization at the end of the year. This approach would guard against people being classified as "high users" solely because they have a disability. Health care utilization by persons with disabilities varies enormously yet insurance companies often assume that all persons with disabilities are "high cost." Once a pattern of higher utilization is established, the full risk adjustment amount could be paid prospectively.*

3. *In conjunction with the previous recommendation, health plans receiving risk adjustments prospectively must be required to collect data on the factors associated with high utilization. These data must be made available to the National Health Board to assist in the development of accurate risk adjustment. Accurate risk adjustment is essential to assure that there are no economic incentives for providers to underserve people with disabilities, and to guarantee that the amount, duration, scope, and quality of services delivered to people with disabilities are determined by their actual needs. The data collected must include information on the type of disability or chronic illness, and information about the type and severity of a person's functional limitations.*

4. *While we oppose placing physicians at financial risk, should such practices be allowed in managed care plans, then risk adjustment payments should be made to the physician who is responsible for the care of persons with severe and ongoing health needs, not to the health plan.*

5. *While accurate risk adjustment methods are being developed, there must be mandatory reinsurance requirements so that plans do not have an incentive to restrict services for persons who incur extremely high costs.*

6. *Persons with disabilities, parents of children with disabilities, and professionals with expertise in serving persons with disabilities should be represented on the Advisory Committee for the Risk Adjustment System.*

7. *The provisions of the bill regulating the marketing of health plans must be retained. If health plans are allowed to market only to low risk individuals, some plans will wind up with a disproportionate share of high-risk individuals.*

B. The Need for Time-Intensive Services

Another incentive to underserve is related to the time-intensive treatment needs of some persons with disabilities. If providers are not adequately reimbursed for their time (e.g. volume and time-based services), particularly in non-salaried, capitated care, or fee-for service arrangements, or if salaried physicians are penalized for not seeing a set number of patients in a given time period, they may be reluctant to provide services to persons with particular disabilities who require more time-intensive service. For example, a gynecologist may be reluctant to treat women with severe cognitive impairments because they may require considerably more time than is usually allotted for a given procedure. While there has been no systematic research on this issue, there is a large amount of anecdotal evidence documenting the problem.

Managed care plans that specialize in the treatment of certain health conditions such as AIDS, report that they need to assign a far smaller caseload to individual physicians because persons with certain conditions need both more services, and more time-intensive services. This need has been recognized by the Physician Payment Review Commission (PPRC), which has proposed a plan to compensate doctors for the time they spend with persons who have disabilities. In its annual report to Congress in 1991, the PPRC endorsed the use of special modifier that would increase payment by a fixed percentage for visit with patients who have communication barriers, disabling cognitive or physical impairments, or an unusual need for counseling or coordination of care.

Risk adjustment formulas consider aggregate utilization and expense, but do not take account of the need for more time-intensive services by some persons with disabilities, who may or may not be high-users of care. *Therefore, CCD recommends:*

1. *The presence of physical, mental, and communicative functional impairments must be added to the list of factors used to calculate risk adjustment formulas.*

2. *Reimbursement formulas for all health professionals must include adjustments that take into account the need for more time-intensive services by some persons with disabilities.*

3. *Financial practices in managed care health plans that penalize physicians and other health providers for not seeing a pre-determined number of patients in a particular time period should be prohibited.*

II. The Elimination of Financial Barriers to Care

CCD is concerned about the effect of price competition among health plans on the ability of persons with disabilities to have a meaningful choice of both health plans and providers. If insurance plans are going to compete on the basis of cost, then choice of insurance plans will, in part, be based on ability to pay. If persons will have to pay more to join fee-for-service plans and to utilize specialists outside of a managed care plan, then access to some specialists will be dependent on ability to pay. These costs may be prohibitive for many persons with disabilities, particularly when added to the costs of supplemental insurance for access to benefits beyond the federally guaranteed minimum. To address this problem, *CCD recommends that:*

1. *Cost sharing provisions must include subsidies for all low income persons with disabilities and chronic illnesses to join the plan that is best able to meet their needs. This includes subsidies for premiums, deductibles, and co-payments. Additionally, there must be lower limits on allowable out-of-pocket costs for persons with low incomes.*

The plan provides for reductions in cost-sharing for low-income families, i.e. for families with adjusted gross incomes below 150 percent of the applicable poverty level. *CCD RECOMMENDS:*

1. *When determining adjusted gross income, disability-related expenses should be an allowable deduction.*

III. Comprehensive Benefits

In the health care reform debate, the question of which services to include in the mandated benefits package is a critical one for persons with disabilities. The opponents of comprehensive reform insist that any mandated benefits package should be kept to a bare minimum and that people shouldn't be "forced to buy benefits they don't need or want." This attitude is short-sighted in the extreme. No one is able to predict what health services they will need in the future. No one can say with any certainty that they will never be in a major accident, will never develop a chronic illness, will never have a child, spouse, or sibling with a chronic health condition or disability. Often, those most at risk for these conditions believe they are at low risk and so would be unlikely to purchase a policy with adequate benefits if they were given a choice. For example, young men in their twenties are the population group at highest risk for traumatic brain injury, yet this group comprises a large percentage of the uninsured.

While a great deal of attention has been given to the 37 million Americans without insurance, there are also millions who are under-insured. The Office of Technology Assessment estimates there are between 38 million and 55 million persons under age 65 years of age who are under-insured. Under-insurance is the result of several factors, including: (1) lack of coverage for pre-existing conditions, (2) exclusion from coverage of certain categories of health care and related services, including preventive and diagnostic services, prescription drugs, extended rehabilitation, durable medical equipment, orthotics and prosthetics, assistive technology, and long-term care, (3) annual and lifetime caps and high copayments for certain conditions or treatments, most usually for mental health and substance abuse services, (4) no limits on out-of-pocket payments for covered services, (5) no limits on expenses that exceed "usual, customary and reasonable" charges for covered benefits, and (6) a host of other exclusions based on restricted definitions of "medical necessity," or arbitrary limitations on services, such as rehabilitation. As a result, many families *with insurance* are faced with financial ruin in the event of a catastrophic illness or accident. In one study of uncompensated hospital care, 47 percent of the 1689 patients who incurred uncompensated costs *had* health insurance.

These limitations in coverage are often not apparent until a person becomes seriously ill. Consequently, most Americans report high levels of satisfaction with their current health insurance coverage. It is only when people experience a catastrophic illness or accident that requires a wide range of ongoing medical, rehabilitative and support services, that they discover just how few services their policies cover. They also find out that hospital and physician charges that the insurer determines are above "usual, customary, and reasonable" charges, are neither paid by the insurer nor applied to the out-of-pocket limits. Thus, out-of-pocket expenses are often far higher than stated limits. Additionally, many insurance plans nominally include a particular benefit, but the services covered are so limited that

they are often insufficient in relation to their needs.

As an example, an HMO typically covers 60 days of rehabilitation, but a person with a severe stroke, a spinal cord injury, or a traumatic brain injury may require intensive rehabilitation for six months or longer, and intermittent maintenance or preventive services for another six to twelve months or for an even longer period. Persons with serious mental illness generally exhaust their inpatient lifetime mental health benefit within a year. Health insurance also rarely, if ever, covers long-term care, services and supports.

The mandated benefit package in the Health Security Act includes many services that are essential for persons with disabilities and chronic, disabling illnesses. The limitations on the scope, duration, and indications for these benefits must be clearly be consistent with what people need and are currently receiving.

There are several issues related to the mandated benefit package in the Health Security Act that require clarifications and changes. These will be discussed below.

A. Outpatient Rehabilitation

Rehabilitation services are indispensable for persons who have experienced a loss or attenuation of physical, mental or communicative functioning as the result of a genetic condition, a congenital disorder or condition, a developmental condition, a disease, an illness or an accident. Rehabilitation is an essential component of the treatment of all these conditions. Additionally, just as primary preventive services like immunizations prevent the incidence of costly disease, secondary preventive services like rehabilitation prevent the incidence of numerous health problems and disabilities. If rehabilitation services to maintain function and to prevent deterioration are not adequately covered, children and adults with disabilities will be at risk for deterioration in their functional status and for the development of complications.

It is irrational to use heroic methods to prevent death and then ignore the need to prevent the complications of chronic illness and the development of secondary disabilities. These conditions lead to higher acute costs over time. Given these inevitable costs, the provision of comprehensive rehabilitation services to persons with disabilities is a rational approach to ensuring system-wide cost reductions by preventing expensive complications. Rehabilitation services also increase individual functioning and productivity.

Section 1123 covers outpatient rehabilitation services such as Physical Therapy, Occupational Therapy, and Speech Therapy, but only when they are provided "to restore functional capacity or to minimize limitations on physical and cognitive functions as a result of an illness or injury." This provision is unduly restrictive for

three reasons.

(1) **The requirement in Section 1123 that rehabilitation services be available only to persons whose need for services results from illness or injury, effectively excludes persons with congenital, developmental and other conditions from receiving services.**

The effect of this provision is to perpetuate a pre-existing condition exclusion for persons with congenital conditions, i.e. conditions that are present at birth. It makes an arbitrary distinction between those born with a disability and those who acquire a disability after birth, even if it is only weeks after birth. For example, under this provision, a child who develops meningitis (an infection of the brain) hours after birth and develops cerebral palsy would be able to receive these services, but a child born with cerebral palsy would not. This is discriminatory and unacceptable policy. To correct this problem *CCD RECOMMENDS:*

1. ***The phrase "illness or injury" must be replaced by the phrase "illness, injury, disorder, or other health condition." This language is consistent with language in the Health Security Act pertaining to the development of practice guidelines. It is also consistent in its effect with language in many current private insurance policies.***

(2) **The requirement that rehabilitation services be provided to restore functioning and to minimize limitations on physical and cognitive functions must be interpreted to encompass medically necessary and appropriate prevention and maintenance.**

While payment for services designed to *maintain* function or to *prevent or minimize deterioration* is provided under current public and private insurance, it is not clear that these services would be covered using the proposed language. Services required to maintain functioning or to prevent or minimize deterioration can be critical to preventing secondary disabilities or exacerbations of conditions. Without therapy, many individuals may lose the little functioning they have. For example, without maintenance physical therapy, a child with cerebral palsy could develop a dislocation of the hip, resulting in a need for expensive surgery and hospitalization.

The standard for re-evaluation in the bill uses improved function as the sole criteria. Maintenance and prevention are also appropriate standards for continuation. Therefore, *CCD RECOMMENDS:*

1. ***Indications for outpatient rehabilitation services should also include maintenance of functioning and the prevention of deterioration.***

(3) The definition of outpatient rehabilitation services fails to recognize the full range of services covered under public and private insurance.

Rehabilitation comprises a range of skilled services provided to individuals in order to minimize physical, cognitive and emotional impairments, and to restore or maximize functional capacity. The full recovery of persons with catastrophic illnesses, injuries and conditions is dependent on the provision of these services. Similarly, individuals with congenital conditions need these services both to attain their full functional capacity and to maintain that capacity. In addition to the three therapies listed in Section 1123, rehabilitation services also include a range of other services, including: respiratory therapy; audiology services (including hearing tests); speech-language pathology services for speech or language problems, augmentative communication and feeding and swallowing problems; cognitive therapies; orientation and mobility training for persons with severe visual impairments; and therapeutic recreation. Additional rehabilitation services currently covered by Medicare when provided in a comprehensive outpatient rehabilitation facility (CORF) include: psychological counseling, nursing services, and social services. Therefore, *CCD RECOMMENDS:*

1. ***The full range of outpatient rehabilitation services, as enumerated above, should be included in the mandated benefits package.***

B. Durable Medical Equipment (DME) and Orthotics and Prosthetics (O&P)

Durable medical equipment (DME) includes such items as wheelchairs, crutches, hospital beds for use in the home, oxygen equipment, and a wide variety of devices that assist people with disabilities and chronic illnesses. Orthotics are orthopedic braces for the arms, legs, back and neck. Prosthetics are artificial arms, legs, and eyes, while prosthetic devices include devices such as hip replacement components and colostomy devices.

CCD is concerned that the definition of DME in the Health Security Act references the overly restrictive, acute-care oriented definition currently used in Medicare. This definition was formulated in 1965 when Medicare was enacted and reflects an outdated orientation towards persons with disabilities as homebound and dependent. This perception of people with disabilities is very different from that embodied in the Americans with Disabilities Act. Therefore, the durable medical equipment benefit within the Health Security Act should be refined to appropriately reflect the needs of people of all ages with disabilities and chronic illnesses.

Currently, there are a number of DME items not covered or otherwise reimbursable under the Medicare program because the item does not meet all the requirements of

the four-part test Medicare has established to determine coverage. Even though such items may have significant therapeutic benefit for particular individuals under specific circumstances, they are considered to be "presumptively nonmedical" by Medicare. The rigidity of the four-part test has resulted in the denial of Medicare beneficiary access to a number of DME items that could maintain and/or improve the health status of millions of older Americans and Americans with disabilities, as well as prevent injury.

CCD RECOMMENDS:

1. ***Some items not currently covered and reimbursable by Medicare should be covered and reimbursable under the Health Security Act and any comprehensive health care reform proposal. These items include, but are not limited to: bath tub lifts and seats; bed baths; bed lifters; dehumidifiers and humidifiers; grab bars; hygiene items (i.e., incontinent pads, irrigating kits); portable whirlpool pumps; raised toilet seats; staircase rail(s); white canes; and air conditioners. These items are relatively inexpensive and may have significant therapeutic benefit for particular individuals under specific circumstances. Coverage and payment for these DME items, in the long run, may save substantial expenditures otherwise spent on more costly corrective therapies and items.***

CCD strongly supports the Health Security Act's definition of "prosthetic devices," which reflects technological advances that have been incorporated into contemporary practice by health care professionals. The bill incorporates a functional test, specifying that "prosthetic devices" are covered not just if they replace the body member itself, but if they "replace all or part of the *function* of an internal body organ."

This language recognizes that prosthetic devices include devices that are surgically inserted. An example of such a device would be a pacemaker. It also recognizes that prosthetic devices include devices that are physically attached to the body, such as colostomy bags and supplies directly related to colostomy care.

Technological advances are enabling health care professionals to prescribe devices that replace all or part of the function of an internal body organ without surgically inserting or physically attaching the device to the body. We are pleased that by including a "functional" definition, the bill recognizes that prosthetic devices include assistive technology devices and other external devices such as augmentative communication devices.

Augmentative communication devices replace all or part of the malfunctioning or non-functioning element of the body's oral motor mechanisms, consisting of the speech center of the brain as well as the nerves, muscles, and organs that together

control the production of speech and improve the functions of speaking for individuals whose oral motor mechanisms do not work. Obviously, "improving functional ability" includes improving the ability to speak; otherwise, Medicare and private insurance policies would not pay for an artificial larynx for this purpose.

The use of this contemporary "functional" definition of prosthetic devices will enable people who require augmentative communication devices for effective communication to receive them. Too often, under the current system, augmentative communication devices are covered only for persons who have had their larynx surgically removed.

CCD recognizes that coverage for such external devices is subject to the general policy that all devices provided under the comprehensive benefits package must be prescribed by a qualified health care professional within the scope of the professional's practice and must be medically necessary or appropriate.

CCD also supports the inclusion of assistive technology devices as authorized expenditures under the Health Security Act's new long-term services formula grant program for home and community-based services. The availability of these devices through the long-term services program will enable individuals for whom such devices are not otherwise covered under the comprehensive benefits package to obtain needed services. We believe that eventually the false dichotomy between acute and long-term care must be eliminated.

The Health Security Act's current language on durable medical equipment, orthotics and prosthetics, and prosthetic devices must be clarified so that it is consistent with private insurance coverage and Medicare policy. ***CCD's RECOMMENDATIONS to do this are as follows:***

1. ***Clarify that accessories and supplies used directly with these devices to achieve the therapeutic benefits and proper functioning of such equipment or devices are covered.***

2. ***Clarify that the replacement of such equipment and devices is covered, not only for a change in a person's condition but also in cases of loss, irreparable damage, and wear.***

3. ***Clarify that repairs and maintenance of durable medical equipment, orthotics and prosthetics, and prosthetic devices are covered, as are fitting and training for the use of these items. These clarifications merely codify current Medicare policy and the policy of most private insurers with respect to coverage of accessories and supplies, repair and replacement, maintenance, and fitting and training, and will not add additional costs to the benefit package.***

Finally, the bill specifies that an item or service is covered only if it "improves functional ability or prevents further deterioration in function." *CCD RECOMMENDS:*

1. ***Items or services should also be covered if they will "minimize" further deterioration in function. This language is consistent with the purpose of the covered devices and equipment and conforms the provision to the language in the section of the bill pertaining to outpatient rehabilitation therapies. We believe that providing services to minimize deterioration will be cost-effective.***

2. ***There should be no arbitrary distinctions in the DME and O & P benefit that prevent people with disabilities and chronic disabling illnesses from receiving the health care services they need to function independently.***

3. ***The definition of durable medical equipment in the final legislation should be broader than the current Medicare definition, which is overly restrictive and does not take account of many of the needs of younger persons with disabilities.***

Hearing Aids

Hearing aids are prosthetic devices but they are explicitly excluded from the mandated benefits package. If surgery for a cochlear implant to improve hearing is a covered benefit, why aren't hearing aids to improve hearing also covered? The importance of hearing aids for children with severe hearing loss cannot be overestimated. The ability to hear and understand speech is crucial for language development in young children. If high cost and inappropriate utilization are a concern, at the very least, hearing aids should be provided to children who have a hearing impairment that interferes with their ability to understand speech. It is virtually certain that hearing aids will not be prescribed for children unless they need them. Therefore, *CCD RECOMMENDS:*

1. ***Hearing aids for children, at a minimum, MUST be covered.***

Disposable Medical Supplies

There is no mention in the mandated benefits package of disposable medical supplies. This category includes such items as surgical dressings, and catheterization and tracheostomy supplies, which are currently covered under Medicare and many private health plans. Such supplies are very cost-effective because they prevent infections, which are potentially life threatening. It is also not clear whether syringes will be covered for persons who need them for injectable medications, e.g. insulin for persons with diabetes.

CCD RECOMMENDS:

1. ***Disposable medical supplies, including syringes, should be covered when medically necessary.***

D. Extended Care and Home Health Services

The indications for extended care and home health services are similar to those used for the outpatient rehabilitation benefit and are equally problematic. As written, these services will only be available for persons whose need for services results from illness or injury. As in the outpatient rehabilitation benefit, this provision effectively excludes persons with congenital, developmental, and other conditions from receiving services.

As noted earlier, the effect of this provision is to perpetuate a pre-existing condition exclusion for persons with congenital conditions, i.e. conditions that are present at birth. It makes an arbitrary distinction between those born with a disability and those who acquire a disability after birth. ***Therefore, CCD RECOMMENDS:***

1. ***The phrase "illness or injury" must be replaced by the phrase "illness, injury, disorder, or other health condition."***

2. ***The full range of outpatient treatment and rehabilitation services, including respiratory therapy, should be available under the Extended Care and Home Care benefit.***

E. Prescription Drugs

(1) Formularies

Overly restrictive prescription drug formularies could have a detrimental effect on the quality of care for some persons with special medication needs. This is a particularly important issue for people with rare disorders, and people with low incidence and prevalence conditions. For persons with these conditions, there may be only one available drug treatment, and this drug may not be included in a formulary, or may be prescribed for an "off label" purpose. Access to the entire range of available pharmaceuticals is also critical for persons with conditions such as epilepsy, where treatment is highly individualized and persons may need to try a number of different drugs in varying combinations prescribed by their physician in order to achieve effective control of their seizures. ***Therefore, CCD RECOMMENDS:***

1. *Minimum standards for the operation of prescription drug formularies must be established to ensure appropriate access to medically necessary medications. At a minimum, the standards should include those set out in Section 1927(d) of Title XIX. In addition, access to medications not on the formulary should be guaranteed through a prior authorization process when justified by medical necessity. A plan's prior authorization process should ensure a response within 24 hours, and the provision of a 72 hour emergency supply of a drug when medically necessary as required in current Medicaid law.*

(2) Generic Drugs

While the use of generic drugs should be encouraged as a way to control the costs of prescription drugs, for certain conditions such as epilepsy, the mandatory substitution of generic drugs without the informed consent of the consumer and the treating physician could severely compromise the effectiveness of treatment. There may be significant differences between the characteristics of a brand name and a generic anti-seizure medication, as well as differences among different generic anti-seizure drugs. In some individuals, these differences could result in adverse effects, including a loss of seizure control and the development of toxic side-effects. *Therefore, CCD RECOMMENDS:*

1. *Health plans should not be allowed to substitute generic drugs for prescribed medications, without the informed consent of the consumer and the treating physician.*

F. Mental Health and Substance Abuse Services

The mental health and substance abuse services are extremely limited in scope and duration and will be inadequate to meet the needs of persons with serious and persistent mental illness, and persons with psychiatric disabilities. Benefit caps for both intensive nonresidential services, inpatient and residential services are so inadequate that they will lead to severe service fragmentation, unnecessarily restrictive care, poor outcomes and higher costs. We strongly support the planned expansion of benefits in the year 2001, which offers fully comprehensive and flexible benefits, but have major concerns about how persons with psychiatric disabilities and persons with drug dependencies will receive the services they need prior to that time.

Services that are particularly important for people with disabling mental illness include in-home services, case management, partial hospitalization, psychiatric rehabilitation and other intensive, non-residential services (INR). INR services are

essential for children with serious emotional disturbances, who should be provided treatment in non-residential settings whenever possible, so that they are not separated from their families. INR services have also been demonstrated to be both cost-effective and more acceptable to consumers of care than 24-hour residential placements.

These services are severely limited under the standard mental health benefit during the period 1998-2001. In addition to inadequate benefits, the higher cost-sharing requirements for mental health services are a major problem for persons with disabling mental illness, particularly since individuals with disabling mental illnesses often require a high volume of services. It is not uncommon for individuals with disabling mental illness to require daily rehabilitation and medication services. High cost-sharing is a major barrier to care because persons with disabling mental illnesses generally have low-incomes resulting from their inability to work. Many are unable to meet any cost-sharing requirements. To address the serious deficiencies in the mental health benefit, *CCD RECOMMENDS:*

1. ***The elimination of arbitrary restrictions on the amount, duration and scope of services.***

2. ***The discriminatory cost-sharing requirements for mental health services must be eliminated for those who cannot reasonably be expected to meet them.***

3. ***Cost-sharing for mental health services must be counted toward the out-of-pocket limit on an individual's annual health expenditures.***

4. ***Persons with disabling mental illness who are Medicaid eligible must continue to receive optional Medicaid benefits such as rehabilitation, clinic services and case management. Given the major deficiencies in the proposed mental health benefit, the continuation of these services is essential.***

IV. Extra-Contractual Services

Currently, some private insurance policies will pay for services not specifically included in the plan, i.e. extra-contractual services, in order to improve the quality of life of a beneficiary and to save money for the insurer over the long-term. For example, Aetna paid to retrofit an individual's house to make it accessible because it cost less to provide services in the home than in a hospital or rehabilitation facility. There is some concern that the language in the Health Security Act related to duplication of benefits in supplemental insurance may limit or prohibit the provision of extra-contractual services by insurance plans offering the mandated benefit package. Therefore,
CCD RECOMMENDS:

1. ***Health plans should be allowed to offer extra-contractual services at their discretion, whenever they will result in an improvement in the beneficiary's quality of life and a cost saving to the health plan.***

V. Services for Children with Special Health Care Needs Under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandates under Medicaid require that children up to their twenty-first birthday are eligible to receive services for the detection and treatment of health conditions, developmental, mental and emotional problems and disabilities. In OBRA 1989, Congress strengthened the protections for children under this program to assure that they receive all the treatment services they need irrespective of any limits in a state's Medicaid plan. This gave children a right to necessary and appropriate services for which the federal and state governments would pay under the existing Medicaid matching formula. Eligibility for EPSDT is, of course, dependent on Medicaid eligibility which can vary by state.

Under current EPSDT law, states are mandated to pay for a wide range of community-based health and mental health services. As a result of the OBRA 1989 expansions, the benefits provided through the EPSDT program are more comprehensive in both scope, amount, and duration than those in the currently proposed basic benefits package. Some of these services may be available under the Administration's proposed long-term services benefit. Services currently provided under the EPSDT mandate include:

- Rehabilitation, including physical, cognitive, psychiatric, psychological, behavioral and other services, e.g. physical therapy, occupational therapy, speech-language pathology and audiology services, psychological and social work services;
- Clinic services for both physical and mental conditions;
- Assistive technology and equipment;
- Targeted case management, which includes the coordination of services, facilitation of access to various benefit programs, and intensive case management services for those with complex or extensive needs;
- Personal care services, including attendant care; and
- Hearing aids.

These services are critical to the full health and functioning of children eligible for

Medicaid and for all children. It is by no means certain that the federal regulations governing the new program proposed in the Health Security Act will include this wide range of services that children now have access to through many state Medicaid EPSDT programs, nor does the bill clarify whether any limits will be allowed on the scope, amount, and duration of services.

The proposals in the Health Security Act for children under Medicaid beginning with Sec. 4221, et seq., are very confusing. It appears that all children currently eligible for Medicaid, (with the exception of "Katie Beckett" children as authorized by TEFRA 134), continue their eligibility for benefits not included in the comprehensive benefit package. However, it appears that children will be eligible for different service packages, depending on how they become eligible for Medicaid. There may also be differences in the funding streams, payment mechanisms and points of access between children. Difference in these areas may result in significant negative consequences for children and their families. Moreover, children who live in low-income households will be eligible for a more comprehensive set of services than children who live in non-low-income households. In the latter situation, families could only obtain such services by paying the full cost. This new "two-tiered" system is totally inconsistent with some of the President's overarching principles for health care reform.

Under Sec. 4222 of the Health Security Act, low-income children who meet the eligibility criteria under current Medicaid law would be provided additional "supplemental" services under a new, fully-federally financed program modeled upon the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate of Medicaid. The legislation does not provide details of this program but directs the Secretary of HHS to issue regulations on how the program is to be administered no later than July 1, 1995. The Administration has estimated that this program will be allocated $9.8 billion over five years, beginning with $264 million in FY 1996. Although annual appropriations are envisioned to increase to $3.2 billion in the year 2000, these figures suggest a very limited program.

This "supplemental" program in Sec. 4222 would provide one hundred percent federal funding for items and services in Section 1905 (a), including also Section 1905 (r), of Title XIX of the Social Security Act, which are not included in the HSA mandated benefits package. The items and services listed in Section 1905 are identical to the current array of EPSDT mandated services.

Sec. 4221 indicates that no change is made in eligibility for Medicaid services; we infer from this that for cash assistance recipient children (AFDC and SSI), the federal government will continue to match, on the basis of an open-ended entitlement, state funds for all reimbursable services for which the state generates its matching funds. To further confuse the issue, the eligibility for the new program under Sec. 4222 clearly includes children on cash assistance programs (SSI and AFDC).

If this new "supplemental" program in Section 4222 will provide funding for the items and services in Section 1905 that are not included in the mandated benefits package, for both cash-assistance and non-cash assistance children, we are concerned that the program is underfunded. But if the language in Section 4221 means that states will continue to be responsible, under existing federal/state matching requirements for all services for children on AFDC and SSI as mandated in OBRA 1989, then it appears that they will not be funded through the new program in Section 4222. If this is correct, then the amount allocated for the new program would not fall quite so short of the need.

The Administration's proposal sets the new program's base at FY 1993 spending levels. Implementation of the EPSDT mandate, including expansions in OBRA 1989, is currently very uneven among the states. Few states have conducted appropriate outreach to low-income families, and as a result, many of the children who should have access to full and comprehensive benefits under EPSDT have not been identified. The Health Care Financing Administration reports that in FY 1993, the year for which the Health Security Act caps the federal contribution, only 41 percent of all children eligible for EPSDT had been enrolled by the states. A number of states, however, have recently put together comprehensive, prevention focused, statewide initiatives. Kansas (Kan-B-Healthy), North Carolina (Healthy Children and Teens), Oklahoma (Sooner Start), Wisconsin (Healthcheck) and other states are attempting to fully implement EPSDT. However, these initiatives are all relatively new and have reached only a limited number of the children they are targeting and so current spending is substantially below what is needed. Also many Medicaid families are unaware of their entitlement to services not included in the state's overall Medicaid plan and thus are not accessing the full range of services to which they are entitled. Providers, too, are ignorant of the extent to which they could lawfully provide medically necessary and appropriate reimbursable services to these children.

The Administration also has not taken account of the enormous variability in state spending on EPSDT services. This raises many questions that must be answered. How will the new program compensate for the lack of appropriate EPSDT programming in many states? How will federal resources be allocated with this existing disparity? The comprehensive of the benefits and the integrity of the service and support systems in place must be maintained, but mechanisms and supports for improvements must be made available where necessary.

It is also essential that provider reimbursement for all covered services be adequate. Otherwise, children may suffer as they do now in having access only to those providers who will accept low reimbursement rates. In addition, if states are not required to raise their Medicaid reimbursement rates for the services in Section 4221 and 4222 so that they are compatible with provider rates paid by health plans, we could well see the continuation of a "two-tiered" system. For many children, this

would mean continued financial barriers to services because no providers will accept these lower rates.

We are pleased to see that the Administration has recognized the importance of the wide array of services provided under the EPSDT mandate for children. However, it is disturbing that the proposal suggested to replace the EPSDT mandate is so unclear, undefined and, we believe, underfunded. It is unclear why this proposal, which could drastically change and perhaps endanger the EPSDT mandate, has been offered at the same time that the Administration promulgated a notice of proposed rulemaking to further the implementation of the EPSDT mandate on October 1, 1993. The confusion over financing is compounded by the description in Secs. 9001, 9002, 9011 and 9012, which describe state payments to the health alliances. These payments will affect the availability of services as well as the availability of other state resources for other Medicaid-reimbursable services that are not included in the basic benefit package, i.e., mandated and optional Medicaid services which are not provided by health plans, e.g. services provided under the Individuals with Disabilities Education Act (IDEA).

All of these funding issues are compounded by the unclear relationship to the state maintenance of effort payments and the cash assistance payments to the health alliances. The Medicare Catastrophic Amendments of 1988 authorized state Medicaid agencies to receive federal reimbursement for special education related services contained in a student's Individualized Education Plan under the Individuals with Education Act and early intervention services included in an Individual Family Services Plan under Part H of IDEA. As a result, most state Medicaid agencies are now allowing school districts and early intervention providers to obtain reimbursement for services provided. The state match for the federal Medicaid funds is often provided either by the local education agency or a state general fund match from the lead agency for early intervention. Many states' programs and services under IDEA have become dependent on this important source of funding during the last six years. **The President's proposal is unclear about the future of this important source of funding to support critical school and early intervention services.**

In any new proposal to fund these critical services, the relationship of any services funded under any "supplemental" program to services provide though health plans, services provided in schools (especially those provided under IDEA, and other health services must be considered. Such coordination will assure that children get all the services they need in an appropriate manner. Such integration will also streamline access for families.

To fulfill the promise of the EPSDT mandate, a comprehensive benefit package must be available to assure the health and optimal functioning of all children. Therefore, *CCD STRONGLY RECOMMENDS:*

1. *The Medicaid EPSDT mandate should be continued with the current eligibility criteria, including the criteria for children eligible under the "Katie Beckett" TEFRA 134 provisions. This will ensure that no children will lose any health care they now have, as they Administration has promised.*

2. *A comparable "supplemental" benefits package funded by the states in partnership with the federal government should be provided to all children. This program should be affordable and have a cap on out-of-pocket costs based on family income.*

Early identification of disabilities and health needs and the subsequent provision of necessary treatment for all conditions are critically important as Congress recognized in 1989 when it strengthened the EPSDT mandate. However, the Administration's proposal to develop a fully federally-funded "supplemental" program does not provide assurances that the full range of EPSDT services currently available under Medicaid will continue to be available. Therefore, *CCD RECOMMENDS:*

1. *The financing must be adequate to meet the treatment needs of children. State participation should be considered.*

2. *The provisions of any "supplemental" program, whether its Medicaid or non-Medicaid funded, must be clarified and better articulated in the legislative language, especially with regard to state maintenance of effort, integration with the Alliances and Health Plans, and relationship to other programs and funding streams.*

VI. Continued Availability of Services Currently Received Through Medicaid

While we applaud the integration of Medicaid beneficiaries into the alliances for acute care services -- a strategy which will help to eliminate the current two-tiered nature of our health system -- Medicaid-eligible individuals must be assured a real choice among the full range of health plans. Individuals with disabilities or chronic health conditions may need to choose a high-cost plan because of its range of specialists or relationship to a center of excellence. Low-income persons whose health needs require extensive specialty care will need a subsidy in order to afford a fee-for-service option or point-of-service options in managed care plans. A subsidy to purchase fee-for-service plans during the transition period was included in the Administration's September 7 draft, in recognition of the fact that many primary care providers -- and health plans -- will not be prepared to meet the specialized health care needs of some individuals with disabilities and chronic illnesses. We urge the Committee to consider this earlier proposal.

Another concern is that adult, non-cash assistance Medicaid beneficiaries who are

receiving services not covered in the HSA mandated benefits package will lose these benefits. These include important services such as dental care and medical transportation for persons with no other means to access health services. Individuals with low incomes who have disabilities may need these services to achieve full functioning. (See the section on EPSDT for additional concerns about children's services under Medicaid). We are also concerned about those individuals who are currently working and continue to be eligible for Medicaid under Section 1619(b) of the Social Security Act.

CCD has major concerns about the co-payment requirements for individuals who are low income and who use a high volume of service. The cap on out-of-pocket expenses should be lower for low income individuals to prevent individuals from putting off care, which could lead to the development of more expensive complications.

Finally, CCD is concerned that persons eligible for long-term services should continue to receive optional Medicaid benefits such as rehabilitation, clinic services, personal care, home and community waiver services and case management. Given the major deficiencies in the proposed mental health benefit, in particular, the continuation of these services is particularly essential to individuals with mental illness. Therefore, *CCD RECOMMENDS:*

1. ***Individuals currently eligible for Medicaid services should continue to receive the full range of Medicaid covered services.***

2. ***Medicaid eligible and low-income individuals with disabilities or special health care needs must be able to access the full range of medicaly necessary covered health services to meet their needs, whether they are in a low cost or a high cost plan. If these services are not adequately provided in their plan, then these persons should be subsidized as needed to choose whatever plan will adequately meet their health care needs, including ongoing access to specialists, centers of excellence and other specialty care.***

3. ***The cost-sharing requirements for Medicaid beneficiaries and individuals with low incomes should be lowered to eliminate financial barriers to care.***

VII. Assuring Choice of Providers in all Managed Care Plans

As health care costs have continued to rise at double digit rates, insurers and employers have searched for ways to control costs. One response has been a growth in managed care plans of many different types. These include staff-model Health Maintenance Organizations (HMOs), Individual Practice Associations (IPAs), and Preferred Provider Organizations (PPOs). The number of people enrolled in managed health care plans has increased dramatically. Today, there are very few fee-

for-service plans that do not employ "managed care" techniques, such as utilization review and pre-admission certification for non-emergency hospitalizations.

Apart from a few well-established HMOs, such as Kaiser in California, the development of many managed care entities is a relatively recent phenomenon and there are serious concerns about some of the financial practices they employ to control utilization. CCD is concerned that while there are incentives in these plans to keep people healthy and decrease inappropriate utilization of expensive services, many plans offer financial incentives to decrease *appropriate* utilization. For example, some plans will withhold a percentage of a provider's income (15 - 20 percent) if they have exceeded a targeted number of referrals to specialists and hospitalizations. To address these concerns, *CCD RECOMMENDS:*

1. ***The Point of Service option for managed care plans must be maintained.***

2. ***There must be strong provisions to assure that physician referrals to physician and non-physician specialists are financially neutral and based solely on the health needs of the patient. Just as physicians should not receive payment for referrals, so they should not receive payment for denying referrals. The legislation must expressly prohibit financial penalties for making referrals and bonus payments for not making referrals.***

3. ***There must be a prohibition against balance billing for medically necessary services obtained outside a network.***

A. Single Source Contracting

The Health Security Act currently preempts state laws that prohibit health plans from contracting with a "single source" to provide all of the services for a particular aspect of health care. For instance, under the HSA, health plans would be able to contract with one orthotic and prosthetic practitioner to provide all of the orthopedic braces and artificial limbs prescribed by physicians in the health plan. Similarly, one home medical equipment supplier could be chosen to service all of the home equipment needs of the plan's beneficiaries.

This approach is undesirable in a number of respects. First, qualified providers will be prevented from gaining access to and competing in the health care market. Monopolies of providers of particular types of services will be encouraged by this policy, thereby decreasing competition and eventually driving up prices. Some qualified providers could be forced out of business. The combined effect of allowing single source providers and decreases in the number of qualified providers in a given area will reduce the service options available to consumers. Consumers will be prevented from choosing a health care provider with whom they may have developed a long-standing relationship or one who is conveniently located.

The quality of care may also be compromised when managed care plans contract with a single provider for a specialized service. As an example, in the area of orthotics and prosthetics (O & P), many certified O & P practitioners specialize in different aspects of orthotic and prosthetic care. One may specialize in advanced upper limb protheses and another in orthopedic braces for the management of spinal conditions such as scoliosis. Other providers may specialize in advanced fitting techniques and material applications. In an area like O & P, where "one size does *not* fit all", allowing a plan to contract with a single provider severely restricts access to providers with expertise in a given area, and has to potential to seriously undermine the quality of care that a persons receives. Consumers must be given a real choice of providers for all services covered under a health plan. Therefore, *CCD RECOMMENDS:*

1. ***The legislation must include incentives for health plans to contract with as many providers as necessary to meet the health care needs of their beneficiaries, particularly persons with disabilities and chronic, disabling illnesses.***

2. ***No health plan should be allowed to engage in practices that have the effect of discriminating against any type or category of provider, or within a category of providers, as long as the provider is authorized under state law or regulations to provide health and mental health services. This will allow the consumer to have a real choice when selecting a health professional for a particular condition. This freedom of choice is particularly important for persons seeking mental health services, where interpersonal variables are important factors in treatment success.***

B. Gatekeepers

While the Health Security Act enables choice of providers outside of a managed care network, it does so at a substantial cost to the enrollee of at least 20 percent of the cost of the service, and there are no provisions to address the problem of balance billing for "out-of-network" services. In addition, in managed care systems, neither the person with a chronic condition or disability, such as severe spinal or head injury, stroke or cancer, nor the generalist gatekeeper are necessarily aware of the services available and needed. To remedy these problems, it is necessary to give individuals who need ongoing specialized services for their particular condition, a right to choose his or her gatekeeper physician, including an appropriate specialist for the condition involved. Each health plan would be obligated to create panels including specialists dealing with the major disabilities.

The National Health Board would define the conditions requiring specialized, ongoing care and would issue guidelines to assist plans in determining appropriate specialties to be represented on such panels. For example, specialists in physical

medicine and rehabilitation would be relevant for managing spinal cord injury or head injury or stroke; specialists in neurology would be relevant for managing stroke, epilepsy, multiple sclerosis, and Alzheimer's disease; specialists in oncology would be relevant to managing cancer.

This right to choose one's main and primary physician is very important and particularly important to a person with a serious health problem. This right is all the more significant in managed care where the main or primary physician has gatekeeper functions. A specialist often is the main or primary physician in terms of personal contact and management for people with disabilities, and would generally be the best informed and competent manager of resources and services for persons with chronic disease or disability. However, managed care systems often prohibit the use of specialists in such roles. To address this problem, *CCD recommends the following change to Section 1402:*

Requirements Related to Enrollment and Coverage by Health Plans

"(h) Any health plan which utilizes a gatekeeper or similar process to approve health care services prior to their provision, shall provide each enrollee who has a chronic condition or disability likely to require substantial health care services over a prolonged period of time, a choice of his or her gatekeeper physician from a panel of physicians which shall include specialists in the medical management of the condition. The National Health Board shall develop and publish a list of the chronic conditions and disabilities that are likely to require substantial specialized health care services over a prolonged period of time. The National Health Board is authorized to develop guidelines to assist health plans in determining which physicians are specialists in the medical management of the conditions or disabilities defined by the Board under this section. A health plan shall annually establish panels of physicians who agree to serve as gatekeeper physicians, including specialists in the medical management of chronic conditions or disabilities such as specialists in physical medicine and rehabilitation, and neurology.

Suggested Report Language:

Individuals with chronic conditions or disabilities of a certain type including spinal cord injury, head injury, or stroke will often need ongoing medical management of a specialist in medicine. This person will often be the primary physician of the patient in terms of the amount of contacts with the patient and the decision making about his or her condition. Individuals with such conditions and disabilities generally desire to have a physician who specializes in the condition they have manage their care in managed care systems. This amendment provides that such individuals have a right to annually select a gatekeeper physician from a panel that shall include specialists in the conditions defined by the NHB as being of such a nature to require specialists case management rather than generalist case management. Many

organizations representing persons with disabilities have urged that persons with disabilities be empowered to select a specialist as their gatekeeper case manager. Conditions which lend themselves to better case management by specialists are usually severe disabilities, for example spinal cord injury, multiple sclerosis, head injury, or AIDS. These conditions often affect many body systems and require a comprehensive approach to medical management and rehabilitation services. Specialists in treating such conditions are trained to understand such complex conditions and to be knowledgeable about the resources available to manage such conditions effectively. Physical medicine and rehabilitation specialists are trained and experienced in handling the comprehensive rehabilitation needs and most general medical problems of persons with severe physical disability of the neuromuscular and musculoskeletal systems. Specialists in neurology are trained and experienced in the diagnosis and medical management of persons with neurological conditions such as epilepsy, stroke and Alzheimer's disease.

C. Access to Academic Health Centers and Centers of Excellence

Academic health centers are entities operated by or affiliated with a school of medicine or osteopathy or a teaching hospital. It is through such centers that many specialized treatments are available, including treatments for rare diseases and disorders, and for unusually severe conditions. A major issue of concern to persons with disabilities and special health care needs is whether persons in managed care settings will be able to receive services at specialized treatment centers. The Health Security Act says that a state "may" require alliances to assure that at least one accountable health plan has a contract with a "center of excellence." This provision does not adequately address the concerns of persons with special health needs. Additionally, we are concerned that persons with disabilities will be financially penalized for receiving medically necessary, specialist services outside the network if these services are not provided in the network. Given that a large percentage of the population is currently enrolled in managed care plans, and this percentage is expected to increase, it is essential that final legislation includes provisions to assure access for all Americans to academic health centers and centers of excellence. Therefore, *CCD RECOMMENDS:*

1. *Regional and corporate alliances must ensure that all health plans have sufficient contracts with eligible academic health centers and centers of excellence so their enrollees can receive specialized treatment services.*

2. *There should be effective quality assurance mechanisms in managed care plans to ensure that people with disabilities and chronic conditions who need ongoing specialized services have appropriate access to these services, and should not be financially penalized when their medical condition requires specialty services.*

VIII. Consumer Involvement and Protections

To ensure that the health care needs of persons with disabilities are met, *CCD RECOMMENDS:*

1. *An advisory committee under the auspices of the National Health Board should be established to address the needs of persons with disabilities and chronic illnesses.*

2. *There must be a formal process for the incorporation of consumer input in the development of "report cards" for health plans. Additionally, these report cards must assess not only the quality of care delivered to the "average" person, but must include assessments of the quality of care delivered to persons with disabilities and chronic health needs.*

IX. Education and Training of Health Providers

While the Health Security Act has provisions to increase the number of primary health care doctors and nurses, it has no comparable provisions to increase training for other key health and rehabilitation professionals including physical therapists, occupational therapists, speech-language pathologists, audiologists, respiratory therapists, rehabilitation psychologists, and nutritionists. These health professionals provide necessary services and supports to individuals with disabilities and their families. Many of these services enable individuals with disabilities to remain in their homes with their families, preventing the need for more costly institutionalization. Because there are documented shortages in many of these profession, *CCD RECOMMENDS:*

1. *The Health Security Act must include provisions to ensure a sufficient number of health and rehabilitation service providers.*

Another major concern of CCD is the lack of education and training for both primary care providers *and* specialists in the delivery of health care to children and adults with disabilities. Like all Americans, individuals with disabilities need access to a range of primary health care services, which do not have to be provided by specialists in their particular disability. For example, children with mental retardation will experience the same broad array of health problems that are experienced by all children, e.g. ear aches, sore throats, chicken pox and other childhood diseases. Treatment for many of these problems is appropriately provided by a family doctor, a pediatrician, a pediatric nurse practitioner, or a physician assistant. All of these primary care providers, and specialists as well, need to be educated regarding the special needs of individuals with physical mental, and communicative disabilities. Therefore, *CCD RECOMMENDS:*

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1. *There must be provisions in the Health Security Act requiring that the training of primary care providers include appropriate content dealing with the delivery of primary health care for children and adults with physical, mental, and communicative disabilities. This content should be available in both basic education and continuing education programs. Programs providing this content should be carried out in collaboration with physical medicine and rehabilitation programs or other specialty programs serving the needs of persons with physical, mental and communicative disabilities.*

Finally, in determining the appropriate ratio of primary care providers to specialists, it is essential to consider secular trends in the incidence and prevalence of specific disabilities and illnesses. For example, in the past decade there has been a dramatic increase in the survival of persons with severe traumatic brain injuries and a concomitant increase in the need for neurologists, neuropsychologists, and rehabilitation psychologists to treat these individuals. Therefore, *CCD RECOMMENDS:*

1. *The National Council on Graduate Medical Education should be required to take account of the incidence and prevalence of disabling conditions, as well as changes in the needs of persons with specific disabilities, in determining the appropriate specialty mix needed.*

Closing

In closing, we would like to state that CCD is committed to working with both the Administration and Congress to assure adoption of our recommendations to improve the Health Security Act and to enact comprehensive health care reform in 1994. With the exception of President Clinton's plan and the Single Payer Plan introduced by Senator Wellstone and Rep. McDermott, all of the other bills currently being considered in the 103rd Congress fail to address the needs of persons with disabilities in fundamental ways. We strongly urge the Committee to reject proposals -- including the Cooper Plan – that do not guarantee universal coverage for comprehensive benefits, long-term services, protection from catastrophic costs, and cost containment measures that will slow the rate of growth in health care costs so that comprehensive benefits remain affordable.

As you proceed with your work on health reform legislation, we would like you to remember one point: "In the long-term, the success of the health care system must be judged less on its success in serving the majority of the population, most of whom have few or simple medical care needs, and more on how effectively it addresses the needs of those with serious and persistent disabling illness, who depend on the health system for their functioning, perhaps even for their lives. To the extent that the reforms address their needs successfully, they are likely to serve us all well."[1]

1. Mechanic, David. Mental health services in the context of health insurance reform. *The Milbank Quarterly*, Vol. 71(3), 1993.

Consortium for Citizens with Disabilities

The Consortium for Citizens with Disabilities Health Task Force is a coalition of over 65 national organizations working to enact comprehensive health care reform that will meet the needs of persons with disabilities and chronic illnesses, and their families.

THE COOPER HEALTH PLAN FAILS PERSONS WITH DISABILITIES AND CHRONIC ILLNESSES

The 49 million Americans with disabilities have an enormous stake in the current health care reform debate. Persons with disabilities and chronic illnesses are disproportionately represented among both the 39 million uninsured and the millions of under-insured. Lack of adequate health coverage is a life-threatening daily experience for those who need health care. Enormous personal and societal costs result from this lack of insurance.

When evaluating the adequacy of a health care reform proposal, whether the needs of persons with disabilities and chronic illnesses are met is an essential litmus test. It is our strong belief that a health care system that meets the needs of these persons will meet the needs of all Americans. ***The Cooper bill (H.R. 3222) fundamentally fails to address the needs of persons with disabilities and chronic illnesses.***

UNIVERSAL COVERAGE

CCD Position

- Coverage must be provided to all persons regardless of age, employment, income, disability or health status, by a specified date.

Cooper Bill

- No mandate for universal coverage.
- Employers must offer, but are not required to pay for, coverage of their employees.
- A health plan may not deny insurance to anyone *who can afford* coverage, but a six month pre-existing condition exclusion is allowed, except for the continuously insured, pregnant women, and infants. Premiums may vary based on age.
- Insurance premiums are based on age-adjusted community rating inside a Health Plan Purchasing Cooperative (HPPC) and either age-adjusted or pure community rating outside HPPCs.

Impact

- The Congressional Budget Office estimated that H.R. 5936, Cooper's similar bill in 1993, would leave 25 million people uninsured.

- Persons with disabilities and chronic illnesses will continue to be disproportionately uninsured, leaving many unable to work because they cannot get health insurance.

- Job lock will continue, with workers having to choose between taking or staying at a job that provides health insurance and a job that does not provide coverage. Persons with disabilities and chronic illnesses, in particular, will be faced with limited employment options, including staying in dead-end jobs.

- Without universal coverage, uncompensated care costs will continue to be shifted to those employers, individuals and health care providers who pay for care. This will lead to higher premiums that will be unaffordable for many.

BENEFITS

CCD Position

- A comprehensive benefits package is essential, particularly for persons with disabilities and chronic illnesses, to ensure that people will receive the services they need.

- The standard benefit package must be specified in the legislation in order to maintain public accountability.

Cooper Bill

- Benefits are not specified in the bill. Benefits will be defined at a later date by a new federal commission and approved by Congress on an up or down vote. The commission has only five members and no requirements for representation by persons who have any expertise with the specialized health needs of persons with disabilities and chronic illnesses.

- State minimum benefit laws are pre-empted.

- Employers will only be allowed to take a tax deduction for the cost of the lowest priced health plan.

- If an employer provides a health plan that costs more than the lowest priced plan, employees will have to pay income taxes on the difference in cost between the two plans.

Impact

- There is no guarantee that the particular benefits needed by persons with disabilities and chronic illnesses will be included in the standard package.

- State benefit mandates will be eliminated before the standard benefits package is federally mandated, which will leave many people with fewer benefits than they currently have.

- Employers will have a tax incentive to offer only the lowest cost plans, which may not meet the needs of persons with disabilities and chronic illnesses.

- The cost of insurance will be shifted to employees because the cost of benefits in excess of the lowest cost plan will be considered taxable income.

- With the standard benefit package probably being inadequate, high risk persons with higher incomes will buy the better supplemental insurance, continuing adverse selection and unfair distribution of costs.

AFFORDABILITY

CCD Position

- The health care system must be adequately financed to ensure universal coverage.

- Financing should include an employer mandate to make health insurance affordable for employees.

- Cost-sharing provisions must include subsidies for premiums, deductibles, and co-payments for all low-income persons so they can join the plan that best meets their needs.

- Low-income consumers must have reduced out-of-pocket limits.

- When determining adjusted gross income, disability-related expenses must be an allowable deduction.

Cooper Bill

- No limits on the cost of premiums or premium increases.

- Employers are not required to contribute to premium payments.

- Premiums for persons with incomes below 100% of poverty ($14,800 for a family of four) are subsidized, but only for the lowest cost plan.

- Premiums for persons with incomes between 100% and 200% of poverty ($14,800 to $29,600 for a family of four) are subsidized on a sliding scale only for the lowest cost plan.

- Cost-sharing is required, except for preventive services.

- Limit on amounts of copayments and deductibles are not set in bill, but rather will be set by the federal commission. Nominal copayments, to be defined by the federal commission, will be charged of all persons with incomes below 200% of poverty.

- Out-of-pocket limits for the insured will be set by the federal commission.

- Low-income assistance subsidy program is capped with no assurance of adequate funding.

Impact

- Insurance will be unaffordable for all but 1) higher income consumers; 2) the very low-income; or 3) those whose employers contribute significantly to the cost of insurance.

- The amount of cost-sharing is completely unknown and will contribute to consumers' inability to afford necessary health services.

- Premium subsidies are inadequate. For instance, a pregnant woman with income at 185% of poverty ($27,380 for a family of four) is likely receiving Medicaid in most states and will now be required to pay 85% of the cost of her insurance premium, a substantial amount of the family's income.

- Low-income consumers will be segregated into the lowest cost plans, perpetuating a two-tier system of health care.

- A cap on the subsidy program leaves all low-income persons at risk of losing their premium payments, reduced copayments and supplemental benefits.

ADMINISTRATION AND SERVICE DELIVERY

CCD Position

- Regional health alliances should be established to ensure that health care risks and their associated costs are spread across as large a population as possible. A very large population base is also needed for community rating to work effectively. Participation in regional alliances should be mandatory.

- Alliances should be required to offer a choice of health plans, including at least one fee-for-service plan.

- Risk adjustments payable to health plans must be set at an adequate level to remove economic incentives for providers to underserve persons with disabilities and chronic illnesses and to guarantee that the amount, duration, scope and quality of care for persons with disabilities and chronic illnesses is appropriately based on medical needs.

- While accurate risk adjustment methods are being developed, there must be mandatory reinsurance requirements so that plans do not have an incentive to restrict services for persons who incur extremely high costs.

- Reimbursement formulas must include adjustments for time-intensive services.

- Access to specialized treatment centers must be assured.

Cooper Bill

- Health Plan Purchasing Cooperatives (HPPCs) are established through which small businesses (fewer than 100 employees) and individuals must purchase insurance to maintain tax deductibility.

- Risk adjustments will made to health plans, but specific factors are not detailed, except for the difference in utilization that may result from lower cost-sharing for persons with low incomes.

Impact

- With such small pools, the current segmented market will continue and the risks and costs of health care will not be spread widely enough. The small size of the pool will also weaken the negotiating power of the alliance which will reduce the ability of employers and individuals to obtain affordable, comprehensive coverage.

CHOICE

CCD Position

- All persons should have a choice of health plans with an affordable out-of-network services option.

Cooper Bill

- Employers do not have to offer more than one plan.

- Employers and individuals are only allowed tax deductions up to the cost of the lowest cost plan, which will restrict the choice of a higher cost plan.

- Low-income persons are subsidized for the lowest-cost plan only and must pay more if they choose a more expensive plan.

- There is no mandate that managed care plans must include an out-of-network option, and states are specifically prohibited from mandating an out-of-network option.

Impact

- With no choice of health plans, low-income persons, including those with disabilities and chronic illnesses will be segregated into low cost plans, which may be underfunded, and there will be no competitive pressures to assure quality.

- The lowest cost plan will often be an HMO, which frequently does not adequately meet specialized health needs. Choice of providers, therefore, will largely be decided by income status.

- With no out-of-network option, many people with disabilities and chronic illnesses will not be able to get the specialty care they need. Even if an out-of-network option is included, there is no guarantee that it will be affordable.

MANAGED CARE

CCD Position

- Contractual provisions in managed care plans that shift financial risk to physicians and other health care providers should be strictly prohibited.

- Managed care plans must include effective quality assurance mechanisms to ensure that persons with disabilities and chronic illnesses have access to appropriate and necessary specialized services.

- Managed care plans must offer persons with disabilities and chronic illnesses who are likely to require substantial services over a prolonged period of time the option of having a specialist as their gatekeeper.

- Provider referrals to specialists should be financially neutral and based solely on the health needs of the individual.

- Access to specialists should not be based on one's ability to pay higher premiums, deductibles and copayments, or one's ability to purchase supplemental insurance.

- There must be an affordable out-of-network option.

- There must be a prohibition against balance billing for medically necessary services obtained outside a network.

Cooper Bill

- Encourages reliance on and growth of managed care networks as a major feature of plan, but there are no quality assurance or consumer protection provisions.
- States will not be able to prohibit or restrict financial risk arrangements for providers in the network.
- No provision is made for persons with disabilities and chronic illnesses to have specialists as their gatekeepers.
- No mandate is made for the provision of an out-of-plan option, and states are specifically prohibited from mandating an out-of-plan option.

Impact

- Managed care has historically barred many persons with disabilities and chronic illnesses from access to the services they need. This will continue with persons who need specialized care experiencing limits on services, difficulty in accessing specialists, and frequent admission to inappropriate and inadequate levels of care.
- Protections for persons with disabilities and chronic illnesses in managed care plans are not specified, leaving them without safeguards for quality but rather at the mercy of an HMO's bottom line.
- Managed care plans will be allowed to give providers financial disincentives not to give care, leaving persons with disabilities and chronic illnesses at risk for not receiving the services they need.
- With no out-of-plan option, many people with disabilities and chronic illnesses will not be able to get the specialty care they need. Even if an out-of-plan option is included, there is no guarantee it will be affordable.
- Care coordination will continue to be driven by the need to contain costs, rather than by the need to assure quality care through the maximization of health care and community resources.

MEDICAID

CCD Position

- The acute portion of Medicaid should be incorporated into the new system, eliminating the current two-tiered system of health care.
- Persons currently receiving services through Medicaid should not lose those services.

- Medicaid-eligible individuals with disabilities and individuals with low incomes should be subsidized for the full range of health plans or to use a point-of-service option if their health care needs require that they have ongoing access to specialists, centers of excellence and other specialty care.

- The Medicaid mandate for Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) should continue for eligible children.

Cooper Bill

- Medicaid acute care is abolished as of January 1, 1995.

- Premiums are paid for persons with incomes under 100% of poverty for only the lowest cost plan offered by a HPPC.

- Payment for prescriptions, hearing aids, eyeglasses and other supplementary benefits (as defined by the federal commission) will be provided only to persons with incomes below 100% of poverty.

- The Medicaid mandate for Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) is eliminated.

- Federal subsidies are capped with no assurance of adequate funding.

Impact

- Medicaid-eligible individuals and other low-income individuals will be segregated into the lowest cost plans, continuing the two-tiered system.

- Premiums for persons now on Medicaid with incomes above 100% of poverty, including millions of children, will not be adequately subsidized. Many will lose health coverage.

- Millions of people on Medicaid could face reduced benefits.

- The need for a supplementary benefits package highlights the foreseeable inadequacy of the undefined standard benefits package.

- Millions of children will lose medically necessary health care because of the elimination of the EPSDT mandate.

- A cap on the federal subsidy program is unrealistic since the cost of the standard benefits package and thus the cost of the supplementary benefits are completely unknown.

LONG TERM CARE

CCD Position

- Provisions to increase the availability of long term care services and supports, including a coordinated, comprehensive range of home and community-based services, must be included in health care reform legislation.

- Financing requirements for any program must not lead to a reduction in the levels or types of long-term services currently provided to those most in need: low-income persons with disabilities and chronic illnesses.

Cooper Bill

- All federal funding for long term care services through Medicaid will be terminated. The states will be expected to pay the full cost of these services with only transitional federal funding.

- There is no specification of where the state will get the revenue to replace the federal funding.

Impact

- Millions of persons of all ages with disabilities and chronic illnesses will lose long term care services because states will be financially unable to replace the former level of federal funding.

- The community services for persons with developmental disabilities and severe mental illness which have been hard fought for will disappear because the states will not be able to pick up the lost federal funding share.

FINANCING

CCD Position

- The health care system must be equitably and adequately financed, and must include an employer mandate with adequate subsidies to small businesses and persons with low incomes. An employer mandate builds on the current system, increases affordability, and ends cost-shifting from employers who do not provide insurance to those who do.

Cooper Bill

- Employers are not required to contribute to employees' coverage.

- No subsidies are provided for small businesses.

- Tax deductibility of employer and individual health costs is limited to the lowest cost plan.

- Medicaid is repealed, including federal funding for long term care services.

Impact

- The plan is inadequately and inequitably financed, and will leave 25 million people uninsured, according to CBO's estimates on Congressman Cooper's similar bill in 1993. Persons with disabilities and chronic illnesses will continue to be disproportionately uninsured.

- Many people will be segregated into the lowest cost plan because of the tax implications and the unaffordability of purchasing a higher cost plan.

- Although some individuals will be given tax deductions not currently allowed, this will not compensate for the increase in premiums and cost-sharing.

COST CONTAINMENT

CCD Position

- Effective cost containment measures must be implemented so that increased costs are not shifted to consumers in the form of higher premiums, increased cost-sharing and reduced benefits.

- Effective cost containment measures include:
  - caps on premium increases
  - competition among health plans in regional health alliances
  - standardization of insurance forms
  - Medicare prescription drug rebates

Cooper Bill

- No limits on what insurance companies are allowed to charge.

- Caps on employer and individual tax deduction to the lowest cost plan.

- Depends solely on hypothesized competition to potentially reduce costs.

Impact

- Premiums will continue to increase, making insurance unaffordable for an increasing number of persons, particularly those with disabilities and chronic illnesses.

- Many services will likely not be covered, including preventive care, making health care costs increase even more because people will have to delay their care until they are very ill and then need costlier care.

THE COOPER PLAN FAILS

On each and every issue of critical importance to persons with disabilities and chronic illnesses, the Cooper bill fails. The Cooper bill offers no choice of health plans, will not assure affordability of insurance, does not define the benefits that will be covered, and will continue to leave people in fear of losing their coverage. Many persons currently covered by Medicaid will actually become uninsured under the Cooper bill. The Cooper bill is NOT health care reform.

For additional information, please contact the CCD Health Task Force Co-Chairs: Kathy McGinley 202-785-3388/Janet O'Keeffe 202-336-5934/Peter W. Thomas 202-659-2900

Chairman FORD. I would like to tell the gentleman from Wisconsin that the most voluminous of these is the critique by the Consortium for Citizens With Disabilities' Health Task Force, 65 national organizations working to enact comprehensive health care reform that will meet the needs of persons with disabilities and chronic illnesses and their family. One of them is entitled, "The Cooper Health Plan Fails Persons With Disabilities and Chronic Illnesses."

Then, in addition, we have the testimony of Henry Aaron on the economics of the plan. Mr. Aaron is an economist with the Brookings Institution, I believe. And I also call that to Mr. Gunderson's attention because he agrees with some of the findings that were in the report that the majority staff released about the economics of this plan.

Mr. GUNDERSON. Mr. Chairman, reserving the right to object. Mr. Chairman?

Chairman FORD. Go ahead.

Mr. GUNDERSON. And I don't intend to object as long as you will also allow me to submit also at this point in the record articles from the pro-life people critical of the bill because they believe it is pro-abortion, and an article from the pro-choice people critical of the bill because they believe it is pro-life.

And the reason all of these groups, including the ones you have articulated, have taken the positions they have is because unlike the Clinton plan which legislates every single benefit by a vote of the House of Representatives and the Senate, the Cooper-Grandy bill establishes a National Benefits Commission to do so.

Now, if everybody in this Congress wants to have a vote every year on chiropractic coverage, acupuncture coverage and everything else, you are right. Then we should vote for the Clinton plan. But I hope that is not what most Members of Congress want.

So, I withdraw my reservation.

Chairman FORD. Without objection, it is agreed to.

Mr. Cooper, I am sorry that you have been delayed so long. You can see there is a lot of interest in this committee in your plan. As a matter of fact, you have a number of cosponsors on the committee.

Are any of them here today? Mr. Gunderson is, and Mr. Miller, but the others are not here.

Mr. COOPER. Mr. Petri.

Chairman FORD. You can proceed in anyway you—pardon me? Oh. Mr. Petri.

You may proceed in anyway you feel most comfortable with. You can add to, supplement or underline your statement, which is already in the record.

STATEMENT OF HON. JIM COOPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. COOPER. Thank you, Mr. Chairman. I appreciate you holding the hearing. My able and distinguished cosponsors who join me today would like to particularly thank the cosponsors on the committee: Mr. Gunderson, Ms. English, Mr. Petri, and Mr. Miller.

What is managed competition, and how has it broken the partisan gridlock on health care reform? As you will hear from John Reiker of General Mills in a few moments, managed competition is

an approach that is being field tested in various forms in Minnesota, California, Florida and Washington State already, as well as in 150 cities across America.

Versions of managed competition have been working for years in places like Memphis, Tennessee; Cincinnati, Ohio; Orlando, Florida; Rochester, New York; and countless other cities around the country are also trying it.

Nine million Federal employees are benefiting from an early type of managed competition that has existed for nearly 30 years.

Managed competition has broken partisan gridlock by combining the best features of market competition and government regulation. It is not a new entitlement program. It is an empowerment program. It is not the old "Please the bureaucrat" regulatory paradigm. It is the new "Please the customer" paradigm."

It enables every American to be able to shop for health care and health insurance. This may sound unremarkable but we have never been allowed to shop for health care in America. We seldom know the price or the quality of health care in advance, and that prevents us from doing any comparison shopping. Now, for the first time in our lives we should have the power and the information to be able to pick out the best plan for ourselves and our families.

We like the idea of annual, menu-based shopping for health coverage similar to the system that Federal employees use today. Instead of Congress keeping a benefits system to itself, we should share that system with the whole country. If done properly, this could enhance consumer choice, promote higher medical quality and contain cost. In fact, managed competition can be tougher and fairer on cost than government price controls could ever hope to be.

We support the health insurance reforms of the Clinton plan. We make sure that every American can get good health insurance at low group rates as if they worked for the biggest company in town. No insurance company could turn you down anymore, and people will be able to keep health insurance no matter what happens to them. No matter if they get sick, no matter if they switch jobs, no matter if they lose their job.

In health jargon, we are for guaranteed issue insurance with a ban on preexisting condition limitations and experience rating. No more canceled policies. No more price gouging. No more insurance company discrimination.

We not only make insurance available, we make it affordable. Every American under 200 percent of poverty would qualify for help from the program that would replace Medicaid. That means that four times more people would be covered than under the current Medicaid program.

Little attention has been paid to the fact that every taxpayer would benefit from a new tax deduction for low cost basic coverage under our plan. Today, only corporations can fully deduct, not the employee, not the self-employed.

The Clinton plan could give the self-employed a full deduction, but not the employee. We think that employees and the unemployed should also benefit. This alone is a $54 billion program over 5 years to help average Americans better afford health coverage. This is effectively a middle-class tax cut paid for by trimming a corporate tax break.

These reforms should remove all obstacles to health insurance coverage for all Americans. There is no reason why everyone won't be covered with these reforms. If there are some, we will soon know who they are and we will be able to cover them on the President's timetable of 1998. No other bill in Congress comes this close to achieving the President's demand that we guarantee every American private health insurance coverage that can never be taken away.

The McDermott bill does not even allow private health insurance. The Chafee bill promises individual mandate coverage by the year 2005, but that is on a pay-as-you-save basis.

When you look at a broad range of health care issues, our bill is the closest bill in Congress to the President's bill. There are many similarities, but there are also some key differences. We disagree on the employer mandate, on bureaucratic price controls, on large and regulatory health alliances, on politicization of the basic benefits package, and on excessive State flexibility. I would be happy to go into these or other issues.

Our bill does promise less than the President's bill, but we are confident that we can deliver on every promise.

To conclude, Mr. Chairman, our bill is closer to the President's approach and closer to the unanimous 50 State Governors' recommendations than any other bill. Ours is the only bipartisan bill. It is certainly far from perfect, but it is the best starting point to achieve a national consensus on this complex issue.

With managed competition we have an opportunity not to copy the health plans of other nations, but to beat other nations. Members who are interested in more information should feel free to refer to the Democratic Study Group report, "Clinton versus Cooper." That contains a more fair and balanced summary of the two plans than perhaps can be found elsewhere.

Thank you, Mr. Chairman.

Mr. SCOTT. [presiding] Thank you, Mr. Cooper.

[The prepared statement of Mr. J. Cooper follows:

STATEMENT OF HON. JIM COOPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Thank you, Mr. Chairman, for holding this hearing on H.R. 3222, the "Managed Competition Act of 1993." I would like to recognize the members of this committee which are cosponsors of H.R. 3222: Steve Gunderson, Karan English, Tom Petri and Dan Miller.

As we attempt to move health care reform through the Congress, I would urge you to be genuinely bipartisan. I know this sounds simple, and it is certainly a goal to which everyone at least pays lip service. But it is the only way to pass a bill through the Senate. It is the only way to pass the House with a majority similar to that of the other great reform bills of this century.

Far more important, bipartisanship is vital to make sure that reform is accepted back home. That is the real test of this legislation and of ourselves. We need a new health care system that makes all of our patients feel comfortable, whether they are Democrats, Republicans, Independents, or apolitical.

The President and First Lady deserve tremendous credit for their courage and leadership in health care reform. As the former Surgeon General, Dr. C. Everett Koop, has said, the Clintons have shown more leadership in health care than all of their living predecessors combined. The President and First Lady have an opportunity to lead an overwhelming bipartisan majority of the House and Senate to a historic health reform bill.

Through two Congresses, our bill is the only comprehensive health reform bill that enjoys real bipartisan support. Health care may be a giant $930 billion issue

that consumes 14 percent of the Gross National Product, but the bipartisan middle ground on this issue may be one inch wide.

What is managed competition, and how has it broken the partisan gridlock on health reform?

It is an approach designed by the Jackson Hole Group of business leaders and health care experts. We modified that approach and consulted with hundreds and hundreds of regular people back home, health professionals, and groups like American Healthcare Systems, a not-for-profit hospital chain, as we put together our bill. The Progressive Policy Institute, for which Dave Kendall will be testifying on the next panel, was an early supporter of pure managed competition.

As you will hear from Jon Reiker of General Mills, managed competition is an approach that is being field-tested in various forms in Minnesota, California, Florida, and Washington State, as well as in 150 cities across America. Versions of managed competition have been working for years in places like Memphis, Tennessee; Cincinnati, Ohio; Rochester, New York; Orlando, Florida, and countless other cities around the country. Nine million Federal employees are benefiting from an early type of managed competition that has existed for over 30 years.

Managed competition has broken partisan gridlock by combining the best features of market competition and government regulation. It is not a new entitlement program; it is an empowerment program; it would create a please-the-patient paradigm.

It enables every American to be able to shop for health care and health insurance. This may sound unremarkable, but we have never been allowed to shop for health care. We seldom know the price or quality of care in advance, preventing us from comparison shopping. Now, for the first time in our lives, we'll have the power and the information to pick out the best plan for ourselves and our families.

We like the idea of annual, menu-based shopping for health coverage, similar to the system that Federal employees use today. Instead of Congress keeping a benefits system to itself, we should share that system with the whole country. If done properly, this could enhance consumer choice, promote higher medical quality, and contain costs. In fact, managed competition can be tougher and fairer on costs than government price controls will ever be.

We support the health insurance reforms of the Clinton plan. We make sure that every American can get good health insurance at low group rates, as if they worked for the biggest company in town. No insurance company could turn you down. And people will be able to keep that insurance no matter what happens to them, no matter if they get sick, switch jobs, or lose their job. In health care jargon, we're for guaranteed-issue insurance, with a ban on preexisting condition limitations and experience rating. No more canceled policies; no more price gouging; no more insurance company discrimination.

We not only make insurance available; we make it affordable. Every American under 200 percent of poverty would qualify for help from the program that would replace Medicaid. That means that four time more people could be covered than the current Medicaid program.

Little attention had been paid to the fact that every taxpayer would benefit from a new tax deduction for low-cost basic health coverage. Today, only corporations can fully deduct, not the employee or the self-employed. The Clinton plan would give the self-employed that full deduction, but not the employee. We think that employees and the unemployed should also benefit. This alone is a $54 billion program over five years to help average Americans better afford health coverage. This is effectively a middle-class tax cut, paid for by trimming a corporate tax break.

These reforms should remove all obstacles to health insurance coverage for all Americans. There is no reason why everyone won't be covered with these reforms. If there are some, we will soon know who they are, and be able to cover them on the President's timetable of 1998. No other bill comes this close to meeting the President's demand that we "guarantee every American private health insurance that can never be taken away." The McDermott bill does not allow private health insurance. The Chafee bill does not promise coverage until 2005, and then it is highly conditional on a pay-as-you-save basis.

When you look at a broad range of health care issues, our bill is the closest bill in Congress to the President's bill. There are many similarities, but there are also some key differences. We agree on most of the goals of health reform, but we disagree primarily on the role that government should play in the reforms. The administration's bill usually favors a big government approach; we usually favor a small government approach.

We disagree with the employer mandate, bureaucratic price controls, large and regulatory health alliances, politicization of the basic benefits package, and excessive State flexibility. I would be happy to go into these or other issues in whatever

detail the committee would like. Our bill promises less than the administration's bill, but we are confident that we can deliver on those promises.

To conclude, M. Chairman, our bill is closer to the President's and closer to the governors' recommendations than any other bill. Ours is the only bipartisan bill. It is certainly far from perfect. But it is the best starting point to achieve national consensus on this complex issue. With managed competition, we have an opportunity not to copy other nations' health systems, but to beat other nations. I hope we will rise to that challenge.

Mr. Grandy?

STATEMENT OF HON. FRED GRANDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GRANDY. Thank you, Mr. Chairman.

I will submit my statement for the record and ask unanimous consent to begin by quoting from an article that I am going to include with my remarks, which is an op-ed piece from the Washington Post, dated February 2, of this year, by Robert J. Samuelson, which is called "The Dishonest and Nasty Health Debate," and I think this paragraph is instructive for all of our colleagues, whether they are sitting on this side of the panel or members of your committee, that made remarks at the beginning.

[The above mentioned material follows:]

Robert J. Samuelson

The Dishonest (and Nasty) Health Debate

A year ago, I held out the hope that we might have an honest health care debate. Perhaps inevitably, it hasn't happened. On the one hand, President Clinton's plan is hugely dishonest. It offers almost everything to everybody. It would mandate universal health insurance, control costs, expand Medicare and provide new benefits for early retirees—all without imposing major new taxes, threatening the quality of care, reducing patients' choice of doctors or requiring federal price controls. The only thing it doesn't promise is immortality.

On the other hand, Clinton's critics now declare that the health care "crisis" doesn't exist. This rebuttal is accurate in the sense that the health system doesn't face collapse and provides good care for most people. But the argument is misleading because it wrongly implies there are no serious problems: high costs, spotty insurance coverage and genuine public anxieties about both. Everything won't get better spontaneously.

Both Clinton and his critics skirt the real problem: Most Americans expect far more from the medical system than it can deliver. In general, we think people should have good care when they need it. Costs should be no bar; insurance should pay. The issue is a moral one. But naturally, we don't want soaring insurance costs to raise our taxes or depress our salaries. All these are worthy goals—but, unfortunately, contradictory ones.

There are no obvious limits to health "needs." If we have all the care we (or our doctors) say we need, costs will skyrocket. So, controlling costs means curbing some treatments or excluding some diseases or people from insurance coverage—or both. The hard part is weighing costs vs. coverage.

What's missing from this debate is a greater awareness of the conflicts between desirable goals. The warring TV ads have distilled the debate into competing sound bites and nasty scare talk. The insurance industry has Harry and Louise complaining about meddlesome government bureaucrats; a pro-Clinton ad ridicules anyone who would go "halfway" with reform. The main antagonists don't raise the debate much higher. The president dispenses rhetorical flourishes, promising "comprehensive care" that "will never be taken away." Meanwhile, Clinton's critics debunk the "crisis," as if there's nothing else to discuss.

The latest twist in this argument is the claim that health spending is slowing on its own. See, say the critics, there's no problem after all. You should treat this contention cautiously. True, increases in health care prices (measured by the consumer price index) have subsided. In 1993, they rose 5.9 percent, down from 9 percent in 1990. But the increase is still double overall inflation of 3 percent. And the rise in health insurance premiums, though reduced, still outpaces the economy's growth.

Health analyst Jon Gabel of KPMG/Peat Marwick attributes the spending slowdown to four causes: (1) lower overall inflation; (2) efforts by companies to push more workers into "managed care"—health maintenance organizations and similar groups; (3) voluntary price restraint by drug companies and doctors out of fear of federal price controls; and (4) the "insurance cycle" that creates wide swings in premium changes.

Gabel thinks spending will speed up in a few years. Underlying cost pressures remain: expensive new health technologies, an aging population and high public expectations of medicine. Previous pauses in spending have proven temporary. In 1984 the Reagan administration claimed that health inflation had been "broken." And indeed, health spending stabilized at 10 percent of the economy's output (gross domestic product) for four years. But then it jumped again; by 1991 it was 13 percent of GDP.

Whatever happens, the spending slowdown has been achieved at the expense of other goals. The number of uninsured has grown. Among the insured, patient choices are shrinking. A Peat Marwick survey of nine companies found, for example, that 58 percent of their workers are now enrolled in "managed care" arrangements, double the 1988 level. Although managed care has advantages (our family belongs to an HMO), lots of choices isn't one of them.

That's the crux of the matter: All our goals can't be met. No health plan can be perfect. All need to be judged against the alternatives, including doing nothing. In its present form, Clinton's plan is worse than doing nothing. It could cause more problems than it solves. Yes, it would provide universal coverage. But it could needlessly disrupt doctor-patient relations, intensify spending pressures and—because it is so complex and contradictory—spawn massive unintended consequences.

The alternative to Clinton's plan, though, isn't simply to keep government out of health care, as many conservatives imply. In truth, the biggest player in health care is already the government. It pays two-fifths of all health bills, mainly through Medicare and Medicaid. It heavily subsidizes private insurance, because employer-paid insurance is not taxed as individual income. (That is: your employer pays $4,000 for insurance for you, but you don't pay taxes on the $4,000.) The real issue is whether government policies can be improved.

It won't be possible unless we decide what we really want. To control costs? To cover the uninsured? To preserve quality of care? Every problem has remedies. To curb costs, we might impose strict spending controls or end tax subsidies for insurance. But the solution to one problem may aggravate others. Spending controls might undermine the quality of care. Ending tax subsidies would mean Americans would buy less insurance; paying more of their bills, arguably, would make people more cost-conscious. But it might also mean they would receive less care.

Hardly anyone wants to raise these discomforting choices. There seems to be a presumption that Americans are too dim-witted to grapple with them. The White House started the debate dishonestly; its critics have responded in kind. What we have now is a titanic struggle to win the battle of public opinion. Each side contends that the other (government or private medicine) can't be trusted with the health care system. It's Public Incompetence vs. Private Greed. The media war is engaging. But as a debate, it sheds more darkness than light.

I quote: "Both Clinton and his critics skirt the real problem. Most Americans expect far more from the medical system than it can deliver. In general, we think people should have good care when they need it, cost should be no bar, insurance should pay, the issue is a moral one, but naturally we don't want soaring insurance costs to raise our taxes or depress our salaries. All of these are worthy goals, but unfortunately contradictory ones."

Mr. Chairman, the reason I lead with that is because the policy problem that affects all of us whether we serve on Education and Labor, Energy and Commerce or Ways and Means or Merchant Marine and Fisheries is that the American consumer is conflicted over health care. They don't know what they want and they want it now.

The problem is that most Americans will tell you they are all for health care reform as long as they don't have to change anything. Well, we are the ones that have to change something, Mr. Chairman, and unfortunately, the Managed Competition Act, the Chafee bill, the Clinton bill, the Nickles bill, the Gramm bill—all of them are for some changes, all of which are unacceptable to other Members of this Congress and to the Senate.

So there is no magic bullet. There is no perfect plan, and I would concur wholeheartedly with my colleague Mr. Petri who says let's not let the perfect be the enemy of the good.

One of the things that is happened to Mr. Cooper's and my bill is we have gained some prominence over the last couple of weeks with the endorsement of the Business Roundtable and the tacit approval of the National Governors Association. As we have moved center stage, we have obviously picked up as many critics as we have comments. And obviously, now that we are being attacked on both the right and the left, it pretty much, I think, typifies what happens around here. When somebody tries to take the lead on an issue, no good deed goes unpunished.

But having said all that, I think this debate is worth joining, and I would also say that I think the debate itself may be as valuable as the decision, because I also concur that, even though I am a cosponsor of this legislation and would hope to guide it toward some kind of resolution, it is an opening draft. It is the first iteration of a product that, hopefully, will reach some kind of closure in this Congress.

But at the same time we must be mindful of the fact that the debate itself is beginning to have some salutary effects on the market such as voluntary price restraints, such as that by doctors and drug companies, who, because of the fear of price controls, are beginning to curb their own costs. This is not all bad.

Recently Mr. Cooper and I had the opportunity to attend a presentation by the Iameter Project, which is a large managed competition project going on in Cincinnati. That project has effectively taken a large number of employees, mostly in the retail sector, mostly individuals who would not have generous plans, provided them with plans, and seen the effective premium increase go from 16 percent annually down to zero in less than 2 years. So, there are, alive and well, examples of managed competition going on in the marketplace.

But let me talk about some of the areas where all of the plans are similar, and it is somewhat disingenuous to criticize any of them on these terms. The first one is mandates.

Mr. Chairman, whether you support Jim McDermott's Health Security Act and want the government to mandate and deliver all the health care and pay for it through taxes or whether you support Phil Gramm's bill and you want medical savings accounts and you want individuals mandated to buy health insurance with those accounts, this argument is not about, anywhere in the spectrum of health care from the left to the right, whether to impose a mandate but where to place it.

There are some disagreements as to whether or not we should have an employer mandate to fund as well as offer. Mr. Cooper and I advocate a mandate to offer but not to fund, and we hope that the incentives will provide the drive to provide coverage. But it is really somewhat insincere to say that there are no mandates anywhere in the legislation.

The question is where do we impose that mandate, and how great a burden is it to the economy, and do we lose more than we get if we impose a mandate on the workplace and the employers of this country to fund 80 percent of the benefits.

Secondly, price controls. There is not a bill before us that doesn't have some kind of price control. You look at the Clinton plan, obviously those price controls are set at the macro level. We are talking about global budgets which recently the Congressional Budget Office said had a minor swing, between $59 billion worth of deficit reduction as proposed by the Clinton plan and $74 billion worth of deficit loss as scored by CBO. The question is can we impose a global budget at the Federal level that we can indeed enforce.

Mr. Cooper and I propose a price control at the micro level. It is a tax cap. It is an attempt to even out and make the tax code fairer to individuals, particularly for people who have no health care.

I would point out that one of the first, I think, arguments in this debate when Mrs. Clinton came up to the Hill was from C. Everett Koop, who was accompanying her at the time, and he said something that I think all members should be aware of, which is clearly that the problem with health care in this country is not just that some people don't have any or enough, it is that many people have too much. And unless we do something to consciously curb appetite and make the responsibility on the individual and the burden on the consumer, we probably won't get cost containment. We will get government control, but we will not get necessarily cost containment.

The whole purpose of the tax cap is to move in that direction and try and split the difference in attitude among American consumers between whether health care is a right or a responsibility. In our view, it is clearly both. But price controls will be imposed, hopefully at the individual level and not at the macro level.

Finally, let me make a point about regulations. This is the largest piece of social engineering at least since Social Security and maybe since the abolition of slavery. So, anybody who wants to play in this park better get used to some major changes, and it is absolutely disingenuous to take the argument that all we want to

do with health care is fix what is broken in the system. If it were that easy we would have done it by now.

All of the parts are interrelated. Maybe not as intricately as the President would like, but clearly it is not something you can do by just adjusting some insurance laws, tinkering with electronic data interchange, glibly saying that we will pass malpractice reform, and saying we will be done with it. There is more to it than that and it will involve some kind of regulation of the marketplace. That is what the Managed Competition Act is about, trying to reconstruct markets so that they work.

But I would also point out this whole question about bureaucracies being involved in health care I think is an argument that again we have to judge by degrees. Mr. Cooper and I do believe that a National Health Board presided over by seven officials appointed by the President and advised and consented to by the Senate with virtually unlimited powers—and from what I can tell the only criteria for being on the National Health Board is that you can have no background in health care—is clearly not acceptable to the majority of American people. When you are considering about a budget that would be three times the collected budgets of all States in the United States, I think you obviously want more control.

We have devised a system that tries to split the difference between what Mr. Gunderson says is the casualty of allowing politics to determine the benefits and the pure bureaucratic decisionmaking form of the National Health Board. The Health Care Standards Board is designed principally to act as a review board. A group of health care professionals and officials that would decide what the benefit policy should be and then return it to Congress for an up or down vote a la the Base Closings Commission. So Congress would be involved in an advisory capacity, but not intricately involved in the politics of whether to enfranchise chiropractors over podiatrists.

Mr. Chairman, I can tell you as a member of the Health Care Subcommittee we have sat for weeks listening to every single provider in the United States, some provider groups that I didn't even know existed, come before us and tell us they absolutely positively had to be included in the national health care bill. Up to this point the only two benefits we have absolutely decided to excise are veterinary benefits and "life after death."

So this political process is destined to fail, and if you look at the history of Medicaid you will know why.

Having made all of those points, I hope that we will begin through this process to consider how these bills are similar and the themes that unite rather than the issues that divide. That is the sole purpose of this bipartisan effort that includes four members of this committee, Republicans and Democrats, members of the Energy and Commerce Committee, members of the Ways and Means Committee, and the colleagues who are before you today.

So, Mr. Chairman, again thank you for holding these hearings. I will be glad to take any questions with my colleagues, but I hope the discussion will shed as much light as it does heat.

Thank you.

Mr. SCOTT. Thank you, Mr. Grandy.

[The prepared statement of Mr. Grandy follows:]

STATEMENT OF HON. FRED GRANDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. Chairman and members of the committee, I appreciate this opportunity to testify on one of the most important policy decisions confronting the United States Congress. Specifically, ensuring affordable, high quality, health care coverage for all Americans.

Today, I am here to provide an overview of health care legislation I am proud to have sponsored with a diverse coalition of 58 of my colleagues including Representative Jim Cooper and four members of this committee: Karan English, Steve Gunderson, Dan Miller, and Thomas Petrie. The official title of the legislation is the Managed Competition Act of 1993. It remains the only comprehensive bipartisan health care reform proposal introduced in the House.

As you are by now aware, the Managed Competition Act [MCA] is a market-based approach to health care reform. It guarantees universal access to high-quality, affordable health care. Like the President's proposal, the Managed Competition Act builds off of what works in the current system and reforms the chronic problems that have plagued our system for too long. Most importantly, like the President's plan, the Managed Competition Act ensures every American access to a private sector health plan.

I would like to address upfront a criticism that has been leveled against the MCA, that we do not provide universal coverage under our proposal. I want to make it clear that we are not opposed to universal coverage. In fact, universal coverage is a goal that is shared by me and all of the cosponsors. I believe that the universal access mechanism in the Managed Competition Act is the best means to achieving universal coverage. These are not mutually exclusive goals. This whole discussion over access versus coverage is really, in my opinion, an issue of semantics. It is more a discussion of time-tables and how do we get to universal coverage. The MCA uses a different mechanism than the administration to achieve universal coverage, but I believe we share the same underlying goal. I am here to offer my aid in achieving our shared goal of ensuring that all Americans are covered under a system of health care that provides the quality of care Americans want and deserve.

Our bill uses a series of strong tax incentives that will encourage providers and insurers to form accountable health partnerships [AHPs] which, for the first time, will be publicly accountable. Accountable not only for the cost of the care they provide but also for the quality of that care. This will enable consumers to purchase health care coverage in a much more cost conscious manner than they do today. It will also provide them with the information necessary to truly determine which of the plans available to them provides the highest quality of care.

To help facilitate individuals' and small businesses' access to these new AHPs and ensure affordability, regional purchasing cooperatives will be developed to give individuals and small businesses the benefits of greater buying power currently enjoyed by larger employers. A national Health Care Standards Commission will establish a basic benefits package which AHPs will be required to offer in order to receive tax-favored status. In addition, AHPs will be required to comply with a series of insurance reforms and disclose information on medical outcomes, cost-effectiveness and consumer satisfaction.

Specific components of the Managed Competition Act include:

[1] Insurance reforms that will encourage insurers and providers to combine and form AHPs. AHPs will not be allowed to exclude coverage of preexisting conditions and will not be allowed to charge higher rates based on an individual's medical history;

[2] Access provisions which will ensure individuals' and small businesses' affordable coverage by joining Health Plan Purchasing Cooperatives [HPPCs]. HPPCs will offer group rates with lower administrative costs. Once a year individuals will be able to choose from a menu of AHPs in the area much like the current Federal Employees Health Benefits Program;

[3] Provisions to change the incentives in the system from "more money for more services" to a system: in which health plans are prepaid so they will have incentives to promote preventive care; which eliminates unnecessary tests and ineffective treatments; and which reduces administrative costs. Because AHPs will be required to provide information on health outcomes and beneficiary satisfaction, they will be driven to improve quality;

[4] A Federal low-income assistance program will pay health plan premiums for all people below 100 percent of the poverty level. Individuals between 100 percent and 200 percent of poverty level will receive sliding-scale subsidies toward the purchase of a health plan;

[5] Tax reforms which allow employers to deduct the cost of the most efficient health plans, but not the cost of excessive benefits or wasteful spending. In addition, individuals and the self-employed will for the first time enjoy 100 percent deductibility of their health plan premiums;

[6] A series of provisions and additional resources to assist underserved areas in recruiting and retaining providers, the development of provider networks, integration of public health clinics and coordination with urban medical centers; and

[7] Savings mechanisms such as enhanced competition among health plans, anti-trust reforms, significant malpractice reforms, administrative simplification and electronic claims processing.

Mr. Chairman, this committee has heard various approaches to expanding access and ensuring affordable health care coverage for all Americans. These range from proposals that would eliminate the current system and replace it with a Canadian-style system, to proposals that would eliminate the current tax deduction provided businesses for their health care expenses and replace it with an individual tax credit. Our proposal clearly comes in well to the right of the single-payer approach and left of the medical IRA approach. On a spectrum with these two approaches as the respective left and right ends, our proposal comes in on the fifty yard line, building upon the very best aspects of our current system and providing the flexibility necessary to address the deficiencies within the system.

As important as the specific policies included in any legislative framework are the politics involved in building a coalition to pass health care reform. In that regard I submit that the Managed Competition Act provides the foundation for bipartisan reform because it represents a true bipartisan approach to reform. Unlike the single-payer approach, the administration's proposal, the House GOP proposal, and the medical IRA approach, H.R. 3222 remains the only bipartisan approach.

We do not claim to have developed the final product of this debate; only the legislative process itself can accomplish that. We do however have the only proposal that has shown a good faith effort to put aside partisan positioning and work together across the aisle and on both sides of the Hill, and as such, I believe the Managed Competition Act represents the best starting point for the upcoming debate. This sentiment has been echoed by the Governors and a broad cross section of the business community.

Thank you once again for holding these hearings and providing me with this opportunity. I would be happy to answer any questions at this time.

Mr. SCOTT. The next on the list is Representative Long.

STATEMENT OF HON. JILL L. LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Ms. LONG. Thank you, Mr. Chairman. And I would ask that my complete testimony be submitted for the record and then I will simply summarize, since we have a fairly large panel.

Mr. SCOTT. All of the statements will be made a part of the record.

Ms. LONG. Thank you.

Let me begin by sharing with you that I am a cosponsor of both this piece of legislation as well as the President's legislation, and I believe that they are very similar, and I think that each has its strengths and each has its weaknesses, and I think it is very important that we try to identify where we agree as a body rather than where we disagree.

And I also believe that health care reform and health insurance reform are needed, and we are only going to accomplish that if we work in a bipartisan way, and that is why we have to look for the common ground in the different approaches to health care reform.

I believe that the Cooper-Grandy bill is a very sound piece of legislation and a point from which we can begin to build. I don't believe it is a perfect piece of legislation, even though I have been involved in developing this plan, but I think that in terms of the principles upon which it is based, the principles of managed com-

petition, the approach, the general approach where we put as much in the market and minimize to the extent possible government regulation and involvement, I think it is very much on track.

Let me also state that I am very supportive of working toward achieving universal coverage and ensuring a comprehensive benefits package that provides equitable coverage for women's health and also for mental health for all Americans, and I think the difference in how it is approached in Cooper-Grandy is how we achieve these goals, and that is where I may differ with some of my colleagues. It is how we achieve these goals versus whether we achieve these goals.

I am chair of the Congressional Rural Caucus, so, obviously, I have concerns about provisions affecting health care in rural areas. And some of my particular concerns are that I think rural providers may need some additional assistance in adapting to a new system.

I think that new requirements for information reporting or quality of care must take into account the resources that are available or not available currently in rural communities, and I certainly urge this committee to give reform provisions that impact rural areas the attention that they need and deserve.

I think that the major strengths of the Cooper-Grandy bill are in the area of malpractice reforms, the limits on noneconomic damages. I also think that the structure and role of the Health Plan Purchasing Cooperatives where they are consumer-run organizations with minimum government—with a minimal government role, I think that is the approach that we ought to be using.

I think the absence of premium controls and the absence of a global budget, those artificial controls would run counter to the incentives that would be created to keep costs low and quality high.

I also believe very strongly that an independent body determining what the basic benefits package is will lead to a more equitable basic benefits package, because we are going to be taking the politics, or at least to the greatest extent possible removing politics from those decisions, and those decisions should be based on sound actuarial tables as well as equitable treatment of both men and women in rural and underserved areas in the country. I think that can be done much better by an independent body than by the United States Congress.

In summarizing, let me say that, again, I don't think that any plan that has been introduced is perfect and we shouldn't expect that. I don't think that any plan that ultimately gets passed and signed into law will be perfect. But, if we can identify those areas where we have common agreement and begin building reform, then I think we will have a good package that is good for the American public.

Mr. SCOTT. Thank you, Ms. Long.

[The prepared statement of Ms. Long follows:]

STATEMENT OF HON. JILL L. LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. Chairman, members of the committee, I am pleased to have the opportunity to testify today in support of H.R. 3222. As some of you may know, I have been supportive of the Cooper bill for over two years and have had the pleasure of working with members of the Conservative Democratic Forum in crafting legislation that I

believe is both thoughtful and realistic. I must also commend President Clinton for his efforts to address health care reform, because without his initiative, we might not be here today.

As a cosponsor of both the Cooper and the Clinton health care reform bills, I may provide a unique perspective to this hearing. Some do not understand why I would support both of these bills because they have been portrayed as diametrically opposed in the media—if you support one, you cannot support the other. In fact, these bills are very similar in the ways that they would restructure health care in our country. I believe it is time that the debate on health care reform turns towards areas of consensus so that we can move forward.

As I know my colleagues are aware, the Cooper and Clinton bills have several similarities. Provisions such as promoting competition among health plans, establishing regional purchasing groups for individuals and small businesses, establishing a standard benefits package, enabling individuals, and not employers, to select their health plan, requiring the reporting of health outcomes by providers and plans, and eliminating preexisting condition exclusions are common to both bills.

I am particularly supportive of both bills' provisions to improve the efficiency of the health care market by creating the right incentives. We have seen the power of the current incentives in our system—being paid based on the number of services provided, denying coverage to those who need coverage most, and no accountability for quality of care. Changing these incentives by enabling health plans to compete on the basis of cost and quality would result in keeping costs low and quality high.

As a member from a largely rural area and Chair of the Congressional Rural Caucus, I have a particular concern that the provisions in each of these bills, and others, addressing health care in rural areas will be overshadowed by larger issues of reform and not receive the attention that they need and deserve. These provisions are extremely important to the numerous communities across our Nation that have experienced the closure of their only hospital or the loss of their town doctor.

Reform legislation must take into consideration the fact that providers in rural areas will need additional assistance in adapting to a new system. In addition, any new requirements for information reporting or quality of care must take into account the resources available in rural areas. As anyone who has talked to a rural doctor recently will tell you, they are very concerned that reform will lead to more regulations and may not make it financially feasible for them to stay in business. I intend to keep these concerns in mind as reform legislation moves through the Congress, as I hope the members of this committee will.

There is certainly the potential to greatly improve access to quality care in rural areas, particularly through the implementation of new technologies, such as telemedicine, and creating networks of providers. I believe the Cooper bill is particularly thoughtful in many of these areas. I urge the committee to give thoughtful consideration to these provisions.

It is my position that no health care reform bill introduced in Congress is perfect—they each have their strengths and weaknesses. I also believe it is unfair to look at the faults of a proposal and dismiss it without looking at its strengths. Admittedly, the major weakness of the Cooper bill is its lack of universal coverage. While agree with Congressman Cooper's assessment of how universal may be achieved, I also strongly support universal coverage as a primary objective of any health care reform bill voted on by Congress. The most vulnerable in our society, particularly women and children, are the ones who are most likely to be left behind if universal coverage is not achieved.

But, to discount the Cooper bill because it does not include universal coverage is to overlook its major strengths. In particular, I believe these strengths to be the organization and role of Health Plan Purchasing Cooperatives, the lack of premium controls and a global budget, and allowing an independent board to define the standard benefits package.

As we all know, the concept of a purchasing cooperative is not new, it is just new to the health care industry. The HPPCs outlined in the Cooper bill would increase the purchasing power and decrease the administrative burdens for individuals and small businesses. Such a consumer-run organization would have the best interest of consumers in mind. Before President Clinton's bill was introduced, I talked to many constituents about the idea of Health Plan Purchasing Cooperatives and they were quite supportive of the idea. Unfortunately, the larger, government-run and regulatory version of these structures in President Clinton's bill have clouded the Cooper version of HPPCs.

I am also strongly opposed to the use of a global budget and premium controls to control costs in the health care system. The incentives that are created through changes to the health care system to keep costs low and quality high are lost when a cap on costs is enforced. This provision also adds enormously to the control and

oversight of health care by the government. I believe a reformed health care system, with the right incentives and no artificial constraints, would have the most potential to reduce waste and inefficiency.

I am also supportive of the provisions to allow an independent board to determine the benefits provided in a standard benefits package. I believe that these are decisions that should be made by the medical and health care community. Allowing Members of Congress to determine the benefits that should be provided for all Americans is a written invitation for politicizing the decisions. We have all heard from numerous constituents about the need to include or exclude the coverage of a service in the benefits package. But, I do not believe that such decisions should be based on the grassroots level of support that the service can garner. I also do not believe that this is leaving the benefits package to chance, but actually leaving such determinations to more qualified medical and health care professionals that would base their decisions on efficacy and appropriateness. Even CBO, in its assessment of the Cooper bill last Congress, estimated the benefits package to be at least as generous as the current benefits package in the Clinton bill.

As we all know, no bill as it was introduced will be what is considered by the full House of Representatives. However, I strongly support using the Cooper bill as a starting point for a compromise in the debate on health care reform for the reasons I have stated.

Mr. SCOTT. Next on the list, Earl Hutto. Mr. Hutto?

STATEMENT OF HON. EARL HUTTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. HUTTO. Thank you, Mr. Chairman.

I am advised that Mr. Cooper had to go next door to testify before another committee, but I think he will be returning shortly.

Mr. SCOTT. Thank you.

Mr. HUTTO. Mr. Chairman, and members of the committee, I thank you all for the opportunity to allow us to testify here today, and though I do not have the expertise on health care that perhaps many of your witnesses will have, I would like to comment on a couple of issues I believe to be critical to the debate.

Reform efforts center around trying to achieve what are two competing, if not mutually exclusive goals, providing everyone with health care insurance while reducing cost. Because these goals are inconsistent, we are faced with a choice. Do we provide universal coverage or universal access?

The complexity of our health care system and lack of consensus on this issue make this choice extremely difficult. Fortunately, our decision has been made easier by Jim Cooper, Fred Grandy, and others and their work on the Managed Competition Act.

The Managed Competition Act represents not only the middle ground of reform philosophies but also a workable compromise between greater access and cost reduction. I know that President Clinton has committed his support for universal coverage, and I share this goal. Although I agree that we must be resolute in our action, we must also be rational.

I believe it only makes sense that we first provide universal access and work toward universal coverage as reflected in the Managed Competition Act. In arguing for universal coverage, many people assert that the best method is to force employers to pay for it. I strongly disagree.

A mandate will have a serious impact on small businesses, employees and on the economy. About 88 percent of all businesses in my district have fewer than 20 employees, and in Florida only 5 percent of businesses have more than 50 employees. Because of tourism, many of these firms use part-time workers and operate on

thin profit margins. This is an important point because of what a mandate will do to those profits and those workers.

When a business loses money, its first course of action is to cut cost. That means jobs. A mandate will quickly consume the profits of smaller firms, and, in Florida, I believe a mandate will be self-defeating. The smallest businesses will close and others will eliminate jobs. A worker cannot receive health insurance from a boss who is out of business.

Ultimately the economy, which is largely measured by the success of small businesses, will suffer. To offset the burden, I realize that mandate advocates also support creating a new entitlement program. In the dark shadow of existing entitlements, I must question the wisdom of such a plan.

For all practical purposes, entitlements are untouchable. As a result, over 60 percent of our budget pays for mandatory programs, and 90 percent of the growth in government spending over the next 5 years will be attributed to entitlement costs.

The question used to be when are we going to cut spending? If we keep creating new entitlements, the question will be where are we going to cut spending?

A subsidy is not going to help the worker in smaller firms. A subsidy is not going to offset the cost of mandated insurance for the business that presently cannot afford it. In the end, the government is going to pick up the tab, just adding to the cost of entitlements. Therefore I believe it makes more sense to first give small businesses the option of providing affordable insurance or at least offering it to their employees.

The Managed Competition Act will expand access and reduce cost without injury to the economy. In fact, by exercising market strength bigger employers have already been successful at reducing their medical expenses. With fundamental reforms in insurance, the Managed Competition Act will extend that same market power to smaller businesses.

The American health care system is not only structurally but also politically complex. Certainly, I do not envy your task of reporting legislation that will change the way Americans receive health care. However, I urge you to be realistic in your charge.

As I said earlier, I am by no means an expert on health care, but I believe that the net effect of an employer mandate will be negative. Moreover, a new entitlement is the last thing our Nation needs.

The bipartisan Managed Competition Act recognizes the inconsistency in our health care goals. We should not overestimate our ability to pay for reform or our society's willingness to accept reform. So, I urge the committee to judge the Managed Competition Act based on its ability to meet our goals through logical and fiscally sound means. It would not build up the bureaucracy and it would cost much, much less.

So I appreciate the opportunity, Mr. Chairman, and members of the committee, to be with you, and I hope that you will give favorable consideration to this Managed Competition Act.

Thank you.

Mr. SCOTT. Thank you, Mr. Hutto.

[The prepared statement of Mr. Hutto follows:]

STATEMENT OF HON. EARL HUTTO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, members of the committee, thank you for providing me the opportunity to be here today. Though I do not have the expertise in health care as many of your other witnesses, I would like to comment on a couple of issues I believe to be critical to the debate.

Reform efforts center around trying to achieve what are two competing, if not mutually exclusive goals—providing everyone with health care insurance while reducing costs. Because these goals are inconsistent, we are faced with a choice; do we provide universal coverage or universal access? The complexity of our health care system and lack of consensus on this issue make this choice extremely difficult. Fortunately, our decision has been made easier by Jim Cooper, Fred Grandy and others, and their work on the Managed Competition Act.

The Managed Competition Act represents not only the middle ground of reform philosophies, but also a workable compromise between greater access and cost reduction. I know that President Clinton has committed his support for universal coverage, and I share his goal. Although I agree that we must be resolute in our action, we must also be rational. I believe it only makes sense that we first provide universal access and work toward universal coverage as reflected in the Managed Competition Act.

In arguing for universal coverage, many people assert that the best method is to force employers to pay for it. I strongly disagree. A mandate will have a serious impact on small businesses, employees, and on the economy. About 88 percent of all businesses in my district have fewer than 20 employees. And in Florida, only 5 percent of businesses have more than 50 employees. Because of tourism, many of these firms use part-time workers and operate on thin profit margins. This is an important point because of what a mandate will do to those profits and those workers.

When a business loses money, its first course of action is to cut costs—that means jobs. A mandate will quickly consume the profits of smaller firms, and in Florida, I believe a mandate will be self-defeating. The smallest businesses will close and others will eliminate jobs. A worker cannot receive health insurance from a boss who is out of business. Ultimately, the economy which is largely measured by the success of small businesses will suffer.

To offset the burden, I realize that mandate advocates also support creating a new entitlement program. In the dark shadow of existing entitlements, I must question the wisdom of such a plan.

For all practical purposes, entitlements are untouchable. As a result, over 60 percent of our budget pays for mandatory programs and 90 percent of the growth in government spending over the next five years will be attributed to entitlement costs. The question used to be, "*when* are we going to cut spending?" If we keep creating new entitlements, the question will be, "*where* are we going to cut spending?"

A subsidy is not going to help the worker in smaller firms. A subsidy is not going to offset the cost of mandated insurance for the business that presently cannot afford it. In the end, the government is going to pick up the tab just adding to the cost of entitlements. Therefore, I believe it makes more sense to first give small businesses the option of providing affordable insurance, or at least offering it to their employees.

The Managed Competition Act will expand access and reduce costs, without injury to the economy. In fact, by exercising market strength, bigger employers have already been successful at reducing their medical expenses. With fundamental reforms in insurance, the Managed Competition Act will extend that same market power to smaller businesses.

The American health care system is not only structurally, but also politically complex. Certainly, I do not envy your task of reporting legislation that will change the way Americans receive health care. However, I urge you to be realistic in your charge.

As I said earlier, I am by no means an expert on health care, but I believe that the net effect of an employer mandate will be negative. Moreover, a new entitlement is the last thing our Nation needs. The bipartisan Managed Competition Act recognizes the inconsistency in our health care goals. We should not overestimate our ability to pay for reform or our society's willingness to accept reform. I urge the committee to judge the Managed Competition Act based on its ability to meet our goals through logical and fiscally sound means. Thank you.

Mr. SCOTT. Mr. Peterson?

STATEMENT OF HON. DOUGLAS "PETE" PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PETERSON. Thank you, Mr. Chairman, and members of the committee, for allowing me to testify before the committee this morning on this very, very important issue. I commend you for holding these hearings.

I support the managed competition framework as contained in H.R. 3222 as the logical method to pursue meaningful health care reform for three reasons: It represents real reform without endangering our current system, it is economically feasible, and it can be passed with bipartisan support in this Congress.

Make no mistake, the political reality that we as legislators face as we attempt to craft comprehensive health care reform is that it must be economically sound, logically funded, publicly excepted, and perhaps most importantly, it must be bipartisan.

Clearly, each of us has our own opinion about how best to provide health care coverage to the 37 million Americans currently lacking health insurance and to bring under control the sky-rocketing cost of health care in this country, which will total about $1 trillion this year. However, the only opinion that will count in the end is the one that can count 218 votes on the floor of the House of Representatives.

Mr. Chairman, health care reform is the singlemost important domestic issue confronted by Congress in over five decades. We must not allow ourselves, both Democrats and Republicans, to be torn apart by pure rhetoric in the process of the debate. My fear is that we are perilously close to allowing differences among us to distract us from the common goals that we all share, thereby killing any chance of passing a meaningful bill.

Because it has generated widespread support, Congressman Cooper's legislation has become a target of every other side of the health care debate. But, if you remember anything I say here today, remember this. We are all on the same side. The sooner we start to work together to build bridges for a final agreement, the sooner we can get down to the business of providing America with comprehensive health care reform.

And, to work together, we must first accept the fact that America is not ready for a major Federal takeover of our health care system. Any bill that is brought to the floor that is perceived as such, correctly or incorrectly, will be overwhelmingly defeated.

President Clinton has provided us with a starting point for the debate on this complex issue. Meanwhile, the Managed Competition Act has gained widespread support. I fully realize that H.R. 3222 is not a perfect bill. I also realize that if we are to pass health care reform this year it will not be precisely like any of the bills that are before us today.

Instead the bill that gains the necessary 218 votes on the floor will contain bits and pieces of each of the various proposals built upon a tenuous mix of policy issues, economic assumptions, academic theory, real-life experiences, political concerns, and the most critical of the entire process, public support.

Clearly, the long process of crafting such a bill should start with the only proposal that has gained acceptance from both sides of the aisle, the Managed Competition Act.

Mr. Chairman, in conclusion, I asked to testify before the committee today because I am committed to passing meaningful health care reform legislation this year. I strongly believe that the Managed Competition Act, while not a panacea, is the most sensible approach for embarking on the first step in the evolution of American health care system reform. It contains major reform at the outset and provides the Nation with a framework that will allow additional building blocks of reform to be added as national consensuses are developed and needs established.

Thank you.

Mr. SCOTT. Thank you, Mr. Peterson.

[The prepared statement of Mr. Peterson follows:]

STATEMENT OF HON. DOUGLAS "PETE" PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Mr. Chairman, for allowing me to testify before the committee this morning about this momentous issue. As many of you know, I have made health care reform a priority item on my agenda, and I have been actively involved with Congressman Cooper's proposal for more than two years.

I support the managed competition framework, as contained in H.R. 3222, as the logical method to pursue meaningful health care reform for three reasons: [1] it represents real reform without endangering our current system, [2] it is economically feasible, and [3] it can be passed with bipartisan support by Congress. Make no mistake, the political reality that we as legislators face as we attempt to craft a comprehensive health care reform bill is that it must be economically sound, logically funded, publicly accepted, and, perhaps most importantly, it *must* be bipartisan.

Clearly, each of us has our own opinion about how best to provide health care coverage to the 37 million Americans currently lacking health insurance, and to bring under control the skyrocketing costs of health care in this country, which will total about $1 trillion this year. However, the only opinion that will count in the end is the one that can get 218 votes on the floor of the House of Representatives.

Mr. Chairman, I want to be very frank with the committee. Health care reform is the single most important domestic issue confronted by Congress in over five decades. We must not allow ourselves, both Democrats and Republicans, to be torn apart by pure rhetoric in the process of the debate. I fear that we are perilously close to allowing the differences among us to detract from the many common goals that we all share, thereby killing any chance of passing meaningful reform this year, and likely, for years to come.

Because it has generated widespread support, Congressman Cooper's legislation, H.R. 3222, has become a target of every other side of the health care debate, from the advocates of the single-payer plan, to supporters of the President's plan, to cosponsors of the Republican plan. If you remember anything I say here today, remember this: *we are all on the same side.* The sooner we can start to work together to build bridges for a final agreement, the sooner we can get down to the business of providing comprehensive health care benefits, that can never be taken away, to every American.

And to work together, we must first accept the fact that America is not ready for a major Federal takeover of our health care system. Any bill that is brought to the floor that is perceived as such, correctly or incorrectly, will be overwhelmingly defeated. Although the American public has high expectations for Congress to meet in addressing this issue, we must not lose sight of the fact that our approach to reform must be evolutionary, not revolutionary. We must make only those changes that are necessary to improve the system as a whole, and leave intact the parts that make the American health care system the finest in the world.

With this in mind, which of the current proposals is the most likely to gain the public support necessary to pass a meaningful health care reform bill in Congress?

President Clinton has provided us with a starting point for the debate on this complex issue, but, as you have heard today from my colleagues, it has a number of major flaws that, if not corrected, will certainly prove fatal. Public support for the President's plan has waned as our constituents have learned more about the mandates, price controls and Federal regulation contained in H.R. 3600.

Meanwhile, the Managed Competition Act has gained widespread support from the business community, the public and the media. As much as some would like to ignore the evidence, the Managed Competition Act is the only plan that can make

that claim. And although some fear that it does not go far enough, it is the only bill that is supported by a bipartisan coalition of House members, which means it is the only bill that can pass.

I fully realize that H.R. 3222 is not the perfect bill. I also realize that if we are to pass a health care reform bill this year, it will not be precisely like any that are before us today. Instead, the bill that gains the necessary 218 votes on the floor will contain bits and pieces of each of the various proposals, built upon a tenuous mix of policy issues, economic assumptions, academic theory, real-life experiences, political concerns, and, most critical to the entire process, public support. Clearly, the long process of crafting such a bill should start with the only proposal that has gained acceptance from both sides of the aisle, the Managed Competition Act.

Mr. Chairman, in conclusion, I asked to testify before the committee today because I am committed to passing meaningful health care reform legislation this year. I strongly believe that the Managed Competition Act, while not a panacea, is the most sensible approach for embarking on the first step in the evolution of the American health care system. It contains major reform at the outset and provides the Nation with a framework that will allow the additional building blocks of reform to be added as national consensus are developed and needs established.

Mr. SCOTT. Mr. Walsh.

STATEMENT OF HON. JAMES T. WALSH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. WALSH. Thank you, Mr. Chairman, and members of the committee, for holding this hearing. I would also like to thank Mr. Cooper and Mr. Grandy for this opportunity to testify on your bill, H.R. 3222, the Managed Competition Act.

Now that the debate on health care is underway, I firmly believe that your bill is a good starting point from which to launch true health care reform. There are a few points I would like to highlight that are of significant importance to my constituents and to myself. They are areas of common ground upon which any reform should spring.

First, the issue of portability. Our citizens need and deserve the security of knowing that their health care is for keeps regardless of their employment status. If a person decides to accept another job, is laid off or fired, he or she should not have to worry about the future health care needs of his family while he seeks alternative employment.

People need to be able to negotiate with insurance companies to find an affordable plan that meets the needs of their family. Perhaps we could extend the current COBRA benefits, with some form of tax relief, while a family or a worker is in transition. This would help a family to keep health benefits without being financially strapped to pay the premium during a period of unemployment.

Second, the issue of preexisting conditions. Where a person has a condition before becoming insured and by current standards must wait almost a year for coverage after being accepted into a plan are not receiving any coverage for care related to that preexisting condition. These current standards are totally unacceptable.

Preexisting conditions are often chronic and require regular uninterrupted care. This includes physician visits and medication. Even the most wealthy in our society can be bankrupted by a serious long-term preexisting condition. Congress should provide legislation that requires all insurance companies to cover all preexisting conditions.

Third is the issue of tort reform. We have a real problem when physicians feel compelled to order additional tests just to cover

themselves in the event of a lawsuit. The cost of these tests are passed on to patients, thereby artificially raising the cost of medical care. We need to examine ways to mediate medical disputes and keep them out of the crowded court system as often as possible.

This is a serious problem, and we need to pay more than lip service to remedy the situation. It will take an active cooperation between physicians, attorneys and patients. We will all gain if a little reason is added. A moderate approach might be to follow California's example and set up hearing boards which provide a setting where grievances are dispensed with fairly.

My final thought for this hearing today will focus on small business. This seems to be one of the most divisive issues between the Cooper and Clinton plans. I am extremely concerned that we don't overburden the very engine that keeps our economy going.

Small business is responsible for most of the new jobs created each year, and this would not be possible if they are saddled with endless additional Federal mandates and high health care costs. Many fledgling businesses barely make their monthly payrolls and more bureaucratic mandates would certainly sink them.

The tax increase passed by Congress last year fell heaviest on small businesses formed as so-called S corporations. These companies could not stand the shock of another large tax increase or unfunded government mandate. All businesses including small business are mandated to pay workmen's compensation, which is an expensive mandate. Part of controlling health care costs should be a way to incorporate workmen's compensation benefits into a plan—into a benefit plan so that health insurance would cover work-related injuries.

In my home State of New York we have a tremendous problem with abuse of workmen's compensation programs and associated exploding costs. I firmly believe that any successful reform needs to closely examine this problem and find a way to alleviate business from this burden.

In concluding my thoughts as a cosponsor of the Cooper-Grandy bill, I am pleased that we have a good working vehicle, albeit imperfect, from which to start the health care reform debate. I find the Clinton plan unworkable in terms of cost, new mandates and bureaucracy.

The Cooper plan is far more realistic in terms of working with the free market system, and I look forward to continued participation in this process to write legislation that our constituents expect and desire.

Again, I thank the Chairman for this opportunity to contribute in this important debate.

[The prepared statement of Mr. Walsh follows:]

STATEMENT OF HON. JAMES T. WALSH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Cooper, Mr. Grandy, I thank you for this opportunity to testify on your bill H.R. 3222, the Managed Competition Act. Now that the debate on health care is underway, I firmly believe that your bill is a good starting point from which to launch true health care reform. There are a few points I'd like to highlight that are of significant importance to my constituents and to me.

PORTABILITY

First, the issue of portability. Our citizens need and deserve the security of knowing that their health care is for keeps regardless of their employment status. If a person decides to accept another job, is laid off, or fired, he should not have to worry about the future health needs of his family while he seeks alternate employment. People need to be able to negotiate with insurance companies to find an affordable plan that meets the needs of their family. Perhaps we could extend the current COBRA benefits with some form of tax relief while a family or worker is in transition. This would help a family to keep the health benefits without being financially strapped to pay the premium during a period of unemployment.

PREEXISTING CONDITIONS

Second, is the issue of "preexisting conditions" where a person has a condition before becoming insured by current standards, must wait almost a year for coverage after being accepted into a plan or not receiving any coverage for care related to that preexisting condition. These current standards are unacceptable. Preexisting conditions are often chronic and require regular, uninterrupted care. This includes physician visits and medications. Even the most wealthy in our society can be bankrupted by a serious long-term preexisting condition. Congress should provide legislation that requires all insurance companies to cover all preexisting conditions.

TORT REFORM

Third, is the issue of tort reform. We have a real problem when physicians feel compelled to order additional tests just to cover themselves in the event of a lawsuit. The costs of these tests are passed onto the patients, thereby artificially raising the cost of medical care. We need to examine ways to mediate medical disputes and keep them out of the crowded court system as often as possible. This is a serious problem and we need to pay more than lip service to remedy the situation. It will take an active cooperation between physicians, attorneys and patients.

We will all gain if a little reason is added; a moderate approach might be to follow California's example and set up hearing boards with provide a setting where grievances are dispensed with fairly.

SMALL BUSINESS

My final thought for this hearing today will focus on small business. This seems to be one of the most divisive issues between the Cooper and Clinton plans. I am extremely concerned that we don't overburden the very engine that keeps our economy going. Small business is responsible for most of the new jobs created each year and this would not be possible if they are saddled with endless additional Federal mandates and high health care costs. Many fledgling businesses barely make their monthly payrolls and more bureaucratic mandates would certainly sink them.

The tax increase passed by Congress fell heaviest on small businesses formed as so-called S corporations. These companies could not stand the shock of another large tax increase or unfunded government mandate.

All businesses, including small business, are mandated to pay workman's compensation which is an expensive mandate. Part of controlling health care costs should be a way to incorporate workers' compensation benefits into a benefit plan so that health insurance would cover work related injuries. In my home State of New York, we have a tremendous problem with abuse of the workers' compensation program and the associated exploding costs. I firmly believe that any successful reform package needs to closely examine this problem and find a way to alleviate business from this burden.

In concluding my thoughts, and as a cosponsor of the Cooper/Grandy bill, I am pleased that we have a good working vehicle, albeit imperfect, from which to start the health care reform debate. I find the Clinton plan unworkable in terms of cost and new mandates and bureaucracy. The Cooper plan is far more realistic in terms of working with the free market system and I look forward to continued participation in this process to write legislation that our constituents expect and desire. Again, I thank the Chairman for this opportunity to contribute to the health care discussion.

Chairman FORD. Mr. Moran?

STATEMENT OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF VIRGINIA

Mr. MORAN. Thank you, Mr. Chairman.

Mr. Chairman, I represent almost 200,000 people who are dependent upon the Federal Employees Health Benefits Plan, which is the same plan that covers the Members of Congress. I know as a former chairman of the Post Office and Civil Service Committee you share my concern for those Federal employees, and I am going to explain why I believe that this Managed Competition Act is clearly in the best interest of Federal employees.

In essence, what it does is to build upon the success that we have experienced with the Federal Employees Health Benefits Plan in administering health insurance.

The Federal Employees Health Benefits Plan is not as comprehensive nor generous as many plans that are currently offered in the private sector, but the vast majority of the ten million Federal beneficiaries of FEHBP are, in fact, satisfied with their health insurance plan. Fewer than 5 percent of Federal employees choose not to participate in the plan either because of existing coverage under a spouse's plan or because they can't afford the premiums.

This may be a good example of what might happen under the Managed Competition Act, and, of course, everyone is concerned about the difference between universal access and universal coverage.

Mr. Chairman, there are only .005 of 1 percent of people that cannot—Federal employees who cannot afford the Federal Employees Health Benefits Plan, and thus don't have health insurance. What MCA does is to strengthen both the quality and the efficiency of the Federal Employees Health Benefits Plan, and uses it as a model of reform for the Nation.

The Health Security Act that the President has recommended dismantles the Federal Employees Health Benefits Plan, which may be the largest, most affordable, most efficiently run health insurance plan in the country.

The Federal Office of Personnel Management functions the way a Health Plan Purchasing Cooperative would function. OPM administers the Federal Employees Plan by contracting with carriers to provide health insurance plans for Federal employees. In the Washington area, Federal employees have almost 36—well, they do have exactly 36 plans to choose from. They are able to change plans once a year during the open enrollment period. The Federal employees' health premium rates averaged only a 3 percent increase this year.

The Managed Competition Act does require that there be a uniform standard benefit package offered by all the plans, and that, in fact, is going to strengthen the Federal Employee Health Benefit Plan, so that all consumers are going to be able to choose between health plans based on quality and price and not on any perceived differences that are primarily due to marketing techniques of the various health plans.

The Managed Competition Act reduces the tendency of plans to segregate the market according to risk so that those who are in the highest risk are most likely to find themselves in the most costly plan regardless of any real differences that may exist in the value

of the benefits among the various plans. This is particularly true of retirees, 83 percent of whom are covered by Medicare as their primary payer. Yet they choose to purchase supplemental plans which largely offer duplicative services. They don't get the value that they pay for these supplemental plans, with the exception of the prescription drug coverage, which, in fact, they do need for supplemental coverage.

These Health Plan Purchasing Cooperatives are going to offer a menu of accountable health plans so that we will be able to compare them using enrollee satisfaction and outcome data. We don't have that today. That is a very important element of this plan. And then we are going to adjust the premiums based upon the proportion of high risk individuals in one plan versus another. That is the fairest way to offer health insurance and to promote competition.

This plan will eliminate the need for COBRA, which is the requirement that insurance coverage continue for both Federal employees as well, of course, as the private sector, because it contains insurance reform which ensures portability, so that you don't have the job-lock that currently exists.

We have a problem with the Federal Employees Health Benefits Plan right now, and this plan addresses that problem. There is a disincentive currently for participating plans in the FEHBP to contain their administrative costs because that is where they get their profits now. Profit derived from premiums must be rolled over to the next year's premiums, so that where they get their real income comes from what they build into administrative costs. If health plans were to operate more efficiently and reduce their cost per claim filed, they could adversely affect their market share and reduce total reimbursement. This would no longer be the case under the MCA.

There will be a substantial incentive to reduce cost because you will be basing premiums on the total operational cost and thus you won't have a situation now where there is no incentive to cut administrative costs. And in many ways Federal employees are paying too much for administrative cost.

I want to emphasize the principal point of this Managed Competition Act and why I support it so strongly. Because it treats Federal employees, Members of Congress, just like everyone else. We are going to be enrolled in the same type of plan, a plan that has shown that it works. The way that the Federal Government has decided to base premiums is based on the highest option, the Blue Cross/Blue Shield High Option.

Under the MCA, the premium contribution of the employer would be tied to the cost of the lowest cost accountable health plan. What is going to happen with FEHBP is that the 100 percent Federal contribution will approximate the current 75 percent Federal matching of the highest cost plan. But the Federal Government would contribute a fixed dollar amount rather than a percentage of premiums, that would reflect measures to constrain the growth of health care costs.

I think that the way that we would design the standard benefit package is very important and is the ideal way because it takes it away from politics. Every single State has fought bloody battles

over what particular types of health benefits should be included in the plan.

We would set up a Health Care Standards Commission, which is comparable to the Securities and Exchange Commission. You would have true health care experts determining what health services ought to be included. It is a mirror, really, of the way the National Institutes of Health goes about determining how research funds should be distributed. That is done by professionals. It takes it out of the political maelstrom and leaves those kind of decisions to people who can best make those decisions.

The structural changes of the Managed Competition Act are going to help the Federal Employees Health Benefits Plan, help Federal employees, help the Congress, and most importantly, help the American people to afford coverage, and good quality coverage, in an equitable, in an efficient, and in an appropriate manner.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Moran follows:]

STATEMENT OF HON. JAMES P. MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman;

Thank you for this opportunity to speak before you on the strengths of the Managed Competition Act.

Rather than repeat the testimony of my colleagues, I would like to focus on the impact of the Managed Competition Act on the Federal Employee Health Benefit Program and what we can learn from the success of the FEHBP in administering health insurance.

The Managed Competition Act [MCA] advances a model for health reform which builds on the best aspects of our public/private health care system. Many of the principles put forth in the MCA are embodied in the Federal Employee Health Benefit Plan [FEHBP]. Despite the fact that the FEHBP is not as comprehensive or generous as many plans offered in the private sector, the vast majority of the 10 million beneficiaries are satisfied with their health insurance plans.

Fewer than 5 percent of Federal employees choose not to participate in the plan, either because of existing coverage under a spouse' plan or because they cannot afford the premiums. The Managed Competition Act strengthens both the quality and efficiency of the FEHBP and uses it as a model for reform. This is in direct contrast to the Health Security Act, which dismantles the FEHBP.

The Office of Personnel Management [OPM] functions much the way a Health Plan Purchasing Cooperative [HPPC] would. OPM administers FEHBP by contracting with carriers to provide health insurance plans to Federal employees and retirees. Federal employees have a wide variety of plans to choose from [approximately 36 in the Washington Metropolitan Area] and are able to change plans each year in open enrollment if they are not satisfied. Furthermore, FEHBP premium rates averaged only a 3 percent increase this year.

The FEHBP is not problem-free and in recent years, a number of unsuccessful attempts have been made to reform the program to operate more efficiently. The Managed Competition Act requires structural changes in the FEHBP to facilitate a more efficient, more consistent, and more equitable program. Furthermore, the Managed Competition Act extends this model to the rest of the country. Large businesses are treated the same as the Federal Government. There can be no claim that health reform under the Managed Competition Act excludes Federal employees or Members of Congress.

Presently, the FEHBP suffers from the absence of comparable health plans which compete for subscribers on the basis of price and quality. The MCA requires that a uniform standard benefits package be offered by all health plans. The introduction of a uniform health benefits package will facilitate comparisons *by consumers* between health plans based on quality and price, rather than on *perceived* differences or marketing techniques of various health plans.

In addition, it reduces the tendency of health plans to segregate the market according to risk, whereby those who are the highest risk are the most likely to find themselves in the most costly plan regardless of any real differences in the value of benefits among the plans. This is particularly true of retirees, 83 percent of whom

are covered by Medicare as their primary payer yet have chosen to purchase supplemental plans which largely offer duplicative coverage [with the exception of prescription drug coverage].

In addition to uniform benefits package, the MCA requires a more aggressive role of the Health Plan Purchasing Cooperative than OPM currently assumes. The HPPC would offer a menu of *accountable* health plans, including clear, standardized information for each plan on its price, quality indicators, and enrollee satisfaction. The HPPC will pay accountable health plans based on a Federal risk-adjustment procedure that will pay more to health plans with high-risk populations and lower payments to low-risk individuals. The FEHBP does not currently use risk adjustment methodologies among the various plans.

Since the late 1980s, OPM has tightened its management and required all participating health plans to abide by certain requirements; such as moving away from reasonable and customary payments to scheduled payments and moving closer to standardized benefits. Because all plans have to respond in the short term, OPM has been able to improve efficiency and establish a more consistent relationship between benefits and premiums. The MCA expedites this move towards efficiency by enabling OPM, as the HPPC, to set the rules of the game and enforce them.

HPPCs will eliminate health plan continuation coverage for businesses, and Federal employees, known as COBRA, as individuals may keep their health insurance plan purchased through the HPPC, regardless of employment status.

In regards to overhead costs, the FEHBP contains disincentives for the participating health plans to contain their administrative expenses. This is because plans are not allowed to make a profit on the premiums; they are obliged to roll over the difference [gains or losses] to the premiums for the following year.

The health plans make their profit on the administrative costs, based on the costs per claim. If health plans were to operate the program more efficiently and impose cost cutting measures to reduce the cost per claim, they could adversely affect their market share, and reduce total reimbursement. Aggressive cost containment would reduce their profit margin, with no gain in premium dollars, due to the "roll over" policy.

Furthermore, the health plans have not had to contain operational expenses to levels competitive with other claims processors. This will no longer be the case under the MCA, as all accountable health plans must compete based on total costs of operation. Under the MCA, a small surcharge is levied on premiums to finance the administrative expenses of the HPPC.

A point that I would like to reiterate again is the fact that the Managed Competition Act treats Federal employees and Members of Congress just like large businesses.

By statute, the government's employer share of the premium is tied to the rising cost of its most expensive plan, Blue Cross/Blue Shield High Option. On average, the Federal Government pays almost three quarters of the total premium for its employees. Under the MCA, the premium contribution of the Federal Government, as with any other employer, would be tied to the cost of the lowest cost *accountable health plan*. It is the author's intent of the Managed Competition Act that a Federal contribution of 100 percent of the premium of the lowest cost plan would be comparable to the current contribution of 75 percent of premiums. The most significant difference is that the government, as employer, would contribute a fixed dollar amount that would reflect measures to constrain the growth of health care costs.

The final issue that I would like to address is the repeated criticism of the MCA for not specifying what health benefits would be covered as part of a standard, uniform health benefits package. The Managed Competition Act sets general parameters for what health benefits must be included and the sponsors of the MCA envision a benefit design which would reflect broad policy objectives of comprehensive primary and preventive health care.

The specific benefit design, however, is left to the professional expertise of an independent Health Care Standards Commission, operating much like the Securities and Exchange Commission. The intent is to avoid congressional tampering with the specific benefits due to political persuasion, rather than relying on the expertise of health care professionals to shape a benefits package which reflects the true medical needs of society. The bloody battles that have been fought in State legislatures over mandated benefits should not be repeated in Congress.

Finally, it avoids the "scope of practice" issues regarding the professional terrain of various medical and health professionals, i.e. ophthalmologists vs. optometrists. Rather, the MCA is "provider neutral." This will encourage health plans to provide cost-effective health services based on outcome rather than on the traditional mode of professional domain.

Interestingly enough, this benefit design process is mirrored in the appropriation to the National Institutes of Health. A scientific committee comprised of medical scientists at the National Institutes of Health determines what the research priorities of the Institutes will be and how funds will be distributed among the various Institutes. This limits the influence of Congress in determining what should be a scientific rather than a political decision.

In closing, the Managed Competition Act expedites structural changes in the health care marketplace which reward cost-conscious delivery of health care. As a result, the FEHBP will operate in more efficiently, more consistently, and more equitably. Overall, I believe that the MCA will enhance beneficiary satisfaction under FEHBP, while extending those same benefits to the rest of the country.

Chairman FORD. Thank you, Jim. I appreciate your notice of some involvement on my part. I might also say that the ranking Democrat on this committee, the next chairman of the committee, has been involved at every step of the way.

I had the pleasure of chairing the Committee on Post Office and Civil Service for 10 years, the first eight of which were with President Reagan whose succession of Directors of OPM and OMB sent us, year after year, budgets that would juggle the FEHBP to save money out of increases in the cost of coverage to the employees and for eight years of Ronald Reagan we succeeded in keeping that from happening.

We didn't have that problem in the first two years of Mr. Bush's Administration, and that was one of the real contrasts between the two administrations. That contrast tended to blur after awhile, but at least with respect to the then fashionable idea of beating up on Federal employees as the handiest people to take a whack at began to change.

It changed during the campaign in which Mr. Bush was elected, and while I did not support him, I always defended the fact that he got elected President without climbing over the prostrate bodies of Federal employees, and I gave him the credit that I thought he was entitled to.

I know something about that plan, not from the perspective of Washington, DC, where you mentioned that the employees in this area have a choice between 36 different insurance plans. Actually, in the FEHBP there are 430 plans that Federal employees have a choice to receive, or to participate in. Depending on where they live, they make the choice on the basis of what is available in that area.

A few years ago, as a matter of fact, in the middle, actually, toward the end of the first term of the Reagan Administration, we hired outside consultants. The Senate was then controlled by the Republicans and by agreement between me and Senator Stevens of Alaska, we brought in outside consultants and had them analyze all of the health plans that the Office of Personnel Management was negotiating on behalf of the employees.

The employees have a choice after the negotiations take place. They don't participate at any stage of the negotiations. So it is not truly a cooperative, because they only have a choice to pick from what Big Daddy has picked out for them.

That study, we found, occurred at the same time that some of the insurance companies were making their own study. One of the outstanding features that has existed in the Federal Employee Health Benefit Program is, in fact, the annual ability to shift plans without prejudice and no waiting periods. The plan that you are here

supporting today would impose for the fist time a six-month waiting period when you change plans, and we are right back into the old game of preexisting conditions.

About the time we were doing this, Aetna, which was one of the largest prepaid plans that we had for Federal employees, and one of the Big Six being used to compute the percentage of the government's payment for premiums, took a real look at what they had and discovered that they had a disproportionate number of retirees, Federal retirees, in their plan, and their actuaries looked at them and said, "If you keep it up, the more you sell the more you are going to lose, because you are insuring the most expensive, from the health care point of view, part of the Federal workforce." Aetna put us on notice that they were going to insure for one more year and then they were leaving.

Now, it is a seldom discussed fact around here that Aetna has been out of the FEHBP for years but Aetna still determines what share of the premium is paid by the Federal Government, because we had no other big insurer willing to step in and become part of the Big Six.

We had the Library of Congress construct Aetna on a computer and that constructed Aetna continues to churn away over at the Library of Congress as if it were insuring people at the same rates and ratio of ages and so on as before, and it produces at the end of the year a premium which is used instead of a real insurance company for one of the six factors that go into determining the Big Six.

Now, having gone through all of that, I have to point out to you that presently the FEHBP contributions by the employees is before-tax money, and under the Cooper plan it would be after-tax money. So it becomes an automatic tax increase for the employee's share of the premium.

The President's plan from the very beginning, and SOME of us who have worked for a long time with it have been a part of the planning and construction of the plan, and it is not nearly as close to a finished product as people who attack it would suggest. I hear all kinds of things coming at me about what is in it, and we haven't decided yet.

And when we get through with the plan and report something out with respect to the Federal employees, it goes to Mr. Clay's committee, and the Post Office and Civil Service Committee will then rewrite or add to whatever we have done with respect to Federal employees.

When the President's plan first surfaced, it was not created out of a vacuum with respect to the Federal employees because I have had too many years of working with their representatives to go off too far without finding out how they felt about it. And at first there was concern that some of the existing union-sponsored plans might be jeopardized. There were other concerns, and at every step of the way in trying to fashion this thing we have tried to respond to those concerns.

It is a long way yet from the point when we decide at what point the Federal employees would become a part of the overall health plan that does emerge, because in the current proposal, in the first years it would be 1998 before anything would happen that is dif-

ferent from what now exists. So until 1998 the present plans would stay as they are and then they would start phasing into the plans that other people have, and be treated as non-governmentally-connected citizens from that point on.

Now that number may change to 2000 or 2004 or 2010. I don't know where it will end up. But there is no magic in the number. It is the people of good will working on this, people with many interests involved in it, who will try to find out the most rational way not to upset the apple cart.

Unfortunately, both Mr. Clay and I, in looking at this bill are of the opinion that it is a big step backward for the Federal employees. And for one thing, President Clinton is taking the most heat for a mandate that employers pay 80 percent of the premium. The Federal Government pays 60 percent of the premium.

Now, all other things being equal, the sooner we can get them to an 80 percent employer share over a 60 percent share the better off they are going to be. But we can't do it just that fast because then we run into other kinds of budgetary problems that we have to deal with, because each agency will have to have a budget increase for their salary allotments to take care of that, salary and benefits.

It is not going to be easy, but I can assure you and the Federal employees that I know you represent so ably that the players in the game on the package that is going to come out of this committee are very, very conscious of their special status. And I am very, very conscious after spending years defending it. I would just like to observe—I don't want to take anymore time—something that I have to give credit to Mr. Nixon for that he never gets credit for. Until Mr. Nixon was President, the Federal Government never paid more than 50 percent of the cost of health insurance, and Mr. Nixon had a national health program. People seem to have forgotten that.

Mr. Nixon proposed that every employer, regardless of size, in the country be forthwith required to pay 75 percent of the premium for a health insurance policy at their place of employment. The Post Office and Civil Service Committee, then under the guidance of Mo Udall with the subcommittee of jurisdiction, said that is a good idea for private enterprise. Why don't we do it for the government?

And the House of Representatives passed a law that changed the government's contribution to 75 percent, as recommended by President Nixon. The Senate being a different body—that is the kindest thing I can say about the other body, is that they are different, and also I am relieved whenever I can reassert that—didn't agree with this, and so they left it the way it was and the settled-upon compromise between them was 60 percent and the structuring of this Big Six method of computing it.

So, in fact, if you buy something other than a Cadillac-equipped health plan, you can get as much as 75 percent of your premium paid by your employer in the Federal Government. If you buy a Cadillac, you are going to get 60 percent. Nobody gets less than 60 percent. Some get as high as 75, and I believe the Post Office is closer to 90 because we gave them contractual bargaining rights to

get it up there. So it varies among discrete groups of Federal employees.

Nobody is going to be left out because we don't know they are there, and I want to reassure you that we will take care of it, and ask you to take another look again and consult with some of the Federal employee organizations on why they are not enthralled with the approach of the bill that you are here to speak for this morning.

Mr. MORAN. Mr. Chairman, may I respectfully respond——

Chairman FORD. Certainly.

Mr. MORAN. [continuing] to a couple of thoughts?

Chairman FORD. If you find a question in there I will appreciate it.

[Laughter.]

Mr. MORAN. Yes. I think the question is why in God's name would you support the Managed Competition Act instead of the plan I am supporting and that the administration is?

But one of the technical things that really needs to be corrected, first of all, is the six-month waiting list. There isn't any six-month delay. The only six-month delay applies to people who choose not to get health insurance and then when they get sick and they need it, they then decide to get it. We felt that that is not really fair to health insurers, so we incorporated a disincentive for people to delay getting health insurance until they are ill.

If there is no disincentive, everyone will wait until they get sick to buy insurance, and then they know they have to be able to get coverage under the Managed Competition Act. So we say, you are going to have to wait six months. If you don't decide to get insurance coverage when it is available to you and you wait until you get sick, then you are going to have a six-month delay.

Let me explain how I feel about this plan, and I know that I should be a good soldier and support the White House plan, and certainly the fact that you and Mr. Clay are supporting it is very persuasive. But I think that Federal employees are being treated as a scapegoat.

Chairman FORD. Let me just say we are both supporting the single-payer plan.

Mr. MORAN. Oh, you are supporting a single payer. Well, I guess that is consistent. But the fact that you are speaking favorably for the administration's plan is nevertheless persuasive. But I think that Federal employees are, in fact, being treated as a scapegoat here.

The reality is that the Federal Employees Health Benefits Plan is the only major plan that is operational that doesn't in fact get grandfathered. It is the only one in the country with more than 5,000 employees that does in fact have to be dismantled and the enrollees have to then go back to their own jurisdictions to enroll in a health plan.

They are being singled out, and we know that the reason they are being singled out is purely politics. The White House doesn't want people to think that they are giving any special preference to Federal employees, and so they are treating Federal employees differently than they would treat any other employee group.

This plan takes the Federal Employees Health Benefits Plan and goes in the other direction. It figures what is good for the feds is good for America. If it is working for us, let's make this kind of plan available for the American people. And that is, in essence, the guiding force behind the Managed Competition Act.

With regard to reimbursement, it is going to work out very consistently with the 75 percent employer contribution under FEHBP. If you choose the highest cost plan, you may have to pay something. But the employer's cost will be about 75 percent and very few employees would be paying more than 25 percent in total premiums and deductibles and copayments out of pocket.

I know that I am alone on this in terms of supporting the Managed Competition Act versus the White House plan. But I was a Federal employee for 15 years and I worked on entitlement programs in the Budget Office for several years. I won't go into all my background, but I think I have enough background to give it a fair amount of analysis, and that analysis is unclouded by political consideration.

Well, I can't say totally unclouded, but I think my feelings are strong enough to rise above political considerations. Clearly it would be more politic to go along with the Federal employee unions. I don't think the Federal employee unions are correct in their decision on which plan to support, Mr. Chairman.

Chairman FORD. I don't want to prolong this discussion because there are other people with questions. But let me call your attention to pages 70 and 71 of the bill. Please take a look at it and read the various sections about amnesty and you will find a definition of preexisting condition. Anything for which there was treatment within three months before the time that you switch plans becomes a preexisting condition in insurance language, and therefore not covered.

Mr. MORAN. Mr. Chairman, it only applies to free riders. This is the "free rider" provision. You can't have a free ride and then when you suddenly need health insurance to then be able to get it immediately.

Chairman FORD. Well, here is the six months transitional amnesty. At the time of initial enrollment you have given them six months to get into the plan.

Now, a period of continuous coverage is dealt with in two bites. First, the period of continuous coverage means the period beginning on the date an individual is enrolled under an AHP and ends on the date the individual not so enrolled for a continuous period of more than three months. So a three-months break breaks the continuity or the portability that now exists for Federal employees.

If you can give us a better construct than that, we will examine it. But we think without fooling around with that and keeping it clean, the right to be free of an insurance company's claims that the Federal employees have now is a better way to deal with them.

Mr. MORAN. But we leave the Federal Employees Health Benefits Plan alone. Ninety-five percent of Federal employees are covered by it. They are continue to be covered by it. Those that are not, except for .005 of 1 percent, those who are not are covered by other spouse's plans and more generous private corporate plans.

The Federal employee is going to stay in their plan, so that this "free rider" provision isn't even going to apply. I don't think it is even relevant to the issue that you are concerned about.

Chairman FORD. What do you call a person who's laid off for six months? Is he a free rider?

Mr. MORAN. But they will keep their insurance coverage.

Chairman FORD. They can dig into their voluminous savings as a working person and pay their own health insurance for six months and then they can come back in.

Mr. MORAN. Up to 200 percent of poverty, health insurance is subsidized. With no income it is free.

Chairman FORD. Well, see if you have a plan with universal coverage and everybody has to get in you don't have free riders. That is the essence of the guiding principle in trying to write this or the single-payer plan. You don't leave any free riders out there. You don't let the same people who are free riders in the present system continue to be free riders.

The employer now in my district who is not providing health care is being subsidized to the tune of about 17 percent, on average, in every hospital in my district by the other employers that do provide health insurance, because the cost of taking care of these uninsured employees is shifted over. There are all kinds of free rides going on at the present time.

The young person who chooses not to opt into health insurance because they have no sense of mortality and no need for it, unless they are interested in child-bearing expenses, stays out and that makes it more expensive for everybody.

This is a big difference. The only two plans that I have seen that throw everybody into the same lifeboat and say you can't bail your end of the lifeboat and leave somebody else out, is single-payer and the President's plan.

Mr. MORAN. So that is the principal source of your objection. It is people who would be RIFed. Not Federal retirees, but it is people who would be RIFed from the Federal Government who would not have the ability to continue the coverage, presumably.

Chairman FORD. They have no continuity. When they come back they start over again.

Mr. MORAN. Well, we think by covering up to 200 percent of poverty that we would cover anybody that has no source of income coming in.

Chairman FORD. Do you know of any—other than Aetna, which had an unfortunate experience with adverse selection by getting an older population, do you know if any of the Federal Employee Health Benefit Plans have gone broke?

Mr. MORAN. No.

Chairman FORD. Well, the insurance companies will tell you it is impossible to let people change from plan to plan every year without regard to preexisting conditions. You can shop the best psychiatric plan, if that is the problem your family has. You shop the best surgical plan if that is the problem your family has. Federal employees have a very unique kind of advantage in that regard and the people writing Federal employee health benefits have been able to survive and make a profit.

The insurance industry will tell you very quickly that that can't be done, and that is what they object to in the President's plan in saying that you won't let us take into account preexisting conditions.

All of these little items sum up to a total of what you are going to do to a group of people when you throw them out there, and I will be glad to work with you, and I know Mr. Clay will, to reassure you at every step of the way that we are not doing anything to disadvantage Federal employees. I have to do the same thing with my auto workers, who if they work for the Big Three have fully paid health insurance.

Mr. MORAN. I understand.

Chairman FORD. And I have to assure them we are not going to give them benefits that are less than they have and it is not going to cost them more money than it is costing them now.

Mr. MORAN. But we don't allow any rejection for preexisting conditions.

But you know, one last point I would like to make. Hawaii has the plan that you are supporting, you and Mr. Clay, and yet they still have the same proportion of noncoverage as the Federal Employees Benefit Plan. They have about 96 percent who are not covered.

But I don't want to belabor this. I appreciate your comments and your concern.

Thank you, Mr. Chairman.

Chairman FORD. Mr. Owens, do you have a question for the panel?

Nobody is picking on Jill Long.

Mrs. ROUKEMA. Mr. Chairman?

Chairman FORD. You want to pick on Jill Long?

Mrs. ROUKEMA. No, I don't want to pick on Jill Long. I want to pick on Fred Grandy and Jim Cooper.

Chairman FORD. Oh, I got a volunteer, Jill. I will try to get us out of here before we get to him.

The gentlelady from New Jersey is recognized.

Mrs. ROUKEMA. Well, I don't know when Mr. Cooper will be back, but perhaps Mr. Grandy or some other member of the committee can address themselves to my questions.

In the first place, I do want to ask unanimous consent to include in the record a letter that appears today in the Washington Post, signed by Governor Campbell of South Carolina and Governor Hunt of Vermont, which disclaim the false impression that the Governor's association has endorsed the Cooper bill, and they outline their reasons for not giving endorsement to the Cooper bill.

They do acknowledge that there are certain elements of it that they favor, but the National Governors Association, I believe someone testified that they were in support of or endorsing the Cooper bill. I want that included in the record that they are not.

[The letter follows:]

The Washington Post

AN INDEPENDENT NEWSPAPER

LETTERS TO THE EDITOR

Governors and the Cooper Bill

The National Governors' Association wants to correct an erroneous impression that the nation's governors have endorsed the Cooper health reform bill. The front-page story "Upstaging the President: Rep. Cooper and His Bill Grab the Limelight" [Feb. 3] said that the NGA had "endorsed elements of health reform that are strikingly similar to Cooper's, although they did not embrace his plan by name."

While there is some common ground, there are striking differences between NGA's health reform policy and the Cooper bill. The Cooper bill is fundamentally a federal system. NGA supports a federal framework with substantial state flexibility. In addition, the Cooper bill would shift the cost of long-term care to states in exchange for the federal takeover of the acute-care portion of Medicaid, which governors strongly oppose. These are two of the most fundamental issues for governors.

It is fair to say that both Republican and Democratic governors believe that a compromise on health care reform legislation is possible using different elements of the several bills now before Congress. However, neither the governors as a group nor the NGA has endorsed any bill. We have suggested the minimum components of any acceptable reform bill. Some of these are consistent with the Cooper bill, but many are not.

CARROLL A. CAMPBELL JR.
Chairman
HOWARD DEAN
Vice Chairman
National Governors' Association
Washington

Gov. Campbell is a Republican of South Carolina. Gov. Hunt is a Democrat of Vermont.

Mrs. ROUKEMA. I also want to say that I am going to restrain myself from some of my usual rhetoric and try to get to something specific, with one exception. Because I happen to know Dr. Koop quite well and have conferred with him over time on health care issues, I am not sure in what context Dr. Koop said that many people or most people have too much health insurance. I don't know what he meant by that, and maybe Mr. Grandy would like to comment on it further.

But I do know, Dr. Koop is one of the knowledgeable people in this country who clearly defines distinctions between some managed competition HMOs and others, and he puts it this way. I am now paraphrasing. There are HMOs and there are HMOs and some are excellent in terms of dealing with cost-cutting and delivering high quality care. But there are many, many others that only cut those costs by rationing and limiting care, and he would go on to define his distinctions there. And this is what I am concerned about, you know.

I know all the warm and fuzzy rhetoric about what managed competition can bring, and we can empower people to shop for health care. But when you translate that into many people's experiences it results in doctors and patients haggling for hours with insurance agents and bureaucrats, and that is what I would like to go beyond here.

I do want to ask Mr. Cooper or Mr. Grandy if they could submit for me, because I didn't understand it in the context of the testimony, how they quantify the $54 billion middle-class tax cut that they said comes back to consumers under the plan of limiting the tax preference. I don't understand that, and I think that should be put in writing for us.

Mr. GRANDY. Would you like me to explain it to you, Mrs. Roukema?

Mrs. ROUKEMA. Fine.

Mr. GRANDY. Would you like me to write you a letter?

Mrs. ROUKEMA. Yes. I would appreciate that.

But the specific question I want to ask now, Mr. Grandy, and any other member, it seems to me that with all the open questions on both your bill as well as the President's bill, and even some of the Republican proposals, would there be anything wrong, in your opinion, with taking the first step knowingly and saying this year we are going to deal with comprehensive insurance reform and then take it beyond that next year and get into some of the more intricate details? Is that self-limiting, Mr. Grandy, or what is your reaction?

Mr. GRANDY. Well, I would ask what comprehensive insurance reform constitutes. Are you talking about guaranteed issue?

Mrs. ROUKEMA. Yes.

Mr. GRANDY. All right.

Mrs. ROUKEMA. And guaranteed issue——

Mr. GRANDY. And eliminating preexisting conditions?

Mrs. ROUKEMA. Exactly. And the portability issue. The part that is far more complex and troubling is the relationship to part-time employees. You know, I don't know if anybody has really addressed that. But there is a growing problem in this country by hiring part-

timers that employers are avoiding and that is adding to the problem of the health care crisis as we know it.

Mr. GRANDY. Well, I have no problem with enacting guaranteed issue and portability and eliminating material preexisting conditions. I don't know if there is a health care bill out there that doesn't do that. But we have kind of lashed ourselves to these terms without realizing that behind the meaning is going to be a requirement probably to specify some kind of basic benefit that you carry with you.

I mean what is going to be portable? Is it going to be a very comprehensive benefit that might include everything from basic hospitalization to in vitro fertilization, or is it going to be some kind of either government specified and congressionally agreed to package or some combination thereof?

The more you get into insurance reform, the more you find yourself pulled into the debate. And assuming we could reach that decision, fine. But one of the things that we uncovered in our GOP task force when we were talking about trying to just do insurance reform was that we could not just do insurance reform. We had to kind of decide what we were going to insure and what we weren't.

And once you start making those choices I think the legislative process is more protracted. That is why I am not completely optimistic that we are just going to be able to knock out guaranteed issue and eliminate preexisting conditions.

If you do, Mrs. Roukema, the problem is it is going to get more expensive first before it gets cheaper, because you are putting more people into the system and those people tend to need more health care. So, if you do that you are going to have some kind of brake on the system or you will probably see health care costs go up.

Mrs. ROUKEMA. I agree with that last statement, but you are paying for those additional people either through a direct tax subsidy paid for by the taxpayers and limiting care under existing——

Mr. GRANDY. Yes. Right now you are paying for it because they are uncompensated care. But if you put them into some kind of insurance pool, the cost of the pool would go up because their benefits would probably cost you more.

Mrs. ROUKEMA. We will take this further at another time, but that is a good opening to the discussion.

Did Mr. Moran want to comment?

Mr. MORAN. No, that is fair.

I do think that if you have any insurance reform you really ought to enable small businesses to pool, because that is one of the worst things right now. One of the principal reasons why we have so many people uninsured is because they are working for small businesses, and small businesses are paying, on average, 35 percent higher premium than a larger size business. So that would have to be an integral element of insurance reform.

Mrs. ROUKEMA. I am glad you made that point. That is excellent.

Thank you very much, Mr. Chairman.

Chairman FORD. Mr. Owens?

Mr. OWENS. Mr. Chairman, I have an opening statement which I will submit for the record.

Chairman FORD. Without objection, it will be inserted in full in the record.

Mr. OWENS. I want to highlight one part of that statement, however, related to people with disabilities.

Three elements of H.R. 3222 also have the potential to inflict tremendous harm on individuals with disabilities. First, long-term care and prescription drugs are among the benefits most needed by individuals with disabilities. They are expensive and thus unlikely to be included as part of the cheapest health plan available. A result would be that individuals with disabilities would have to pay for these services out of pocket without taking any tax deductions under your plan.

Second, the bill would allow for preexisting condition exclusion periods for up to 6 months, as we have just discussed. For an individual with a disability that could mean the difference between life and death.

Third, the bill will shift the cost of long-term care not now covered by Medicaid to the States. However, the bill would not require the States to offer long-term care to people with disabilities.

As Chairman of the Subcommittee on Select Education and Civil Rights I think it is important to take note of these deficiencies in your plan.

I would like to ask one question. That is hospitals now receive about $15 billion annually in Medicaid disproportionate share payments to pay for uncompensated care. Under the Cooper plan these payments are eliminated.

What will hospitals do? How are these hospitals going to survive? Millions of Americans will remain, under your plan, without health coverage. Hospitals in all parts of the country are going to have to continue to provide care for uninsured people. What do you propose to deal with this problem?

Mr. GRANDY. Mr. Owens, the disproportionate share in Medicaid is converted to a low income subsidy for people all the way up to 200 percent of poverty and is used to offset their cost of care. Rather than paying the hospital it would go to the potential beneficiary. So, in a sense we direct the acute care portion of Medicaid and use those dollars to provide the subsidy, the idea being that the hospital wouldn't need the disproportionate share payment because those people wouldn't be uncompensated anymore. That is the whole theory behind the plan.

Mr. OWENS. That is great for those who are eligible for Medicaid. What about all the other uninsured that the hospitals have to cover?

Kings County Hospital in my district, 45 percent of the people have no insurance at all. Most of the older patients that they have are covered by Medicaid. It is in a very poor area, but 45 percent have no insurance at all.

Mr. GRANDY. Well, as I said, this subsidy is for those below 200 percent of poverty, so it stretches beyond the Medicaid threshold right now.

I might point out that the President's plan only goes to 150 percent of poverty. So indeed we are probably enfranchising more low income individuals in our plan at the outset than the President's plan.

Mr. OWENS. The President's plan covers other people in other ways. Everybody is covered under the President's plan. Your plan is not the same. You don't cover everybody.

Mr. GRANDY. Well, I guess I would say we are decoupling from welfare, so we are covering other people too. But I would think in terms of the populations most at risk, the Managed Competition Act probably moves faster towards insuring, or at least providing the tools to get insurance faster than the President's bill.

Mr. OWENS. Do you have an estimate of who you leave out? How many people?

Mr. GRANDY. What do you mean by leave out in people who wouldn't buy insurance? People who would not use the subsidy?

Mr. OWENS. People not up to 200 percent.

Mr. GRANDY. Up to 200 percent——

Mr. OWENS. They don't qualify.

Mr. GRANDY. Well, if you go up to 200 percent of poverty—what is the income threshold?

Mr. MORAN. It varies by State, actually. But, you know——

Mr. OWENS. You are going to cover it by the State, you said?

Mr. MORAN. An important point to emphasize is that the number of people covered by Medicaid within the 200 percent of poverty that is included in the MCA plan is 50 percent. We double the number of people who will get full coverage up to 100 percent, and then it is graded up to 200 percent.

Mr. OWENS. Do you have an estimate of how many you will leave out?

Mr. MORAN. A lot more people that will have Federal subsidized health insurance.

Mr. OWENS. In your calculations you are pretty precise that you double it. Do you have any estimate as to how many are still left out? Are not covered at all?

Mr. MORAN. Well, within 200 percent, we know that only about 50, approximately 50 percent actually are enrolled within Medicaid, and we would anticipate that virtually 100 percent of people up to 200 percent would. Now some will make irrational economic decisions, but once they go into a hospital they would be encouraged and led through the process of getting their insurance coverage.

Mr. OWENS. All right. I will pursue it further with some more questions in writing to the gentleman. I think we have to go vote.

Mr. MORAN. Fred, did you want to elaborate on that?

Mr. GRANDY. I don't think there is much more to elaborate, except that there is no reason why anybody would be uninsured unless they made the conscious effort not to be insured.

Mr. OWENS. Are you saying your plan will cover everybody?

Mr. GRANDY. I am saying that the plan provides the opportunity to be covered through subsidies so that every family—and I would say up to 200 percent of poverty is probably around $28,000 for a family of four. So the subsidy on a sliding scale would stretch out to that family.

Now, at the same time you are also enjoying full exclusivity of any benefit you might get from an employer that he did not pay for. So, in a sense, the opportunity to have your health care costs defrayed are probably greater certainly under our plan than they

are right now, and perhaps even greater than they would be under the Clinton plan. Depending on the size of the package, of course.

Mr. OWENS. The opportunities are certainly greater than they are right now but you would not have universal coverage. You don't pretend to have universal coverage.

Mr. GRANDY. Well, I won't—let me try and qualify that, Mr. Owens. I guess I would have to acknowledge that what we guarantee in our bill is universal access. What the President purports to guarantee is universal coverage.

To me, universal access is a means toward the end of universal coverage and I would rather, I think, move more slowly and deliberately towards that, have fewer cost controls, less hemorrhaging of Medicare, and move in a more, as I said, deliberate manner than to try and do it as quickly as the President requires.

Mr. OWENS. You would achieve universal coverage then when? The year 2000?

Mr. GRANDY. I don't know exactly when we would achieve universal coverage. In the year 2000, I am not sure. Statistically, we would probably achieve it roughly about the same time as the President. But it depends on what your statistics are.

Mr. OWENS. Thank you.

Chairman FORD. The gentleman from Virginia.

Mr. SCOTT. Mr. Grandy, I think it is the Chairman's—Mr. Grandy, the Chairman is not going to break to vote. Are you willing to stay?

Mr. MORAN. It is a Journal vote.

Mr. GRANDY. I would like to vote, if it is all right, Mr. Chairman.

Chairman FORD. Go ahead. I will wait for you.

Mr. MORAN. I will skip the Journal vote. There is ample precedent for that.

Mr. SCOTT. Well, Mr. Moran, you have the benefits for children, preventive care, drug rehabilitation, long-term care, pharmaceutical drugs, mental health. The coverage of all of those benefits will be decided by the Commission, is that right?

Mr. MORAN. That's correct. There will be broad policy guidelines emphasizing preventive and primary care, but the specific composition of that preventive primary care package would be determined by professional medical experts. It would work much the way that the NIH panel works deciding what should be the priorities for Federal health research.

Mr. SCOTT. The affect on those with disabilities, is there a cap on individual lifetime benefits anywhere in this plan?

Mr. MORAN. No. There is—I think there is in the President's plan, isn't there? There is one plan that has a cap on total lifetime benefits. Most insurance companies have such a cap now. We don't have one in our plan.

Mr. SCOTT. Would there be effect on veterans and senior citizens on Medicare now?

Mr. MORAN. Would there be an effect?

Mr. SCOTT. Right.

Mr. MORAN. Yes. Medicare continues under the Managed Competition Act.

Mr. SCOTT. Therefore there would be no effect on those presently on Medicare?

Mr. MORAN. We think that the health care costs are going to go down somewhat. I think all elderly people are going to be affected somewhat by any health care plan, and certainly by the relative level of the cost of health care.

I don't think that Federal retirees would be affected, certainly not adversely. I don't know any other specific way that they would be affected other than there will be a greater emphasis upon preventive care.

Mr. SCOTT. Okay.

Mr. MORAN. Incidentally, we are working on a long-term care benefit that would be a very important element but it is not refined at this point. It would be an addendum, though, as envisioned, to this plan.

Mr. SCOTT. You have in the bill a prohibition against underwriting. That is, you can't—there is a prohibition against underwriting.

Mr. MORAN. That is correct.

Mr. SCOTT. And do we know that the insurance companies will actually write in certain areas? There is community rating, as I understand it, is that right?

Mr. MORAN. Um-hum.

Mr. SCOTT. Will the rate be higher in some communities than others as is presently the situation in automobile insurance?

Mr. MORAN. There will be community rating, risk adjustment. You have got to do that to be fair so that you can have adequate competition. Insurance companies need some adjustment by the Health Plan Purchasing Cooperatives. That was one of the basic elements.

Mr. SCOTT. How big are the communities? In automobile insurance some areas, some ZIP Codes, for example, have significantly higher insurance rates than nearby ZIP Codes. Will we see that same kind of disparity in health care?

Mr. MORAN. I don't believe you will. You will not have as large, generally speaking—we don't expect to have anywhere near as large an alliance as the President's plan envisions, which would be probably one or two alliances statewide. In other words, Virginia might have two alliances. We would anticipate more.

But I think that this Managed Competition Act is a substantial improvement over the White House's proposal in this regard. For example, in the Washington Metropolitan Area, everyone is going to have to go back to their jurisdiction of residence. This plan does not split Metropolitan Statistical Areas. You would have alliances that are regional in nature, so you would have a Washington Metropolitan Alliance, which I think is a lot more reasonable than the President's plan.

You know, Medicare has geographical variations currently. We would retain those. So I think the answer to your questions basically is yes.

Mr. SCOTT. Yes, there will be the disparity.

Mr. MORAN. No. Well, that wasn't your question. How are people going to be treated? The point that needs to be made is that I don't think people are going to be adversely affected by any kind of geographical designation of these alliances. In fact, they would be better treated by including the entire Metropolitan Statistical Area than forcing them to be segregated according to State of residence.

And we have these metropolitan areas all over the country that oftentimes are composed of two or three individual States. They would all have to have their own alliances under the President's plan. Under our plan you would recognize the metropolitan relationship and they could have their own Health Plan Purchasing Cooperative that would be regionwide.

Mr. SCOTT. Now, as I understand the—just very quickly—the plan, if you are at under 100 percent of poverty you are totally covered?

Mr. MORAN. That is correct.

Mr. SCOTT. Is that with Medicaid—is Medicaid still in existence?

Mr. MORAN. No, Medicaid gets incorporated into that. You take the stigma of Medicaid away. People are going to have health insurance coverage without being designated as welfare recipients. It is just their health insurance coverage, if you can't possibly afford it, then people under 100 percent of poverty, we don't think can possibly afford it, the Federal Government pays for it in its entirety.

Mr. SCOTT. And can we get an idea of what the subsidy would be at various levels?

Mr. MORAN. Sure.

Mr. SCOTT. At 199 percent of poverty, obviously, it is almost——

Mr. MORAN. Yes, but let me explain that to you. At 125 percent of poverty you would get a 75 percent subsidy; at 150 it is a 50 percent; at 175 it is 25 percent; at 200 percent it is zeroed out entirely.

But you would still get your deduction which you don't get now. Very few people ever get the advantage of that 7½ percent cutoff of point. So very few people get any deduction for their health care cost.

Under our plan you would get 100 percent tax deduction for the minimum standard benefits package, which in many cases is going to substantially improve the dynamics of purchasing insurance, particularly for people who are self-employed or in small businesses.

Mr. SCOTT. And finally, on your choice of various plans, how much freedom of choice is—you have a list of plans. You pay more for the higher priced plans or you would have a deduction, a limited deduction for—no deduction for the value of the plan above that.

Mr. MORAN. Well, that is right. The deduction only applies to the minimum standard benefits package. Whatever plan offers what this Health Care Standards Commission says is the minimum that needs to be offered, preventive, primary care, et cetera. Any frills in addition to that, you don't get any tax deduction, no tax break for that.

Mr. SCOTT. And the break would be the amount of the cost of the lowest plan for that year?

Mr. MORAN. That is correct. But it is also important to understand the dynamics here. We don't think that insurance companies are going to be anxious to be that lowest cost plan. They are not going to want to underwrite the rest of the market to pick up this number of people because they are going to go out of business very soon. So I think they will be forced by the dynamics of the market-

place to offer a plan that is reasonably consistent with the marketplace and what other insurance companies would be able to offer.

So the benefit, the tax deduction benefit is going to be significant.

Mr. SCOTT. And can you just say a word about how portability is handled when you change from one company to the next? For example, if you switch jobs?

Mr. MORAN. Absolutely. But we have the expert here. Mr. Cooper has just joined us, so I am going to turn it over to Jim as the author of this, and I know he will do a more articulate job.

Mr. SCOTT. I would like to thank my colleague from Virginia. You have done an excellent job in responding to the questions.

Mr. MORAN. I appreciate your asking questions that brought out the benefits of our plan, Mr. Scott, as well. Thank you.

Mr. COOPER. I appreciate my colleague Congressman Moran not only for his brave and strong cosponsorship of our proposal but for his leadership in many health care issues over the years.

And I am sorry that I was detained in the Public Works Committee hearing because, unbelievably, they are thinking about repealing motorcycle helmet laws over there and automobile seat-belt laws, which in a year of health care reform would be a terrific step backwards. But there are a lot of different health care issues we have to face.

On the portability question, our bill is just as good as the President's bill. We are basically wanting the individual employee to pick out their favorite health plan, and that company would no longer have the right to cancel a policy or to raise the rate.

Your health care experience, your employment experience is irrelevant. It is not the company's business, and we think that that is a very important and positive reform because it is a mobile country, benefits should be portable. They should have been portable years and years ago. We need to end job-lock, and we think under this menu-based system that we share with the Clinton proposal, with the Chafee proposal and some others, Federal employees have had it for 33 years now.

Mr. SCOTT. So, if you have a job, you develop a preexisting condition, and you change jobs, you are no longer subject to job-lock, who would cover you after you switch jobs?

Mr. COOPER. You get the same group rate and you can carry your policy with you wherever you go.

Mr. SCOTT. So once you get a policy you can keep it?

Mr. COOPER. See everyone in America will be able to get the federally defined basic benefits package. That will be uniform nationwide. No State in America, no city or town could have a substandard benefits package. Every package would have to meet that standard. We think that preexisting condition limitations should be banned, your own health history should be irrelevant in the process, that it is not your fault if you get cancer, and you shouldn't be discriminated against by insurance companies as a result.

Mr. SCOTT. Well, obviously, if you developed a preexisting condition whoever covers you after that is going to be taking, suffering a loss. Is it your present company or the one you join after you switch jobs?

Mr. COOPER. See every insurance company would have to offer near community rating to all people. Then if they ended up with an undue number of unhealthy people, they would not be penalized for that under the risk adjustment mechanism, which is not only in my bill, but it is also in the President's bill.

Companies would actually be rewarded for treating the sick, and companies would be punished if they saw an undue number of young, healthy, wealthy people. Because the old insurance practice of skimming the cream off the market, of picking all the cherries off the tree has got to stop. Our bill stops it, just as the President's bill stops it.

We have substantially the same insurance reforms as are in the President's package. They are also in the Chafee package. They are in a number of these packages including a lot of them are in the Nickles-Stearns package. So there is remarkable consensus between parties on these small group insurance reforms. We think it is a very important and positive step forward that we can make to ban preexisting condition limitations, to ban experience rating, and to make a near community rated insurance product available for all of our citizens.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman FORD. Jim, while you were out, Fred Grandy said something that has me a little bit confused, and I feel I should give you the chance to straighten it out for us. In describing how the bill handles Medicare, it turns Medicare into a program that instead of making payments directly to health care providers would make payments to people and then they would use that money to buy insurance.

Now, for a long time I have read study after study that says that under the present existing system one of the real problems is that between 30 and 33 percent of the close to a billion dollars a year that comes out of our economy for health care goes to what you could call roughly insurance overhead—profit, advertising, management, sales, all the other things that have the insurance company handle my money and pay my doctor.

Why would it be to our advantage to give someone who is presently covered by Medicaid the money to go out into the market and buy insurance? Why not continue to pay providers directly? Why insert between the Federal taxpayer and the provider of services to poor people a profit-making company, whether it is called insurance or HMO or anything else?

Mr. COOPER. Mr. Chairman, I think you meant to say Medicaid, the program for the poor.

Chairman FORD. First of all, is that a correct interpretation of what would happen? It is what I understood Fred to say.

Mr. COOPER. The Chairman means Medicaid, the program for the poor, and we do buy in low income people into the same health plans that other Americans belong to. We think this is a very important and positive reform because today there are many doctors who refuse to see Medicaid patients.

Why? The government systematically reimburses them at below cost. Many doctors today are turning their backs on the poor. Under our approach we would buy in the poor and the near poor

into the same health plans that well-off Americans belong to to end the two-tier medical system in this country.

Because if you are a human being in America you should be treated like a human being and not rejected by a substantial portion of the medical community. This is a way of empowering all citizens, including the poor, so that they can participate in the same health plans, see the same doctors, that rich people do.

It is a very positive reform and we think that we can lower insurance overhead. You are quite right to point out that in today's system a great amount of money is wasted by insurance company paperwork, overhead, red tape, sales calls, a whole lot of things like that.

We share with the President a belief that managed competition can reduce that to below 5 percent, whereas some small businesses today are paying as much as 40 percent in unnecessary overhead and red tape.

The President does believe in a private health insurance system. Now, I think the Chairman may have, perhaps, been implying perhaps his own preference for a Canadian system or a single-payer system, and that does have some positive arguments in its behalf. But the President has not supported that approach.

We join with the President in supporting a private health insurance system. We think we can reduce the cost of administrative overhead to below 5 percent to get the waste out of the system.

Chairman FORD. Thank you.

I want to apologize to the present panel and the one that is waiting to come on. We don't make the schedule for the consideration of legislation on the floor, and we have a bill which provides $10.5 billion a year to elementary and secondary schools that has been on and off the floor. And when it is convenient they tell us we've got to come to the floor and legislate, and then when they have something else to do they pull us off. I guess they like to keep returning every day to let people talk about something nice like education.

And they are getting very close to the end of the 1 minute over there when we will be required to handle that bill on the floor. Mr. Scott is going to stay until 12:30 p.m., and the staff will continue trying to find somebody who is not deeply involved in the legislation on the floor to stay so that we can accommodate the next panel that comes after you.

I personally want to thank all of our colleagues from the House for testifying on this legislation, and for taking this opportunity to clear up some of the possible misconceptions that surrounded it.

Jim, I know you have been very sincere about this. I think you and I attended health care meetings three years ago and you started talking about managed health care, Sam Gibbons started talking about super-Medicare, and some of these things haven't changed.

I have changed considerably in those three years. As you have accurately indicated, I think ultimately the only way we are going to have a decent health care plan in this country that does all of the things that everybody's proposing, all the things they want to do, is to go to a single-payer plan. And I see the President's plan as a step in that direction.

Mr. Grandy sees your plan and his plan as a step in the direction of the President's program. That would suggest that all roads lead to Damascus. That everybody is trying to get to the same place and it is a question of whether we wait one generation or two.

Mr. COOPER. No, Mr. Chairman.

Chairman FORD. Which leaves me with the concern I had the other day when I read that the FBI said that the CIA was told seven years ago about the latest scandal, and that 8 of the 10 Russians that were on his [A. Ames'] payroll were executed in the seven years that they dawdled with that before they acted on a tip that was given to them by another CIA employee, and I don't want to dawdle while another generation of people die prematurely or suffer pain unnecessarily.

That is really the difference. It is how eager and anxious we are to get to Damascus.

If everybody wants to take the position that what we really want to do is get everybody covered and make it cheaper and better and everything else, the real question becomes how much are you willing to stick your neck out to take that step, and that is what we are going to find out in these various committees and in the House sometime this year.

Something is going to past and go to the President before Congress adjourns this year. I feel that in my bones. I hope with every fiber of my body that it does, because this is my last chance to shoot at it, and I have been promising prescription drugs to people since I voted for Medicare in 1965, and right now there are only two plans that propose to keep that promise.

So I don't really think that I can go back on a 30-year career that was in large part sustained by people believing me when I made political promises that yes, we made a mistake with Medicare, we couldn't get the thing put together, and we will get back to prescription drugs for non-hospitalized people right away.

Well, it will be 30 years in the spring and we are not back to it yet. So that is why I am a little less patient than I might be with what I consider your all too cautious and gradual approach to the ultimate problem.

You might be interested in this. The Speaker has just received a letter from Mr. Natcher indicating that he could not, because of the advice of his doctors, be brought back to the floor again today, and so he has missed his first vote in, I think, 42 years, and it is actually a historical moment for this institution. They are over there now.

I am told I have a little more time than I expected, by virtue of them getting into nice words about Bill Natcher, and I am told by the staff now that I should dismiss the panel and run because Mr. Fawell is waiting to ask you a question. I am sure it will be friendly, so you should enjoy him.

Mr. SCOTT. [presiding] Mr. Fawell?

Mr. FAWELL. Thank you, Mr. Chairman. I realize the hour is late, but I am interested in the Cooper bill. I think there are a lot of positive points to it. And I would like to zero in only in regard to the regional alliances aspect.

As I understand it, the regional alliance mandate in regard to small businesses would, from where I view it, in effect mandate

small business people, those with employees of 100 and less, to be mandated into a regional alliance if they purchase health insurance.

I am assuming that is on the same basis as the Clinton plan, based on the residency of, apparently, the employees. What bothers me there is that it covers a significant amount of the workforce. I have been told approximately 55 percent of the workforce would be included, assuming that is roughly the percentage of the workforce that is in small firms of 100 or more or are self-employed.

That bothers me a bit, because I think that when you mandate people to in effect give up insurance policies they now have or small businesses may now have, and be directed into a certain regional alliance, you do detriment to the competition aspect of managed competition. And I think to the degree that you eliminate competition you weaken your bill a great deal. And that is the gist of my query.

Is it possible that we can truly have voluntary regional alliances? And I will go even one step further. I have often thought of regional alliances being much like multi-employer plans. I can see some day even having international alliances for the purchase of health care, national alliances for the purchase of health care would then be attractive, obviously, for the small business and any individual, and they would have the collective bargaining ability to do quite a lot in bargaining with health care providers or with accountable health plans.

So I have trouble with a regional alliance even having a monopoly within a certain area. I see the same thing with Medicaid. They are mandated into regional alliances, which gives those regional alliances that much more difficulty in being able to come up with a premium that is attractive, especially if one recognizes as one has to, that in the Medicaid population you have more severe problems of health.

But is there a chance that your bill could be amended so that we would have truly voluntary regional alliances and then bank basically on the assumption that you would have enough people voluntarily joining so that you would have attractive premiums and many people would be attracted to that?

Mr. COOPER. I appreciate the gentleman giving me an opportunity to discuss the alliance issue. It is very important that we be clear in this debate.

The Clinton alliances are large and regulatory. Any employer with 5,000 or fewer employees would have to join the Clinton alliance. The Clinton alliances would be in many cases, not all cases, State agencies, bureaucracies. They would have regulatory powers to exclude certain health plans, and remember it is not from the alliance that you get health coverage. It is from the health plan. The alliance is a grouping mechanism.

Our approach is entirely different, and we share a great deal in common with the so-called Chafee bill in this regard. We think only that firms with 100 and fewer employees should have to join, and these alliances should be genuine cooperatives, not a State agency, not run by bureaucrats, but really run by the members themselves, a whole lot like a chamber of commerce.

And just like a chamber of commerce, you wouldn't want multiple chambers of commerce to represent a single town in your district. If they did that they would probably spend most of their time not promoting the town or recruiting industry but more undercutting each other.

It is very important that we have several things that a genuine cooperative can provide. Genuine risk spreading—and remember when you look at the customers of these alliances or these cooperatives in our bill, look who has endorsed our approach. The largest small business organization in America, the National Federation of Independent Business likes our bill and likes the Chafee bill, likes the fact that we have this sort of, essentially grouping mechanism.

Because what we do is offer each one of these small businesses a menu of health plans. It is the health plan that bids for your business, that tells you the quality of the care it is providing, tells you its consumer satisfaction. The health plan is the risk-bearing entity. The cooperative is just a way of allowing a small business the same purchasing power that big business enjoys today.

And the cooperative is also a way—and this is very important, seldom understood—the cooperative is also a way of allowing the individual employee in the small business to choose the health plan that is best for his or her own family instead of having to go with the boss's choice.

Individual choice should be enhanced in health care reform, not limited. And remember the alliance doesn't sell you anything, the cooperative doesn't sell you anything. It is the health plan that really does the health care, and insurance business. And by expanding that menu of choices, we think we have an exciting opportunity to give small business group purchasing power.

And it is not just the NFIB that likes our approach. Look at the National Restaurant Association, look at the National Grocers Association, look at companies like that, generally small companies that want the power that the Big Boys now have, that want the group purchasing clout, and we think the cooperative is an exciting way to provide that.

Mr. GRANDY. Could I say something about this?

Mr. FAWELL. Could I just add one more caveat to this question. I am assuming therefore that the regional alliance is not a government entity then.

Mr. COOPER. Is not a government entity in our bill.

Mr. FAWELL. I misunderstood that.

Mr. MARTINEZ. [presiding] Mr. Fawell, your microphone is not on.

Mr. FAWELL. It is on. I am just not——

Mr. MARTINEZ. Okay.

Mr. FAWELL. So it is private——

Mr. COOPER. Exactly.

Mr. GRANDY. With locally elected and locally accountable people presiding over the management of it, Mr. Fawell.

Mr. COOPER. Like a chamber of commerce, you know.

Mr. GRANDY. If I could just add one thing about the reason the Cooper-Grandy bill has mandatory purchasing alliances as opposed to Chafee which has voluntary, and some of the Republican alternatives which are all voluntary. Two reasons, basically.

One, we want to make sure that that purchasing power is as large as it can possibly be, so we ask businesses of 100 and fewer employees to go into them. We are concerned about businesses that are too small to self-insure still having that option to do that and having actuarily unsound plans, one. Two, we specify that we want people who compete for these purchasing cooperative territories to take care of all of the potential uninsurable risks, the Medicaid eligibles, the people with material preexisting conditions.

A voluntary mechanism would at least without some kind of rigid community rating outside it, and even perhaps with it, create a kind of de facto adverse selection. You take all your best risks and some of the people that might not be able to get into the purchasing cooperative would be selected out.

That though is a topic that has caused quite a bit of debate within our coalition, is still being discussed. But until we can find a viable risk readjustment mechanism that will allow for voluntary pooling cooperatives but ensure that everybody gets into one if they want it and nobody is left out we have kept the mandatory language.

Mr. FAWELL. Who determines the boundaries of these regional alliances then? How is that determined?

Mr. COOPER. The key thing is here to have a large enough group in each alliance so you have real purchasing power, so that hospitals and doctors and insurance companies pay attention to you. And also to preserve existing markets.

For example, cities could not be divided. You would be crazy to try to divide them because if you interrupt patients getting care from doctors you are going to be in big trouble.

We also think that you shouldn't be burdened with the problems of other parts of the country, especially on both coasts that have not minded their health care businesses as carefully as they should. Within a region, a given market area, and many of these will be multi-State, there will be traditional commuting and shopping patterns.

Mr. FAWELL. It could be multi-State?

Mr. COOPER. In many cases. You look at a State like Tennessee. Memphis, Tennessee, right next to Arkansas and Mississippi, half of our patients are from other States.

Mr. FAWELL. Who organizes them?

Mr. COOPER. Well, we would have the Governors. You could not split a city. The Governors get together to form these multi-State arrangements, to essentially make political State lines and county lines irrelevant to the patient. Because when you are sick or injured you don't care about politics. You care about access to high quality, affordable care.

In the DC area, for example, we would want this cooperative to cover two States plus the District, because so many folks who live and work in this area have doctors that live in all three jurisdictions. It is very important that we preserve existing purchasing patterns, and so the DC Metropolitan Area has incentives to get its cost down and that we are not burdened by the behavior patterns of Miami or New York or Los Angeles or other large metropolitan areas. So that we are trying to do the best job we can getting our costs under control in this area.

Mr. FAWELL. Will the Governors then have the authority to ultimately make the decision as to which particular regional alliance, for instance, I might be in?

Mr. COOPER. No part of a State could be excluded. You couldn't leave a part out. Every citizen of a State would have to be served by one purchasing cooperative.

So we leave it primarily to the Governors but we limit their discretion somewhat. They couldn't have areas below 250,000 people, and they couldn't divide cities. So we think using that approach we can get Governors' cooperation, and Governors will be very interested in cooperating once they realize the political damage that would result if they don't cooperate.

Mr. FAWELL. And then just my final comment, if I may. That makes it much more attractive than what I had been led to believe was the situation.

I tend to believe, too, if all of this is accurate, and I assume it certainly is accurate, that the potential, even if it was voluntary, would be immense. Because that is the future, as I see it. What we will be doing here, though, even though there will be a lot of attractive potential purchases for one who is in a voluntary alliance, we nevertheless are not going to allow them to be subject to the kind of competition that is needed. Your bill has the tremendous advantage of saying that we are not knocking employers out of this, they can continue to innovate, do all the things they can do and so forth and so on. We are not knocking insurance companies out of this. They can innovate, be creative and so forth and so on.

But there is still that little bit of reticence on my part to fully embrace the idea of regional alliances where there still is this mandate involved. I think if it is as you describe it, it has a tremendous potential.

Because, I repeat, I see the day when there are going to be international alliances, and you are going to be competing with Europe on the best health care. People will go to London for angioplasty, for instance, and be able, perhaps, to have the procedure done with high quality and lower cost and so forth and so on. That is going to be part of the tremendous advantage of moving in the direction I think the Cooper plan moves.

I am looking at it, and it may be something that I can cosponsor. I believe it is a tremendous effort, and I appreciate very much your explanation of the regional alliance aspect of it.

Mr. COOPER. If you are ready to cosponsor, I won't say anything more. But if you need additional persuasion, I would be delighted to go on at length.

Mr. GRANDY. I will handle Mr. Fawell.

Mr. FAWELL. I am a bit concerned about the mandated aspect. I still don't fully appreciate that. But it is much, much better than I had been led to assume because it is not a governmental mandate where the government is going to be doing it.

Mr. COOPER. There has been a lot of misinformation on the subject. In fact, from both sides of the aisle we have gotten studies recently that are little better than hatchet jobs with a very dull blade. People have not read these bills. They have not portrayed accurately what is in the bills.

And on the voluntary question, unless you are interested in two or three chambers of commerce for every town in your district, I think you are going to have some second thoughts about having two or three cooperatives in every region of the country.

Also, remember that if it is entirely voluntary it is usually only your bad risks that will want to sign up. Your good risks will tend to stay out on their own, and in a sense that creates the free rider and creaming and cherry-picking problem that we have seen too much of in insurance.

Remember the key thing is whether small businesses will be well served. Talk to them more than to the insurance companies, and some others who have a selfish interest in promoting existing cream-skimming and cherry-picking behavior.

It is very tempting. I have heard from some trade associations, for example, that would love to continue serving every one of their members, even when it is not in the members' interest. For example, some quite dangerous small manufacturers where people lose fingers and limbs, where they smell dangerous chemicals, still want to serve that market and only that market when it would be very much in the interest of those small manufacturers to be grouped in with others, office workers, young people, old people, people who work indoors, people who work out of doors, to get a balanced risk pool so that we can have a genuine community rating. Essentially we are returning the insurance industry to its roots.

So I think with a little bit more understanding of this issue we will be a lot closer than perhaps we may seem today.

Mr. FAWELL. Yes. I just would again say that I agree that many a trade association or multi-employer plan cannot possibly meet what you are talking about here. I think that is good. I think what you are talking about has so much advantage, though, that you need not worry as much as you might be worrying about having to mandate people into it. If you do the job, and if you are subject to competition, and I think you can outcompete others, outcompete even the biggest employers.

You should look at it that way with a much more positive attitude. I think you are not going to need mandates for people to get in there. You will attract them. The problem with multiemployer plans now is that we have this mixed jurisdiction, nobody knows really what to do. You have the States demanding things and setting the Cadillac policies and all these kinds of things, and there is no way for it to take off. It should be, I think, Federal jurisdiction, and I think you have the potential that can really make the difference if it were truly voluntary.

Mr. MARTINEZ. The time of the gentleman has expired.

Mr. Roemer?

Mr. ROEMER. Thank you, Mr. Chairman. And again, welcome.

Mr. Cooper, you said sometime ago, I think it was a couple of hours ago when you testified, you said that your bill comes close to achieving universal coverage. You were there when the President said his bottom line is universal coverage.

Can you tell our committee how many people fall short of your bill in terms of not being covered for the universal aspect, and what do we tell those people?

And finally, where are you willing to work with the President in achieving this?

Mr. COOPER. First of all, it is very important to be accurate in this debate, and when the President issued his veto threat in the State of the Union message, he said, "Hear me clearly. If you send me legislation that does not guarantee every American private health insurance coverage that can never be taken away," then he brought out his veto pen and threatened to veto the measure.

Our bill is closer to the President's demand than any other bill. The McDermott bill, for example, that seems closer is not even for private health insurance, and the President is.

Our bill of all the other bills will come closer to meeting the President's goal, and let's loosely call it universal coverage, on the President's timetable. Now, in the State of the Union message, the President did not mention his timetable.

What is his timetable? It is to achieve universal coverage by 1998. Why does it take so long? Because it is hard to achieve. Universal coverage is not like flipping on a light switch. I wish it were that easy. It is more like a dimmer switch, and our bill is 80 percent bright without blowing any economic fuses.

How do we get to that number? Well, today there are 39 million uninsured people in America. They need help. They need access to health insurance. Look at who those people are. Sixty percent of them—60 percent, are below double the poverty level. And our bill commits—we've committed for three years, since before there was a Clinton Administration or a Clinton bill on health care—to cover these people. That is 60 percent of the uninsured right there.

User friendly insurance, which we have advocated again for three years, should help us get 10 to 20 percent more of the uninsured included. User friendly insurance, so that if you want a health policy you can get it, no insurance company can turn you down anymore for any reason.

You can keep it regardless of your health status or where you work, and you get this policy at low group rates as if you work for the biggest company in town. We are just like the Clinton bill in most all of that. In fact, we go beyond it because we would allow the individual employee to deduct the purchase of that coverage. Today, the average American citizen cannot deduct the premiums they pay for health insurance.

So we think we are at about 80 percent of the President's goal right now, and we can complete the job on his timetable of 1998. We will probably need a follow-on bill to do that. Why? Because the President may need a follow-on bill.

Let me cite an administration spokesperson who was at a health care forum in Memphis, Tennessee, just a week or so ago. This spokesperson said at that meeting that basically the administration bill will not achieve universal coverage even by 1998. She said that basically Hawaii is about as good as we can do, leaving 4 or 5 percent of the people uninsured.

It is well known that in addition to that population left out by the administration's plan, no bill really intends to cover illegal aliens. So there is going to be a substantial percentage of our citizenry that is probably not going to be covered even under the administration's approach.

But we still support the administration's goal of covering everyone and his timetable. But the data in this area are so poor. I have checked with the Census Bureau. I have checked with all of the other consultants I can find to really find out who are the uninsured and how can we cover them in an affordable, cost effective fashion, and the sad answer is basically today no one really knows how to complete the job. At least not with private health insurance.

So we want to work with the administration. We have been working closely with them for all of last year and this year. We want to work with others as well, anyone with a good idea in this area, to cover every American and on the President's timetable.

We don't think the President has to give on this timetable, by the way. And when I called the White House after the State of the Union message and asked why 1998 wasn't mentioned in the speech, the informal answer I got was, "Well, they may be flexible on that."

They don't need to be flexible on that. We can cover most every American by 1998 by working together in a bipartisan fashion. Cover the poor and near poor, have user friendly insurance, and let's figure out how to cover the remainder group. But remember who the remainder folks are, folks who are over double the poverty level who have turned down the offer of a good group rate policy. Who have turned it down.

A lot of these folks, not all, but a lot of them are likely to be yuppies and students. They have no employer. And an employer mandate will not reach these people. Thirty percent, 30 percent of the uninsured today have no contact with an employer, so an employer mandate is not going to do the job.

Also remember that 12 percent of the uninsured today make over $50,000 a year. They are not poor. But they have chosen for one reason or another, in some cases due to a preexisting condition they have been unable to get a policy, they have no coverage. We can make sure that regardless of your health history, regardless of your employment status, you can get and keep a good health insurance policy.

So we think that there is a lot more in common here. No other bill comes closer to the President's bill than ours. There has been some thought that the Chafee bill with the so-called individual mandate was closer to the President's approach. Read the Chafee bill. He is for universal coverage in the year 2005 on a pay-as-you-save, if we can afford it basis.

There are many fine features of the Chafee bill, but look at the universal coverage part. We are closer, we think, to the President's bill, than any other. But we will need a follow-on bill.

Is that an unusual congressional process? Take a look. Most every major bill at least has a technical corrections bill following in six months or a year. Major bills like NAFTA, did we pass NAFTA? Well, we did. But did we fund NAFTA? We haven't done that yet.

Most bills come in stages, as we get more information, as we are able to do the job, and especially in this area, we think it is very important to aim before we shoot. We do not have good data in this area. And until we get good data, we think it would be at least pre-

mature, if not a terrible mistake, to endorse a clumsy and expensive approach to universal coverage like the employer mandate.

Mr. ROEMER. So you believe that you can work with the President, one, to achieve universal coverage, not necessarily through your plan but through some kind of a hybrid or modified plan; and secondly, you believe that the timetable is realistic that the President has either formally or informally set out.

Mr. COOPER. Yes.

Mr. ROEMER. Let me ask you a question about the alliances. We will hear testimony later on today or next week, whenever we get to it, from different people that say such things as "It is vital for the achievement of universal coverage and cost control that such alliances be created and become politically legitimated."

It goes on to say, "But nothing can happen unless politically legitimated sub-Federal entities are created whether they be called alliances or purchasing cooperatives." What do you think of that statement?

Mr. COOPER. Well, the health alliances that are in the Clinton bill are too large and too regulatory. They are not part of managed competition. The first time they ever appeared was in the President's staff draft of the bill. Managed competition advocates have never favored anything that large or that regulatory. Managed competition advocates have usually favored smaller and less regulatory ways of grouping small businesses, genuine cooperatives.

Mr. ROEMER. So would your alliances and cooperatives be limited by city or State, or what kind of boundaries are we talking about, Mr. Cooper?

Mr. COOPER. Every State would have to make sure that every citizen of the State in every county was covered by a cooperative, and the boundaries would be drawn by the Governors, but these cooperatives would be run by the small businesses in the area. Each cooperative would at least have to have 250,000 covered lives so that it would have some clout, so that hospitals and insurance companies would pay attention to them.

Also, you could not divide a city. It is very important that Standard Metropolitan Statistical Areas be unified. We need to preserve existing markets, existing commuting patterns, existing shopping patterns, because that is what people are used to both for health care and other needs.

And we think that the Governors will work together to make sure that we have multi-State entities where appropriate, and that we have sensible in-State groupings. But these are genuine cooperatives. These are not State agencies in our bill. They could not be State agencies. These are genuine member cooperatives run by the small businesses.

And in the answer to Mr. Fawell's question earlier, I compared them really to chambers of commerce. They are not threatening. They are ways that businesses can ban together to get a better deal. Big business has a lot of purchasing power today. They can go to a hospital or an insurance company and say, "Hey, we have 10,000 employees. Pay attention to us." Small business——

Mr. ROEMER. Let me interrupt and ask a question. If they are like chambers of commerce, are there any licensing or certification

or any kind of local regulatory requirements and ways by which we check and balance what they do, and assuring local accountability?

Mr. COOPER. We need to make sure, obviously, that they adhere to minimum standards. That they cover the folks they say they are covering. That no county is left out.

Mr. ROEMER. Who assures that?

Mr. COOPER. Well, we have a National Health Care Standards Commission to make sure that nationwide wherever you live in this great country that you can be part of our health care system. That you have access to at least the Federal minimum package and hopefully a whole lot more. That you have the opportunity for a good health insurance product, good health care at low group rates as if you work for the biggest company in town.

Because the exciting thing about this is small businesses who have been discriminated against for years by insurance companies can finally have the clout as if they were a Fortune 500 company. Because insurance companies today have competed not only to get rid of people if they got sick or they switched jobs, but they have also competed to splinter us into tiniest possible groups to pretend that you could only get a policy if you are a small business. You couldn't have small businesses grouping together to get a better deal. To pretend that families by themselves were an insurable unit when there is no reason that families shouldn't be able to band together and say we want a better deal.

We have used the cooperative principle in America ever since New Deal days to make sure that every gravel road in America gets electric and telephone service. We have used it in many other ways to make sure that people have power. This is an empowerment concept, and it is fundamental to managed competition.

And it doesn't need to be the giant regulatory health alliance of the Clinton bill. It can be the smaller and consumer friendly approaches of real managed competition, of our bill. A similar approach is really used in a number of other bills.

And if you pick a number of about 100 employees or less you will find something very exciting. That takes care of your area of greatest need, the small businesses that have been discriminated against the most, and it also gives you two balanced purchasing groups, one group composed of about half the employees in an area that belong to the cooperative, and the other group of employees who work for larger companies. So it is about a 50–50 break. That means that each local hospital, each insurance company is equally interested in doing business with both groups. So they have equal purchasing power with the big boys.

And you also have a local way to tell how you are doing. You don't have to check with bureaucrats in Washington. Check and see how the other folks in your own area are doing in getting a good deal from a hospital and getting a good deal from an insurance company.

We think it is a concept that can really work. It promotes competition at all levels, and it empowers individuals to get a better deal.

Mr. ROEMER. Is the entire Medicaid system under the alliance under your proposal?

Mr. COOPER. We think there are so many problems with today's Medicaid system, the program for the poor, that we need to really need to start all over. I mentioned some of the problems briefly to Chairman Ford earlier.

A great number of doctors today will not see any new Medicaid patients, period. They just cut them off. We also have a problem with Medicaid beneficiaries getting completely free care and using the hospital emergency room as if it were a 24-hour walk-in clinic.

We also have problems with unfunded Federal mandates from Washington and with States playing games with State share. So what we advocate for individuals is to essentially give them a voucher, to buy them in as low income people into same health plans that rich people belong to.

They are human beings, just like anybody else in the country. They have rights. We shouldn't have a two-tier medical system anymore, and this is a very exciting advance. As I say, we have had this in our bill for three years now, since before there was a Clinton Administration, since before there was a Clinton health bill, to buy in the low income into the same health plans that well-to-do people belong to, and to make sure that our health plans see all of our people, rich or poor, old or young, urban or rural.

Mr. ROEMER. So there would be a shifting here in small businesses then would be required to subsidize those Medicaid patients?

Mr. COOPER. We don't see it that way. First of all, a number of the uninsured today—see remember today Medicaid only serves half of the poor. We advocate covering four times more low income people. And a number of these folks are just as healthy as anybody else. They are not an increased health risk. If you just look at today's Medicaid population there may be a higher risk associated.

But we think the purpose is not to in anyway burden any small business group. The purpose is to spread risk evenly through the population. Because the fact is we are paying their bills anyway. Every time you go to the hospital you are paying an extra charge of considerable proportion for the uninsured, for the medically indigent, for the charity care cases that the hospital is providing.

We want to manage that cost at the front end, and most of the other health approaches take the same approach, by buying these folks into a good preventive care system so that we can take care of the bad cold before it turns into double pneumonia, to make sure that they have access to primary care advice so they don't have to go to the emergency room too late where care is so expensive.

There are so many exciting ways to not only save money here, but to help real people. Help human beings by getting access to early preventive care and by making sure that all of our health plans have to see the poor, so the doctors can no longer say no to the poor.

To us it is an exciting way to empower all of our citizens, not just the well-to-do, but the poor as well, and to empower our small business groups. The NFIB, the largest small business group in America, as I mentioned earlier, the National Restaurant Association, the National Grocers Association, these folks like our plan. They don't feel threatened by it. They feel empowered by it, and I think it is an exciting opportunity.

Mr. ROEMER. Well, I thank both gentlemen for their time.

Fred, did you have anything to add?

Mr. GRANDY. Well, I would just say, Mr. Roemer, that there are under the category of "Enforcement" civil money penalties that are actionable by employees if employers do not offer plans, and if they are not in compliance with the basic benefit, and if they violate nondiscrimination agreements. So it is an actionable offense.

We really cannot determine what agency would police that yet because we haven't put that, obviously, into law.

To the other point on Medicaid, remember that Medicaid comes in two parts, and we are essentially creating a new kind of scenario for the acute care portion. Long-term care Medicaid dollars would go back to the States, and those States such as, I believe, Mr. Miller's situation in Florida and mine in Iowa, where those few States that get more long-term care dollars than acute care dollars there is a four-year phase-in of subsidies to help those States manage their long-term care populations with additional dollars. So we are not trying to rob long term to pay acute. What we are trying to do, as Jim says, is reach more people of the poor and near poor more quickly.

Mr. ROEMER. Fred, in your comments and your testimony you said, I think, that you believe that health care reform and health care coverage for people are both a right and a responsibility, and I think you and Mr. Cooper bring some good ideas and genuine concern to the table, and I appreciate your time and your efforts here today.

Mr. GRANDY. Thank you.

Mr. MARTINEZ. Would the gentleman yield for a question?

Mr. ROEMER. I would be happy to yield to the gentleman.

Mr. MARTINEZ. Mr. Scott?

Mr. SCOTT. Thank you, Mr. Chairman.

Let me follow up just a little bit on these alliances because in your absence we had questions about how these—whether reliance on the community rating actually took place.

In an alliance, if you have adjoining alliances, will there be differences in costs for health care in one alliance rather than in another? And I mention that with the realization that we have trouble with redlining in banks and insurance, and I understand there is some adjustment that will take place to equalize the cost so that you won't get into that. Is that accurate?

Mr. COOPER. Remember the cooperatives would have to be fairly drawn. You could not divide a city. You could not redline a city. You would have to have the entire——

Mr. SCOTT. Wherever you draw a line there is going to be a difference, and once the lines are drawn you will have one group with one health care experience different from the adjoining alliance. And no matter how you draw it there is going to be a difference. And there will be serious political concerns for a county that could probably swing either way to get out of the high cost area for obvious reasons.

Is there any adjustment mechanism so that you won't have areas with a high incidence of certain diseases or higher elderly population where just by the nature of the demographics you will have higher health care costs in one area than the adjoining alliance.

Mr. COOPER. I don't think you will see any interruption in current purchasing patterns. For example, in your State, if people are used to getting their tertiary care in Richmond, they will probably continue to do so. If they are used to getting it in the DC area, they will continue to do so. If they are used to getting it in Norfolk-Newport News, they will probably continue to do so.

What we want to do is make sure that all the inner city areas and all the rural areas are in that current purchasing pattern, so that each area is doing all that it can to improve quality of care and to lower cost.

But we do not feel that, for example, folks in Roanoke, Virginia, should be subject to the same cost patterns as folks in the District of Columbia because it is a different market entirely. They should be struggling to get their costs down, just as folks in the DC area should struggle to get their costs down. But here in DC, the area here would have to be the entire Standard Metropolitan Statistical Area, which is not only DC, it is most of suburban Maryland, it is most of suburban Virginia, it is probably going to have to go deeper out into rural counties even than that, because you cannot leave any county out. They all have to be included. They all have to be linked up with essentially the same tertiary care center that they have been going to all along.

Another way to understand that, it is a lot like television markets. Wherever you get your broadcast signal from——

Mr. SCOTT. Well, I think you are avoiding the question. I think what you are saying is you are going to draw the alliances so there won't be much of a difference.

Mr. COOPER. Well, I think they will be large enough so that you will see fairness within a State. But I think there will be significant differences between parts of the country.

For example, if you look at Medicare data today, you will discover that New York, Miami and Los Angeles have by far the highest cost of serving Medicare beneficiaries. Sometimes it is two or three times more expensive to take care of a senior citizen in those areas than it is, say, in Minnesota, a State that has had, by the way, managed competition, or very close to it, for years now and has 18 percent below average health care costs and healthier people.

There are exciting ways to not only lower health care costs, but improve the quality of care, and that is what we are seeking to promote all over the country, because we don't think that folks in Virginia should be saddled with Los Angeles health care costs. Likewise we are worried about other unfair cross-subsidies today.

Mr. SCOTT. Well, the problem is when people are moving into an area, if you find there is a line right here you can move on one side of the line just within the city boundaries or just within the county boundaries or the adjoining county. You know, when you buy a house the Multiple Listing Service will list what schools you go to and this kind of thing. They will probably, if there is a difference in these alliance costs, indicate what your alliance is going to be.

If there is an adjustment, it doesn't matter. I mean if there is not too much difference one way or the other. If there is a significant difference on one side of the line than another, you are going to have a problem.

And I think what you are saying is the difference won't be a big deal.

Mr. COOPER. I don't think it will be a big deal, and I also think that these costs are there today, they are just hidden. All we are doing is bringing them out in the open so that people can see them.

Mr. SCOTT. No, you have underwriting. You have underwriting, because if you are healthy it doesn't matter where you live. You get rated based on your own individual health. If you move into—no?

Mr. COOPER. I think costs vary for a lot of reasons today. Personal health is one. There are a lot of other factors. There is terrific redlining and other problems in the business today. There are some companies who don't choose to serve entire areas of a State, and we are trying to make sure that all health plans, health insurance and health providers, serve all the people in the area. They can no longer redline or exclude.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. MARTINEZ. Thank you, Mr. Scott.

Mr. Castle?

Mr. CASTLE. I always hesitate to walk in after I have been absent for a while and ask questions for fear you have been answering them. But I raised this in my earlier discussions, Jim, for you or for Fred.

My concern is how are you moving towards more universal health coverage and basic coverage for people. I assume you are talking about eliminating the problems of portability and preexisting conditions, and Medicaid melds in with your plan, I believe, in some way or another so that the underserved may be served better, et cetera.

But what else are you doing, and can you give me numbers in terms of how close you are getting to the concept or how your universal access helps with the real coverage of people, particularly those who are either undercovered or not covered today?

Mr. COOPER. I gave Tim Roemer the long answer. Let me give you the short answer.

Mr. CASTLE. Then I apologize.

Mr. COOPER. The President is for universal coverage by the year 1998. We are for the same goal and the same timetable. We achieve it in the following fashion.

There are 39 million uninsured today. Sixty percent of those—60 percent—are below double the poverty level. We commit to covering them. We have had this for three years. That is 60 percent of the problem right there. That is step one.

Step two is user friendly health insurance. The portability, accessibility, noncancellability, all the things you were talking about awhile ago.

We think that you can probably pick up another 10 or 20 percent with user friendly insurance. So that should get you up to about 70 or 80 percent of the uninsured right there. And that is what we can agree on today on a bipartisan basis.

How do you complete the job? To be honest with you, no one really knows.

Mr. CASTLE. What is the rest of that population—not to interrupt you, what is the rest of the population?

Mr. GRANDY. Well, you have a lot of people who are currently self-employed who do not take health care. They go bare because they can only deduct 25 percent. You have a certain portion of people who are uninsurable because of risks. They are automatically included under the new law.

But I think the important point to draw here is that the premise of the bill is to let markets work before mandates. The government, this Congress is very good at imposing mandates whether they are individual or employer, and I think we are trying to move towards, obviously, universal coverage, but would want to see what our progress would be given the conditions that Mr. Cooper just specified.

And you gave some arguments earlier. You have got roughly 39 million uninsured, as we say 60 percent of those folks are the poor and near poor that we are trying to deal with—is that correct?

And that to me is the target that is most at risk. That is the purpose of the public policy first and foremost. Not to necessarily realign insurance benefits among the middle class, but to go after people that have nothing or have such minimal coverage that they essentially have nothing.

Mr. CASTLE. I am not in anyway implying that there is anything in your plan that would be negative with respect to it. I am actually trying to close the gap in this argument. Because my feeling is that all these plans, I don't think any of the plans that talk about universal coverage per se are quite as universal as one might think either, except maybe single-payer. And I just think this whole gap is a little bit less of an issue than it is being made out to be by various proponents of different plans.

But thank you very much. I apologize for having you repeat it.

Mr. MARTINEZ. Thank you, Mr. Castle.

Let me ask you something. A little earlier on you were talking about choice and allowing the people, employers with over 100 employees to choose their plans, but less than that not. Why?

Or it is vice versa. The small companies would be able to choose their plan for their bosses—rather their bosses, but the companies over 100 the bosses would choose. If it is good for the companies under 100, why isn't it for the ones above?

Mr. COOPER. Well, we think it is very important for as many individuals as possible to be able to choose their favorite health plan. We can open this up, certainly for the small business market, a hundred employees or fewer, using the same annual menu approach that Federal employees have had for a long time.

Most companies today over 100 employees already offer choices. They are large enough to have an employee benefits manager. They are able to have enough clout in the marketplace to get several different folks interested in their business. So you don't really have the problem in the larger group market that you do today in the smaller group market.

We think it is very important too to have this equal purchasing power. About half of the folks in your area, in the cooperative and about half outside the cooperative but working for larger businesses because they already have clout. Hospitals sit up and take notice when they, you know, ask for something. Hospitals don't

tend to pay much attention if it is a business of 5 or 10 people saying, "Hey. We are upset with your care."

Mr. MARTINEZ. Well, you know you are right in a way, but in another way—think of it this way. Only 29 percent of those companies with 5,000 or more employees are able to choose their plans. So that is a whole big percentage that don't get to choose their plan.

But understand this. In a small business, and a lot of times even today—you know, alliances, they have been bantering this thing around as if it is something great and new. And earlier you said that small companies couldn't band together to get insurance coverage. That is not true.

In fact, in my State in my trade association we were able, a bunch of small businesses, to get together to get a health care plan for ourselves. We formed our own alliance and were able to leverage that number to get the kind of a rate that we needed.

In fact, which brings me to the idea that, you know, already we have what I consider the best health care plan that we could make universal in the Nation. And I go along with Senator Moynihan, I believe it was, who said, we ought to give the people out there, the public out there, the same coverage we have.

Right now the Federal employees have the best plans available generally. There may be a plan like, let's say, Calpers in LA—in California rather—that provide a better health care plan than any of the Federal Government plans, but that is an alliance that already exists because of the number of employees they have in that plan, and the numbers are the ones that bring the insurance companies to deal with the rate and the coverage for that rate.

In fact, the most efficient office we have in government is the Office of Personnel Management in regards to how they negotiate the rates for the Federal plans. Now, in this area we have I think eight or nine plans that we can choose from, but that is everything from HMOs to fee-for-service to managed competition, anything you want in that already. And throughout the United States there are over 400 different plans that different areas are able to provide choice to the employees, the Federal employees.

And, of course, you know, depending on where you are, in what region, what area and what government agency it is, whether they pay 80 percent or 20 percent, but that is the general average, the Federal Government paying 80 percent, the employee paying 20 percent, which is an ideal plan.

The problem is that we don't think in terms of embellishing what we have and moving that to the general public, but we want to reinvent and everybody is rushing to reinvent, and sometimes in doing so we create a worse situation than we had initially, and really what we started out to do was cover that 39 million people that were uncovered or undercovered, and we are getting into a lot of other areas and jeopardizing alliances that already exist, jeopardizing plans that already exist, jeopardizing agreements that have been entered into between employers and workers that are represented by a bargaining agency.

And let me ask you this. In your plan is it true that it contains a 34 percent excise tax on employers for any health insurance they provide their employees above the lowest cost plan? In other words,

if employers offer their employees good benefits in excess of the lowest cost plan, they are going to have to pay a 34 percent penalty tax for offering those benefits.

Isn't it inevitable that under your bill that many people will in fact lose coverage they currently have as employers are forced to, by your bill, to drop that coverage? Isn't the purpose of the provisions, in fact, to assure that people have less coverage so they are paying more out of pocket?

It seems to me that that is a goal which is directly contrary to the goal of health care reform, which is greater security.

Mr. COOPER. I would be delighted to explain the tax provisions in my bill. I believe Mrs. Roukema had a question about that earlier as well, so if you would permit me to go into some detail.

We are all for cost containment. We are all for getting our money's worth from health care, keeping costs down but making sure that the quality of care stays up. How do you do that? What is the best way?

There are two fundamental approaches. One is bureaucratic cost controls, if you think bureaucrats in Washington or in State capitals can hold a lid on prices and can still preserve quality of care. I happen to think that is a failed approach.

The other approach is markets, and I think markets overall have done a pretty good job of making sure that we get our money's worth and that quality is maintained. And I am not saying that no Federal involvement is appropriate. I am saying that we do need very, very limited Federal involvement to make sure that at least the minimum standards are met. Okay.

What is the best marketplace approach to holding down costs? We think, and there are a world of folks who agree with us on this, including Senator Chafee and 20 Senate Republicans, including many thoughtful Democrats who realize that heavy bureaucratic approaches don't really work.

Today, if you look at our Nation's third largest health care program, what is it? Well, I won't put you all to the test. Very few people even know its name, even though we spend about $75 billion a year doing it.

Well, what is it? Medicare is the biggest. Then there is Medicaid. And what's the third. Most people say the Veterans Administration. But that spends far smaller—far less money than this one that I am talking about.

What is it? It is a system of tax breaks that really have no name but are extraordinarily expensive. And they are for a very worthy purpose. They are in there to help folks get coverage.

But we have looked at these tax breaks so seldom and it is so touchy politically to even discuss the subject that these tax breaks have turned into one of the most unfair and inefficient programs in all of Federal Government.

Let me give you some examples. There are two basic programs here that we are talking about. One is the exclusion. What is that? The exclusion is when you are boss buys your health coverage and that does not show up as income on your return.

Well, most folks in my district don't even think that is a tax break, and I am not going to try to explain it to them that it is. I suggest leaving that alone. Don't touch it.

Guess who does touch it. The President in his health plan. Not immediately, but in the year 2004 that break would be eliminated. We think that that is not good policy. I have called it nitroglycerin. It is too dangerous to touch it seems to me.

Other folks who touch that. Look at the Stearns-Nickles bill, the so-called Heritage Foundation approach. They eliminate it.

I say leave it alone because that is an individual tax break that our citizens have known and enjoyed for a long time. Don't touch it.

Mr. MARTINEZ. Let me interrupt you there for just a minute because it is a little inconsistent now. If you believe that those should not be treated as taxable items and that is a tax break, but let's say, on the other hand, we don't—I myself don't particularly believe it is, and let me tell you why. Because in many cases people forego—forewent—they gave up raises and wages so they could get a health benefit because the difference in the wage they would earn to what they would pay in income tax would just about eliminate the raise they got. But if they could get the health benefit which they needed more desperately, and so in a way that was an incentive that the Federal Government provided so that people would provide that health care and that employees could get the health care.

So, on the other hand, though, you say that if somebody is going to get a better plan they are going to pay a 34 percent excise tax.

Mr. COOPER. I was getting to that. We are in agreement on the exclusion. I think you are saying don't touch the exclusion. I say don't touch the exclusion. The administration bill touches the exclusion, so does the Nickles plan, so does the Chafee plan, so does the Stearns plan. I say leave it alone.

What do we do? We touch the deduction. The deduction is not nitroglycerin. It is still dangerous. It is dynamite. But it can be handled safely.

What is the deduction? Who enjoys the deduction today? Usually only corporations, and they get an unlimited blank check deduction. In fact, it is about the last unlimited deduction left for corporate America.

Fortunately, most corporations understand that this is too sweet a deal. What do we do? We do not get rid of it. We suggest trimming it. And the practical effect of the excise tax that you are mentioning is to trim the deduction, to limit it to the price of the lowest cost basic benefits package in an area. Why do we do this? For a couple of reasons.

We think that it would raise revenue and we need it to help cover the poor and the near poor and for other health care reform reasons. We also think it is important to encourage corporations to shop more wisely for health benefits. They will still be able to deduct the majority of any health plan, and they can still deduct 100 percent of any health plan if they choose the lower cost one.

And folks who shop wisely for health benefits discover something very exciting. Oftentimes the highest quality plan is not the most expensive. It is the most affordable. Some people call it the Mayo Clinic effect. Kings and queens go there. It is one of the most prestigious and highest quality places in the world, and yet it is also

one of the cheapest. The Mayo Clinic has paid their doctors a salary forever.

Health care works, not only there but in countless other places across the country in every State. The President in his first health care address last September mentioned the heart operation in Pennsylvania that could cost $84,000 or $21,000. And guess what. As the President said, the $21,000 operation is just as good, if not better, than the $84,000 operation.

But because medicine is so complex and health insurance is so complex many of us have used high price as if it meant high quality. That is wrong. Because when you shop for quality in medicine, and in the field it is called outcomes reporting, outcomes research, you discover the fact that higher quality care is not the most expensive.

Remember too we would have a federally defined minimum package so there could be no substandard plans anywhere in America. There is a Federal safety net for all of our citizens for the first time.

But what we are talking about here is a competition among these Federal plans. Not federally run, but at least have to adhere to Federal minimum quality standards. A real competition among those plans to see who can do the best job of delivering basic health coverage to all the people in that area.

That is essentially a market-based bidding process. These health plans will have to come up with the best price possible. Bidding in advance so that we will know the price in advance. And what you will find in that competition is something very exciting.

In the Calpers system that Chairman Martinez was mentioning earlier, which is one of the better examples in the country of managed competition already working, what you will find is the price differences become remarkably small. Because when you are offering the same benefits package, there is not as wild a variation as there would be of some plan offered in vitro fertilization and liposuction and, you know, all sorts of other things, and other plans did not.

You are basically offering the same package, but the competition is on to see who can do the best job of offering that same package at the highest possible quality at the lowest possible cost.

So the exciting news of this whole thing is what? The average citizen is not hurt with our tax changes. The average citizen gets a new tax break. We take most all of the money, that we are taking away from corporations and what do we do with it? We turn it over to individuals, average citizens, average employees, so that they can deduct the purchase of health insurance for the first time in their lives.

How much of your health insurance can you deduct? How much can any American deduct? Usually the answer is zero. Why? Because under current tax law you are able to deduct the excess over 7½ percent of your income, and health insurance is almost always in that first 7½ percent.

For the average American family that rule basically means you can deduct the second medical catastrophe of the calendar year, but you can never deduct the first. That is not fair.

Meanwhile we are allowing corporations to deduct extravagant policies. Chrysler today could fully deduct, no questions asked, a policy to send Lee Iacoccoa's successor to Switzerland in a private jet if he was afraid he had the hiccups, and every taxpayer in America is helping Chrysler afford that policy.

Meanwhile today if you work for small business, your boss can't afford to buy you coverage, if you have the most pitiful plan you have had to pay for every penny of that yourself with your own after-tax dollars. You are not getting one penny of help from the $75 billion tax system that should be there.

Our purpose is to help every American afford Chevrolet coverage at least before we subsidize any Cadillac plans. If you want a Cadillac plan, fine. You can still deduct the Chevrolet element of it. And since most Americans have never been able to deduct even a skateboard or a bicycle, it is a very exciting and positive tax change.

This, by the way, is a $54 billion subsidy program over the next five years for average citizens, and it is not in the President's plan. They would allow self-employed people to fully deduct. We not only do that, we would allow the average employee to deduct.

So it is very important to understand our Nation's third largest health program, the program with no name, the program that has turned out to be one of the most unfair and wasteful programs in the Federal Government, the program we have to understand if we are going to reform our health system. Because the bottom line is this. Who do you want to control casts, bureaucrats or the market? This is the best market mechanism you can find.

Mr. MARTINEZ. I thank you very much, Mr. Cooper. We want to move on to the next panel, and I want to thank you for your testimony here today.

I will just close by saying the assumption that the lowest cost plan is necessarily the most efficient is not necessarily accurate. It may be in some wild instance, but not necessarily true throughout, and generally you get what you pay for.

And the other thing is that if everyone went to the lowest cost plan, the revenues that you wanted to raise to offset the cost wouldn't be there because nobody would be paying that excise tax.

But then again we agree to disagree agreeably. Right?

Thank you very much, Mr. Cooper.

Mrs. ROUKEMA. Mr. Chairman, I just want to say make one observation.

Mr. MARTINEZ. Mrs. Roukema.

Mrs. ROUKEMA. It would seem to me, and we won't belabor this point here but I will have some follow up questions for you. But it would seem to me that your plan on the tax basis either has been wildly changed since it was first introduced or your Republican advocates wildly misrepresented it to a lot of people.

But I just want to challenge you on your assertion, and your dogmatic assertion, that this reference to the current tax program is a wild giveaway or a wasteful giveaway. I would suggest to you that the elements that have made quality health care in the United States available to more average citizens than any other country in the world should not be characterized as a giveaway and a tragic failure, whatever the language was.

I would suggest to you that doesn't mean that we can't do better, but that we should be preserving those elements that have extended that quality of health care to so many of our average workers whether they be in labor unions or unorganized workers working for high quality small businesses that currently, at great expense to themselves, are providing high quality health care for their employees.

And there are only some small businesses that are claiming that it is too expensive. But those we have to help them out. But I tell you my small business people, my business people large and small who have been good citizens and good employers because they want the loyalty of their employees are pretty fed up with the small businesses and those others who are cost shifting and whose costs they are paying for.

Your plan does address that lower end of the scale well. But I don't want anyone to think that your assertion here about the tax benefits will go unchallenged. It is a debatable question and an interesting one, but don't characterize it as being the most wasteful in the world when in fact that system has extended more health care and better health care to more people than any other system in the industrialized world.

Mr. MARTINEZ. Thank you, Mrs. Roukema.

Mrs. ROUKEMA. Thank you very much.

Mr. MARTINEZ. Mr. Cooper, your enthusiasm for your plan is to be commended. There are in every plan some good and some bad. There is a lot of good in your plan.

There are some things that I think as you move your plan forward you will find that people would—if they would adopt it they would want to amend certain sections of it, and I am sure you have been here long enough to understand that that is the process.

But I want to thank you for the time that you have given because it has been considerable.

Mr. COOPER. Thank you.

Mr. MARTINEZ. Thank you.

Our next panel consists of Dr. Marilyn Moon, Health Economist of the Urban Institute, Washington, DC; Dr. Irwin Redlener, Chief, Community Pediatrics Division, Montefiore Medical Center, Albert Einstein College of Medicine, President of the Children's Health Fund, from the Bronx, New York; Mr. Jon Reiker, Vice President–Benefits, General Mills, Inc., Orlando, Florida; Mr. Ernest Clevenger, President of AP Benefits, Inc., Brentwood, Tennessee; Ms. Peggy Connerton, Director of Public Policy, Service Employees International Union, Washington, DC; Mr. Mike Tarre, Director of Compensation and Benefits, IBM Corporation, Washington, DC; Mr. David Kendall, Senior Analyst for Health Policy, progressive Policy Institute, Washington, DC; and Mr. Ronald F. Pollack, Executive Director, Families USA, Washington, DC.

And why don't we start with you, Dr. Marilyn Moon?

STATEMENTS OF MARILYN MOON, Ph.D., HEALTH ECONOMIST, THE URBAN INSTITUTE, WASHINGTON, DC; PEGGY CONNERTON, DIRECTOR OF PUBLIC POLICY, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, DC; IRWIN REDLENER, M.D., CHIEF, COMMUNITY PEDIATRICS DIVISION, MONTEFIORE MEDICAL CENTER, ALBERT EINSTEIN COLLEGE OF MEDICINE, PRESIDENT OF CHILDREN'S HEALTH FUND, BRONX, NEW YORK; MIKE TARRE, DIRECTOR, COMPENSATION AND BENEFITS, IBM CORPORATION, WASHINGTON, DC, ON BEHALF OF THE CORPORATE HEALTH CARE COALITION; JON REIKER, VICE PRESIDENT-BENEFITS, GENERAL MILLS, INC., ORLANDO, FLORIDA; DAVID B. KENDALL, SENIOR ANALYST FOR HEALTH POLICY, PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC; ERNEST A. CLEVENGER, PRESIDENT, AP BENEFITS, INC., BRENTWOOD, TENNESSEE, ON BEHALF OF SELF-INSURANCE INSTITUTE OF AMERICA, INC.; AND RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES U.S.A., WASHINGTON, DC

Ms. MOON. Thank you.

I appreciate the opportunity to be here to address the committee today, Mr. Chairman, and a number of the things that I want to talk about have certainly been touched on, so I am only going to mention a few issues. I know the time is late.

I do think that it is important to pick up on the theme that Congressman Grandy raised, and that is that much of the debate gets confusing and sometimes is misrepresented, and that is the spirit in which I wrote the comments that you have before you today.

I believe, for example, that this legislation is not incremental as it has often been characterized. I think it is incremental, perhaps, only in terms of coverage and not in terms of its effect on the economy and on the health care sector, and that is essentially the bottom line of what I have to say.

I also talk in my testimony about the fact that it is very difficult to characterize a lot of the elements of the plan because of the lack of specificity on the benefits package. I think we heard some very good reasons why they are not specified in this legislation, but since so much of the financing of the system and the ability of low income individuals to afford coverage will turn upon what that benefit package looks like I think that is a critical element that needs to be addressed.

In terms of the organization and delivery of care I mostly talk about, or one of my largest concerns is in terms of the question of the ability of firms to self-insure, to select out of the pool that Mr. Cooper talked about as being so important to make sure that there is risk adjustment and so forth.

And, as I see this plan with employers of more than 100 able to opt out and self-insure, as well as some other problems in terms of the risk selection that is going to occur when you put, for example, disabled Americans into pool for small employers, I think that it can make care more expensive for small employers, for the people who face the subsidies and for anyone that is in those open AHPs in this plan.

In terms of expansion of coverage, I emphasize the fact that phasing out at 200 percent of poverty means that subsidies in

many cases will be too small to assure full coverage. Congressman Cooper was dismissing the problem of those 60 percent of the population that are uninsured that have incomes under 200 percent of poverty.

I think a young family of four with two children, where the family earns $25,000 a year and where the cost of the subsidy will be such that their subsidy is only about 21 percent of the cost of the premium, leaving them with, perhaps, $4,000 a year to make up, that family is likely not to buy insurance unless it is a high risk family. Then it will raise the risk selection in that pool and it will have a circular effect because it will tend to raise the cost of premiums over time. That is a dilemma for those young families, and I think that is a really critical part of this proposal.

That is something that you could solve or improve by expanding up the income scale who gets protection in this plan, but then the plan becomes much more expensive very quickly, because there are many young families in exactly that situation.

In terms of financing, then, I talk about the problems with the elimination of Medicaid as the chief financing mechanism for this proposal. That is where most of the dollars are that this proposal gets, and it means that services for those above 100 percent of poverty who now have good coverage under Medicaid are going to be curtailed in many cases, and I think that is a problem, especially for young children who now in many cases have been getting improved coverage under Medicaid.

And secondly, the disturbing problem of leaving to States the issue of long-term care, particularly since some States that have made a major effort in the long-term care area and that have relatively low incomes I think will be considerably disadvantaged.

Finally, the last thing that I think is interesting about this proposal that has not been mentioned is the question of the safety valve. What happens if Federal savings are not enough to pay for the subsidies for low income people? What happens if lots of people, as in Oregon, trot out and say we want insurance, we are willing to pay even high cost for insurance because we think it is important, and the savings are not enough through the means that Congressmen Cooper and Grandy and others propose?

And the answer in this legislation is that there will be discounts that will be enforced not only on the plans that get these people but that will be shared across all health care plans in the United States, including self-insured closed plans. These HPPCs that are going to be so incredibly inconsequential are going to have the job of charging self-insured employers like IBM or General Mills an additional amount of money to make up the shortfall.

I think there are a number of strong elements of this proposal. I think that there are a number of good things about it, as anyone who is an analyst says, though, it is generally focused on some of the concerns and problems, and I would hope that these get the attention as we debate this important piece of legislation.

Thank you.

Mr. MARTINEZ. Thank you, Dr. Moon.

[The prepared statement of Ms. Moon follows:]

Marilyn Moon

The Urban Institute

I appreciate the opportunity to testify before the committee on H.R. 3222, the Managed Competition Act of 1993. This legislation, sponsored by Congressman Jim Cooper represents one of the major approaches to health care reform now under consideration. And while this bill has received much favorable publicity of late, it has not been closely scrutinized for what its impact would be.

The Cooper bill is sometimes characterized as an incremental approach less sweeping than legislation proposed by President Clinton, but one which could achieve nearly universal insurance coverage. On the contrary, I will argue today that the legislation would likely have major impacts on the way in which health care financing is organized in the United States, but that it would still likely fall short of the goal of universal coverage. Indeed, this is echoed by the preamble to the legislation which indicates that its goals are to contain health care costs--an activity that must change the way care is delivered for all Americans--and only to improve access to health care, with no promise of universal coverage.

After discussing the basic elements of the legislation, I will focus my analysis on the strategies of cost containment through market reorganization, expanded coverage initiatives and financing mechanisms.

The Plan's Basic Approach

Like other approaches relying on managed competition, H.R. 3222 seeks to strengthen the economic incentives present in the health care system to promote price competition among health insurance plans as the major way to hold down health care costs. Although we have a system that already allows market competition, proponents of this approach argue that there

are a number of barriers that prevent competition. One major impediment addressed in the legislation is the tax treatment of insurance that encourages "Cadillac" plans since health benefits are offered to workers as before-tax benefits. This distortion of the market leads to the encouragement of plans that are richer than would otherwise be chosen. Consequently, the Cooper bill restricts what employers and individuals can deduct to a standard benefit package at the premium charge of the lowest price plan in a particular area. This should reduce the willingness of employers to offer rich health benefit packages, but it could also mean tax increases for middle and upper-income families.

In addition, improved competition requires that some of the undesirable strategies that insurers use to compete be eliminated. Insurers have found that one of the most effective ways to hold down the costs of insurance they offer is to discriminate against people with poor health risks. They do this by establishing pre-existing condition exclusion clauses and by refusing to write policies for employers who have high risk employees. Alternatively, they may agree to write policies for such firms but charge them very high prices so that they can offer lower insurance premium rates to the firms with more desirable risks. Moreover, insurance is often very expensive for individuals who are not in groups such as employer-based plans. All of these activities need to be eliminated or substantially reduced if there is to be reasonable competition among insurers. The Cooper bill does offer a number of reforms which are stronger than many of the Republican proposals, but weaker than the Clinton Administration's bill.

Further, small employers or individuals who wish to purchase insurance face very high administrative costs because of the marketing and other expenses that insurers face when

dealing with small numbers of potential enrollees. Thus, H.R. 3222 introduces health plan purchasing cooperatives (HPPCs) to facilitate purchase of insurance by small firms and individuals. HPPCs operate as a clearinghouse for offering a range of health plans to these groups. By offering several plans, competition is also fostered; individuals may choose among several options rather than just being directed into one plan.

The Cooper bill also offers subsidies to low income persons. Medicaid would be eliminated, but in its place premiums would be fully subsidized for all persons below the poverty level. Near-poor persons with incomes above 100 percent of poverty would be offered partial subsidies that decline as their incomes rise and phase out for anyone above 200 percent of poverty. There would also be some additional supplemental benefits for persons below 100 percent of poverty beyond the basic benefit package.

Financing for these subsidies would come from several sources. Higher income taxes would likely be paid by corporations and individuals because of the limit on the deductibility of insurance as described above. Moreover, the elimination of Medicaid would result in considerable savings; while the federal government would still have to pay for many of those previously covered by Medicaid in the form of new subsidies, there would be some reductions in benefits especially by making states responsible for long term care. The Medicare program would also be cut to achieve further federal savings.

It is difficult to undertake a careful analysis of this legislation, however, because some key elements are missing. Most important of these is the basic benefit package which, for example, affects the level of tax deductibility and the costs of the premium subsidies for low income persons. If the package is very basic--as the text implies at several points--then many

employers and individuals would be affected by the deductibility limits, but the costs to the government of subsidies would be quite low. If the benefit package is generous, few revenues would be raised from limiting deductibility and it would be difficult to pay for the subsidies for those with low incomes. Further, there are a number of areas where the bill promises some complicated adjustments, but the details indicating how that would be done and what enforcement mechanisms might be used are lacking, leaving the impression at least that these are not serious elements of the proposal.

Reorganizing the System of Financing Health Care

Characterizing the Cooper bill as an incremental approach makes it seem as though only minor tinkering with the way in which Americans get their health care will occur. But this is not the case. Although mandates on employers are limited to offering insurance to employees and no one is required to purchase insurance, this legislation would use instead very strong economic incentives to achieve major changes.

For example, employers or individuals could deduct the costs of their health care insurance premiums only for accountable health plans (AHPs) which meet certain conditions and even then only up to the standard benefit package priced at the rate of the lowest cost plan in a regional area. Many employers who now offer generous benefit packages and relatively expensive fee-for-service plans, would face the choices of major changes in health care offerings to employees or paying higher taxes. This could mean that many Americans would have to rethink the way in which they now get their insurance coverage. Choosing more generous benefits would effectively mean substantially higher out-of-pocket spending

for many. And while the plan does not require that AHPs be health maintenance organizations or other managed care entities, the intent is to push people in that direction.

This change in economic incentives is the major engine for cost containment in the bill. But it would only work if several things happen. First, employers and individuals must begin to choose lower cost plans. They must become price sensitive--a phenomenon that is alien to most Americans with regard to their health care. Second, the plans must be able to find ways not only to start out with lower prices, but to hold down the rate of growth over time. But will plans be able to do this on their own? There is little evidence to suggest that even aggressive managed care plans hold down costs over time very well. Moreover, since Americans have indicated their reluctance to face change in the delivery of care, plans that offer very tough controls may alienate their enrollees and lose out to less stringent competitors. Again, one of the important and unknown questions is whether this reorganization of health care will lead to lower growth in health care spending. Even these changes may not be enough to foster healthy competition in this market. Thus, it is possible that we could have a major reorganization of the structure of insurance, but no long term solution to the problem of health care cost growth.

Another important aspect of the legislation is the reforms of insurance practices requiring that all accountable health plans meet certain standards. One goal is to eliminate selection on the basis of risk that results in major variations in the price of premiums or even denial of insurance. So-called "open" AHPs would have to offer insurance to any qualified buyer and they would charge premiums that would vary only according to a standard set of adjustments for age. These so-called "rate bands" would substantially reduce price

discrimination against those with health problems. But for several reasons, risk selection problems may arise that increase the costs of premiums in the open AHPs. First, the pools that AHPs must consider in setting their premiums will contain some very high risk individuals: former Medicaid enrollees who qualified by being disabled. Second, employers with more than 100 workers would be allowed to self insure and operate as "closed" AHPs. If the pool of individuals covered by the open plans contained many high risks, employers would face strong economic incentives to self insure, thus reducing the effectiveness of the nondiscrimination goals of the legislation. In fact, this can become a self-defeating proposition because the more employers who choose to self insure, the greater the risk of adverse selection in the open AHPs and the greater the incentive for employers to self insure. The remedies for risk selection within the HPPCs that are proposed in the plan do not solve this problem; since enrollment is voluntary, the problems of risk selection will remain.

If there is a problem of poor risks in the AHPs, the goal of making insurance more affordable for small businesses would be undermined. Small employers are required to participate in the HPPCs. Small businesses that now offer insurance are likely to have a healthy risk pool which keeps their costs low. Consequently, their costs may actually rise under this proposal if the expense from including higher risk persons offsets any savings from reduced administrative costs. It seems likely that some small firms with high risk employees would find relief in the premium levels they face and sign up. Others would see their costs rise and might cut back on contributions for their employees. If this is the case, then these reforms may not expand the number of small businesses willing to subsidize the costs of insurance for their employees. That could substantially reduce the effectiveness of these

reforms in expanding coverage.

H.R. 3222 would not eliminate pre-existing condition exclusions, but it would substantially reduce the ways in which pre-existing condition clauses may now discourage people from changing jobs or from obtaining any insurance. Those who shift coverage and have a period of six months of prior coverage would face no limits. The restrictions instead apply to people who were not covered before and who have in the past three months been diagnosed or treated for a particular disease. Such individuals would face a six-month pre-existing condition exclusion. This is a reasonable rule to discourage individuals from declining to purchase insurance until they are sick and then signing up since the plan is voluntary.

Thus, even though this part of the legislation appears to be only a reorganization of the private market, it would likely lead to considerable change in the structure of insurance and to the creation of a number of "winners and losers." And despite these large changes, it may not achieve the goals of more affordable coverage for small businesses or control of health care spending. The most likely group to benefit would be middle and upper income people who now have a hard time getting insurance because of their employment situations or health problems. What about those who need help to make care more affordable?

How Well Would Subsidies Do in Expanding Coverage?

To assure coverage to low and moderate income families requires subsidies of insurance to make care more affordable. Although the Cooper bill technically offers subsidies up to 200 percent of poverty (which is equivalent to about $28,000 in income for a family of

four), the subsidy diminishes to zero at that level. And above about $21,000 for a family of four, the subsidy would be less than half of the costs of the lowest price plan.

To entice people to enroll, subsidies would need to be generous and the subsidies of the Cooper plan may not be sufficient. For example, a family of four with $25,000 of income would be eligible for a subsidy of 21 percent of the costs of the basic plan. If the premium were $5000, the family would still owe nearly $4000--or 16 percent of their income. If the premium were lower, reflecting a less generous policy, the situation for this family might not improve; the premium costs would be lower, but they would then have to pay higher out-of-pocket costs for any uncovered health care which would not be subsidized at all.

But the cost of even the subsidies offered under H.R. 3222 could quickly get to be very high. For example, there are about 77 million people under age 65 and with incomes below 200 percent of poverty in the United States. About 39 million of these people have incomes below the poverty level and they would need to be fully subsidized. This includes over 2 million disabled persons who now get Medicaid and whose costs of care are quite high. Although about 23 million have employer-based coverage, if individual subsidies were offered, employers of low wage workers would face strong incentives to cut back on their coverage. The number with employer-subsidized insurance would likely fall. Thus, about 55 to 60 million people would be eligible for federal aid, over half of whom would be fully covered by federal contributions. If subsidies averaged $1500 per person for 55 million people, subsidy costs would reach $82.5 billion annually--not a very incremental cost. CBO's 1992 estimate of the costs of an earlier version of this legislation were $132 billion in 1996 just for the subsidies of persons below poverty.

Actually a more important problem may arise if many fewer people decide to participate. As noted above, the subsidies would not be generous for low income families with incomes in the range of 150 to 200 percent of poverty. If employer based coverage declines a bit for this group of the population (as seems likely given the economic incentives they will face), and if half of those who would do not have additional employer support do not purchase insurance, over 10 million people would remain uninsured. These are persons who would not be able to afford care if they face a major health problem and hence would continue to face hardships for themselves and continue the problem of uncompensated care that complicates attempts to control the system.

And there would be fewer resources in the system to provide charity care for these individuals. Since Medicaid would be eliminated and Medicare disproportionate share payments reduced, the current sources of federal help for such persons would no longer be available. And if the economic incentives on employers work as anticipated, private insurance would contain little cushion for such care. Thus, although the number of uninsured would likely fall, a large share would remain uninsured and have even less access to care than they do now.

Over time one of the most important considerations for the success of the subsidies in the Cooper bill is whether health care cost growth slows. Otherwise, each year as incomes rise more slowly than the costs of health care in the U.S., more and more families would require subsidies to be able to afford insurance. If the limit remains at 200 percent of poverty each year, the low income protections will be less adequate and more people will swell the ranks of the uninsured each year.

Financing The Reforms

Any serious attempt to expand coverage to the uninsured in the U.S. requires a substantial commitment of resources. A proposal that promises to do so at no cost is either not doing enough to make inroads on reducing the number of uninsured or is using subtle means for financing the changes. The strategy of H.R. 3222 is some of each. As argued above, a subsidy that is very small for families with incomes in the range of $25,000 will leave a large number of persons uninsured. But the Cooper plan would still be expensive as up to 60 million people qualify for subsidies.

One of the financing strategies that Cooper proposes would eliminate the Medicaid program. Since federal payments are projected to amount to about $86 billion in 1994, this provides a large potential source of funds. But many of those dollars would be required to cover those who now have Medicaid, particularly those below 100 percent of poverty. The savings would come from reductions in some existing Medicaid services. The approximately 25 percent of Medicaid recipients who are now above the poverty line--for example, low income pregnant women and children--would receive only a partial subsidy for the costs of a reduced benefit package. Their coverage would thus decline as compared to their current situation. Thus, some of the financing for the plan comes from reducing the protections that some low income persons now have.

Even more important for financing, the federal government would shift to states the responsibility for the costs of long term care. Thus, some of the new dollars for acute care coverage will come at the expense of long term care. Not only does this proposal have no expansions of long term care, it would likely result in cutbacks in availability of long term

care services over time. A further issue of concern is that the tradeoff for many states would not be an even one. High income states with generous acute care Medicaid programs would be able to continue their long term care programs at the same level as before and use fewer state funds than at present. But lower income states with large long term care programs would be losers. To maintain long term care benefits, they would have to increase their own spending as compared to their current Medicaid commitments. These states would get some initial partial protection for this redistribution, but only for four years. Preliminary analysis at the Urban Institute indicates that ten states would face a deficit equivalent to more than 10 percent of their current Medicaid programs, requiring these states to either pay substantially more or scale back their long term care efforts.

Another piece of the financing for the plan would be revenues from the reduced deductibility of insurance coverage. But the amount to be gained from this source is uncertain. The level of revenue raised will depend on the benefit package and on the ability of reform to lower growth in health care spending. If there are great pressures to keep the package relatively generous or if health care premiums--including those for the lowest cost plans--continue to rise rapidly, revenues may increase more slowly than anticipated. This could leave a shortfall in funds necessary to pay the low income subsidies.

The Cooper plan's "safety valve" for such a shortfall is to simply discount what the government pays to the plans on behalf of those entitled to subsidies. The risk for any shortfall thus rests with the insurers, who are likely to pass on the costs of providing care for these low income families and individuals to all enrollees in the form of higher premiums. Indeed, the plan specifies that the HPPCs can spread the burdens of these shortfalls across all

the AHPs by requiring contributions from AHPs with lower than average enrollments of subsidized persons to be given to AHPs with higher enrollments of those with low incomes. The HPPCs even have the ability to require such payments from self-insured plans. A condition of tax deductibility is that all AHPs enter into agreements with HPPCs for these transfers. This very formalized cost shifting thus means that private insurers need to estimate any likely shortfalls in federal subsidies and build the charges into their premiums. This may not be easy to do and could generate considerable uncertainty across plans.

Conclusion

The best justification for an incremental approach is the argument that only minor tinkering is needed to achieve the goals of health care reform. And some of those who support H.R. 3222 indicate that it is its incremental nature that they find appealing. But in fact, the Cooper plan goes well beyond tinkering to help hold down costs of care and to finance the subsidies it offers to those with low incomes. It needs to be closely examined to understand the full range of its impacts. Insurance reforms are proposed that would affect all the currently insured, the deductibility limits would also have major impacts on what insurance would look like in the future, and the plan even allows the new purchasing cooperatives to effectively tax self-insured plans to finance some of the subsidies for those with low incomes. These changes go well beyond incremental tinkering. Moreover, the Cooper plan's subsidies could be quite expensive, but they still may not be generous enough to substantially reduce the number of uninsured to an acceptable level.

Mr. MARTINEZ. Ms. Connerton.

Ms. CONNERTON. Thank you. I am also going to keep my statement brief because it is been a long morning.

Let me just say that the Service Employees International Union represents about a million employees, all of whom are service workers and many of whom are low wage.

I would like to talk about why it is, after listening to the presentation of Representative Cooper, why it is that we believe that this bill will not only not help many of our members but will be detrimental to workers who currently have health coverage.

First of all, roughly 10 percent of our membership has no health insurance. Some of these workers work for employers that don't provide health coverage today. Others are part-time workers who can't get enough hours to qualify for coverage under their employers' policy. Still others work for employers that offer them health coverage, but because they are low wage workers they cannot afford to pay the premium copay.

Now, the Cooper bill will not help these workers. By and large, our employees are not poor enough to be fully subsidized. Their family income is not 100 percent—is not at 100 percent of poverty, and our experience where employers offer health coverage is that many low wage workers choose not to participate because they can't afford to pay partial premiums.

Now, even those low wage workers today that have health insurance are in grave danger of losing it. Many SEIU members work for small businesses who are providing health insurance while trying to compete with other services businesses, some of whom are large like General Mills, who provide little or nothing. For us it has become a competitive issue. Every time one of our service employers loses a contract, loses business to their competitors simply because in these labor-intensive industries they provide health coverage and their competitors don't, our members lose their jobs.

They have no jobs, and they lose their health insurance at the same time. It is a double hit.

In fact, in many parts of the service sector it is now becoming virtually impossible for employers that provide health coverage to coexist with employers that don't, and the end result of this, of course, will be that, as many of our employers are doing, they are dropping coverage every year.

Mr. MARTINEZ. Could I interrupt you for just one minute? What is the average salary of an SEIU employee?

Ms. CONNERTON. Well, the average, because we represent service workers and some are in the public sector and are professionals, I would say the average is about $22,000.

Mr. MARTINEZ. Thank you.

Ms. CONNERTON. But we represent many workers who are at minimum wage as well as part of this.

Mr. MARTINEZ. Thank you.

Ms. CONNERTON. The growing disparities in labor costs between workers with health coverage and those without, as you know, are causing serious distortions in the labor market. We have heard a lot of discussion this morning, concerns by Congresswoman Roukema about the growth of part-time workers, the part-time and temporary workforce, which is directly linked to the fact that em-

ployers are seeking to avoid using workers for whom they would be forced to extend health care coverage.

Now the bottom line here is that you now have a system in many parts of the economy where, unless all employers are required to contribute something to the health financing system, firms in many service businesses, smaller businesses, are going to continue to drop health coverage in order to survive, and the Managed Competition Act in fact will exacerbate the problem of employers dropping health coverage because, in fact, they have, you know, some subsidies available to low-wage families.

The other point I would like to deal with is a point that has really plagued all unions and all employers that provide health coverage, and that is the fact that health costs have really risen out of control. In our opinion, we have seen our premiums—two-thirds of our members, by the way, are in managed care plans, and despite all of the efforts that we have made in the past 10 years to try to hold down the growth in health care spending, costs have continued to escalate out of control, and you can see in our written testimony that in the past six years our premiums have more than doubled. So you will have to forgive me and forgive our members if they are somewhat skeptical of claims that somehow we will get it right this time and the market will really get health care costs under control.

Now since Congressman Cooper talked about the Calpers plan, and since it is such an important issue, and since we represent the workers who are part of the system, I would like to suggest that competition doesn't always work as advertised.

For most of the 1980s our members were not particularly satisfied with Calpers. Calpers simply relied on the ability of consumers to switch among plans, mostly HMO's, as the primary method to control costs, and despite the apparent existence of a competitive market, Calpers actually did worse that other employers nationally in managing health costs in the 1980s.

It was only in the last couple of years, because the State went through a budget crisis and because the new directors of the organization took a tough stand in negotiations with Kaiser and other health plans, that the premium growth has been—that they have achieved the kinds of outstanding results that have been noted in the press, and it is clear to me that the tactics that they are using at the bargaining table, negotiating back and forth with carriers, is exactly the kind of mechanism that the health alliances in the Clinton plan are talking about, and, in fact, they set premium targets, they sent notices out to all of their carriers saying that they want zero growth in premiums this year, they want a 5 percent reduction in premiums this year. They use premium targets, and that is a way in a negotiating sense to put carriers on notice as to what it is that the consumers expect.

But let me just say that there is, when you finish talking about health alliances and competition and so forth, there is a potential cost control provision in the Managed Competition Act, and this is the tax cap, or the cap on employers' tax deduction for insurance casts. But let me say, Congressman Cooper said, "Well, we are not going to deal with the exclusion, we are just going to deal with limiting business deductibility." Whether the tax is levied on employ-

ers or workers, it is the workers who end up footing the bill. They will either have to forgo wage increases, they will have to pay more, or else they will have to see their benefits reduced.

So the bottom line is, you can talk about businesses, you can talk about individual tax deductibility, but it is the workers who are going to end up paying, and the bottom line is that the Cooper tax cap is a middle class tax increase in everything but name.

Now his tax cap is made even worse by the fact that he ties it to the lowest cost plan in an area. Now we have in the testimony Calpers, everybody provides the same benefits. Look at the price differences there between the high-cost plan and the low-cost plan. And many of our Calpers members under his proposal would have to pay $1,000 or more a year. There is tremendous variability in prices between plans.

So what he is proposing is, I think as Congressman Grandy said, this is radical social engineering that he is proposing to make consumers more conscious, so called, of the cost of health care, and on that point let me end by saying that, in our opinion, we have faced a lot of increased cost consciousness in the last 10 years. We have seen our deductibles go up, we have seen our premium copays go up, and that has done nothing to stem the rise in health care costs, and, in our opinion, blaming consumers for the health care cost crisis is like blaming the victim of a robbery for the crime.

[The pepared statement of Ms. Connerton follows:]

TESTIMONY OF PEGGY CONNERTON
DIRECTOR OF PUBLIC POLICY

My name is Peggy Connerton and I am the Director of Public Policy for the Service Employees International Union. With over one million service-sector workers in the United States, Canada and Puerto Rico, SEIU is the fourth largest union in the AFL-CIO, and the largest union representing service workers.

SEIU members come from both the public and private sectors and include 450,000 health care workers who work in acute care hospitals, nursing homes, mental hospitals and other health care facilities. On their behalf, I would like to thank Chairman Ford, and the other members of the committee for this opportunity to testify on one of the most critical issues facing our nation today. Let me also take this opportunity to applaud the chairman for your outstanding leadership in this area over the years.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. Over the last decade, health care has been the number one issue at the bargaining table. Our members have fought hard to hold on to their health insurance, often foregoing wage increases and benefit improvements to maintain coverage for themselves and their families. They have faced greater out-of-pocket costs and declining choices, as employers have tried to restrict where and when they can see a doctor.

While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies such as utilization review and managed care. While these measures showed some short-term success, they were unable to blunt the long-term rise in costs. Only system-wide reform can provide the relief that workers and their employers need.

I am here today to speak in opposition to the Managed Competition Act of 1993 (H.R. 3222). SEIU is opposed to H.R. 3222 because it does not meet SEIU's principles for reforming the health care system. These principles include universal coverage regardless of health or employment status, comprehensive benefits, real cost control, quality improvement, fair and equitable financing, and protection for health workers. These are the criteria by which we judge the various health care reform proposals that have been put forward. Unfortunately, H.R. 3222 completely fails the test. It creates the illusion of reform without the substance.

The Managed Competition Act is not merely a painless placebo that simply maintains the status quo. In many ways, it would actually make things worse for middle-class families. The bill creates tax incentives for employers to shift more of the burden of health insurance onto the backs of workers. Its reliance on community rating as a substitute for cost control would actually raise premium costs for the majority of businesses, without any compensating slowdown in the rate of increase in health costs.

In my testimony today, I want to address three issues in detail: the failure of the Managed Competition Act to guarantee universal coverage; the reasons why the Act would not successfully control health care costs; and the likely negative impact of this proposal on the nation's public health system.

Universal Coverage: No Compromise

It should be a source of shame to us that in the richest nation on earth there are 39 million people without any form of health insurance whatsoever. Millions more are underinsured and often do not discover the crucial gaps in their coverage until it is too late. In addition to the high cost of health insurance, many individuals and families are denied coverage because their employer does not provide it or because of pre-existing conditions that the insurance company refuses to cover.

Over the past year, more than two million people have lost their health insurance, raising the number of uninsured to 39 million. One out of every four Americans will lose their health insurance for some period during the next two years. Many of our members report that their employers have been trying to scale back the scope of their insurance coverage and place greater restrictions on its use.

Unlike the Health Security Act, H.R. 3222 would not require employers to make any contribution toward their employees' health insurance costs. This would mean that millions of Americans would still be unable to afford insurance. Workers could still lose their insurance if they lost their jobs or if they changed jobs. By failing to guarantee universal coverage, the Managed Competition Act fails to provide working families with the health security they so desperately need.

Cost Control: Why the Market Can't Do it Alone

A remarkable aspect of the Managed Competition Act is its complete faith in the idea that, with a little tinkering here and there, market forces would be capable of keeping health care costs under control. This scenario flies in the face of our experience over the last decade with deregulation in the health care industry. Reagan-era reliance on market forces brought us the highest rates of medical price inflation ever. This does not mean that SEIU is opposed to making the market for health insurance more competitive and responsive to consumer needs. We simply feel that these measures alone will not bring health care costs under control.

In our view, the cost control strategy in H.R. 3222 suffers from seven major weaknesses:

- Capping the employers' tax deduction for health insurance will increase costs for middle-class families.
- Price competition between plans won't necessarily bring costs down.
- "Managed Care" plans may not be more cost-effective.
- Voluntary purchasing cooperatives will be undermined by adverse selection.

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- Insurance reform without cost control may raise costs for those with insurance.
- Allowing the benefits package to be determined later makes it harder to assess the likely effectiveness of cost control measures.
- Only universal coverage can prevent cost-shifting.

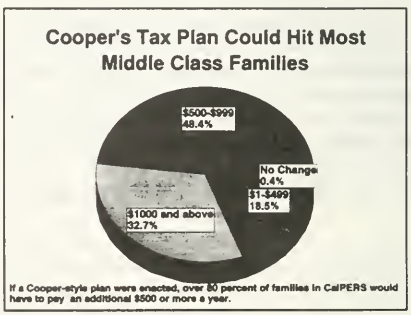
I want to deal with each of these points in turn.

Taxing Health Benefits Will Hurt Middle-Class Families

A key feature of the Managed Competition Act is a cap on the employer tax deduction for health insurance costs. The bill would limit the deduction to the price of the lowest cost plan. While this allows supporters of the Act to claim that no one's taxes are being raised, they clearly assume that employers will respond by limiting their contributions for health insurance to the price of the lowest cost plan. This, in turn, is meant to make workers more "conscious" of the cost of their benefits, encouraging them to enroll in cheaper health care plans.

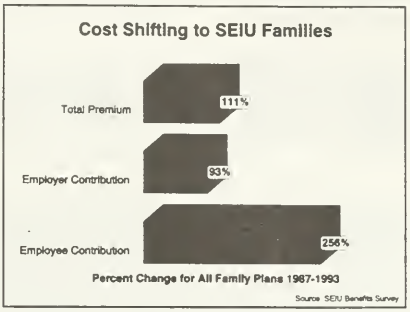
The bottom line is that whether the tax is levied on employers or workers, it is the workers who will end up footing the bill. They will have to pay more, potentially hundreds of dollars more, to maintain their health insurance coverage. If they cannot come up with the money, they will be forced to enroll in cheaper, possibly substandard plans which will almost certainly limit their ability to choose their doctors.

SEIU recently examined the impact of a Cooper-style reform plan on the members of one of our largest locals, the California State Employees Association (CSEA), SEIU Local 1000. Local 1000 members receive their health benefits through the California Public Employee Retirement System (CalPERS), which gives workers a choice of over 20 HMOs, PPOs, and fee-for-service plans. If a Cooper-style plan was enacted that gave the state government an incentive to limit its premium contribution to the price of the lowest cost plan in the system, we estimate that 80 percent of the families enrolled in CalPERS would have to pay an additional $500 or more a year in premiums just to maintain their current coverage. One-third of those families would face an annual premium increase of $1,000 or more.



SEIU members are *very* conscious of the cost of health care. Health care is the number one issue at the bargaining table and the number one cause of strikes. Workers are paying a greater share of the premium than they used to, they are paying more out-of-pocket for health care services, and they have given up wage increases in order to preserve their health benefits. It should also be noted that non-union workers aren't able to "shop around" for health plans because it is the employer who chooses what plan to offer.

We have been tracking the cost experience of plans that cover our members since 1987. Over the past six years, SEIU family premium contributions have risen an astounding 256 percent, nearly three times as fast as the increase in employer contributions, which rose 93 percent. Workers with family coverage now pay almost $1,000 a year on average in premiums payments alone, up from just $270 just six years ago.

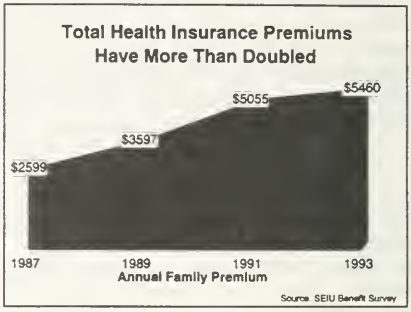


In some cases these premium increases can be financially devastating. SEIU Local 100 represents 200 community mental health workers in Lafayette and West Bank, Louisiana. Most of these workers make around the minimum wage. Last November, the employee contribution was raised from $20.49 a month to $54.74 a month. Most of those workers had to drop their coverage.

Premium payments are only a part of a worker's total health care bill. Workers also have to meet their deductibles, as well as foot the bill for copayments on physician's visits, prescription drugs, and hospital stays. Family deductibles for SEIU members have increased 16 percent over the past six years. Copayments for major medical expenses have risen from 16 percent of the cost of the service in 1989 to 18 percent in 1993.

Despite dramatic increases in employee cost-sharing, health premiums have continued to climb at double-digit rates. Today, total SEIU family premiums average $5,460 -- more than double the average premium of $2,600 just six years ago. I want to emphasize that the reason that premium levels for SEIU plans are so high is *not* because our members have "cadillac plans." In fact, first dollar coverage is increasingly rare. SEIU members are concentrated in some of the highest cost areas of the country, such as the Northeast, the industrial Midwest, and California, and many work for smaller employers and industries, like health care, that insurers have designated as high-risk.

Experience provides little support for the assumption that shifting even more of the burden of health care costs to workers will help keep costs under control. Heightened consumer sensitivity to costs failed to slow health care spending in the 1980s. In this context, it is clear that capping the employer deduction for health insurance costs will merely add insult to injury.



Competition Between Plans Won't Necessarily Bring Costs Down

A key assumption of the Managed Competition Act is that the creation of a more competitive climate for health insurance will lead to premium reductions. The experience of SEIU Local 1000, the California State Employees Association, suggests that competition may not work as advertised.

As I noted earlier, Local 1000 members receive their health benefits through the California Public Employee Retirement System (CalPERS). For most of the 1980s, CalPERS had most of the elements that proponents of managed competition argue must be present if the system is to work. Over 20 plans, most of them HMOs, competed with each other for enrollees. The vast majority of enrollees are in managed care plans, such as HMOs or PPOs. There were significant differences in the prices charged by plans and the state government contributed a fixed amount per worker (although the amount was not tied to the lowest cost plan), so consumers had an incentive to enroll in lower cost plans.

Despite the apparent existence of a competitive market, CalPERS actually fared worse than other employers nationally in managing health care costs during the 1980s. According to Lewin-VHI, average family premiums for the nation as a whole increased 9.4 percent annually between 1982 and 1992, compared to 12.9 percent for CalPERS fee-for-service plans and 9.8 percent for CalPERS HMO plans.

Managed Care Has Had Disappointing Results

The primary cost-containment tool of the Managed Competition Act is to give people strong incentives to switch into managed care plans. Our members' experience is that while managed care, UR, and other innovations can produce "one time" savings, they haven't kept costs under control over the long term.

For example, about 6 years ago, members of SEIU Local 79, which represents building service and health care workers in Detroit, opted to switch from their indemnity plan to an HMO

to save money. However, within three years the cost of the HMO equalled that of the previous indemnity plan. In the fourth and fifth years, the cost of the HMO was actually higher than the indemnity would have been and the workers also began to lose benefits. At the end of the fifth year, the workers dropped the HMO and went back to the original indemnity plan.

In the early 1980s, SEIU Local 668, which represents social service workers in the state of Pennsylvania, negotiated with employers over a number of cost-control provisions (second surgical opinion, pre-admission certification, generic drugs, etc.) that were instituted for most contracts. These measures were successful for three or four years. By the time the contracts were up for renegotiation, costs had begun to rise again and employers were asking for further concessions. The next round of negotiations saw the introduction of HMO and PPO options, as well as increased premium sharing. Despite the introduction of all of these measures, costs continue to rise at the same pace.

Surveys of employers, consumers, and health care industry leaders have consistently found that managed care has not lived up to its promise. For example, a 1991 American Hospital Association survey of chief executives of voluntary health insurance purchasing cooperatives found that only 10 percent agreed that HMOs had been successful in controlling health care costs. Only 22 percent agreed that PPOs had been successful.

I don't want to give the subcommittee the impression that our members have uniformly negative attitudes toward HMOs and PPOs. In many cases, we have had to fight hard to get employers to provide these options. Often, managed care allows us to preserve benefits without increasing the cost to our members. We realize that no health plan is going to suit every single person and we want to give our members the widest range of choices that we can. What we object to is attempts by employers to make an HMO or a similarly restrictive plan the only option available to workers.

But we also recognize that, in most cases, savings from managed care plans come from the discounted rates that those plans pay to providers. Providers make up the difference by shifting those costs onto other payers with less market power. Cost shifting among payers by providers should not be confused with overall cost control.

Adverse Selection Will Undermine Voluntary Health Plan Purchasing Cooperatives

A central feature of the Managed Competition Act is the Health Plan Purchasing Cooperative (HPPC), which would offer group purchasing power to employers with 100 or fewer employees. Employers would be required to offer employees coverage through the HPPC, but they would not be required to make any contribution to the cost of that coverage.

The lack of such a mandate is almost certain to lead to adverse selection among workers in the HPPC. Those employees who are more likely to be sick will purchase coverage, while those are relatively healthy may go without coverage. This, in turn, will raise costs for those

who do choose to purchase coverage. The result could be a vicious cycle that could well destroy the HPPC as a meaningful entity. If small employers are unable to realize lower premiums as a result of their membership, then they would be no more likely to purchase coverage for their workers than they are now.

An additional problem is that the repeal of Medicaid will mean that millions of relatively high-cost individuals will be part of the same insurance pool for the purposes of community rating. This is likely to raise the cost of purchasing care through the HPPC substantially. Under the Clinton plan, the Health Alliance pools will be large enough that the effect of adding the Medicaid population will be much less than under the Managed Competition Act.

With the help of the Robert Wood Johnson foundation, a number of states have experimented with purchasing cooperatives for small business that also operate on a voluntary basis. While some small employers did obtain coverage through these arrangements, even the most successful project only enrolled 17 percent of employers who previously had not offered insurance. The Arizona Health Care Group, one of the longest running projects, only succeeded in enrolling 939 small firms, for a total of 3,093 covered lives, during the first three and half years of its existence. Similar experiments in other states proved similarly disappointing.

The results of the American Hospital Association's 1991 survey of chief executives of voluntary purchasing cooperatives were also discouraging. Less than half of those surveyed agreed that the cooperative had made a difference in controlling health care costs in their community.

Insurance Reforms Without Cost Control Could Make Things Worse for Businesses and Consumers

The Managed Competition Act proposes to regulate the insurance market in ways that would make it easier for those without insurance to obtain it. These provisions, which are common to most health care reform bills, include prohibiting pre-existing condition exclusions and requiring insurers to community-rate instead of experience-rate.

Without an employer mandate, these reforms would significantly increase the risk profile of most insurance pools. Insurance companies would have to raise their rates to cover the additional cost. This could lead businesses who are currently providing insurance to drop coverage, potentially creating a vicious circle that would ultimately undermine the entire health insurance market.

An employer mandate, by contrast, would bring millions of younger, relatively healthier workers into the health insurance system, which would greatly reduce the overall level of risk in a community-rated system. This brings down costs for insurance companies, businesses and consumers.

While insurance reforms are clearly necessary to eliminate discrimination in the health insurance market, they must be implemented in tandem with cost control provisions that ease the burden on those businesses and consumers whose costs will go up under reform. To do otherwise creates the potential for a political backlash that could undermine the entire health care reform effort.

The Benefits Package Cannot Be Considered Apart From the Rest of the Plan

The Managed Competition Act also fails to establish a uniform package of benefits to which all Americans would be entitled. The establishment of such a package is left to a newly-established Health Care Standards Commission. Once the Commission determines the benefit package, Congress may vote it up or down, but may not amend it.

SEIU is strongly opposed to this process. The scope of benefits, and how the costs are to be shared by government, employers, and consumers are the central decisions to be made in comprehensive reform. They should be made by the Congress, not deferred to an appointed Commission.

It is also difficult to imagine how accurate estimates of the revenue gained by the bill's "tax cap" proposal can be generated if we do not know the particulars of the benefit package. It will also be difficult to determine just how more much middle-class families are likely to be paying because of the "tax cap."

Clearly, the decision by the drafters of the Managed Competition Act to defer the hard decisions about the scope of the benefit package has political benefits. This sleight of hand has allowed some backers of the legislation to attack the supposed "generosity" of the Health Security Act's benefit package while allowing them to remain unspecific about what they would cut.

Universal Coverage is the Key to Controlling Costs

A key failing of the Managed Competition Act is its rejection of universal coverage. The growing number of uninsured has contributed to rapidly rising health care costs. Uninsured persons still seek care, often through very costly and inefficient mechanisms. These costs are passed on by providers to their paying customers, the insured population.

Many employers who are currently providing insurance are paying more than their fair share because they are paying to cover the uninsured and paying to provide coverage to the working spouses of their employees. In essence, they are subsidizing their competition. A 1991 National Association of Manufacturers study found that the cost of providing coverage to working dependents increases costs for firms providing insurance by 20 percent.

The growing disparity in employee compensation costs between firms that do provide insurance and those that don't is beginning to generate serious distortions in the labor market. The dramatic increase in the number of part-time and contingent employees, which constitute half of all new jobs created during the past year, is being driven in large part by the desire of employers to avoid the cost of health care benefits. Firms that do provide health benefits to all of their employees are increasingly finding themselves at a competitive disadvantage.

For example, SEIU Local 750 represents building service workers in Orlando, Florida. One of the contractors whose employees Local 750 represented lost a contract with Delta Airlines that it had held for over eight years to a non-union contractor. The non-union contractor did not provide health insurance for its workers, and thus was able to underbid the unionized contractor.

If we can agree that universal coverage is an imperative, the question becomes how to provide it. The strength of an employer mandate approach is that it builds on the existing system. Nearly two-thirds of the non-elderly have employment based coverage. Among the 39 million Americans who lack insurance, 85 percent belong to families that include an employed adult. A system that required all employers to contribute to the cost of health insurance for their workers would reach the vast majority of the uninsured. Unfortunately, the backers of the Managed Competition Act have rejected an employer mandate and even the concept of universal coverage.

It is ironic that the backers of the Managed Competition Act style themselves as supporters of "pure" managed competition, as opposed to the modified form of managed competition that is found in President Clinton's Health Security Act. The original Jackson Hole Initiative, which is widely regarded as the basis for a number of Congressional managed competition proposals, *specifically included an employer mandate*. Even the drafters of the Jackson Hole proposal understood that, short of a totally government funded plan, there is no other way to guarantee universal coverage. While it is true that the Jackson Hole Group just this week retracted its support for an employer mandate, we feel that their change of heart was motivated by politics rather than by the merits of the issue.

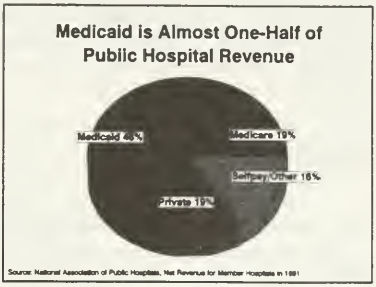
While the Act provides some subsidies for low-income households, a family earning $30,000 could be stuck with the bill for a $5,000 policy. A recent New York Times editorial commented: "Mr. Cooper calls that universal access; we call it merciless" (Jan. 16, 1994).

The bottom line is that no other nation with a national health care system relies solely on the market to control health care costs. While the specific regulatory tools vary from country to country, all nations with such systems have imposed some kind of limit on the amount they spend on health care. For all of the reasons that I have outlined above, SEIU feels that the advocates of unbridled managed competition are dangerously mistaken.

The Impact of the Managed Competition Act on Healthcare Workers

One final issue I want to deal with today is the impact of the Managed Competition Act on health care workers, particularly those in the public sector. The Act would eliminate the Medicaid program in favor of a system of federal subsidies that would allow low-income families to purchase coverage through Accountable Health Plans. While the drafters of the Managed Competition Act should be given some credit for wanting to make it easier for low-income families to obtain insurance, their solution would devastate the public health infrastructure, particularly public hospitals, on which those families depend.

State Medicaid programs currently pay out over $25 billion annually to hospitals for inpatient and outpatient services. The National Association of Public Hospitals estimates that Medicaid constitutes just under half of net revenues for public hospitals. The elimination of Medicaid could be financially devastating for safety-net providers, and would lead to the kind massive layoffs of public sector health care workers that we've seen in the steel and auto industries over the past decade.



Advocates of H.R. 3222 are likely to argue that the extension of health insurance to all of those under the poverty line will actually increase the amount of funds flowing to providers in underserved areas. But there are no requirements in the bill that Accountable Health Plans (AHPs) contract with public hospitals or other essential community providers in underserved areas. Lacking such a requirement, it is almost certain that AHPs will seek to prevent their enrollees from using those facilities because of their historically higher costs. While the bill does allow states to mandate that AHPs operate in underserved areas, it does not include any provider protections. If they are unable to obtain services from providers in their communities, enrollees in underserved areas may have to travel much farther to obtain services and may postpone needed primary care. The result will be higher costs for everyone.

The repeal of Medicaid will also be disastrous for nursing home and home-care workers and their patients. Medicaid currently funds long term care for the elderly in nursing homes. Coverage for home and community-based care services is also provided by a number of state Medicaid programs. By repealing Medicaid, the Cooper Bill would eliminate these services. Seniors would have to rely on fiscally-strapped state governments to help with nursing home costs and hundreds of thousands of home-care and nursing home workers would be at risk of losing their jobs.

Nursing home workers and patients would also suffer from the repeal of nursing home standards contained within the Medicaid program. These standards regulate the scope of

services provided, staffing levels, the rights of residents, and the quality of the physical environment. They protect elderly patients from unscrupulous nursing home operators. By repealing Medicaid, the Cooper bill would eliminate those standards and the put the health and safety of elderly Americans and the jobs of health care workers at risk.

Despite the fact that the Managed Competition Act places the jobs of millions of health care workers at risk, the Act includes no protections for health care workers who could lose their jobs as a result of the passage of the legislation. Our members recognize that the health care industry is going through a massive restructuring. They support a reform of the health care system that places the patient's needs at the center and strives to eliminate the inefficiencies that have contributed to rapidly rising costs. But our experience has been that when administrators and managers try to cut costs in response to competitive pressures, they tend to take the low road of layoffs and wage cuts rather than the high road of reorganizing work and retraining workers.

Conclusion

By way of conclusion, let me reiterate that the members of the Service Employees International Union believe that the United States is engulfed in a health care crisis that threatens to leave an increasing number of our citizens without access to health care and to rob the treasury of the funds needed for other public investment. Given this situation, the members of SEIU cannot afford to support the kind of halfway measures embodied in H.R. 3222.

Rather than settling for the Managed Competition Act's piecemeal approach to reform, we urge the members of this committee to support the Health Security Act (H.R. 3600), which would provide America's working families with the health security they so desperately need. SEIU is committed to defending the Health Security Act against those who advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to working in coalition with consumers, senior citizens, businesses both large and small, community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank Chairman Ford and the other members of the committee for this opportunity to testify. We look forward to working with you to make the vision of "health care that's always there" a reality for America's working families.

Mr. MARTINEZ. Thank you, Ms. Connerton.

Let me ask you before I move on to Mr. Redlener, what is the number of Calpers employees covered by their plan?

Ms. CONNERTON. Close to a million.

Mr. MARTINEZ. Thank you.

Mr. Redlener.

Dr. REDLENER. Thank you. I am Irwin Redlener. I am actually a pediatrician and director of community pediatrics at Montefiore Medical Center in New York, and just for a second to tell you the prospective that I am bringing here today, that our Division of Community Pediatrics runs the Nation's largest health care program for homeless children, it happens to be in New York City, and our foundation called the Children's Health Fund, has established programs serving underserved inner-city children in Newark, New Jersey, and South Central Los Angeles, in the Anacostia district here in Washington, DC; we run a program for homeless children in Dallas, Texas, and several programs for children living in isolated areas of rural poverty in the Mississippi Delta and western West Virginia, and in actually South Florida in the area that was devastated by Hurricane Andrew, and I am here really to talk to you exclusively about the issue of children and health reform with specific focus on Congressman Cooper's plan, but I would say that the children for whom our programs provide crucial health care, and in addition to those, the millions of other children who lack the means to secure regular comprehensive primary care in America, are all desperately awaiting definitive action to ensure that access will be theirs, as it is, as it should be, for all other Americans.

But I must tell you that, as an American pediatrician, I am embarrassed and horrified about just how long our children have waited for the kind of access to care afforded to kids in virtually every other industrialized country in the world. You probably already know, but I will say for emphasis, that the United States currently, in 1994, has one of the lowest completed immunization rates among two-year-olds of any industrialized country, and, secondly, there are many, many families of the working poor who are forced every day to sacrifice preventive medical care like immunizations so they can provide food and shelter for their families, and, finally, that our estimation is that there are approximately 15 million—I say 15 million—children who lack adequate or sometimes any insurance coverage or access to care in the United States.

So the question for us is, how will children fare under Congressman Cooper's plan or any other plan? And that is a question that I think myself and other advocates for children are going to be confronting and hoping you will confront in the months to come.

Unfortunately, though, the Cooper proposal, in our estimation, would create a system whereby the extraordinary health needs of America's children are neither sufficiently acknowledged nor effectively addressed, and there are three principal reasons that I am making this judgment. The first reason is that, in spite of what Congressman Cooper has said this morning, the Cooper bill does not offer what we would consider to be appropriate universal coverage or access to care for children.

All children, as far as we are concerned, need to be in the system, and they need to be in the system as quickly as possible to

cover the essential medical needs that they are now waiting for. The children, in fact, that don't have this care—and this is, as I say, a good 12 to 15 million kids—are waiting as we speak with chronic ear infections and hearing loss, the kinds of medical problems that may significantly delay their development and particularly the development of language skills. They wait with the visual defects that keep them from reading or see blackboards in school situations, and they wait with a series of debilitating conditions like asthma which, untreated, inhibit social interactions, interfere with normal playing, and keep them from attending school. So I am trying to relate this to some real world problems that we are dealing with every day here.

Congressman Cooper and supporters of his bill say, in essence, that many of these children, whether it is 10 to 20 to 50 percent of the uninsured right now, will have to wait for health care. I am not sure what they are waiting for or why they are waiting. Are they waiting for market forces to kick in? Are they waiting for documented savings in the system? Are they waiting until we can afford to let them into a system, which should be right now, accessible and affordable for every child in the country?

So our question to supporters of the Cooper bill is exactly which children, whose children, should be waiting for health care? Are they the children who live with families below or near the poverty line? Are they the children of the traditionally disenfranchised populations in America? Exactly, I would ask Congressman Cooper, which children are waiting until 1998 or 2000 or 2010, or never to get the health care that they should have?

The second problem with the Cooper bill is that it fails to spell out in advance a nonfiscally-encumbered comprehensive children's benefits package, and this is, as far as I am concerned, a fatal flaw in the Cooper bill, and I will get to the point about this. We cannot, I don't think, accept a reform proposal that doesn't spell out in detail the precise covered children's benefits. There must be coverage, as we see it, for illness prevention, for immunization, for the care of chronic and genetic and handicapping conditions; the package must include dental care and visual and hearing care, et cetera; and there should be no fiscal barriers whatsoever interfering with access to these essential children's health services, especially preventive care like immunizations.

Congressman Cooper's bill, as far as we are concerned, is a mystery package for children that is totally unacceptable to the child health advocacy community.

The third problem with the Cooper bill is that it reflects, as far as we are concerned, a very serious misunderstanding of the difference between insurance coverage and actual functional access to health care, and I want to say as an aside here that I am befuddled and amazed that the term "access" has taken on now a confusing aura of maybe some people meaning it to mean, do you have access to coverage, do you have the ability potentially, if you have the money, to buy health insurance? That kind of access is not what people who deliver health care are talking about. We are talking about, do actual human beings get health care? Do they get health care? And our concern is that the difference between just having health insurance coverage and actually having that actual func-

tional health care is grossly misunderstood and is emphatically misunderstood in the Cooper plan, because there are many barriers to people getting health care even if they have insurance, and those barriers include everything from language difficulties to homelessness to lack of transportation to health providers, to absolute lack of health providers in various parts of the country, and the Cooper proposal, as far as all of these things are concerned, offers very, very little support to the public health infrastructure and far too little support to enabling services or mechanisms to improve actual access to getting health care, and not only that, not only does it in general have far too little of those kinds of supports, but the fact is that children will suffer disproportionately from this lack of attention to dealing with the known barriers to care that are experienced by many underserved kids.

So what I conclude with is this simple message. The McDermott-Wellstone single-payer bill comes close, but as far as we are concerned, for children there is no bill currently under consideration that provides the health care coverage and genuine access that is offered by the President's Health Security Act, and that is exactly why the American Academy of Pediatrics and so many of the country's leading health experts and leading advocates have praised or endorsed the President's bill.

Conversely, all of the proposals under consideration, of all of them, none reflects less interest in or attendance to the crucial health needs of the Nation's children as does the Cooper bill, and I say let's not be fooled by terms like "Clinton Lite," because when it comes to kids and families, we think the Cooper bill is clearly an empty promise.

Bipartisanship is not the goal of health reform. The paramount goal is to get Americans, including our children, covered, included with comprehensive health care as soon as possible, and anything that leaves out our children explicitly, as far as I am concerned, is something that should never be allowed to happen.

Thank you.

[The prepared statement of Dr. Redlener follows:]

Irwin Redlener, M.D.

EMPTY PROMISES: THE COOPER/BREAUX PROPOSAL AND AMERICA'S MEDICALLY UNDERSERVED CHILDREN

I am Dr. Irwin Redlener, Director of the Division of Community Pediatrics at the Montefiore Medical Center in New York City. My Division runs the New York City Children's Health Project, the nation's largest health care program for homeless children, and a neighborhood-based children's health center in the South Bronx.

I am also President of the Children's Health Fund which, in addition to supporting the work of the New York Project, has established programs for very underserved inner city children in Newark, N.J., South Central Los Angeles and the Anacostia District here in Washington; for homeless children in Dallas, Texas; for children living in the isolated rural poverty of the Mississippi Delta and West Virginia; and for poor children in the hurricane devastated communities around Homestead, Florida.

The children for whom our programs provide vitally needed health services and the millions of other children who lack the means to secure regular comprehensive primary care, all desperately await definitive action to ensure the access that all Americans deserve.

I must tell you that, as an American pediatrician, I am embarrassed about how long our children have waited for the kind of access to care afforded to kids in virtually every other industrialized country in the world.

And I'm not just referring to the poor and near poor children I take care of today. I remember just a few years ago, when I ran a busy private practice, listening in horror to a family who lost everything they had - all their savings including a fledgling new business - because their health insurance carrier didn't cover the cost of caring for their terribly sick premature baby. This was one of many, many cases - living proof of a system in deep trouble.

There is little dispute that America needs to seriously reform its health care system. But for me, the question is: what exactly will children get under the umbrella of health reform? In specific, I have been asked to provide this statement with respect to the consequences of the Cooper bill for children.

Redlener
Testimony, 3/3/94

In a nutshell:

The Cooper plan is profoundly disappointing, with an inexplicable disregard for the enormous health care needs of the nation's children.

In 1994:

* we know there are families of the working poor who are forced to sacrifice preventive medical care - like immunizations - to provide food or shelter;
* we consistently document one of the lowest completed immunization rates among two-year olds of any developed countries;
* we know that there are nearly 15 million children who lack insurance coverage or access to care.

Yet, in spite of all this, the Cooper proposal would create a system where these and similar problems are neither sufficiently acknowledged nor effectively addressed.

Here are three principle reasons for this judgement:

1. The Cooper bill does not offer universal coverage or access to care for children.

All children need to be in the system of health care coverage, they need to be covered for essential medical needs and they need that coverage now. The kids who are waiting wait with chronic ear infections and hearing loss - causing significant delay in development of language skills; they wait with visual defects that keep them from reading or seeing the blackboard; they wait with debilitating conditions like asthma which, untreated, inhibit social interactions, interfere with normal play and keep kids from attending school.

Congressman Cooper and the supporters of his bill say, in essence, that many of these children will just have to "wait for health care". They are to wait for market forces to kick in, wait for documented savings in the system, wait until we can afford to let them into a system which should be accessible and affordable for every child in this country.

So we would ask supporters of the Cooper bill: exactly which children should wait for health care? The children who live with families below or near the poverty line? The children of the traditionally disenfranchised? Who decides, in this country of mind-boggling wealth and resources, which children should have the luxury of decent health care and which children wait on the sidelines?

I am sure that at this point in the debate, no one would suggest that we can't afford to include all children. I'm assuming that every informed citizen, that all of our elected officials and policy-makers by now understand that preventive care for all children is cheap and it's cost-effective. It is absolutely vital to our long-term national interests to ensure good health and good education for all of our children.

Even on a purely practical basis, the failure to provide insurance coverage for uninsured individuals, especially high need individuals, undermines the ability to really control, and ultimately contain costs within the health care system. This is because these individuals eventually do get care, albeit care that is delivered inappropriately and within the most expensive venues in our health care system, the emergency rooms and in-patient hospital facilities. This means that these extraordinary costs are shifted back into the insurance premium structure or to public sector tax-financed uncompensated care pools.

In fact, by continuing to exclude the high-risk uninsured, we sustain the conditions which contribute to the high cost of health care. This approach will essentially guarantee that the structural "savings" needed under the Cooper plan to pay for inclusion of currently uncovered children and their families will never be realized.

2. The Cooper bill fails to spell out a "non fiscally encumbered" comprehensive children's benefit package.

Let me get to the point: we cannot tolerate a reform proposal that doesn't spell out, in detail, the precise covered children's benefits. There must be coverage for illness, for prevention, for immunization, for the care of chronic, genetic and handicapping conditions. The package must include dental care, vision and hearing care, and home care. And, there can be no fiscal barriers, whatsoever,

interfering with access to essential children's health services, especially preventive care like immunizations.

Not only does the Cooper proposal fail to delineate the benefit package for children, but, alarmingly, establishes an inevitable collision course between children and infinitely more powerful interests representing other age groups and special interest forces. All of these elements would be fighting for preferential benefit consideration in some ill-defined process after the basic bill is passed.

This situation is intolerable for those who care about equity and health access for children. Kids cannot and will not be able to muster the advocacy fire-power to get what they need in the kind of environment which would be locked in place by the Cooper proposal. The benefits must be spelled out in detail, in advance and reflect what is in the best interest, finally, of our children.

The Cooper plan offers a "mystery package" of children's benefits. We have to do better than that.

3. The Cooper bill reflects a serious misunderstanding of the difference between insurance coverage and actual functional access to health care.

What we know is that many of the chronically underserved families and children in America need more than just insurance coverage. Many barriers, from language to homelessness, to lack of transportation or available health providers, encumber attempts to attain actual access to medical services. The Cooper proposal offers far too little support of public health infrastructure, enabling services, or mechanisms to improve access to care. Children will suffer disproportionately from this lack of attention to the known barriers to care experienced by many of the chronically underserved.

Conclusion

Not only does the Cooper Bill fail essential tests important to the nation's children and families, it also creates a cruel dilemma for American families who are struggling to survive economically.

Why do I say this? Because the Cooper proposal calls for subsidies to low-income households to purchase coverage. But these subsidies, which would be phased out gradually as income level approaches only 200% of the poverty level, represent a particularly painful disincentive for those attempting to elevate themselves from poverty while making sure that they have the health care they need.

Families of near-poverty status would be faced with the additional burden of having to finance purchase of health care coverage (approximately $5,500 per year for the median health insurance plan now provided by employers). This might make health coverage available, but it clearly would remain unaffordable.

Where would families accumulate the money for health insurance at this rate? from rent money? from money for clothing? This would create a series of **unconscionable critical choices for America's working poor.**

What I conclude with is this simple message: the McDermott-Wellstone single-payer bill comes close, but **no bill currently under consideration provides the health care coverage and genuine access that is offered by the Administration's Health Security Act.**

That is why the American Academy of Pediatrics and so many of the country's leading child health experts and advocates have praised or endorsed the President's bill.

Conversely, of all the proposals under consideration, none reflects less interest in or attendance to the crucial health needs of the nation's children as does the Cooper Bill.

Those seeking compromise in the health reform debate have sometimes referred to the Cooper Bill as "Clinton light". Don't be fooled. When it comes to kids and families, the Cooper bill is an empty promise.

Thank you.

Mr. MARTINEZ. Thank you, Mr. Redlener.

I need to be in touch with you at some point in time. I asked the First Lady when she was here before our committee testifying on the President's plan that very question: What happens to all of these runaway children, homeless children, that are now being taken care of by the community-based organizations and are receiving that health care service through them? Because nowhere in the plan could I find that it did cover or pay any attention to that.

Not only them, but there are a lot of our Americans, the older Americans, who are receiving health care through definite programs that are in place now, and it seems that the bill itself does not, any of the bills do not, address what replaces those programs other than the alliances that you are talking about or some other plans that are all inclusive of everyone that is out there, and I have to date not received an answer on my questions.

I would hope that as we move forward, that I would offer some amendments to make sure that those children that you talk about and those other Americans, older Americans that we talk about, are covered in this plan somehow as adequately as they are covered now, and they are not that adequately covered now. As you stated, there are 15 million who are not receiving it, and I want to see those 15 million covered too.

So I think I would like to talk to you later.

Mr. Tarre.

Mr. TARRE. Thank you, Mr. Chairman.

My name is Michael Tarre, and I am director of compensation and benefits at IBM. I am here today on behalf of the Corporate Health Care Coalition. We are a group of large, multi-State, self-insured employers, and at present the coalition has 22 members. In total, we provide health benefits to over 3.7 million lives, which is nearly 1.5 percent of the U.S. population in all 50 States, and for health care each year we spend over $7 billion. Over the years we have had extensive experience in designing and operating health benefit plans and have been a major force in ongoing efforts to restructure the health care delivery system.

We are committed to enactment of comprehensive health care reform in 1994 with universal coverage and cost controls, and we applaud President Clinton and the First Lady for getting the country to focus on this issue and for advancing the concept of managed competition. Mr. Cooper and others do the same. In our view, managed competition provides the best field of play for health care reform, and we believe that the best way to accomplish this is by extending the employer-based system that already covers 138 million Americans.

Employers of all sizes should have the ability, individually or through purchasing groups, to use the techniques that are working well today for large employers. In a properly structured marketplace, employers operating as direct and active purchasers, can drive the health care system to more efficient results and also to higher quality health care coverage for our employees and their families.

For this approach to work, it is critical that large employers that have traditionally played an active role in the market be able to continue to operate their own plans. This means that they must be

able to remain self-insured. It means they must be able to benefit from experience rating, and to operate in a market of multiple purchasers where price and quality are driven by market factors rather than by government rules.

Multi-State companies providing uniform nationwide benefits for their employees and their families must be able to operate under uniform Federal standards and not be subject to State single-player systems.

If an employer-based system with these elements is the basis for health care reform, then we believe it is reasonable to pursue universal coverage by requiring that all employers eventually participate financially.

There has been some interest, I know, in the Congress in either waiving ERISA preemption to allow individual States to enact their own health care systems or permitting States to opt for State level single-payer systems. Both options would be a mistake. Letting the States carve up our national health care system into 50 different financing and service delivery jurisdictions could have serious consequences not on only for the health plans that must operate in a number of States but for the participants and patients who must consume health care across State lines.

Tens of millions of residents in over 50 border cities regularly get their health care across State lines, and in our own case, in my company, over 13,000 employees commute across State lines, and that doesn't count the many thousands who might relocate from one State to another in the course of the year or be on temporary assignment between States. National Centers of Excellence serve a nationwide population; for example, the Mayo Clinic which draws 70 percent of its physician referrals are patients from out of State.

If States are allowed to assume control over health care benefits and financing, it could result in a disruptive health care system. For example, a State trying to retain and bolster State resources could require that residents use only in-State facilities, employees transferred from one State to another suddenly could lose coverage for a particular condition or treatment during the course of their illness, or the efforts of one State to finance health care or unilaterally enact universal coverage could drive employers to relocate to neighboring States or encourage uninsured individuals to move into that State.

Neither our health care problems nor the solutions are unique to any one State, and no State will be helped in the long run by the failure to enact a uniform national solution. Even the National Governors Association supports a national system.

While the coalition would like to see strong Federal standards, we also believe that the States do have a legitimate and important role in administering elements of the health care system. In our written statement we call for federally-set benefits, employer responsibilities, financing, cost containment, and data collection that preempts State rules. We also, however, support State certification of health plans and purchasing groups, State supervision of health care delivery, and State consumer protection efforts.

Now I would like to make some specific comments on the Managed Competition Act introduced by Mr. Cooper and Mr. Grandy. The Cooper–Grandy bill relies heavily on a competitive market to

manage costs and improve quality, and in that sense it is close to our position. It also moves aggressively toward a national system and thus is more consistent with our views than the single-payer bills or the single-payer option for States that is in the Health Security Act.

Unfortunately, the Cooper–Grandy bill has some serious shortcomings from an employer perspective. Employers who cover their workers already pay a 30 percent surcharge for the uninsured and for cost shifting for workers from other companies. The Cooper–Grandy bill would make this cost shifting worse by financing 64 percent of its subsidies to the uninsured through the excise tax on the employers who now cover their workers.

Additional provisions, including community rating without universal coverage, which we think would actually increase the number of uninsured, and allowing regional HPPCs to tax self-insured plans to offset their own shortfalls prevent us from supporting this legislation.

We are very concerned that the Congress may decide to expand coverage by either levying additional Federal taxes on companies who already cover their workers or waiving ERISA preemption to allow the States to establish single-payer systems and/or tax self-insured employers.

Making coverage voluntary and taxing employers who provide it will not lead to universal coverage, nor will permitting States to set up their own health care systems lead to universal coverage. These solutions will, however, penalize the very companies who are providing high-quality innovative health benefits to their employees and their families.

We urge this committee to work toward a seamless national health care system that truly uses employers to help achieve universal coverage and to manage and control costs through a restructured marketplace.

Thank you.

[The prepared statement of Mr. Tarre follows:]

Testimony of

Michael Tarre
Director, Compensation and Benefits
International Business Machines Corporation

on behalf of the

Corporate Health Care Coalition

on the

Managed Competition Act of 1993

before the
Committee on Education and Labor
United States House of Representatives

March 3, 1994

CORPORATE HEALTH CARE COALITION

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U S West

EXECUTIVE SUMMARY

The Corporate Health Care Coalition is a group of 22 large, self-insured, multi-state employers. In total, Coalition members provide health benefits for over 3.7 million lives (nearly 1.5 percent of the U.S. population) in all 50 states at a cost of more than $7 billion per year. Coalition members have extensive experience in designing and operating health benefit plans, and have been a major force in ongoing efforts to restructure the health care delivery system.

Commitment to National Reform

The Coalition is committed to the enactment of comprehensive health care reform this year. The best way to accomplish this is by extending the employer-based system that already covers 138 million Americans. Employers of all sizes should have the ability individually or through purchasing groups to use the techniques that are working well today for large employers. In a properly structured marketplace, employers operating as direct active purchasers can drive the health care system to more efficient results.

For this approach to work, it is critical that large employers that have traditionally played an active role in the market be able to continue to operate their own plans. This means they must be able to remain self-insured, to benefit from experience rating, and to operate in a market of multiple purchasers where price and quality are driven by market factors rather than government rules. Multi-state companies providing uniform nationwide benefits for their employees and families must be able to operate under uniform federal standards and should not be subject to state single payer systems. If an employer-based system with these elements is the basis for health care reform, then it is reasonable to pursue universal coverage by requiring that all employers eventually participate financially.

Federal Standards and ERISA Preemption

There has been some interest in the Congress in either waiving ERISA preemption to allow individual states to enact their own health care systems or permitting states to opt for state-level single-payer systems. Both options would be a mistake. Letting the states carve up our national health care system into 50 different financing and service delivery jurisdictions could have serious consequences not only for the health plans that must operate in a number of states, but for the participants and patients who must consume health care across state lines. Tens of millions of residents of over 50 border cities now regularly cross state lines for health care services. National centers of excellence serve a nationwide population -- like the Mayo clinic, for example, which draws 70 percent of its physician-referred patients from out-of-state. We are concerned that states controlling health care benefits and financing might require, for example, that residents use only in-state facilities. Additionally, employees transferred from one state to another might suddenly lose coverage for a particular condition or treatment during the course of their illness. Also, states

reforming their health care systems may enact employer taxes, driving employers to relocate to neighboring states, or provide benefits attracting uninsured individuals from other states. Neither our health care problems nor the solutions are unique to any one state, and no state will be helped in the long-run by the failure to enact a uniform national solution. Even the National Governors' Association supports a national system.

While the Coalition would like to see strong federal standards, we also believe the states have a legitimate and important role in administering elements of the health care system. The CHCC supports federally set benefits, employer responsibilities, financing, cost containment, and data collection that preempt state rules. We also support state certification of health plans and purchasing groups, state supervision of health care delivery, and state consumer protection efforts.

Managed Competition Act

The Coalition is pleased that the Cooper-Grandy bill is aimed at getting bipartisan support and generally embodies the principles of managed competition. The bill relies more heavily than the Health Security Act on a competitive market to manage costs and improve quality, and in that sense is closer to our position. It also moves more aggressively toward a national system, and thus is more consistent with our views than are the single-payer bills or the Health Security Act with its single-payer option for states. Unfortunately, the Cooper-Grandy bill has some fatal shortcomings from an employer perspective. Employers who cover their workers already pay a 30 percent surcharge for the uninsured and workers of other companies. The Cooper-Grandy bill would make this cost-shifting worse by financing 64 percent of its subsidies to the uninsured through an excise tax on the employers who now cover their workers. Additional provisions, including community rating without universal coverage -- which we think could actually increase the number of uninsured -- and allowing regional HPPCs to tax self-insured plans to offset their own financial shortfalls, prevent us from supporting this legislation.

Conclusion

The Coalition is very concerned that the Congress may decide to expand coverage by either levying additional federal taxes on companies that already cover their workers, or waiving ERISA preemption to allow the states to establish single-payer systems and/or tax self-insured employers. Making coverage voluntary and taxing employers who provide it will not lead to universal coverage, nor will permitting states to set up their own health care systems. These solutions will, however, penalize the very companies who are providing high-quality, innovative health benefits to their employees and their families. We urge this committee to work toward a seamless national health care system that truly uses employers to help achieve universal coverage and to manage and control costs in a restructured marketplace.

Mr. Chairman and Members of the Committee:

My name is Michael Tarre. I am Director of Compensation and Benefits for the International Business Machines Corporation. I am here today on behalf of the Corporate Health Care Coalition, a group of large, self-insured, multi-state employers, recently formed to support the enactment of health care reform legislation. At present, the Coalition has 22 member companies -- all Fortune 200 -- who operate health plans for employees, their families, and retirees, covering over 3.7 million lives (1.5% of the U.S. population) and providing more than $7 billion per year in health benefits.

Our Coalition is distinguished by its exclusive focus on issues of significance to large, self-insured employers. Our primary health care concerns are those of active purchasers of health care for our employees and not those of vendors of insurance or health care products. Members of the Corporate Health Care Coalition have been in the forefront of efforts to ensure high-quality and cost-effective benefits for employees. We have extensive experience in designing, administering, and delivering employee health benefits; and are a major force today in ongoing efforts to restructure the health care delivery system.

We are committed to enactment of comprehensive health care reform in 1994 and we applaud President Clinton, Mr. Cooper, and Mr. Thomas for advancing reform proposals that embrace the employer-based system through the concept of managed competition.

AN EMPLOYER-BASED SYSTEM

Members of the Coalition believe that a system that expands employer coverage can most effectively deliver high-quality, cost-effective benefits within a restructured health care market. Nearly 140 million Americans -- 3 million of them our employees and their families -- are covered through their employers, and most are well-satisfied with their health benefits. Disrupting this part of the market, which works well, to fix the parts that have failed makes little sense economically or politically.

An employer-based system is one in which employers -- individually and in groups -- act as organizers and active purchasers of health benefits for their employees. For an employer-based system to work over the long run, there must be a competitive market structure, reformed under uniform federal guidelines (with ERISA protections), with adequate broad-based financing and some appropriate financial participation of all employers.

A COMPETITIVE MARKET

As the health care market evolves, large employers remain the driving force behind more efficient and accountable delivery of health care. In the unusually complex health care market, large employers have worked closely with providers and insurers to encourage delivery system restructuring and to begin reporting on outcomes and use of practice parameters to improve quality and efficiency of care. Were individuals to shop independently for coverage, they would exert far less leverage on providers or insurers to be efficient and accountable. Large employers and business coalitions buying on behalf of large groups of employees, however, bring expertise and purchasing power to the table. Purchasing pools (HPPCs, health alliances) can provide smaller employers and individuals with the market leverage that large employers have used to drive down health costs and propel delivery system restructuring.

While our member companies support expanding the employer-based system, their support is conditioned on employers staying involved in managing their health care plans. A system in which employers merely write a check for coverage is not truly an employer-based system. Such a system would eviscerate companies' efforts to contain health care costs, and instead would commit companies to be the primary payer for a health care entitlement system directed by the federal government.

Rather, we believe that a properly aligned market operating with multiple purchasers, in which all employers and individuals share in the financing of coverage, would be effective in driving down costs and achieving high-quality care. To have an incentive to promote wellness and monitor health plans for cost and quality, companies must themselves realize the savings achieved by actively working -- either through purchasing groups or independently -- to control their employees' health care costs. In a multi-purchaser market, large employers can serve as benchmarks against which to judge efforts of other purchasers. Our companies already use these practices, and as managed care techniques have grown more sophisticated in recent years, we have experienced considerable success in limiting annual cost increases.

Let me be clear that our coalition members realize that every employer cannot be an expert at purchasing health insurance. Indeed, we believe that steps must be taken to make insurance affordable and accessible for small companies and individuals, including small group and individual insurance market reforms -- community rating, limits on pre-existing condition exclusions, portability, and open enrollment -- and pooled purchasing arrangements. Already small and medium-sized employers are experimenting with purchasing coalitions -- by banding together and asking for providers to bid for their business, and by working closely with local providers to devise alternative risk-based financing arrangements. But these efforts and reforms alone will not be sufficient to address all the problems in the health care market.

UNIVERSAL COVERAGE

If we are ultimately to achieve the goal of universal coverage and rely upon an employer-based system to organize health care for workers and their families, then it is fair that eventually all employers be required to participate. While all employers need to contribute to employees' coverage, the level of financing, as determined by the benefit package required, the proportion of cost borne by the employer, the length of the phase-in period, the cost sharing required of the employee, definitions of an employee, and part-time and full-time labor, and other determinants of required coverage, can all be modified to ease the impact on employers participating for the first time.

Other approaches to achieving universal coverage are not likely to be effective or accomplish an equitable distribution of the burden of financing health care. Some people have suggested, for example, that reforming the health insurance market and providing subsidies might by themselves stimulate additional coverage by making insurance more affordable and available. Health insurance reform without a mandate could have the reverse effect on coverage. Reform that required insurers to cover all applicants for a community-rated premium would raise premiums for those with low risk who currently have insurance. Without a mandate, low-risk firms and individuals who did not want to pay higher premiums would have to drop coverage, increasing the risk of the remaining pool, raising premiums, and stimulating a further erosion in coverage.

Evidence from existing projects that attempt to encourage small employers to buy health insurance by sharply lowering premiums does not show increased coverage beyond a few percentage points among uninsured small businesses. The results of projects evaluated to date leave serious doubt that reforms absent a mandate will produce universal coverage.

Some would propose an individual mandate, enforced through the tax code and through financial penalties for the uninsured when they seek care, to expand health insurance coverage. But given that the majority of uninsured people have incomes under twice the federal poverty level and that many do not file for taxes, the Coalition questions the enforceability of an individual mandate. Assuming subsidies are provided for the low-income uninsured, an individual mandate is also likely to be costlier to the federal treasury than an employer mandate. In addition, an individual mandate would not end the cost-shifting by other employers to our member companies, as working spouses and dependents of our employees could seek coverage through our companies. We would continue to shoulder the costs of employers and industries not providing health benefits to workers.

For these reasons, we believe an employer-based system can only achieve universal coverage and effectively address private sector cost-shifting if costs are borne equitably by all employers. We believe that to spread costs more evenly throughout the economy, all employers should be required to contribute toward the cost of their employees' health insurance and that all individuals should be required to have health insurance. Subsidies or obligation limits can be used as necessary to minimize the disruption for small companies with predominantly low-wage employees.

FEDERAL STANDARDS (ERISA)

Health care reform raises complex issues related to the right mix of federal and state responsibilities for designing and implementing various features of a reform package. The more extensive the reform, the more it forces us to reevaluate traditional divisions of responsibility. Some people have argued for a uniform federal system and others would like to see the states go first with reform. The Coalition believes there can be a middle position in which states can have some flexibility in administering federal reforms. By and large, however, we believe ERISA has worked very well and should continue to be the basis for a uniform regulatory framework governing employer-provided health care.

Some people believe that the states should play a leading role in health care reform. They either argue that the Congress should delay national reform and let the states test a variety of health care reform strategies to find one that can be implemented nationwide, or they argue that national reform should give the states broad discretion to design their own state health systems. The Health Security Act, for example, would permit states to establish a single-payer system at the state or regional level and to force all employees in the state into the state system. We oppose this provision.

At the same time, a number of states have been busy preparing their own comprehensive health care reform plans. Some of the states that have enacted these plans believe they are blocked from implementing them by the Employee Retirement Income Security Act (ERISA)'s preemption of state laws. In some cases the states have requested ERISA waivers or advocated outright repeal of ERISA.

States have focused on the federal statute regulating employee benefit plans as the target because it preempts any and all state laws that may also seek to regulate those plans. ERISA preemption has been limited to self-insured plans as the result of a Supreme Court ruling in 1985 that ERISA did not preempt the application of state insurance law to insured employee benefit plans. States' concern about ERISA preemption has been heightened by recent lower court decisions that rule that states may be preempted from indirect as well as direct taxation of employee benefit plans to finance uncompensated care.

It should be made clear, however, that states have the ability to tax all other aspects of an employer's activities. Notwithstanding, states feel they cannot finance comprehensive reform without the ability to tax self-insured employee benefit plans. We strongly disagree with this because it compounds the cost-shifting placed on employers providing benefits. An ERISA waiver allowing a state to tax self-insured employee benefits as a way of funding statewide needs is not a good resolution --it allows companies that do not provide benefits to avoid such a tax. This is inconsistent with our preference for broad-based revenues.

The Federal Dimensions of Health Care

The argument for letting the states set up their own health care systems is based on the belief that "health care is local". In fact, much of our health care system is national and is becoming increasingly so. It is true that providers tend to be local -- hospitals are fixed in specific communities, and physicians are licensed to practice in states. But this is where the local aspects of health care end. The use of services, the payment for care, the standards and practices of the medical profession all cross state lines. Today natural medical marketplaces exist unbounded by state lines. For example:

Medical care facilities in over 50 border cities serve residents of multiple states, the way Cincinnati, Ohio clinics, hospitals, and tertiary care facilities provide care for residents of Kentucky, Indiana, and Ohio;

Centers of Excellence like the Mayo Clinic in Minnesota, Johns Hopkins Hospital in Maryland, M.D. Anderson in Texas, or Sloan-Kettering Memorial Cancer Center in New York provide medical care to patients from across the country -- 70 percent of the patients referred to the Mayo Clinic by physicians come from out of state;

Large companies provide their employees consistent health benefits no matter where they are located -- for example, a Boeing Company employee relocated from Washington State to Washington, D.C., may live in Maryland, work in Virginia, and come to the District of Columbia to receive their health care, all without changing their insurance coverage or worrying about how crossing state lines will affect their health care.

Our health care system is now largely multi-state if not national in character, and is becoming even more so with advances in communication and transportation. How would this evolution be jeopardized if states were to create their own unique systems for organizing and financing health care?

Problems with State-Run Health Care

Let me suggest a few issues that might arise if the Congress were to cede to the states substantial authority to design their own health systems:

- One state might prohibit an employer from offering health plans by enacting a single-payer system while a neighboring state was mandating the same employer to provide a health plan;

- Residents covered under one state's health plan who wanted to use a health facility in another state might be required to get prior approval to use out-of-state facilities, or to establish that there was reciprocity between the states for treatment;

- Businesses in a state with an employer mandate or employer tax to finance care (e.g. California) might be driven to relocate to a neighboring state without an employer requirement (e.g. Nevada or Arizona);

- Low-income residents of a state without subsidized health care coverage might have an incentive to move to a neighboring state that has universal coverage and provides generous subsidies, much like today's unemployment insurance dilemma in many parts of the country;

- Residents of one state might not have the same access to critical treatments as residents of neighboring states;

- Employees of multi-state companies may have to change their covered benefits, access to care, benefit rights under the law, and overall compensation as they move from facility to facility, and

- Multi-state employers may have to comply with vastly different administrative systems in different states, thereby substantially raising the cost to a company of managing a plan nationwide.

A federal framework for universal coverage and benefits is necessary to ensure broad equity for individuals, maintain a smooth flow of health care services and financing across state lines, and enable employees of multi-state companies to have consistent benefits company-wide.

At the same time, states should be involved in the parts of health care that are inherently local, such as: overseeing health care providers and service delivery, certifying health plans that market to private individuals or firms within the state, overseeing the operations of cooperative or commercial health pools, protecting consumers, and delivering public health services.

Proposed Federal Responsibilities

The Coalition believes a federal framework containing the following elements would provide the necessary consistency and equity in the system:

Benefit Standards: any requirement to provide or incorporate in a health plan specific benefits should be uniform nationwide, and should preempt existing and future state benefit mandates.

Employer Responsibilities: any requirement for employers to offer health plans or finance a portion of health plan costs, or for individuals to purchase coverage; and any associated definitions of employer, covered employee, and covered individual should be uniform nationwide to ensure equitable coverage.

Cost Control: the strategy to improve the functioning of the health care market to slow the growth in health care costs should be applied nationwide to ensure consistent incentives from state to state and avoid merely shifting health care costs and resources across state lines.

Financing: societal costs for medical education, medical research, and other aspects of health care whose benefits transcend state lines should be financed equitably nationwide to avoid burdening states that house a large portion of these resources.

Individual Protections: private rights of action and other protections and grievance procedures for health care problems should apply uniformly regardless of state -- as private rights of action for health benefits now do under ERISA.

Technology Assessment: the judgement of when new treatments are deemed safe and effective should be a national determination to ensure that individuals have equal access to treatment regardless of state;

Data Collection: any standards, forms, or procedures for data collection, clinical information systems, and electronic claims submission should be uniform nationwide to ensure data compatibility, minimal redundancy and complexity, and ease of comparison of costs and quality nationwide.

Medicare: benefits, financing and administration of Medicare should remain federal and consistent with federal standards for the private sector to avoid variations in coverage for retirees or cost shifting to private employers.

Proposed State Responsibilities

States have broad experience working with health practitioners, facilities, and insurers, and should administer certification and licensing procedures and enforce standards for the state-based providers, insurers, and publicly-marketed health plans. For this reason, the Coalition believes that state responsibilities should include:

Health Plan Certification: current state responsibilities for certifying publicly-marketed health plans should be expanded through health care reform, subject to new federal standards for coverage, reserves, rating, nondiscrimination, and dissemination of plan information. Self-insured plans should remain subject to federal certification.

Purchasing Group Certification: states should additionally certify and oversee the operations of purchasing groups, HPPCs, or Alliances, subject to federal standards for these groups. State authority should extend to the determination of geographic areas of coverage.

Health Care Delivery: states should continue to license providers and run public clinics and hospitals.

Consumer Protection: states should continue to have responsibility for protecting consumers from fraud in marketing and defective services, including protecting them from substandard publicly-marketed health plans.

Medical Malpractice: states should be able to institute stricter malpractice reforms than the minimum standards set by the federal government.

Medicaid: given uniform federal eligibility standards for acute care -- adequately funded by the federal government -- states should have greater flexibility to experiment with increasing access to care and actively purchasing care for enrollees.

Long-term Care: to the extent that the federal government funds acute care for the poor, states should have the flexibility to fund and regulate need-based long-term care services.

FINANCING

Several bills, including the President's and Congressman Cooper's, utilize large purchasing pools (regional alliances or HPPCs) to spread the risk of more costly populations -- e.g., Medicaid, early retirees -- among a broad group of people. Through broad pooling and community-rated premiums, both of these proposals bury the financing of Medicaid's underfunding in employer and individual premiums. The coalition believes that these cross-subsidies should be explicit and financed through broad-based revenues rather than hidden in community-rated premiums or financed by employers already providing coverage. Medicaid underfunding should be corrected with additional federal revenues. At the same time, subsidies should be targeted to areas of substantial need.

POSITION ON THE MANAGED COMPETITION ACT OF 1993

The Corporate Health Care Coalition finds features we like and features we do not like in all major reform bills. We have not supported any single piece of legislation at this time, but are focusing, instead, on the issues we have articulated above that are important to us. We do want to see comprehensive health care reform enacted this year and therefore are here to work cooperatively with all parties to help fashion a health care reform bill we can support.

Since this hearing is on the Cooper-Grandy bill (H.R. 3222), I would like to take a few moments to discuss our thinking on that bill. The Coalition applauds Mr. Cooper, Mr. Grandy, and the other sponsors of the House bill and its Senate companion -- the Breaux-Durenberger bill (S. 1579) -- on their efforts to construct a moderate bill with bipartisan support.

We believe the Cooper bill headed generally in the right direction but, unfortunately, incorporated a number of provisions that we strongly oppose. On the other hand, in comparison to the President's Health Security Act proposal, we view a number of the Cooper

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bill provisions positively. Most importantly, it relies more heavily on a competitive marketplace to manage costs and improve quality. While the President would constrain costs by imposing premium caps to meet a federally determined national health care budget, Mr. Cooper would hold down costs through price competition among insurers and health care providers, which realigned market incentives would foster. Although we are not convinced that Mr. Cooper's mandatory health plan purchasing cooperatives (HPPCs) are necessary, they have the advantage of being smaller and less dominant than the President's regional health alliances, and thus allowing for a more dynamic health care market than under the Administration's proposal.

We applaud Mr. Cooper's commitment to a national, but not nationalized, system and believe he has at least attempted to go further in this regard than any of the other major bills. The reliance by the three major managed competition bills -- Mr. Cooper's, Mr. Thomas, and the President's -- on managed care, individual cost-sharing, and administrative simplification to reform health care delivery is very good.

The Coalition has some concerns about the Cooper bill, however. First, by raising 64 percent of its funding for expanded health insurance coverage from an excise tax on employers' excess health expenses (i.e., the tax cap on the employer deduction), the Cooper bill would effectively tax businesses with health benefits to subsidize the employees of businesses without. Employers already paying once for the uninsured through cost shifting would be twice penalized. Mr. Cooper contends that the tax on employer contributions would make consumers more price sensitive purchasers of insurance. However, we question the logic of taxing employers to make employees more cost-conscious. A limit on the exclusion of health benefits from an employee's taxable income would better achieve the desired effect of promoting cost-effective health care choices by employees. Additionally it seems wrong to rely on an employer-based system and then punish the employers who are providing benefits.

Second, the Coalition is concerned that the aggressive insurance market reform in the Cooper bill, without an employer or individual mandate, might actually increase the number of uninsured people. Under Mr. Cooper's proposal, many low-risk employers and individuals currently paying low experience-rated premiums would be forced to purchase coverage through the HPPCs along with Medicaid beneficiaries and high-risk individuals and pay higher community rates or else drop coverage altogether. These rate hikes will induce some relatively healthy people who are now insured to drop their coverage, raising premiums for those remaining, forcing more people to drop coverage, and leading, quite possibly, to what insurers call a "premium death spiral". We believe that aggressive insurance market reform cannot be sustained without compulsory participation in some form.

Third, the Coalition is concerned that the Cooper bill would give HPPCs the authority to assess self-insured plans to finance HPPC shortfalls. Since HPPCs are creatures of state government, this assessment or tax authority would violate ERISA's preemption of state laws taxing or regulating employee benefit plans.

CONCLUSION

The Corporate Health Care Coalition supports a centrist approach on health care reform that would combine elements of the President's proposal, the Cooper-Grandy bill and the Chafee-Thomas bill.

Reform should build on the strength of employers and an employer-based system to manage health care costs. We believe if the aggressive purchasing demonstrated by large employers today is extended to other purchasers in the system, the rate of growth in health care costs will begin to slow noticeably.

Large employers should continue to operate their own health plans and be able to realize savings from plan management and wellness efforts. They should also have the ability to join forces with other large employers to purchase health care for their employees. It would be disruptive and unnecessary to change those parts of the system that now work well.

Small employers and individuals should have the ability to join purchasing groups that would purchase care in much the same way as large employers do today.

Given a properly functioning employer-based system, all employers and individuals should be required to contribute some portion of the health care premiums for their employees.

Insurance market reform should pool risk and prevent risk selection by insurers to enable small groups and individuals to purchase health insurance at the same costs as large employers.

Clear federal guidelines, preempting applicable state laws, should ensure the availability and continuity of health care across state lines, and the ability of multi-state health plans to provide continuous benefits nationwide -- as they now can under ERISA.

Subsidies for low-income individuals and low-wage, small firms should be targeted to those in greatest need and financed overtly through broad-based taxes, rather than buried in cross-subsidies in large alliances or HPPCs and community-rated premiums.

Thank you for the opportunity to present our views to the Committee. We have been providing more detailed proposals on various aspects of our position for congressional staff in response to questions they have raised, and would be pleased to discuss these issues with you and your staff at greater length.

Mr. MARTINEZ. Thank you, Mr. Tarre.

Mr. Reiker.

Mr. REIKER. Thank you. I appreciate the opportunity to testify today.

I am vice president of benefits for General Mills Restaurants, operating health plans for full and part-time employees in 49 States and Canada. Perhaps more to the point today though, I am serving my fifth term as chairman of the Central Florida Health Care Coalition and have recently been elected as chairman of one of Florida's CHPA's, perhaps the closest thing actually in implementation to the Cooper bill, and I will be commenting on the successes of some of these organizations.

My testimony is going to cover three areas: First, basic parameters that we think are going to be necessary in any successful health care reform; secondly, specific results of successful coalitions and purchasing alliance activity; and lastly, comment on our strong support of the Cooper–Grandy bill, managed competition bill, as a starting point for health care reform.

General Mills' hands-on health care reform experience in Minnesota and Florida have led us to strong opinions about what actually works and won't work, and I will be discussing these strategies and tactics in a minute, but first let me state some parameters.

We do agree with President Clinton that all Americans should be able to get affordable, high-quality health care that can never be taken away. We agree that no one should be denied coverage because of a preexisting condition. No one should lose coverage because he or she becomes sick, changes jobs, or gets divorced. We also agree that persons with low and moderate incomes should receive government assistance so that they will not be denied coverage because they can't afford it.

All of the wrenching examples of personal hardship that the President cited in his State of the Union Address can and should be taken care of by relatively simple insurance market reforms.

Further, though, we believe that the managed competition approach is the best way to contain costs and improve health care quality.

One of the most pervasive criticisms of managed competition is that it is an untested theory. On the contrary, our experience has convinced us that the cooperative purchasing of health care based on demonstrated cost quality and patient satisfaction has proven consistently to deliver the best health care at the lowest possible price.

In 1984, General Mills Restaurants helped found the Central Florida Health Care Coalition. The coalition is a nonprofit organization comprised of over 85 employers and providers in the Greater Orlando Area representing over 300,000 covered employees and dependents. In 1990, our coalition joined with three other Florida coalitions to form the Employers Purchasing Alliance, a consumer-designed and information-driven cooperative which purchases managed care on the basis of demonstrated outcomes. To be included in the alliance programs, local hospitals and physicians must agree to collect and report detailed clinically-based severity-adjusted outcomes data. Hospital staff and physicians meet regularly with em-

ployers to review progress on improving appropriateness, effectiveness, and efficiency of health care delivery.

Just to summarize real quickly the results we have seen over the last three years, community-wide hospital costs have actually fallen in each of the last two years. In fact, average charges have dropped more than 10 percent in the community. Ancillary utilization rates have fallen 20 to 40 percent, Cesarean section rates have dropped from 34 down to 20 percent. Perhaps more significant are the changes in the marketplace. Physician referral patterns now are based on demonstrated outcomes. A primary care physician in many circumstances are only referring upon seeing positive statistical results, positive outcomes.

Secondly, physicians with the best batting averages are seeing reductions of up to 25 percent on malpractice premiums, and many employers, including General Mills Restaurants, are now entering their third year with no premium increase.

It is important to note that these results are community wide, not just for coalition or alliance members, and that all of this was accomplished with no government intervention and at absolutely no taxpayer expense. On the contrary, these initiatives are reducing public burdens. In fact, the Orange County School Board, one of our members, for example, reports that cost savings from this initiative have resulted in the saving of 20 teachers' jobs last year.

The alliance has now expanded to include several coalitions outside the State of Florida and actually has managed care programs operating and serving members and members' employees in 43 States, which brings us to the health care reform in Florida.

Last year, the Florida legislature passed a comprehensive health care reform plan creating 11 community health purchasing alliances. These local CHPA's, as they are called, pool the buying power of small business and government to obtain high-quality health care plans at the best price. They are governed by local 17-member boards who represent the various interests of consumers, small business, and large businesses. Community-based volume purchasing is at the center of health care reform in Florida.

To ease consumer comparison, Florida has defined a basic and standard benefit package. Small employer policies can be sold inside or outside the voluntary CHPA, but regulations require guaranteed issue policies with modified community ratings and limited preexisting condition exclusions. If a small employer purchases through the CHPA, they must offer a choice of plans to their employees with any price differences being borne by the employee.

In December, we sent out requests for proposals to all accountable health plans who had expressed interest. We hope to get five or 10 companies bidding on the business. In fact, we had 32 accountable health plans bid with a total of over 300 plans. For purposes of comparison, all plans were asked to calculate the monthly premiums for two sample companies. On average, those that reported premiums for 1993 and 1994 showed a rate reduction of 17 percent, and again that is with guaranteed issue and modified community rating.

So far, most of the small- to mid-sized employers who have requested bids through the CHPA on existing businesses have found lower premiums for better coverage. On average, our CHPA has

been able to quote monthly savings of over $650 to employers on plans with lower deductibles and more comprehensive coverage; perhaps most significant, though, the convenience, peace of mind, and competitive pressure that comes to bear when an employer at one sitting can select from over 300 plans offered by 30 companies.

In his health care address to the Nation, President Clinton related the tragic story of a small employer in Brevard County who was forced to lay off his parents because he couldn't afford to cover them under his company health plan. Yesterday afternoon we were given the opportunity to see if the CHPA could help this employer. Brevard is one of our counties. The employer currently offers a basic hospital-only plan with no doctor's care or maternity benefits and with $1,000 deductible. Due to the purchasing power of this alliance, this employer would be able to provide a much more comprehensive plan with a deductible of only $500, half the amount, and still recognize premium savings of 32 percent, and remember, these policies are guaranteed issue regardless of medical history and can't be taken away.

Lesson learned. In summary, we have learned several key principles in terms of implementing health care reform. Number one, managed competition can and has worked. Number two, if comparisons of costs and quality are made easily available and simple to understand, consumers can and will make intelligent buying decisions. Thirdly, if providers are held accountable with credible quality data, can and will make significant improvements in both costs and outcomes; and finally, voluntary alliances can expand access by making health insurance available and affordable to small business.

As more and more people begin to understand the full implications of the various reform proposals on their own families and businesses, the potential for divisiveness will rise. The cardinal tenet of physicians for many centuries has been, "First do no harm." Let many say that reform is underway in many places and working in communities, and I would encourage that reform take that into account.

Let me conclude where I began. We believe that every American should be able to get affordable, high-quality health care that can never be taken away. Achieving this, though, does not require highly regulatory mandate-oriented, government-controlled programs. It is neither the best approach nor the only approach. H.R. 3222 is, in our opinion, a far better model for reform. The Cooper–Grandy bill neither creates nor relies on government regulatory mechanisms to dictate health care delivery or contain costs. It would restore responsibility and reestablish competition on the costs and value of care consumed, with equitable subsidies for persons who could not otherwise afford coverage. The Cooper bill would make high quality health care available and affordable for every American.

We believe the Cooper–Grandy bill is the starting point upon which to build a workable bipartisan solution to health care reform.

[The prepared statement of Mr. Reiker follows:]

Testimony Of Jon R. Reiker

Vice-President, Benefits, General Mills Restaurants, Inc.

House Education & Labor Committee, March 3, 1994

INTRODUCTION

I appreciate the opportunity to testify today. My testimony will cover three subjects. The first is General Mills' successful experience using market forces and incentives to control health care costs in our company and in our communities. Second, I will cover the fundamental principles of health care reform derived from our experience in various private-sector coalitions and purchasing alliances. Third, I'll comment on our strong support for the Cooper-Grandy bill as the starting point for health care reform. This bill relies on the same market forces and incentives that have proved so successful in our own experience.

GENERAL MILLS' EXPERIENCE

With more than 126,000 employees, General Mills is one of the 25 largest employers in the United States. Unlike many major U.S. corporations, employment at General Mills is growing sharply. We added 19,000 new jobs in the past year alone and more than 60,000 new jobs since 1988. Our restaurant operations employ over 105,000 workers in 49 states and Canada.

As a result of innovative health benefit design and aggressive cost management, health care costs at General Mills are currently 5.6% of payroll in our consumer foods business and 4.3% of payroll in our restaurant business. Our per capita health expense grew only 1.6% from 1991 to 1992 and actually fell from 1992 to 1993.

PRINCIPLES OF HEALTH CARE REFORM

Our "hands-on" health care reform experience in Minnesota and Florida has led us to have strong opinions about what actually works and what won't. These experience-based principles of health care reform are outlined below.

1. We agree with President Clinton that all Americans should be able to get affordable high-quality health care that can never be taken away.
2. We agree that no one should be denied coverage because of a pre-existing condition. No one should lose coverage because he or she becomes sick, changes jobs or gets divorced.

3. We agree that persons with low and moderate incomes should receive government assistance so that they will not be denied coverage because they can't afford it.

All the wrenching examples of personal hardship that the President cited in his State of the Union address can and should be taken care of by relatively simple insurance market reforms.

THE POWER OF MANAGED COMPETITION

One of the most pervasive criticisms of managed competition is that it is an untested theory. On the contrary, our experience has convinced us that the cooperative purchasing of health care based on demonstrated cost, quality, and patient satisfaction has been proven consistently to deliver the best health care at the lowest possible price.

In 1984, General Mills Restaurants helped found the Central Florida Health Care Coalition. The Coalition is a non-profit organization comprised of over 85 employers and providers in the greater Orlando area, representing over 300,000 covered employees and dependents. In 1990, our coalition joined with three other Florida coalitions to form the Employers Purchasing Alliance, a consumer-designed and information-driven cooperative which purchases managed care on the basis of demonstrated outcomes. To be included in the Alliance's programs, local hospitals must agree to collect and report detailed, clinically-based, severity-adjusted outcomes data. Hospital staff and physicians meet regularly with employers to review progress on improving the appropriateness, effectiveness, and efficiency of health care delivery.

To date, in Central Florida, our accomplishments have included:

1. Community-wide hospital costs have actually fallen in each of the past two years.
2. One major hospital group has moved from an annual $12 million loss on Medicare to profitability, while improving outcomes.
3. Average hospital charges have dropped more than 10%.
4. C-section rates have dropped from 34% to under 20%.
5. Ancillary utilization rates have fallen 20-40%.
6. Significant improvements in all mortality and complication rates.
7. Physician referrals are now based on demonstrated outcomes.
8. Physicians with the best "batting averages" have seen reductions of up to 25% on malpractice premiums.
9. Many employers, including General Mills Restaurants, are entering their third year with no premium increase.

It is important to note that :

1. These results are community-wide, not just for coalition or Alliance members.
2. All of this was accomplished with no government intervention and at absolutely no taxpayer expense. On the contrary, these initiatives are reducing public burdens. The Orange County School Board, for example, reports that cost savings from this initiative resulted in the saving of 20 teachers' jobs.

The Alliance has now expanded to include several coalitions outside the state of Florida, and actually has managed care programs serving members' employees in 43 states.

HEALTH CARE REFORM IN FLORIDA

Last year, the Florida legislature passed a comprehensive health care reform plan, creating 11 regional Community Health Purchasing Alliances. These local CHPAs, as they are called, pool the buying power of small business and government to obtain high quality health care plans at the best price. They are governed by local 17-member boards which represent the various interests of consumers, small business, and large business. Community-based volume purchasing is at the center of health care reform in Florida.

To ease consumer comparison, Florida has defined a basic and standard benefit package. Small employer policies can be sold "inside" or "outside" the voluntary CHPA, but regulations required guaranteed-issue policies with modified community rates, and limited pre-existing condition exclusions. If a small employer purchases through the CHPA, they must offer a choice of plans to their employees, with any differences in price borne by the employee.

In December, Requests for Proposal were sent out to all Accountable Health Plans who had expressed interest in bidding on the Alliance business. In the Central Florida area, a total of 32 health plans responded. For purposes of comparison, all plans were asked to calculate the monthly premiums for the standard benefit plan for two small employers who had requested information. AHP premiums ranged from $258 to $667 for Employer # 1 and $1180 to $2729 for Employer #2. On average, for those Health Plans who reported premiums for both 1994 and 1993, premiums fell 17%.

So far, most small employers who have requested bids through our CHPA on existing business have found lower premiums for better coverage. On average, our CHPA has been able to quote monthly savings of over $650, on plans with lower deductibles and better coverage. Perhaps more significant, though, is the convenience, peace-of-mind, and competitive pressure that comes from being able to select, at one sitting, from over 300 plans offered by more than 30 companies.

In his health care address to the nation, President Clinton relayed the tragic story of a small employer in Brevard County who was forced to lay off his parents because he couldn't afford to cover them under his company health insurance plan. Yesterday afternoon, we were given the opportunity to see if the CHPA could help him. This employer currently offers a basic hospital only plan, with no doctors care or maternity coverage, and with a $1000 deductible. Through the CHPA, he would be able to provide a much more comprehensive plan, with a deductible of only $500, and still recognize premium savings of 32%. And remember, these policies are guaranteed-issue, regardless of medical history, and cannot be taken away.

LESSONS LEARNED

In summary, we have learned several key principles for health reform:

1. Managed competition can and has worked.
2. If comparisons of cost and quality are made easily available and simple to understand, consumers will make intelligent buying decisions.
3. Providers, if held accountable, can and will significantly improve both cost and quality of care.
4. Voluntary alliances can expand access by making health insurance available and affordable to small business.

COOPER/GRANDY SUPPORT

As more and more people begin to understand the full implications of various reform proposals on their own families and businesses, the potential for divisiveness will rise. The cardinal tenet of physicians for many centuries has been "First, do no harm." Reform is under way and working in communities across this county.

Let me conclude where I began: Every American should be able to get affordable, high-quality health care that can never be taken away. Achieving this does not require a highly regulatory, mandate-oriented, government- controlled program. It is neither the best approach, nor the only approach.

H.R. 3222 in our opinion, is a far better model for reform. The Cooper-Grandy bill neither creates nor relies upon government regulatory mechanisms to dictate health care delivery or constrain costs. It would restore responsibility and reestablish competition on the cost and value of care consumed. With equitable subsidies for persons who could not otherwise afford coverage, the Cooper bill would make high-quality health care available and affordable for every American.

The Cooper-Grandy bill is the starting point upon which to build a workable, bi-partisan solution to the health care problem.

Mr. MARTINEZ. Thank you, Mr. Reiker.

Mr. Kendall.

Mr. KENDALL. Thank you, Mr. Chairman. I appreciate this opportunity to testify on health care reform.

My name is Dave Kendall, representing the Progressive Policy Institute, which is associated with the Democratic Leadership Council.

I guess listening to this panel and many others just like it, it is very hard to imagine how from all these diverse opinions you are going to come up with a bill that is going to pass Congress, and I don't want to make your job any easier, so I really wish you the best of luck in this effort.

The Progressive Policy Institute has supported managed competition since 1993 when it came out for a health plan in "Mandate for Change," which was published just as President Clinton took office.

We believe that the Cooper–Breaux approach in this Congress comes closest to this vision of managed competition. The Cooper–Breaux plan has much in common with the President's plan. Both plans rely on a new competitive structure, purchasing groups to pull the buying power of consumers, new rules for the insurance industry to stop the cherry-picking and the discriminatory package, and the standard benefits package, consumer information on costs and quality, and tort reform, and we are happy that the President has opened the window for a fundamental change in the marketplace.

In several key respects, however, we think his own solution is a top-down approach relying on government price controls and global budgets rather than a bottom-up strategy using consumer choice and competition.

We strongly support the goal of universal coverage, but the responsible path to universal coverage comes only after, not before, controlling costs. A mandate that all Americans receive comprehensive benefits will greatly increase the demand for health care services and drive up costs.

What the administration has done to solve the surge in demand is proposing a global budget with price controls, which we believe will fail. CBO got to the heart of this problem when it issued the warning that the President's proposed premium caps are likely to create immense pressure and considerable tension. In practical terms, what this means is essentially putting the government at odds with patients and their care. The likely result will be that the spending will increase beyond the caps amounts.

The administration claim that these caps are just a backup to competition has been rejected by the CBO. In fact, CBO says the premiums in the President's bill, not competition, will hold down national health care spending.

What a global budget means is that the government, not consumers, will control the level of spending. The government can only make an arbitrary decision about how much spending is the proper amount for health care. As a result, Congress would have to use public opinion to gauge at what level to set health care spending.

Health care providers faced with this dilemma of declining income and patients denied care or forced to wait in line for it would find the caps an easy target around which to demand increases.

This situation would put Members of Congress in either the position of defending the caps as necessary fiscal restraints or, more likely, succumbing to the pressure that they should increase them.

What is the alternative? We have to level the playing field on which consumers choose health plans. Today, workers receive an unlimited tax break for the premiums paid by employers. This tax policy encourages employers to increase workers' health benefits rather than their wages. Under the Cooper–Breaux plan, health plans that charge higher premiums would no longer receive favorable tax treatment. The tax deduction for businesses would be capped at the cost of the least expensive plan in the area, removing the incentive to increase benefits rather than raises. Employees would be free to spend their own money on more expensive health care coverage if they chose.

The President's plan has avoided the tough and crucial question of a genuine tax cap. His plan simply stipulates that, 10 years after enactment, tax subsidies would be limited to the standard benefit. For example, if dental benefits were not included in the standards benefit package, they would not get a tax deduction. This is all the President's plan does. He does not set a limit on the tax amount that is subsidized through the Tax Code, and therefore his approach is ineffective.

Ironically, the President's plan erects new obstacles to cost control. The cap of 7.9 percent on payroll costs for employers in regional alliances reduces the incentive for businesses to control costs. Once employers' premiums are capped at 7.9 percent of payroll, it will become a tax to them and they will lose their ability and their incentive to negotiate a better deal.

The President's bill would also put most large employers and all other small employers into regional alliances where employers lose their ability to negotiate on a one-to-one basis with the providers. By contrast, the Cooper–Breaux bill keeps large and mid-sized companies out of the purchasing groups. These companies, therefore, would retain the ability to negotiate costs, and they would have new incentive to do so from the tax cap.

The cry for universal coverage has confused mandates with universal access to health care insurance. Advocates of universal coverage sometimes lump together those who oppose mandates and those who support the status quo of discriminatory insurance practices. In fact, there is little or no debate on such insurances practices. All the major bills eliminate these practices, and insurance market reform will happen, but it alone won't break the back of runaway costs of the health care system.

Universal coverage must frame the debate, as the President as insisted, but it cannot drive unrealistic demands. A disciplined step-by-step approach to universal coverage is needed to define precisely what level of subsidies will be needed to make health care affordable.

The Cooper–Breaux plan, while it lacks a mandate to purchase health care, offers the best starting point to achieve universal coverage. It covers all the poor immediately and provides subsidies for the near poor. It removes the barriers to coverage erected by insurance companies, and it allows for the possibility of instituting a mandate.

Mandates make much more sense once all the barriers to health care coverage have been eliminated, and free riders who voluntarily choose not to purchase health care coverage are the only ones left and out of the system.

Recently several Members of Congress have declared that alliances are dead. Alliances are the linchpin of market-based reform. Without alliances, the real alternatives are incrementalism that fails to address runaway health care costs or a government-run health care system. Neither will satisfy the American public.

The problem with alliances in the President's bill is that they are vehicles for regulation of health care spending. By channeling nearly all private health care spending through the alliances, they become essentially single-payer systems and mechanisms for controlling premiums.

By contrast, the Cooper–Breaux bill uses alliances in a fundamentally different way. Their version requires that purchasing groups be nongovernmental and not-for-profit organizations which operate much like a farmers market. These purchasing groups will give the employees of small businesses the market clout of large businesses. By empowering consumers, their decisions can guide the future of the health care delivery system.

The typical health care plan of the future will combine many values that consumers have today. It will offer more choice of physicians than today's HMO's and better preventive care than today's fee-for-service plans.

In short, I believe that health care reform should and will happen this year, but the debate has to move to the question of how to empower consumers. The government should set the rules for the game to let consumers win by exercising their right to choose and by accepting responsibility for the decisions.

Thank you.

[The prepared statement of Mr. Kendall follows:]

Testimony of David B. Kendall
Senior Analyst for Health Policy
Progressive Policy Institute

United States House of Representatives
Committee on Education and Labor

Hearing on H.R. 3222, The Managed Competition Act
March 3, 1994

Thank you for this opportunity to testify on health care reform. The Progressive Policy Institute (PPI) endorsed managed competition in Mandate for Change, published in 1993 as President Clinton took office.[1]

PPI believes that the approach to health care reform proposed by Congressman Jim Cooper and Senator John Breaux comes closest to this vision of managed competition. This approach seeks to harness the power of choice, competition and market incentives to control costs, enhance quality, reward efficiency, encourage innovation and empower consumers. It promotes individual responsibility as a response to our "cost-unconscious" health care financing system. With subsidies for persons who could not otherwise afford coverage, the Cooper-Breaux plan can achieve universal access.

The Cooper-Breaux plan has much in common with the President's plan. Both proposals rely on a new competitive structure: purchasing groups to pool the buying power of consumers; new rules for the insurance market to stop the cherry-picking and end discrimination in coverage and pricing; a standard benefits package; consumer information on cost and quality; and tort reform.

Most important, the President has opened the window for a fundamental change in the markets. In several key respects, however, his own solution is a top-down approach reliant on global budgets and price controls, not a bottom-up strategy

[1]Jeremy D. Rosner, "A Progressive Plan for Affordable, Universal Health Care" in Mandate for Change, Will Marshall and Martin Schram, eds., Berkley Books, New York: January 1993.

based on consumer choice and competition.[2] The Cooper-Breaux approach is bottom-up because it is built on principles that can extend to every community as people fashion a new health care system through their own choices.

PPI strongly supports the goal of universal coverage, as well as restructured health care marketplace. But we can responsibly achieve universal coverage only after, not before, controlling costs. A mandate that all Americans receive comprehensive benefits would greatly increase demand for health care services, driving up costs.

The Administration has anticipated this surge in demand and proposed a global budget and price controls in an attempt to constrain health care spending. It will not succeed. CBO noted the heart of this problem when it recently warned that the premium caps in the President's health proposal "are likely to create immense pressure and considerable tension."[3] In practical terms, the caps mean placing the government at odds with patients and the health care they demand with the likely result that spending will increase.

Market Forces, Not Price Controls

The Cooper-Breaux bill, like the President's plan, would level the playing field for all kinds of health care delivery systems. Fee-for-service plans, HMOs and PPOs all will have to compete by the same rules to provide the same benefits to everyone without denying coverage or increasing premiums to those who are sick.

Health plans that deliver better care for less cost should be rewarded with more customers, challenging all plans to improve quality while lowering costs, by adopting the same kind of total quality management used by other industries.

To achieve this goal, we have to trust consumers to make the right decisions. This approach has already delivered impressive results in health care systems for employees of government and large companies. Here are some examples:

* CalPERS, the California Public Employees Retirement System offers health care coverage to about 900,000 local and state employees. These employees are free to choose from among 27 health plans. No one is denied coverage.

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[2]see Alain C. Enthoven and Sara J. Singer, "The Clinton Health Plan: A Single Payer in Jackson Hole Clothing," *Health Affairs*, special supplement, 1994.

[3]Congressional Budget Office, "An Analysis of the Administration's Health Proposal," U.S. Congress, February 1994, p. 76.

Premium increases have been held to single digits in recent years.

* FEHBP, the Federal Employee Health Benefits Program, has held premium increases to single digits in recent years as well. In 1991 and 1992, FEHBP premiums increased an average of 4.7 percent and 7.4 percent respectively, compared to the 12 percent to 12.5 percent annual increases at U.S. corporations.[4] Over the past dozen years, FEHBP premiums per person have risen 3.5 percentage points less a year on average than those for large private-sector employers.[5]

* Twenty large employers in Minnesota have formed a buyers group that will hold annual cost increases to 3 percent to 4 percent.[6] These savings are on top of costs in Minnesota that are 15 percent to 20 percent below national averages.

The President's bill pays does not rely sufficiently on genuine competition and consumer choice. The Administration's claim that caps on insurance premium increases act as merely a backstop for competition has been rejected by the Congressional Budget Office. In CBO's view, the premium caps in the President's bill, not competition, will hold down national health care spending.[7]

Through these premium caps, the President's bill would impose a global budget on most health care spending. The government, not consumers, would control health care spending. Yet the government can only make an arbitrary decision about the proper amount of spending on health care, relative to other sections of the economy. As a result, Congress would have to use public opinion to gauge the level at which to set spending.

Health care providers faced with declining revenues and patients denied care or forced to wait for it would find the caps an easy target around which to demand increases. This situation would put members of Congress in the position of either defending the caps as necessary fiscal restraints or more likely, succumbing to the pressure to increase them. The likely result, judging from past experiences, will be

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[4]Robert E. Moffit, The Heritage Foundation, "Consumer Choice in Health: Learning from the Federal Employee Health Benefit Program," November 9, 1992.

[5]Spencer Rich, *The Washington Post*, April 5, 1993.

[6]Jan Malcolm, "Managing Minnesota," *The New Democrat*, December 1993, p. 19.

[7]Congressional Budget Office, "An Analysis of the Administration's Health Proposal," p. 76.

rising caps and declining restraints on costs.[8]

Only a well-functioning marketplace can determine the proper level of spending on health relative to sections of the economy. By levelling the playing field for health plans, the Cooper-Breaux bill will increase the likelihood of this occurring.

New Incentives, Not New Obstacles, to Control Costs

Levelling the playing field is just as important for consumers as for health plans. Today, workers receive an unlimited tax break for health plan premiums paid by their employers, the only major employee benefit without a limit. This tax policy encourages employers to increase their workers' health benefits rather than their wages.

Under the Cooper-Breaux bill, health plans that charge higher premiums would no longer receive favorable tax treatment. The tax deduction for businesses would be capped at the level of the lowest cost plan in the area, removing the incentive to increase benefits rather than raise wages. Employees would be free to spend non-subsidized dollars on more expensive health coverage.

CalPERS adopted a similar approach when the state of California froze employers contributions to employees' health plans. According to the General Accounting Office, this change made state employees more sensitive to premium rates and gave plans an incentive to peg their rates close to the state's contribution.[9]

The President's plan has avoided the tough and crucial question of a genuine tax cap. It stipulates that 10 years after enactment, tax subsidies would be limited to the benefits in the standard benefits package. But it does not set any dollar limit on the tax subsidy, which renders it ineffective.

Ironically, the President's plan also erects a new obstacle to cost control. The cap of 7.9 percent of payroll costs for employers reduces the incentive found in the current system for businesses to control costs. Once employers' premiums are capped at 7.9 percent of payroll, it will become a tax to them and they loose their ability and

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[8]see Steven Mufson, "Price Controls: Past as Health Care Prologue," *The Washington Post*, March 14, 1993.

[9]U.S. General Accounting Office, "California Public Employees' Alliance Has Reduced Recent Premium Growth," November 1993, p. 6.

incentive to negotiate a better deal with providers.[10]

Today, employers reduce costs by directly negotiating with health plans. The President's bill would put most large employers with more than 5,000 employees, and all other smaller employers, into regional alliances. Once in the alliance, employers loose the ability to negotiate with health plans. By contrast, the Cooper-Breaux bill keeps large and med-sized companies out of the regional purchasing groups. These companies would retain the ability to negotiate costs, and they would have new incentives to do so through the tax cap.

Access First, Mandates Second

The cry for universal coverage has confused mandates with universal access to health care. Advocates of universal coverage sometimes lump together those who oppose mandates with those who oppose ending current discriminatory insurance industry practices such as medical underwriting, pre-existing condition exclusions and the lack of portability. In fact, there is little or no debate on such insurance practices.

Under all the major health proposals, Democratic and Republican, health care coverage would be portable from job to job, and the cost of coverage could not according to a person's medical condition.[11] Insurance market reform will happen, but it won't break the back of runaway health care costs. Those who argue forcefully for mandates also want government to be in the business of controlling health care costs.

Universal coverage must help frame the debate, as the President has insisted, but it cannot drive unrealistic demands. A disciplined step-by-step approach to universal coverage is needed to clarify precisely what level of subsidies will be necessary to make health care affordable. At the same time, the effect of reforms on costs can be evaluated empirically without relying as heavily on uncertain economic and budgetary forecasts.

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[10]Although large employers with over 5,000 employees could form corporate alliances, and thus not be subject to the cap, the CBO estimates that most large employers would join the regional alliance due to additional requirements on corporate alliances. Although the 7.9 percent cap will not apply for eight years to large employers who seek to opt in the regional alliances, the point remains that large employer will loose the ability to negotiate prices once they join the alliance. See Congressional Budget Office, "An Analysis of the Administration's Health Proposal," p. 31.

[11]The comparison of major bills includes Clinton, Cooper/Breaux, Chafee/Thomas, Lott/Michel, Nickles/Stearn, and McDermott/Wellstone.

The Cooper-Breaux bill, while it lacks a mandate, offers the best starting point to achieve universal coverage. It covers all the poor immediately and provides subsidies for the near poor. It removes the barriers to coverage erected by insurance companies. And it allows for the possibility of later instituting a mandate. Mandates make much more sense once all barriers to health care coverage have been eliminated and free riders, who voluntarily choose not to purchase health care coverage, are left out of the system.

For example, solving the free-rider problem through mandates will be easier for the average person to accept when the barriers for health care reform have been removed. Those refusing to purchase health coverage will not be lumped in with those who want to purchase but cannot due to insurance company practices or prohibitively high costs. For all these reasons, mandates should not be implemented until the health market has been fundamentally reformed and has delivered better results.

Put Consumers, Not Bureaucrats, in the Driver's Seat

Several prominent members of Congress have declared that alliances are dead. Alliances -- health plan purchasing cooperatives in the Cooper-Breaux bill -- are the linchpin of market-based reform. Without alliances, the real alternatives are incrementalism that fails to address runaway health care costs, or a government-run health care system. Neither result will satisfy the American public.

The problem with the alliances in the President's bill is that they are vehicles for the regulation of health care spending. By channelling nearly all private health care spending (except for Medicare) through the alliances, they become single-payer systems and mechanisms for controlling premiums.

By contrast, the Cooper-Breaux bill uses alliances in a fundamentally different way. This version requires that purchasing cooperatives be non-governmental, not-for-profit organizations, which operate much like a farmers' market. These purchasing groups will give the self-employed, non-working individuals and employees of small businesses the market clout of large businesses.

As much as 40 percent of health plan premiums paid by small firms today go toward administrative costs; large group purchasing reduces that amount to 5 percent. Purchasing groups also spread risks more evenly through the population, so that no group suffers when one member becomes seriously ill.

With consumers in the driver's seat, their decisions can guide the future of the health care delivery system. As a result, the typical health care plan of the future will combine many values that consumers hold today. It will offer more choice of

physicians than HMOs of today and better preventive care and coordination of care than the fee-for-service plans of today.

Consumers will need new and more reliable information to judge the quality and satisfaction delivered by each health plan. Both the Cooper-Breaux bill and the President's plan would require health plans to report the health outcomes of services provided to plan enrollees. More than any other reform, this requirement has the potential to re-orient the practice of medicine towards what really works to improve the people's health status. If a medical procedure does not improve the health, functioning, or well-being of the patient, then its use will not be warranted.

Conclusion

Health care reform will fail if it denies the public an active role in shaping the new system. The government should set the rules of the game to let consumers win by exercising their right to choose and by accepting responsibility for their decisions.

Mr. MARTINEZ. Thank you, Mr. Kendall.

Mr. Clevenger.

Mr. CLEVENGER. Mr. Chairman, I am Ernie Clevenger. I am president of American Progressive Benefits in Brentwood, Tennessee, and I am also a director of the Self-Insurance Institute of America, SIIA. Today I am speaking on behalf of both organizations as well as a private citizen. Joining me today is also Jim Kinder who is the executive vice president of SIIA.

My fellow Tennessean, Congressman Jim Cooper, introduced the Managed Competition Act, H.R. 3222. This alternative to President Clinton's national health care reform proposal has a good starting point, just as Mr. Cooper indicated, but I believe that H.R. 3222 should be combined with some of the provisions of the House Republican proposal, H.R. 3080. The combination could serve as an effective basis for a successful health care reform, and I hope that the two bills could be blended so that broad bipartisan support can be achieved.

We do have some problems with H.R. 3222 concerning the exclusive HPPC's and the mandate that all employers with less than 100 employees—that they be required to offer coverage through these exclusive arrangements. But forcing employers with less than 100 employees to participate in these exclusive HPPC's, Americans would have less, not more, competition, resulting in increased cost, lower quality, and a reduction in individual freedom.

On the other hand, H.R. 3080 provides a framework for greater competition using a voluntary approach. If HPPC's are considered and incorporated into the legislation, we would prefer competing health alliances rather than the exclusive approach.

Health care reform is on everyone's mind. The public is confused and uncertain as to various proposals and how it would affect their employment base, benefit programs, their access to care, and of course the cost. The employer involvement is critical. The employer evaluates various health care plans to determine the best way to meet the needs of the employees. Without the employers' accessible and customized aid, the employee is lost. Employer choice must be preserved in this employment-based system. Maximizing employer choice increases the options available, thus providing more options for the employee.

H.R. 3222, Mr. Cooper's bill, calls for individual States to regulate the HPPC's. We strongly oppose the establishment of a system of health alliances or purchasing cooperatives under State authority. The Federal Government must have an exclusive authority over the health care system to ensure a uniform environment for all Americans and to ensure simplified administration. It is essential that employers are free from inconsistent and conflicting State regulation.

In accordance with Mr. Cooper's proposal as well as the House Republican proposal, we support insurance reform portability of benefits, access to coverage for all, medical malpractice reform, as well as a crackdown on fraud and overutilization of the health care system. We believe that the part of the health care system that needs fixing should indeed be fixed but the entire system should not be dismantled.

The type of untested health care reform proposed by the administration and others is not a proven panacea for solving the Nation's health care problems. It would only serve to disrupt the present system which is already improving as a result of competitive forces.

The time is right for House Republicans and Democrats to sit down and consolidate the best parts of the H.R. 3222 and H.R. 3080 bills. We believe that a bill is needed that offers voluntary HPPC's where the employer has the freedom to fund benefits through the most economical means. The intent of each bill is to improve our own health care system, but the combination of the two bills is the speediest way to achieve the broadest bipartisan support which will result in a bill designed to give Americans the greatest access to health at the best cost.

I appreciate the invitation for being able to speak today. The industry association stands ready to assist the committee, and I would be happy to answer any questions.

[The prepared statement of Mr. Clevenger follows:]

STATEMENT OF
SELF-INSURANCE INSTITUTE OF AMERICA, INC.
to the
EDUCATION AND LABOR COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
March 3, 1994

Mr. Chairman, members of the Committee, my name is Ernest Clevenger. I am appearing here today both as an employer -- I am president of American Progressive Benefits in Brentwood, TN -- and on behalf of the Self-Insurance Institute of America to offer comments on the Managed Competition Act of 1993 (H.R. 3222).

The Self-Insurance Institute of America, Inc. (SIIA), is a national trade association serving the self-insurance industry. SIIA has over 1500 members -- representing over 60 million American workers -- and includes employers, third-party administrators, managing general underwriters, insurance companies, reinsurers and others dedicated to the advancement of self-insurance. SIIA is the only U.S. association that represents firms, individuals and organizations which participate in the broad spectrum of self-insurance.

SIIA, like my own firm, believes that health reform legislation should build upon our current employment-based system. H.R. 3222 is a step in the right direction in preserving the current employment-based system, while addressing the important problems of health care cost containment and access.

An expanded employment-based system of health care coverage is essential to assuring the delivery of appropriate, quality health care to all working Americans. Employment based plans should be encouraged to maintain and further utilize the most effective and economical means available to provide efficient health care, regardless of the funding mechanism selected. This includes the free choice of employers to fund health care benefits using the most efficient health plans available, including traditional insurance arrangements, self-funded plans, or prepaid health maintenance organizations. However, the cost of health care should be the shared responsibility of all.

We believe the Clinton Administration's call for an employer mandate and establishment of an exclusive system of health alliances under state regulatory authority for all practical purposes would eliminate employment-based health benefits, including self-funded health plans, which provide benefits to two-thirds of all employees covered by group health plans.

While employers would continue to contribute toward the cost to pay employees and their families, their ability to self-fund health benefits and to design health plans which meet the specific needs of these employees, as well as to control costs and to improve quality, would be eliminated under the Clinton plan and in many respects under H.R. 3222 as well.

Employer involvement is critical. The employer evaluates complicated health care plan alternatives to determine which is best to meet the needs of employees and to attract new employees. The employer provides explanation and assistance for better understanding to employees. Employer involvement is important. Without it, the employee is lost.

For this reason, we cannot support the Health Security Act nor can we support H.R. 3222 as written in spite of our belief that there are problems with the nation's health care system that require changes. We agree with the President and others that escalating health care costs must be contained. While President Clinton has identified many problems in our health care system, we believe his health reform plan goes in the wrong direction and, thus, we must look at alternative approaches.

Managed Competition Act of 1993

Today, I would like to concentrate my comments on "The Managed Competition Act of 1993" (H.R. 3222) sponsored by Congressman Jim Cooper who hails from my own state of Tennessee.

While I and the self-funded industry support some of the provisions in H.R. 3222, we differ with Congressman Cooper on two principal aspects of his bill which I would like to discuss today.

1. Health Plan Purchasing Cooperatives (HPPCs).

First, the managed competition approach in H.R. 3222 calls for establishment of a system of Health Plan Purchasing Cooperatives, or HPPCs. While this is a significant improvement over the Clinton plan, we believe all HPPCs should be voluntary and that private purchasing cooperatives should be allowed to compete with HPPCs.

Under H.R. 3222, employers with fewer than 100 employees would be required to offer access to health coverage through HPPCs thus eliminating employer options to select more efficient and less costly alternatives. By forcing employers to participate in exclusive purchasing cooperatives, Americans would have less -- not more -- competition resulting in increased cost, lower quality, and restrictions on individual freedoms. The provision also undermines uniform regulation of health care plans, again adding cost to consumers.

We suggest Congress allow any purchasing cooperative which can meet applicable federal standards to offer coverage to small employers. We agree with Rep. Cooper that small employers should have access to increased efficiencies afforded by large groups and to join purchasing groups or cooperatives. Any reformed health care system should use the experience of qualified associations and include industry and employer group pooling as a means of organizing the private sector consumer market in providing greater and more competitive alternatives.

If any aspect of managed competition is implemented, its goals should be to bring more, not less, competition into the health care system and to give employers and employees more choice in selecting efficient, affordable health plans. The challenge for the employer should be to select among a variety of competing health plans, including insured and self-insured plans that meet requisite federal standards. To require a reformed national system of exclusive health alliances is contrary to the principle of open and free employer choice to fund employment-based health plans through the most economical means possible.

In this respect, we point to H.R. 3080, the "Affordable Health Care Now Act" sponsored by Rep. Michel, which includes a provision to allow federally regulated self-insured multiple employer welfare arrangements to offer health benefits to small employers. These multiple employer welfare arrangements are a form of private sector health plan purchasing cooperatives organized along industry or employer lines.

2. Regulatory Framework.

Second, H.R. 3222 calls for the development of a managed competition system regulated by individual states based on federal standards set by a Health Care Standards Commission (HCSC).

SIIA and I on behalf of my company, AP Benefits, strongly oppose the establishment of a system of health purchasing cooperatives under state regulatory authority. The federal government must have exclusive authority over reform of the health care system in order to ensure a uniform environment for all Americans for the provision of health care coverage. It is essential for employers to be free from inconsistent and conflicting state regulation. SIIA supports a federally regulated system.

Moreover, SIIA does not believe that it is necessary or productive to establish a new national SEC-type board with responsibility for setting policy over the health system. Current federal laws already address the regulatory climate for health care plans.

Other Reforms

Other reforms which merit support include:

1. Malpractice - SIIA supports effective malpractice reforms, including requiring binding arbitration between consumers and health care providers. We also support the imposition of sanctions against those who present fraudulent or frivolous claims.

2. Administration Simplification - SIIA supports standardized claim forms and procedures for administering claims and outcome analysis for both private and public health benefit plans. Cost shifting of federal and state programs along with duplication of benefits should be eliminated.

3. Fraud and Abuse - SIIA supports criminal penalties for health care fraud and the imposition of sanctions for over-utilization of medical services.

Conclusion

It is a known fact that the great majority of all Americans have health care coverage, most of whom are covered through their employers. We believe that the part of our health care system which needs fixing should be fixed, but that the entire system does not need to be dismantled. The type of untested managed competition system proposed by the Administration and others is not a proven panacea for solving the nation's health care problems, and would only serve to disrupt the present system, which is already improving. We believe that H.R. 3222, with the changes suggested above, could create a viable framework for meaningful reform in the nation's health care system.

Respectfully submitted,

Ernest Clevenger
President, American Progressive Benefits
Director, Self-Insurance Institute of America, Inc. (SIIA)

ABOUT THE SELF-INSURANCE INSTITUTE OF AMERICA, INC.

The Self-Insurance Institute of America, Inc. (SIIA) is the world's largest professional trade association dedicated exclusively to the advancement of the self-insurance industry.

Our goal is to improve the quality and efficiency of self-insurance plans through education and create a general acceptance in the public and business communities of this viable alternative to conventional insurance.

Founded in 1981, SIIA has over 1,500 members representing the interests of independent administrators, utilization review companies, managed care companies, underwriting management companies, insurance companies, reinsurers, agents, brokers, CPAs, attorneys, financial institutions, manufacturers, trade associations, retail and service companies, municipalities and more.

SIIA designs and implements programs and services for the benefit of its members, the industry, and the general public to increase the general level of knowledge about self-insurance plans; achieve greater professionalism in the industry; gain wider acceptance of self-insurance; and enhance the general well-being and mutual interests of members.

SIIA achieves its goals and objectives through:

- International/national conferences and industry forums that are held to provide educational opportunities, with substantial discounts on the registration fees offered to SIIA members.
- A bi-monthly magazine, *The Self-Insurer*, featuring useful technical articles as well as updates on topical issues of importance to the self-insurance industry.
- *Hotline*, a legislative/regulatory update bulletin which is distributed as "hot" issues arise.
- *Lookout*, a publication which outlines significant developments in the self-insurance industry and informs members of legislation and regulations, both state and federal, that affect particular states or disciplines.
- The Self-Insurance Educational Foundation, Inc. (SIEF) which is dedicated to doing statistical research regarding the industry and granting educational scholarships to promising students whose studies center on the self-insurance industry.

SIIA enjoys federal representation in our Nation's Capital through counsel and staff on key legislative and regulatory issues. SIIA is the only national voice for the total self-insurance industry.

If your company is involved or interested in self-funding risk for:

- workers' compensation insurance programs,
- employee benefit plans, or
- property and casualty protection,

then it should be a member of the association serving the industry -- *the Self-Insurance Institute of America, Inc.*

Leading the Way since 1981...

Mr. MARTINEZ. Thank you, Mr. Clevenger.

Mr. Pollack.

Mr. POLLACK. Mr. Chairman, first let me congratulate you on our endurance here today, and let me say to you that I won't tax that endurance, I will be mercifully short.

Mr. Cooper talked about his bill as being Clinton Lite. I would suggest it is more Clinton veto than Clinton Lite, and I would like to actually focus my comments on one aspect of the Cooper bill, but before doing it, I just want to point out that there are a wide variety of ways that the Cooper bill really falls short from a consumer perspective. Certainly it does not achieve universal coverage, and I am going to get to that point in a moment. The Clinton bill certainly does.

We have no idea what the benefit package is going to look like. It is asking us to buy a pig in a poke. The Clinton bill, on the other hand, provides a comprehensive benefit package that is spelled out in the legislation.

The Clinton bill gives us some security about what the costs of health care are going to be through the backstop of limitations on premium increases. Of course, the Cooper bill does not give us that security, and for senior citizens there is precious little in the Cooper bill, there is nothing with respect to improving long-term care. In fact, there is a diminution in Federal support for what limited long-term there is today, and there is no coverage of prescription drugs that senior citizens very much want and are looking for as part of health care reform.

But if I may, I want to focus on one very narrow aspect of the Cooper bill that I thought the congressman was more glib about than I feel comfortable about, and that is, when he was asked the question about universal coverage, and he talked about, as in fact Mr. Kendall did a few moments ago, that we are really covering the vast majority of people, and, after all, there is this wonderful subsidy system in the Cooper bill that provides some subsidies for people below 200 percent of poverty, and then the congressman would have us believe that in as much as that subsidy is provided for people below 200 percent of poverty, we really don't have to worry about that group of people, those people are now going to have coverage because of the subsidy.

Unfortunately, it fails to examine what that subsidy is and whether that subsidy really is adequate to make it realistic to assume that these individuals and these families are really going to have true access, are really going to get true coverage. So let me give you a few numbers here.

We unfortunately can't tell you what the cost of the Cooper benefit package is because he doesn't define it for us. Hopefully, the Congressional Budget Office will give us some understanding as to how they would calculate it. So let me give you some arbitrary numbers here, but I think it makes a point.

Let's first look at what the Clinton package costs and take a look at how the Cooper subsidies would fare with respect to purchasing the Clinton benefit package, and then let's look at a lesser package.

The Clinton benefit package, according to CBO, would cost a family $5,565 dollars. Under the Cooper plan, the way the subsidies would work, the responsibility for such a package for a fam-

ily at 150 percent of poverty, which is a little over $22,000 in income, that family would have to pay approximately $2,800 in premiums in order to pay for that package.

Now mind you, this does not include deductibles, it does not include coinsurance, it does not include uncovered services; but just the premiums alone with the Cooper subsidization effort would have that family pay 12.5 percent of its pre-tax income. Another way of looking at it, by the way is, they would be paying one and a half months of their wages, pre-tax wages, just as a premium, not including deductibles, coinsurance, and uncovered services.

At 175 percent of poverty, that family would be paying almost $4,200 under the Cooper subsidy scheme, and it would be paying approximately 16 percent or two months of its pre-tax income just on premiums. Again, this doesn't include deductibles, coinsurance, and uncovered services.

At 200 percent of poverty, almost $30,000 in income for a family of four, they would be paying the full $5,565 or about 19 percent of their pre-tax income.

Now I assume that the Cooper benefit package is going to be less generous than the Clinton benefit package, but again, I can't tell you how much it is going to cost, so let's assume for a moment that the benefit package costs about $4,700 or 15 percent less than the Clinton plan. At 150 percent of poverty, a family would be paying 11 percent of their income on premiums or almost a month and a half of their income. At 175 percent of poverty, they would be spending 14 percent of their income, and at 200 percent of poverty, they would be spending two full months of their pre-tax income to pay for this premium.

I suggest to you that, unlike Mr. Cooper's assertions that he is providing subsidies and therefore those people below 200 percent of poverty are well taken care of and therefore he achieves rather close proximity to the Clinton plan in universal coverage is absolutely absurd, and my hope is that with regard to this committee, as you mark up a bill, whether you look at Cooper, Clinton, or some different piece of legislation, what I think we need to know is what will the actual burden be for families with the premiums they have to pay before you can make an assessment as to whether they will actually be covered.

[The prepared statement of Mr. Pollack follows:]

Ron Pollack
Executive Director
Families USA Foundation

Mr. Chairman and Members of the Committee:

Good morning. Thank you for allowing me to testify before you today. Families USA is a national nonprofit organization that represents consumers on health and long term care issues. The topic of this hearing today is on H.R. 3222, The Managed Competition Act of 1993. We believe that the current crisis state of Americans losing and lacking health care coverage can and must be fixed. We strongly support the President's goal, and his specific proposal, to achieve universal and comprehensive coverage for all Americans. I will focus my testimony today on why an employer mandate is the most effective and practical way to achieve universal coverage. I have attached to my testimony our most recent report which analyzes the impact of H.R. 3600, The Health Security Act and H.R. 3222, The Managed Competition Act of 1993, on ten American families. I hope you find it informative.

Is there a health care crisis?: Millions Are Losing Health Insurance

The goal of health care reform must be to assure every person in America that he or she will never lose his or her health insurance, no matter what. Attached is a copy of a report we released earlier this year that found that over 2.25 million people lose their health insurance each month. In the State of Michigan, for example, 76,000 people lose their health insurance each month. Most of the people who lose their coverage will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more. During this time, families are at grave financial risk if a member becomes sick or injured. Over the course of a year, nearly one out of every four Americans lose or lack health insurance for part of the year.

People lose their health insurance for a variety of reasons. Many people, for example, lose their coverage because they lose their jobs, their employer's policy is canceled, or they change jobs. While most of them regain coverage in the future, some never regain their coverage and others will be subject to limitations on coverage for pre-existing conditions.

American families with a member who has chronic a health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.

Achieving Universal Coverage

We believe that no one should lose or lack high-quality health care coverage. Health security must be assured for all Americans. Several alternatives to reform the health care system have been proposed by Members of Congress. They do not all reach the goal of universal coverage. Three basic approaches could result in universal coverage: an individual mandate, a single payer system, and an employer mandate.

Families USA has concluded that the best way to reach universal coverage is through an employer mandate. Compared to all other solutions, an employer mandate builds on our employer-based insurance system and would be the least disruptive. It would level the playing field among different employers, most of whom provide such coverage today. It would also eliminate the large, unpredictable and inequitable cost shifts that employers bear today for the uninsured workers of other employers. It is a practical and fair way to achieve our goal.

I would like to further explain why an employer mandate is the best solution for our current crisis.

The status quo

Today, most businesses provide insurance for their employees. Yet, small business owners, employees and their families encounter great difficulties obtaining affordable health insurance.

Small groups generally must pay ten to forty percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage because of medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status and high claims for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.

Tinkering will not solve the crisis.

Some Members argue that changing the rules by which businesses purchase coverage is sufficient reform. In 1992, we prepared a study of insurance market reforms that concluded that changes in insurance company rules, in isolation, would mean that many more businesses would see their premiums rise as would see their premiums go down. Market reforms only might result in increased access for some minority of people who are without coverage but the premiums for most businesses would continue to soar and even be exacerbated. The major problems of eliminating the extra costs for uncompensated care and out-of-control premiums would continue unabated for all businesses and millions of people would continue to lack coverage. While we agree that health care reform must change the rules by which insurance companies operate, insurance reform without comprehensive reform will not work.

Similarly, creating insurance pools, as some Members have suggested, which do not include a sufficient number and cross section of people, thereby resulting in higher premiums for people who are in the pool. If insurance pools only include the Medicaid population, self-selected, previously uninsured people and a small number of businesses that self-select to buy coverage, the pool will consist of the riskiest population only. This pool will not be large

enough to spread the financial risk and will result in higher premiums for those people in the pool.

Some Members have suggested that an employer mandate is not necessary to ensure coverage for low income people because government subsidies would be sufficient to help them purchase coverage. The amount of the subsidy will determine whether this population can afford the coverage. Under The Managed Competition Act of 1993, H.R. 3222, the subsidy scheme is woefully inadequate to ensure affordable coverage. To illustrate our concern, we took the average premium for the benefit package in H.R. 3600, which is $5,565, and applied the subsidies required in H.R. 3222. Under this scenario, a family of four whose income is 150% of poverty (using 1994 federal poverty guidelines) would have to pay 12.5% of their income for that plan. The same family at 175% of poverty would have to pay 16% and at 200% of poverty would pay 18.8% of income for premiums.

We also applied the subsidy structure in H.R. 3222 to a plan which costs $4,730. This figure, $4,730 ia an approximate premium for the low cost plan. We reached this amount by reducing the H.R. 3600 premium of $5,565 by 15%[1]. A family of four whose income is at 150% of poverty would have to pay 11% of their income for this low cost plan. The same family at 175% of poverty would have to pay 14% of their income toward premiums and the same family at 200% of poverty would pay 16% of their income for premiums. They also would have to pay more to cover their out-of-pocket expenses for copayments and services that are not covered by the plan. Since the services in H.R. 3222 are not specified in the bills, uncovered services could be a significant cost to families. The H.R. 3222 subsidy scheme leaves health health insurance unaffordable for lower income families.

Individual Mandate

One way, in theory, to reach the goal of universal coverage is the individual mandate. Under this scheme, all individuals, not employers, are required to purchase their own health insurance. Employers could be required to offer coverage, but would not be required to pay for any part of the premium.

But, can coverage under this scheme be affordable? In order to make coverage affordable for individuals significant subsidies would have to accompany such a mandate. We know that most businesses that do not provide coverage are small businesses, many with low-wage workers. Without employers contributing a portion of the premium cost, the entire burden becomes the individual's. These are the individuals that can least afford to pay the

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[1]This figure is based on a CBO analysis that group and staff model HMO can provide health care more efficiently than any other organizational forms and reduce personal health expenditures by 15%. *CBO Estimates of Health Care Proposals from the 102nd Congress, July 1993.*

entire premium for coverage. For example, a worker making $12,000 a year would have to pay a quarter to a third of his entire income for health insurance. Without an employer contribution, in order to make the coverage affordable, taxpayers will have to foot the entire cost of adequate subsidies.

Additionally, employers that now provide financial help for coverage may decide to drop their contribution if federal subsidies are available for individuals. This would, in turn, increase the total funds needed to make the individual mandate affordable.

Federal government costs would also increase as a result of increased administrative responsibilities. An individual mandate would necessitate an enlarged bureaucracy to keep track of each individual's coverage status.

Given the current budget constraints this country faces, an individual mandate would create a significant financial burden that the taxpayers and Congress are not likely to embrace.

Single Payer

A single payer, Canadian-style system has been touted by many as the most simple, straightforward approach to ensuring universal coverage. For Canadians to receive care, they must present their national card to doctors, who bill their provincial governments; the provinces fund hospitals directly under set budgets. All this is paid for from significant provincial and federal revenues collected from citizens and employers.

Clearly, the goal of providing health security for all Americans would be reached if this model were enacted in this country. The political, as opposed to the substantive, practicality of this approach, however, is questionable. The wholesale redistributional changes, as well as the need for unpopular tax increases makes the tax-financed option less politically viable.

Employer and Employee Mandate

It is clear that an employer mandate which requires all employers and employees to contribute toward their coverage is a fair and practical way to reach the goal of universal coverage.

The reasons we support an employer mandate are as follows:

• It is the alternative that is least disruptive to the current system. Since most employers now provide coverage, an employer mandate would help fill in the gaps for working families. It would not unravel a system that does work for many Americans.

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• It levels the playing field. Most employers are contributing toward their employees' coverage now. Additionally, many employers are paying for the coverage of working spouses whose employers do not want to pay their fair share. Employers who pay for coverage also foot the bill for uncompensated care of those people who are uninsured and who have jobs that do not provide coverage.

• It requires a smaller tax burden than either an individual mandate which leaves the whole burden of the cost on the individual and the taxpayers or the single payor model which requires massive changes in the collection and distribution of tax dollars.

• Recent polling seems to indicate that Americans are comfortable with building on the current employer-based system by imposing an employer mandate.

We recognize that some employers and employees will need subsidies to help meet their financial obligations. Small businesses and low-income individuals specifically will need such assistance. The federal government, we believe, should provide these subsidies, which would total far less than under an individual mandate.

A frequently heard criticism that is made of the employer mandate is that jobs will be lost if this system is imposed. Yet, under the President's health reform bill, significant subsidies are given to small businesses (and individuals) that will need financial assistance to meet their obligations. For the worker that makes $12,000, for example, the employer contribution equals a $.20 and hour increase. Increases in the minimum wage at even higher levels have never produced the doom and gloom scenarios of job loss that were predicted. Moreover, for the businesses that already pay for health care coverage, they will receive relief because they no longer will need to subsidize the costs of uncompensated care.

Conclusion

This year we must enact comprehensive health care reform that will guarantee that families will never lose their health insurance. The goal is within our reach. Requiring employers and employees to contribute to coverage can get us to that goal. We look forward to working with you as we complete this task.

PEOPLE WHO WILL LOSE THEIR INSURANCE

Over two million Americans lose their health insurance each month.[1] Most of these people will lack insurance for less than five months, yet a significant portion will lack insurance for six months or more.[2] During this time, families are at grave financial risk if a member becomes sick or injured.

Jerry and Donna Weldon live in Fenton, Missouri with their two young children. Jerry is a plumber and the family is covered through Jerry's union. Every three months, Jerry must work a minimum number of hours in order to qualify for health insurance coverage. Lately, work has been slow and the number of hours required by the union for health insurance will be increasing. The Weldons' eight-year-old son has leukemia and he had a bone marrow transplant this fall. After this procedure, he will need ongoing medical care and prescription drugs. The Weldons are worried that they will lose their insurance in the future because of Jerry's lack of work and the increasing number of required hours for insurance.

CLINTON:

The Weldons would always have the same comprehensive insurance, regardless of how much work Jerry gets.

As of 1998, the Clinton bill would guarantee that no American would lose their health insurance, regardless of any changes in health, employment or economic status.

Workers and their families would receive insurance coverage through their employment. Self-employed or unemployed people and their families would purchase coverage directly. Their insurance premiums would be fully tax deductible, instead of only 25 percent deductible as they are now. Discounts would help businesses and families afford their premiums.

Families would choose from a variety of health plans offered by regional health alliances where they live. Employees of firms with more than 5,000 employees could choose from at least three plans offered by their firm.

COOPER:

The Weldons would still have to worry about losing health insurance.

Under the Cooper bill, all individuals, families and small businesses that *choose* to purchase health insurance would do so through their local cooperative. Employers would choose to contribute or not contribute to their employees' health insurance premiums, as they do now.

Employees and their families could still lose their health insurance if they lost their job; if they changed jobs; if their employer could no longer afford the premiums; if they retired before age 65; and for a variety of other reasons.

Low-income families and individuals who choose to purchase insurance would be eligible for some financial assistance.

Families and individuals who purchase insurance on their own could deduct from their taxes the premium for the lowest-priced plan.

1. Families USA Foundation, *Losing Health Insurance* (Washington, D.C.: Families USA Foundation, 1993).

2. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.

CARE UNAVAILABLE FOR MEDICAID BENEFICIARIES

Low-income Americans face numerous barriers to medical care, even when they are covered by Medicaid, the government's health insurance program for low-income persons. Last year, almost one out of five adults receiving Medicaid were turned away by a hospital or a doctor. Another 20 percent had to go to an emergency room for care because they did not have a regular doctor.[1]

In late 1990, Sherri Wilburn of Blount County, Tennessee learned she was pregnant. Although she qualified for Medicaid coverage, neither Sherri nor a social worker at the local health department could find a doctor willing to provide Sherri with prenatal care. Sherri was finally able to schedule her first doctor visit for in her seventh month of pregnancy. Three days before her scheduled appointment to begin prenatal care, Sherri went into labor. Her daughter, Cassandra, suffered brain damage and was hospitalized for months. Cassandra will need special education and ongoing physical therapy. According to one of Cassandra's doctors, Sherri's pregnancy was "complicated by a lack of prenatal care."

CLINTON:

Sherri Wilburn would have her choice of any insurance plan offered in her region with an average premium or lower.

Under the Clinton bill, all Medicaid beneficiaries would have access to the same plans offered by the regional health alliances as everyone else.

For individuals like Sherri Wilburn who are eligible for Aid to Families with Dependent Children (AFDC) or individuals who receive Supplemental Security Income (SSI), the Medicaid program would make payments to the health alliances and allow beneficianes to choose among all health plans with premiums equal to or below the average.

Those who receive cash assistance would be responsible for very small copayments. They would continue to receive all mandatory Medicaid benefits and any optional benefits that the state chooses to provide that are not included in the comprehensive benefits package.

Sherri's daughter would be eligible for services through a new federal program for low-income children with special needs.

Persons currently receiving Medicaid, but not receiving cash assistance, would obtain their health insurance through their regional health alliance in the same manner as all other persons. Persons with incomes below 150 percent of poverty would be eligible for some assistance with their premium costs.

COOPER:

Sherri Wilburn would be fully subsidized for only the lowest-priced plan offered by her local purchasing cooperative.

Under the Cooper bill, Medicaid would be replaced. The funds would be used to pay the premium for the lowest-priced plan offered by the local purchasing cooperative for individuals and families with incomes under 100 percent of poverty.

All individuals and families with incomes between 100 and 200 percent of poverty would be eligible for some assistance with the cost of the premium for the lowest-priced plan, based on a sliding scale. All individuals and families with incomes under 200 percent of poverty would be responsible for only a portion of the difference in premiums between the lowest-priced plan and higher-priced plans and for reduced deductibles and copayments.

For those with incomes under 100 percent of poverty, the Cooper bill would cover prescription drugs, hearing aids and eye-glasses and other benefits currently covered by Medicaid and not included in the standard benefits package.

1. Kaiser Family Foundation, "News Release: New Survey Shows Significant Gaps in Medicaid Safety Net" (Menlo Park, CA: Kaiser Family Foundation, March 17, 1993).

INADEQUATE INSURANCE

*Millions of Americans have inadequate insurance that can leave them with thousands of dollars in medical bills. Such inadequate coverage is most common for families who buy non-group coverage and can only afford or qualify for very limited coverage with high deductibles, high copayments or limitations in benefits. Families USA estimates that 18 million Americans who have insurance are currently spending ten percent or more of their pretax income on out-of-pocket health expenses, **excluding** expenses for nursing home care, health insurance premiums, Medicare payroll taxes, federal, state and local taxes, and wages lost because of their employers' costs for health insurance.[1] Economists generally consider individuals to be underinsured if they are **at risk** of spending ten percent or more of their income on out-of-pocket health costs.[2]*

Susan and David Mast live in Wheaton, Maryland with their three young children. David Mast is a self-employed contractor. In 1992, his income was about $20,000. He paid $4,000 to purchase health insurance on his own for his family, but couldn't afford the extra $4,000 a year maternity coverage would have cost. Even then, the coverage wouldn't have been effective for one year. Their son, Joshua, was born in February 1992. Susan Mast worked two jobs as a proofreader and typesetter and took in babysitting and accounting work to pay off the $3,300 bill from that birth.

CLINTON:

The Mast family would have a choice of health insurance plans that provide comprehensive benefits, and would save about $2,000 a year in premium costs.

The Clinton bill specifies a comprehensive benefit package that would cover a full range of services.

The guaranteed national benefits have no lifetime limitations on coverage and would include: hospital services; emergency services; services of physicians and other health professionals; mental health and substance abuse services; family planning services; pregnancy-related services; hospice care; home health care; extended-care services; ambulance services; outpatient laboratory and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation services; durable medical equipment, prosthetic and orthotic devices; vision and hearing care; dental services; and health education classes.

A variety of preventive services would be available at no cost. Prescription drug, dental, vision and mental illness services would be more generous than many plans today.

No individual would have to spend more than $1,500 annually for covered services and no family would have to spend more than $3,000 annually.

Based on national average premiums, the Mast family would pay approximately $2,000 for health insurance, and that amount would be fully tax deductible.

COOPER:

Would not guarantee the Mast family comprehensive health benefits.

The Cooper bill would require all health plans to provide a uniform set of effective benefits, but the bill fails to specify what benefits would be covered within the broad categories of medically appropriate treatments, the full range of effective clinical preventive services and a full range of diagnostic services. The bill does not specify limits on the amount families would have to pay in deductibles and copayments. The bill leaves these decisions to a Health Care Standards Commission and then to the Congress.

The Heath Care Standards Commission and the Congress could review annually the uniform set of effective benefits. Thus, benefits could be modified or eliminated every year.

Because their family income is under 200 percent of poverty, the Mast family would be eligible for some assistance to cover the cost of their premium. Given their income, the Masts would have to pay about 19 percent of the premium for the lowest-priced plan, and that amount would be tax deductible.

Since the Cooper bill does not specify a benefit package, it is impossible to determine the amount the Mast family would have to pay for premiums, deductibles, copayments and uncovered services.

1. Families USA Foundation, *Half of Us: Families Priced Out of Health Protection* (Washington, D.C.: Families USA Foundation, 1993).

2. Pamela J. Farley, "Who Are the Underinsured?" *Milbank Memorial Fund Quarterly/Health and Society* vol. 63, no. 63, (1985), pp. 477-501.

HIGH PRESCRIPTION DRUG COSTS

An estimated 72 million Americans currently lack health insurance for prescription drugs.[1] Medicare does not cover outpatient prescription drug costs. Elderly persons take more prescriptions, on average, than younger people and have higher drug costs, but less than half (49%) of all elderly Americans have prescription drug coverage.[2] As a result, elderly persons pay almost two-thirds (64%) of their prescription drug costs out of pocket.[3]

Iona O'Neill is an 83-year-old resident of Spring Hill, Florida. Iona's income from Social Security is less than $700 per month. She has no insurance covering prescription drug costs. Iona suffered bladder cancer and now spends $300 per month on medicine. Her income is too high, however, to qualify for any public assistance with prescription drug costs.

CLINTON:

Iona O'Neill would not have to pay more than $1,132 a year for prescription drugs.

As of January 1, 1996 under the Clinton bill, Medicare beneficiaries would be eligible for a new outpatient prescription drug benefit.

After an annual deductible of $250 per person, Medicare beneficiaries would pay only 20 percent of prescription drug costs up to an annual maximum of $1,000 (including the deductible). After reaching that maximum, Medicare would cover all drug costs. The benefit would be part of Medicare Part B. Medicare beneficianes pay Part B premiums that cover 25 percent of Part B costs. The additional Part B premium for the prescription drug benefit would be approximately $11 per month. After 1996, the deductible and out-of-pocket maximum would increase only for inflation.

Those Medicare beneficiaries who purchase Medigap insurance will also benefit from this new coverage. Three of the ten Medigap policies on the market today have prescription drug coverage. The most generous prescription coverage available through Medigap has a $250 deductible, 50 percent coinsurance and a $3,000 maximum annual benefit. Medicare beneficianes who purchase Medigap insurance with some prescription drug coverage will be able to save money by purchasing policies without this coverage *and* see their benefits improve.

All Americans under age 65 also would have coverage for prescription drug costs as of 1998 under the Clinton bill. Under the lower cost-sharing plan, individuals and families would pay only $5.00 per prescription. Under the higher cost-sharing plan, after meeting a $250 deductible per person, individuals and families would pay only 20 percent of prescription drug costs. If an individual's health costs exceeded $1,500 or a family's costs exceeded $3,000 in a year, they would no longer have to make any additional payments for prescription drugs.

COOPER:

Iona O'Neill would still have to spend $3,600 or more a year for prescription drugs.

The Cooper bill would not expand Medicare coverage to include prescription drugs.

For those under age 65, the Cooper bill does not require coverage of all prescription drug costs. A Health Care Standards Commission would define, and the Congress would approve, a uniform set of effective benefits that provide medically appropriate treatment. As part of the uniform set of effective benefits, the Commission also would specify the level of deductibles and copayments.

The uniform set of benefits could be reviewed annually by the Health Care Standards Commission and the Congress. Thus, benefits could be modified or eliminated every year.

The Cooper bill would cover prescription drugs for persons with incomes under 100 percent of poverty.

1. John Rother, "Statement of the American Association of Retired Persons on the Health Care Crisis in America: A Growing Threat to Economic Security," Testimony before the Joint Economic Committee, U.S. Congress (Washington, D.C.: AARP, September 15, 1993).

2. American Association of Retired Persons Public Policy Institute, "Older Americans and Prescription Drugs: Utilization, Expenditures and Coverage," *Issue Brief Number Nine* (Washington, D.C.: AARP, September 1991).

3. Families USA Foundation, *Prescription Costs: America's Other Drug Crisis* (Washington, D.C.: Families USA Foundation, 1992).

EARLY RETIREES LOSING HEALTH BENEFITS

One-third (32%) of all retirees who have health insurance coverage through their former employers are under age 65.[1] In light of skyrocketing health care costs and new accounting rules requiring employers to report this liability, companies are cutting health benefits for current and future retirees. A recent major survey of larger corporations found that 12 percent of companies responding have eliminated or plan to eliminate all retiree health benefits. Another 56 percent have reduced or plan to reduce health benefits covered.[2]

Kazimer "Casey" Patelski and his wife Bonnie live in Costa Mesa, California. Casey was a design engineer for McDonnell Douglas for 28 years. He helped design various aircraft, missiles, satellites and the Skylab Space Station. Casey, who suffered from polio as a young man, turned down numerous job offers from other companies over the years because of the generous retirement benefits, including health insurance, promised by McDonnell Douglas. When Casey retired at age 63, he was assured that he and Bonnie would have health insurance coverage for the rest of their lives. A year later, McDonnell Douglas announced that it was eliminating health insurance benefits for all retirees. Current retirees, like the Patelskis, were allowed to purchase health insurance coverage with their pension funds.

CLINTON:

The federal government would pay 80 percent of the Patelskis' health insurance premiums until Mr. Patelski was eligible for Medicare.

The Clinton bill would provide early retirees and their families with guaranteed health coverage. Under this bill, the federal government would pay 80 percent of premiums for retirees between the ages of 55 and 65. For retirees whose previous employers currently pay retiree health costs, their employers would now pay the retirees' share of premiums (20 percent).

COOPER:

The Patelskis would still have to pay 100 percent of their health insurance premiums.

The Cooper bill would provide no federal assistance for early retirees who are not yet eligible for Medicare, or their families.

If the Patelskis choose to buy insurance, under this bill they would buy that insurance through their local purchasing cooperative.

Their premiums would probably be less than if they had to buy insurance on their own, but they could pay higher premiums than others in the purchasing cooperative because of their age.

1. Steven DiCarlo, Jon Gabel, Gregory de Lissovoy and Judith Kasper, *Research Bulletin: Facing Up to Postretirement Health Benefits* (Washington, D.C.: Heath Insurance Association of America, 1989).

2. Hewitt Associates, *FASB Retiree Health Accounting* (Lincolnshire, IL: Hewitt Associates, October 1993).

JOB LOCK

American families with a member who has a chronic health condition can easily find themselves in the position of being unable to change jobs because the family is dependent on the health insurance obtained through one family member's job. One in five (19%) workers report that they or a family member are locked in their jobs because new work offers limited or no health insurance.[1]

Melanie and Randy Wood live in Houston, Texas with their three children. After her third child was born, Melanie intended to leave her job to become a full-time mother. At the time, the family had health insurance coverage through Melanie's job. Jordan, now ten, was born with Sturge-Weber syndrome, a congenital neurological disorder. Jordan also has hydrocephalus and needs a shunt to drain excess fluid from his brain. Melanie started calling insurance companies immediately after Jordan's birth and found that Jordan was uninsurable. Since Randy is self-employed, Melanie was forced to return to work in order to keep health insurance for her family.

CLINTON:

Melanie Wood could become a full-time mother and the Wood family would have a choice of health insurance plans for the same premium as everyone else, approximately $2,000 a year.

The Clinton bill would eliminate job lock because it guarantees all Americans affordable, comprehensive health coverage.

As of 1998, all employers would contribute 80 percent of average premium costs for health insurance for workers and their families, or more if they choose. As a result, workers would no longer have to choose between jobs that offer health benefits and those that do not.

This insurance would be affordable for small businesses and individuals because low-wage businesses and individuals would be eligible for discounts on premiums; because no business or self-employed individual would have to spend more than 7.9 percent of their payroll on premiums; and because premiums could increase no faster than inflation by the end of the decade.

Immediately upon enactment, the Clinton bill would prohibit insurers from excluding pre-existing conditions for individuals and their families who were insured within the previous 90-day period. For individuals and their families who were not previously insured, insurers could limit coverage for pre-existing conditions for no more than six months. This bill also would require insurers to accept immediately all newly-hired, full-time employees and their families added to groups currently insured. By 1998, this bill would prohibit exclusions for pre-existing conditions under any circumstances.

If Melanie Wood stayed home with her children, the Wood family would purchase their insurance through their regional health alliance and have the same choices as everyone else in the region. They would be eligible for significant discounts on their premiums based on their income. Based on national average premiums, the Wood family would pay approximately $2,000 a year for comprehensive health insurance. Since Randy Wood is self-employed, that amount would be fully tax deductible.

COOPER:

If Melanie Wood became a full-time mother, the family could purchase insurance and would be eligible for assistance with premium costs, but there is no way of knowing what benefits their premiums would cover and what out-of-pocket expenses they would have. This bill would not eliminate job lock for workers who wish to change from a job with health benefits to a job that does not have health benefits.

The Cooper bill would not eliminate job lock. Since employer contributions to health insurance would remain voluntary, most employers who do not contribute to health insurance now would not in the future. Thus, workers would still have to choose between jobs that offer health insurance benefits and those that do not.

Individuals and small businesses could purchase insurance through their local purchasing cooperative. The premium cost would be tax deductible, but only up to the cost of the lowest-priced plan. Insurance premiums would vary by age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible. For individuals and families who lacked insurance coverage for three months, insurers could limit coverage for six months for any pre-existing condition that appeared in the last three months.

The Cooper bill would not limit the amount insurance premiums could increase each year. It would not provide any discounts to small businesses or self-employed persons, or limit the percentage of payroll they could spend on premiums.

Under this bill, individuals and families with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced and higher-priced plans. Individuals and families with incomes between 100 and 200 percent of poverty would pay a percentage of the premium equal to the percentage their income is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since Randy Wood is self-employed, the Woods could purchase insurance through their local purchasing cooperative. Since the Woods' income from Randy's business is 19 percent above the poverty line, the Woods would pay about 19 percent of the premium of the lowest-priced plan. Since Randy Wood is self-employed, this cost would be tax deductible. Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Woods would have to pay for premiums, deductibles, copayments and uncovered services.

1. Henry J. Kaiser Family Foundation and Louis Harris and Associates. "News Release: One in Five American Families Victim of 'Job Lock.' High Cost and Lack of Insurance Top Reasons" (Menlo Park, CA: Kaiser Family Foundation, October 15, 1993).

SMALL BUSINESS OWNERS AND THEIR FAMILIES

Small business owners, employees and their families encounter great difficulties obtaining affordable health insurance. Small groups generally must pay ten to 40 percent more for health insurance than large groups. Those who would purchase health insurance as individuals or as part of a small business group face another formidable barrier to health coverage—medical underwriting practices. Medical underwriting is the process by which an insurer evaluates the health history and the potential for poor health status, and high claims, for an individual or group. Based on current underwriting practices, approximately 15 percent of all small businesses are ineligible for insurance or eligible only for restricted coverage.[1]

Ann and Hubert Maddux live in Corpus Christi, Texas with their four-year-old daughter and infant son. Hubert runs a tackle shop and makes approximately $25,000 a year. As a small business owner, the best insurance Hubert could get for himself and his family was through his alma mater in 1986. At that time his premiums were $1,000 a year. After their daughter was born with Downs Syndrome and serious heart defects, the Maddux family's premiums increased to $17,000 annually. For the last two years, the Madduxes have cut back on their insurance coverage because of the high costs. As of January 1994, the Madduxes pay $8,520 a year for their insurance. But the policy requires a $5,000 deductible per person, and payment of half of the first $10,000 in covered expenses per person. Both children need prescription drugs which the family's insurance does not cover. Medicine for the children costs the family between $100 and $200 per month.

CLINTON:

The Maddux family would save about $5,700 on health insurance premiums and would have a choice of plans that provide comprehensive benefits. They would have to spend no more than $3,000 out of pocket annually for their family's health care.

Under the Clinton bill, most Americans would obtain their insurance through consumer-controlled regional health alliances. This pooling of individuals and businesses would result in lower premiums for those who previously purchased insurance alone as small businesses or individuals. The Maddux family would pay the same premium as all others under age 65 purchasing insurance through the alliance.

Small businesses and individuals would no longer see their premiums skyrocket from year to year. This bill would limit the amount by which insurance companies can raise premiums each year so that, by the end of the decade, premiums would go up no faster than inflation.

Insurers would no longer be able to set the premiums for small businesses on the basis of that group alone. Instead, premiums would be based on health costs for the entire region. Insurers would no longer be able to reject businesses or individuals for any reason.

Small businesses would be eligible for significant federal discounts on premiums. No business would have to spend more than 7.9 percent of its payroll for health insurance costs. Businesses with 75 or fewer employees would pay less if their average wages are $24,000 or less. The lowest wage small businesses would pay only 3.5 percent of payroll.

Many small business owners would pay less to cover themselves, their families and their employees than they now pay just to cover themselves and their families. Based on national average premiums, the Maddux family, for example, would pay no more than about $2,800 for health insurance premiums. This amount would be fully tax deductible. The amount the Madduxes currently pay for health insurance would cover the cost for the Maddux family and two additional families under the Clinton bill.

COOPER:

The amount the Maddux family would pay for premiums and the coverage they would have, including deductibles and copayments, are unknown.

Under the Cooper bill, the Maddux family and other small businesses and individuals who choose to purchase health insurance would purchase it through their local purchasing cooperative. Since not all small businesses and individuals would choose to purchase insurance, the purchasing cooperatives would not pool as much risk or have as much negotiating power as if all small businesses and individuals had to purchase insurance through the cooperative.

The Maddux family's premiums would differ from others who purchase insurance through the cooperative based on their age. Any plan that denied coverage to any person, family or group because of one person's health condition would not be tax deductible.

This bill does not specify the standard benefits, or the deductibles and copayments.

Small businesses and families could deduct the cost of their health insurance premiums, up to the cost of the lowest-priced plan, and only for the benefits included in the unspecified uniform set of benefits. Small businesses would not receive any discounts on premiums for low-wage workers, nor would there be a cap on the percentage of payroll spent for premiums.

There are no limits on the amount premiums could increase each year.

Since this bill provides no subsidies for small businesses, small business owners and their families would be eligible only for individual subsidies. Families and individuals with incomes under 100 percent of poverty would be fully subsidized for the cost of the lowest-priced plan and would pay ten percent of the difference between the cost of the lowest-priced plan and higher-priced plans. Families and individuals with incomes between 100 percent and 200 percent of poverty would pay the percentage of their income that is above the poverty line for the lowest-priced plan and that same percentage of the difference between the cost of the lowest-priced plan and higher-priced plans.

Since the Maddux family's income is 74 percent above the poverty line, they would pay 74 percent of the cost of the premium for the lowest-priced plan. This amount would be tax deductible.

Since the Cooper bill does not specify a standard benefits package, it is impossible to determine the amount the Maddux family would pay for premiums, deductibles, copayments and uncovered services.

1. Wendy Zellers, Catherine McLaughlin and Kevin Frick, "Small Business Health Insurance: Only The Healthy Need Apply," *Health Affairs* vol. 11, no. 1, (Spring 1992), pp. 174-180.

LONG TERM CARE AT HOME

At any given time, there are an estimated three and one-half million Americans who have great difficulty taking care of themselves. These persons require assistance with three or more of the five most basic activities of daily living—eating, bathing, toileting, dressing and getting out of a bed or chair. The services that they need are largely non-medical in nature and, as a result, options for financial assistance or insurance coverage are very limited. Approximately half of these Americans currently do not receive any paid home care services.[1]

Roz and Harold Barkowitz live in North Miami Beach, Florida. Harold is a 72- year-old retired shoemaker who had to give up his business six years ago to care for Roz, age 67, who has multiple sclerosis. They had to sell their house and move into an apartment because Roz could no longer climb the stairs. They get no outside assistance caring for Roz, only someone who comes to clean once a week. Harold's greatest fear is that something will happen to him and he will no longer be able to care for Roz. He currently spends 24 hours a day taking care of her.

CLINTON:

Mr. and Mrs. Barkowitz would be eligible for services to assist Mr. Barkowitz with caring for his wife. The new program would ensure such care is affordable.

The Clinton bill establishes a major new program to provide services to individuals with severe disabilities without regard to age. Beginning in 1996, the federal government would provide significant new funds for states to develop plans of care for, and provide services to, persons with severe disabilities.

These persons would be eligible for services that include personal assistance and a wide variety of other services that would help them continue to live in their homes and community. This new program would be fully phased in by the year 2003. Individuals would be responsible for modest copayments based on income.

COOPER:

The Barkowitzes would receive no assistance.

The Cooper bill does not provide families any new assistance with providing long term care at home.

Under this bill, states would become entirely responsible for long term care expenses currently financed jointly by the federal government and states through the Medicaid program. Thus, fewer services could be available than currently.

1. Data provided by Lewin-VHI, Inc. This estimate includes persons with physical disabilities only. Due to limitations in the data, it does not include persons with cognitive impairments.

EMPLOYEES VULNERABLE TO ARBITRARY LIMITS ON BENEFITS

Approximately 40 percent of all employees and their families are covered by employer health plans that are self-insured.[1] Self-insured companies do not purchase health insurance from a private insurance company. Instead, they pay the cost of their employees' medical care directly. The U.S. Supreme Court recently ruled that self-insured employers may limit or eliminate health insurance benefits at any time, even after an employee or a family member contracts a serious illness.

John and Joan Cleveland of St. Louis, Missouri had health insurance through Joan's employer, a company that is self-insured. John was diagnosed with leukemia in September 1990, and he needed a bone marrow transplant. Even though his insurance had a $500,000 lifetime maximum, the policy capped coverage of organ and tissue transplants at $75,000. John's transplant cost about $250,000. John died of complications from his transplant in June 1993.

CLINTON:

John and Joan Cleveland would have had to pay no more than $3,000 out of pocket for John's medical care in the year that he had his bone marrow transplant.

The Clinton bill would prohibit all employers and insurers from imposing caps or exclusions on coverage for specific medical conditions or any lifetime limit on benefits for covered services. The bill would require all businesses, whether they pay for their employees through a regional health alliance or through their own corporate alliance, to provide the comprehensive benefits specified by federal law. John Cleveland's bone marrow transplant would have been covered.

COOPER:

Joan Cleveland's employer could not impose arbitrary limits on the Clevelands' health benefits, but it is impossible to know if John's bone marrow transplant would have been covered. It is impossible to determine the amount the Clevelands would have had to pay out of pocket for John's medical care.

The Cooper bill would prohibit all employers who provide insurance, either through a purchasing cooperative or on their own, from limiting any benefits in the uniform set of benefits.

The bill, however, does not specify the uniform set of effective benefits within the broad categories of medically appropriate treatments, clinical preventive services and diagnostic services. The bill also does not specify the amount families would have to pay in deductibles and copayments. The uniform set of benefits could include limits on benefits for specific treatments or diseases. The bill leaves these decisions to a Health Care Standards Commission and then to the Congress.

The Health Care Standards Commission and the Congress could review annually the uniform set of benefits. Thus, benefits could be modified or eliminated every year.

1. Cynthia B. Sullivan, Marianne Miller, Roger Feldman and Bryan Dowd, "Employer-Sponsored Health Insurance in 1991," *Health Affairs* vol. 11, no. 4, (Winter 1992), pp. 172-185.

EMPLOYERS WITH SKYROCKETING PREMIUMS

The amount American families and businesses are charged for health care has far outpaced increases in family income and business profits. Today, business spending for health care nearly equals the amount corporations make in after-tax profits. By contrast, in 1980, business health care spending amounted to 41 percent of corporations' after-tax profits.[1] If health care inflation had been held to the same rate of inflation as the rest of the economy from 1980 to 1992, health care costs for businesses today would be one-third less than they are. This difference averages about $1,000 per worker.[2]

Roger Flaherty owns a small company, Floor Covering Resources, in Kensington, Maryland. He has two employees, and they are covered by a small group health insurance plan. Both employees have ongoing health problems. In 1987 Roger paid $285 a month to cover these employees. In November 1993, his premiums increased to $885 a month. The business pays the full cost of the insurance. Roger is committed to providing health insurance for his employees, but doesn't know if he can continue to afford it.

CLINTON:

Mr. Flaherty would see his health insurance premiums for his employees go up no faster than inflation by 1999.

The Clinton bill would limit the amount by which all insurance companies could raise premiums. By 1999, American families would no longer have to swallow health insurance premium increases that are larger than general inflation. American families would see larger wage increases and more disposable income and businesses would see less of their profits eaten up by health cost increases and have more money to invest and to create new jobs.

COOPER:

Mr. Flaherty and other employers would see their health insurance premiums continue to climb uncontrollably.

The Cooper bill does not limit the amount health insurance premiums could increase annually. Mr. Flaherty's expenses could continue to increase far faster than inflation. Employers and workers would not be protected from the devastating economic effects of rapidly rising health insurance premiums.

1. Cathy A. Cowan and Patricia A. McDonnell, "Business, Households and Governments — Health Spending 1991," *Health Care Financing Review* vol. 14, no. 3, (Spring 1993), pp. 227-248.

2. Service Employees International Union, *Out of Control, Into Decline: The Devastating 12-Year Impact of Healthcare Costs on Worker Wages, Corporate Profits and Government Budgets* (Washington, D.C.: SEIU, October 1992).

Losing Health Insurance

Every month more than two million Americans lose their health insurance, and millions more lie awake at night worrying that they might be next. During any period of time Americans must go without health insurance, they are in a position similar to skidding on an icy mountain road. It may be over quickly. They will probably survive it, but their family may go over the cliff.

Tom L. suffered a heart attack while he was between jobs. His surgery left him with a $25,000 bill to pay out-of-pocket.

Kathleen and Don N. lost their health insurance when Don lost his job. Shortly thereafter, Kathleen was diagnosed with cancer. To pay for her cancer treatment, they ultimately had to sell their house and move to a small apartment.

This Families USA special report presents the first state-by-state estimates of the number of Americans who each month lose their health insurance and the peace of mind that they will able to take care of their families' health care needs.

- Nationally, 2.25 million Americans a month lose their health insurance.

- The following states have the largest numbers of persons who lose their insurance each month:

California (306,000)	Michigan (76,000)
Texas (173,000)	North Carolina (64,000)
New York (130,000)	Georgia (62,000)
Florida (113,000)	Virginia (55,000)
Illinois (90,000)	Louisiana (51,000)
Ohio (89,000)	Massachusetts (50,000)
Pennsylvania (89,000)	

Why Do Americans Lose Their Health Insurance?

Americans lose their health insurance each month for a variety of reasons. Many are laid off from their jobs or have a spouse or parent who is laid off. They either cannot afford to continue paying their full health insurance premiums on their own, or are no longer eligible to do so.

Ms. H. is a laid off computer technician. To continue paying for health insurance for herself and two children would have cost her $500 a month which, without a job, she could not afford.

Other Americans lose their health insurance when they change jobs. This can happen because many jobs require a waiting period before new employees are eligible for health benefits.

Mrs. S.'s husband recently lost his job at AT&T. They cannot afford the $464 a month it would cost to maintain their health insurance through AT&T. Mrs. S. is a nurse and can only get insurance through the hospital for which she works beginning January 1, 1994. Mrs. S. has had meningitis twice and is afraid that, if it recurs during the period when they are without insurance, her family will be destroyed financially.

Often new coverage excludes preexisting health conditions, leaving individuals unprotected for those health problems for which they are most likely to need health insurance.

Larry P. injured his knee at home and required surgery to remove bone fragments and almost

all of the cartilage in his knee. When he left his job that required heavy lifting and took a new job at a video store, his new health insurance did not cover his knee.

Many Americans who are self-employed or work in small businesses lose their insurance when they can no longer afford the high premiums insurance companies charge individuals and small groups.

***Patricia P.**, a self-employed office worker, was paying $9,000 a year for a major medical policy with a $1,000 deductible. This policy was her largest single expense, more than her mortgage. She had to drop her coverage.*

Mrs. A. and her husband run a plumbing business. They had to drop their insurance when premiums increased from $350 a month to $550 a month.

Americans lose their health insurance when insurance companies take advantage of fine print to cancel coverage for those who need insurance the most—those who develop a serious health condition.

Dr. S. is a dentist. For 15 years he paid premiums for himself and his family. When he developed cancer, the insurance company first raised his premium from $2,650 to $10,000 a year, and then canceled the policy.

***Jean and Tom M.** own a small grocery store in rural Tennessee. For eight years they paid their health insurance premiums. When Tom developed cancer, the insurance company canceled his policy because "they were no longer profitable.*

In other cases, insurance companies raise health insurance premiums for those with a serious health problem to the point where the insurance becomes unaffordable for individuals and for entire groups.

Mrs. B. needed angioplasty. Six months later her health insurance premiums went from $215 a month to $1,700. She had to drop her coverage.

Sometimes individuals lose their health insurance when insurance companies go bankrupt.

***Nancy and Marshall M.** paid $500 a month for their insurance coverage, which had been recommended by Marshall's professional organization. In January of 1991, they had twins and one needed neonatal care because of a heart problem. Their insurance company was insolvent and did not pay their $100,000 bill. They now have a collection agency breathing down their necks.*

Among the Americans most likely to lose their health insurance are those who have graduated from college and are no longer eligible for coverage through their parents' policies.

Anna P. graduated from college in 1990. She came from Los Angeles to Washington D.C. to find a job. She was covered by her mother's policy until she turned 25. Now she has two jobs, neither of which offers health insurance. Her husband's job provides insurance that covers him, but it would cost them $300 a month to cover her. As a young family, they cannot afford that expense.

Number of Persons Losing Health Insurance Each Month By State, 1993

State	Average Number of Persons Losing Health Insurance Each Month
United States	2,255,000
Alabama	36,000
Alaska	6,000
Arizona	41,000
Arkansas	30,000
California	306,000
Colorado	41,000
Connecticut	23,000
Delaware	6,000
District of Columbia	6,000
Florida	113,000
Georgia	62,000
Hawaii	11,000
Idaho	13,000
Illinois	90,000
Indiana	44,000
Iowa	23,000
Kansas	20,000
Kentucky	32,000
Louisiana	51,000
Maine	11,000
Maryland	43,000
Massachusetts	50,000
Michigan	76,000
Minnesota	36,000
Mississippi	28,000
Missouri	43,000
Montana	12,000
Nebraska	14,000
Nevada	15,000
New Hampshire	9,000
New Jersey	46,000
New Mexico	21,000
New York	130,000
North Carolina	64,000
North Dakota	6,000
Ohio	89,000
Oklahoma	32,000
Oregon	27,000
Pennsylvania	89,000
Rhode Island	8,000
South Carolina	33,000
South Dakota	6,000
Tennessee	45,000
Texas	173,000
Utah	24,000
Vermont	5,000
Virginia	55,000
Washington	49,000
West Virginia	18,000
Wisconsin	36,000
Wyoming	6,000

SOURCE: Lewin-VHI estimates based on the 1990 Survey of Income and Program Participation, the 1987 National Medical Expenditure Survey and four years of pooled March Current Population Survey data.

Estimating the Number of Americans Losing Health Insurance

The estimates in this special report are based primarily on data from the 1990 Survey of Income and Program Participation (SIPP). The SIPP was conducted by the Bureau of the Census and contains the most extensive information to date about families' health insurance coverage on a month-by-month basis. The 65,369 persons interviewed as part of the SIPP represent the civilian, non-institutionalized population of the United States.

In order to update the estimates from the 1990 SIPP to 1993, Bureau of the Census estimates of the change in the population from 1990 to 1993 were used.

The state-by-state estimates are based on state-level estimates of the distribution of persons with health insurance for part of the year. These state-level estimates are based on a dataset that matched four years of the most recent March Current Population Survey (CPS) data to data from the 1987 National Medical Expenditure Survey (NMES). Due to the sampling frame and size of the pooled samples, the CPS data allow for state-level estimates.

The SIPP data allow examination of the number of persons losing health insurance of any kind, including private, Medicaid and other public insurance. Approximately 79 percent of all persons who lose their insurance were covered previously by private insurance.

Who Loses Health Insurance?

This special report focuses on the more than two million Americans who lose their health insurance each month. These Americans are likely to be without insurance for less than a year and have some distinctive demographic characteristics.

Based on data collected 1983 to 1986, half (48%) of those who lost insurance lacked health insurance for five months or less; 16 percent lacked insurance for six to nine months; and eight percent lacked health insurance for 10 to 13 months.[1]

Based on 1987 data, 29 percent of those who lacked health insurance for part of the year lacked insurance for four months or less. Another 39 percent of those who lacked health insurance for part of the year lacked insurance for five to eight months. For those having private insurance for part of the year in 1987, one-third (34%) lacked insurance for four months or less. Another 38 percent of those who lost their private health insurance for part of the year lacked insurance for five to eight months.[2]

Based on the 1990 SIPP data, Americans who lose their health insurance have some distinctive demographic characteristics. Over one-third (36%) were full-time workers in the month before losing their insurance; almost one-third (30%) had family incomes of $30,000 or more; and over one-fourth (27%) had at least some college education. Almost one-third (29%) of those who lost their insurance were under age 18. Sixteen percent of those who lost their insurance worked in professional and related services and 14 percent worked in manufacturing in the month prior to losing their insurance. These demographic groups are more highly represented among those who lost their insurance at some point during the year than among those who lacked insurance for the entire year.[3]

Other research has focussed on the demographic characteristics of those who lose their health insurance and are likely to experience relatively short periods without health insurance. This research shows that those who lose their health insurance for relatively short periods of time have the following characteristics immediately before losing their health insurance: annual family income above $29,500; a high school diploma or higher educational level; and employment in a number of industrial sectors (manufacturing, trade, utilities, finance/ insurance/real estate, business services and professional services). Other characteristics of those who lose their health insurance for relatively short periods are: working full-time in the month prior to losing insurance and in the month of losing insurance; being between the ages of 18 and 24; living in the Northeast; and being married.[4]

Conclusion

More than two million Americans lose their health insurance each month. These Americans are likely to lack insurance for significantly less than a year. But, as many Americans have experienced, a period without health insurance, no matter how brief, can lead to financial catastrophe.

Americans who lose their health insurance suffer long-term consequences. When they gain new insurance coverage, that coverage is likely to exclude coverage for preexisting health conditions, the very conditions for which they are most likely to need insurance.

Endnotes

1. Katherine Swartz, John Marcotte and Timothy McBride, "Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells Are Included," *Inquiry* vol. 30, (Spring 1993), pp. 77-83.

2. Kathleen Short, *Health Insurance Coverage: 1987-1990*, U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Household Economic Studies, Series P-70, n. 29, (Washington, D.C.: Government Printing Office, 1992).

3. Lewin-VHI analysis of the 1990 Survey of Income and Program Participation.

4. Katherine Swartz, John Marcotte and Timothy McBride, "Personal Characteristics and Spells Without Health Insurance," *Inquiry* vol. 30, (Spring 1993), pp. 64-68.

Mr. MARTINEZ. Thank you, Mr. Pollack. Did I say that right?

Mr. POLLACK. That is all right.

Mr. MARTINEZ. Let me ask this question since you almost ended up with it. Under the Cooper bill, Congress would vote on a standard package. If it is a comprehensive benefit package, the cost to the government in subsidies is going to be very high, and we are either going to have to raise taxes or cut programs to pay for it.

If we choose a bare bones benefit package, we are going to inflict the biggest tax increase on the American middle class that this country has ever seen. Isn't the Cooper bill designed so that Americans will have to choose between higher taxes or less health care or some combination of the two?

Mr. POLLACK. No, there is no question about this. The Cooper bill, as the Chafee bill does, they really raise questions about the strengths and weaknesses of an individual-based system or an employer-based system.

Now I believe, frankly, that from an academic standpoint you can have either an individual-based system or an employer-based system and have it work, but there are some consequences that flow from that, and clearly the consequence that you are raising is one that I think has not received enough attention, namely, that if you have an individual-based system, as the Cooper plan does and the Chafee plan does, then if we are going to really achieve universal coverage, we are going to have to stand up to the plate and say we are going to have to provide adequate subsidies to make it affordable, and that is going to mean that we are going to have to raise additional revenues or we are going to have to strip the benefit package to a bare bones plan which is going to force people, maybe not paying that much in a premium, but they are going to get hit in the back end once they get sick.

So you are absolutely right that with an individual-based system we are either going to have to face up to our additional responsibilities on additional revenues or we are going to have a much lower benefit package.

Mr. MARTINEZ. Would anyone else care to respond to that?

Ms. MOON. Could I add to that, that one of the interesting things about the subsidy is that the subsidy will be less expensive to the government and will seem to be less expensive to these moderate income families if it is a more basic package, as Ron was indicating. But the problem there is that then if that means that people have a lot of uncovered services and high deductibles, then they have to pay 100 percent of the costs of that and not even get a minimal subsidy. So it has a double whammy on the moderate income individuals as well as meaning higher tax increases for middle income folks.

The other element of this, I think, that also needs to be thought about in terms of thinking about an incremental approach with subsidies for low-income individuals is the fact that over time, unless health care spending comes down really fast, incomes will not rise, particularly for these moderate-income families, nearly as fast as health care costs, and even if you set next year subsidies that would be sufficient to allow them to afford insurance, in two or three years they would not be affordable any longer, and so you will have an increased problem of rising uninsurance over time un-

less you have that target goal of the subsidies also rising and becoming more expensive.

Mr. MARTINEZ. Thank you.

Anybody else?

Mr. KENDALL. Could I just say two things?

Mr. MARTINEZ. Mr. Kendall.

Mr. KENDALL. Thank you.

First about the benefit package, in the Cooper bill, the benefits package is determined by the health standards commission that is appointed by the President. If this bill were to pass this year, the people appointed would be appointed by the President in office today, President Clinton. There is no reason to believe that they would support anything other than something very similar to what the President has already proposed in a benefits package.

So I think this debate over what level the benefit package is relatively moot, because the supporters of managed competition believe in a comprehensive benefits package, not something that is more of a bare bones type.

The second point on benefit package design is that the CBO, when they estimated the bill last year, assumed a benefits package that was just as generous as what the Clinton bill is proposing this year.

The second point I would like to make about the issue of costs and how we have all these trade-offs: It is very easy to forget as we are looking at the question of an employer mandate which many people have been advocating—the President has been advocating to get to universal coverage—employers aren't stupid, if they get a mandate to cover 80 percent of the costs that they are currently not covering, they are going to try to find a way to reduce their employees' wages, and I know that part of the equation has not been fully fleshed out in the debate, and certainly there would be a difference for minimum wage workers which we has to be taken into account. But for most workers who are above the minimum wage, we would have a situation in which there would be a reduction in wages for those workers under an employer mandate.

Mr. MARTINEZ. Well, let me ask you this. There are people who have said that the Cooper bill is potentially the biggest middle class tax increase in history, and maybe I should ask IBM, but if IBM decides to continue to pay for the generous benefits that you described in your testimony that it now provides for its employees and retirees and is taxed on the difference between the cost of those plans and the cost of the lowest cost plan that is available in your area as was described by Mr. Cooper, the lowest cost plan in the area, how much additional taxes will IBM and its employees have to pay?

Mr. TARRE. We have looked at that, and we have developed a number of models and some assumptions based on what the minimum plan would cover, and we conclude that that excise tax would cost us somewhere between $50 and $100 million a year.

Mr. MARTINEZ. We have talked about alliances as if they are something new, and they are not new. You people all have been aware of alliances that have existed out there out of necessity over a great number of years and have been formed, and whether or not cooperative this Cooper plan says that small businesses cannot be-

come a part of an alliance, that is not true. I was a small business owner myself, and I became a part of an alliance that we formed through an association that we created. So there are ways to do it.

The problem is that there are not enough of that vehicle available to small businesses, and then small business is concerned more with operating business and making themselves come out with any kind of profit at all, especially in today's economy. The last thing they are concerned about, unless their employees are pressing them, is health care. Some don't realize how important health care is. I happen to believe in it, and I provided it for my employees, and I was a small businessman, very small businessman, but because I realized that being without health care could be catastrophic, I did that, but there are a lot of people that still won't.

So some form of requirement of all employers to provide health care for their employees is going to have to be enforced, is going to have to be put in place.

But let me ask you, on managed competition, somehow these alliances and managed competition are magical words here that are going to provide the solutions to all our problems, but let me tell you—and I forget who it was that testified now that managed competition works—I believe it was you, Mr. Reiker—but let me tell you what is happening with managed competition in California as it is being provided.

The State allows for HMO's or doctors or individuals to come in and apply for contracts in which they are awarded a contract, and they are given $30 per month per client that they would sign up. So they go and stand in front of the unemployment lines, in front of the Social Security offices, and every place they can and sign people up.

Now this individual, without realizing what they are getting into, then go to their own doctor for that doctor's visit they need to make and are all of a sudden told by the doctor, "I can't service you because you are signed up by this particular group," whether it is an HMO, and some of them that are really not providing that good a health care, to tell you the truth, and then they find out that they don't have the choice that they thought they had. Mr. Cooper has expounded on the issue of choice.

Can anybody explain to me how in the devil managed competition is going to work if, in the case that I have seen it, it really doesn't work and work that well, because I will tell you what happens. The doctors that are signed up get $30 per month per client. Now if that client never comes in or if they turn him away because they say, "Well, you are not really ill, you don't need any health care," and create a bigger health care problem later on, and at the end of the year all of these people get together and they divide up these $30s per month that were never used, and everybody makes money on it but the health care isn't provided, explain to me how in the Cooper plan the managed competition is going to be any different.

Mr. KENDALL. Let me take a stab at that.

Mr. MARTINEZ. Mr. Kendall.

Mr. KENDALL. First of all, the Cooper bill gives employees much more choice than would have today. If they sign up with a plan

that doesn't give them good health care coverage, they change, just like in the Federal employees program today. If you don't like your health plan, you switch it on an annual basis. So by giving consumers real choices, they can drive the marketplace to where they are actually getting the kind of services that they are expecting for the money that they are paying.

Mr. MARTINEZ. Let me interrupt you right there. You know, we have a system in the Federal Government that drives the marketplace, and that is competition, because all of these insurance companies, over 400 throughout the United States, want to compete for a part of that market. You know what that market is? Ten-point-nine million people. Now, hey, I would vie for that market and so would any other insurance company, just a part of Calpers, one million, and Calpers tells me that their plan is better than any of the Federal plans, and yet we have had testimony that it isn't.

But do you know why they want to say that it is better? Because Calpers are able to at least control for that one million employees that insurance coverage, and it means a lot.

So if you say that managed competition is going to drive it, I think that the competition that exists now by having numbers, which is the more important thing, numbers—in fact, the alliance that I was a part of in my small business, we, as individuals, could not afford health care for us or our employees. We were only able to afford it when we developed a large enough group with a large enough number that we could go to an insurance company and command a better rate. So it is the numbers that demand the better rate.

Mr. KENDALL. Yes, I think that is exactly the point. The minimum size for purchasing groups under the Cooper bill is 250,000 lives. That is the minimum number. Most of them would be much larger. Unless you get to that size purchasing power for the small businesses and individuals who are not empowered in the marketplace today, you won't be able to get the kind of purchasing power that we want to see in the system.

Mr. MARTINEZ. Very good.

Mr. Reiker, let me ask you—there is another vote on, and I think that was the first bells, and I don't want to miss the second vote, but out of courtesy to all of you who have waited so long to provide your testimony, I did not go to the last vote. I do not want to miss two in a row, though. So I just want to ask you, how many employees do you have in your consumer food business?

Mr. REIKER. In the consumer foods business, there are probably 15,000/10,000. In restaurants we have a little over 100,000.

Mr. MARTINEZ. The employees of the restaurants are 100,000?

Mr. REIKER. Yes, sir.

Mr. MARTINEZ. So that is 115,000 roughly.

Mr. REIKER. Roughly.

Mr. MARTINEZ. Okay.

How many are full-time, do you know?

Mr. REIKER. It depends on what your definition is, you know, whether you set it at 25 or 30 hours, but roughly 60 to 65 percent are part-time.

Mr. MARTINEZ. Sixty five percent are part-time?

Mr. REIKER. About 60 percent are part-time.

Mr. MARTINEZ. How many of your employees are covered?

Mr. REIKER. Well, all employees are eligible for coverage once they meet our kind of standard eligibility in the industry. Our employees can have coverage down to actually 15 hours a week. Of those, about half decide to take coverage.

Mr. MARTINEZ. So the benefits are provided to part-timers?

Mr. REIKER. Absolutely.

Mr. MARTINEZ. Of the part-timers, do you have any idea how many of them opt to take the health care?

Mr. REIKER. For the part-timers, it tends to be a lower amount, but probably about 30 to 40 percent of the part-timers elect to take coverage.

Mr. MARTINEZ. Thirty to 40 percent. What is their contribution to the health care?

Mr. REIKER. It will vary depending on single-family coverage, but the company pays slightly over half of the cost of care.

Mr. MARTINEZ. Sixty percent?

Mr. REIKER. Well, it is like 52 percent, something like that. The employee contribution will range from $15 to $18 for single. It could be as much as $40 a week for a family.

Mr. MARTINEZ. I understand that in the restaurant business, because you have particular hours of the greatest volume of business, that you need employees, a larger number of employees, at a particular time, and then there are slack periods in the day where you don't need them, so you do need a lot of part-time employees.

Mr. REIKER. That is right.

Mr. MARTINEZ. But, you know, 52 percent is still not as much as what the President's plan calls for of 80 percent. Who should really pay for those part-timers in that kind of a plan?

Mr. REIKER. It depends. An employee that works 10 hours a week, I am not sure that an employer should be responsible for an annual cost of $5,000 for family coverage.

There is a mistaken belief that in the President's plan the playing field is leveled by saying that no employer will pay more than 7.9 percent. Well, that is after eight years of the President's plan. In the meantime, a small employer would be capped at 7.9 or, in fact, with low-wage workers such as restaurants, 3.5 percent.

So if you take a typical server working in one of our restaurants, our competitor could provide health care coverage for 7 cents an hour. If I hire that same employee and give them family coverage, it is going to cost me more than $3 an hour under the President's plan. That is not a level playing field, and it doesn't make sense that we should have to pay for that relative to a competitor in the same business right across the street.

Clearly, one of the most difficult challenges we are facing is how to provide health care for the low-income workers, and part-time workers are a part of that. That is one of the reasons that we feel that the Cooper bill takes a very realistic approach to that and says that at least for some low to moderate-income families there needs to be a subsidy.

Mr. MARTINEZ. Thank you.

The second bells just went, and I am going to have to adjourn this to go on to vote, but before I do, I want to commend you all for your testimony. It was very enlightening, and it is certainly in-

formation that we can use as we debate this health care issue further and go on to providing some kind of health care, to at least as many people as we can, as close to universal health care as we can.

Mr. Pollack—I will get it right yet—Mr. Pollack, you said earlier about my endurance. I want to commend all of you for your endurance. You waited through a long first panel to give your testimony, and I admire you for that. Thank you for testifying before us.

[Whereupon, at 2:04 p.m., the subcommittee was adjourned.]

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