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# IN CRITICAL CONDITION: AMERICA'S AILING HEALTH CARE SYSTEM

## HEARING

BEFORE THE

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# IN CRITICAL CONDITION: AMERICA'S AILING HEALTH CARE SYSTEM

**MONDAY, MARCH 10, 2003**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The committee convened, pursuant to notice, at 2:02 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux presiding.

Present: Senators Breaux, Craig, Stevens, and Collins.

## OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. The Committee on Aging will please come to order, and good afternoon, everyone. Thank you for being with us.

This week, as many of you may or may not have seen already, is referred to as "Cover the Uninsured Week," the week of March 10 through 16. There are a number of organizations ranging from the U.S. Chamber of Commerce to the AFL–CIO, the Business Roundtable, a number of international unions, the Health Care Leadership Council, you name it. If you are involved in health care, they have all joined together, really, in an effort to try and point to America and to Congress, I am certain, the importance of addressing the question of the uninsured in dealing with health care in this country.

So we thought it would be appropriate to use the Aging Committee as a forum this afternoon to have a discussion on the state of America's health care, and particularly emphasizing the uninsured in our country. Obviously, in meetings that we have been having, in talking to large employers, the problems that they have in providing insurance, particularly for their retired workers, the older Americans, is becoming an increasingly more and more difficult problem. So I think it is appropriate that the Aging Committee use this forum to have a discussion this afternoon on the overall question of the uninsured, and in doing so, keeping it with the Uninsured Week of March 10 through 16.

If you look at the news, we find that health premiums are going up. The number of small businesses that offer health insurance is going down. The number of uninsured Americans is going up. The financial conditions of both Medicare and the Medicaid program are heading downward.

Last year, premiums for the employer-sponsored health insurance increased by nearly 13 percent. The number of small businesses offering health insurance to their employees continues to decline, dropping from 67 percent down to 61 percent just last year.

Medicare, I have argued, in its current form is unsustainable. Medicaid, the safety net for our most vulnerable, is crippling State budgets and many benefits on the State level are being scaled back or eliminated completely.

We depend on our coverage on health care in this country under what I have called the box system of health care, which means that if you are an older American, you are in the Medicare box, which spends $236 billion a year. If you are a veteran, you are in the VA box, where we spend $26 billion a year. If you are poor, you fall into the Medicaid box, which is $170 billion a year. If you are working and have the fortunate situation where your employer provides health insurance, you are in the employer-sponsored box, where we spend $140 billion a year in government subsidies. That adds up to about $1.4 trillion that we spend on health care annually in the United States of America.

Yet, there is a box that is not on that table but on the bottom, rather, that has 41 million Americans in it that have no insurance whatsoever because they don't fit in any one of the boxes up on top. So we have a situation where we are spending an incredible, large amount of money every year and yet we still have a relatively large percentage of our citizens who have no access to health care insurance whatsoever.

It seems to me that Congress spends an inordinate amount of time just trying to tinker with the boxes. We are trying to tinker with the Medicare box this year, with adding prescription drug benefits, and the President has proposed a reform program which I think moves it in the right direction. We continue to tinker with the Medicaid box, trying to help the States. Just this week, the National Governors Association made that one of their priority concerns, not having enough money for the Medicaid program within their States. Every year, we try to do things for the employer-sponsored box in terms of tax credits or other means to allow them to do a better job and to stay in the program.

So the problem is, we tinker with all the boxes, but we very seldom take a look at the overall problems that our health care delivery system has in this country in the larger picture, and hopefully, we can get some discussion on that this afternoon.

We have got a good group of witnesses that are with us. They have been around almost as long as I have, dealing with these problems from different perspectives, and I think that is healthy. They have got different perspectives, but we are all going to talk about the same subject matter.

With that, I would like to recognize our Chairman, Senator Craig, who has allowed me to chair this hearing. Senator Craig.

## OPENING STATEMENT OF SENATOR LARRY E. CRAIG

The CHAIRMAN. Mr. Chairman, thank you very much. You have outlined clearly, I think, a great concern that we have here in the Congress as it relates health care and the insured, the cared for and the uninsured.

After nearly a decade of relatively modest health care cost growth, we are now back into the double-digit annual increases, partly driven by prescription drugs and a lot of other issues coming together, and I think the failure of us to move with some degree of speed in a comprehensive way prolongs and causes the whole situation to worsen.

Last month, we had the Chairman of the Federal Reserve, Alan Greenspan, here, not to talk about interest rates but to talk about another passion of his and that is the aging of the world and the costs of that. I think his testimony was very sobering. He warned us that we simply cannot afford to wait much longer to begin seriously tackling the long-term challenges of Medicare and Social Security and, of course, the uninsured was not mentioned, but clearly is a reality out there that is being brought to our attention for the balance of the month, coupled with these hearings.

I think the idea of comparing and relating and looking at the overall impact that these programs have is an important part of what this committee can do and must do as we put together the record that the Finance Committee will ultimately have to deal with in working on these issues.

I would ask unanimous consent that the balance of my statement become a part of the record.

Senator BREAUX. Without objection, so ordered.

The CHAIRMAN. I look forward to the testimony of our witnesses.

Senator BREAUX. Thank you, Mr. Chairman.

Any comments from Senator Collins?

## STATEMENT OF SENATOR SUSAN COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman. I was trying to decide how I address you both. Is it Mr. Chairmen? Mr. Chairman and Mr. Chairman? What would work? [Laughter.]

I want to thank you both for holding this extremely important hearing to focus on the problems plaguing our nation's health care system and the options for reform to ensure that more Americans—indeed, our goal should be that all Americans—have access to affordable health care.

The United States health care system is experiencing serious problems that are driving more and more Americans into the ranks of the uninsured. Rising health care costs, spiraling health insurance premiums, coupled with the recent slowdown in the economy have created conditions that one commentator has likened to the "perfect storm," a confluence of forces, each worrisome in itself, but together posing a lethal threat.

One of my top priorities in the Senate has been to expand access to affordable health care for all Americans. There are far too many of our citizens without health insurance or with woefully inadequate coverage. Last fall, the Census Bureau told us the number of uninsured Americans had increased to more than 41 million. Moreover, just last week, Families USA released a study that esti-

mates that some 75 million Americans have been without health insurance at some point during the past 2 years.

Health insurance matters. The simple fact is that people with health insurance are healthier than those without. People without health insurance are less likely to seek care when they need it and tend to forego services, such as periodic check-ups and preventive services. As a consequence, they are more likely to be hospitalized or require costly medical attention for conditions that could have been prevented or treated successfully at an early, curable stage. Not only does this put the health of those individuals at greater risk, but it also puts additional pressures on our hospitals and emergency rooms, many of which are already financially stressed.

Maine, like many States, is in the midst of a health insurance crisis, with premiums rising at alarming rates. Whether I am talking to a self-employed fisherman, a displaced worker, the owner of a struggling small business, or the human resources manager of a large corporation, the soaring cost of health insurance is a common concern.

Maine's employers are facing premium increases of 20, 30, or even 40 percent a year. This is particularly burdensome for our smaller businesses, which are facing a dilemma. If they pass on the cost of the health insurance to their employees, more and more of their employees will decline coverage because they simply cannot afford their share of the premium. On the other hand, the smaller businesses cannot continue to absorb double-digit increases in rates.

The problem is even more acute for the many Mainers who are self-employed and must purchase health insurance on their own. What we are finding in Maine is that monthly health insurance premiums often exceed the family's mortgage payment. So it is no wonder that more than 150,000 Mainers are now uninsured.

Earlier this year, I joined with my colleague, the other distinguished Senator from Louisiana, Senator Landrieu, in introducing a plan that combines a variety of public and private approaches to make quality health coverage more affordable and available. I also believe that we need to press hard to include in the administration's economic recovery package some fiscal relief to the States that is targeted to the Medicaid program. We need to increase the Medicaid match over the next 18 months to help preserve the health care safety net for our low-income families that is now in danger of being shredded due to State budget cuts.

I know that the distinguished chairman for the day, Senator Breaux, has also introduced an important proposal, as have others, to lay out their vision for reform. My hope is that this hearing will serve as a springboard for further discussions to find a bipartisan solution to this pressing and growing problem. Thank you, Mr. Chairman.

[The prepared statement of Senator Susan Collins follows along with prepared statement of Senator Ted Stevens:]

PREPARED STATEMENT OF SENATOR SUSAN COLLINS

Mr. Chairman, I want to thank both you and the Ranking Member of the Aging Committee for holding this hearing to examine the problems plaguing our nation's health care system and the options for reform to ensure that all Americans have access to affordable health care.

The U.S. health care system is experiencing serious problems that are driving more and more Americans into the ranks of the uninsured. Rising health care costs and health insurance premiums, coupled with the recent slowdown in the economy have created conditions that a recent David Broder column likened to "The Perfect Storm: a confluence of forces, each worrisome in itself, but together posing a lethal threat."

One of my top priorities in the Senate is to expand access to affordable health care for all Americans. There are far too many Americans without health insurance or with woefully inadequate coverage. Last fall, the Census Bureau announced that the number of uninsured Americans increased to more than 41 million in 2002. Moreover, just last week, Families USA released a study that estimates that 75 million Americans have been without health insurance at some point during the last two years.

Health insurance matters. The simple fact is that people with health insurance are healthier than those who are uninsured. People without health insurance are less likely to seek care when they need it, and to forgo services such as periodic check-ups and preventive services. As a consequence, they are more likely to be hospitalized or require costly medical attention for conditions that could have been prevented or treated at a curable stage. Not only does this put the health of these individuals at greater risk, but it also puts additional pressure on our hospitals and emergency rooms, many of which are already financially challenged.

Maine, like many states, is in the midst of a growing health insurance crisis, with premiums rising at alarming rates. Whether I am talking to a self-employed fisherman, a displaced worker, the owner of a struggling small business, or the human resource manager of a large company, the soaring costs of health insurance is a common concern.

Maine's employers are currently facing premium increases of as much as 40 percent a year. These premium increases have been particularly burdensome for small businesses, the backbone of the Maine economy. Many small business owners are caught in a cost-squeeze: they know that if they pass on the premium increases to their employees, more of them will decline coverage. Yet, these small businesses simply cannot afford to absorb double-digit increases of 20, 30 or 40 percent, year after year.

The problem of rising costs is even more acute for individuals and families who must purchase health insurance on their own. Monthly health premiums in Maine often exceed a family's mortgage payment. It is no wonder that more than 150,000 Mainers are now uninsured. Clearly, we must do more to make our health care system more efficient and health insurance more available and affordable.

Earlier this year, I joined my colleague from Louisiana, Senator Mary Landrieu, in introducing the Access to Affordable Health Care Act, a seven-point plan that combines a variety of public and private approaches to make quality health care coverage more affordable and available. Our bill will bring millions more Americans into the health system by providing tax credits for small businesses that offer health insurance to their employees. It would strengthen the health care safety net by increasing funding for Community Health Centers, and it would address inequities in the Medicare system that hurt rural states like Maine.

Mr. Chairman, I know that Senator Breaux and others have also introduced proposals that lay out their visions for reform. This hearing will serve as a springboard to further discussions, and I look forward to working with my colleagues to find a bipartisan solution to this pressing and growing problem.

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PREPARED STATEMENT OF SENATOR TED STEVENS

Thank you, Mr. Chairman. I'm pleased to be here today to discuss ways in which our American health care system might be changed to make sure that more people get health coverage at a cost our society can afford.

Our employer-based health care system has served us well for many decades now, but there are new pressures on that system—and on our public health programs like Medicare and Medicaid—that are causing large holes in the system that leave many with no coverage, or with coverage that doesn't provide basic necessities like prescription drugs.

In Alaska we have many small businesses for which the cost of providing health benefits to their employees is very high. Alaska thus has a higher rate of uninsured than does the rest of the country.

I'm also, however, concerned about access to care for those who do have health insurance.

The Medicare program, for example, in Alaska, pays doctors less than 40 percent of the cost of seeing Alaska seniors. As a result, many physicians are unable to accept new Medicare patients, leaving those patients with few options for getting needed care.

Some of these patients end up using costly services in hospital emergency rooms because they can't find a physician.

We're also finding it harder to recruit new doctors to Alaska because of the extremely low payment rates compared to the cost of seeing patients. Yet, more than 50 percent of our primary care doctors in my State are over 50 years old and are looking to retirement.

The fast rising costs of malpractice insurance, due in some part to extremely large jury awards to patients for "pain and suffering" are also contributors to fast rising health costs as well as to decreased access to services like those needed by pregnant women.

These access issues must also be considered as we proceed with this debate.

I look forward to hearing from our panel.

Senator BREAUX. Thank you, Senator Collins, for that excellent statement.

I would like to welcome our witnesses, and under the rule, the last shall be first. We will start left to right from the chair with Mr. Dan Crippen. Dan, of course, served as our Director of the Congressional Budget Office from February 1999 until January of this year. He has also served in senior positions in the White House and the U.S. Senate and has done a great deal of work on the Federal budget as it relates to the issue of health care and retirement and we are delighted to have him this afternoon. Dan, welcome to the committee.

## STATEMENT OF DAN CRIPPEN, FORMER DIRECTOR OF THE CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Mr. CRIPPEN. Mr. Chairman, Senator Collins, first, let me apologize for my tardiness. It has been 4 years since I have had to look for a parking place on the Senate side. [Laughter.]

It is not as easy as it used to be.

Mr. Chairman, as you observed on many occasions and just a few minutes ago, we have developed an array of health care delivery systems in this country which result in a disparate treatment in payments, unequal quality of care, substantial numbers of people who may not be receiving adequate care, all the while spending more than any other nation. Further, our attempts to fix parts of this system, our so-called incremental reforms, well intentioned as they may have been, have often caused as many problems as they have solved.

I am reminded though, Mr. Chairman, at the outset of this hearing, as in many other gatherings like this, of a friend of mine who I don't think I have told you about. He is a tunneling engineer. After he graduated from college, he took a qualifying exam, I guess to be a tunneling engineer, and he failed it, and it, needless to say, irritated him a great deal. So he studied a lot for the second chance, and as he was taking the exam, he finished, he looked up, he had an hour left. So he turned over his test booklet and he wrote on the back side, "These things I also know." [Laughter.]

Very often, we find ourselves with such a broad topic before us that we wander into the very tempting position of talking about all the things we happen to know. I am going to try to avoid that today and speaking only for a few minutes, I want to propose to

focus on one thing. We ought to know the nature of the problem before we try to fix it.

That sounds pretty straightforward, and I have characterized that in the past, Mr. Chairman. You have heard me talk about Moynihan's several laws. Well, the first Moynihan law that I think is appropriate here is, if you don't ask the right questions, you are not likely to get the right answers. The second Moynihan law, also appropriate here, is before you can solve a problem, you have to be able to measure it, to size it correctly.

I will use two quick examples today, but two issues that are very much in the forefront of your concerns in the Senate to hopefully make this point. Since, as you said, this is the "Week of the Uninsured," I will start there.

Ask almost anyone in this room, as we have already heard, how many uninsured Americans there are and the answer is likely to be the one you have in your chart, 40 million, plus or minus, thereabouts. Inquire further about the nature of these 40 million and most people will say that these are folks who have extended periods of uninsurance, who you might say are chronically uninsured.

The truth is, the number of chronically uninsured—for this purpose, I will use 12 months or more without insurance—is substantially lower than 40 million, perhaps as much as 20 million lower than 40 million when you examine other surveys on this issue. How can that be, because headline after headline, newspaper and television advertisements all use the number 40 million?

Well, the 40 million may be uninsured today as we sit here for a given day, but it turns out that about half of the 40 million people are temporarily between coverage of some kind, between employers, between spousal coverage, between public programs, so much so that the average period of uninsurance for the 40 million in the CPS survey is less than 7 months. Only 40 percent of this 40 million are uninsured for less than 4 months.

This perspective, I would suggest, deals a much different picture and one that likely suggests different policies. A tax credit, for example, may be unnecessary and ineffective for filling short gaps. A policy along the lines of COBRA coverage might be more suited.

As for those who are without insurance for 12 months or more, we might want to look even more closely at them before deciding on the right policy. Of these, one-quarter are families with incomes over 200 percent of poverty. Another 20 percent, likely the younger of this group, say they have no need for insurance. Some number, perhaps a very substantial number, are eligible for Medicaid, but either unaware they are eligible or don't yet need medical care.

Mr. Chairman, there is an underlying metaphysical question here, of course, with public programs. If you are eligible for Medicaid but haven't used it, are you uninsured? I strongly believe the answer is no. I think you are insured, because the first time anyone eligible shows up at a hospital, they will be enrolled, and the 3 months' prior expenditures will be reimbursed, as well. To say otherwise is akin to saying that anyone who is privately insured should be counted as uninsured until they make a claim.

Similarly, as you know better than I, there are many veterans who rely on VA for health care and do not buy insurance. Are they really uninsured as well?

Let me hasten to add at this point, I am not trying to downplay the important problem making sure citizens get health care. Even if there are only 15 to 20 million chronically uninsured in this country, that is a potentially big problem and certainly deserving the attention of government. What I am saying is that until the nature of the problem is clear, the solutions we devise may be ineffective and unnecessarily costly.

With your indulgence, Mr. Chairman, I want to quickly turn to another issue before the Congress and the country, that of providing pharmaceutical benefits for Medicare beneficiaries, something you have all been very involved in, Senator Collins in particular, and you, Senator Breaux, as well. The debate thus far is largely predicated, in my view, on the need to prescribe prescription medicines to the elderly. The truth is, Mr. Chairman, three-quarter of the elderly already have insurance of one kind or another that covers some drug spending, maybe not enough, maybe with hardship, maybe with deprivation. But again, it is not that we have 40 million seniors without any drug coverage.

If you look behind this, those 30 million beneficiaries with insurance fill about 32 prescriptions a year at an average cost of $45. Importantly, the quarter of the Medicare population that has no insurance for pharmaceuticals fills 25 prescriptions a year at an average cost of $37. It may well be that this gap of seven prescriptions per year is important, critical, necessary, to put a word on it, but the perfectly targeted policy if you are worried about access could be ensuring access for these seven prescriptions for the 25 percent of the population that aren't insured, and the cost of that would maybe be around $3 billion a year, not 30, not 300, but three.

The issue, I would suggest, is not necessarily access. What is really at issue, and we are not debating it in these terms, I understand, but what is really at issue is the financing of drug benefits. Drugs are being supplied now. The question is, who should pay? There may be very good and compelling reasons to change the financing from what exists today and place it in the Federal budget and on current workers, but that reason is not access.

I will conclude, Mr. Chairman, by saying everyone at this table and many in this room have spoken eloquently, certainly more eloquently than I am able, about the need for Medicare reform and the desirability of adding drugs to that benefit. Mr. Chairman, I would suggest until we are clear-eyed about the nature of the problem, until we understand better than we do today the current system, hodgepodge and inefficient as it is, until we understand what kind and quality of health care we are buying in programs like Medicare, it is very hard to see how we might productively reform them. As Senator Moynihan would say if he were here, if we don't take the time to ask the right question, we aren't likely to get the right answer.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Crippen follows:]

Mr. Chairman, thank you for inviting me to address the Committee today.

Mr. Chairman, as you observed last Thursday (and on many previous occasions), we have developed an array of healthcare delivery systems that has resulted in disparate treatments and payments, substantial numbers of people who may not be receiving adequate care, all while spending more than any other nation.

Further, our attempts to fix parts of the system, our "incremental" reforms, well-intentioned as they may have been, have often created at least as many problems as they have solved.

The nature of this problem is so broad, especially given the way we have divided up the "solution," that it is hard to know where to start…or when to stop.

I am reminded of a friend of mine—a tunneling engineer—who after failing his first qualifying exam

studied diligently before his second attempt. During the course of the second exam, Jim finished and looked up only to discover he had over an hour left. So he turned his test booklet over and wrote on the back: "These things I also know."

A hearing on health care is often like that, Mr. Chairman. Lest I fall into the dilemma of Jim's examination, I propose today to focus on one thing: KNOW THE NATURE OF THE PROBLEM BEFORE YOU TRY TO FIX IT.

Mr. Chairman, you may have heard me refer to Moynihan's several laws previously, the first two of which are: 1) if you don't ask the right question, you're unlikely to get the right answer; and, 2) before you can solve a problem, you have to be able to measure it—to size it—correctly.

I'll use two examples—two issues that are at the forefront of the healthcare debate—to, I hope, make this point.

Since this is the "week of the uninsured" I'll start with an examination of some of what we know, and don't know about the folks in the country without insurance.

Ask almost anyone in this room how many uninsured Americans there are and the answer is very likely to be +or- 40 million. Inquire further whether these 40 million souls are without insurance for extended periods or only temporarily and most will say "extended periods"...chronically uninsured, if I may use that term.

Truth is, the number of chronically uninsured—for this exercise let's say, at least 12 months without insurance--is substantially lower, perhaps 20 million lower, when you examine other surveys that are likely to produce better results on this issue.

How can that be? Headline after headline, television and print advertising, learned articles—all use the number 40 million...

While there might be forty million on any given day, turns out up to half the 40 million are temporarily between coverage of some kind—between employers, between spousal coverage, between public programs—so much so that the average period of "uninsurance" for the 40 million in the CPS survey is less than 7 months—nearly 40% of the 40 million are uninsured for less than 4 months.

This perspective yields a much different picture, and one that likely suggests different policies. A tax credit, for example, may be unnecessary and ineffective in filling short gaps—a policy along the lines of COBRA coverage might be more suited.

As for those who are without insurance for 12-months or more, we might want to look more closely at them before deciding the right policy. Of these, , one-quarter are in families with incomes over 200% of poverty, 20% (likely younger) say they have no need for insurance, and some number, perhaps a substantial number, are eligible for

Medicaid but either are unaware they are eligible or don't yet need medical care.

Mr. Chairman, there is an underlying "metaphysical" question here: if you are eligible for Medicaid but haven't used it, are you insured? I strongly believe the answer is YES, because the first time anyone eligible shows up at a hospital, they will be enrolled and the three-months prior expenditures reimbursed as well. To say otherwise is akin to saying that anyone who is privately insured should be counted as uninsured until they make a claim!

Similarly, there are many veterans who rely on VA for health care and do not buy insurance—are they really uninsured?

Let me hasten to add at this point I am not trying to downplay the important problem of making sure our citizens get healthcare. Even if there are only 15-20 million chronically uninsured in this country, that is a potentially big problem deserving the attention of the

government. What I am saying is that until the nature of the problem is clear, the solutions we devise may be ineffective and unnecessarily costly.

With your indulgence, Mr. Chairman, I want to quickly turn to another issue before the Congress and the country--providing pharmaceutical benefits for Medicare beneficiaries. The debate thus far is largely predicated on the "need" to provide prescription medicines to the elderly.

Truth is, Mr. Chairman, 3/4 of the elderly already have insurance of one kind or another that covers some drug spending—may not be enough, may be with hardship or deprivation—but again it is not that we have 40 million seniors without drug coverage.

These 30 million beneficiaries with insurance fill an average of 32 prescriptions a year at an average cost of $45 per script. Importantly, the quarter of the Medicare population that has no insurance for pharmaceuticals fills 25 prescriptions a year at an average cost of $37. It may

well be that this gap of 7 prescriptions a year is critical, but the perfectly targeted policy for insuring access would entail these 7 scripts for the 25% of the population at a cost of around $3 billion.

The issue is not access. What is really at issue--and we are not debating it on these terms--but what is really at issue is the financing of pharmaceutical benefits. Drugs are being supplied now; the question is who should pay. There may be very good and compelling reasons to change the financing from what exists today to place it in the federal budget and on current workers—but that reason is not access.

Everyone at this table and many in this room have spoken eloquently, certainly more eloquently than I am able, about the need for Medicare reform and the desirability of adding drugs to the benefit. Mr. Chairman, until we are clear-eyed about the nature of the problem, until we understand better than we do today the current system, hodge-podge and inefficient as it is—until we understand what kind and

quality of health care we are buying in programs like Medicare—then it is very hard to see how we might productively reform them. If we don't take the time to ask the right question, we aren't likely to get the right answer.

The CHAIRMAN. Thank you, Mr. Crippen, very much. Dan, would you give me, just before we move to the next witness, what were the numbers you had, the 32 prescriptions at $45 a year versus what, 47 prescriptions at what?

Mr. CRIPPEN. I want to be precise. I looked it up just this morning. Thirty-two prescriptions a year for those who have insurance at a cost of $45 per prescription. Those who are uninsured fill 25 prescriptions a year, on average, at a cost of $37 per prescription. The lower cost, it is assumed, because of more use of generics.

The CHAIRMAN. OK, thank you.

Our next witness will be Mr. Len Nichols. Mr. Nichols joined the Urban Institute's Health Policy Center in November 1994, but prior to that, he was a Senior Advisor for Health Policy at OMB, where he managed and coordinated the cost and revenue estimates for President Clinton's Health Security Act and the Congressional successors. We thank him for being with us this afternoon.

**STATEMENT OF LEN. M. NICHOLS, PH.D., VICE PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, DC**

Mr. NICHOLS. Thank you, Mr. Chairman, Mr. Chairman, and Senator Collins. My name is Len Nichols. I am the Vice President of the Center for Studying Health System Change, which is a nonpartisan health policy research organization exclusively funded by the Robert Wood Johnson Foundation, and I will try to address the question of the hearing, is our health care system in a crisis, in the 4½ minutes I have left.

I think our health care system looks like it is in a crisis from a number of different vantage points, but our health care system also performs amazing feats every day and it serves most of us very well most of the time. But we do have three key interrelated problems. I will label them waste, uneven quality, and uneven access to care, and these problems add great stress to our system every day. We cannot solve any of these problems without attacking them all simultaneously, and systemwide reform, as you yourselves know quite well, will require Federal leadership, and I will come back to that in a moment.

On waste, you probably know we spend substantially more on health care than any nation on earth, yet we rank 28th in infant mortality, right below Cuba, Ireland, and Portugal, countries that usually beat us at soccer, but not at health care, and 26th in life expectancy after 60. One way to interpret these numbers is we perform much costly unnecessary care. Rates of excess care vary inexplicably across the nation. One major consequence of waste is that an increasing fraction of our workforce cannot afford comprehensive health insurance. Growth in per capita health care cost has outstripped earnings growth by 260 percent since 1980.

On uneven quality, it is unambiguously true we have many of the best doctors, nurses, and hospitals in the world, but our Institute of Medicine tells us that between 50,000 and 100,000 people each year die in our hospitals due to medical errors. The biggest quality gaps stem from not doing what we know should be done, that is to say, for example, providing routine medication after heart attacks and performing certain tests regularly for diabetics. The

most spectacular quality failures, as the recent transplants at Duke indicate, result from endemically poor communication among different parts of our incredibly talented health care system.

Finally, but by no means least, we suffer from uneven access to care. As you know and as will be pointed out later, the uninsured are disproportionately low-income and minority, especially Latino. The uninsured are less likely to access care, and delayed access often leads to unnecessarily poor outcomes and even death. All of us could become uninsured as a result of bad luck, as all of us know. Even controlling for insurance and income, et cetera, minority death rates are higher than whites for a large number of diseases. We are a long way from color-blind equality in our health care system.

Now, most recently, it is true, as Senator Collins pointed out, our three key problems of waste, uneven quality, and uneven access have been intensified by a reacceleration of health care cost growth, which is, in my view, has been ignited by a wholesale retreat from effective but unpopular techniques of managed care. As a result, our three major problems are, indeed, deeply connected. Waste and poor quality raise costs, which creates more uninsured, especially among low-income working families, and the cost of paying for universal coverage in our current system seems so daunting that policy is easily paralyzed.

The market return to investing in the quality enhancing infrastructure, which are primarily measurement and communications tools, has been low because most patients are not aware of our health care system's quality problems and because knowledgeable payers fear they are too small to make a difference. Profound fear of malpractice claims and economic loss generally have retarded provider engagement in quality-enhancing and error-reducing efforts, which keeps costs high, and this is how the dysfunctional set of interactions continues to stress our health care system.

Therefore, in my view, we have to attack all these problems simultaneously and Federal leadership will be necessary and this will require substantial new resources to be committed.

But before I outline specific roles for Federal leadership, I would like to take just a second and celebrate the fact that we are entering into a new national conversation. Senator Breaux has recently laid out a vision for system reform that includes a new kind of social contract between individual responsibility and our collective obligation to make group health insurance affordable and available to every American. His vision, in my view, can serve as a cohesive and catalytic springboard for ongoing discussions by this committee, Members of Congress, Presidential candidates, the Secretary of HHS, and the President himself.

Indeed, this might be a good time to remind ourselves of some key lessons from the last national conversation we had about health care reform in the 1993–94 period under the leadership of President Clinton, and my written testimony lays a number of these out. I will focus on the one that I think is the key analytic one today.

The Clinton proposal at its core assumed that the health plan is the key unit in our health care system, as the agent that would solve all problems. It is becoming increasingly clear to me that the

key unit in our health care system is actually the patient-provider interaction. We must get incentives right at that level. If we do, much else will take care of itself. If we do not, no matter what else we do, we will fail to reduce waste and improve quality and thus will never feel able to afford more equal access for all.

Now, what kind of system is most likely to get these incentives right? A system that pays for good quality health care and good health outcomes and does not pay for failure to provide quality care. This kind of system will require public investment in information infrastructure so that providers and patients will find it easier to jointly produce good health care and the best health outcomes possible.

Current efforts underway at IOM, AHRQ, and CMS are a good start, but they need your unwavering and continued support. This kind of system will also require group purchasing. Information economies of scale are simply too great to expect comparable efficiencies from individual health care consumers acting with their own knowledge alone. Our major Federal purchasing agencies, CMS and OPM, if equipped with the tools and the power and discretion to use quality data to guide choices, can provide essential and catalytic leadership in this area.

Finally, the system will have to extend access to all Americans, which will require Federal subsidies, else will always suffer too many inequities to solve our uneven quality problems.

In the long run, I think research is very clear. Technology drives cost growth. Our decentralized health care financing system, however, is biased in favor of paying for virtually everything the medical industrial complex offers us, regardless of its effectiveness for many types of patients.

So my plea to you is and my claim is, we have to learn how to buy health services and technologies now so that we can reduce waste, improve quality, and learn how to decide which future technologies we will pay for together and which we will leave to individuals on their own. As we become better buyers, we will be better able to afford quality health care for all Americans. Thank you very much.

Senator BREAUX. Thank you very much, Mr. Nichols, for a very detailed statement.

[The prepared statement of Mr. Nichols follows:]

*Providing Insights that Contribute to Better Health Policy*

# INCREASING STRESS ON THE U.S. HEALTH CARE SYSTEM: STRUCTURAL CRISIS OR TEMPORARY?

**Statement of**
**Len M. Nichols, Ph.D.***
**Vice President**
**Center for Studying Health System Change**

**Before the**
**Special Committee on Aging**
**U.S. Senate**

**Hearing to Examine the State of the Nation's Health Care System**

**March 10, 2003**

*I am grateful to Gigi Liu for research assistance and to Paul Ginsburg, Kyle Kinner, Alwyn Cassil and Richard Sorian for suggestions and comments on earlier drafts.

Mr. Chairman, Senator Breaux and members of the Committee, my name is Len M. Nichols, and I am the vice president of the Center for Studying Health System Change (HSC). HSC is an independent nonpartisan policy research organization funded exclusively by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. We conduct recurrent nationally representative surveys of households and physicians, site visits to monitor ongoing changes in the local health systems of 12 U.S. communities, and monitor secondary data and general health system trends. Our goal is to provide members of Congress and other policy makers with unique insights on developments in health care markets and their impacts on people. Our various research and communication activities may be found at www.hschange.org.

The U.S. health care system is undergoing a period of growing stress. Rising health care costs and health insurance premiums, combined with the recent slowdown in economic activity, have forced many employers and workers to make tough choices about who will bear the brunt of cost increases and who will risk going without health insurance. The uninsured population did not shrink appreciably with the strong economy in the 1990s and has risen recently. Most coverage gains that did occur were due to the State Children's Health Insurance Program (SCHIP),[1] but now with states in unprecedented fiscal distress, they are looking to reduce spending on public insurance programs, and some may actually reduce the number of people covered. Partly in response to long-term budgetary and demographic trends, the Bush Administration has proposed far-reaching Medicaid and Medicare reforms and benefit changes that could significantly alter not only the programs themselves but the nature of financing them as well.

So it is understandable that many are asking if our health care system is in crisis. The word "crisis" may be too strong, but the answer to the question may also depend on where you sit and what your goals are for the system as a whole. The system looks like it is in a crisis when, for fear of out-of-pocket cost, an uninsured woman does not seek care until symptoms have persisted and worsened, and then discovers it is too late for even our incredible delivery system and dedicated professionals to save her.

The system looks like it is in crisis for a small employer and his workers when insurance premiums jump beyond their reach. The system looks like it is in crisis when there are not enough nurses to staff hospital beds for patients who need them, and there are not enough people going into nursing school to meet our future needs. The system looks like it is in crisis when physicians refuse to heal out of frustration with our malpractice insurance system. The system looks like it is in crisis when a heart and lung, incompatible with her blood type, are nevertheless transplanted into a teen-aged girl at a first-rate academic medical center. To some policy makers, the system looks like it is in crisis when tens of millions of Americans go without health insurance for a year or more. To other policy markers, the system looks like it is in a crisis when they discover we now spend more than 14 percent of gross domestic product (GDP) on health care. Some policy makers may have concluded that the cost growth crisis is the reason we cannot solve the uninsured crisis, and they apparently prefer to avoid discussing both.

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[1] Strunk, Bradley C. and James D. Reschovsky, *Working Families' Health Insurance Coverage, 1997-2001*, Tracking Report No. 4, Center for Studying Health System Change, Washington, D.C. (August 2002); Cunningham, Peter J., James D. Reschovsky and Jack Hadley, *SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage*, Issue Brief No. 59, Center for Studying Health System Change, Washington, D.C. (December 2002).

These valid concerns notwithstanding, our system also does marvelously or at least passably well for most of us most of the time. Most of us have health insurance all the time, most of us have a regular doctor whom we trust,[2] and most of us have confidence that if we need serious secondary or tertiary care, we will have access to it without undue delay or financial ruin. Thus, to a majority of Americans at any given time, our system does not look like it is in crisis in relation to their personal concerns. Opinion polling does show cycles of unease about the system as a whole, and we are apparently in a complex period, wherein most are dissatisfied with the availability and affordability of health care, but other issues were much more important to voting patterns in the recent mid-term elections.[3]

But rather than debate the breadth and depth of our health system "crisis," I will focus on three fundamental problems—key sources of much stress that are wearing our system's strengths and resilience down. These problems are deeply connected to each other, and thus attempts to solve them in isolation are likely to prove disappointing. It may indeed take system-wide reform to make real progress in any dimension. But system-wide reform is expensive and complex, as we learned painfully in our recent past. Thus, I will conclude with some key lessons from the Clinton reform era that seem relevant to your current deliberations.

In my view, the three fundamental problems in our health care system today are waste, uneven quality and uneven access to care.

**Waste.** In 2001, we spent 14.1 percent of our GDP on health care, substantially more than any other nation (Germany and Switzerland both spend a little over 10 percent). Yet, among the nations of the world, we rank 28th in infant mortality, right below Cuba, Ireland and Portugal, and 29th in life expectancy at birth. Assuming that some of our poor performance on these measures is due to the fact that most other nations have universal health insurance coverage and access for all their citizens, it is sobering to note that we also rank 26th in life expectancy at age 60, which means our almost universal Medicare program helps our elderly catch up a little—to be tied with Cuba, Korea and Slovenia—but we still live much shorter lives on average than our wealth and our system resource expenditure should buy, if we lived our lives and bought health care as wisely as other nations do.[4]

There are two other related ways to think about wasted resources in our system. One is care that is costly but has no strong clinical justification and, therefore, could be reduced without harm to patients. Dr. John Wennberg, perhaps our nation's leading authority on geographic medical practice variation, recently and usefully described three categories of health care.[5] One is effective care, whose use is supported by well-articulated medical theory and strong evidence for

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[2] Marie C. Reed and Sally Trude, *Who do you Trust? American's Perspectives on Health Care, 1997-2001*,Tracking Report No. 3, Center for Studying Health System Change, Washington, D.C. (August 2002).

[3]Robert J. Blendon et al. "Where Was Health Care in the 2002 Election?" *Health Affairs* web exclusive (December 11, 2002).

[4] All international comparisons are from either *Health United States, 2002*, or the World Health Organization Web site, www3.who.int/en/.

[5] John Wennberg, Elliott S. Fisher and Jonathan S. Skinner. "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002).

efficacy, as determined by clinical trials or valid cohort studies. Another is preference-sensitive care, wherein at least two valid alternative treatment strategies are available. In these cases, the choice of treatment involves trade-offs between risks and benefits that patients and caregivers should explore before choosing one.

The final category of care is what Wennberg and colleagues call "supply sensitive." In contrast to effective and preference-sensitive care, supply-sensitive care has much less well-developed medical theory governing decisions, especially around certain kinds of hospitalizations and the frequency of follow-up visits to specialists. Variation in practice patterns is particularly pronounced during the last six months of life, when 20 percent of Medicare spending occurs. Frequency of visits to specialists varies by 12-fold (two per decedent beneficiary in Mason City, Iowa vs. 25 in Miami, Fla.), and the number of hospital days per decedent varies by a factor of five (4.6 days in Ogden, Utah vs. 21.4 days in Newark, N.J.).

Variation in Medicare spending per capita is highly correlated with medical specialist visits, diagnostic tests, and the use of hospitalizations and intensive care for medical (non-surgical) conditions. There is a growing body of research that strongly suggests that areas with higher rates of supply-sensitive care do not have better health outcomes.[6] Unproductive medical practice variation, long established through Medicare program data, is likely to extend to treatment patterns in the privately insured under-65 population as well and could at least partially explain the tremendous geographic variation in premium rates observed around the nation.

One final way to think about the burden of waste in our health care system is to consider how much care we are paying for that we do not need, and how much a typical insurance premium costs as a proportion of typical family income. Jon Gabel and colleagues estimate that a typical group family policy cost $7,954 (single $3,060) in 2002.[7] That is 15 percent of our median family income of about $52,000.[8] In 1987, a typical group family premium was about 8 percent of median family money income. Only about 35 percent of families today make enough to prevent more than 10 percent of their gross income from going toward the purchase of health insurance for their family (either in foregone wages or out-of-pocket payments).[9] Thus, as health care costs have continued to grow faster than wages for decades, an increasing share of our work force is finding it harder and harder to purchase comprehensive health insurance as we have come to know it.

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[6] E.S. Fisher et al. "Associations Among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors," *Health Services Research*, Vol. 34, No. 6 (2000); J.S. Skinner, E.S. Fisher and J.E. Wennberg. "The Efficiency of Medicare," National Bureau of Economic Research Working Paper No. 8395 (July 2001).

[7] Jon Gabel et al. "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs*, Vol. 21, No. 5 (September/October 2002).

[8] The most recent family income data are for 2001. I inflated that median income level at last year's growth rate, 1.3%, to estimate median family income level for 2002. Given the recession, that is probably optimistic.

[9] Author's calculations based on 1988-2002 Kaiser Family Foundation/Health Research and Educational Trust, KPMG Peat Marwick, and Health Insurance Association of America employer surveys, as well as Bureau of the Census family income measures. The latter can be found at www.census.gov/hhes/income/histinc/f08.html.

**Uneven quality.** It is true that the world's wealthy elite come to the United States for much secondary and tertiary medical care. We certainly have many of the best physicians and treatment facilities in the world. At the same time, to quote from the Institute of Medicine's (IOM) National Roundtable on Health Care Quality:

> Serious and widespread quality problems exist throughout American medicine...[They] occur in small and large communities alike, in all parts of the country and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a result.[10]

Two path-breaking IOM reports followed this Roundtable. *To Err is Human*[11] reported how it is likely that medical errors—mostly from poor communication and coordination among health professionals—lead to as many as 98,000 unnecessary hospital deaths a year. *Crossing the Quality Chasm* identified the major system problem areas in quality measurement, attainment, and improvement, and remarkably also laid out a blueprint for how we as a nation could begin to address our stunning shortcomings. The most recent IOM report summed up our situation quite well:

> ... we have extraordinary knowledge and capacity to deliver the best care in the world, but we repeatedly fail to translate that knowledge and capacity into clinical practice.[12]

Our quality gaps range from often not doing things that should be done (e.g., cancer screenings, certain blood and eye tests for diabetics, beta-blockers for post-heart attack patients, childhood immunizations), to too often doing things that should not be done if care were being managed appropriately (e.g., hospitalizations for ambulatory sensitive conditions like asthma and diabetes, hospitalizations for medical conditions generally, overuse of ICUs in the last six months of life, unnecessary follow-up visits to specialists, contradictory information from sequentially treating health professionals, and more than one simultaneous prescription, from different doctors, that might interact in harmful ways).

Spurred by the *Quality Chasm* and preceding research, the IOM,[13] the Agency for Healthcare Research and Quality (AHRQ),[14] and the Centers for Medicare and Medicaid Services (CMS)[15] have all now developed measures of quality clinical care that should (but cannot now) be tracked in a systemic manner, as they try to lead our health care system toward a higher and more uniform level of quality performance. AHRQ will release a much-anticipated report on the state of quality in our health care system later this year. Early research on quality indicators for

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[10] M.R. Chassin and R. W. Galvin, "The Urgent Need to Improve Health Care Quality. Institute of Medicine *National Roundtable on Health Care Quality," Journal of the American Medical Association, Vol. 280, No.* 11:1000-5. (1998).

[11] Institute of Medicine. *To Err is Human: Building a Safer Health Care System.* L.T. Kohn, J. M. Corrigan, and M. S. Donaldson, eds., National Academy Press, Washington, D.C. (2000).

[12] Institute of Medicine. *Priority Areas for National Action: Transforming Health Care Quality.* Karen Adams and Janet M. Corrigan, eds., National Academy Press, Washington, D.C. (2003).

[13] Ibid;

[14] National Healthcare Quality Report: Update on Current Status. AHRQ Fact Sheet.

[15] S.F. Jencks et al. "Quality of Medical Care Delivered to Medicare Benficiaries," *Journal of the American Medical Association,* Vol. 284, No. 13 (October 4, 2000).

Medicare patients, based on random samples of medical records, indicates: "Care for Medicare fee-for-service plan beneficiaries improved substantially between 1998-99 and 2000-01, but a much larger opportunity remains for further improvement."[16] The National Committee for Quality Assurance (NCQA), a private non-profit organization, has developed and published HEDIS measures on important dimensions of care and service at the health plan level for the last five years, and these too have shown improvement recently, but also indicate just how far we have to go.

For example, the HEDIS measures that we have today mostly apply only to health maintenance organizations (HMOs) that cover about one quarter of insured Americans. The sad truth is at the moment very little systematic quality information is recorded for most care that is delivered in the United States today, especially in the preferred provider organization (PPO) and fee-for-service arrangements that still dominate provider-insurer contracts.

The NCQA publishes conservative estimates of avoidable deaths in the US from inappropriate treatment:

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| Beta blocker treatment | 1,200 each year |
| Breast cancer screening | 4,800 over 20 years |
| Cervical cancer screening | 32,000 over 35 years |
| Cholesterol management | 4,700 each year |
| Diabetes care | 5,100 over 10 years[17] |

These estimates are derived by assuming everyone in America received care as good as that dispensed in the top 10 percent of reporting health plans, and they assume that the baseline is the care delivered by the median reporting plan. (Some would argue this is an optimistic baseline assumption, but it is impossible to say because we have no national data collection effort beyond the private efforts led by NCQA and specific research projects). And despite the improvements that five years of data reporting have brought to health plan performance and perhaps system-wide performance as well, the norm remains astounding variability across health plans. For example, childhood immunization rates that vary from 48 percent to 81 percent, and eye exams for diabetics are performed in only 70 percent of cases in the 90$^{th}$ percentile managed care plan, and a mere 35 percent of cases in the 10$^{th}$ percentile plan. There is great regional variation as well, with managed care plans in the south performing 20 percent to 40 percent worse on key measures like those mentioned above.[18]

Perhaps our basic problem here stems from this fact, noted by the NCQA: "No widely used system of reimbursement rewards high quality based on performance measurements, and some [reimbursement] systems are actually detrimental to it."[19] Any economist will tell you, if we do

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[16] S.F. Jencks et al. "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-99 to 2000-01." *Journal of the American Medical Association*, Vol. 289, No. 3. (January 15, 2003).
[17] National Committee for Quality Assurance, *The State of Health Care Quality*. (2002).
[18] Ibid.
[19] Ibid p.7.

not set incentives appropriately, we cannot expect optimal behavior, either at a personal, professional or systemic level.

**Uneven access to care.** First of all, 41 million people did not have health insurance for the entire year in 2001. The absence of insurance reduces access to needed care, reduces the chances of early detection and good health outcomes from serious conditions, and generally places a number of risks onto many of our most vulnerable fellow citizens. It is fairly well known that health insurance coverage rates vary substantially by income level, race and ethnicity. For example, Latinos are about three times as likely to be uninsured as whites, and have been since 1987, when detailed statistical record keeping began. African Americans, by contrast, are roughly twice as likely as whites to be uninsured.

Access to care is higher among the insured than the uninsured. Partly due to coverage disparities then, Latinos and African Americans, when compared with non-Latino whites, are less likely to have a regular health care provider, to have had a doctor visit in the last 12 months, to have seen a specialist, and more likely to visit an emergency room. These gaps have persisted for years, and would likely be reduced—but not eliminated—if coverage were expanded to all groups equally.[20] And these access gaps are the proverbial tip of the iceberg, since lack of timely access often leads to significantly worse health outcomes, including higher risk of mortality.[21] Perhaps the most surprising and troubling inequity is that even if you control for income, insurance and age, minority death rates are still higher than whites by quite a margin for a large number of diseases.[22] We are a long way from colorblind equality in our health care system.

Recently, these key problems of waste, uneven quality and inequities have been exacerbated by a re-acceleration of health care cost growth, made possible by the wholesale retreat from the most effective but even more unpopular tools of managed care. This cost growth is partly price recovery for providers who are asserting their renewed bargaining power vs. health plans, but the cost growth is actually mostly driven by increases in utilization.[23] Many analysts consider this double-digit rate of health care cost growth to be unsustainable, and, therefore, it is likely to abate fairly soon, leaving us with less immediate cost growth pressure but the continued problems of waste, uneven quality and inequities at even higher levels of resource claims.

Each of these three major problems with our health care system—waste, uneven quality, and inequity—is daunting enough to discourage many who seek solutions. Incremental efforts to solve one are often frustrated by spillover effects flowing back from the other two. Waste and poor quality exacerbate our cost problem, which in turn creates more uninsured, especially among low-income people, who are disproportionately racial and ethnic minorities. It is impossible to solve the quality problem without coordinated care and real-time communication

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[20] Hargraves, J. Lee, *The Insurance Gap and Minority Health Care, 1997-2001*, Tracking Report No. 2, Center for Studying Health System Change, Washington, D.C. (June 2002).

[21] Institute of Medicine. *Care Without Coverage, Too Little, Too Late*. National Academy Press, Washington, D.C.. (2002).

[22] Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academy Press, Washington, D.C. (2002).

[23] Strunk, Bradley C., Paul B. Ginsburg, and Jon R. Gabel, "Tracking Health Care Cost: Growth Accelerates Again *in 2001," Health Affairs, Web exclusive, (September 25, 2002).*

among different providers, but communication infrastructures do not exist because no one has been willing to spend more than they already do to construct them.

The market return from investing in quality—both for providers and for health plans—has been low because most patients do not perceive there is a quality problem and trust their own doctor and the local hospital he recommends, regardless of what elites and the information advocates think. Uninsured and low-income patients present particular communication challenges with the overworked health professionals who see them. They are in general less compliant with treatment regimens than middle-class, privately insured patients, and since so much of quality care requires self-management and health literacy, coverage and access gaps maintain the quality chasm for vulnerable populations even more so than for the general population. Finally, profound fear of malpractice and economic loss generally has retarded provider engagement on the quality and error-reporting fronts, all of which serves to keep costs high, and so the dysfunctional set of interactions continues to stress our system.

Thus, all three problems need to be addressed simultaneously with system reforms and federal leadership on all fronts. This will require substantial new resources to be committed, even though waste reductions and general quality enhancements can be expected to offset some of these new costs in the long run.

It is still early, but not the first day, of a new national conversation about system reforms that could ultimately relieve the stresses on our health care system. Much detail remains to be worked out, understood and digested, and the range of possible forms an improved system might take is quite broad.[24] Senator Breaux has already laid out a vision for system reform that can serve as a cohesive springboard for ongoing discussions and proposal refinement, as have Democratic presidential candidates, Health and Human Services Secretary Thompson and the President, himself.[25]

This might be a particularly opportune moment to look back at the experience of the Clinton reform effort in 1993-94 for overarching lessons that may inform current efforts to reduce the key and related problems of our health care system.

1. **Bipartisanship.** Our health care system is too large, complex and deeply personal to reform by narrow legislative margins of victory. If we cannot build a consensus from the middle of the political spectrum that can attract wide support, we are not ready to reform our system, as we apparently were not in 1993-94.

2. **Federal leadership, not micromanagement.** Federal leadership is indispensable, for the interests involved are just too powerful for any other actor to lead the way for systemic reform. Federal legislation must define responsibilities for all, including state governments, employers, health care providers, insurers, and most importantly

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[24] See Covering America for a representative sample of alternative but feasible models of our health delivery and financing systems.

[25] http://breaux.senate.gov/~breaux/releases/2003123A14.html; http://www.os.dhhs.gov/budget/04budget/fy2004bib.pdf;

individuals, but important choices regarding implementation must also be left with states and local market participants who know our heterogeneous health care markets best. Federal resource commitments must also be substantial, both in terms of creating an information infrastructure to support quality improvement and in terms of subsidies for coverage expansion, or this entire effort will prove disappointing.

3. **Transparency.** The Clinton Administration, elected in 1992 with 43 percent of the vote, believed that the people would not support payroll or income tax increases to pay for universal health insurance and fundamental system reform. They then devised financing arrangements—Medicare provider payment cuts and statewide global budgets—that turned out to be technically feasible but politically unsustainable. Many analysts and observers doubted that the nation could actually do something on this scale with no new taxes. The primary risk of the Clinton plan was that technological advances might have been curtailed due to the global budgets on expenditures that made the financing plans technically feasible. Those risks were not made clear, and other risks were imagined and exaggerated. The key point is, the loss of credibility on financing was partially self-inflicted and due to a lack of transparency. A successful system reform campaign will elicit a straightforward willingness to pay for a better health care system for all Americans, or not, in which case we are not ready, again.

4. **Do not make enemies of key players in the health care system.** Almost all feel justified in blaming someone else for our current system's failures. There is plenty of blame to share, and blame is not the point; developing a simultaneous approach to waste, uneven quality and uneven access is the point. We cannot get out of our morass without the enthusiastic participation of most providers, health plans, employers, governments, and citizens/workers/patients. There is plenty of work for all major players to perform, and most are willing. We just need to reform information and payment systems to encourage, facilitate and reward better health and health care choices.

5. **The key health system unit is not the health plan.** All managed competition proposals, like the Clinton plan, put the health plan at the vortex of health system reform. In essence, since 1994, employers hired managed care plans to take care of their cost growth problem, and they did, until patient and provider backlash made the employers tell their agents—the health plans—to back off on the techniques that worked. This backlash has revealed the difficulty of depending on a *deus ex machina* to solve our health care cost, quality and access problems for us, magically and painlessly. Health plans cannot be the silver bullet we may wish for. But they are very likely to be part of the solution, for they remain potentially useful devices for organizing and disseminating information to providers and coordinating care for patients among networks of collegial providers. Professional specialty societies and government agencies are alternative communication devices that will be necessary as well.

   But the key health care transactions will always be between caregivers and patients. Incentives must be correct for this set of transactions, or we have no hope. If we are able to get the incentives right here, much else will take care of itself.

What kind of system is most likely to get these key incentives right?

A system that pays for quality care and good health outcomes, and does not pay for failure to provide quality care, is the kind of system most likely to have sustainable incentives. Building this system will require public investment in an information infrastructure so that providers and patients will find it easier to jointly produce good quality health care and the best health outcomes possible. This kind of system will also require organized group purchasing, with serious leadership from our public insurance programs, to create an environment in which widespread provider participation in quality improvement efforts is not an option dependent on the balance of local market power but a reality.[26]

In the long run, improvements in technology drive health care cost growth. We certainly value these technological improvements, but heretofore our financing and delivery system has been biased in favor of paying for everything, whether truly effective in promoting better health outcomes or not. By learning now about how to reduce unhelpful services, the supply sensitive sort that Wennberg and colleagues have identified, and to improve quality in the *Chasm* sense, we would not only create savings we can then spend more wisely, we might also create an evaluation infrastructure that can help us decide which future health technologies should be financed with pooled resources and which should be financed outside our insurance system, if at all.

This seems to me to be the wisest way to prepare for the future; learn how to decide what health care we really want to buy. Otherwise, I see two unhappy fates. We could spend 25 percent of GDP on healthcare by 2030 and still have uneven quality and mountains of wasted care. Or we could render our inefficient care even further out of the reach of ever-larger fractions of our population, and keep our GDP share down by making access to health care even more exclusive than it is today. I would much rather see our nation invest now in learning how to buy and deliver health care more effectively so that we can always afford good quality care for all.

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[26] Christianson, Jon B. and Sally Trude, "Managing Costs, Managing Benefits: Employer Decisions in Local Health Care Markets," *Health Services Research*, Vol. 38, No. 1, Part II (February 2003).

Senator BREAUX. Our next witness will be Ms. Karen Davis. Welcome. Ms. Davis is currently the President of The Commonwealth Fund, which is a national philanthropy that does independent research on both health and social policy issues. Before joining The Commonwealth Fund, she served as Chairman of the Department of Health Policy and Management at Johns Hopkins School of Hygiene and Public Health, where she is also a professor of economics and currently one of the promoters of an annual conference on health care that brings together some real experts, and we thank her for that participation. Ms. Davis, thank you very much.

**STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY**

Ms. DAVIS. Thank you, Mr. Chairman, Mr. Chairman, Senator Collins, Senator Stevens, for this opportunity to be with you today.

We have entered the 21st century encumbered by a health system that is not up to the challenge of ensuring a healthy and productive nation. It was really set in motion over 50 years ago, after World War II, and it has resulted in a system that is costly, complex, and confusing. Most important, it is failing to meet the twin objectives of health insurance, to ensure that people have access to needed medical care and to protect them from the financial burdens of costly medical bills.

Today, I would like to focus on five types of costs that are inflicted by our fragmented health insurance system. First of all, we have already heard today about the costs of the growing number of uninsured. I include in my testimony a number of charts at the end that demonstrate, for example, in Chart 1, that we are not making any progress in reducing the numbers of uninsured. They have gone up steadily since the mid–1970's and we do have 41 million Americans today that, as Senator Breaux reminded us, fall between the boxes of our American health care system because they are not lucky enough to be covered by employer-based coverage, Medicare, Medicaid, or the Children's Health Insurance Plan.

We also know that coverage is eroding dramatically for retirees. Senator Breaux mentioned the situation of retiree health insurance coverage. In Chart 11, I note that it has dropped from 66 percent of large firms in 1988 that provided retiree coverage to 34 percent today, and only 3 percent of small firms provide retiree coverage. We know that Medicare is not enough on its own, that people need prescription drug coverage, and yet there are a fourth of Medicare beneficiaries who do not have such coverage.

I think it is important to know that there are both health and economic consequences of the gaps in health insurance coverage. The Institute of Medicine released a study last year, which I have shown in Chart 16, indicating that there are 18,000 deaths of adults ages 25 to 64 that occur each year as a direct consequence of the absence of health insurance coverage. If you look at deaths of those non-elderly adults, it makes uninsurance the sixth leading cause of deaths in this age group, greater than the number of deaths from HIV/AIDS or from diabetes.

At The Commonwealth Fund, we have supported numerous studies that look at those who do not have health insurance coverage, either part-year or full-year, and we find that whether you are a

long-term uninsured or a short-term uninsured, you have greater difficulty getting needed care, greater difficulty getting preventive services, and you incur much greater financial problems as a consequence of that exposure.

We also know that the cost shifting that occurs in a fragmented financing system, especially as health care costs accelerate, as Senator Collins mentioned, creates inefficiency in the system.

There are 70 million American workers who are covered by their own employer. There are 20 million more workers who are covered under a family member's coverage, typically a spouse's, and there are 30 million workers who are not covered at all. So we really have a "pass the buck" system of health insurance, where we are perpetually shifting costs from one party to another.

Those large employers that cover their workers cover that cost as well as the cost of dependents whose own employer is not picking them up, and they also pick up the costs of the uninsured that are reflected in higher rates charged by hospitals, and some physicians, that result in higher health insurance premiums. Employers, in turn, try to shift more cost to workers in the form of higher premiums or cost sharing.

States allege that the Federal Government shifts costs to them by not picking up all of the costs of Medicare beneficiaries. I give one example in Chart 23, where State Medicaid prescription drug spending for dual-eligibles that are covered by both Medicare and Medicaid comes to $6.8 billion a year, and I have indicated how that breaks down across the various States.

In addition, hospitals shift costs from one to the other. Those hospitals that are willing to serve the uninsured are much more financially fragile than those who do not provide care to the uninsured, and care is increasingly concentrated in a limited number of safety net and teaching hospitals.

But my basic point is that far more energy goes to shifting costs than to enhancing efficiency or quality of health care. Insurance companies are profitable because they attract favorable risk and drop unfavorable risk, not necessarily because they provide innovative incentives to improve quality and efficiency.

There also is the cost of churning in health insurance coverage as people's economic and personal circumstances change. Mr. Crippen pointed to the fact that about half of people who are uninsured at some point during the year, 62 million people, were uninsured all year long. About half were insured part of the year, and about, as Senator Collins noted, 75 million people were uninsured over a 2-year period.

But as this churning occurs, these people are at risk for not getting care when needed and they face unaffordable medical bills when care could be incurred. But I think most importantly, we pay a high price in high administrative costs. Every time somebody enrolls, disenrolls, reenrolls, it is administrative cost to the insurance company or the public program. It is also an administrative cost to the health care providers that have to change their records, perhaps forward medical records to another provider.

As I show in Chart 29, the U.S. spent $111 billion in 2002 on private insurance or government program administrative costs, and that doesn't include the administrative cost that is incurred by hos-

pitals and other health care providers or by individuals as they enroll, disenroll, and reenroll, changing insurance coverage and plan.

The final point I want to make is simply the cost of complexity from a pluralistic system of health insurance without an integrating framework and consensus on basic principles. As I show in Chart 31, Professor Reinhardt has developed a chart that he uses to explain the U.S. health care system, and it is a Mondrian diagram of cuts that are on the basis of whether you are a child, an adult, or an elderly, whether you are poor, near-poor, working income, middle class, or rich, and there are separate ways in which you get covered depending upon which of those categories you fall in.

But I also provide in Chart 32 at the very back of the testimony an example of the complexity of different benefit packages. This is just in our Medicare+Choice program in Tampa, where there are eight different plans available, but they each have their own set of premiums, cost sharing requirements, drug formularies. It is really impossible for either the beneficiary or a family member or a consumer advocacy group to explain which plan best fits the circumstances of those individuals.

Thus complexity leads to the costs of large numbers of people who are eligible but not enrolled. It leads to costs of lost productivity, and lost resources wasted on administration. It also leads to the cost of inefficient and low-quality care. Senator Collins mentioned the high costs in emergency rooms for preventable conditions and for hospitalizations and the costs of different standards of care that depend on insurance status. In fact, the U.S. spends twice as much per capita on health care as other industrialized nations, and yet is the only one to fail to cover everyone.

There simply has to be a better way to go about providing coverage, and that should include automatic and affordable coverage for all, a balance between choice, flexibility, and innovation, and between simplicity, efficient administration, and standardization that facilitates informed choice; shared responsibility for financing coverage, including, I would argue, contributions from employers, both the insured and the uninsured, health care providers, Federal, State and local government; a commitment to quality improvement and greater efficiency in care and in insurance administration using modern information technology. Finally, we need to set the goal of high-quality health care for all as the top national policy priority essential to a strong and healthy and productive nation. Thank you.

The CHAIRMAN. Thank you very much, Ms. Davis.

[The prepared statement of Ms. Davis follows:]

# TIME FOR CHANGE:
# THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM

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Invited Testimony
In Critical Condition: America's Ailing Health Care System
Senate Special Committee on Aging
March 10, 2003

## TIME FOR CHANGE:
## THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM
### Executive Summary

We have entered the 21st century encumbered by a health system that is not up to the challenge of ensuring a healthy and productive nation. Set in motion over 50 years ago, the system is costly, complex, and confusing. Most important, it is failing to achieve the twin objectives of health insurance: to ensure that people have access to needed medical care and to protect them from the financial burdens of costly medical bills.

There are five types of costs inflicted by our fragmented health insurance system:

- Costs of a growing number of uninsured
  - 41 million Americans in 2001 fell through the cracks of the American health care system because they were not lucky enough to be covered by employer-based coverage, Medicare, Medicaid, or the Children's Health Insurance Plan
- Health and economic consequences of gaps in health insurance coverage
  - 18,000 deaths of adults ages 25 to 64 occur each year as a result of the absence of health insurance coverage—making it the sixth-leading cause of death in this age group, ahead of HIV/AIDS or diabetes
- Cost-shifting that occurs in a fragmented financing system, especially as health care costs accelerate
  - 70 million American workers are covered by their own employer; 20 million by a family member's or previous employer; 30 million are not covered by an employer
  - Our "pass the buck" system of health insurance perpetually shifts costs from one employer to another, employers to workers, federal government to state governments and back, and to safety-net hospitals serving the uninsured
  - Far more energy goes into shifting costs than enhancing efficiency or quality of health care; insurance companies are profitable by attracting favorable risks, not through innovative incentives to improve quality and efficiency
- Costs of churning in health insurance coverage, as people's economic and personal circumstances change
  - Churning results in frequent gaps in insurance. Sixty-two million—one of four were uninsured during 2000; 75 million were uninsured in 2000 and 2001. These people were at high risk of not getting care when needed and facing unaffordable medical bills when care could not be postponed.

- The U.S. spent $111 billion in 2002 on private insurance and government administrative costs—not including administrative costs incurred by hospitals and other health care providers or by individuals as they enroll, disenroll, and re-enroll and change insurance coverage and plans.

- Costs of complexity from a pluralistic system of health insurance without an integrating framework and consensus on basic principles
  - Cost of large numbers of individuals eligible for but not enrolled in public programs
  - Cost of lost productivity, health, anxiety, sick days, and valuable time of uninsured patients spent seeking care
  - Cost of resources wasted on administration—jobs underwriting, screening, and verifying eligibility; new administrative apparatuses to cover narrow target groups of eligible individuals; costs of enrolling and disenrolling for public and private insurers and for individuals
  - Costs of inefficient and low-quality care—high costs in emergency rooms for preventable conditions and hospitalizations; costs of differing standards of care depending on insurance status
  - The U.S. spends twice as much per capita on health care as other industrialized OECD nations and is the only one to fail to cover everyone

There has to be a better way:

- Automatic and affordable coverage for all
- Balance between choice, flexibility, and innovation; and between simplicity, efficient administration, and standardization that facilitates informed choice
- Shared responsibility for financing coverage—employers, insured and uninsured, health care providers, federal, state, and local government
- Commitment to quality improvement and greater efficiency in care and insurance administration, using modern information technology
- Setting a goal of high-quality health care for all as a top national policy priority, essential to a strong, healthy, and productive nation

# TIME FOR CHANGE:
# THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM

**Karen Davis**

Thank you, Mr. Chairman, for this invitation to testify on the state of our nation's health insurance system. We have entered the 21st century encumbered by a health system that is not up to the challenge of ensuring a healthy and productive nation. Set in motion over 50 years ago, it is costly, complex, and confusing. Most important, it is failing to achieve the twin objectives of health insurance: to ensure that people have access to needed medical care and to protect them from the financial burdens of costly medical bills.

Today, I'd like to focus on five types of costs inflicted by our fragmented health insurance system:

- Costs of a growing number of uninsured;
- Health and economic consequences of gaps in health insurance coverage;
- Cost-shifting that occurs in a fragmented financing system, especially as health care costs accelerate;
- Costs of churning in health insurance coverage, as people's economic and personal circumstances change; and
- Costs of complexity from a pluralistic system of health insurance without an integrating framework and consensus on basic principles.

**Costs to the Nation from a Growing Number of Uninsured**

The primary cost to the nation of having a fragmented health care system is the large and growing number of Americans who do not have health insurance. Forty-one million people fall through the cracks of health insurance coverage. They are not lucky enough to have a job with health benefits. Coverage under Medicaid depends on income, assets, where people happen to live, and whether they have children or are disabled; in addition, people must be aware that they qualify for the program and be able to document their eligibility. Coverage for Medicare requires waiting two years as a disabled person or reaching age 65, plus meeting Social Security work history requirements. Buying coverage through the individual market depends on one's health, age, and income sufficient to afford substantial premiums.

We have made no serious progress in reducing the numbers of uninsured since the mid-1970s (Chart 1).[1] Many factors have either improved or reduced coverage, but on balance, the numbers have risen. The loss of manufacturing jobs in the American economy reduced insurance coverage in the 1980s, but with more women entering the workforce more families had two earners and two chances at a job with health insurance coverage. More low-income children were added to Medicaid in the late 1980s and early 1990s. In the late 1990s, welfare reform—largely unintended—contributed to a loss of coverage for women leaving welfare, their children, and legal immigrants. The enactment of the Children's Health Insurance Program (CHIP) in 1997 picked up many of these children at the turn of the century and, paired with a strong economy, there was a slight rise in coverage rates. But since 2000, the numbers of uninsured have again risen. Most of the increase in the uninsured last year was due to loss of private insurance as rising rates of unemployment led to job and insurance loss. In the coming year, public coverage is likely to erode as states hit by fiscal crises move to restrict coverage.

There are a number of paths to health insurance coverage in the United States (Chart 2). The dominant path to insurance is having a job with an employer who offers such a benefit: 160 million Americans have employer-based coverage. Medicare covers 39 million people ages 65 and over and those who have been disabled for two years or more who meet the work history requirements for Social Security. It is the only universal health plan in the country and, although there are gaps in what it covers, it is still the most popular.[2] Medicaid covers 40 million people, mostly low-income children, their parents, disabled people, and the elderly (some of whom are covered both by Medicare and Medicaid). It is the largest insurer of the very poor and very sick, filling gaps left by the private system. During the recent recession, Medicaid has seen its enrollment climb rapidly, mitigating the increase in the uninsured. About 15 million people under age 65 rely entirely on coverage they buy on their own.[3]

Sources of health insurance coverage vary widely depending on income (Chart 3). Among those living below the federal poverty level, just 19 percent receive coverage through an employer. Forty two percent are publicly insured, and a small group buys individual coverage. Nearly one-third are uninsured. As income increases, employer-sponsored insurance rises, with more than three-fourths (78 percent) of those making more than three times the poverty level getting their coverage through an employer.[4]

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[1] National Health Interview Survey, EBRI, Current Population Survey, and Current Population Report.

[2] K. Davis, et al. "Medicare Versus Private Insurance: Rhetoric and Reality." *Health Affairs* (October 9, 2002).

[3] Analysis done by the Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

[4] Analysis done by the Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

In addition to the large number of people who report that they are uninsured all year, almost the same number—13 percent of those under age 65—report that there was a time in the past year when they were uninsured (Chart 4).[5] Young adults ages 19 to 29 are especially likely to experience a gap in insurance coverage as they leave their parents' insurance policies or Medicaid, or fail to find a job with benefits or meet categorical eligibility requirements for Medicaid. Among 19- to 23-year-olds, about half were uninsured part or all of the year (Chart 5).[6]

Employer-sponsored health insurance typically allows young adults up to age 21 or 23 to remain on their parents' policies as long as they are full-time students. However, there are more young adults who are part-time students or not in school than there are full-time students, and they are not afforded the same protections. As a result, 36 percent of young adults who are not full-time students are uninsured (Chart 6).[7]

Another group that regularly falls outside the protections of health insurance is Hispanics. Hispanics are more than twice as likely as white, non-Hispanics to be without health insurance (Chart 7). Those who are newer to the United States and working in the lowest-wage jobs, including many Mexican and Central American workers, are among the most likely to be uninsured. Nearly half of people coming to the United States from Mexico lacked health insurance at some time in 2001.[8]

It is a common misperception that many uninsured workers are offered insurance but turn it down, either because they don't need or don't value it relative to other types of compensation. In fact, 60 percent of uninsured workers are not offered insurance by their employer, and another 11 percent are not eligible for their employer's plan because of their part-time status or a waiting period (Chart 8). Twenty-two percent of uninsured workers decline their employer-offered coverage, mainly because of cost.[9]

The rate at which workers take-up coverage varies by how much they earn. People making less than $10 per hour are much less likely to participate in their employer's plan than those making more than $10 per hour (Chart 9). Firm size matters as well. Compared with the smallest firms, medium and large employers tend to offer better coverage at lower or comparable premiums, contributing to the higher take-up rates at larger firms. As a result, the highest uninsured rates are among low-wage workers

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[5] J. Rhoades and J. Cohen, *Statistical Brief #6 – The Uninsured in America, 1996–2001*. (Rockville, MD: Agency for Healthcare Research and Quality, November 2002).

[6] Analysis done by Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2000 Medical Expenditure Panel Survey.

[7] Analysis done by Commonwealth Fund Task Force on the Future of Health Insurance and Sherry Glied, Columbia University, using March 2002 Current Population Survey.

[8] M. Doty, *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*. (New York: The Commonwealth Fund, February 2003).

[9] Analysis of the Commonwealth Fund 2001 Health Insurance Survey.

employed in small firms. Uninsured rates are almost 10 times higher for these workers than for higher-wage workers in larger firms.[10]

"Nonstandard" employees are also at much higher risk of being uninsured. About one-fourth of part-time workers are uninsured—nearly as many as the unemployed (Chart 10). But even full-time workers who are new on the job can wait two to four months for coverage.[11] Independent contractors or employees who are "leased" through an outside firm are often denied health benefits, even if they effectively work full time for a firm that provides coverage to "standard" employees.

Coverage for retirees has also deteriorated markedly over the past decade (Chart 11). More and more firms are declining to provide health insurance, both for early retirees and supplemental coverage for retirees whose primary source of coverage is Medicare. In 1988, 66 percent of large firms provided retiree health benefits; today, only 34 percent do so.[12]

Supplemental insurance coverage is also problematic, even for Medicare beneficiaries. While almost everyone age 65 and over is covered by Medicare, limits on program benefits mean that Medicare covers only 55 percent of the costs of beneficiaries' care.[13] As a result, most Medicare beneficiaries have some form of supplemental coverage, through retiree plans, enrollment in Medicare+Choice plans, purchase of private Medigap coverage, or coverage under Medicaid (Chart 12). Yet, almost one-fourth of Medicare beneficiaries have no prescription drug coverage and almost half are without prescription drug coverage at some point during the year.[14] Many of the most important sources of prescription drug coverage—retiree coverage and Medicare+Choice—have been eroding in recent years.[15]

Maps reveal a great deal about who experiences the inequities of the health insurance system in the United States (Chart 13). By virtue of where a person lives, he or she may or may not be eligible for public coverage, or may work in an industry in which insurance coverage is commonplace. Uninsured rates vary from a low of 8 percent in five

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[10] S. Collins, C. Schoen, D. Colasanto, and D. Downey, "On the Edge: The Health Insurance Coverage of Low-Wage Workers," Findings from the Commonwealth Fund 2001 Health Insurance Survey (New York: The Commonwealth Fund, March 2003).

[11] J. Gabel, J. Pickreign, H. Whitmore, and C. Schoen. "Embraceable You: How Employers Influence Health Plan Enrollment." *Health Affairs* (July/August 2001): 196–208.

[12] Kaiser Family Foundation/Health Resource and Educational Trust, Employer Health Benefits 2002 Annual Survey. (Menlo Park, CA: Kaiser Family Foundation, 2002).

[13] Kaiser Family Foundation. *Medicare Chart Book*. (Menlo Park, CA: The Kaiser Family Foundation, 2001).

[14] B. Stuart, D. Shea, and B. Briesacher, *The Dynamic of Prescription Drug Coverage for Medicare Beneficiaries* (New York: The Commonwealth Fund, November 2001).

[15] B. Stuart, D. Shea, and B. Briesacher, *The Dynamic of Prescription Drug Coverage for Medicare Beneficiaries* (New York: The Commonwealth Fund, November 2001).

states (Rhode Island, Minnesota, Massachusetts, Iowa, and Wisconsin) to highs of 23 percent in Texas and 22 percent in New Mexico.[16]

Part of the state variation can be understood by looking at Medicaid (and CHIP) eligibility rules and enrollment processes. Since the 1980s, Medicaid programs have been growing to provide health care access for the lowest-income children, elderly, disabled, and, more recently, parents (Chart 14).[17] Medicaid is a major source of coverage for pregnant women and poor children. One-third of all births are covered by Medicaid. However, this coverage varies widely across the states (Chart 15). Furthermore, recent state budget crises portend a flattening out of the programs, or even a retrenchment. Even in the best of times, state programs—with a few exceptions—have fallen well short of providing a uniform base of coverage for those most at risk.

**Health and Economic Consequences of Gaps in Health Insurance Coverage**

The Institute of Medicine estimates that, each year, 18,000 25- to 64-year-old adults die because they lack health insurance coverage.[18] This would make lack of health insurance the sixth-leading cause of death among people under age 65—after cancer, heart disease, injuries, suicide, and cerebrovascular disease, but before HIV/AIDS or diabetes (Chart 16). Such numbers make a compelling case for addressing this national disgrace.

Failure to act will result in costs to all sectors of society—to the uninsured, who pay in lost years of life; to employers, whose employees miss work or retire early for health reasons; to the health system, which is encumbered by bad debts and inefficient care resulting from inadequate insurance; and to society at large, which forgoes the economic benefits and taxes of a healthier, more productive labor force. We all pay when we fail to invest in health care that would make us a stronger and healthier nation.

Of course, being uninsured exposes individuals to risks in addition to greater probability of death. Lack of health insurance often results in poor-quality care, which can have a multitude of health consequences. The Commonwealth Fund 2001 Health Insurance Survey found that the uninsured are less likely than the insured to see a physician when needed or to get needed specialist care; they are also less likely to fill prescriptions ordered by physicians when they do seek care, and are less likely to get recommended tests or follow-up treatments (Chart 17). More than half (54%) of those

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[16] www.statehealthfacts.kff.org, accessed 3/5/03; R. Bovbjerg, et al. "Medicaid Coverage for the Working Uninsured: The Role of State Policy," *Health Affairs* (November/December 2002):231-243.

[17] Centers for Medicare and Medicaid, *An Overview of the U.S. Healthcare System: Two Decades of Change, 1980-2000*. (http://www.cms.gov/charts/healthcaresystem/, accessed 3/5/03)

[18] Institute of Medicine, *Care Without Coverage: Too Little, Too Late*. (Washington, D.C.: The National Academies Press, 2002).

uninsured all or part of the year reported one of these problems in terms of access to care, compared with one-fifth (21%) of those who are continuously insured.

The uninsured who do obtain care are more likely to experience financial burdens from medical bills. Those without insurance are twice as likely as those continuously insured to be required to pay cash in advance to get care. More than half of the uninsured reported that they were not able to pay medical bills and more than a third said that they had been contacted by a collection agency about unpaid medical bills. Overall, twice as many uninsured as insured said that they experienced cost-related problems in accessing care or paying for medical bills (70% vs. 34%).[19]

The uninsured are also less likely to have a regular source of care, and are thus less likely to receive preventive care or benefit from early detection of medical problems (Chart 18).[20] For example, among adults ages 45 to 64, the uninsured are less likely than the insured to have had a cholesterol screening in the past five years. Early detection of abnormalities is critical to the successful treatment of breast cancer, yet among women ages 50 to 64, 32 percent of the uninsured compared with 11 percent of the insured had not received a mammogram in the past two years.[21] Moreover, the uninsured say they are less satisfied with the quality of care they receive and are less likely to follow their physician's advice because of costs. In terms of the quality framework set forth by the Institute of Medicine, the uninsured are systematically less likely than the insured to receive effective, safe, and timely care.

A recent study estimates that an individual's earnings are 15 to 20 percent lower as a result of being uninsured, largely because of reduced workforce participation and productivity.[22] Employers, too, may incur costs when employees miss work, leave jobs, or retire early for health reasons. The Fund's 2001 Health Insurance Survey found that 16 percent of the uninsured were absent from work during the year because of a problem with their teeth, compared with 8 percent of those with health insurance. Almost half (45%) of the uninsured said that they went without needed dental care over the course of a year.

Caregiving responsibilities for a sick or disabled child, spouse, or parent may also keep employees from the workplace. Women in particular may miss work to care for sick

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[19] L. Duchon, et al., *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk, Findings from the Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund, December 2001).

[20] K. Collins, et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans, Findings from the Commonwealth Fund 2001 Health Care Quality Survey* (New York: The Commonwealth Fund, March 2002).

[21] J. Ayanian, et al., "Unmet Health Needs of Uninsured Adults in the United States," *Journal of the American Medical Association* 284 no 16 (2000): pp 2061–2069.

[22] J. Hadley, *Sicker and Poorer: The Consequences of Being Uninsured* (Menlo Park, CA: Kaiser Family Foundation, 2002).

family members, especially children, and uninsured children are more likely than insured children to miss school.[23] In an analysis of women previously on welfare, one study found that having a health limitation and having a child with a health limitation were associated with significantly increased risk of job loss—even after accounting for differences in social and demographic characteristics.[24] In a 1999 study, about 37 percent of women on welfare were caring for a child with a chronic condition.[25]

**Cost Shifting that Occurs in a Fragmented System**

Health care costs have accelerated markedly in recent years. In 1988, we were spending $600 billion on health care in the United States. Estimates are that we spent $1.5 trillion last year, and that number will double to more than $3 trillion by 2012 (Chart 19).[26] After years of relatively stable growth in the mid-1990s, health spending as a percent of gross domestic product increased to 14.1 percent in 2001, up from 13.3 in 2000.[27] Health spending is projected to reach 17.7 percent of GDP in 2012 (Chart 20).

Health insurance premiums are growing rapidly too, at about 13 percent in 2002. By contrast, workers' earnings are growing at just 4 percent a year (Chart 21).[28] Even this increase in premiums understates the rising cost for the same benefits, since there has also been about a 2-percent reduction in the actuarial value of covered benefits through increased cost-sharing or other restrictions on covered services.

The fragmentation in the U.S. health care system leads to an uneven distribution of the costs of coverage. About 70 million American workers get coverage from their own employer. Another 20 million American workers get coverage from another employer, typically that of their spouse.[29] Employers who cover their own workers often pay in multiple ways—for the cost of coverage for their workers and their workers' dependents, and for higher premiums that reflect the costs of uncompensated care that are passed on by hospitals and other health care providers. By contrast, employers who do not offer coverage effectively shift this cost and responsibility onto other employers or

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[23] B. Wolfe and S. Hill, "The Effect of Health on the Work Effort of Single Mothers." *Journal of Human Resources* 30(1) 1994.

[24] A. Earle and J. Heymann. "What Causes Job Loss Among Former Welfare Recipients: The Role of Family Health Problems." *Journal of the American Medical Women's Association* 57(1) 2002: 5–10.

[25] J. Heymann and A. Earle. "The Impact of Welfare Reform on Parents' Ability to Care for Their Children's Health." *American Journal of Public Health* 89(4) 1999:502–505.

[26] Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs* (February 7, 2003).

[27] Stephen Heffler et al., "Health Spending Projections for 2002–2012," *Health Affairs* Web exclusive, February 7, 2003.

[28] Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs* (Sept/Oct 2002):143–151.

[29] S. Collins, et al., "On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey." (New York: The Commonwealth Fund, forthcoming).

public programs. Many of their uninsured employees are minimum-wage workers who—despite an economic theory that assumes backward shifting of health insurance costs—are unlikely to be paid higher wages in lieu of health insurance coverage.

Similarly, some states do a good job of covering low-income children and adults who fall through the cracks of employer-based coverage. But others have quite restrictive income and asset limits, thereby shifting the cost of care to safety net institutions, which in turn try to shift the costs to those with private coverage.

As a result of its fragmentation, we have a "pass the buck" health care system in which cost-shifting among payers is commonplace. This problem only intensifies as health care costs grow, and more payers attempt to hold the line on their own spending. Most recently, employers who cover their workers have been shifting a greater proportion of that cost directly onto employees in the form of higher premiums and cost-sharing.[30]

While the problem of rising health care costs is troubling to those who are insured, it can be devastating to those who are not. When the uninsured absolutely cannot skip needed health care, they seek care at safety net institutions and from charitable providers. The cost to the system of caring for the uninsured was estimated at $40.6 billion in 2001. The biggest portion of this—more than $24 billion—was the amount providers report as uncompensated care. The uninsured paid an additional $14 billion out of pocket, and worker's compensation covered about $2 billion.[31]

Public programs also indirectly fund care for the uninsured (Chart 22). Medicaid and Medicare contributed $17 billion in 2001 through disproportionate share payments to hospitals and support for medical education. The Veterans Administration spent $7.4 billion on health care, many for uninsured men who could not afford care through other health care providers, or for elderly without prescription drug coverage. Community health centers, Ryan White centers for people with HIV/AIDS, the Indian Health Service, and other public programs also provide funding for care of the uninsured. Together, these public sources of care spent $30.6 billion in 2001 for the health needs of the uninsured.

Government is not immune to the temptation to shift costs as well. For years, states have complained that the Medicare program fails to pick up the costs of Medicare beneficiaries, instead shifting that cost in part to states through the federal-state Medicaid program. Prescription drug coverage, which most agree is a glaring omission in the Medicare program, winds up being covered by the states for the poorest of the elderly. In 2002, states spent approximately $6.8 billion on prescription drugs for Medicare

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[30] J. Edwards, M. Doty, and C. Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey* (New York: The Commonwealth Fund, August 2002).

[31] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for it?" *Health Affairs* Web Exclusive, February 12, 2003.

beneficiaries with full Medicaid benefits; there was wide variability among states in terms of spending for this group (Chart 23).[32] Similarly, by setting an arbitrary two-year waiting period for coverage of the disabled, Medicare shifts to states the cost of covering low-income disabled individuals during that period, even after they have qualified for Social Security Disability Insurance.

The federal government provides higher matching rates for low-income children under CHIP than under Medicaid. States thus have an incentive to restrict eligibility under Medicaid and instead cover children under CHIP. Groups without federal matching assistance, particularly low-income single individuals and childless couples, are the least likely to be covered by state programs.

There can also be shifting among state and local governments. If states limit eligibility under Medicaid, costs are shifted to public hospitals supported by localities. In some states, localities share in the cost of Medicaid but not CHIP, changing the calculus of who wins and who loses when coverage is expanded or restricted. The uninsured are often forced to use costly emergency room care that could have been provided in lower-cost primary care settings.[33] As their beds fill with uninsured patients, hospital emergency rooms routinely have to turn away patients who have insurance, and overcrowding adversely affects the quality of care for all patients.[34]

"Passing the buck" also occurs among health care providers. Some hospitals treat patients without health insurance coverage, others do not. As fiscal pressures have tightened with managed care, and greater restrictions have been placed on Medicare and Medicaid payments to hospitals, certain hospitals—particularly public hospitals, teaching hospitals, and other safety net institutions—have provided an increased share of care of the uninsured (Chart 24). This has threatened the hospitals' fiscal stability, leading many to restrict admission for people who can not pay.

Some have viewed the expansion of community health centers as an alternative to providing health insurance coverage. These primary care centers are often models of care, serving low-income and minority communities with a commitment to providing quality care. But they are not funded to provide specialized services, and it is often difficult for them to find providers to perform mammograms, colonoscopy exams, MRIs, ultrasound

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[32] S. Dale and J. Verdier, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles*. (New York: The Commonwealth Fund, forthcoming.)

[33] Schur, C., P. Mohr, and L. Zhao, *Emergency Department Use in Maryland: A Profile of Use, Visits, and Ambulance Diversion*. Report to the Maryland Health Care Commission, Project HOPE: Bethesda, Md., February 2003.

[34] The Institute of Medicine, A Shared Destiny: Community Effects of Uninsurance. (Washington, DC: National Academies Press, 2003)

tests, cardiology consultation, orthopedics, infectious disease consultation, or inpatient hospital care for their uninsured patients (Chart 25).[35]

"Passing the buck" is a way of life in certain segments of the health insurance market. The individual insurance market, except in a few states, can exclude those with serious health problems, or charge such high premiums that individuals cannot afford to purchase coverage. Individual health insurance premiums typically vary by age, and are often unaffordable for uninsured individuals with limited incomes (Chart 26). The Commonwealth Fund 2001 Health Insurance Survey found that 53 percent of individuals who explored obtaining health insurance on the individual market reported that it was very difficult or impossible to find a plan they could afford.[36]

Medicare's experience with Medicare+Choice also illustrates how risk selection can take place. Plans can withdraw from market areas where they are losing money, and focus their marketing on geographic areas where they attract healthier or more profitable patients.

When we use large groups to gain economies of scale and spread risk, the cost of administering benefits is low. Medicare and Medicaid have administrative costs in the range of 2 to 4 percent (Chart 27). Private plans, on the other hand, have the costs of marketing, advertising, sales commissions, claims administration, reserves, and profits, and so have a higher overhead rate. This is most apparent in the small group and individual market, where small firms pay administrative costs of 30 percent.[37] By comparison, Canada, which has a uniform national benefit plan that is administered by the government and delivered by private hospitals and physicians, spends just one percent a year on administration.[38]

**Costs of Churning**

While a great deal of attention is focused on the 41 million people who are uninsured at a point in time, there is much less awareness of the high rate of turnover in health insurance coverage. Sixty-two million people were uninsured at some point during 2000. About 13 percent of people under age 65 are uninsured all year, and a nearly equal percentage are

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[35] M. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured." *Health Affairs* (November/December 2003): 188–194.

[36] L. Duchon and C. Schoen. *Experiences of Working-Age Adults in the Individual Insurance Market* (New York, The Commonwealth Fund. December 2001).

[37] U.S. House of Representatives, *Health Care Resource Book* (Washington, D.C.: Government Printing Office, 1993).

[38] U.S. House of Representatives, *Health Care Resource Book* (Washington, D.C.: Government Printing Office, 1993).

uninsured at some point during the year. A recent study estimates that 75 million people were uninsured at some time over the two-year period 2000–2001.[39]

In a recent analysis of the reasons people move on and off coverage, Leighton Ku and Donna Cohen Ross estimated that if people were able to stay on the insurance they had at the beginning of the year for the entire year, there would be 40 percent fewer uninsured low-income children and 28 percent fewer uninsured low-income adults (Chart 28).[40] Just helping people keep their coverage would make an enormous difference in the numbers of uninsured.

People can lose their insurance coverage when they lose or change jobs, are widowed or divorced, become sick or disabled and leave the workforce, move from one state to another, experience a change in income or wages, or fail to complete recertification processes in public programs. Young adults can lose coverage just by celebrating their 19th birthday—what a birthday surprise that is! Workers lose employer coverage when they become unemployed, and many either do not quality for COBRA extension of coverage or cannot afford the high premiums.[41]

This churning in health insurance coverage also imposes a hidden cost on the U.S. health system. Every time an individual or family signs up for insurance coverage, whether public or private, there is a cost of enrollment. There are other costs when disenrollment or reenrollment occurs. Low-income families, particularly, have unstable incomes and changing employment status. This can lead a low-income family to have multiple episodes of public program coverage over time, with frequent changes in insurance status. Public programs also require reenrollment administrative processes, even when circumstances do not change, and families burdened with other issues of daily living may not have the time or resources to provide a second round of documentation to qualify for coverage. Health plans participating in public programs also incur the expense of starting a new beneficiary in their networks only to lose them again—one New York HMO estimates that they spend a full two months' worth of the initial premium to set up a new family.[42] This is wasted if the enrollment is short term.

Employer coverage can also be very unstable, not just because people change jobs but because employers change plans that are offered to employees. Particularly in the managed care era of the 1990s, plan changes were frequent. Consolidation in the

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[39] FamiliesUSA, *Going Without Coverage: Nearly One in Three Non-Elderly Americans* (Robert Wood Johnson Foundation: Princeton, NJ 2003).

[40] L. Ku and D. Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (New York: The Commonwealth Fund, 2002).

[41] M. Doty and C. Schoen, *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (New York: The Commonwealth Fund, December 2001).

[42] Personal communication with Benjamin K. Chu, M.D., President and Chief Executive, New York City Health and Hospitals Corporation, February 27, 2003.

managed care industry, with mergers and conversions, added to this instability. Plan withdrawals from selected geographic areas also required many Medicare, Medicaid, federal employees, and privately insured individuals to change coverage.

Not surprisingly, both U.S. spending on health insurance program administration and the net cost of private health insurance have soared over the last three decades (Chart 29). In 1970, the U.S. spent $2.8 billion on administrative costs. In 1980, it was $12.1 billion. By 1990 it was $40 billion. In 2002, it was $110.9 billion. By 2012 it is expected to reach a staggering $222.6 billion—8 percent of all personal health care expenditures.

These costs do not include the administrative costs borne by health care providers. When patients change insurance status or their doctor, insurance eligibility needs to be verified, administrative records changed, and medical records forwarded to a new doctor.

Perhaps most troubling of all, this turbulence in coverage undermines the continuity of care for patients. The Commonwealth Fund 2001 Health Care Quality Survey found that only 20 percent of the uninsured have been with their physician for five years or more. But it is also troubling that only 35 percent of adults under age 65 who are currently insured have been with their physician for five years (Chart 30). When patients do not have a regular doctor or have a limited choice of where to go for care, they are likely to be less satisfied with their care and have less confidence in their physicians.[43] In addition, discontinuity in care may contribute to higher costs. One study found that Medicare patients who had been with the same physician for 10 years or longer had fewer hospitalizations and incurred lower Medicare payments.[44]

**Costs of Complexity**

Professor Uwe Reinhardt of Princeton University has a famous chart that illustrates the way in which Americans get health insurance coverage, depending on their age and income (Chart 31). It's an amusing and confusing chart. But when he explains Qualified Medicare Beneficiary coverage, Specified Low-Income Beneficiary, and Qualified Individuals I and II coverage to an international audience he leaves his audience bewildered. How could Americans design a Medicaid program with federal/state funding to cover Medicare beneficiaries with incomes below 100 percent of poverty to pick up their Medicare premiums and cost-sharing, another program to pick up premiums between 100 and 125 percent of poverty, another program to pick up their premiums between 125 and 135 percent of poverty, and another program to pick up the "home health" portion of their Medicare premium between 135 and 175 percent of poverty. But

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[43] Analysis of the Commonwealth Fund 2001 Health Care Quality Survey.

[44] Blustein, J. and Weiss, L.J., 1996. "Faithful Patients: The Effect of Long-Term Physician–Patient Relationships on the Costs and Use of Healthcare by Older Americans." *American Journal of Public Health* 86 (December):1742–47.

if it's confusing to an international audience, it's equally confusing to frail elderly Americans with limited incomes. Not surprisingly, many people who qualify for these "Medicare Savings Programs" fail to enroll simply because they do not know they are eligible.[45] Add to that the asset limits that vary from state to state for Medicaid supplemental coverage, and it is no wonder that many elderly fail to receive the help they need in affording care.[46] More than half of children who are uninsured qualify for either Medicaid or CHIP but are not enrolled, in large part because their families do not know about the programs or think they are ineligible.[47]

By narrowing coverage to a given "current object of concern," in Professor Reinhardt's terminology, (e.g., workers displaced from their jobs by international trade who qualify for a 65-percent tax credit toward their employer COBRA coverage), we often create costly new administrative apparatuses, designed as much to keep the ineligible off as to ensure that the eligible qualify.

This also leads to different standards of care, with some covered under Medicaid, some under CHIP, and some not at all. Different managed care plans, hospitals, and physicians participate in Medicaid and CHIP. The quality of health care delivered in Medicaid, Medicare, and commercial managed care plans differs not only across plans and geographic regions, but also across sources of coverage.[48] Different providers are covered in different employer managed care plan networks. When your doctor thinks you need to see a specialist, the specialist he thinks is best and with whom he has had the best experience may not be a member of your managed care plan network.

A given hospital may serve patients covered by more than 100 different managed care contracts. Each contract has a different method and rate of payment, and varying requirements on prior authorization of hospitalization and approved length of stay. The administrative cost to the hospital of our complex system of care is not inconsequential.

We have moved away from insurance plans that allow patients to go to any doctor or hospital to more restricted networks. But giving consumers a choice among health plans may allow individuals to find physicians and networks that meet their health care needs, including those who practice in their communities. However, complex benefit designs that vary from plan to plan make informed choice impossible. An analysis of Medicare+Choice plans in Tampa found so much variation among copayments for such services as radiation therapy and inpatient hospital care, as well in the design of drug

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[45] M. Moon, C. Kuntz, and L. Pounder, *Protecting Low-Income Medicare Beneficiaries* (New York: The Commonwealth Fund, December 1996).

[46] L. Summer and R. Friedland, *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs* (New York: The Commonwealth Fund, October 2002).

[47] Center on Budget and Policy Priorities analysis of March 2000 Current Population Survey

[48] National Committee for Quality Assurance, *The State of Health Care Quality 2002*. (Washington, D.C: NCQA. 2002).

benefits, that no beneficiary—with or without the assistance of family members or consumer advocates—could hope to make an informed choice (Chart 32).[49] Many individuals will be penalized for making choices not in their best interest, or that do not serve them well when an unanticipated event such as cancer occurs. The purpose of insurance to provide financial protection and greater certainty is undermined by widely various benefits, hidden out-of-pocket costs, and networks that fail to provide stable access to physicians or specialized services.

**Conclusion**

The United States is the only major industrialized nation that fails to provide health insurance coverage to its people. Yet, it spends far more than any other country—devoting more than $110 billion just to health insurance administrative costs in 2002. There has to be a better way.

Most important, we need a system that provides health coverage for all. The cost of not covering the uninsured—including 18,000 preventable deaths a year—is one we should not accept. This is not only a human tragedy but an economic loss as well, as we are deprived as a society of their productive contributions.

We have built an incredibly complex, costly, and confusing health insurance system. We need a single guiding framework for coverage. It can include multiple sources of financing, multiple choices of public and private coverage, and multiple benefit packages, but it needs to be integrated within a single framework. Certainly, we should have a system that preserves innovation, flexibility, and choice, but some standardization will be required to cut through the maze of complexity in our current system. Reaching consensus on the parameters of choice versus standardization is an important part of public debate on this issue.

We also need to reach agreement on the shared responsibility for financing health insurance coverage. In my view, covering everyone will only be possible if everyone contributes—employers, those currently uninsured as well as insured, health care providers, federal, state, and local government. But we need to begin to have public discussion about what constitutes a fair share of financial responsibility.

We need a health care system that promotes quality improvement and much greater efficiency. Investment in modern information technology to reduce administrative costs, provide information for consumer choice, and serve as a tool for quality improvement must also be a component of what we do.

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[49] Geraldine Dallek and Clair Edwards. *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages*, New York: The Commonwealth Fund, October 2001.

We need to build on efficient administrative mechanisms, whether that is group coverage or using the tax system to identify people without coverage and ensure that they are automatically enrolled and provided with the financial assistance required to make coverage affordable. Making coverage easy to obtain, automatic, and affordable—rather than difficult, confusing, and expensive—must be at the heart of comprehensive reform.

But most fundamentally we need to commit to high-quality health care for all as a national policy priority. If we continue to put cutting taxes over ensuring a strong and healthy nation, we will pay a heavy price. Our health care system will not be there when we need it. Investment in better health care can have a significant return—in terms of healthier, more productive workers who are able to continue longer in the workforce, children who grow up to be healthy, productive adults, and healthy immigrants, who can help fuel our economic growth and bring vitality and diversity to our cultural life. The returns also include prevention of serious illness, better management of chronic conditions, and better functioning and quality of life in old age. We have a shared stake in working together to find common ground. It is a challenge worthy of the 21st century. Thank you

# Time for Change: The Hidden Cost of a Fragmented Health Insurance System

**Karen Davis**

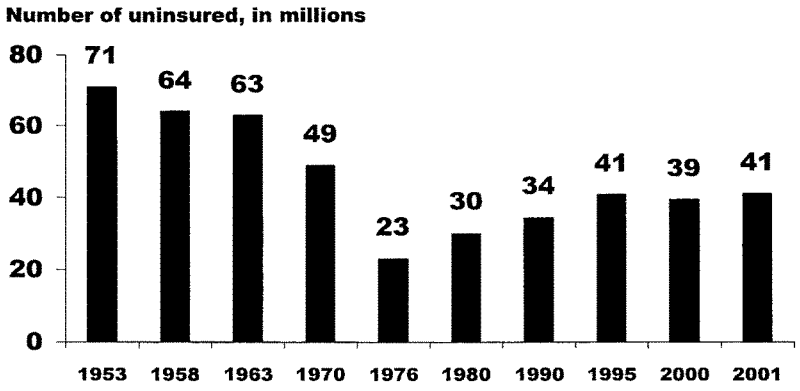
**President, The Commonwealth Fund**

**Testimony to the Senate Aging Committee**

**March 10, 2003**

1

## Growth in the Number of Uninsured, 1953–2001

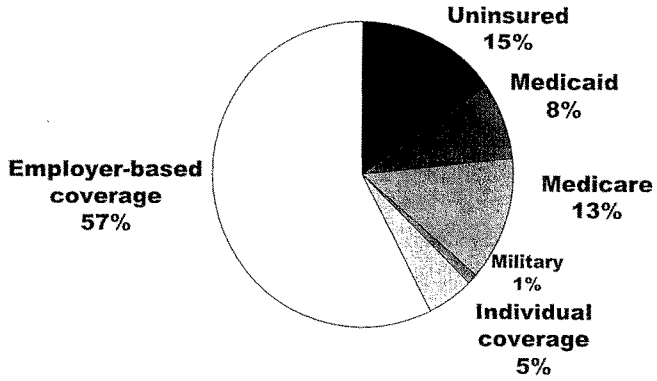



Source: 1953–1976, National Health Interview Survey; 1980, EBRI; 1990–2001 Current Population Survey

2

## Primary Source of Health Insurance, 2001

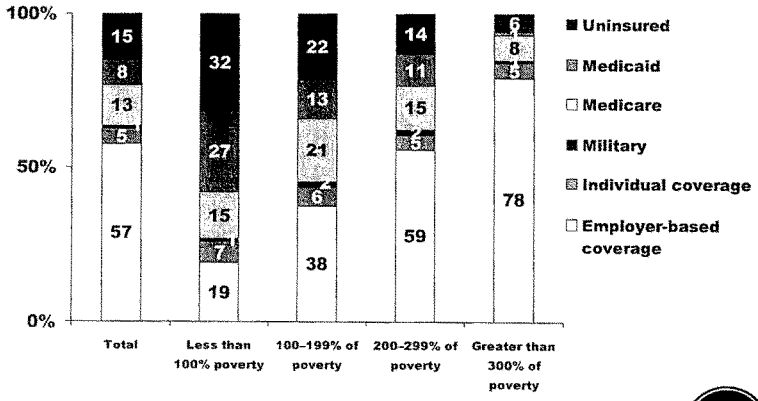
### Employers Paid $335 Billion in Premiums



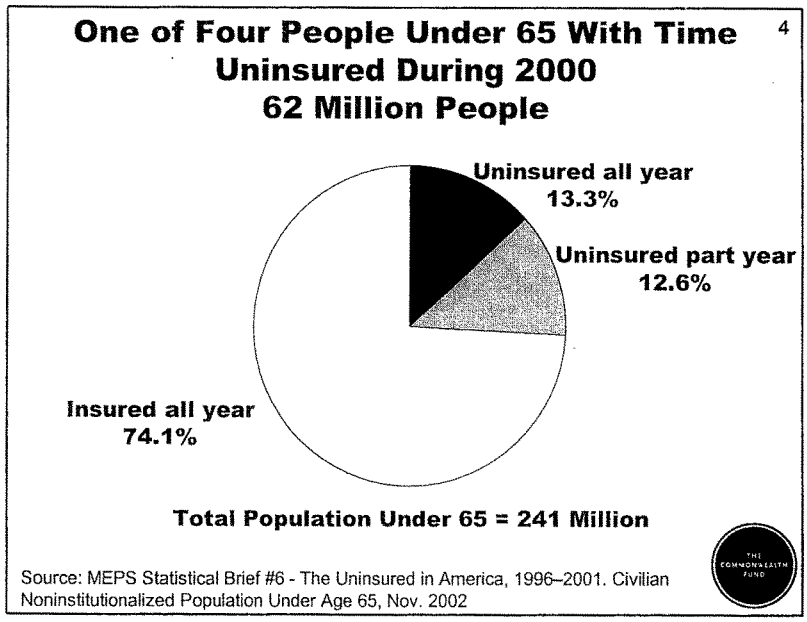

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey

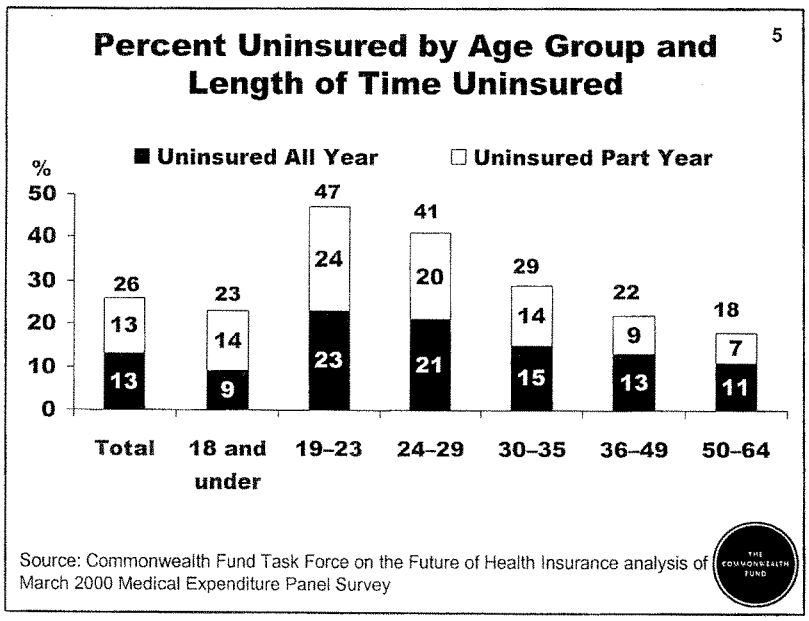
3

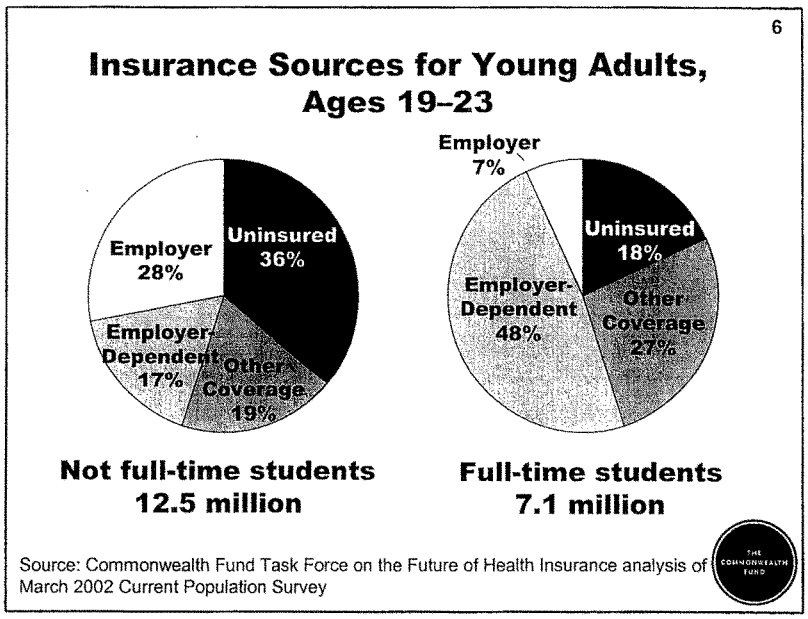
## Sources Health Insurance by Poverty Level, 2001

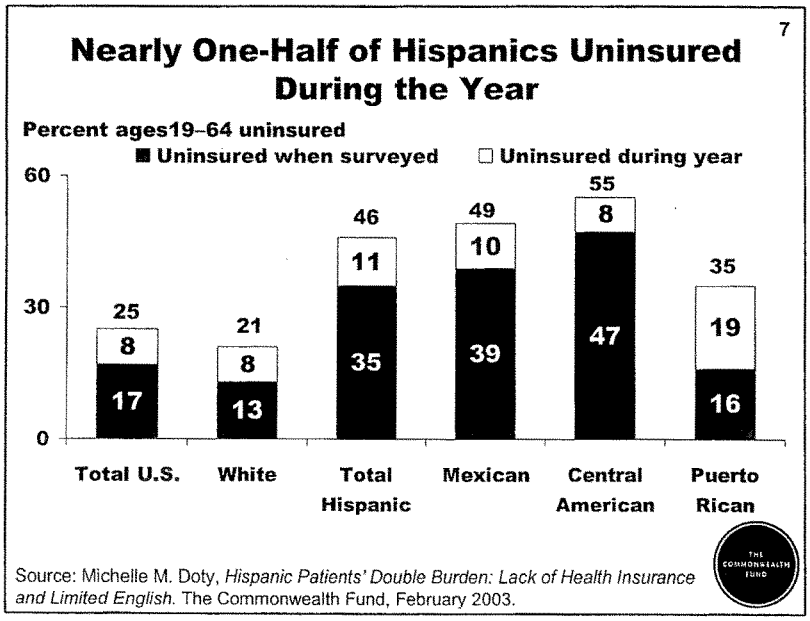



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey


One of Four People Under 65 With Time Uninsured During 2000
62 Million People
4
Uninsured all year
13.3%
Uninsured part year
12.6%
Insured all year
74.1%
Total Population Under 65 = 241 Million
Source: MEPS Statistical Brief #6 - The Uninsured in America, 1996–2001. Civilian Noninstitutionalized Population Under Age 65, Nov. 2002

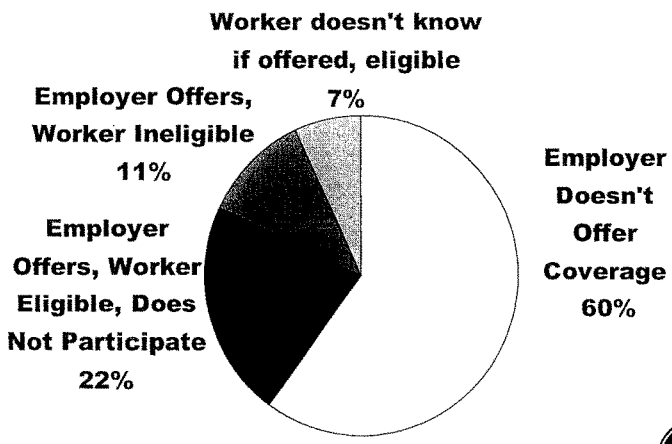

Percent Uninsured by Age Group and Length of Time Uninsured
5
Uninsured All Year
Uninsured Part Year
%
50
40
30
20
10
0
26
13
13
23
14
9
47
24
23
41
20
21
29
14
15
22
9
13
18
7
11
Total
18 and under
19–23
24–29
30–35
36–49
50–64
Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Medical Expenditure Panel Survey


6
Insurance Sources for Young Adults, Ages 19–23
Employer 28%
Uninsured 36%
Employer-Dependent 17%
Other Coverage 19%
Not full-time students
12.5 million
Employer 7%
Uninsured 18%
Employer-Dependent 48%
Other Coverage 27%
Full-time students
7.1 million
Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2002 Current Population Survey


7
Nearly One-Half of Hispanics Uninsured During the Year
Percent ages19–64 uninsured
Uninsured when surveyed
Uninsured during year
60
30
0
25
8
17
21
8
13
46
11
35
49
10
39
55
8
47
35
19
16
Total U.S.
White
Total Hispanic
Mexican
Central American
Puerto Rican
Source: Michelle M. Doty, Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English. The Commonwealth Fund, February 2003.

8

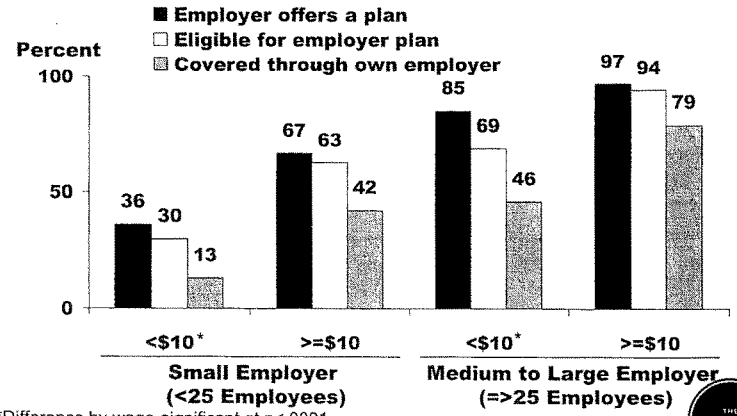
## Uninsured Workers: Reasons for Lack of Insurance Coverage, Ages 19–64




Source: S. Collins, et al., *On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey*. The Commonwealth Fund, forthcoming.

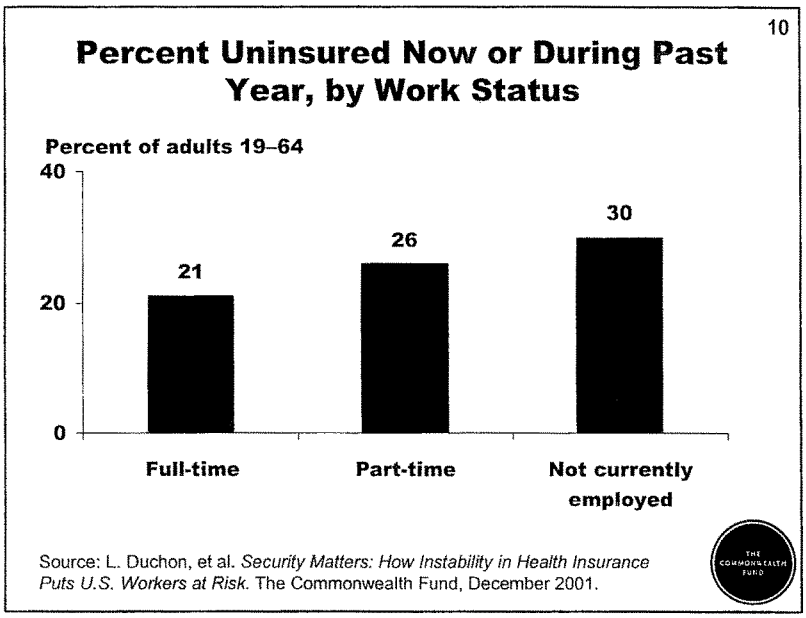
9

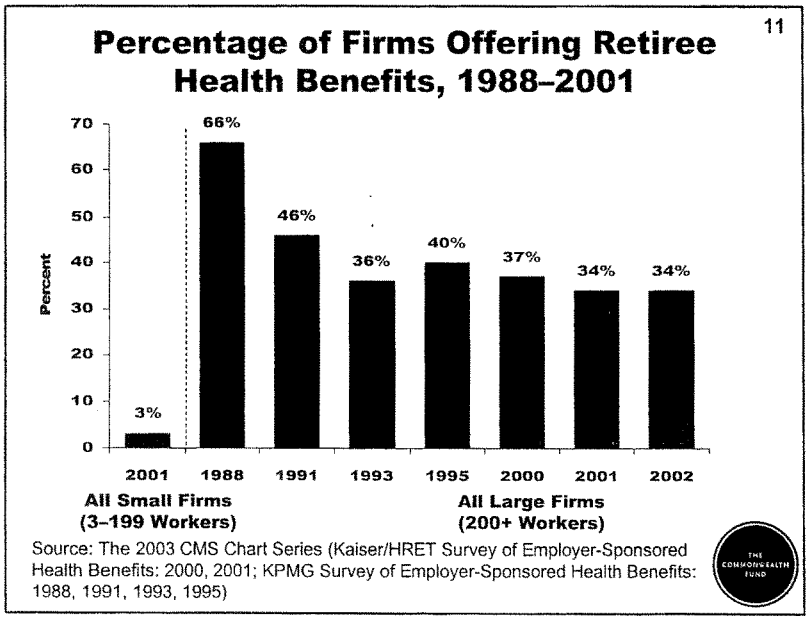
## Workers who are Offered, Eligible, and Participate in own Employer Health Plan, by Firm Size and Wage, All Workers, 19–64



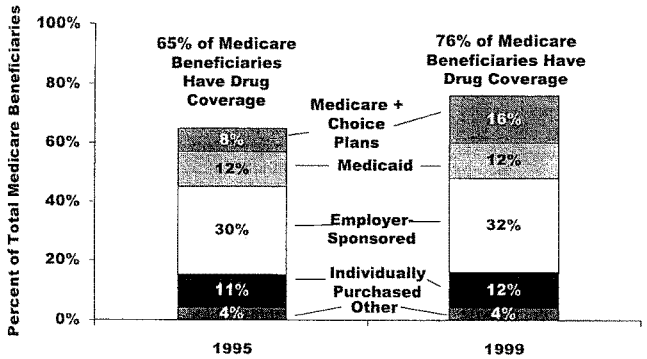

*Difference by wage significant at p<.0001

Source: S. Collins, et al., *On the Edge: The Health Insurance Coverage of Low-Wage Workers Findings from the 2001Commonwealth Fund Health Insurance Survey*. The Commonwealth Fund, forthcoming.


10
Percent Uninsured Now or During Past Year, by Work Status
Percent of adults 19–64
40
20
0
21
26
30
Full-time
Part-time
Not currently employed
Source: L. Duchon, et al. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. The Commonwealth Fund, December 2001.


11
Percentage of Firms Offering Retiree Health Benefits, 1988–2001
Percent
70
60
50
40
30
20
10
0
3%
66%
46%
36%
40%
37%
34%
34%
2001
1988
1991
1993
1995
2000
2001
2002
All Small Firms (3–199 Workers)
All Large Firms (200+ Workers)
Source: The 2003 CMS Chart Series (Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000, 2001; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1991, 1993, 1995)

## Medicare Beneficiaries With Drug Coverage[12] by Primary Source of Supplemental Coverage, 1995 and 1999

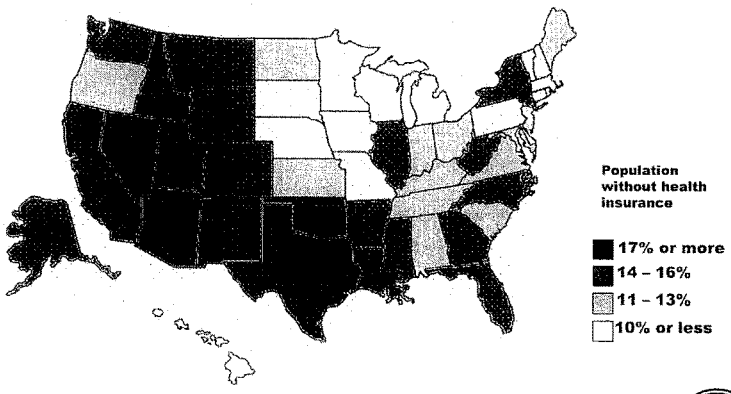



Note: Data are based on the non-institutionalized beneficiaries.
Percentages shown in bars are Medicare beneficiaries with drug coverage as a percent of total Medicare beneficiaries. Beneficiaries do not necessarily get drug coverage from their primary sources of supplemental insurance.

Source: The 2003 CMS Chart Series (CMS/Office of Research, Development and Information. Data are from the Medicare Current Beneficiary Survey).



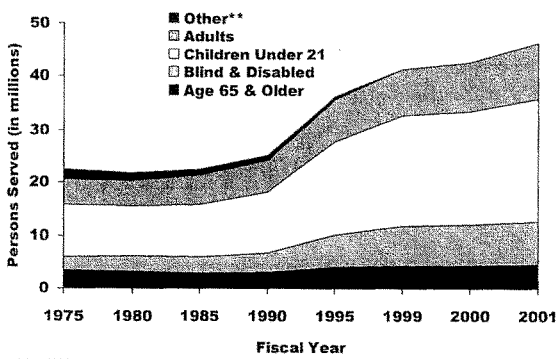
## Percent of Non-Elderly Population Uninsured by State, 1999-2000




Source: R. Mills, U.S. Census Bureau, Current Population Reports, P60-220, *Health Insurance Coverage: 2001*, 2002. Uninsured rates are three-year averages, 1999-2001.

14

## Medicaid Beneficiaries by Eligibility Group, 1975–2001




**2001 Total = 46.1 million**

**Adults 10.4 million**

**Children Under 21 23.1 million**

**Blind & Disabled 7.9 million**

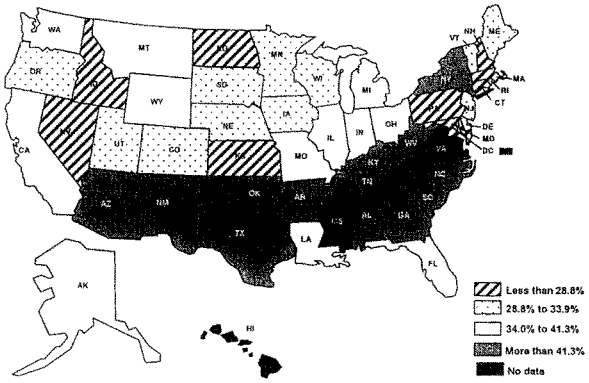
**Age 65 & Older 4.8 million**

*Note: (1) In 1998, a large increase occurred in the number of persons served, mainly the result of a new reporting methodology of classifying payments to managed care organizations; FY 1998 was the first year capitation payments were counted as a service for purposes of the HCFA 2082 reporting, and thus all managed care enrollees were counted as individuals receiving services. This new methodology probably has the greatest effect on the reported number of children; (2) the term "adults" as used above refers to nonelderly, nondisabled adults; (3) disabled children are included in the blind & disabled category shown above. **The Other category was dropped in 1999.

Source: The 2003 CMS Chart Series (CMS, CMSO, Medicaid Statistical Information System.)

15

## Births Financed by Medicaid as a Percent of Total Births by State, 1998




Note: CO, GA 1997 data; KY, NJ, VT 1996 data.
Source: The 2003 CMS Chart Series (Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children, National Governors Association, February, 2001, Table 23, at http://www.nga.org.)

16

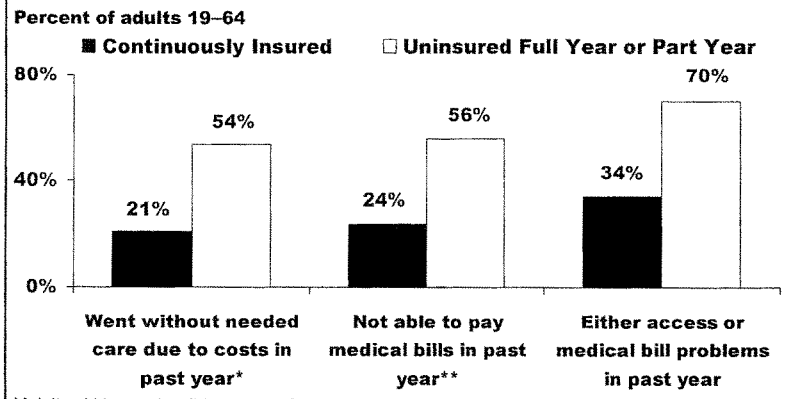
## Deaths of Adults Ages 25 – 64, 1999

1. Cancer – 156,485
2. Heart disease – 115, 827
3. Injuries – 46,045
4. Suicide – 19,549
5. Cerebrovascular disease – 18,369
6. Uninsured – 18,000
7. Diabetes – 16,156
8. Respiratory disease – 15,809
9. Chronic liver disease and cirrhosis – 15,714
10. HIV/AIDS – 14,017

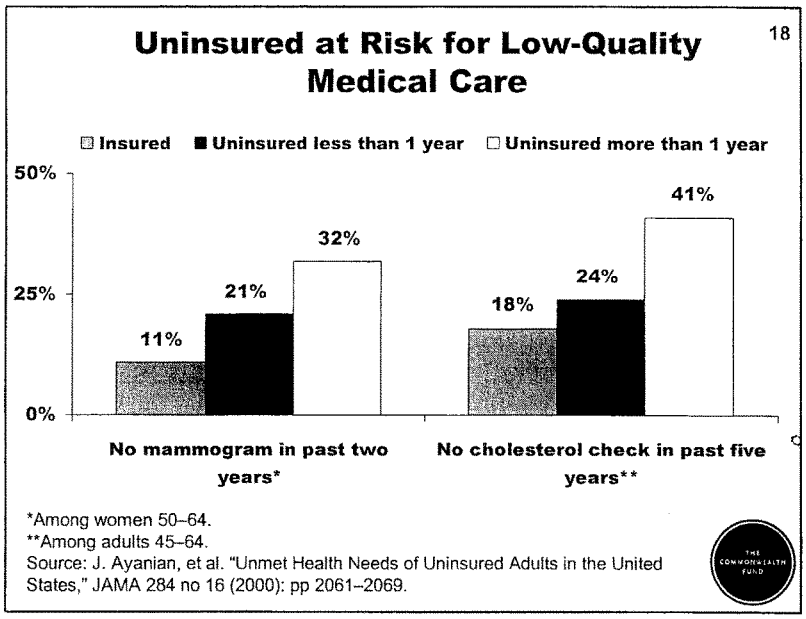
Sources: U.S. Department of Health and Human Services, National Center for Health Statistics, Health, United States, 2002, Table 33, p. 132 – deaths for causes other than uninsured; Institute of Medicine, Care Without Coverage, Appendix D, p. 162, deaths attributable to higher risks of uninsured adults 25–54.

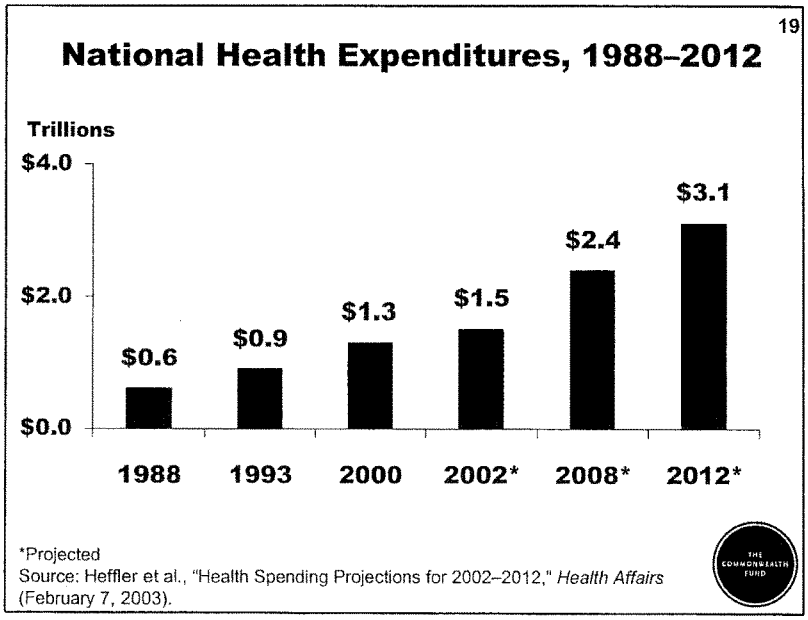
17

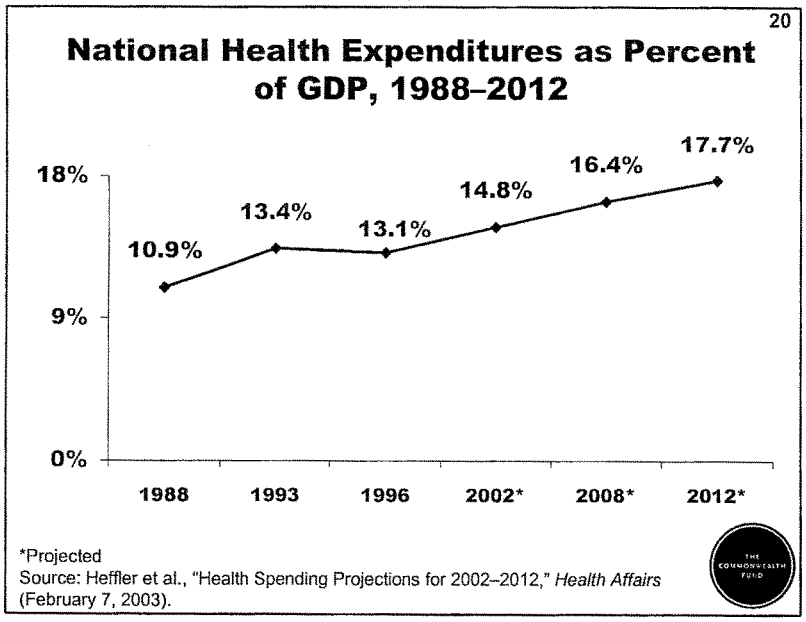
## Uninsured at Risk for Access and Medical Bill Problems

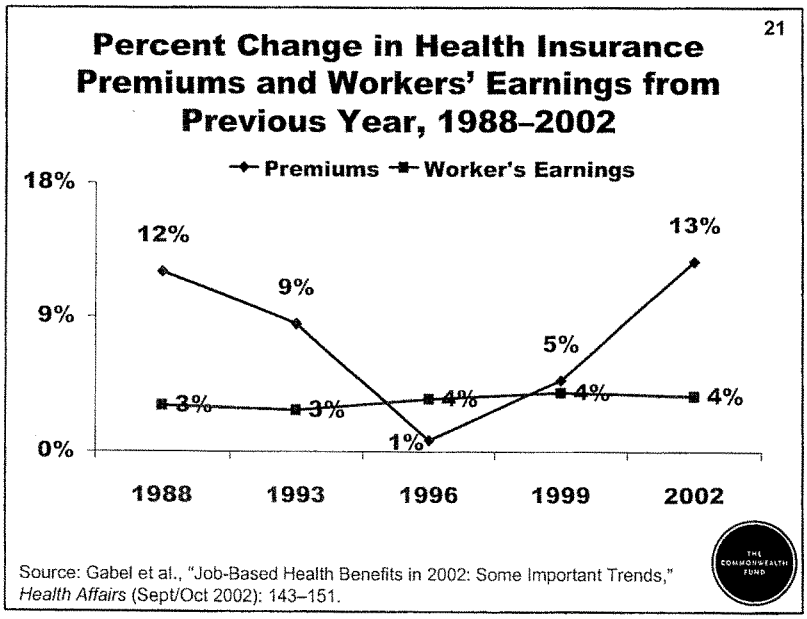



*Adult said he or she did not go to the doctor when needed, did not fill a prescription, did not follow up on recommended tests or treatment, or did not see a specialist due to costs
** Adult said he or she not able to pay medical bills, has been contacted by collection agency, or had to change way of life to pay bills
Source: The Commonwealth Fund 2001 Health Insurance Survey


18
Uninsured at Risk for Low-Quality Medical Care
Insured
Uninsured less than 1 year
Uninsured more than 1 year
50%
25%
0%
11%
21%
32%
18%
24%
41%
No mammogram in past two years*
No cholesterol check in past five years**
*Among women 50–64.
**Among adults 45–64.
Source: J. Ayanian, et al. "Unmet Health Needs of Uninsured Adults in the United States," JAMA 284 no 16 (2000): pp 2061–2069.

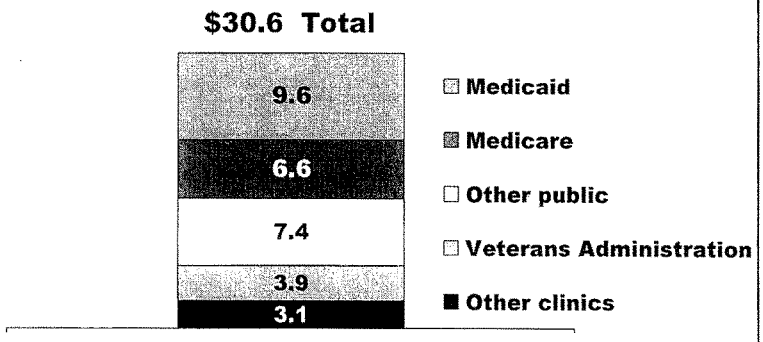

19
National Health Expenditures, 1988–2012
Trillions
$4.0
$2.0
$0.0
$0.6
$0.9
$1.3
$1.5
$2.4
$3.1
1988
1993
2000
2002*
2008*
2012*
*Projected
Source: Heffler et al., "Health Spending Projections for 2002–2012," Health Affairs (February 7, 2003).


20
National Health Expenditures as Percent of GDP, 1988–2012
18%
9%
0%
10.9%
13.4%
13.1%
14.8%
16.4%
17.7%
1988
1993
1996
2002*
2008*
2012*
*Projected
Source: Heffler et al., "Health Spending Projections for 2002–2012," Health Affairs (February 7, 2003).


21
Percent Change in Health Insurance Premiums and Workers' Earnings from Previous Year, 1988–2002
Premiums
Worker's Earnings
18%
9%
0%
12%
9%
1%
5%
13%
3%
3%
4%
4%
4%
1988
1993
1996
1999
2002
Source: Gabel et al., "Job-Based Health Benefits in 2002: Some Important Trends," Health Affairs (Sept/Oct 2002): 143–151.

## Sources of Government Funding Available for Uncompensated Care of the Uninsured, in Billions of 2001 Dollars

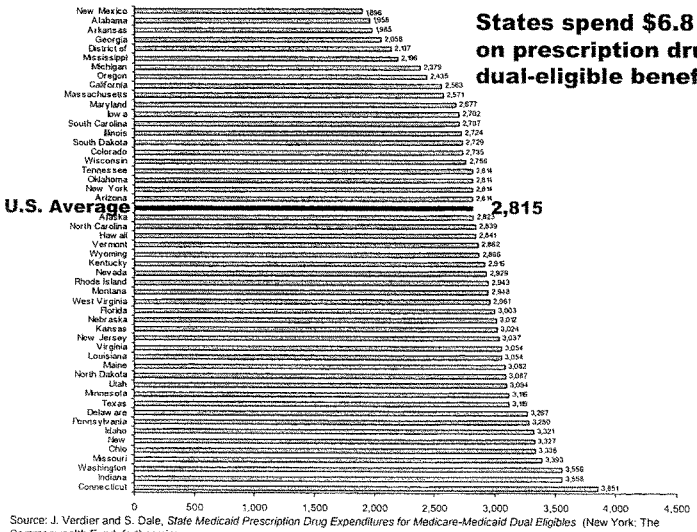
22




Source: J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* Web Exclusive February 12, 2003.

## Projected Annual Medicaid Prescription Drug Expenditures Per Dual Eligible With Full Medicaid Benefits, 2002 (In Dollars)

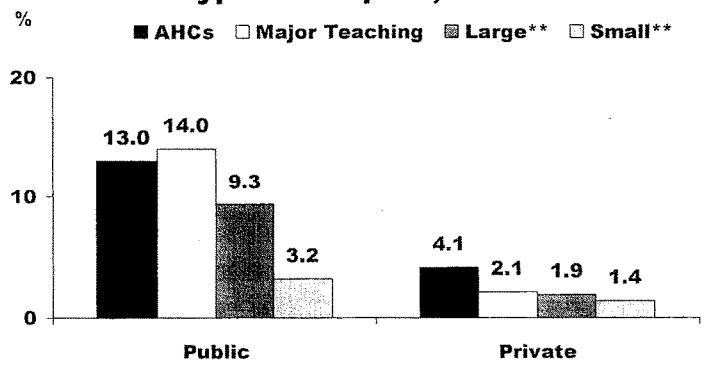
23




Source: J. Verdier and S. Dale, *State Medicaid Prescription Drug Expenditures for Medicare-Medicaid Dual Eligibles* (New York: The Commonwealth Fund, forthcoming).

24

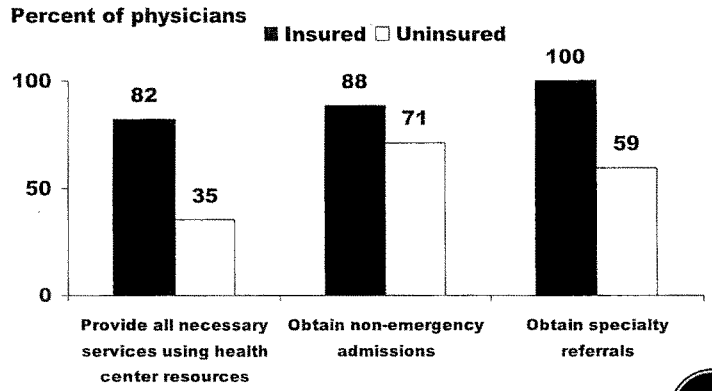
## Uncompensated Care* as a Percentage of Gross Patient Revenues, by Ownership and Type of Hospital, 1996




*Bad debt plus charity care
**Includes minor teaching and non-teaching hospitals
Source: Commonwealth Fund Task Force on Academic Health Centers. *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured,* The Commonwealth Fund, April 2001.

25

## Percentage of Community Health Center Medical Directors Who Report That Additional Care Can Be Provided For Their Patients Very Frequently or Frequently




Source: M. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured." *Health Affairs* (November/December 2002) 188–193.

26

## Comparing Annual Premiums for Single Coverage: Employer-Sponsored PPOs vs. Individual Insurance, by Market Area

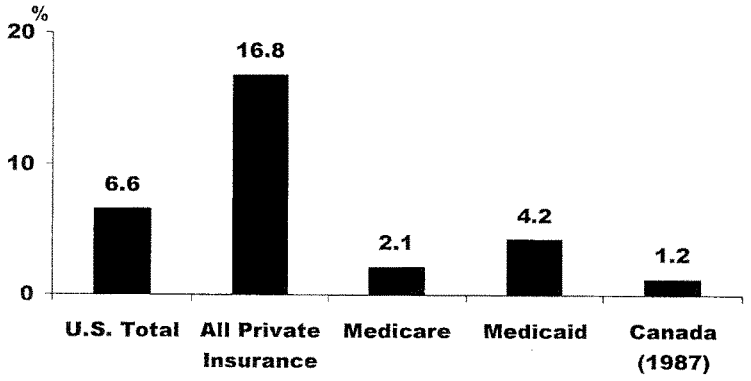
| Metro Area | Average Group Premium | Individual Insurance Premium for Males Age 55 | Individual Insurance Premium for Females Age 55 | Individual Insurance Premium for Males Age 27 | Individual Insurance Premium for Females Age 27 |
|---|---|---|---|---|---|
| Providence-Fall River-Warwick, RI/MA | $2940 | $6480 | $6456 | $2256 | $2880 |
| Los Angeles-Long Beach, CA | 2736 | 9528 | 9504 | 3324 | 4788 |
| Rural Texas | 2436 | 6660 | 6648 | 2328 | 3348 |
| Chicago, IL | 2688 | 3336 | 3384 | 1020 | 1284 |
| Greensboro, NC* | 2712 | 3900 | 3888 | 1368 | 1716 |
| Median | 2736 | 6120 | 6108 | 2136 | 2880 |

* Group insurance data presented for Greensboro were based on averages for the state of North Carolina

Source: J. Gabel, K. Dhont, and J. Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance?* The Commonwealth Fund, May 2002.

27

## Administrative Cost as Percent of Benefits, Various Programs, 1991

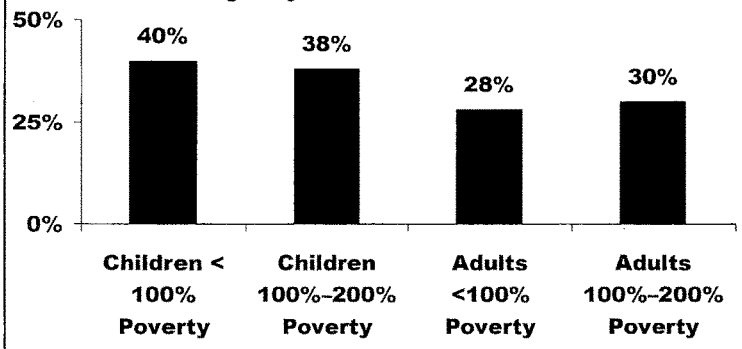



Source: Committee on Ways and Means, U.S. House of Representatives. *Health Care Resource Book.* U.S. Government Printing Office, Washington:1993

28

## Reduction in the Number of Uninsured Over the Course of a Year

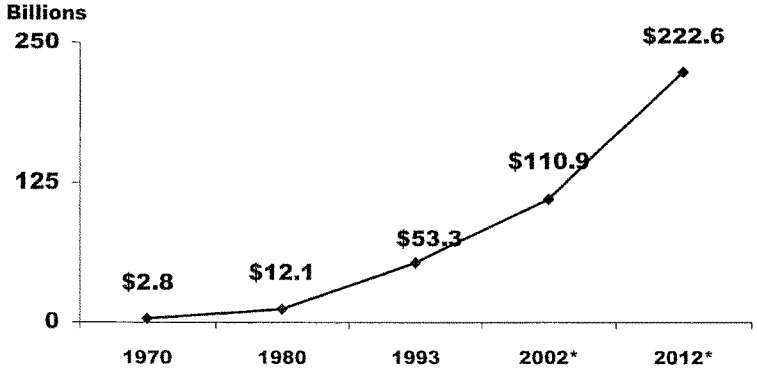
**Percent reduction in uninsurance if everyone with coverage retained it during the year**



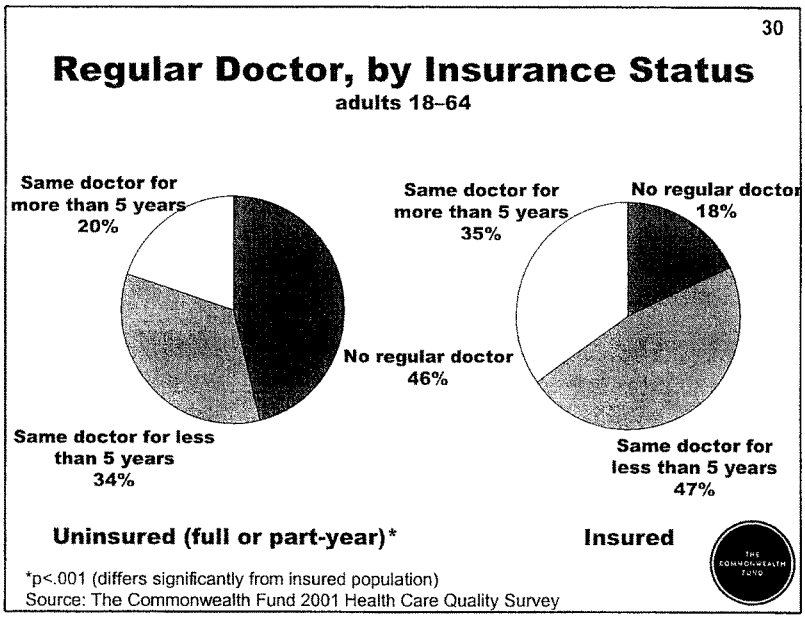

Source: Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families*. The Commonwealth Fund, December 2002.

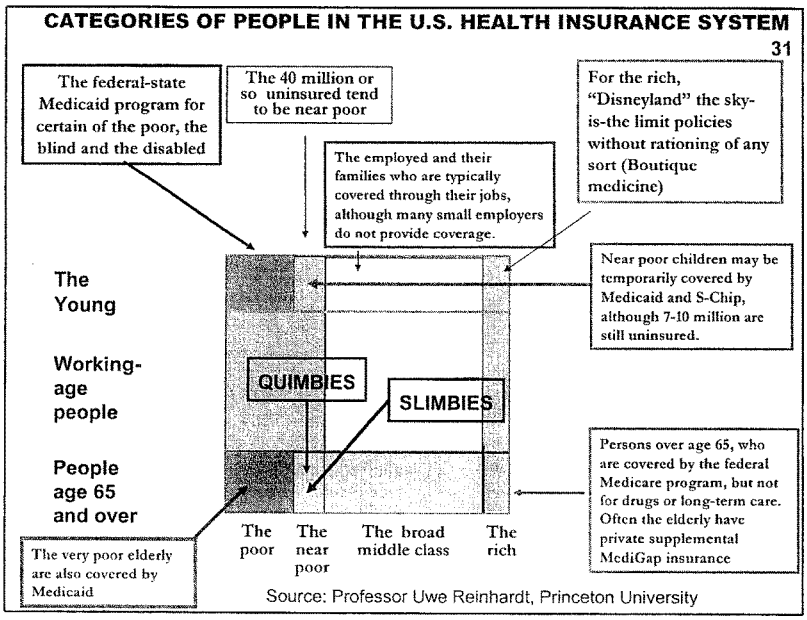
29

## Government Program Administration and Net Cost of Private Health Insurance, in billions 1970–2012




*Projected
Source: Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* (January/February 2003): 154–164 and Heffler et al., "Health Spending Projections for 2002–2012," Health Affairs (February 7, 2003).


30
Regular Doctor, by Insurance Status
adults 18–64
Same doctor for more than 5 years 20%
No regular doctor 46%
Same doctor for less than 5 years 34%
Uninsured (full or part-year)*
Same doctor for more than 5 years 35%
No regular doctor 18%
Same doctor for less than 5 years 47%
Insured
*p<.001 (differs significantly from insured population)
Source: The Commonwealth Fund 2001 Health Care Quality Survey


CATEGORIES OF PEOPLE IN THE U.S. HEALTH INSURANCE SYSTEM
31
The federal-state Medicaid program for certain of the poor, the blind and the disabled
The 40 million or so uninsured tend to be near poor
For the rich, "Disneyland" the sky-is-the limit policies without rationing of any sort (Boutique medicine)
The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.
Near poor children may be temporarily covered by Medicaid and S-Chip, although 7-10 million are still uninsured.
The Young
Working-age people
People age 65 and over
QUIMBIES
SLIMBIES
Persons over age 65, who are covered by the federal Medicare program, but not for drugs or long-term care. Often the elderly have private supplemental MediGap insurance
The very poor elderly are also covered by Medicaid
The poor
The near poor
The broad middle class
The rich
Source: Professor Uwe Reinhardt, Princeton University

**2001 Premium and Selected Benefit Copayments: Tampa Medicare+Choice Plans** **Chart 32**

| | Plan $V_1$ | Plan $V_2$ | Plan W | Plan $X_1$ | Plan $X_2$ | Plan Y | Plan $Z_1$ | Plan $Z_2$ |
|---|---|---|---|---|---|---|---|---|
| Enrollment limit | No | No | Yes | No | No | No | No | Yes |
| Premium | $63 | $0 | $63 | $179 | $0 | $0 | $0 | $19 |
| Doctor visits: Primary care | $10 | $15 | $10 | $10 | $10 | $15 | $10 | $5 |
| Specialist | $5–$200 | $15–$400 | $25 | $15 | $15 | $20 | $15 | $10 |
| Outpatient visits: Ambulatory surgery | $200 | $500 | $0 | $35 | $50 | $100 | $25 | $25 |
| Hospital visit | $200 | $500 | $50 | $35 | $50 | $50 | $25 | $25 |
| Durable medical equipment | $0 | $0 | $0 | $0 | $0 | 20% | $0 | $0 |
| Diagnostic test: Clinical lab | $0 | $0 | $0 | $0 | $0 | $5 | $0 | $0 |
| X-rays/diagnostic lab | $40–$200 | $40–$350 | $0 | $0 | $0 | $5 X-ray; $50 other radiation services | $0 | $0 |
| Radiation therapy | $40/visit | $40/visit | $0 | $0 | $0 | $5–$50 | $15/service | $10/service |
| Outpatient rehabilitation services | $40/visit | $40/visit | $25/visit | $10–$15/visit | $10–$15/visit | $25/visit | $15/visit | $10/visit |
| Inpatient hospital care | $500 per admiss.; $200/day for days 7–30 at network hospital | $500 per admiss.; $200/day for days 7–30 at network hospital | $150/day | $100/stay | $300/stay | $150/day | $200/stay | $0 |
| Skilled nursing facility: Days 1–20 | $0/day | $0/day | $0 | $0 | $0 | $75 | $0 | $0 |
| Days 21–100 | $85/day | $90/day | $97 | $0 | | $75 | $0 | $0 |
| Home health care | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Bone mass measurement | $10/physician's office, $40 non-physician clinic | $15/physician's office, $40/non-physician clinic | $0 | $0 | $0 | $0 | $0 | $0 |
| Prescription drugs | | | | | | | | |
| Formulary drugs | | | | | | | | |
| 30–31-day supply | | | | | | | (31-day) | (31-day) |
| Generic copay | $10 | No prescription drug coverage | $5 | $5 | $10 | $8 | $7 | $5 |
| Brand copay | $20 preferred | | $20 | $15 | Not covered | $40 | $20 | $15 |
| 90-day mail order | | | | | | | | |
| Generic copay | $20 | | $15 | $15 | $30 | $24 | Not available | Not available |
| Brand copay | $40 preferred | | $60 | $45 | Not covered | $120 | | |
| Cap | | | | | | | | |
| Generic | $150/3 months generic and preferred & non-preferred brand | | Unlimited | Unlimited | Unlimited | $500/year | Unlimited | Unlimited |
| Brand | | | $250/6 month formulary & non-formulary brand | $50/month formulary & non-formulary brand | Not covered | | $125/3 months non-formulary generic & all brand drugs | $125/3 months non-formulary generic & all brand drugs |
| Non-formulary | | | | | | | | |
| 30–31-day supply | | | $35 | $30 | Not covered | Plan has no formulary | | |
| Generic copay | $10 | | $35 | $30 | | | $30 | $30 |
| Brand copay | $40 | | | | | | $30 | $30 |
| 90-day mail order | | | $105 | $90 | | | | |
| Generic copay | $10 | | $105 | $90 | | | Not available | Not available |
| Brand copay | $80 | | See above | See above | | | | |
| Cap | See above | | | | | | See above | See above |

[a] Plan Y has a $3,500 out-of-pocket limit protection for combined inpatient and outpatient services, not including certain office visit copays, prescription drugs, medical supplies, and selected other benefits.

[b] $40 specialist per visit copay, except $10/visit to Allergy physicians, $5/specimen to hospital pathologists, $5/interpretation to hospital radiologists, $50/visit to ER physician, $200 for cataract surgery, $50/each allergy skin testing, and 40% of charges for non-plan second medical opinion.

[c] $50 specialist per visit copay, except $15/visit to Allergy physicians, $15/specimen to all hospital pathologists, $15/interpretation to hospital radiologists, $50/ visit to ER physicians, $400 for cataract surgery, and 50% of charges for non-plan second medical opinion.

[d] $200 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copay for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[e] $350 copay for complex procedures, defined as Cardiac Catheterization, MRI, Lithotripsy, Nuclear Stress Test, CAT Scan, and PET Scan; $40 copayment for all other simple diagnostic testing procedures; and $50 copay for allergy skin testing.

[f] $1,000 per admission and $200/day for days 7-30 at non-participating hospitals.

[g] $1,000 per admission and $300/day for days 7-30 at non-participating hospitals.

[h] Glucose monitors, test strips, lancets, and self-management training.

Source: G. Dallek and C. Edwards, *Restoring Choice to Medicare + Choice: The Importance of Standardizing Health Plan Benefit Packages.* (New York: The Commonwealth Fund, October 2001.)

Senator BREAUX. Next, we will hear from Mr. Stuart Butler, who is from the Heritage Foundation. He is currently the Vice President of Domestic and Economic Policy Studies there and he has argued for a long time for a health care system based on consumer choice and also market competition and we are delighted to have him with us. Mr. Butler.

**STATEMENT OF STUART BUTLER, VICE PRESIDENT, DOMESTIC POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC**

Mr. BUTLER. Thank you, Mr. Chairman and Senators. All of us in this room want to see an America in which everyone can count on a decent basic level of health care, but we need to make sure we reach that goal in a manner that is affordable, efficient, fair, and as seamless as possible. Our current system has none of these features.

As you mentioned, Mr. Chairman, and others have done on this panel, millions of Americans currently have no regular coverage at all, and most with coverage move over time from one program or plan to another, each with different benefits and eligibility rules depending on the person's situation at that time. For instance, an American faces totally different health care coverage depending on whether he or she currently is employed in a small firm, a large firm, has changed jobs, is unemployed, is unemployed because of the impact of trade, is a veteran, is poor and on welfare, is poor but not on welfare, is retired and age 64, is retired and age 66, or is a member of this committee. Everyone is different.

Not only is there a fragmented patchwork of programs, but also, these programs or plans are run on totally different operational principles with wide variations in Federal subsidies that defy logic. Some, like the VA, are run directly by the government. In Medicare, by contrast, the government contracts out the delivery of services, but Congress fixes the benefits. Elsewhere, employers basically decide whether a sick child will or will not see a specialist. Meanwhile, the Federal Government gives Bill Gates thousands of dollars each year in tax breaks to help him because he no doubt struggles to afford his dental check-ups, yet gives little or nothing to help the busboy down the street pay for minimal medical care for his family.

Mr. Chairman, we will never achieve universal coverage simply by adding here and there to this mishmash of programs and this indefensible method of subsidizing people. Moving toward a fairer and more rational system will, of course, be difficult, but the best way to do so would be to take some steps consistent with four strategies that I discuss in my written testimony.

First, I agree with others on the panel and with you that we should commit ourselves to a social contract on health care that is explicit and fair. In a rich country like America, we should declare that it is the obligation of society to assure that all residents will have affordable access to at least a basic level of health care. But a contract is a two-way process. Residents should also have the legal obligation to use a reasonable level of their finances to contribute to the cost of basic coverage so that others in society are not needlessly called upon to help.

Second, tax breaks or other subsidies to help people afford coverage should not vary significantly because of the particular piece of the patchwork people happen to be in, or very significantly, if they move from one piece to another. This implies such things as delinking the eligibility of tax relief from employment status. It also means gradually redesigning the method of tax relief so that help is focused where it is really needed. For Medicare, it means that assistance toward the cost of such things as Part B premiums or new benefits, such as a drug benefit, should be focused on those who need that help the most.

Third, the place of work should function more as a clearinghouse for choosing and enrolling in health coverage and less as the place where an employer decides what your coverage will be. The place of work is a convenient place today for people to pay their taxes through the withholding system, yet employers do not sponsor the tax system. They do not decide what taxes their employees will pay. It should be the same in health care. In the case of workers in small firms especially, the health subsidy reforms I have suggested would permit employees to sign up at the place of work for coverage that they want rather than coverage decided by their employer.

Fourth, Mr. Chairman, there remains the obvious question of how do we move from a patchwork with many holes to a more consistent and complete tapestry. To be sure, there are deep disagreements about what a reform system should look like, and you will hear disagreements on this panel. There is also uncertainty about what will actually happen on the ground when certain policy changes are made.

Recognizing this, I suggest that the Federal Government, with the States, should embark on a systematic strategy of creative federalism to test comprehensive approaches to achieving universal coverage. To do this, the Federal Government should establish the goals and dedicate some funding. Congress should also enact a menu of policy tools that would be available to States, but not imposed upon them. These tools might include such things as association plans, as opening up the FEHBP, or modifying Medicare and SCHIP. A State could then propose a covenant combining State actions with selections from the Federal menu designed to test an approach to achieving universal coverage. Rather than arguing endlessly about what the end result should look like, let us instead learn systematically what really works.

Mr. Chairman, thank you for the opportunity to testify.

[The prepared statement of Mr. Butler follows:]

The Heritage Foundation 214 Massachusetts Avenue, N.E. Washington, D.C. 20002-4999 (202) 546-4400

Congressional Testimony

# Laying the Groundwork For Universal Health Care Coverage

**Testimony before**
**The Special Committee on Aging**
**United States Senate**

**March 10, 2003**

**Stuart Butler**
**Vice President**
**Domestic Policy Studies**
**The Heritage Foundation**

My name is Stuart Butler. I am Vice President of Domestic and Economic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Mr. Chairman, any observer of the American health care system is immediately struck by two of its central features.

*Gaps and unevenness in coverage.* Despite the huge expenditures devoted to the system, there are enormous gaps in the degree in to which it covers Americans and there are wide difference in the level and type of benefits available to people of similar circumstances.

Millions of Americans lack any insurance protection at all, and many of these are middle class. Many poor and non-working Americans are eligible for a wide range of benefits, while others struggle to keep their families just out of poverty yet lack any insurance. A worker may have coverage one week, arranged by his employer, yet lose it the following week because he switched jobs to a firm without coverage. Similarly, workers who are perhaps forced in to early retirement by economic conditions, or their health, are not eligible for Medicare or any other program and can find themselves suddenly in dire straits for lack of affordable coverage.

The level of benefits available also can widely differ. An elderly person who happens to qualify for veteran's benefits can obtain general support for their outpatient pharmaceutical needs. Yet an otherwise identical retiree in Medicare has no such coverage.

So our "system" is a system in name only. It is really a patchwork of public and private programs with widely differing eligibility criteria. And many people end up falling between the eligibility requirements of the programs and many others have benefits only loosely connected to their needs.

*Multiple systems of health care.* The second distinctive feature of the American system is that different parts of it are run on totally different principles of design and economics. The Veterans Administration health system, for example, has similarities to single payer systems in other countries, in that the VA maintains its own hospitals, pays its own staff, and decides centrally on the distribution of medical resources. Meanwhile another government program, Medicare, runs on other principles, with private providers reimbursed by government for the services they render to eligible beneficiaries. In Medicare, the primary package of benefits is decided in detail by Congress. Moreover, Medicare is actually two separate programs. The hospital insurance system functions as a traditional mandatory social insurance program. The other part of Medicare, principally covering physician costs, is a voluntary system with a subsidy for government-sponsored insurance.

Yet another government program, The Federal Employees Health Benefits Program (FEHBP), covers over nine million federal employees, their families and federal retirees, and operates on yet another approach. The FEHBP provides a direct subsidy which is used by eligible families to reduce the premium cost of the private plan of their choice, providing that plan meets basic requirements laid down by the government. The benefits in FEHBP plans vary significantly. Congress sets down only a very basic set of benefit classifications, and the actual content of each plan is determined by consumer demand in the competitive market place.

In parallel to these widely differing government-sponsored programs is the extensive private insurance system that covers most working age Americans. The primary component of this system is insurance sponsored by employers to cover their employees and families. The families obtaining health coverage in this manner enjoy an often very large tax benefit since the value of the employer sponsored component of there compensation is free of all taxes. Other individuals obtain private insurance by purchasing it directly from insurance companies, often because their employers do not provide such coverage. While some tax benefits are available for this form of purchased insurance the criteria for tax relief are so restricted that many in this market have no tax subsidy at all.

Our experience with this fragmented patchwork of programs should lead us to draw some important lessons as we ponder ways to achieve universal coverage in America. Among these lessons:

***Lesson 1: The employment-based system, while successful for certain families, has severe weaknesses as the basis for universal coverage***

The employer-sponsored system is often pointed to as a success story, despite the current concerns about escalating costs. In the case of coverage offered through larger firms, employment-based coverage does have advantages. For instance:

*Pooling.* A company with a large workforce obviously also has a large pool for insurance purposes. A large number of individuals can be grouped together and insured as a group for a standard premium, despite possibly wide variations in medical risks among employees. Large companies also have the economies of scale and the sophistication to provide insurance at a low administrative cost per employee.

*Advantages for bargaining and administration.* Larger companies also can bargain very effectively with insurers and providers, and so are able to deliver cost-effective coverage that is often tailored specifically for their work force.

*Choice.* Because of the size of their insurance pool and their sophistication, large companies can arrange a choice of health plans, making it more likely that workers will be reasonably satisfied with their coverage.

*Employment-based insurance is very convenient.* When an employer provides coverage, it is normally very easy for an employee to take part in the plan. Premiums are paid directly by the employer, and the worker does not have to apply for a tax exclusion;

the W-2 form, indicating the worker's income for tax purposes, simply makes no mention of the value of the employer's contribution to his health insurance. Moreover, if the worker has to pay something toward the cost of his plan, this is usually done in the form of a convenient payroll deduction during each pay period.

*Problems for Small Firms Sponsoring Health Insurance*

While these advantages of employer-sponsored coverage certainly apply to workers in many firms, they are less likely to apply to certain specific categories of workers, especially those employed in small firms.[1] Among the reasons for this:

- Small firms by definition are small insurance pools. A retail store with a handful of employees is a dismal pool for insurance purposes. Hiring a new employee with a disability, for example, can mean a huge change in insurance costs for the employer. States and the federal government recognize this and are exploring various ways to group small firms together to form larger insurance pools. But the need for these efforts only underscores the fact that the place of employment is not a particularly good basis for the pooling of these insurance risks for employees of small firms.
- Small firms face relatively high administrative costs, and many small-business owners do not wish to organize insurance. Because they lack the economies of scale and the management resources of larger firms, small businesses tend to face high costs when administering plans. According to data collected by the Congressional Budget Office, overhead costs for providing insurance can be over 30 percent of premium costs for firms with fewer than 10 employees, compared with about 12 percent for firms with more than 500 employees.[2] Moreover, many small-business owners have little desire to engage in the demanding task of trying to organize health insurance that meets the often-varied needs of their employees.
- Small firms can rarely offer a choice of plans. If a small employer provides coverage, it tends to be a single "one-size-fits-all" plan. Small companies rarely offer a choice of plans. While 81 percent of workers with insurance in firms of 5,000 or more employees had a choice of at least three plans in 2000, only 2 percent of covered workers in companies with fewer than 25 employees had a similar choice of at least three plans. Meanwhile, 95 percent of covered workers in the smaller companies had only one plan available to them.[3]

These obstacles to employment-based coverage in the small-business sector help to explain the high level of uninsurance among families with workers in that sector. According to a recent survey by the Kaiser Foundation, 74 percent of the uninsured are in families with at least one full-time worker, and while 99 percent of large firms offer insurance, only 55 of firms with fewer than 10 employees do so. Among low-wage

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[1]For a summary of the pros and cons of employer-sponsored coverage, see Uwe E. Reinhardt, "Employer-Based Insurance: A Balance Sheet," *Health Affairs*, Vol. 18, No. 6 (November/December 1999), pp. 124-132.

[2]Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance*, 1994, p. 8.

[3]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2000 (Menlo Park, Cal.: Kaiser Family Foundation, 2000), p. 57.

workers (defined as those who earned less than $7 an hour in 1996), 45 percent are not even offered insurance.[4]

***Lesson 2: The primary method for subsidizing insurance for working families is inequitable, inefficient and fundamentally flawed.***

Today we subsidize for insurance very efficiently. In fact, the current form of subsidy encourages an inefficient overuse of medical care by most non-poor Americans while providing little or no help to the lower-paid uninsured, and it actually exacerbates the problem of uninsurance for many Americans. This happens because by far the largest subsidy for insurance for working Americans is the tax exclusion for employer-sponsored insurance. The exclusion means that the portion of a worker's compensation devoted to employer-paid health insurance is not subject to federal or state income taxes, or payroll taxes. In aggregate this subsidy dwarfs even the value of the mortgage interest deduction. John Sheils and Paul Hogan valued the subsidy in 1998 at over $111 billion at the federal level and nearly another $14 billion in exemptions from state taxes.[5] In contrast to a subsidy aimed at those who need help the most, a tax exclusion provides most help to upper-income workers (who are in the highest tax bracket) with the most generous coverage. Sheils and Hogan have estimated the average annual federal tax benefits in 1998 as ranging from $2, 357 for families with incomes of $100,00.

But the exclusion is highly inequitable. Sheils and Hogan estimated the average annual tax benefit at just $71 for families with incomes of less than $15,000. Thus the exclusion provides little help to lower-paid workers, who often face hardship in paying for family coverage or out-of-pocket costs, and it is not available to workers lacking an employer-sponsored plan. It is hard to imagine a less efficient system of subsidies for helping people to obtain coverage.

***Lesson 3: The Medicare program does not represent a sound structure for universal coverage.***

The trust fund woes of the Medicare program indicate the financing dangers of a social insurance approach to health care. Similar to the experience of maturing social insurance programs around the world, Medicare is plagued with huge unfunded liabilities as political pressure for ever-larger defined benefits today mean ever-larger obligations on future generations. The 2002 report of the Medicare trustees provided a dire picture of the program's finances, with expenditures rapidly outstripping dedicated revenues in future decades.[6]

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[4]Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: Key Facts* (Washington, D.C.: Kaiser Family Foundation, 2000).

[5] John Sheils and Paul Hogan, "Cost Of Tax-Exempt Health Benefits In 1998," Health Affairs, vol. 18, no. 2, March-April 1999, pp. 176-181.

[6] The 2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds (Government Printing Office, Washington, D.C., 2002), p.10.

But the structural problems of Medicare are not confined to its financing. When Medicare was created in 1965, its benefit package was based on the prevailing Blue Cross/ Blue Shield package for working Americans in large firms. As such, it was seen as state-of-the-art coverage. Since that time, however, the benefits for Medicare recipients gradually slipped further behind the benefits routinely available to working Americans. For example, Medicare provides no outpatient prescription drug benefit. It would be virtually unthinkable for a large corporation today to offer its workers a plan without at least some coverage for outpatient pharmaceuticals, or, for that matter, protection against catastrophic medical costs.

The main reason that Medicare's benefits package is out of date—despite the general awareness that it needs to be updated—is that all major benefit changes require an act of Congress. Consequently, discussions about changing benefits (especially about introducing new benefits by reducing coverage for less important ones) are necessarily entangled in the political process. Providers included in the package fight diligently—and usually effectively—to block serious attempts to scale back outdated coverage for their specialties. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties that seek to be included in the Medicare benefits package. Invariably, the result depends as much (if not more) on shrewd lobbying than on good medical practice. The understandable reluctance of most lawmakers to subject themselves to this pressure further slows the process of modernizing benefits.

*Formula Payments.* Medicare today uses complex formulas to determine its payments to managed care plans serving beneficiaries and payments to physicians and hospitals under the traditional fee-for-service program. Through legislation and regulation, the government tries to create a payment schedule that will work in all parts of the country and that takes into account local conditions. But as is typical of attempts by government to set payments by formula, these schedules rarely match the actual market, which constantly changes. As a result, policymakers and health care providers grumble constantly that the formulas systematically and wastefully overpay some plans and underpay others, and that many payments to physicians and hospital are far out of line with the cost and difficulty of providing specific services.

*Bureaucratic Decisionmaking.* Just as arcane and problematic the complex administrative process used by the Centers for Medicare and Medicaid Services (CMS) to modify benefits, to determine whether certain medical treatments or procedures are to be covered under Medicare, and to define under what conditions or circumstances services are to be delivered and paid for. This byzantine process is marked by intense pleading by medical specialty societies, and a degree of congressional micromanagement that makes efficient management of the program impossible.[7]

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[7] For a recent review of management problems arising from congressional micromanagement, see Sheila Burke *et. al., Improving Medicare's Governance and Management*, (Washington, DC.: National Academy of Social Insurance, 2002), pp. 39-42.

**Moving Towards Universal Coverage**

If we are to construct a health care system in this country that focuses resources efficiently to help those who need assistance to obtain health coverage, we need to take the following important steps:

1. **Agree on a health care social contract between society and individuals that is explicit and fair.**

Today there is a legal and moral obligation on society to provide some level of health care to those who become ill. Under federal law almost all hospitals must provide immediate health services to individuals entering the emergency room. In addition, physicians and hospitals routinely provide services to individuals unable to pay for these. A recent study by Jack Hadley and John Holahan estimates that as much as $38 billion is spent each year in public and private resources on health care services for the uninsured.[8]

This implicit "social contract" is both inefficient and unfair. It is inefficient because the method of providing services often means they are delivered in the most expensive setting. And because the services are not part of a comprehensive plan they are inefficient from a medical point of view. The contract is unfair because it discourages many families with the means to obtain adequate coverage from doing so.

The current social contract should be replaced with a more rational one. In a civilized and rich country like the United States, it is reasonable for society to accept an obligation to ensure that all residents have affordable access to at least basic health care – much as we accept the same obligation to assure a reasonable level of housing, education and nutrition.

But as part of that contract, it is also reasonable to expect residents of the society who can do so to contribute an appropriate amount to their own health care. This translates into a requirement on individuals to enroll themselves and their dependents in at least a basic health plan – one that at the minimum should protect the rest of society from large and unexpected medical costs incurred by the family. And as any social contract, there would also be an obligation on society. To the extent that the family cannot reasonably afford reasonable basic coverage, the rest of society, via government, should take responsibility for financing that minimum coverage.

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[8] Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, And Who Pays For It?" *Health Affairs* web exclusive, February 12, 2003, available at: http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm

The obligations on individuals does not have to be a "hard" mandate, in the sense that failure to obtain coverage would be illegal. It could be a "soft" mandate, meaning that failure to obtain coverage could result in the loss of tax benefits and other government entitlements. In addition, if federal tax benefits or other assistance accompanied the requirement, states and localities could receive the value of the assistance forgone by the person failing to obtain coverage, in order to compensate providers who deliver services to the uninsured family.

2. **Provide support to people to obtain health care based on their need, not where they happen to work, or their eligibility for welfare, or their military record, or their age. Enable individuals and families to use this support to enroll in a seamless system of coverage according to their choice.**

The central public policy objective of a health care system is to use public funds in an efficient and economical way to enable every household to obtain at least an acceptable level of health care services and protection from large financial burdens associated with ill health. Whether a US resident is able to count on that commitment should not depend on their current circumstances. Moreover, resources should be used as efficiently as possible to provide help those who need it most to obtain coverage. That requires us to overhaul current subsidy methods to target funds more efficiently and to achieve horizontal equity between similar people.

An important step towards that would be to overhaul the tax treatment of health care, gradually ending the regressive tax exclusion for employer-sponsored health insurance and replacing it with a more progressive subsidy. That is the logic behind the various refundable tax credit proposals in numerous proposals for addressing uninsurance. These proposals would increase the subsidy to lower-income households relative to upper-income households.

The same rationale lies behind various approaches designed to alter the Medicare program to target a higher proportion of benefits on lower-income seniors, in contrast with the traditional social insurance vision of equal benefits regardless of income. And while there is fairly universal support for a residual safety net public program for indigent or dysfunctional households, replacing part of the Medicaid program with a refundable tax credit or voucher-like assistance is in line with the same goal.

It is also important to de-link financial support from household work status. In other words assistance for health care coverage should not be based on employment or retirement status, and it should be available for the cost of coverage from any reasonable source. Thus an unemployed person and his or her family should have the same degree of assistance as an employed household of similar income with employer-sponsored coverage. A worker with employer-sponsored coverage should get the same tax break or direct subsidy for coverage as a similar worker whose firm does not provide insurance. A

60 year-old early retiree should be able to count on the same help as a similar person who is still in the workforce.

The value of the assistance should also not differ according on the source of coverage. Thus a household should receive the same subsidy value were it to obtain coverage through an employment based insurance plan or by buying into a public program. On the other side of the same coin, an individual or household should be able to continue the same form of coverage throughout their life if they wish. Thus a worker with a private insurance plan should be able to continue that coverage into retirement, receiving "Medicare" benefits in the form of assistance towards the cost of continued insurance coverage.

3. **Make it possible for the place of work be the location through which most families can get coverage, without employers necessarily being the sponsor of coverage.**

Most people in America pay their taxes through a place of work. This is a very convenient system under which employers withhold income and Social Security taxes and send the money to the government. In addition, employees typically adjust their withholdings to take advantage of any tax breaks for which they may be eligible (for example, the mortgage interest deduction). This means that employers actually operate the basic income tax system; but they do not in any sense design the tax code for their employees or "sponsor" the tax system. They could more appropriately be considered a clearinghouse for tax payments.

The place of employment is likewise particularly convenient and efficient for handling health insurance enrolment and payments. Workers with employer-sponsored health insurance benefits typically sign up for the firm's plan when they take a job and arrange for a payroll deduction to cover premium costs for them or their family. With individual tax credits or other forms of subsidy discussed above, employers could carry out the critical clearinghouse role for plan choices, tax adjustments, and premium payments. Such employers would not required to organize or sponsor a plan for their employees to obtain tax relief or other subsidies for the cost of coverage.

In other words, smaller employers could handle the mechanical aspects of arranging for payroll deductions and premium payments (similar to their role in the tax collection system) without having to sponsor a plan. Thus, the employer could play a very important role in facilitating coverage without having to organize coverage. In this way the place of employment could be the "point of service" for selection and payment decisions, and for the receipt of subsidies, without the employee being restricted to coverage decisions made by the employer.

*Using automatic enrollment to boost coverage.* Whether or not they sponsored insurance, employers could be encouraged to institute an automatic enrollment and payment system to make health insurance premium payments and to obtain health-related subsidies. This means that employees would automatically be enrolled in a health plan

unless they explicitly declined to do so, perhaps by signing a document indicating that they understood the possible consequences of not enrolling in a plan. Alternatively, a state could establish a default bare-bones health plan in conjunction with a private insurer, to which anyone not otherwise choosing a plan would be assigned.

Evidence from pension plans indicates that an automatic enrollment system for health insurance could have dramatic effects on sign-up rates.[9] This payment system is also very similar to the way in which the FEHBP enables a federal worker who may work in a small workplace, such as the local office of a Member of Congress, to choose from possibly dozens of plans.

**4. Use "creative federalism" to discover the best arrangements for organizing health coverage.**

Any approach designed to secure universal coverage, and perhaps especially one which seeks to encourage greater equity and freedom of choice in coverage, has to confront the challenge of organizing the system of coverage. There is no consensus on which structures are best to deliver health care. Some argue for government-sponsored plans. Others for individual insurance. Others still argue for various group arrangements. In addition, allowing people to make choices in health care, even within government-sponsored programs, raises such issues as risk selection. Moreover, views differ on how to achieve the right combination of subsidy and insurance regulation to secure affordable and efficient coverage for people of differing health status.

Perhaps the fastest way to discover the best methods of organizing health coverage under a universal system would be to institute a modified form of the idea of "creative federalism." Under this approach, federal-state covenants would be instituted to test comprehensive and internally consistent strategies at the state level designed to move towards universal coverage. Congress would provide federal funds to assist states to experiment with a chosen strategy for arranging health insurance and services. In contrast to a simple system of block grants, these federal-state covenants would operate within policy constraints designed to achieve national goals for achieving universal coverage.

The Institute of Medicine (IOM), one of the national academies, recently proposed a limited version of this strategy designed to stimulate and test creative methods of expanding coverage for the uninsured.[10] The IOM proposed that the federal government create a number of statewide 10-year demonstrations based on combinations

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[9] A recent study found that automatic enrollment for 401(k) plans boosted participation rates from 37 percent to 86 percent for such voluntary pensions, with even sharper increases for young and lower-paid employees. See Brigitte Madrian and Dennis Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, National Bureau of Economic Research Working Paper No. 7682, May 2000, p. 51.

[10] Janet M. Corrigan, Ann Greiner, Shari M. Erickson, Editors, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington, D.C.: Institute of Medicine, 2002).

of proposals, including federal and state tax credits, as well as Medicaid and SCHIP expansions partly financed by the federal government.

Congress should consider the IOM recommendations. But it could also pursue a more comprehensive strategy to trigger state experimentation. Under such a more comprehensive "creative federalism" approach the federal government would do four things:

1) **Congress would establish goals for universal coverage**. The goals could include a certain percentage reduction in uninsurance rates in each state over a period, and steps towards ending multiple programs and eligibility criteria. Congress would also establish boundaries in policies that could be adopted in reaching the goals (e.g. that no person could face unreasonable coverage costs as a result of their medical condition)

2) **Congress would enact a number of changes to provide an "*a la carte* menu" of federal policy options that would be available to states to help achieve the goals**. These options might include making a version of the FEHBP available within the state, allowing some Medicaid/SCHIP money to be used in creative ways, removing regulatory/tax obstacles to churches, unions, and other organizations providing health insurance plans, and the creation of association plans and other innovative health organizations that would then be available to states.

3) **Congress would provide an amount of funding.** This would be for two purposes. Part of the money would help states fund certain approaches. The other part would "reward" states according to how successful they were in meeting the goals.

4) **The federal government would enter into agreements, or covenants, with states to achieve the goals**. States would propose some combination of modifications of their current programs, initiatives with their federal allocation, and a selection from the federal menu. The states could also negotiate regulatory waivers to the extent allowed by law. The federal agreement would have to agree to the covenant before it could proceed and evaluation procedures would have to be included.

The goal of universal coverage is likely to remain elusive under our current health care system. Today we provide help to people to afford coverage in such an inefficient and inequitable way that it is impossible to help all those who need it to afford coverage. In addition, we have a patchwork of programs and subsidy systems with a multitude of complex eligibility requirements that guarantees people will fall through the cracks. Reaching the goal of universal coverage will be difficult. But it will be much easier if we rationalize subsidies for health coverage, enable people to pick the form of coverage that is best for them, and encourage state-federal experiments to explore innovative ways of organizing health care coverage.

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Senator BREAUX. Well, thank you, Mr. Butler, and thanks to all the members of the panel for your comments and thoughts and suggestions. I think they are very, very important.

Let me ask each one of you if you could just maybe comment. The only question I have is to the point of looking at all the boxes. As I have said, and you have all heard me say it, that this boxed area of getting health care just cannot continue. We try to put band-aids on each one of the boxes and each one of the boxes is a huge bureaucracy with red tape and regulations and fraud, waste, and abuse, and what I have suggested, that in the long term, what we ought to do is guarantee that Americans get health care, not because they fit into one of the boxes but because they, in fact, are an American citizen, which means I am talking about an individual mandate that people buy health insurance in this country which would be subsidized by the Federal Government for low-income individuals.

I would involve the States in sort of the role that OPM provides for those of us who are Federal workers, to create the pooling arrangements to allow for purchasing and group rates as opposed to individual rates. That is the concept I think most of you are fairly familiar with.

Can you give me a short comment, and we will start the opposite way, Mr. Butler, and work back to Dan.

Mr. BUTLER. I strongly agree with that approach. I believe that it is important to try to gradually move toward consistency in the system for the very reasons that you mention and to make sure that if we do require people to obtain at least basic coverage, coverage that protects the rest of us from unnecessary expense, then we have to give that subsidy in a form that is far more rational than it is today. I think the best way forward is to experiment with States, but also, as we begin to move forward, to rationalize the subsidy system so that it becomes easier for these different boxes right now to begin to function in a similar manner.

For example, in the Medicare program, let us look at premium support approaches that recognize that we have got to help people in certain situations get assistance, such as the SLIMBY and QUIMBY case that Karen Davis mentioned. This recognizes that lower-income people need a lot more help to afford what is even available in Medicare today. We need to begin to start fixing that particular inequity will help all of these boxes in the first instance to start functioning in a rather more similar way than they do today.

Then simultaneously, we have got to look at the infrastructure of information that others have mentioned so people can navigate the system that they currently are in. So I think if——

Senator BREAUX. You hit upon a thought that I hadn't really thought about. We have got this box theory, but each one of the boxes is actually, in most cases, a different type of delivery system.

Mr. BUTLER. Absolutely. Absolutely.

Senator BREAUX. You are in a box because of whether you are old or whether you are poor or whether you are a veteran, but not only are you in the box that is supposed to be for you, each box is sort of a different delivery system on top of it.

Mr. BUTLER. Right.

Senator BREAUX. Ms. Davis.

Ms. DAVIS. Mr. Chairman, I think you are to be congratulated for really calling for making comprehensive health insurance for all a top priority. I think until we are serious about really committing the resources that it takes to make coverage automatic and affordable for everyone, we are going to continue to suffer both the health and the economic consequences of our current system.

So I think trying to set up a simpler system where coverage is automatic is key. It can go as far as an individual mandate or simply just making it so easy for people and so affordable that you get virtually everybody covered.

I think looking at the experience of the Federal Employees Health Plan makes a lot of sense. I think that works well for Federal employees, and works well for Members of Congress. I don't think one wants to add new groups into that plan specifically, but instead use it as a model, for something that I call the Congressional Health Plan that would cover Members of Congress, small businesses, and individuals. But link the two by requiring any plan providing coverage through the Federal employees plan to also provide coverage through this new pool.

I think having premium assistance that is income-related makes a lot of sense. I think building on the income tax system, makes a lot of sense because that is one thing that we do verify and it is an administrative system that is out there. I think there is a way of really checking people's insurance status at tax time and then referring people who are uninsured to something like a Congressional Health Plan pool. So I like all of those ideas.

I think the ones that I think need to be looked at fairly carefully and are very difficult to look at is the employer-based health insurance system that we have now. There are about 160 million people covered under employer plans. Employers put up $335 billion a year for that coverage, so I don't think we want to risk moving backwards and eroding that coverage. I think that is going to require looking at a fair contribution from all employers, everybody contributing at least something toward coverage, whether they provide coverage to their workers or their workers wind up getting covered through something like the Congressional Health Plan.

Finally, we have to think about the role of public programs. I think that Medicaid and Medicare are very important programs. They cover the sickest and the poorest of all beneficiaries and these are beneficiaries that are, for the most part, not attractive to private insurance firms. Medicaid, for example, covers the homeless, people with HIV/AIDS, people with very serious physical and mental problems, children with special health care needs, quadriplegics. So there are subsets of the Medicaid population, that represent a large portion of Medicaid dollars and that really need this coverage. We are going to need to turn to public programs to cover the sickest and poorest, but perhaps we can offer people choices of other options, as well.

So I think the broad framework that you have set forward is critical and the commitment of resources is also very important, to begin thinking about moving from where we are today to getting to such a system is the major challenge.

Senator BREAUX. Mr. Nichols.

Mr. NICHOLS. Mr. Chairman, when I think about your theory of the boxes and how your proposal attempts to create a framework where everyone would have a home, I have to applaud. I think there are five major goals we want to achieve here and I keep coming back to something like the group purchasing arrangement as the best way to achieve those goals. We have to have a system that is efficient. We have to be good both at enrolling people—we can only get low administrative costs through group enrollment. At the same time, all the quality issues and waste issues I talked about in my testimony, I think, can only be addressed in a big group purchasing kind of arrangement.

We want to have good risk pooling so that people of different risks can be pooled together so that you are not held accountable for being unlucky in life. At the same time, you want to make sure that those who are healthy don't pay premiums that are way out of balance with what they are expected to cost. You have to have some compression there.

You have to have a choice. I think Stuart's point about how most individuals today in the employer system really don't have much choice because they basically end up with the one choice their employer makes for them. Maybe it is best for some group of workers, but it is surely not best for all workers. So we want to make sure we have more choices.

We want to have subsidies tied to the circumstances of individuals. I am very impressed with the notion that the individuals who most need subsidies in our country tend to float in and out of different kinds of employment arrangements. That is why they are sometimes uninsured and sometimes not. That is why that is the common circumstance. The notion that one subsidy will be right for them at all times is probably not true. Therefore, we want to have a system that follows individuals and not other kinds of circumstances.

Finally, we want seamless. We want a system where when they have a life change, they don't have to change their health care system or have to change their providers who they know and, our surveys at least show, they trust, and that is the good news about our health care system today.

To me, the way you accomplish all of that is to make one big box, that is to say, to make a box where everyone has a right to go. As you know, I have argued that you don't want to force people into that box. You want to leave people with choices outside the box if, indeed, they think they can do better on their own. But it is perfectly consistent with my view of what we want here and what we all agree on to enforce an individual mandate to buy coverage, but you can choose to get it where you want. In my view, most people will, as Karen said, drift to the bigger box over time. If you create it, they will come, but you don't want to force them all to come the first day.

Senator BREAUX. Thank you, Mr. Nichols. Dan.

Mr. CRIPPEN. Mr. Chairman, a couple of kind of disparate comments, but, I think, saving the most important for the last.

Looking at Federal programs, of course, we can often find what we are looking for and ignore some of the more obvious points. The FEHB works well in large measure because it is 72 percent sub-

sidized. If we had other health care systems that were as heavily subsidized, they would work better, too, but it is not that we probably can't afford them.

Similarly with Medicare, while, as Len says, central purchasing may give you some efficiencies, we only spend 3 percent on administrative costs on Medicare. At the same time, Medicare, since 1965, on a per capita basis, has increased in cost more than any other system we know of, more than other public programs, more than private, more than private premiums plus cost sharing, and substantially faster than the economy itself, inherently, by definition, unsustainable.

So we can point to some aspects that are advantageous, but taken as a whole, it is not clear these systems are sustainable. What we do think we know—that is a real statement, we do think we know—— [Laughter.]

The economists tend to believe, at least, that incentives matter and that if you develop a system in which individuals at least have some responsibility for making the decisions and paying in part for their own care, whether it is small amounts, and whether they are subsidized or not, that that is important.

For example, we believe that the existence of Medigap, because it very often provides first dollar coverage, results in the average Medicare beneficiary spending $2,000 to $3,000 a year more than they would otherwise. Now, they may have better health care because of it. I don't want to interpret that otherwise. But the point is that first dollar coverage incents people to use a lot more health care, and so as we have discovered in things like pharmaceuticals, where we have multiple or tiered copays, other things, those kinds of incentives work if individuals are faced with those choices. So any system you develop needs, I think, to keep that very clearly in mind.

Senator BREAUX. Thank you all for that comment. I have some additional questions, but I want to recognize Senator Collins.

Senator COLLINS. Thanks very much, Mr. Chairman, and let me commend you for putting together a truly extraordinary and balanced panel. Your testimony has been excellent and very thought provoking and I really appreciate your taking the time to be with us.

When I approach the issue of the uninsured, I start with the fact, and I think one of you, maybe Ms. Davis, said it today, that 82 percent of uninsured Americans are part of households where at least one person works. This is contrary to what most people think of when they think of the uninsured. They believe that uninsured individuals are unemployed individuals, yet the majority of them are in households where someone is working.

Of those who are uninsured and working, 60 percent of uninsured workers are employed by small firms. If we could figure out how to make insurance more affordable to those small employers so that population, that 60 percent, had access to affordable health insurance, we could go a significant way toward lessening the number of uninsured. We would bring literally millions into the system.

The legislation that I have introduced tries to take a variety of approaches. It would provide tax credits for small employers. It would allow them to form purchasing coalitions to increase their

bargaining power. What it would not do, however, is authorize, as the administration has proposed to deal with this problem, association health plans. Having supervised the Bureau of Insurance in the State of Maine for 5 years, I have a lot of reservations and concerns about association health plans because I think they will lead to cherry picking. I also don't like the idea of such plans being preempted from State regulation, which I think is problematic.

I would like to get your views on the merits of association health plans now that I have told you my bias against them. So, Mr. Nichols, I am going to start with you in the hopes that I am starting with someone who might agree with my opinion before I move on to the other panelists. [Laughter.]

Mr. Nichols.

Mr. NICHOLS. Well, I am impressed you picked me out of a crowd.[Laughter.]

You may have heard I testified before your Senator from Maine about a month ago on precisely this issue and I would just say you are right in spades on this matter. There is no question that a number of us are very concerned about small business's ability to offer health insurance. I think the one thing that I think all of us hope is that we can find a way for them to find the cheapest possible coverage available.

What association health plans would like do, as the legislation that was introduced in the House last session and as legislation introduced by Senator Snowe a few days ago, I am afraid, would permit, or would indeed encourage a situation where the healthiest would join those association health plans, where those who wanted to join and couldn't would be the less healthy, and, thus, it would serve to destabilize the existing risk pools, which as you know in Maine are already fragile enough in that small group market and, therefore, would make kind of a bad situation worse, except for the few who got the good coverage in the short run.

The problem would be some of them who were the healthiest would always want to peel off from the existing group, and so it would introduce instability, which brings you back to the point about regulation. Exempting them from solvency requirements that are serious, exempting them from oversight on the part of people who actually know how solvency matters, what guarantee funds are all about, would leave a lot of workers at great risk.

I will say the problem of small business offering insurance needs to be thought about, I think, in a context of the way labor markets work. What most of us observe who study these markets carefully is that there are kind of two kinds of labor markets. There are markets where most of us have lived most of our lives, and that is where jobs have health insurance attached because the productivity of workers is high enough to merit and to pay for that in the marketplace.

Then there is a set of jobs, they are not as many jobs, but there is a set of jobs where health insurance is never attached, and in fact, those workers tend to have lower productivity, lower human capital. It is not fair, but it is the way it is. In those firms that need those kinds of workers exclusively, there is just not enough surplus there to pay for health insurance. The workers who get those jobs have low wages. They are not willing to pay out of their

own wages. The employers who employ them don't make enough money to make it something they can just give away.

Firms do what they do to compete for labor and margins are driven down to those competitive edges. So I am afraid for some class of workers in some firms, we are never going to get them to offer unless we can offer two things, serious subsidies to defray the costs so they can afford it, just like other low-income people are sometimes eligible for public programs they are not, as well as a home.

I come back to Senator Breaux's idea. There is going to have to be a home where they can buy. In my view, the place to do that is building on existing pools. State employee plans are a natural experiment. I love Stuart's idea of allowing States to do this in lots of different ways. I would climb onto that this afternoon or this morning or whenever it is we can sign.

Mr. BUTLER. I will sign you up.

Mr. NICHOLS. That is the way to go. Let people buy into existing pools that are large and not create a new destabilizing force, and you can refer to my testimony for details if you would like.

Senator COLLINS. You raise a really good point that I want to emphasize. The small employers in my State that don't provide health insurance don't provide it because they can't afford it. They don't even have it for themselves in most cases. It is not only their employees. They can't afford the coverage for themselves.

Mr. Crippen, any comments or thoughts on how we expand access to health insurance for this critical group?

Mr. CRIPPEN. I think it is important to recognize, Senator, that without attributing motives, the reason insurers or companies or associations are trying to change the nature of the pools they are dealing with is they are not looking so much for least risk as they are looking for something like average risk or stable risk. In fact, least-risk pools may be very unprofitable in some ways. So by trying to eliminate or cordon off or deal with a more knowable risk pool, they come up with an average risk that is easier to underwrite, easier to manage, all those kinds of things.

Clearly, the smaller the pools, the harder it is to do that, and if the result of policy is to make smaller and smaller pools, it is going to be harder and harder to get something that has average risk.

I am more familiar with public programs, of course, given my last 4 years, and I can tell you that for Medicare, we have done a lot of simulations that suggest you need about 100,000 elderly in any given risk pool to have average risk. Now, the distribution of expenditures by the elderly are a little more skewed than they are for a non-elderly population, but it is still a very skewed distribution. High-cost individuals drive the average, and those are a relative handful compared to the non-high-cost.

So one needs to be concerned about size of the pool, how average risks are determined, but there are many ways to adjust risk, many that we haven't thought about, frankly, particularly in public programs. Medicare, for example, you could look at high-cost individuals and see if there were a way to compensate for them perhaps differently. If they were removed from a risk pool, then the average risk would be much more stable and lower.

So the same phenomenon applies to non-elderly, as well, whether it is State risk pools, as I think Len was talking about, other ways to say risk or insure catastrophic cost, the high cost, the extreme costs, would then give you a much more manageable risk pool with much lower cost and, therefore, lower premiums. So you might think about reinsurance or State pools for catastrophic ways to manage the high cost risk that will then allow more normal risk to permeate the rest of the pool.

Senator COLLINS. Ms. Davis.

Ms. DAVIS. I agree with many of the points that Mr. Nichols made. I think you are right, based on your experience at the Bureau of Insurance in Maine, to be concerned about association health plans. I think what we need is broad risk pooling, not risk segmentation, because risk segmentation would just accelerate the deterioration of the better risk sorting out into certain plans, leaving the worst risk for others. So I also am attracted to the notion of either something like a State public employees' health plan as a pool or an analog to the Federal Employees Health Plan as an option.

I, too, support the notion of State demonstrations. I was a member of the Institute of Medicine committee that issued a report last November called "Fostering Rapid Advances in Health Care" that called for Federal funding of the incremental cost of providing universal coverage in three to five States and testing either a tax credit, private insurance approach, or expansion of public programs or a combination of those. So I do think that we need to move forward. State demonstrations with Federal funding, because I don't think States are in a situation to do this with their own money, is a good first stop.

I also believe the deck is stacked against small businesses. They pay much higher premiums than large business. Administrative costs for a very small firm can run 30 percent, contrasted with 10 to 15 percent in large firms. Large firms are more likely to have plans available to them with large provider price discounts, physician fees, hospital rates. So large firms, ironically, can get coverage cheaper than small firms and that is why I think we do need pools, larger pools available at either the State level or the national level, available to small businesses.

You mentioned tax credits for businesses, and Len talked about the money following the worker. I tend to favor the money following the worker and to have tax credits for workers to make sure they can afford the coverage that employers offer to them and have premium assistance that would pick up a big portion of the premium in excess of, say, 5 percent of income of a low-wage worker.

I personally am an outlier in that I think every firm ought to contribute something. I think we will find an erosion and a deterioration of the coverage that employers now provide if there is assistance for firms that don't provide, since they would get left holding the bill. So it can be modest, whether it is a dollar an hour or 5 percent of earnings, but I think every firm ought to contribute something into a pool to finance this coverage.

Mr. Crippen mentioned reinsurance. I do think that looking at adding a publicly subsidized reinsurance to something like a Federal Employees Health Plan is important, but I also think we need

to keep the worst risk in public programs, Medicare covering the disabled, Medicaid covering many of the sickest and the poorest, and that those programs have the effect of helping private insurance markets work by pulling the worst risk out. We know that if you take the 1 percent of the people with the most serious health problems and take them out of the individual market or out of the small business market, it will reduce premiums by 28 percent.

So certainly covering all of the disabled, not having a 2-year waiting period for coverage under Medicare, and opening up Medicaid to everyone below a certain income level with a serious problem, are ways in which we can help the private market to work better. Thank you.

Senator COLLINS. Thank you. Mr. Butler.

Mr. BUTLER. Senator, I have wrestled with the whole idea of employment-based coverage for many years, trying to think about what is the proper role and appropriate function of employer-sponsored coverage. It is interesting that I believe this is the only country in the world, certainly the only large country in the world, that has an employment-based system. You could say maybe Germany does, but that is more of an industry-based system.

That is an interesting point to just bear in mind, because when you look at the employment-based system in this country, you do see a spectrum of effectiveness. If you work for the Federal Government, or if you work for General Motors you have lots of choices. If you intend to work for either of those for all of your life, it is a pretty good, stable system.

When you get down to the other extreme, however, such as the ones you mentioned in Maine of the small firm in the fishing industry or something like that, or a restaurant, where the people who are working for you next year may not even be the same people who are working for you this year, it begs the question. Is this really the best place to help people organize their health care?

I have come to the conclusion that the more you go down the employment system, to smaller firms, to low-paid firms, particularly in firms with people moving in and out of the workforce, the less and less that makes sense as the basic method to get coverage. Therefore, I am leery of approaches, that say, "Well, let us help people get coverage, but let us do it via the employer." When you have got employers that may be facing 30 percent more of overhead costs for getting coverage, and may not know anything about insurance, or may have three different people working for them, one is 18, one is 65, and one has got a major heart problem, how can they possibly figure out and organize insurance?

I think that leads you into starting to think about pooling arrangements, whether it be association plans or whatever, and you almost get to the stage eventually where you say, "Well, if we do all these things, in what sense is this an employer-based system anymore?" The place of employment ends up being really where you sign up and where you become eligible for a subsidy.

So that is why I am very interested in looking at approaches that say, "Let us use the place of employment, particularly in the case of smaller firms, as a convenient place to sign up." But let us make the subsidy system, and the kind of plans available to you in the

system you are in, not connected to your place of work for these people.

Let me just go on to talk about specifically association plans. I am really open-minded on that particular approach. I do agree with the others on the panel that we must look at people who work for these small firms, people who do move in and out of the workforce for different employers, and try to group them in a different way. Maybe the way you do it in Maine is not the right way in Texas or in Alaska, Senator Stevens.

That is why I think it is important to say to States, well, we are not going to tell you to put an association plan in place or open up the FEHBP, as Karen Davis suggested, but let us make that available and if you think in your State that that is something you think might be part of the equation, well, then that is available to you. I think that is the way to look at these things.

Quite frankly, I am sure Len and others would be hard-pressed to say that they were 100 percent certain in their views of any of these approaches and how they would work, and therefore I think the Federal Government should not impose them on anybody. We should make them an available menu to be tried in these different places, and that is why I favor going down that road.

Senator COLLINS. Thank you.

Senator BREAUX. I thank the panel. Let me just ask one other question with regard to the concept of the individual mandate. We have tried the employer mandate in the first Clinton Administration and we saw the problems that that brought up and the intense political opposition that that had. If we had an individual mandate, two questions—I mean, there are a million questions, but two of them that we are still wrestling with.

First how do you enforce it? I think there are ways to do that. I mean, obviously, we have an individual mandate that people buy liability insurance before they drive a car in this country and people have sort of accepted that and there are penalties if you don't do that. But the question is, how do you enforce an individual mandate, and second, how do you enforce—or maybe I should say it this way—how do you continue to have the participation by employers, which are very, very important if any system is going to work? There is some fear that if we went to an individual mandate, that employers would just bail out of their participation in the system and we can't have that happen, at least not initially, because of the huge amount of costs that would be associated if their contributions were not available.

So can I have anybody talk about either one of those or both of those, enforcement of an individual mandate, and second, how do we guarantee the continued participation of employers who are currently providing employer-sponsored health insurance? Anybody?

Mr. BUTLER. Well, maybe I can take a crack at it first. First of all, I think it would be unjust to require somebody, to put a mandate on somebody to do something if they do not have the capabilities of discharging that mandate. I mean, in the case of automobiles, we do that, and if you can't afford it, you don't have a car. But obviously if you say you have got to have health insurance and so on and it is is illegal if you don't, if you have to have this and

you can't afford it, you are in a problem. So I think that does require you——

Senator BREAUX. Although the concept, obviously, is in the context of a subsidy for those who would be low-income.

Mr. BUTLER. Right. I do think that there are various forms of enforcement that you can consider. You can have something that is called hard enforcement or a soft enforcement. You can say, "It is illegal, and if you don't do it we put you in jail." That would be hard enforcement. I certainly wouldn't recommend that.

But you can also say that there are certain things you can't avail yourself of if you don't do this. For example, certain tax benefits could be contingent on that. You can also say to a State, "Well, if certain people don't sign up, rather than sending the State police out to find them, maybe at the Federal level we will compensate the State in some way in the amount these people would have gotten in tax subsidies had they actually signed up so the State, at least, is not left holding the bag on people who don't take part in that enforcement."

As far as how to keep employers involved, I do think it is important to recognize that employers today are not under any obligation to provide health insurance to people. There is no law that says you must, as an employer, do this. They do it for certain very sound economic reasons. They do it because of the labor market, because employees expect this. So I don't think for a moment that if you said, "Well, we will help your employees to obtain coverage, then somehow that will then mean suddenly the whole logic of providing health insurance to employees suddenly disappears."

It might in certain parts of the market, where an employer may say, "Look, I have got four employees, and may have four different people next year." It really makes more sense for me to add a little bit to your wages, take your subsidy and then go and join a plan that is far better than anything I can find for you. I don't find that such a problem.

I think within that range, you can look at approaches that have requirements on employers to continue coverage for a period if they already provide it, such as maintenance of effort approaches. Under these if they do for whatever reason eliminate their coverage, then they must compensate the employee, at least in the first year, to the equivalent cash amounts. There are all kinds of ways, I think, to minimize a kind of change in the approach of employers that you want to avoid. But if some employers decide to drop coverage, give cash, and allow that person to join an FEHBP-type plan that is, in fact, far better in the current situation and should not be avoided.

Senator BREAUX. Any other comments?

Ms. DAVIS. Well, I have given a little bit of thought to how one might enforce an individual mandate or something just short of that that I call an automatic enrollment with opt-out, but it is basically using the income tax system. So, first of all, each year there is insurance verification, so just like you submit forms from your employer saying what your earnings were, you get a form saying you had health insurance coverage or Medicare, SCHIP provides the documentation of coverage.

But if you don't have coverage, then you are automatically enrolled in what I call the Congressional Health Plan and you are charged a premium which you pay through the income tax system. So if you are filing in April, you pay a premium that is roughly 5 percent of your income in the lower tax brackets or 10 percent in the higher brackets for coverage that starts on July 1 and you get the packet just as Federal employees get a packet of insurance choices and then there is a default mechanism that assigns you to a plan.

So I think there is a way to enforce it by having the enrollment happen through the income tax system, through an OPM-like administrative structure, but assessing a premium and giving people effectively a tax credit for any portion of the premium over 5 percent of income.

Senator BREAUX. It has been suggested on that point—sorry to interrupt you, but that if a person during the year went to an emergency room, for instance, for health care and did not have insurance, they could be enrolled at that point, as well.

Ms. DAVIS. Absolutely. So you would also, and again, this was part of the Institute of Medicine recommendation, have an electronic insurance clearinghouse, so once you get this up and running, you know at tax time what people's coverage is, and if anybody goes to a provider at any point during the year and they are uninsured, the provider says, "These are your circumstances, you qualify for this and you are signed up and you start paying a premium through the tax system that is based on your income over a year's period."

In this particular scheme that I have had modeled and some cost estimates done, for it also gives people below 150 percent of poverty the right to go into a Medicaid or a SCHIP family health insurance plan. That would be done without premiums, so you have got that option, 5 percent of income in the lower tax brackets, 10 percent of income in the higher tax brackets.

So I certainly agree with Stuart that you need to make it affordable and people may have different amounts that they consider affordable, but that is what I have looked at.

Your second question was how to have employers continue to make contributions toward coverage. Obviously, as Stuart says, they do it voluntarily now, so many will continue. But I am concerned that many might drop if they felt like their workers can always get this coverage in an affordable way through the Congressional Health Plan. So I have leaned towards something that was called "play or pay." If you don't provide coverage to your workers, you have to contribute something.

In this particular model, employers are contributing a dollar per hour up to 5 percent of earnings, and the estimates are that if you did that, you would keep roughly the same mix of public-private coverage that you have now. About two-thirds of the population under age 65 would be covered under private insurance. About a third would continue to be covered under public programs, Medicare.

Now, some small businesses would shift from the coverage that they now buy to buying coverage through the Congressional Health Plan because they would be getting better premiums, so they would

move their workers in there, but would still have the private plan coverage like that available to Federal employees.

Mr. NICHOLS. Mr. Chairman, I would just add on the individual mandate piece that the one thing I would be sure of, to speak back to Stuart's point, is that we are never going to get 100 percent of Americans signed up for anything, but that is kind of OK, because, in fact, the ones you would miss through all the nets that others have talked about, so I won't belabor the point, are healthy. So they're not sort of the problem. I mean, the problem would be contributing money, and you would certainly want to catch them, but you could catch them, I think, in lots of these nets. But most of them, if they are going to need to go to the services, the providers will sign them up just like they do Medicaid now and that problem will take care of itself, coupled with the tax incentive.

Senator BREAUX. But the question is, I mean, for those that do not have insurance today, they tell me the largest percentage of the 40 million, or whatever they are, are between 18 and 41 years of age and basically in fairly good health. We want those people in an insurance plan.

Mr. NICHOLS. Yes, sir, we do, and over half of them go to the doctor every year and a fair number of them know exactly how tenuous their situation is, and so I think the ones that are sort of not 22 and immortal are going to think hard about signing up for something that is going to be basically free for them.

So I think the problem you would have, as you are always going to have, is on that margin where people have to pay something out of pocket because we can't afford to do better and it is perceived to be relatively high compared to what they used to have to pay because they used to get their care for free. Those folks are going to be the margin you have got to worry about, but, therefore, what you want to do is not destroy the safety net but keep that safety net there so they can have access and we can get them signed up. So on that front, I am less worried.

On the employer side, I think it is a very interesting kind of analytical question. My view is, as you know, is that a lot of employers offer today because they have to in the labor market. That compulsion will not go away once this kind of system would be in place. If they didn't continue to make a contribution toward my health insurance, they would have to give me wages or I would switch employers. So I am not worried about that.

Karen is right. There is a class of firms who are on the cusp. They tend to be those smaller firms who are trying to offer now and are finding it increasingly difficult. Those firms may very well find an incentive to pull out, and I think the way to deal with that is a 1-year maintenance of effort kind of requirement, where you say if you contributed to health insurance last year and you drop, then you have to give workers the wages equal to what you contributed last year. Then from that moment on, those workers' compensation has been raised equivalent to what the premium would have been. In a sense, they are made whole from what they were, but they have relieved the firm from the fear of having these premium increases over time.

Senator BREAUX. Mr. Crippen.

Mr. CRIPPEN. I think, Mr. Chairman, as Len just said, "While it may be possible in a transition to force employers to do something they wouldn't otherwise do, it is probably ephemeral and temporary, and there is a lot of evidence that it doesn't matter." That is, as Len just said, "If, as the evidence shows, fringe benefits are an alternative to wages, if fringe benefits change, wages will change to compensate the other way." So trying to force companies to do something or other probably is unproductive and unnecessary.

Equally importantly, I mean, it depends on what the plan is that you are mandating, obviously, and you have thought a lot more about this than I have, and if it is a mandatory catastrophic kind of coverage, then there is certainly a lot of insurable risk left for employers and others to give as fringe benefits or to work with at individual markets, as well. So it really depends on the nature of the package that you are mandating.

Senator BREAUX. I think this has been very helpful, Senator Collins. I think that it has been a good discussion. You all are experts in this area. You have been very helpful up to this point and we would encourage you to continue your involvement with all of us who are looking at these issues.

The question of uninsured and the question of these boxes that are up there are not going to go away in any short-term venue. It is going to be an ongoing battle to come up with answers. I mean, I just happen to think it is time to think outside of the boxes, so to speak, and think in a broader picture about where we are going to be down the road in this country when it comes to health insurance and that people should get it because they are an American citizen, not because they fit into one of the boxes.

We thank you very much, and that will conclude this hearing.

[Whereupon, at 3:26 p.m., the committee was adjourned.]

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