CBO TESTIMONY

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

February 2, 1993

NOTICE

This statement is not available for public release until it is delivered at 10:30 a.m. (EST), Tuesday, February 2, 1993.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee. My testimony today will cover the Congressional Budget Office's (CBO's) methods for examining the effects that cost containment provisions in health legislation would have on national health expenditures. These methods will be illustrated using two bills that were introduced in the last Congress.

THE EFFECTS OF COST CONTROL PROVISIONS ON HEALTH EXPENDITURES

Over the past two decades, both public and private payers have made concerted efforts to apply many cost control strategies to the current health care system. As a result, there is evidence of how at least some types of cost containment approaches affect health care spending.

To give you an understanding of CBO's estimating methods, let me describe several options for controlling health care costs and the issues that these options raise for cost estimating. Where possible, I will also indicate the magnitude of the potential reduction in national health expenditures that might be estimated for each proposal.

Increased Cost Sharing for Health Services

Strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would become more cost-conscious if they paid more. In other words, they would be more likely to consider whether the value of an additional visit to the doctor was worth the extra cost or they would seek out providers who were more economical or charged less. In considering this strategy, however, it is worth noting that average cost sharing in this country is continuing to decline. Consumers paid 27 percent out-of-pocket for their health care in 1980, but only 22 percent in 1991.

Cost sharing for health services could be increased in a number of ways. One could mandate minimum cost-sharing requirements for private insurance, eliminate dual insurance coverage that offsets cost-sharing requirements of individual policies, or prohibit the use of flexible benefit accounts to pay deductible amounts and coinsurance requirements.

As an example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private fee-for-service health insurance by 40 percent in 1990, then national health expenditures would have been about 1 percent to 3 percent lower. This effect would be

relatively small because consumers are not particularly sensitive to changes in their out-of-pocket costs. The reason is, in part, that they lack knowledge about alternative treatments, their costs, and their efficacy and, therefore, they delegate decisionmaking to physicians and other providers.

Expanded Controls on the Use of Services

Managed care can reduce inappropriate or unnecessary health care. Overall, however, the evidence of its effectiveness in reducing costs--other than through fully integrated health maintenance organizations (HMOs) with their own delivery systems--suggests that substantial savings could not be achieved by extending it to more people. Some reduction could occur, however, if expanded controls on the use of services were concentrated on populations with above-average hospital use.

One legislative approach might be to provide federal financial incentives to expand enrollment in HMOs. Incentives, however, would not necessarily elicit the desired increase in voluntary enrollment in HMOs unless the incentives were very large. Further, because only some types of HMOs are effective at reducing use and expenditures, only a portion of any new enrollees would actually use fewer services. Finally, the federal costs of the financial

incentives to expand enrollment in HMOs could be as high or higher than the savings.

Another legislative approach would be to require that all consumers receive care through managed care organizations. For example, if everyone were required to enroll in a staff or group model HMO--the only type of managed care that has to date been demonstrated to achieve substantial savings--CBO estimates that national health expenditures could decline by as much as 10 percent. This is not an insignificant amount of savings; in 1991, national health expenditures were $752 billion, and a 10 percent drop would be $75 billion. Since there is no evidence, however, that even effective HMOs have been successful at reducing the rate of growth of health spending, and health care has been increasing recently at a 10 percent to 12 percent annual rate, we would still face the problem of higher health care costs in every subsequent year after these savings occurred.

Price Controls

Price controls could be effective in reducing both the level and the rate of growth of spending, but their impact would be partially offset because providers would increase the volume of services (or change billing practices)

to recover lost revenues. In addition, price controls applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physician services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would drop 5 percent. This estimate reflects our assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physician services by the non-Medicare population could also rise. As a result, although Medicare's spending for physician services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

Stringent price controls may also affect access to care in some segments of the market. Access to care by Medicaid beneficiaries, for instance, has been adversely affected by the much lower prices that providers are offered in some states for serving this population.

Alternatively, government regulation could set maximum prices for physician services that all payers would have to follow. In other words, insurers would not be allowed to pay more, and physicians would not be allowed to bill

patients for amounts above the regulated prices. Under such an all-payer system, providers could increase volume to offset some, but probably not all, of their lost revenue. Administrative costs would decline somewhat, since providers would not have to maintain and monitor many separate price schedules and claim forms. In addition, the authority that determined prices would also control their rate of increase. If the legislation included rules that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system could generate lower national health expenditures than would otherwise occur.

Price controls carried out through a single-payer system could also reduce reimbursements and sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around $30 billion to $35 billion in 1991, under the conservative assumption that only the administrative costs related to billing and processing of claims would be reduced, if a single-payer system had been fully in place that year. National health expenditures would, however, have fallen by this full amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred.

In both an all-payer and a single-payer system, legislation that included provisions for uniform monitoring of providers' patterns of care would have an

even greater impact than price controls alone. Such monitoring could reduce the magnitude of the response in volume and would allow the rate-setting process to take any volume increase into account in determining the next year's reimbursement rates.

Limits on the Tax Exclusion for Employer-Paid Health Insurance Premiums

In 1993, federal income and payroll tax revenues will be about $70 billion lower because health insurance received through employment and health care costs paid through flexible benefit accounts are not treated as taxable income. Limiting the tax exclusion for employer-paid health insurance coverage could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. If the new policies incorporated higher cost sharing by consumers, for example, the number of services used would fall. Alternatively, consumers might join effective HMOs, with the same result.

One way to limit the exclusion would be to treat some tax-exempt employee health benefits as taxable income. In 1990, for example, employer contributions averaged about $110 a month for individual coverage and $270 for family coverage. If the tax exclusion had been capped at those levels, the implicit federal subsidy for health insurance would have been reduced by about

$10 billion in that calendar year. National health expenditures would also fall in response to the lower subsidy, but by less than the reduction in the subsidy.

If such limits were enacted, workers who currently have coverage above the limits would have two choices. They could continue their current coverage and pay federal income and payroll taxes on the excess coverage. Alternatively, they could negotiate with their employers to cut back some, or all, of the coverage above the limit in exchange for higher wages, thereby also raising their taxable incomes. (Most employers would probably be indifferent between continuing current health benefits or substituting higher wages for them because both are tax-deductible business expenses.)

Lower amounts of coverage could be accomplished in several ways that would also help to control health care costs. First, traditional insurance could be replaced with effective HMOs. Second, higher copayments could be used to lower the cost of coverage. Third, coverage for some benefits (for example, chiropractic and dental care) might be dropped or scaled back. Finally, insurers could reduce the level of their reimbursement to providers, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs.

Limits on Expenditures

Legislation that provided for prospective budgets for hospitals, expenditure targets for physicians, or caps on overall national health spending would involve major changes in the existing U.S. health care system, but it could substantially reduce the rate of increase in health spending. The legislation would, however, have to include specific details of the mechanisms for setting, monitoring, and enforcing the limits.

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them. Assume also that there was no leeway to increase the budget for a hospital when overruns occurred. In such a case, the impact on national health spending would be the difference between total spending for hospital services under the budgets and projected spending without the legislation. Similarly, if legislation set caps on expenditures for various segments of the health care sector, specified the formulas to determine the annual rate of increase in the caps, provided for monitoring performance under the caps in a timely way, and put in place enforcement mechanisms that would either make it impossible to exceed the cap or would make it possible to fully recover excess spending after it occurred, then one could estimate the savings by comparing the caps with projected spending in their absence.

Based on our assessment of the evidence on the effectiveness of limits on expenditures as they have been applied in the United States and in other countries, CBO believes the likelihood of success increases with a single payment mechanism or clearinghouse, restrictions on the ability to purchase health care outside the regulated system, and global budgeting for hospitals and other institutions. In addition, a continuously adjusting payback mechanism for physicians, as has been used in Germany and in some Canadian provinces, and budgeting or rate setting that applies to all providers and services would be effective in enforcing the limits. A good data system with uniform reporting by all providers to allow quick feedback would also be an important component of an effective strategy for limiting expenditures.

CBO's approach to estimating the potential impact of limits on expenditures in legislative proposals is to examine the proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on our best judgment, we then assign a rating for effectiveness, with a fully effective limit receiving a 100 percent rating and a completely ineffective proposal receiving a rating of zero. The estimated savings for any expenditure limit would equal the difference between the projected costs without the limit and the expenditure limit, multiplied by the effectiveness rating.

To illustrate the effect on national health spending of a fully effective cap, assume that legislation had been put in place beginning in 1986 that included a cap constraining the increase in national health expenditures to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If such a cap were fully enforced, we estimate that national health expenditures would have been only $651 billion in 1991, or about 13 percent lower than the approximately $752 billion that was actually spent that year.

If, however, limits on expenditures were applied selectively to some groups and not others, then providers could increase prices and the volume of services for other groups in order to maintain revenues, without incurring penalties for exceeding the limits for the covered population. Although the market segment subject to the limits would realize savings, national health expenditures might not fall much.

Managed Competition

Managed competition is the central feature of proposals to restructure the health care market in ways that would create incentives for consumers to be more cost-conscious in their insurance and health care decisions. Increased

cost-consciousness by consumers would give insurers and providers, in turn, the incentives to become more cost-conscious and efficient.

Many different proposals have been put forth under the "managed competition" umbrella. Some proposals of this kind could reduce health care costs, and others would have little effect. CBO is currently preparing a paper on managed competition. It will identify features that would help maximize the savings in national health expenditures under that approach. These elements include:

- The creation of regional organizations (for example, health insurance purchasing cooperatives, or HIPCs) that would oversee and operate the restructured insurance market and help consumers make better-informed choices;

- Limitations on the tax-exempt amount of employee health benefits and a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits;

- Standardized benefits and copayment rules, with a prohibition on supplemental insurance that would cover out-of-pocket costs under the standard package;

- The availability of uniform, reliable data on costs, outcomes, and quality;

- Universal insurance coverage;

- The requirement that all insurers offer open enrollment periods and base premiums on community rating;

- An accurate method to adjust for differences among insurers in the health status of their enrollees; and

- A significant reduction in the number of insurers and the creation of insuring organizations that would offer substantially nonoverlapping networks of affiliated providers.

In combination, these changes to the current system could result over time in a reduction in the rate of increase in national health spending. Omitting some of these elements from a proposal for managed competition would significantly

lessen its potential effectiveness. Even if all these elements were included, however, it would be extremely difficult for CBO to estimate the magnitude and the timing of the effects on national health spending, because of the complexities of analyzing a dramatic restructuring of the markets for health insurance and health services.

Two aspects of these proposals do provide some indication of the direction CBO's cost estimates will take. First, we have consistently taken the position that savings could be achieved by moving people from fee-for-service medicine into group or staff model HMOs. Thus, estimated savings would depend on the extent that a particular proposal would shift people into these types of managed care organizations. In addition, most proposals for managed competition would limit in some manner the tax-exempt amount of employee health benefits. Federal revenues would be increased to the extent that the limits are tightened. If employees then chose insurance with more limited benefits and higher cost sharing because there was less subsidy to health insurance, there could also be a further impact on national health expenditures.

Assessing the full effect of restructuring the entire health insurance market, however, is much more difficult. Little information from either the United States or abroad is available on the time that it would take for all the changes to occur or on the magnitude of the impacts of these changes once

they were fully implemented and all behavioral responses had occurred. We are convinced, however, that even if a managed competition approach with all the critical elements described above were carried out, its effects would occur over an extended period of time. Significant savings in national health expenditures would probably not occur within the usual five-year time horizon of CBO cost estimates.

A PRELIMINARY ASSESSMENT OF THE COSTS OF TWO LEGISLATIVE PROPOSALS

Estimating the potential costs or savings of health reform proposals is one of the most difficult tasks CBO has attempted. First, health expenditures are currently about 14 percent of gross domestic product and are projected to rise to at least 18 percent by the year 2000. The effects of changes in this large a system must be uncertain. It is often difficult even to forecast spending in current federal health care programs, as CBO has found in recent years when Medicaid spending increased by 19 percent in 1990, 28 percent in 1991, and 29 percent in 1992, far exceeding projections. Moreover, many of the health reform proposals under consideration include provisions for which there is no actual experience and no solid evidence to be used as the basis for our estimates.

The task of estimating costs becomes even more complex since five years--the usual time frame for cost estimates--is not a long enough period for forecasting the impact of some health reform proposals. Some of them might require longer than five years to be fully carried out, and cost estimates that stop at five years would not provide the information that is needed to assess all their effects.

In addition, CBO is being asked not just to estimate the impact of these proposals on the federal government's budget, but also to examine their effect on national health expenditures and on the number of people with health insurance. National health reform involves important interactions between the private sector and the federal budget, but analyzing these interactions and their impacts is extremely difficult. As a result, estimating the costs and savings associated with health reform proposals requires more thought, more coordination and consultation with other federal offices such as the Joint Committee on Taxation, and more time than most cost estimates.

To illustrate the estimating issues and principles, CBO is providing a preliminary assessment of two health reform bills introduced in the 102nd Congress: H.R. 5936, the Managed Competition Act of 1992, and H.R. 5502, the Health Care Cost Containment Act of 1992. Although they are not current bills, the proposals represent different approaches to health reform and

illustrate the complexity of making cost estimates in this area. CBO has not yet completed year-by-year estimates for the two bills, but it is possible to give you an outline of their probable effects on national health expenditures.

Our analysis reflects H.R. 5936 as introduced and H.R. 5502 as reported by this subcommittee. For both bills, we have delayed the implementation dates by one year to reflect possible enactment in late 1993. The Congressional Budget Office and the Joint Tax Committee have worked together in examining the effects of changes in the tax law.

The Managed Competition Act of 1992

H.R. 5936 would attempt to control costs and expand access to health insurance by restructuring the way health insurance is provided. The bill would establish a National Health Board to define a standard health plan; to establish standards for reporting prices, health outcomes, and measures of consumer satisfaction; and to provide information to consumers on the quality of care. Plans that met board standards would be defined as Accountable Health Plans (AHPs).

Changes in the tax code would encourage the use of AHPs, because employers paying more than the cost of the lowest priced AHP in the area would be required to pay a 34 percent excise tax on the costs above this amount. The self-employed would be allowed to deduct 100 percent of the costs of the lowest priced AHP. In each state, Health Plan Purchasing Cooperatives (HPPCs) would be established, and all individuals except those working for businesses with more than 1,000 employees (up to 10,000 employees at each state's option) would be required to purchase their health insurance through the HPPC to receive the favorable tax treatment. Individual contributions for health insurance could be deducted for tax purposes only up to the cost of the lowest priced AHP.

Finally, H.R. 5936 would replace the Medicaid program with a new federal program that would help purchase health insurance coverage through HPPCs for low-income individuals. Individuals and families with incomes below the poverty level would be eligible to join AHPs with no premium and only nominal copayments. Individuals and families with incomes between 100 percent and 200 percent of poverty would be responsible for paying a portion of premiums, based on a sliding scale.

CBO's preliminary assessment is that, after a few years, H.R. 5936 would leave national health expenditures at approximately the same level they

would reach otherwise. Initially, however, national health expenditures would increase. This result stems in large measure from the assumption that the National Health Board would select a comprehensive set of benefits for its AHP. Because these benefits would be available to a larger group than is currently covered by health insurance, national health expenditures would be higher in the first few years.

The growth in per capita health expenditures would gradually slow, however. Because group model or staff model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest priced bidders in many HPPC areas. Based on past performance, we expect their prices would be 10 percent to 15 percent below the price of similar fee-for-service plans, and the cost of enrolling in these HMOs would be fully tax-deductible. Thus, enrollment in them would probably rise more rapidly under managed competition than under current law, thereby slowing the growth in national health expenditures. After a number of years, these savings could offset the increased health care costs resulting from extending access to those who currently lack health insurance.

The Health Care Cost Containment Act of 1992

H.R. 5502, the Health Care Cost Containment Act of 1992, would attempt to control health costs by establishing limits on national health expenditures. Separate limits would be applied to Medicare spending and to national health expenditures. Limits would be enforced through rate setting, although states with approved programs and federally qualified HMOs would be exempt from the maximum rates. Access would be extended by expanding Medicaid coverage for pregnant women and children with family incomes below 200 percent of poverty and for all nonaged individuals with incomes below 100 percent of poverty. Medicaid payment rates would also be increased, and a new federal health insurance program for children would be started. Finally, Medicare would expand its coverage of certain prevention benefits and add a new prescription drug benefit.

CBO estimates that H.R. 5502 would reduce national health expenditures about 5 percent by the year 2000. Our preliminary assessment is that the Medicare expenditure limits would be 75 percent effective. We have a great deal of experience with rate setting and potential volume offsets in the Medicare program, which indicates that expenditure limits could be reasonably effective in controlling Medicare spending. At the same time, we are much less sanguine about the effectiveness of limits on other health spending. States

would be permitted to operate their own systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates. This calculation would be very difficult to make, and specific data on states would not exist in usable form for several years. Finally, the bill exempts federally qualified HMOs from rate setting. Federally qualified HMOs are more broadly defined than group or staff model HMOs and include organizational forms that have not been shown to be cost-effective. Because of these and other potential sources of leakage, we have assumed that the limits on expenditures for non-Medicare spending would be only 25 percent effective. It is our understanding that H.R. 200, the Health Care Containment Act of 1993, would limit the HMO exemption to group or staff model HMOs. While we have not completed an assessment of H.R. 200, we expect that its expenditure limits will be more effective than those in H.R. 5502.

The savings from the limits on Medicare and national health expenditures would be partially offset by provisions in H.R. 5502 that would expand insurance benefits and extend the population covered by health insurance. Overall, however, we estimate that H.R. 5502 would result in national health expenditures falling about 5 percent below the level they would otherwise reach by the turn of the century.

CONCLUSION

In the past, most health care legislation changed payment methods or levels in relatively small, discrete ways or expanded eligibility for existing programs. Thus, CBO has considerable experience estimating the impact on costs of such changes to Medicare and Medicaid. In general, reasonably good data and research studies permit us to develop well-founded estimates.

The task we are facing today, however, is a much more difficult one. Reform of the health care system is likely to involve massive changes in current health care financing and delivery systems and perhaps comprehensive restructuring of the markets for health insurance and health services. Estimates of the effects of such sweeping changes on overall health care spending, as well as on individual components such as federal health spending, will be much less precise than estimates of changes in Medicare and Medicaid. For one thing, past experience does not encompass changes of this magnitude. Although there is some evidence from other countries, these findings must be used cautiously, because the substantial differences in cultures, politics, and economic systems mean that the responses of citizens, providers, and insurers in other nations may have only limited relevance to the United States.

In addition, it is likely that any health reform policy would require a number of years of development and would be phased in over a period of time. Moreover, it might take a few more years before it would be possible to discern the behavioral responses of all the participants in the health care and health insurance markets who would be affected. At the same time, of course, many other things will be changing, including overall economic conditions, the introduction of new technologies for diagnosis and treatment of illness, and--as our experience with AIDS and the recurrence of tuberculosis in recent years has shown--even the health status of the population. Thus, considerable uncertainty surrounds any estimates of the longer-term effects of health reform proposals on national health expenditures and on the federal budget. Nonetheless, estimates of the effects of different health reform approaches will provide useful comparative information on the relative costliness of, or the potential savings to be gained from, alternative proposals.

INTRODUCTORY REMARKS OF THE HONORABLE PETE STARK

HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1993

H.R. 200

JANUARY 5, 1993

Mr. Speaker, today I am pleased to introduce H.R. 200, the Health Care Cost Containment and Reform Act of 1993.

This bill is the product of hard work and careful thought by the Democratic members of the Subcommittee on Health of the Committee on Ways and Means during the 102nd Congress.

H.R. 200 addresses the fundamental problems that plague our health care system today. It responds to the number one concern of the American people by establishing real and significant cost controls in the health care sector -- cost controls that really work, and are not just rhetoric.

Through a disciplined national health expenditure budget enforced through State cost containment programs and through local health maintenance organizations, the bill assures that skyrocketing health costs will finally be brought under control.

This bill provides for a managed competition system throughout the country to assure that consumers have a choice of cost-effective health plans. Under H.R. 200, individuals would have the freedom to elect coverage under a managed care plan; there are no requirements for enrollment under the bill.

H.R. 200 would also implement significant improvements in the health insurance system. These reforms are designed to assure the availability of private insurance at a fair price, regardless of health status or condition.

A uniform electronic system for health insurance would be created by the bill to minimize unnecessary and costly paperwork. It also imposes strict Federal standards to combat health care fraud and abuse.

This bill is a significant and important step forward toward universal health insurance coverage. Under this bill, 25 million of the 35 million uninsured Americans would be provided health insurance through the Medicaid program within the next decade.

This bill establishes a framework for universal health insurance coverage without prejudicing the discussion of future comprehensive reform plans. It is compatible with all of the major alternatives now under discussion including a Canadian-style comprehensive plan, a fully-public system, Medicare-for-all, and a pay-or-play plan.

It should be emphasized that H.R. 200 includes no new taxes. Savings achieved from cost containment are used to expand health insurance coverage and to improve benefits under the Medicare program.

All cost provisions are fully funded with savings achieved from cost containment, rather than taxes.

HEALTH CARE COST CONTAINMENT

The American people are justifiably concerned about the rising cost of health care.

Health care costs are out of control, increasing at more than twelve percent a year, more than three times the rate of general inflation.

Rising costs are driving up health insurance premiums by more than 15 percent each year. At the current rate of increase, health insurance premiums will double every four years.

Ever-increasing costs are the number one reason small businesses are not providing health insurance to their employees.

Rising costs restrict our ability to compete in international markets. The United States spends more on health care as a percent of its Gross Domestic Product (GDP) than any of our major trading partners.

The U.S. spends 14% of our GDP for health, whereas Canada is at 9%, Germany is at 8%, and Japan is at 6%. While health as a portion of the GDP remains relatively constant for many countries, in the United States health is expected to continue to grow to 18% of the GDP by the end of the decade.

Under this plan, a national health budget would be set for 1995 to reflect current spending plus one percent less than the projected increase. The annual increase would phase down over five years to equal the increase in the nominal GDP.

Total payments to hospitals and physicians would not be reduced. When the growth limits proposed in this bill are fully phased-in, hospital and physician payments would grow at the rate of increase of the economy as a whole, about 6% a year.

The annual increase in national health spending would be held to pre-set levels through a three-part system of State programs, qualified HMOs and a system of residual maximum payment rates.

Under this bill, States could establish their own payment programs for hospital and/or physician services, however, the total cost of services covered by a State program would be limited to the projected total costs for such services under the national rates.

It is anticipated that over several years, most States would establish State payment programs. The national payment rates would only apply to providers in States without approved programs.

The residual national maximum payment rates for hospitals, physicians, and other health services would be set annually following Medicare methods. The rates would be the maximum could be charged by providers for services payable by insurers or individuals.

MANAGED CARE AND MANAGED COMPETITION

The bill includes strong incentives to enhance the development of cost-effective managed care. The bill would also create a new system of health plan purchasing cooperatives to enhance competition in the health care financing system.

Under the bill, all health care plans, including HMOs, PPOs, and other types of managed care plans would be free to negotiate rates below those set under the national payment rates. In addition, staff and group model HMO plans could negotiate rates with hospitals and physicians directly, as they would be exempt from all of the provisions of the national payment rate program.

To assure the creation of more staff and group model HMOs, the bill would provide grants to develop and expand these cost-effective types of managed-care organizations. Staff and group model HMOs are the only types of managed care organizations for which there is solid evidence of effectiveness in controlling costs; therefore, developing organizations of this type is an important part of the bill's overall cost containment strategy.

The bill creates a new system of health plan purchasing cooperatives throughout the nation. These cooperatives will allow employers and employees to choose cost-effective health care plans on a competitive basis.

HEALTH SYSTEM REFORMS

H.R. 200 would provide for significant reforms of the private health insurance system, bringing fairness and reliability to the private market. It would greatly simplify the administration of the health care system, saving tens of billions of dollars in paperwork costs each year. It would set up tough Federal standards to combat fraud and abuse in the private sector.

It is not surprising that Americans are demanding a response to the problem of health insurance coverage. Our constituents are worried that they will lose their health insurance when they need it most or that their insurance will not be adequate to cover their medical expenses.

There is great fear about "job lock," not being able to change jobs because pre-existing condition exclusions at a new employer will curtail coverage for an existing illness.

The health insurance reforms of this proposal provide for real, comprehensive reform of the health insurance system. The reforms will apply to all insurers, not just those in the small group market.

The plan would impose non-discrimination requirements for all employer groups, including self-insured groups. Discrimination based upon health status or medical condition would be prohibited.

Health insurers, other than self-insured employer groups, would be required to provide year-round open enrollment for groups and individuals within a geographical area. Premiums would be based on community rates phased in over three years. Renewals of policies would be guaranteed.

Under the proposal, workers would be protected from "job lock". Pre-existing condition exclusions would be limited to the first six months a worker is employed. Any worker changing jobs with less than a three-month break in employment-based health insurance coverage, including coverage under COBRA, could not have a new exclusion period applied. Pre-existing exclusions would otherwise be limited to a six-month period.

The United States health care system is severely crippled by unnecessary paperwork requirements and multiple layers of rules imposed by 1,500 health insurance companies and thousands of self-insured plans.

The administrative simplifications proposed in this bill would virtually eliminate costly paperwork. Under this proposal, there would be uniform, electronic billing for all health insurance claims. Electronic billing will save doctors, hospitals and payers billions of dollars in claims processing costs.

A uniform system for processing claims would assure that all claims are processed in the same way. Uniformity in processing will allow doctors and hospitals to reduce their current staff assigned to billing by more than 60%. This would also have the benefit of assisting providers in meeting the cost containment targets of the bill.

The plan calls for universal health insurance identification cards. Coupled with computerized verification of eligibility and benefits, this reform would allow doctors and hospitals to know up front who to bill for services.

In addition to insurance reform and administrative simplification, the plan would establish a Federally coordinated program to fight fraud and abuse in the health care system.

Fraud and abuse wastes vast amounts of vital resources every year. According to the United States General Accounting Office, $80 billion each year is lost to fraud and abuse. The GAO report found there to be a general failure on the part of private payers to develop effective systems to control fraud.

The bill, in applying Medicare's proven and effective fraud and abuse policies, would establish a coordinated program to control health care fraud and abuse in both private and public health care programs.

EXPANSION OF BENEFITS

H.R. 200 would provide health insurance coverage to approximately 25 million low income Americans under a greatly-improved Medicaid program.

Under the plan, all pregnant women and children to age 18 with income up to 200% of the federal poverty line would be eligible to be covered under the Medicaid program on a phased-in schedule beginning October 1, 1997. All non-aged adults with family income up to 200% of the Federal poverty level would be eligible for benefits by fiscal year 2003, with phased-in coverage beginning on or after October 1, 1999.

The new benefits provided by this plan would be fully funded with Federal dollars, preventing further burdens on State budgets.

All of the Medicaid provisions of the bill are, of course, under the jurisdiction of the Committee on Energy and Commerce, and would be considered by that committee.

The bill would establish a new, voluntary health insurance program for children to age 19. Parents would be able to buy into the public plan in order to purchase reasonably priced health insurance for their children.

The plan would provide coverage for newborn, well-baby, and well-child care without copayments or deductibles. In addition, it would cover the usual Medicare-type services.

A second benefit funded with savings achieved from cost containment would be prescription drugs for the elderly.

Under this bill, coverage for outpatient prescription drugs would become a Part B benefit. It would be subject to a deductible -- $850 in 1997 -- and would be funded with the usual 25% premium.

In addition, the bill would establish special coverage for low-income senior citizens. Beneficiaries with income below 100% poverty, known as Qualified Medicare Beneficiaries, would be entitled to prescription drug benefits under the State Medicaid program, and would not be subject to the Medicare prescription drug copayments.

The bill would also improve Medicare coverage of essential preventive health services. It would provide Medicare coverage under Part B for annual mammography screening, colorectal cancer screening, and annual influenza and tetanus vaccinations.

Finally, this bill would help self-employed farmers and others who purchase health insurance on their own. It would allow such individuals to deduct up to 100% of their health insurance expenses effective January 1, 1993.

CONCLUSION

H.R. 200 will control the growth in the health care costs, greatly simplify the health care system, and provide coverage to more than half of the uninsured Americans.

Health care costs in the U.S. must be limited someday. We cannot afford to spend 18% in the year 2000 -- or 30% by 2020 -- of our economy for health care when our major trading partners like Canada spend 9% or Japan only 6%.

The costs to our society and to our economy as whole of spending hundreds of billions of additional dollars in health care are far too high.

I urge all my colleagues to join the support for the Health Care Cost Containment and Reform Act of 1993. A summary of the major provisions of the bill follows.

Dangerous Diagnosis

Most policy experts assume that the public will have to make sacrifices if the health care system is overhauled. The public assumes nothing of the kind. The upshot could be a major political backlash against Bill Clinton and Congress.

BY JULIE KOSTERLITZ

In a gesture picked up by most network television news shows during his two-day economic summit last month, President-elect Bill Clinton pounded the table with his fist as he warned about the threat posed by health care costs. The nation's health care system, he said, is "a joke. It's going to bankrupt this country."

That's what's known as taking your case directly to the people. But Clinton is going to have to dent a lot more tabletops and probably sustain a few broken hand bones before it's all over, according to some experts who have been taking a hard look at public attitudes on health care reform. Forget the doctors, hospitals, insurers and drug companies. There's a far more powerful potential obstacle to reform: the American public.

But wait a minute—didn't Clinton ride into office on a wave of public outrage over the health care system? What about the polls that showed health care the No. 3 concern of Americans, right after the economy and the deficit? How about the 30-point advantage that the public gave Clinton over President Bush on the question of who could better handle the health care crisis?

"It's an entirely different world to campaign on health care than to be a policy maker," said Celinda C. Lake, a principal in the Democratic political consulting firm of Greenberg-Lake/The Analysis Group Inc. "As a candidate there is no way he could have lost on the issue. As President there is no issue that is more dangerous [for him] politically than health care."

The main problem is that the public and the experts have expectations of health reform that are vastly different and potentially directly at odds. Everyone says that a dramatic overhaul of the system is needed—but on closer examination, the public strongly resists the kinds of sacrifices that the experts assume will need to be made. It's a problem that has thus far been papered over by the fact that both groups use the same language to mean entirely different things. The problem could even be papered over when health care reform is being legislated. But just wait until it comes time to try it out on real people.

"Health care policy is made in the abstract, [measured] in the aggregate by analysts. Health care is consumed in the particular by people who are either frightened or hurting or both," said Leonard D. Schaeffer, chief executive of Blue Cross of California and a former Carter Administration health aide.

Both groups, for example, say that skyrocketing health care costs are their overriding concern. But the health policy crowd is interested mainly in slowing the growth in national spending on health care to reduce the deficit and boost productivity. For consumers, it's simpler: They don't want to have to dig so deeply into their own pockets for health care. Policy makers assume that the public will have to pay more and accept dramatic changes in the way they receive their care. But pollsters have found that most people like the care they're getting now and think the cost problem can be solved by cutting waste, fraud and abuse and by taxing others.

The achievements of health care reform, no matter how real, are likely to be largely intangible to individuals, while the sacrifices will be all too concrete. Slowing the double-digit annual increases in national spending on health care by 2 or 3 percentage points in the near term would be considered a coup by policy makers. But consumers might hardly notice the difference. They would surely notice, though, if the government slapped financial penalties on them if they didn't join health maintenance organizations (HMOs) or similar managed care plans, which typically restrict patients' choices.

Remember, 83 per cent of Americans have health insurance, and most are reasonably happy with the care they get. Health care reform "needs to be defined as an economic issue, but you also need to show individuals how they will benefit," said Drew E. Altman, president of the San Francisco-based Henry J. Kaiser Family Foundation, which has commissioned polls on health issues.

Failing to lay the political groundwork could lead to a major backlash, not only against Clinton but against Members of Congress. Congress learned this the hard way in 1988, when it added a new catastrophic illness benefit to the medicare program. Elderly Americans rebelled, and Congress repealed the measure even though it would have offered important new benefits to most seniors at a negligible cost. The problem: Most people didn't understand what they were gaining, while the upper-income elderly balked at paying a surtax for benefits that many of them had already obtained privately.

Now, as then, special-interest groups will be poised to manipulate public sentiment for their own ends. Many groups are already polling extensively on the issue. *(See NJ, 2/15/92, p. 390.)*

Of course, no one yet knows exactly what Clinton has in mind, much less how it might be modified with time. But many of the options he is said to be considering—from taxing employee health care benefits, to creating incentives to join HMOs and other managed care plans—could trigger public anger. Unpopular features can always be softened, but doing so would either add to the price tag of reform or postpone the promise of universal health care coverage. "What ultimately produces the breakthrough is not a more ingenious diagram, it's leadership," Altman said.

John Boyle

Celinda C. Lake, who's done polls on health reform
No issue is more dangerous politically for Clinton.

It's tempting to accuse the public of naïveté or venality. But the public is only reflecting the information it has been given. Politicians who finger doctors, drug companies and hospitals as the villains reinforce such views. Employers and government programs also obscure the real costs of health care and other middle-class social programs. "There's been little effort to tell them what [health care programs] cost," said John Immerwahr, a senior research fellow at the Public Agenda Foundation, a New York City think tank that studies public opinion. "The effect of what's done has been to obscure these lessons for people."

I'M OK, THE SYSTEM'S NOT

On the face of it, Americans are clamoring for health care reform. Poll after poll shows that people want fundamental change in the system, and that they believe Clinton is the man to deliver it. Of voters who said health care was among their top two concerns, two-thirds voted for Clinton, according to exit polls. Over all, voters considered Clinton far likelier to do a better job of handling the health care issue.

But beyond that, the mandate for reform gets shaky. Actually, polls show that most people haven't the faintest idea what kind of reform Clinton will propose (the experts aren't too sure either), although they believe he will make health care more affordable and guarantee that everyone has access to it.

The public has been confused and ambivalent about the various plans that were discussed during the campaign, and a large majority confess that they don't really know how the system should be changed. In polls taken during the campaign, voters split evenly when presented with what were considered the three major options for change: setting up a government-financed system, requiring all employers to provide coverage or pay into a government fund for the uninsured, and leaving the system largely intact while providing tax credits to help defray insurance premium costs. On election night, when voters were presented with descriptions of Clinton's and Bush's plans—without being told whose plans they were—Clinton's had only a narrow lead over Bush's, 53-41 per cent, according to a Kaiser Family Foundation poll.

While voters profess to be dissatisfied with the national health care system, they're reasonably satisfied with the way it treats them personally. A January 1992 poll by the Democratic firm of Mellman & Lazarus Inc. found that only 36 per cent of people were satisfied with the quality of the nation's system, but that 75 per cent were satisfied with the quality of their own care; while just 22 per cent thought that the health insurance system was satisfactory, 69 per cent said they were satisfied with their own insurance. "You're misreading the polls if you think people are ready for a massive change in the way care is provided and who provides it," said William D. McInturff, of Public Opinion Strategies, a Republican polling firm that has found a similar split in more-recent polls.

Confronted with the possibility that change means sacrifice, Americans quickly get uneasy about overhauling the system. That was a clear finding of an in-depth study conducted during the winter of 1991-92 by DYG Inc., an Elmsford (N.Y.)-based public opinion analysis firm headed by Daniel Yankelovich, for the American Association of Retired Persons. Using a combination of polling and focus groups, the firm found that after considering some of the potential downsides of reform, such as additional cost, reduced services and reduced choice, the percentage of those favoring major changes in the system dropped from 52 to 42 per cent, and the share of those saying the system needed to be completely rebuilt dwindled from 32 to 25 per cent. "People are theoretical revolutionaries but cautious reformers," pollster Lake said. "When evaluating actual policy, they are far more cautious and have more concerns about how it will affect their care, their costs and their choices."

That's why all the talk these days about the "new consensus on health care reform" is dangerously deceptive.

It's true that in the rabbit warrens of the transition offices, the halls of academe, cluttered congressional offices and even the Oriental-carpeted rooms of many K Street lobby shops, a broad intellectual agreement has been developing on the causes of the health care crisis and its cures. There's some haggling over syntax, but they all speak the same language.

Not so the public. "When the public listens to the politicans talk about health care reform, they sound like they're from Mars," Altman said. "Even when they're talking about the same thing, they're not truly communicating."

GREED AND SACRIFICE

The way most experts see it, the nation is losing out because the dollars that employers might otherwise pay in wages

are being gobbled up on spending for health care benefits. Similarly, government revenues that might be used to reduce the deficit, invest in infrastructure and education or expand health care to the uninsured are instead eaten up by the burgeoning costs of care for the elderly and the poor. As Clinton told an MTV audience in June, "You will never, ever get the deficit down as long as health care costs go up two and three times the rate of inflation."

But from the consumers' standpoint, the only problem with health care is that it costs *them* too much. In focus groups, researchers from the Public Agenda Foundation discovered that people vastly overestimated how much of the nation's health care spending came out of patients' pockets: They put the figure at 70-80 per cent, and the government and employers' share at 20-30 per cent. In reality, the reverse is true.

The size of national expenditures meant little to them: "When you ask them about aggregate spending, they're just as often for spending more as they are for spending less," Altman said at a recent press briefing.

When it comes to assigning blame for the cost problem, the cracks in the consensus become a chasm. Immerwahr recalls that when he told a focus group that health care costs were driven partly by new technology and an aging society, "they said, 'No, that's not really part of it. It's greed.' " Immerwahr asked how greed—an age-old phenomenon—explained the recent explosion in costs; group members told him it was because "there was an explosion of greed."

The public's cure is as simple as its diagnosis. As much as it mistrusts government, the polls show, the American public strongly supports government price controls on doctors, hospitals, drug companies and insurers.

The experts agree that doctors and hospitals charge too much and that there is a good deal of waste, fraud and abuse. "Managed competition," the approach to reform that many of them favor, and that Clinton has endorsed, envisions forcing down prices through a combination of regulation and marketplace competition.

But most economists also firmly believe that consumers will have to make sacrifices. "You don't achieve cost control by eliminating waste, fraud and abuse," said Henry J. Aaron, director of economic studies at the Brookings Institution. "It's going to take large-scale reforms in the way business is done, which will entail some restrictions to which the public has not so far been subject."

For example, workers now pay no taxes on the share of their health insurance premiums paid by their employers. But most managed competition proposals would tax any premiums that exceed the cost of a "standard" benefits package. The idea is to steer people into less-expensive, more-efficient managed care plans.

Moreover, managed care plans could erode some of the features of the current system that consumers cherish most. Such plans typically require their members to choose from a list of approved doctors and hospitals, who closely supervise patients' care and are themselves tightly supervised. *(See NJ, 10/31/92, p. 2515.)*

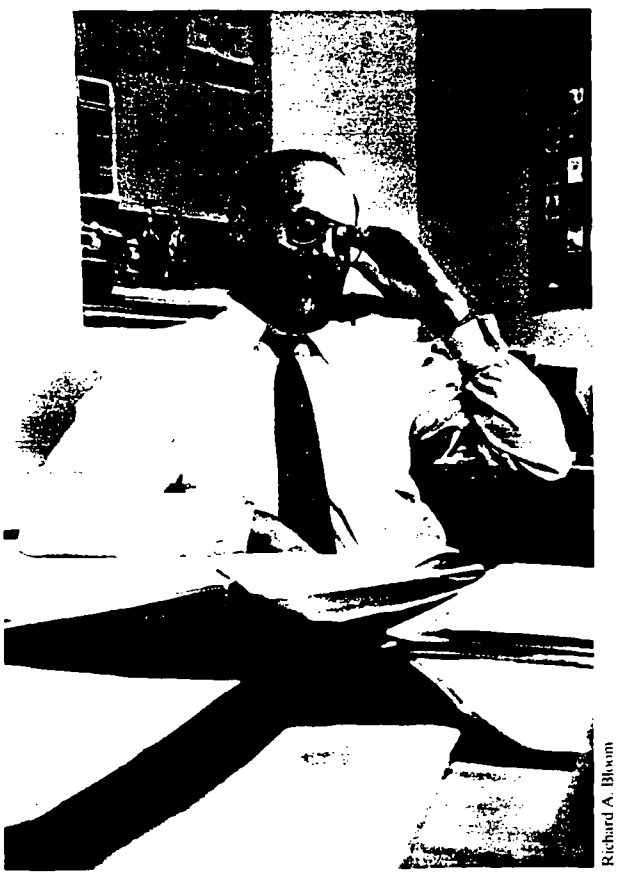
But most polls show that free choice of a doctor is very important to people. The Kaiser election-night poll found that when asked to choose, 52 per cent opted for a system in which the government regulates health care prices, and just 41 per cent backed the idea of having individuals choose between competing plans with limited choice of doctors and hospitals. To the 83 per cent of Americans who already have health coverage, managed competition might not look like such a bargain. Robert Blendon, a professor at the Harvard School of Public Health, said half-jokingly that advocates of managed competition will have to make a sales pitch something like this: "The good news is we're going to raise taxes on your insurance and you can go to the doctor of your choice, but you're going to have to pay more."

Clinton has said that he would impose annual spending targets on health care; no one knows exactly what that means. But the Kaiser poll showed that only 43 per cent of voters favored setting a limit on national health spending; support fell to 23 per cent when voters were told that spending limits could lead to longer waits or travel for care. "People assume that with price controls, they will still have the same access and quality, but if you have global budgets, the system could run out of money and affect their access and quality," Lake said.

MORE TAXES?

Any reform that truly squeezes out unnecessary care could encounter public resistance. "When people talk about waste in health care, they don't usually see it in their own care, particularly if it's something they want," said M. Jean Johnson, vice president of Public Agenda. In an August 1992 poll commissioned by the Employee Benefit Research Institute (EBRI), a think tank financed by employers and benefit consultants, 77 per cent of respondents agreed that "the cure to rising health care costs is not to put limits on what is available to average people, but to cut the waste, high profits and fraud in medicine." Only 20 per cent agreed that "sooner or later we are going to have to accept limits on what health care is available to the average person."

Serious fat trimming could also lead to politically unpopular hospital closings and layoffs in a large and fast-growing industry that has been relatively immune to job losses during the recession. *(See NJ, 11/30/91, p. 2917.)* "There's a relatively substantial jobs issue buried under the cost containment issue," a Washington health care consultant said.



Richard A. Bloom

Pollster William D. McInturff
Voters aren't "ready for a massive change" in health care.

Another clash is shaping up on the matter of providing health coverage to all Americans. Most experts say that creating

a universal system will require substantial new subsidies for low-wage workers, who constitute the bulk of the uninsured. And providing insurance to people who are now denied coverage because of health problems would probably raise premiums for healthier people.

The public, on the other hand, "feels that asking them to bear more costs is ludicrous. They think enough money is going into the system, and all we need to do is squeeze out the waste, fraud and abuse," said William S. Custer, director of research at EBRI.

Richard A. Bloom

Henry J. Aaron of the Brookings Institution
Politicians have focused on scapegoats, not sacrifices.

Polls suggest that the public isn't willing to pay much for improvements in the system. The Kaiser election-night poll found that 50 per cent of respondents were willing to pay an additional $20 a month to create a universal health plan. But DYG Inc.'s focus groups suggest that in return, the public would expect a plethora of new benefits—including prescription drugs and nursing home care—whose costs would vastly exceed the additional revenues.

Trying to avoid an unpopular tax, health care reformers might try to hide some new subsidies by requiring that all businesses insure their workers. But once the public is told what economists already know—that these costs ultimately could lead to lower wages or pink slips at small businesses—support could waver. Asked if they would favor mandatory health insurance even if it meant the loss of some jobs, support for that approach fell from roughly two-thirds of the public to less than a third, according to an analysis of polling data by Kaiser.

The political difficulty of health care reform isn't only that it is likely to impose costs, but that the benefits for most people are likely to be abstract.

"We have learned from the polling . . . that Americans do not focus on this issue as a national problem—the national problem worries Gov. Clinton—but as their problem," said Blendon, who has worked with Kaiser on its surveys. "They have no interest in the aggregate, but in what it will cost them and what they'll get."

True, guaranteed coverage will make a big difference to the 36 million people who now lack insurance. But for those who already have employer-sponsored insurance, particularly those with generous coverage, the benefits may be subtler. They will gain an extra measure of security because losing their job won't mean losing their health benefits.

But when it comes to the issue they care most about, out-of-pocket costs, the calculus gets tricky. Much depends on what is included in the basic benefit plan. Still, no health care economist expects health care spending or prices to drop; many economists say that the most that can be expected in the near term is a modest slowdown in the rate of increase.

While this could have important benefits for the country, it may be hard for most people to gauge the impact of such gains on their daily lives. "You can't buy more hamburger on the money you save by health care costs not going up as fast as they would have otherwise," said William Knapp, a partner in the political consulting firm of Squier, Knapp and Ochs Communications.

MASKING THE COSTS

Actually, you *can* buy more hamburger if restraints on health spending lead to an improvement in real wages. The questions are, how long will it take before voters see this payoff, and will they make the connection between the more-restrictive health care plan they have to join and the bounty they reap at the grocery checkout?

Clinton evidently hopes that if he can thump enough tables, people will make the connection. "Clinton has done for health care what Perot did for the deficit," said Jerry Johnson, research director for the public relations firm of Powell Tate.

But there's another problem: Policy makers have gone out of their way to mask the real costs of the current health care system to the average person. "We've tried hard to make medicare and social security look like private insurance programs that are paid for by the recipients, which obscures the fact that they're really paid for by society," Immerwahr said. "Likewise, we've tried to make workers think their health insurance is paid by employers," when in fact it is paid out of workers' own wages and with tax breaks that mean lost revenues to the Treasury.

Politicians have made the task of reform harder by looking for scapegoats. "There's a temptation to wrap these dry trade-offs in the more emotional and politically effective language of malefactors of insurance, drugs and physician payments," Aaron said. "These can be useful in motivating and getting people angry, but they're not focused on the real trade-offs people have to make."

Clinton played these themes with abandon during his campaign. His position papers vowed to "take on the insurance companies. . . . stop drug price gouging. . . . require employers to insure their workers."

He also promised the public a great deal at little apparent cost. "We don't need to lead with a tax increase that asks hardworking people who already pay too much for health care to pay even more, until every effort has been made to squeeze excess costs out of the system," a Clinton campaign fact sheet said. "We'll bring down costs for middle-class families, maintain a choice of providers and assure comprehensive coverage," the fact sheet promised. In return, Americans would be asked only to "take advantage of preventive care, take better care of themselves and use health care services appropriately."

It's tough to sell a frightened public on reforms by telling them about the sacrifices they will have to make. But it's nothing like the trouble you get when people find out about them after the fact. "Unless the facts are explained, you run the risk of backlash," Aaron said. ■

HHS NEWS

DRAFT #300

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: Anne Verano
(202) 690-6145

America's health expenditures continued a trend of double-digit growth in calendar year 1991 and reached $751.8 billion, up 11.4 percent from the 1990 level.

The increase marked the fourth consecutive year in which health spending grew at a rate exceeding 10 percent. It was the second consecutive year of growth exceeding 11 percent.

The nation's health expenditures in 1991 amounted to an estimated average of $2,868 for every person in the country.

The cost of government health programs grew 15.7 percent in 1991; payments of private health insurance premiums by business, other organizations and individuals increased 10 percent; and consumers' out-of-pocket spending rose 5.7 percent to cover costs not met by government or private health plans.

The data released today by HHS Secretary Donna E. Shalala are in an annual report that will be published in the winter edition of Health Care Financing Review, the quarterly journal of the Health Care Financing Administration.

According to the report, the share of the economy claimed by health spending increased faster in 1991 than at any time in the past 30 years, an effect produced by sluggish economic growth in combination with the rapid growth of health care costs.

National health spending in 1991 accounted for 13.2 percent of the gross domestic product -- the total value of goods and

- More -

services produced in the United States -- up from 12.2 percent in the previous year.

Although national health expenditures include research, administration and construction costs, 88 percent of the total is for personal health care services and products. These personal health expenditures in 1991 amounted to $660.2 billion, an increase of 11.6 percent.

Health expenditures consume increasing shares of government budgets. Federal spending on health in 1991 amounted to 16.7 percent of total federal expenditures, up from 15.3 percent in 1990. As a percent of state and local spending, health expenditures claimed 14.1 percent in 1991 and 12.9 percent in 1990.

A third of America's personal health care spending in calendar year 1991 was financed by the Medicare program for the elderly and disabled and the Medicaid program for the poor. These programs accounted for two-thirds of all government spending on health care.

Spending on Medicaid program benefits, for which costs are shared by the federal and state governments, increased 34.4 percent in calendar year 1991 to reach $96.5 billion.

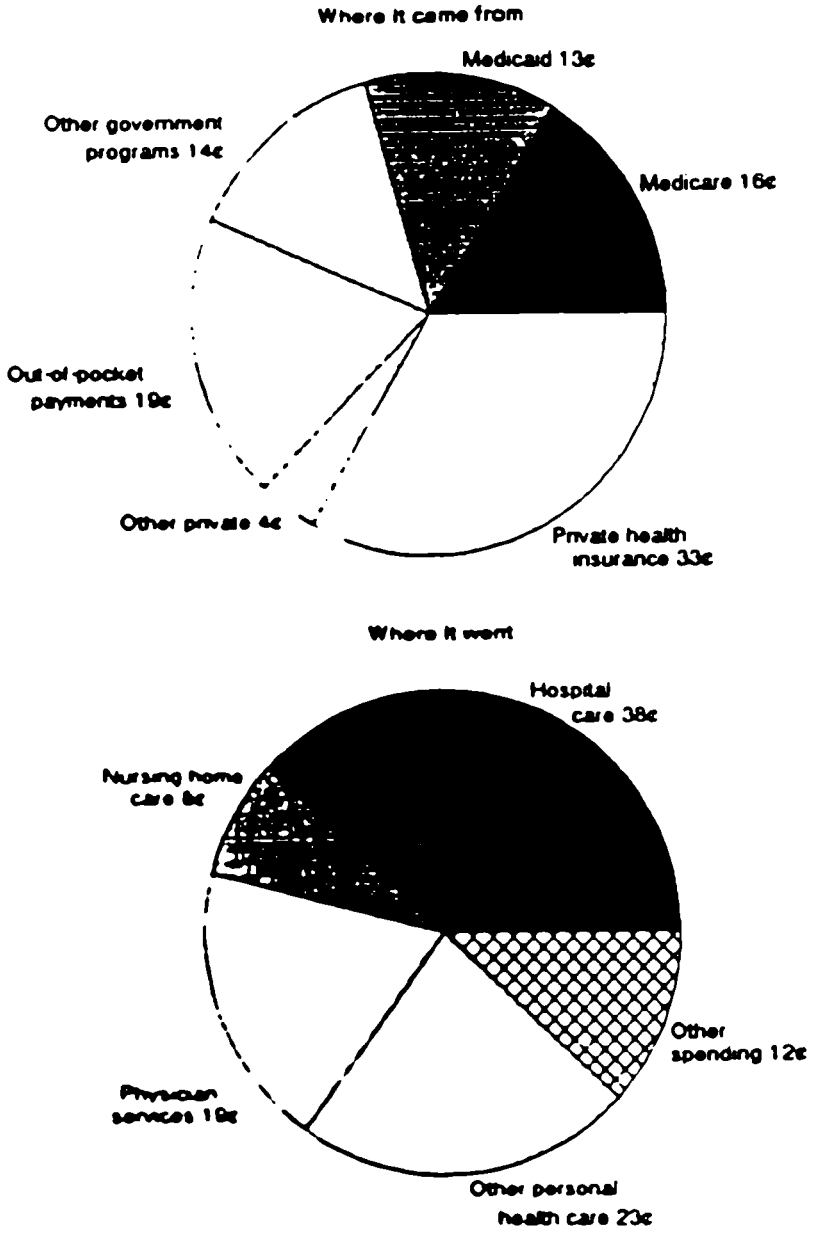
Medicaid costs increased rapidly when enrollments, affected by economic recession and legislation that expanded eligibility, jumped from 25.3 million in 1990 to 28.3 million in 1991. The spending was accelerated by states' use of special provider taxes and donations that swelled the flow of federal funds to their growing Medicaid programs.

The federal Medicare program spent $120.2 billion for benefits in calendar year 1991, an increase of 10.9 percent from the 1990 level.

###

EDITOR'S NOTE: The Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services, directs the Medicare and Medicaid programs, which help pay the medical bills of more than 67 million Americans. HCFA's estimated FY 1993 expenditures are $230 billion, the 12th largest government budget of any kind in the world.

The Nation's health dollar: 1991



NOTES Other private includes industrial in-plant health services, non-patient revenues, and privately financed construction. Other personal health care includes dental, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health care services. Other spending covers program administration and the net cost of private health insurance, government public health, and research and construction.

SOURCE Health Care Financing Administration, Office of the Actuary. Data from the Office of National Health Statistics.

Table 1

National health expenditures aggregate and per ... as, ... distribution, ... average ... percent growth, by ... of ... Selected ... 81

Item	1960	1970	1980	1985	1986	1987	1988	1989	1990	19
				Amount in billions						
National health expenditures	$27 1	$74 4	$250.1	$422.6	$454.9	$494.2	$546.1	$604.3	$675.0	$751
Private	20.5	46.7	145.0	248.0	265.2	286.2	319.0	351.0	390.0	421
Public	6 7	27 7	105.2	174.6	189.6	208.0	227.1	253.3	285.1	330
Federal	2.9	17.7	72.0	123.5	132.5	143.6	156.6	175.0	194.5	222
State and local	3.7	9 9	33.2	51.2	57.2	64.4	70.5	78.3	90.5	107
				Number in millions						
U S. population 1/	180.1	214 8	235.1	247.0	249.5	251.9	254.4	257.0	259.6	
				Amount in billions						
Gross domestic product	$513	$1,011	$2,708	$4,039	$4,269	$4,540	$4,900	$5,251	$5,522	$5,6
				Per capita amount						
National health expenditures	$143	$346	$1,064	$1,711	$1,824	$1,962	$2,146	$2,352	$2,601	$2,8
Private	108	217	617	1,004	1,063	1,136	1,254	1,366	1,502	1,6
Public	35	129	447	707	760	826	893	986	1,098	1,2
Federal	15	83	306	500	531	570	616	681	749	8
State and local	20	46	141	207	229	256	277	305	349	4
				Percent distribution						
National health expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	10
Private	75.5	62.8	58.0	58.7	58.3	57.9	58.4	58.1	57.8	56
Public	24 5	37.2	42.0	41.3	41.7	42.1	41.6	41.9	42.2	43
Federal	10 7	23.8	28.8	29.2	29.1	29.1	28.7	29.0	28.8	29
State and local	13.8	13.3	13.3	12.1	12.6	13.0	12.9	13.0	13.4	14
				Percent of gross domestic product						
National health expenditures	5 3	7 4	9.2	10.5	10.7	10.9	11.1	11.5	12.2	1
				Average annual percent growth from previous year shown						
National health expenditures	-	10 6	12.9	11.1	7.6	8.6	10.5	10.7	11.7	1
Private	-	8 6	12.0	11.3	7.0	7.9	11.5	10.0	11.1	8
Public	-	13.3	14 3	10.7	8.6	9.7	9.2	11.5	12.5	1
Federal	-	19 8	15.0	11 4	7.3	8.4	9 1	11.7	11.1	14
State and local	-	10 2	12 8	9 0	11.8	12.6	9.5	11.1	15.8	1
U S. population	-	1 2	0 9	1 0	1.0	1.0	1.0	1.0	1.0	
Gross domestic product	-	7 8	10 4	8.3	5.7	6.4	7.9	7.2	8.2	

1/ July 1 Social Security area population estimates

NOTE: Numbers and percents may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Office of National Health Statistics.

Table 2 National health expenditures in 1991 by source of funds, and type of expenditure

Type of expenditure	Total All Sources	Private					Government		
		All private funds	Consumer						
			Total	Out of Pocket	Private insurance	Other	Total	Federal	State and local
	Amount in billions								
National health expenditures	$751.8	$421.8	$388.6	$144.3	$244.4	$33.2	$330.0	$222.9	$107.1
Health services and supplies	728.6	412.7	388.6	144.3	244.4	24.1	315.9	212.0	103.9
Personal health care	660.2	377.0	353.5	144.3	209.3	23.4	283.3	204.1	79.1
Hospital care	288.6	126.0	111.4	9.9	101.5	14.7	162.6	119.1	43.5
Physicians' services	142.0	92.5	92.5	25.7	66.8	0.1	49.4	39.0	10.4
Dentists' services	37.1	36.0	36.0	19.9	16.1	--	1.1	0.6	0.5
Other professional services	35.8	27.5	23.0	9.7	13.3	4.4	8.4	6.4	2.0
Home health care	9.8	2.7	2.0	1.2	0.7	0.7	7.1	5.7	1.3
Drugs and other medical nondurables	60.7	53.3	53.3	44.3	9.0	--	7.3	3.6	3.7
Vision products and other medical durables	12.4	8.8	8.8	7.7	1.2	--	3.5	3.1	0.4
Nursing home care	59.9	27.6	26.5	25.8	0.6	1.1	32.3	19.5	12.8
Other personal health care	14.0	2.4	--	--	--	2.4	11.6	7.0	4.6
Program administration and net cost of private health insurance	43.9	35.7	35.1	--	35.1	0.6	8.1	5.2	3.0
Government public health activities	24.5	--	--	--	--	--	24.5	2.7	21.8
Research and construction	23.1	9.1	--	--	--	9.1	14.0	10.9	3.2
Research	12.6	0.9	--	--	--	0.9	11.7	10.2	1.5
Construction	10.6	8.2	--	--	--	8.2	2.4	0.7	1.6

NOTE: Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but are included in the expenditure class in which the product falls. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 3 Sources of funds for personal health care in 1991

Source of payment	Total	Hospital care	Physicians' services	Dentists' services	Other professional services	Home Health care	Drugs and other medical nondurables	Vision products and other medical durables	Nursing home care	Other personal
					Amount in billions					
Personal health care expenditures	$660 2	$298 6	$142 0	$37 1	$35 8	$9 8	$60 7	$12.4	$59.9	$14.0
Out-of-pocket payments	144 3	8 9	25 7	19 9	9 7	1 2	44 3	7.7	25.8	-
Third-party payments	516 0	278 7	116 3	17 2	26 2	8 5	16.3	4.7	34.1	14.0
Private health insurance	209 3	101 5	66 8	16 1	13 3	0.7	9 0	1.2	0.6	-
Other Private	23 4	14 7	0 1	-	4 4	0 7	-	-	1.1	2.4
Government	283 3	162 6	49 4	1 1	8 4	7.1	7.3	3 5	32.3	11.6
Federal	204 1	119 1	39 0	0 8	6 4	5 7	3 6	3 1	19 5	7.0
Medicare	120 2	73 3	32 8	-	4 2	4 4	-	2 9	2.7	-
Medicaid	53 5	23 9	4 0	0 5	1 5	1 4	3 5	-	15.7	3.0
Other	30 4	21 9	2 2	0 1	0 7	—	0 1	0 2	1.1	4.0
State and local	79 1	43 5	10 4	0 5	2 0	1 3	3 7	0 4	12 8	4.6
Medicaid	42 9	19 4	2 9	0 4	1 2	1 3	2 7	-	12 7	2 4
Other	36 2	24 0	7 5	0 1	0 8	0 0	1 1	0 4	0 1	2.2
EXHIBIT Total Medicaid	96 5	43 4	6 9	0 9	2 7	2.6	6 2	-	28 4	5.4
					Percentage distribution					
Personal health care expenditures	100 0	100 0	100 0	100 0	100 0	100 0	100 0	100.0	100.0	100.0
Out-of-pocket payments	21 9	3 4	18 1	53 7	27.0	12.7	73.1	61.9	43.1	-
Third-party payments	78 1	96 6	81 9	46 3	73 0	87.3	26.9	38.1	56.9	100.0
Private health insurance	31 7	35 2	47 0	43 4	37.2	7.6	14.8	9.6	1.1	-
Other Private	3 6	5 1	0 0	-	12.4	7.5	-	-	1.9	17.3
Government	42 9	56 3	34.8	2.9	23.4	72.2	12.1	26.5	53.9	7
Federal	30 9	41.3	27.5	1.6	17.8	58.8	6.0	25.4	32.5	80.0
Medicare	18 2	25.4	23.1	-	11.7	44.7	-	23.6	4.4	-
Medicaid	8 1	8.3	2 8	1.4	4.2	14.1	5.7	-	26.2	21.6
Other	4 6	7 6	1 6	0 2	1.9	-	0 2	1.8	1.9	26.4
State and local	12 0	15.1	7.3	1.3	5.6	13.4	6.1	3.1	21.4	32.7
Medicaid	6 5	6.7	2 0	1.1	3.3	13.0	4.4	-	21.3	16.9
Other	5 5	8.3	5 3	0.2	2.3	0.4	1.7	3.1	0.1	15.8
EXHIBIT: Total Medicaid	14 6	15 0	4 9	2.5	7.5	27.1	10 1	-	47.4	5

NOTES: 0.0 denotes less than $50 million. Medicaid expenditures exclude Part B premium payments to Medicare by States under "buy-in" agreements to cover premiums for eligible Medicaid recipients. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

HHS NEWS

DRAFT #309

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: Anne Verano
(202) 690-6145

If current laws and practices were to continue, health expenditures in the United States could reach $1.7 trillion by the year 2000, according to projections by the Health Care Financing Administration.

Without changes, the HCFA study shows, national health expenditures could increase from 13.2 percent of the gross domestic product in 1991 to 18.1 percent in the year 2000, with per-capita spending of more than $6,000 for every American. Gross domestic product is the total value of goods and services produced in the United States.

The projections also show that in theory, as baby boomers reach their 70s and 80s in the first third of the next century, U.S. health care spending could climb to 32 percent of GDP by 2030, with total expenditures of $16 trillion by 2030, including inflation.

"These estimates show us the course we are on today, and our urgent need to change that course," said HHS Secretary Donna E. Shalala in releasing the projections. "The nation cannot sustain spending growth at this rate. We need a health system that delivers quality care for all our people, at a reasonable cost. The Clinton Administration is committed to doing the hard work that will be needed to achieve those goals."

- More -

The study, "National health expenditures projections through 2030," will be published in the Health Care Financing Review, a quarterly journal issued by HCFA.

National health spending includes hospital care, physician and dental services, purchase of prescription and over-the-counter drugs in retail outlets, nursing home treatment, government public health activities, research and construction.

According to HCFA's latest released statistics, health expenditures grew to about $750 billion in 1991, up 11.4 percent from 1990 levels. Health spending, as a share of GDP, rose to 13.2 percent in 1991 from 12.2 percent in 1990.

HCFA's study projects an average annual growth rate of 10.1 percent in health expenditures through the end of this century and an overall 8.3 percent rate from 1990 through 2030. Health spending expanded at a 10.3 percent annual rate during 1980-90.

Projected health spending will place increased burdens on federal and state budgets. In 1990, total federal spending for health accounted for 15.4 percent of the U.S. government's budget, principally funding for Medicare, Medicaid, and health care for the military and veterans. By 2000, this share could nearly double to 28.8 percent, according to the HCFA projections.

Federal spending as a percent of national health expenditures is likely to grow more slowly. The study forecasts an increase from 29.3 percent in 1990 to 35.5 percent in 2000 or, in actual federal dollars, from $195.4 billion to $617.5 billion.

Medicare's share of health expenditures is expected to rise from 16.7 percent in 1990 to 18.8 percent by 2000 and to 25.9 percent by 2030.

In line with Medicaid's recent rapid growth, its portion of health expenditures are projected to rise from 11.3 percent in 1990 to a high of nearly 21 percent in 2000.

"The aging of the population will result in more reliance on government programs, specifically Medicare and Medicaid, in the future," the study says.

An increasingly older population is expected to lead to higher health expenditures. An earlier HCFA study showed people aged 65 and older spend four times as much per capita on health care as do people under 65.

A decline is anticipated in population growth, resulting in a dramatic change in the population's composition, the study says. Currently, 12.4 percent of the population is 65 or older, and 5.3 percent are 75 or older. By 2030, people 65 and older will comprise 20.1 percent of the population, with those at age 75 or more accounting for 9 percent.

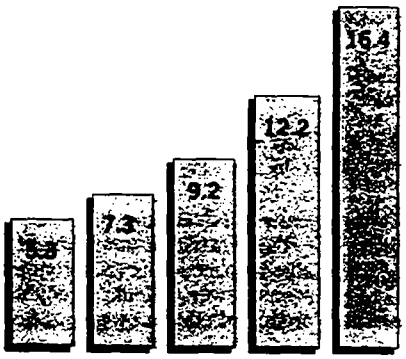
The demographic changes will substantially affect the use of some types of services. During the period from 1990 to 2030, the increasingly aged population, for example, will double spending for nursing home care, the study says. Hospital care will be similarly affected, though not to the same degree. But the overall spending for physician services is not expected to be changed very much by the projected population change.

# # #

EDITOR'S NOTE: HCFA, an agency of the U.S. Department of Health and Human Services, directs the Medicare and Medicaid programs, which help pay the medical bills of more than 67 million Americans. HCFA's estimated fiscal year 1993 expenditures are $230 billion, the 12th largest governmental budget of any kind in the world.

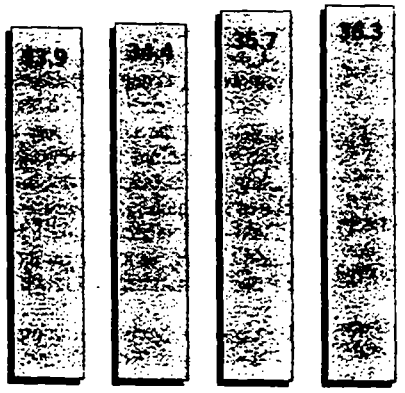
The Road to Reform Health Care

PERCENTAGE OF U.S. GROSS NATIONAL PRODUCT SPENT ON HEALTH CARE



SOURCE: Health Care Financing Administration

NUMBER OF NONELDERLY AMERICANS WITHOUT HEALTH COVERAGE, IN MILLIONS



SOURCE: Employee Benefit Research Institute tabulations of the Current Population Survey, March '89, '90, '91, '92

The statistic is straightforward: one in every seven dollars spent in this country each year—an estimated $939 billion in 1993—goes to hospitals, doctors, insurance and drug companies, equipment makers, bureaucrats and others in the U.S. health care system.

But that is where straightforwardness stops. The "system" is not a system at all. It is a collection of dissimilar and often wasteful practices that has left 37 million Americans uninsured. Unrestrained health spending has climbed to 14 percent of the Gross Domestic Product.

The call for reforming the U.S. health care system—the most costly and advanced in the world—is fueled by startling contradictions:

While individuals, corporations and federal and state governments continue to spend an ever-increasing amount of money on health care—costs grew 11.5 percent last year— 100,000 individuals a month continue to move into the ranks of the uninsured. They lack coverage because their jobs do not offer it or because they can no longer afford to buy it on their own, or are dumped by insurers when they become ill or old.

While the United States spends more per capita on health care than any other country, its infant mortality rate is the among the highest in the industrialized world, and publicized personal appeals for money too often determine whether someone can afford a life-saving procedure such as a transplant.

While private companies and the Medicare and Medicaid programs have set price controls on medical services and negotiated volume discounts from hospitals and insurers, spending on health care has risen from $250 billion in 1980 to $838 billion in 1992. Family spending on health care has tripled in the past decade.

As candidate Bill Clinton said in his major health care address during the presidential campaign: "We are the only advanced nation in the world that does not provide basic health care to all its citizens. We spend 30 percent more of our income than any other country in the world on health care at a time when we desperately need to spend more on new plants, new equipment, new businesses, reinvesting in education and training of our citizens. . .We cannot go on like this."

What It Will Take

Leadership, Sacrifices and Defiance

to Cure Health Care

of Powerful Interest Groups Are Needed

SPECIAL INTEREST GROUPS

There are so many special interests involved in health care that trying to sort them all out can be like traveling through a maze made of distorted mirrors: nothing appears as it really is and the political path from the current system to a reformed one is not at all straightforward. While most groups by now have jumped on the rhetorical reform bandwagon, the positions they take on the toughest issues—guaranteeing access and controlling costs —are based largely on their economic interests.

The Washington Post
1/26/93

The reasons health care in the United States costs so much are numerous and interconnected. They include ever more complicated medical procedures, a largely unfettered consumer demand for services, an aging population that requires more care, fraud and abuse in programs like Medicare and Medicaid, wasteful and overlapping administration costs among hospitals, doctors and insurers. Most important, the incentives for those providing care are to spend more rather than less in every area of medicine and in almost every case.

"These incentives, moreover, have influenced the everyday rules of thumb that doctors use in deciding about tests, hospitalization, operations, and so on," writes Princeton University sociologist and Pulitzer Prize-winning author Paul Starr in his book, *The Logic of Health Care Reform*. ". . .American physicians' practice styles are partly the product of financial arrangements that for decades rewarded the decision to treat even if there was no good evidence the treatment would work."

With no logical and effective cost restraints, American hospitals have been built too big, with expensive equipment that is under-used. There are too many costly specialists and not enough primary care doctors.

"The result," says Starr, "is not just incidental waste and a few flagrant abuses but a vast misallocation of resources."

For these reasons many policy experts, and Clinton, believe that only comprehensive reform can solve the twin problems of containing costs and financing universal access to affordable, high quality services.

Piecemeal legislation, argue experts, will only result in piecemeal changes that will not go far enough to reverse the systemic problems in the health care system. A piecemeal approach may also dampen the momentum in Congress and the public for more complete reform—momentum that Clinton created by highlighting the issue during and after the campaign.

But systemic reform means taking on the powerful, effective and diverse special interests all at once. Registered lobbyists are already at work for more than 750 different health care organizations, from the largest medical societies to the smallest manufacturers of disposable medical equipment. Industry giants are already mounting their media campaign to shape public opinion in their favor. Business groups have begun meeting with new members of Congress to express their concerns.

It is not only the lobbyists and industry leaders that Clinton and Congress will have to contend with, however. About 10 million people work in the health care field and can be counted on to make their feelings known to any legislator who supports changes that would close a local hospital or put the local insurance agents out of work. Reducing health care spending means reducing health care jobs.

So how has Clinton promised to fix such a mess?

He has said repeatedly that he would propose a reform plan within the first 100 days of his administration. During his pre-inaugural economic summit, he emphasized the need to get health costs under control in order to reduce the federal deficit, heightening public expectations that real reform is around the corner.

The two primary goals of his campaign proposal were to provide everyone access to health care and to contain sky-

See HEALTH CARE, Page 15

The call for reforming the U.S. health care system—the most costly and advanced in the world—is fueled by startling contradictions.

HEALTH CARE, *From Page 12*

rocketing costs. He also embraced the managed competition model as the way to structure the system.

His promises include the following elements:

- Require insurance companies to provide the same coverage to everyone in the same region for about the same price (called "community rating") and prohibit them from denying coverage to individuals because they have pre-existing illnesses.
- Create a government board that would set annual national spending targets for public and private health care. The goal is to limit health cost increases to the rate of inflation.
- Instruct the board to establish a comprehensive, standard benefit package that all insurers would have to offer.
- Adopt an employer mandate that would require employers to provide part of their employees' health premium. This requirement would be phased in to lighten the burden on small businesses, and government subsidies would be available to some businesses.
- Expand government health care subsidies for the unemployed and poor.
- Create insurance-purchasing cooperatives through which companies and individuals could purchase a health plan. The cooperatives would negotiate the best price and quality from competing plans.
- Create incentives—most likely lower costs and special tax benefits—for people to join managed care networks, which are more cost-effective.
- Establish primary and preventive health care clinics in the inner cities and rural areas.
- Emphasize health education and prevention in schools and the workplace.
- Invest more in health care research. ■

The Washington Post
1/26/93

By Victor Cohn
Washington Post Staff Writer

Can President Clinton control our ruinous health costs in order to cure the health system and the economy?

Can anyone?

The answer is "no"—unless . . .

■ *Unless he and Congress act firmly and courageously.*

During the transition, Clinton said, "If we don't do something on health care . . . it's going to bankrupt the country." For nearly 25 years American presidents have tried to tame health costs and failed. To get control will require a degree of leadership, a defiance of powerful interests and a public willingness to make sacrifices that have so far been lacking.

■ *Unless the reform proceeds with all prudent speed.*

PATIENT'S ADVOCATE

Candidate Clinton promised a plan in "the first 100 days." Some health experts are urging caution, lest a hasty plan fail. Yet a credible effort must at least begin while there is momentum.

■ *Unless the effort is total, for there is no one magic bullet.*

No plan now getting attention can alone do the job. A successful one must attack many villains: the huge profits now being extracted by many businesses and entrepreneurs, over-use of costly technologies, medical ignorance of what truly works, the malfunctioning malpractice system—and a lack of primary care doctors, of prevention and of information to tell patients who provides good care.

■ *Unless the American people, and many interests, accept the fact that true reform will involve pain.*

Pain means less money for many doctors and others. Loss of jobs if 1,500 insurors are squeezed down to a more efficient 50 and hospitals are forced to close unneccessary beds. Almost surely new taxes in some guise to cover the uninsured and curb use of the system. And medical pain, being told, "You'll get less care than you'd like. You can no longer see any doctor you want."

True, there is enough money in the system—approaching a trillion dollars this year—to give everyone reasonable care, if drastically reshuffled. But doing so could take years.

The choices are hard, and "Americans have no stomach for hard choices," in the words of former Colorado Gov. Richard Lamm, head of a University of Denver policy center.

Yet the nation has no choice but to act. There can be no control of the national deficit—and no care for all—without control of the health costs that will cause half of the deficit's projected increase in the next five years.

The situation now, Lamm said, is "a national tragedy." Health spending in 1992 rose at nearly four times the rate of general inflation. Yet millions saw their health benefits shrink or disappear as employers cut back or abandoned coverage, and the ranks of the waiting rose at crumbling public hospitals and clinics.

AIDS and an ever aging population aggravate the problem. "Health care is eating our lunch," said Henry Aaron, Brookings Institution economist. "There isn't going to be money to do anything"—not educate, not rebuild industry, not clean the environment—"unless health care costs are brought under control."

"The longer we wait, the more expensive this will be," said Kenneth Thorpe of the University of North Carolina. Without comprehensive reform, predicts the Congressional Budget Office, by the year 2000 health spending will reach $1.68 trillion, consuming nearly a fifth of the nation's gross product.

George Lundberg, the physician who edits the Journal of the American Medical Association, sees the result then as "meltdown"—still fewer covered, hospitals going bankrupt, desperate emergency appropriations to maintain bare-bones services. Congress will then panic, he predicts, and nationalize all health care.

At this point, "Welcome to Canada"—Canada's government-paid health care—said Rep. James Cooper (D-Ky.), health reform advocate. Canada's provincial governments pay all the bills out of tax dollars, but pay no more each year than budgeted. No one goes without basic care, but, compared with Americans, Canadians get less heart surgery and advanced imaging, less treatment by specialists and some irksome waits. Canada's way of curbing spending while covering everyone is advocated by some Americans, although not enough today to make it a leading reform candidate.

There are in fact only so many ways to cut any nation's medical expenses, mainly:

■ Requiring those with health insurance, including Medicare, to pay more for it.

■ Reducing health benefits—or doing less for the sick. One way to do less is doing only procedures proved medically beneficial, a nice goal but one that is years away since so little is known now for lack of enough research. Another way would be to stop keeping very sick, often aged patients alive a few more days, weeks or months. "No other society would take a 90-year-old with congestive heart failure out of a nursing home and put him into an intensive care unit to die," Lamm wrote in Medical Economics.

■ Cutting payments to hospitals, closing some, since the nation has too many hospital beds. On the average day a third are empty.

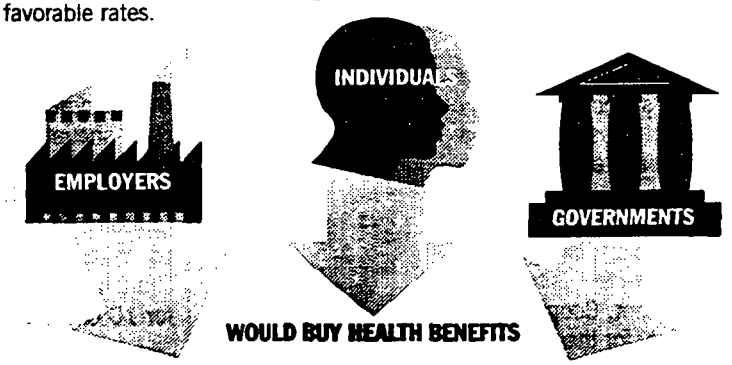
■ Cutting payments to doctors. Medical groups argue against this, saying that

The Washington Post
1/26/93

1/3

ELEMENTS OF 'MANAGED COMPETITION'

President Clinton has endorsed a form of health care reform called "managed competition". Under the broad outlines of the concept, most people would purchase health insurance from large, HMO-like managed-care networks that would compete for customers in a given region. A federally created board would set up nonprofit insurance purchasing organizations to bargain with networks for the most favorable rates.

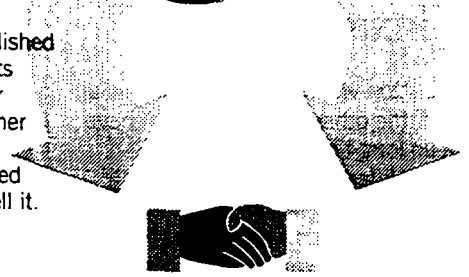


WOULD BUY HEALTH BENEFITS

either through

or directly from

HEALTH INSURANCE PURCHASING COOPERATIVES
a government-established nonprofit agency acts as a price negotiator between the consumer who needs health benefits and approved health plans who sell it.



APPROVED HEALTH PLANS

The various approved health plans would probably be organized by insurers who create large networks of doctors, hospitals, clinics, and the like. It is likely that most of these would evolve into "super-HMO's", in which medical services and physician practices are scrutinized for cost-effectiveness and medical appropriateness.

- AHP's Cannot base rates on medical history or pre-existing conditions.
- All AHP's must at least offer the same basic benefits.

NATIONAL HEALTH BOARD

- Standardize accounting and paperwork; establish a standard benefits package
- Provide consumer infromation on the quality of AHP's, including price and outcome information
- Make a subsidy payment to plans with a large number of sick deople so that no plan suffers disproportionately

cutting doctors' incomes by 20 percent would cut the nation's health bill by a mere 2 percent. But doctors order 75 percent of all care, so cutting payments for procedures and restricting their use can also help curb the rise in medical costs. So can changing practice incentives. Currently, doctors as a group—by no means every one—tend to do more of the things that pay them well. There is a trend already toward paying them so much per patient, or paying them salaries, rather than added dollars for every procedure.

■ Delivering care more efficiently, with less personnel and less of the paperwork demanded by too many rules by too many insurers. By various estimates, between 18 and 24 percent of U.S. health dollars are spent on administration while countries with government health systems spend around 10 percent. Lamm told of a 300-bed Bellingham, Wash., hospital with 42 billing clerks, while a few miles away in Vancouver, B.C., a 300-bed hospital had one.

The trick for health reform is to incorporate all or most of these cost-cutting measures while assuring decent care for everyone.

See REFORM, Page 17

The Washington Post
1/26/93

2/3

True, there is enough money in the system—approaching a trillion dollars this year—to give everyone reasonable care, if drastically reshuffled. But doing so could take years.

REFORM, *From Page 16*

Few people think Congress can pass any extensive health reform bill before 1994. Few think any plan could then be phased in and begin to affect costs in less than three to five years. And it might take 10 years to get the reforms working.

Minnesota Physician Paul Ellwood, an advocate for the so-called "managed competition" approach, has said "we may have only five years" to control costs before Congress gives up and goes the Canadian way. Hence, many health thinkers argue for a federally set national health budget a la Canada—this and no more to be spent, with controlled payments to doctors and hospitals.

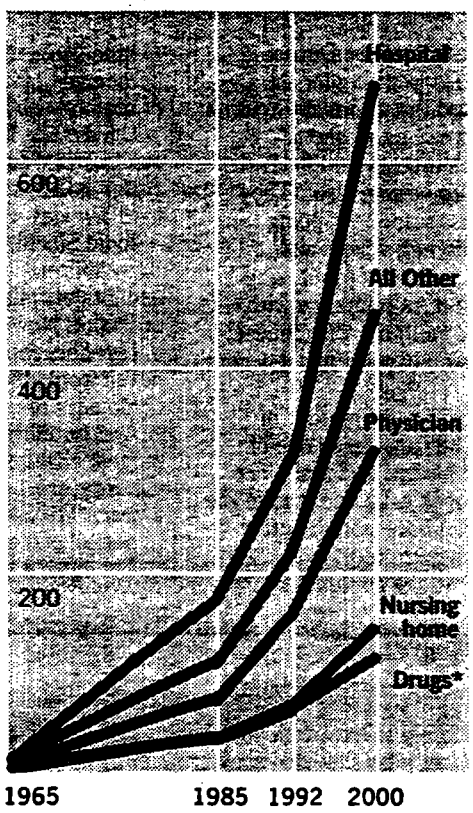
A firm lid on spending might have a quick effect. But, historically, price controls tend to break down. And they would do nothing, critics say, to affect long-term inflationary pressure by changing medicine's culture, encouraging doctors to do not just less, but less of the ineffective and unneccessary.

Elwood and the like-minded call a marriage of managed competition and an overall spending limit incompatible. There is much talk, however, of such a wedding, or at least a combination using annual spending targets rather than firm lids, with more drastic action possible if the targets aren't met. Proponents of an annual lid or tough target include Brookings' Aaron; Stuart Altman, former Nixon Administration health official and Clinton adviser; Paul Ginsberg, director of Congress' Physician Payment Review Commission; Karen Davis, former Carter Administration health official, and Senate Majority Leader George Mitchell.

Some reform advocates say they can manage to cover everyone without addding to the nation's health bill, except in a few start-up years. Some say their plans can save as much as $40 billion a year within a few years of enactment, enough to cover all those now uncovered.

Other authorities believe that covering all of America's unprotected could cost somewhere between $22 billion and $135 billion yearly, depending on how the reform is designed. "There is no way Clinton can deliver on his promise to achieve universal access that will not boost federal spending," Aaron contended.

PROJECTIONS OF NATIONAL HEALTH SPENDING, IN BILLIONS OF DOLLARS



SOURCE: Congressional Budget Office
* includes other non-durables
NOTE: 1992, 2000 are projected

The opposition to any true reform will be fierce. Much of the health industry will fight to keep profits, which must be trimmed or eliminated if health care inflation is to be trimmed. Taxpayers will resist any new taxes. Even affluent seniors will resist paying more for Medicare or being taxed more for Social Security benefits.

"Choices will be difficult," said Sen. Mitchell. "Mistakes will be made that need correction."

Yet, said Judith Feder, head of the Clinton health transition team, "To wait for consensus . . .is to do nothing . . .What's needed is leadership." ■

The Washington Post
1/26/93

3/3

A handful of lawmakers are strongly identified with one brand of reform or another. To get their support, Clinton will have to either make enough compromises to satisfy these powerbrokers or find ways to make it politically too costly for any member to derail his plan. With a supposed end to the era of gridlock, voters expect health care reform. Once legislation is proposed, members of Congress will have no one but themselves to blame for inaction.

There are six major health committees and about 70 other committees and subcommittees with jurisdiction over some pot of health money and policy. Here are the top health care players on Capitol Hill:

IN THE SENATE:

GEORGE MITCHELL (D-Maine): Majority leader Mitchell introduced a "pay or play" bill last session but has put his legislation on hold. He heads a working group of more than 20 Democratic members and their staffs who have divided themselves into sections to work on crucial areas in the coming debate, such as the concerns of small business and ways to impose national spending limits. The staff met with Clinton's health transition team. Mitchell's hope is to merge his team with the administration's to begin work on legislative language for a bill that Clinton, House majority leader Richard Gephardt and Mitchell can all bless.

EDWARD KENNEDY (D-Mass.): As chairman of the Labor and Human Resources Committee, Kennedy has long served as the unofficial spokesman for health care reform. His position has evolved from support for the single-payer Canadian model to one closer to the pay or play model. He has two goals that he insists on: universal access and containing health costs. He will have to be convinced that Clinton's plan will achieve these things before he signs off on it.

JAY ROCKEFELLER (D-W.Va.): In three years, Rockefeller has become the Senate's health care reform salesman and conscience, a role he played tirelessly during the presidential campaign. He has close ties to Clinton's health advisers and is likely to be one of the president's unofficial liaisons with the Senate. He believes some form of government regulation is necessary to control costs and to guarantee health coverage for all Americans.

DANIEL PATRICK MOYNIHAN (D-N.Y.): He becomes chairman of the Finance Committee this year, which has responsibility for tax matters. Moynihan replaces the more conservative Lloyd Bentsen (D-Texas), Clinton's secretary-designate for the Treasury Department. Although Moynihan has not been a leader in the health care field, he wants to be supportive of Clinton.

NANCY KASSEBAUM (R-Kansas): She takes over as the ranking minority member on Kennedy's Labor and Human Resources Committee. Kassebaum is interested and committed to reform, much more so than her predecessor on the committee, Orrin Hatch (R-Utah). She supports the general managed competition concept, wants to impose caps on insurance premium increases but is opposed to employer mandates that require businesses to provide coverage and rate or fee setting for hospitals and doctors.

BOB DOLE (R-Kansas): Well versed and experienced in health care matters, he is poised to be the stalking horse for the conservatives. He has been an advocate of market-based, incremental reform similar to that proposed by President Bush during the campaign. Dole is expected to oppose most forms of government regulation, most especially mandates on businesses, but has not entirely closed the door on some type of price controls to control costs. He wants to make sure that rural areas fare well under any plan.

IN THE HOUSE:

RICHARD GEPHARDT (D-Mo.): Majority leader Gephardt has asked House members not to introduce health policy legislation until after Clinton's bill is sent to Congress. He tried hard but failed last session to get consensus on health care reform; his own proposal emphasized voluntary spending limits on doctors and hospitals with government-imposed price controls to back it up. He is expected to help Clinton steer a plan through Congress and intends to introduce the new president's legislative proposal.

DAN ROSTENKOWSKI (D-Ill.): The chairman of the Ways and Means Committee, which has jurisdiction over tax matters, supports government price regulation and the "pay or play" model. He is skeptical of any managed competition plan that cannot guarantee enough government savings that could then be used to pay for

the Washington Post
1/26/93

1/3

health coverage for the uninsured. But Rostenkowski is also under investigation by a federal grand jury and dealing with his legal problems might take him out of the debate. If Rostenkowski were to give up his chairmanship it would fall to Sam Gibbons (D-Florida), whose approach is more radical. He favors eliminating the age requirement for Medicare and bringing all Americans into that system. He does not believe competition can work. "Did you ever see anyone bargain with a doctor?" he said to explain his position.

FORTNEY "PETE" STARK (D-Calif.): Stark, chairman of the Ways and Means health subcommittee, broke ranks with a leadership request not to introduce any health legislation by reintroducing the Gephardt-Stark bill, minus Gephardt. The 300-page bill would impose government cost controls over public and private health outlays, with a national limit on total spending, enforced by government fee schedules. A committed liberal who has spent his whole career on health issues, Stark wants to be cooperative but also wants to remain in an activist role.

JOHN DINGELL (D-Mich.): Dingell, chairman of the Energy and Commerce Committee, is considered one of the more independent of the health committee chairmen. Long a supporter of national health insurance financed through a value added tax and a payroll tax, he has indicated that he will wait and see what Clinton proposes before endorsing or criticizing it.

HENRY WAXMAN (D-Calif.): Waxman was the chief co-sponsor on Dingell's bill last session. He chairs Energy and Commerce's health subcommittee and has been a respected crusader for national health insurance. He cares very much about reforming the system and is expected to be an active consumer-minded watchdog over Clinton's legislation.

The Washington Post
1/26/93

JIM MCDERMOTT (D-W.Va.): He takes over the single-payer mantle for Marty Russo (D-Ill.), who lost his reelection bid. McDermott has close ties to the grassroots and consumer groups. While Clinton moved the debate significantly away from a government-financed system during the campaign, the idea continues to have appeal to many consumer groups. McDermott is one of a handful of doctors in the House. He is a psychiatrist.

JIM COOPER (D-Tenn.): Over the last year Cooper's stock in the health care debate has skyrocketed nearly as rapidly as health care costs because he is a principal author of the Conservative Democratic Forum's "managed competition" bill. After Clinton became an adherent, Cooper has stumped tirelessly for the model. He will pressure Clinton not to impose a global budget. A junior member, his clout is derived from the CDF, which counts more than 40 members in the House and support from a fair number of Republicans.

THE ADMINISTRATION

One thing is certain: Clinton will make the most crucial decisions himself. Most of the other people who will have prominent roles have been long-time friends and/or associates of both Bill and Hillary Clinton, a factor that became all the more significant this week when the White House announced that Hillary Clinton would head the health care task force charged with writing Clinton's plan.

Judging from the size of the undertaking—the conceptualization, the numbers crunching and the public relations effort required to sell the eventual legislative proposal to Congress and the public—there will be plenty of work to go around.

2/3

Administration players include:

HILLARY RODHAM CLINTON: While not an expert on health policy and economics, the First Lady began to steep herself in the intricacies of health care reform during the campaign. Her role as leader of an interagency task force would give the subject an instant high profile. The coordinating role would be a familiar one to her; Clinton named his wife to an Arkansas commission to improve the education system there. She held hearings, drew up a final proposal and testified before the legislature. Her work with the Children's Defense Fund leads some insiders to believe that her first priority would be to provide health coverage to uninsured children.

IRA MAGAZINER: His official title is "senior adviser to the president on policy development" in the White House. As successful business consultant from Rhode Island and a former anti-war activist at Brown University, Magaziner's relationship with Clinton goes back to their days as Rhodes scholars. He was influential during the campaign in

convincing the candidate to adopt a more market-oriented approach to reform.

DONNA E. SHALALA: The new secretary of the Department of Health and Human Services is a longtime friend of Hillary Clinton. Her last job was as chancellor of the University of Wisconsin at Madison. While familiar with health care matters, she too, is not a policy expert on the subject. HHS has traditionally been in charge of health policy; it has jurisdiction over Medicare and Medicaid as well as the National Institutes of Health and the Food and Drug Administration. Shalala has made it clear she intends to be prominent in health care reform.

CAROL RASCO: Also a longtime associate of both the Clintons, Rasco is assistant to the president for domestic policy, a large portfolio. She has said her priority will be "health, health, health." Rasco was an adviser to Clinton for 10 of his 12 years as Arkansas governor.

JUDITH FEDER: Feder is the only professional health care policy expert in the group. Before joining the campaign as an adviser, and then heading the health care transition team, she co-chaired the Center for Health Policy Studies at Georgetown University. Feder is Shalala's principal deputy for health care. She became well known on the Hill and elsewhere as the staff director of the Pepper Commission, a bipartisan congressional commission that studied health care reform. She has close ties to Sen. Jay Rockefeller (D-W.Va.), who headed the commission after Sen. Claude Pepper (D-Fla.) died.

—Dana Priest

The Washington Post
1/26/93

3/3

Gearing Up for the Fights

The status quo is out. Change is in. Just about every health care group imaginable now says it endorses change and most say they endorse reform "similar" to President Clinton's proposals. That's the hitch. "Similar" but not quite the same. In fact, major knock-down-drag-out fights are expected in some critical areas, including:

GLOBAL BUDGETS. There is not a health care business group around, including doctors, hospitals, insurers, etc., that supports a government-imposed annual health care budget that might require price controls. The architects of managed competition, such as Stanford University professor Alain Enthoven, believe government price-setting is incompatible with their model and will significantly distort the market's ability to weed out inefficient health providers and drive down costs. Others believe savings are not possible without government-imposed controls.

TAXING EMPLOYEE BENEFITS. Labor unions, consumers and many business groups are opposed to changing the tax treatment of health benefits. It is a lucrative benefit they do not want to give up.

MANDATING THAT EMPLOYERS PROVIDE COVERAGE. Employers of all stripes, and most federations that represent them, oppose such a mandate, as do proponents of a single-payer system who say coverage should not be employer-based.

HOW TO FINANCE UNIVERSAL COVERAGE. Even with an employer mandate, major disagreement is expected over how fast the government should commit new resources to financing universal coverage.

The problem is linked to how Clinton deals with the federal deficit. If he decides to wait and use the savings from reforming the entire health care system to help subsidize expanded access, then it will be several years before the government can do much. If he decides to use savings to reduce the deficit, an even longer wait is ahead. On the other hand, he could impose strict price caps to achieve quick savings or increase deficit spending and pay for expanded access more quickly.