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PRESERVATION

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STATEMENT OF ERSKINE B. BOWLES
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BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE
OCTOBER 28, 1993
HEALTH CARE REFORM

* DRAFT *

Mr. Chairman, I am pleased to testify today on the economic effects of the Health Security Act on our nation's small businesses. I want you to know up front that I am excited about this plan and I am excited about what it can do for small business. For the first time ever, small business will be able to buy rock solid, comprehensive insurance at an affordable rate. I believe this plan will be good for small business and it will create jobs.

I am also concerned by what could happen to our country and to small business if we don't enact comprehensive health care reform and do it now.

RIISING HEALTH COSTS: THE BIG PICTURE

Mr. Chairman, the statistics reflecting the current health care system are frightening. Every month, two million people lose their health care coverage. During the next two years, one out of four Americans will be without health care for some period of time -- that's 63 million people. There are 37 million Americans without insurance today, and another 22 million who are underinsured.

The rising cost of health care could literally bankrupt this country. The U.S. now spends more per capita on health care than any other country in the world; more than double what Japan spends and 40% more than Canada, which is the second most expensive country. Twenty-five years ago, health care consumed 5.9% of GDP. In 1992, that number topped 14% to reach a staggering total of \$840

billion. By the year 2000 we will see health care spending top \$1.6 trillion and approach 20% of GDP if this trend continues. If we do nothing, health care costs will consume about two-thirds of the increase of GDP in the rest of this decade. This is simply unacceptable. Clearly, from a macro economic viewpoint, we have a serious problem in this country with our health care costs.

SKYROCKETING HEALTH CARE COSTS HURT SMALL BUSINESS

Small business is faced with the worst of all worlds with respect to rising health care costs. The two-thirds of small businesses that are still able to afford to provide their employees with health care coverage are experiencing skyrocketing cost increases. Health care costs have increased for small business at a rate of 20% to 50% a year. Small businesses pay 35% more for the same insurance than do big businesses, and the rate of increase in the cost of health care for small businesses is 50% higher than the rate of increase for big businesses. Unfortunately, the smaller the company, the more disproportionate are the costs they pay for health insurance.

ABUSES OF CURRENT SYSTEM DISADVANTAGE SMALL BUSINESS

Not only have small businesses experienced skyrocketing increases in the cost of health care, they also have been subjected to every one of the most blatant abuses that occur within the health care system. These abuses include such practices as occupational redlining, whereby insurers will simply refuse to cover entire industries perceived to be too high a risk. These industries often include such basic businesses as automobile dealerships, florists, grocery stores, barber and beauty shops, construction companies, and trucking firms.

Some insurance companies also engage in price baiting and gouging, by offering discounted rates for the first year of coverage, to be followed by much higher rates in the next year when pre-existing condition exclusions expire. Many insurance companies refuse to renew insurance policies if one of the employees of a small business gets sick and really needs insurance. When this happens, the insurer may either pull the policy or jack up the cost to an unaffordable level.

OTHER WAYS THE CURRENT SYSTEM PENALIZES SMALL BUSINESS

Unlike large firms, small business owners generally don't generally have a benefits department. The small business owner or a valued employee must perform all the functions of such a department. As a result, the small business owner not only loses valuable time away from his business, but he also is at a disadvantage when trying to negotiate the purchase of a benefit for his employees that is extraordinarily complicated to understand and is constantly changing. A self-employed individual also operates at a disadvantage because of the inequitable tax policies for the self-employed. A self-employed individual is only allowed to

OCT 28 '93 11:25 SBA CONGRESSIONAL AFF. 11475
deduct as a business expense up to 25% of the cost of health care coverage. All other businesses are able to deduct the full cost of coverage. This is clearly unfair to the self-employed and almost, by definition, increases their cost of insurance for their families.

Workers compensation has also become a bigger burden to small business owners. Increasing at an even faster rate than the rest of the health care system, workers compensation medical costs grew more than one and a half times as fast as medical costs between 1980 and 1985. Between 1982 and 1992, the average workers compensation medical claim rose from \$2,584 to \$8,900.

Clearly, small businesses have a large stake in solving the health care crisis in this country.

SOLUTION: UNIVERSAL COVERAGE

Today, together with individuals, three major groups finance the cost of health care in this country:

1. The government;
2. Self-insured companies -- generally big corporations; and
3. Businesses which insure through traditional insurance companies -- generally small businesses.

These groups finance virtually all of the nation's health care spending. When one of these groups pays less, the others must pay more to cover the cost. The federal government system, which sets the amounts Medicare pays for particular services, can reduce the government's expenses for Medicare. However, when this action is taken, it has done nothing to lower the overall cost of health care and government has actually driven up costs for the privately insured.

When health care providers cannot get adequate compensation from the government, they simply raise the prices charged to everyone else. Large, self-insured plans frequently have a great deal of clout in a given area and can negotiate with providers to reduce the impact of this cost shift on them. However, small employers have no ability to reduce this cost shift and must bear its full brunt.

This same cost shifting scenario also occurs when providers deliver uncompensated care, primarily to the uninsured. Make no mistake about it, the uninsured are provided health care in this country. They simply get it at the emergency room at four or five times the cost it would be at the doctor's office. And because there is no insurance coverage, someone has to pay for this treatment. Today this cost is shifted onto the backs of small business. Clearly, no part of the business community is hit harder by the high cost of the uninsured than small business.

A solution that doesn't offer universal coverage for the 37 million workers who are uninsured is simply no solution. Unless these uninsured Americans are provided insurance, we will continue to have the cost shifting that has gone on in the past. Unfortunately, the sector of the economy that will bear a big portion of this cost shift will be the small businesses that are currently paying as much as 35% more for the same insurance that big business pays today.

HOW THE HEALTH SECURITY ACT WORKS FOR SMALL BUSINESS

The Health Security Act provides small business with comprehensive insurance coverage at an affordable rate. The President worked hard to give small business comprehensive and affordable insurance that couldn't be just jerked away.

The Health Security Act will control the skyrocketing cost of health insurance by increasing competition in health care, reducing administrative costs, and imposing budget discipline. By forming buying groups and health care alliances, the Act shifts the power of the marketplace to benefit the consumer.

The Act simplifies the health care system and eliminates waste. The plan reduces administrative costs through standardized forms, uniform billing, electronic claims submission, coordinating benefits, and malpractice reform.

The Act also reduces the enormous burden of paperwork and administration that currently falls on small business. The cost of administering coverage in small companies declines because they purchase through health alliances that exercise market power reserved only for large employers in today's system.

The Health Security Act will give small business what it needs by offering:

1. Rock solid, comprehensive insurance coverage -- not a bare bones plan or just catastrophic coverage, but real insurance.
2. Affordable coverage with caps and subsidies to hold down the cost of health insurance for small businesses. National Small Business United estimates that the average small business that currently provides its employees insurance has a payroll of \$15,600. If that is the case, then these small businesses will see their annual insurance cost fall to only \$827 per employee. That's about \$2.25 a day per employee, representing a significant savings for that average small business currently purchasing insurance.
3. Mechanisms to bring the cost of health care under control and to ensure that the cost of health care will increase by approximately the rate of growth of wages, as opposed to current skyrocketing costs.

4. Elimination of abuses of the current health care system. If one worker in a small business becomes seriously ill, the business will no longer see their rates jacked up beyond belief or lose coverage for the sick employee or dependent.
5. Full, 100 percent tax deductibility of coverage for the self-employed instead of the current 25% deductibility.
6. Choice to employees to pay more for health care insurance if they choose more expensive health care coverage. This will give the employee strong incentive to choose an economical provider group.
9. Finally, the plan removes the hassle that small businesses must now undergo in dealing with insurance companies and frees up valuable time for the small business owner to manage and grow his or her business.

Mr. Chairman, I am confident that when small business owners who provide insurance compare the Health Security Act their current plan, the vast majority of them will see both a decrease in cost and better coverage. Small business owners who have wanted to offer their employees insurance but couldn't afford will see a comprehensive plan that they can afford. And those very small businesses that pay low wages are going to be able to offer their employees rock-solid, comprehensive insurance coverage that will cost the small business owner as little as \$1.00 to \$2.00 a day per employee.

Clearly, every small business will not be better off under the Health Security Act, but the vast majority will. Those small businesses that have been scared off by the constantly escalating cost of health insurance and the relatively poor coverage will see a plan that they can afford to offer.

In summary, Mr. Chairman, I am convinced that small business owners, when they examine the facts, will realize the value of the Health Security Act. They will understand that the Act is good for small business.

Thank you.

DRAFT

**STATEMENT OF ROBERT B. REICH
SECRETARY OF LABOR
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEES ON
ENERGY AND POWER
AND
HEALTH AND THE ENVIRONMENT
OCTOBER 28, 1993

HEALTH CARE REFORM**

Chairmen, Members of the Committee. Thank you for giving me the opportunity to discuss the Administration's health care reform plan. These hearings demonstrate your commitment to a thorough exploration of an issue which is of profound importance to the Nation.

In the past month, President Clinton and the First Lady have each made historic appearances before Congress. They have described for you a comprehensive plan for providing all Americans with health care coverage. This plan is based on six principles: security, simplicity, savings, choice, quality, and responsibility.

Rather than repeat their descriptions of the principles and structure of the plan, today I will focus on the urgent need for health care reform and the substantial benefits it will bring for workers, business, and the economy.

The Cost of Doing Nothing

Even before the Administration's plan was unveiled, special interest groups, lobbyists, and sentries of the status quo were out in full force. Foremost among their dire predictions has been the complaint that we can't possibly afford to provide real health security for all Americans.

Mr. Chairmen, Members of the Committee, if there is one point we must agree upon, it's that we can't afford not to reform this badly broken health care system. Exploding health care costs are choking our economic competitiveness and robbing American workers of the fruits of their labor. Fundamental change is needed to ensure our future prosperity and security.

Americans will spend over \$900 billion on health care this year. Next year, this amount will rise to nearly a trillion dollars. Since 1980, the nation's health costs have nearly quadrupled, growing at 2-3 times the rate of inflation. Health care's share of the gross domestic product (GDP) has risen from 9% to 14% during this period. If medical costs continue growing at this pace, health expenditures will be over 18% of GDP by the year 2000 and will swallow up 40% of all the real per capita GDP growth we will achieve from 1993-96. No other advanced industrialized nation spends more than 10% of GDP on health care.

These soaring costs are a function, in part, of a bloated and inefficient administrative structure. Over \$45 billion of health

care expenditures went for administrative expenses in 1992. And no wonder. Doctors, nurses, and hospital administrators must contend with 1500 different claims forms, most of which must be filled out by hand and submitted to more than 1000 different health insurers. We have heard endless horror stories about physicians and nurses spending hundreds of hours each year on paperwork instead of patient care. And on top of all this, fraud and abuse may account for up to 10% of U.S. health care costs.

Every dollar our society unnecessarily spends on health care is a dollar we can't spend on education, training, infrastructure, environmental protection, and other important needs. For American families, every dollar unnecessarily spent on health care is a dollar that can't be spent on food, clothes, transportation, household goods, tuition, or other expenditures that improve the quality of life.

Business currently spends over \$200 billion on health care. Real business spending on health care per employee has risen by 200% since 1970. For business, every dollar unnecessarily spent on health care is a dollar that cannot be invested in wages, capital improvements, marketing, workforce development, or R&D. Remarkably, business health care expenditures now nearly equal after-tax profits.

The cost of providing health care is a major source of

contention between labor and management. This issue has been a major concern in [insert number here] percent of labor-management disputes.

These exploding health care costs are putting American companies at a competitive disadvantage in the world marketplace. For instance, health care costs add \$1100 to the cost of an American car -- double the burden carried by Japanese imports. This disparity will continue to widen as heavy corporate obligations for retiree health care come due.

Health care costs are so high partly because \$25 billion in costs for uncompensated care are shifted to companies that do provide insurance. Many people who cannot afford insurance wait until they are acutely ill to seek emergency room health care. Since these people cannot afford to pay for this expensive treatment, these expenses are shifted to those who can afford to pay for care, the insurance companies. That cost shows up in the rapidly rising price of premiums charged companies providing health care coverage.

As the President said in his address last month, rising health care costs are a special nightmare for small business, an important source of entrepreneurship and job creation in this country. Health care premiums for small businesses are up to 35% higher than for large corporations. Even so, a majority of workers in

businesses with less than 100 employees work in companies that provide health insurance. Small firms that provide insurance are at a competitive disadvantage with respect to both large firms and small businesses that do not provide coverage. To add insult to injury, the cost of premiums for small companies that do insure is so high in part because they are subsidizing the health care costs of their competitors' uninsured employees.

Rising workers' compensation costs are further increasing the health care burden on American firms, both small and large. Between 1980 and 1985, workers' compensation medical costs grew more than 1.5 times faster than medical costs generally. They now account for more than \$16.8 billion a year in health expenditures, or about 40% of total workers' compensation costs.

American workers spend \$55 billion a year on premiums and out-of-pocket costs. In addition, the excessive cost of health insurance translates into lost wages or reductions in other forms of compensation. It is estimated that the average worker today would be earning \$1000 more per year if the cost of health insurance had not outpaced wages over the past 15 years. If the cost of health insurance continues at the current pace, by the year 2000, workers may lose another \$650 in annual wages. The Brookings Institute has estimated that rising health care costs have consumed 58% of workers' potential wage increases since 1980, and, unchecked, would soon consume 100%.

Skyrocketing health care costs are only part of the problem for American workers. Of the 37 million uninsured in this country, almost 85% are workers and their families. Millions more American workers are, as the President said, just a pink slip away from losing their insurance. The tragedy of job loss is compounded by loss of health insurance. Surveys show that up to 30% of workers are locked into their current jobs because they fear their new employer may not offer insurance, or because someone in their family has a preexisting condition that would not be covered if they switched jobs.

Concerns about health insurance also contribute to "welfare lock." Studies show that a substantial number of non-working welfare recipients would be more likely to work if they could be assured of continuous health care coverage.

Among part-time workers, only 28% of those who work in large firms, and 6% of those who work in small firms, participate in health care plans at least partially supported by employers. Temporary workers have an even harder time qualifying for medical benefits.

The Remedy: The Clinton Plan

Let me move to the specific job effects of President Clinton's health care reform plan. The benefits of the plan can be best

understood by analyzing the job consequences under the following four-point framework:

1. Competitiveness -- Lifting the extraordinary burden of health care costs from American companies will increase their competitiveness, resulting in higher profits, more investment, higher wages, and more jobs.
2. Worker Mobility -- Enabling people to keep their health insurance when they find a better job or leave welfare to join the job market will end job lock and welfare lock. Guaranteed coverage will also free individuals to join or start new businesses.
3. New Jobs -- Universal coverage will increase the demand for health care services and therefore expand the number of health-related jobs. For instance, dramatic growth in the use of home health care services will result in a significant increase in number of people needed to care for people at home.
4. Low Wage Workers -- The Clinton plan is designed to minimize any potential adverse employment effects on low-wage workers.

1. Competitiveness

Soaring health care costs are weighing down the competitiveness of American firms. The cost per product for health care in the United States is apt to be much higher than the health care cost per product manufactured in other countries. That makes our businesses less competitive, and less successful in the marketplace. When we get health care costs under control, we are making American industry more competitive.

Under the Administration's reform plan, no firm that participates in a regional alliance will pay more than 7.9% of its total payroll for the guaranteed basic health insurance. This cap will lower costs for most large corporations, making it easier for them to hire future workers, give wage increases to existing workers, and invest in training, capital, equipment, and R&D. They can also lower prices to increase competitiveness. Firms with older workforces will benefit from community rating and a reduction in the cost of fulfilling their obligations to early retirees. Firms will benefit from less-protracted labor-management disputes as the issue of providing basic guaranteed health care benefits is removed as a source of controversy. These effects will provide a much needed shot in the arm for manufacturing firms, which have borne more than their fair share of the nation's uncompensated health care costs.

The small businesses that are currently providing health insurance have a special stake in reform. While it is true that

small businesses that now fail to insure their workers will pay more under the new system (since they pay nothing now), small businesses currently providing insurance will be much better off. Here are some of the ways:

- o The pooling of small businesses into regional alliances that are able to offer a community-rated premium will let small firms realize the same administrative efficiencies and cost advantages that large firms already enjoy.
- o Firms with less than 50 workers and low wages will be eligible for discounts. Many small firms will pay as little as 3.5% of total payroll on health insurance.
- o The Clinton plan will eliminate the free-rider problem and level the competitive playing field between businesses that currently provide insurance and those that don't. Firms will compete on the basis of the quality of their products and services, not on the ability to avoid health care costs.
- o Small businesses are likely to experience less turnover once they are able to provide workers with good health insurance.
- o Administrative costs for small business should decline

significantly. Small firms currently pay as much as 40% of their health insurance expenditures on administrative activities. The President's plan will shift most of these administrative burdens to alliances, whose size and efficiency will lower overall administrative costs.

These reforms will allow small businesses to better compete with large firms and will enhance their ability to generate jobs and pay higher wages.

The partial integration of workers' compensation medical costs into the new system will help lessen the burden that these costs impose on American industry. Under the President's plan, workers who are injured on the job will receive care through their regular health plan, and the doctor they have chosen. Employers will continue to buy separate insurance through workers' compensation insurance carriers on an experienced-rated basis. Regional alliances will set fee schedules for workers' compensation cases.

This policy will ensure that the cost savings of health care reform are passed on to the workers' compensation system, while preserving the employer's incentive to maintain a safe and healthful workplace. It also will eliminate wasteful disputes over which provider will treat a work-related injury. And the fee schedule will prevent providers from charging exorbitant fees for workers' compensation cases.

Large and small businesses alike will benefit from the plan's increased-emphasis on preventive care. This will result in fewer lost work days and a healthier, more productive workforce.

2. Enhanced Mobility and Other Benefits for Workers

The reform plan will provide substantial benefits to workers. First, the guarantee of comprehensive coverage will eliminate job lock, welfare lock, and other limitations on the mobility of workers in and out of the workforce. As the President said, if you switch jobs or lose your job, you're covered. If you're laid off, you're covered. If you have a preexisting condition, you're covered. If you're on Medicaid and you get a job, you're covered. If you decide to retire early, you're covered. If you are a part-time or temporary worker, you're covered. If you leave your job to start a new business, you're covered.

As a consequence, people will no longer feel they cannot get a better job because they fear that if they leave their present job, they will lose their health insurance. People on welfare will no longer feel that they cannot join the workforce, because they are afraid of losing their health insurance. Individuals who would like to start or join a small business will not be prevented by fear of losing their own health insurance or by the prohibitive costs and burdens of providing their employees with health insurance.

Second, by putting the brakes on health care inflation, the President's plan will allow workers to pay lower premiums, earn a higher income, and enjoy a better standard of living.

Third, the President's plan will guarantee workers a choice of plans, both in the regional and corporate alliances. Only 29% of companies with fewer than 500 employees currently offer any choice of plans. Under the new system, workers, not employers, will choose the plan that suits them best. They will have at least three categories of choices in the reformed system: an HMO, a PPO (preferred provider organization), and a fee-for-service plan. And, in all likelihood, there will be several plans to choose from in each of these categories.

Fourth, by requiring all employers to contribute to their employees' health care coverage, the plan also eliminates the incentive to hire people based on their health insurance status rather than their productivity and qualifications. And firms will no longer have an incentive to hire part-time and temporary workers simply to avoid paying health care benefits.

3. The Reform Plan Will Create New Jobs and Occupational Shifts

Because the vast majority of large firms will pay less for health insurance, they will have more funds available for better wage increases, hiring new workers, and investment. Each of these

results will stimulate the economy and increase employment. In addition, small businesses that already provide insurance will see lower costs under the reform plan, and will not face the uncertainty of unbridled rising costs. As a result, these firms also will be able to create more jobs and pay higher wages.

Increased demand for health care resulting from universal coverage will likely lead to short-term increases in employment in the health care industry. Thousands more nurses, physician's assistants, home health aides, and other non-physician health providers will be required to directly or indirectly support the health care system during the first few years.

Undoubtedly, the purpose of much of the reform plan is to reduce paperwork. We have seen an extraordinary increase in what may be called the "paper health care industry." A lot of people put data into computers and take data out of computers, monitor forms and process paper. This does not generate health care, it generates the monitoring of health care. These jobs would not grow as fast; in fact, many of these jobs may be eliminated.

The plan will contain a workforce development proposal to ensure an adequate supply and mix of health care workers in the new system. This program will also create new training and employment opportunities for workers in the health and insurance industries, offering them a chance to move to higher-wage, higher-skilled

health care provider positions or to switch from one field to another.

4. Impact on Minimum Wage and Lower Skilled Workers

Finally, it is true that the cost of health care reform will put some pressure on low-wage jobs in firms that do not currently provide insurance. But this pressure will be greatly alleviated by the discounts provided by the President's plan. With discounts, firms in regional alliances will only spend between 15-34 cents an hour more for minimum-wage workers. The empirical evidence shows minimum wage changes of this magnitude have not had substantial effects on employment in the past. Indeed, an increase of this amount would not even bring the real value of minimum wage up to its mid-1980s level and would provide an important safety net for low-wage workers and their families. In any case, any worker who loses his or her job during the health care reform transition period will be eligible for enhanced retraining and employment services through a comprehensive dislocated workers program which the Administration will be developing in coordination with many of you.

Conclusion

In short, we cannot afford not to reform our current health care system. If we don't get costs under control and provide true

health care security, many more jobs will be lost in the long-term as American businesses of all sizes are forced to spend an increasing share of their payroll on health care, eroding their competitive advantage in the world marketplace.

Even when change is in the best interest of all Americans, there is a natural fear of stepping beyond the status quo. I am convinced that many concerns about the President's plan have little to do with health care reform per se, and much to do with the pervasive anxieties arising from economic and social changes that are already affecting Americans. We cannot let these anxieties paralyze us and prevent necessary reforms. Our health and the health of our economy depends on our ability to provide health care security at an affordable price for all Americans.

I look forward to working closely with the members of this Committee in our efforts to improve the lives of American workers and their families.

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10/25/93

STATEMENT OF**KENNETH THORPE, Ph.D.****DEPUTY ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION (HEALTH)****BEFORE THE****COMMITTEE ON LABOR AND HUMAN RESOURCES****UNITED STATES SENATE****OCTOBER 22, 1993**

Mr. Chairman and Members of the Committee:

I approach today's hearing with a special sense of excitement and anticipation. As the President said, I believe we have embarked on a truly historic journey. The President's Health Care Security Plan will restructure our current health system so that all Americans will have access to quality health care at a price they and the Nation can afford. The plan builds on a foundation of what works in the existing system and seeks to fix those parts of the system that are broken.

BACKGROUND

The First Lady and her task force have put forward a comprehensive proposal that will provide security, savings, quality, simplification, choice and responsibility -- six objectives that must be achieved in health care reform.

The issues raised in health care reform are complex and difficult to resolve. We continue to work on the policy and details of the President's plan, and we value your advice and counsel as we work through the nuts and bolts of the system.

At the outset, we must agree that our Nation has the resources to meet the health care needs of all our citizens, if we spend our health dollars wisely.

It is the lack of rational spending in today's health care system, with costs growing at twice the rate of the rest of the economy, that cannot be sustained and must be dealt with in any approach to health care reform.

We need health care reform as an economic strategy -- to bring the growth in health care in line with overall economic growth, and to be able to invest our resources in areas other than health care. We need to fix the current system's incentives in order to increase competition, improve consumer choice, reduce administrative costs, increase the negotiating power of small businesses and individuals, and impose budget discipline. The President has proposed a plan to do this.

OVERVIEW

As we have discussed in other statements, there are three primary sources of private and public funding that will support the President's plan: premiums, savings, and tax revenues. This financing will support:

- Coverage for all Americans with discounts for low income individuals, small and low wage businesses, and early retirees,

- New long-term care and Medicare prescription drug benefits, and
- Public health initiatives.

Today, I will focus on the savings that will result from the Health Security Plan.

Savings In Health Care Expenditures

In the plan we are proposing reforms that will result in savings in private and public health spending. Assuring access to health care for the previously uninsured or underinsured will by itself yield savings. Primary care for these newly insured people will move out of emergency rooms -- the most expensive and least appropriate sites for such care -- and preventable hospitalizations will decline. In this city, for example, poor children are hospitalized for asthma five to seven times as often as middle class children because they lack access to comprehensive outpatient care.

In addition, the private health care industry will see immediate cost savings upon passage of the President's health care plan as a result of

administrative simplification, reform of the insurance markets, and stiff penalties for fraud and abuse.

We have all heard countless grievances about the problems of administering health care. By establishing uniform administrative procedures, we will cut much of the overhead and waste from the health care system. Steps we're taking that will be of particular interest to this Committee include:

- Development of standard forms for enrollment, billing, claims, medical records, and reimbursement. These forms will build on both Medicare and private sector models, and will save money and time by simplifying administration for consumers, providers, and health plans.
- Reforming standards for automating insurance transactions which will help eliminate conflicting information, formats and definitions used by health care providers.

Fraud is yet another high-cost factor of our health care system. The President's plan increases the penalties for those who cheat the system and commits more investigative and prosecutorial resources to pursuing and ultimately deterring such behavior.

Our most substantial savings will be achieved through market-based forces which will aggressively control costs through negotiation and competition. The President's plan will make it possible for families, small businesses, and individuals to band together to get the same clout as big businesses, allowing them to bargain for high quality care at affordable prices. We are encouraged by local reforms that have already headed in this direction.

Consumers will be able to review annual quality report cards and choose plans based on the value they get for their dollar. Each year, people will have the opportunity to say yes or no to their health care plan. This will be a powerful mechanism for promoting efficiency and quality among health care insurers and providers.

While we expect that market incentives created by our health care reform plan will control costs, the national health care budget will serve as a backstop by limiting the growth of premiums in regional alliances to a national inflation factor anchored to the Consumer Price Index. The National Health Board will adjust the budget for each alliance to reflect unusual changes in the demographic and socioeconomic characteristics of the population covered by the alliance.

The National Health Board will calculate a per capita premium target for each alliance using the national per capita baseline target as a reference point. For each alliance, the Board will adjust the national target for regional variation in health care spending and for rates of underinsurance and overinsurance. The alliances then negotiate with health plans in order to meet the alliance premium target. If the target is exceeded, the amount above the target is recouped from plans in the alliance area.

We are well aware of the controversy that surrounds the savings figures in our plan. I want to assure the Committee of our ability to achieve significant one-time savings in the early years of this plan as well as long run savings from productivity improvement in the health system.

Significant health care expenditure reductions will result from eliminating the small group and non-group insurance market; from standardizing and streamlining hospital and physician reimbursement and reporting requirements; from consumers switching to lower cost plans; and from providers improving their productivity.

Under the President's health reform plan, providers will have to examine ways to make their systems more efficient -- without sacrificing quality.

"Business as usual" will no longer be acceptable -- or profitable. We already have many existing examples of how technology, quality improvements and heightened productivity can reduce costs and we have every reason to believe the health care sector will respond positively to incentives to reduce costs.

We know, for example, under the prospective payment system, that the more successful hospitals have learned to utilize their bed and equipment capacity more efficiently, to employ labor in more creative and productive ways, to manage inventories of supplies and medications much more economically, and -- perhaps most critically -- to work with their medical staffs to identify and eliminate practices and procedures that are wasteful and detrimental to high quality.

We have also seen that the more heart surgery, cataract surgery, or AIDS treatment performed at a particular hospital, the lower the costs per case -- and the better the outcome. There are, in other words, significant and identifiable economies of scale in the treatment of many conditions. And we've long known that the better managed HMOs use fewer specialty referrals, lab tests, and invasive procedures; and produce better care than typical fee-for-service practices.

For years doctors, nurses, and hospital administrators have been saying me that they could do things much more efficiently if only they weren't penalized economically for doing so. Under the President's plan, health plans and providers will finally have the right incentives to increase productivity.

It wouldn't be fair to ask Americans and their employers to carry the burden of financing a universal health care system without a promise from the

Government to do its part in making the system as economically efficient as possible.

Our plan -- and virtually every Democratic and Republican plan that has been proposed -- recognizes that with national health care reform, we can save money by lowering the rate of growth in Medicare and Medicaid. Our bill will identify specific, scoreable, line-by-line savings in the Medicare program -- an amount comparable to the savings proposed by the Senate Republican plan, and less than the savings called for by some single-payer proposals. And while the amount of our seven-year savings may seem high today, we must keep in mind they will be taken from a future base of \$1.4 trillion in projected Medicare spending over the years 1996 to 2000.

At the same time, let me assure you that the President has no intention of putting Medicare beneficiaries at risk. The President is committed to a strong Medicare program and, in fact, Medicare recipients will see their benefits enhanced under our plan. Unlike a budget reconciliation bill, our savings will be a result of a thorough reform of the entire system in which everyone stands to gain. In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services. And reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

Shortly, Mr. Chairman, we will be submitting to you the specifics of these savings, and you will see that a substantial proportion are a result of reducing or eliminating payments that now address the financial pressures on providers created by uncompensated care. With universal coverage, uncompensated care will be substantially reduced.

In addition to the Medicare savings discussed above, the President's plan will also produce Medicaid savings by reducing Medicaid disproportionate share payments to States and by folding into the alliances the acute care portion of the Medicaid system. We also anticipate substantial cost offsets

from other federal health programs such as the Defense Department's health program and the Federal Employees Health Benefits program.

For additional revenues, corporations who choose to form their own health alliances will be asked to pay an assessment. Employers in the regional alliances will pay premiums that include a contribution toward the costs of biomedical research and health professions training incurred by our academic health centers. Because academic health centers are so critical to the continued high quality of our health care system, we believe it is fair to ask all payers -- including the self-insured employers -- to help support these investments.

CONCLUSION

In conclusion, the President's Health Security Plan provides an ambitious agenda for restructuring our Nation's health care system. The President's plan provides a unified system to cover all Americans, one that is built largely on the foundation of existing employer health coverage, with federal assistance for low income individuals and small businesses. And the price

of doing this is a shared responsibility that we can afford without compromising quality or limiting the availability of necessary health care services.

The President's plan calls for financial responsibility, fiscal prudence and budgetary discipline in the way we set premium rates, select and pay for insurance coverage, and compensate providers for services they render. We will curb the dramatic growth of health care costs by linking cost containment controls in both the public and private sectors. We have set hard objectives, but ones I think we can agree are critical to the health and welfare of this Nation.

We look forward to working with the Committee in the months ahead to forge a consensus on health care reform that promotes the improved health status of our citizens and strengthens our national productivity.

JAN 21 '94 18:16 SBA CONGRESSIONAL AFF.

P.2/16

DRAFT

**QUESTIONS & ANSWERS FOR ERSKINE BOWLES' HEARING
BEFORE THE HOUSE EDUCATION AND LABOR COMMITTEE
ON NOVEMBER 16, 1993**

- #1 The Administration previously advertised their health plan as costing \$1,800 for individual coverage and \$4,200 for family coverage. In testimony last week, the numbers for 1994 were changed to \$1,932 for individuals and \$4,360 for families.

Health care in high cost urban areas today may cost twice this much. When the President went to New York, he said that a family whose coverage costs over \$8,000 today would see the cost halved. It doesn't seem possible that a regional health alliance could reduce their baseline premiums in this fashion, virtually overnight.

My question is what the \$1,932 and \$4,360 figures actually mean. Would they be applicable to any given regional alliance or would they vary alliance by alliance?

Answer

The \$1,932 (single) and \$4,360 (family) are the preliminary estimates for health insurance premiums for the regional alliances. They are based on 1994 numbers. The specific numbers average will vary by region and by alliance.

While full reductions in premiums may not occur "overnight", substantial savings should be achieved with further economies over time.

Do these premiums represent a national average for only regional alliances or for regional and corporate alliances?

Please break down the premium for the following and any additional factors needed to fully explain the 1994 dollar cost -- 1994 expected claims costs; increases for uninsured, Medicaid, over 65, and presently underinsured groups; induced demand; increases or decreases for insurer expenses, alliance expenses, other expenses; decreases, if any, for any controls (please specify which); increase or decrease for uncompensated care; etc.

Answer

The premiums represent a national average for the regional alliances only.

The break down of the premium and dollar cost is explained in the attached 33 page document titled "Methodological Description of Health Care Reform Premium and Discount Estimates."

if actual premium bids in the baseline year exceed the estimated baseline premiums, will alliances have to obtain rebids or will the baseline for each alliance be adjusted to the actual average premium bid?

Answer

The premium target bid will vary by regional alliance. If the weighted average final bids from health plans are above the target for a regional alliance area, then the National Health Board would assess what action might be taken to assure that the target is achieved.

- #2 Who pays for alliance shortfalls? Under section 1571 of the Health Security Act, the Secretary of HHS is given the role of auditing alliance performance in the area of financial management including shortfalls. What is the procedure that HHS will invoke in the event that one of the regional alliances has a funding shortfall? How will the shortfall be paid for and by whom?

Answer

The Secretary of HHS can make loans available through the Treasury in order to cover any temporary period of cash flow shortfall. The loans are to be repayable with interest over a period not to exceed two years. Future premiums will be increased or decreased as needed to allow for repayment. In general, if total premium payments made by the regional alliance to the health plans exceed or are less than the total estimated by the alliance, then in the next year the premium amount is reconciled -- either increased or decreased.

- #3 According to Secretary Shalala, the National Health Board is "a minor oversight group with some functions." As I understand the National Health Board, it appears to be much more than a minor oversight group. The NHB will oversee all cost containment requirements (p. 256), establish premium tax factors (p. 257), develop a risk adjustment mechanism for premium payments to regional alliances (p. 257), establish minimum capital requirements for state guarantee funds and health plans (p. 258 and p. 262), and promulgate rules for how states pay the debts of a failed plan (p. 103), just to name a few.

The Health Security Act also gives the NHB the power to hire whatever staff is needed, and delegate any function necessary (p. 259). How many additional staff do you expect

3

Will have to be hired by not only the National Health Board but by HHS and DOL to carry-out the Board's function?

Answer

The National Health Board will consist of seven members. Any staff of the Executive Branch may be detailed to the Board to assist the NHB in carrying out its duties.

Please describe the enforcement power of the National Health Board. If the states do not conform to the regulation of the Health Security Act and the National Health Board, who will enforce these regulations? The National Health Board, the Department of Labor, or the Department of Health and Human Services, or whom?

Answer

If states do not conform to the regulation of the Health Security Act and the NHB, the Board notifies the Secretary of Health and Human Services. Upon receiving notice, the Secretary of HHS can take steps to establish new regional alliances, which must meet all requirements that apply to a regional alliance established and operated by a participating state. Guaranty Funds must be established by the Secretary of HHS in order to provide financial protection to health care providers and others in the case of a failure of a regional alliance health plan established and operated by the Secretary.

The premiums charged under the regional alliance (established and operated by the Secretary of HHS) in the state shall be equal to premiums that otherwise would be charged under a regional alliance established and operated by the state, increased by 15 percent. The 15 percent increase will be used to reimburse the Secretary of HHS for any administrative or other expenses incurred as a result of establishing and operating the state system.

#4 Do you consider the minimum health benefits package under the President's plan a federal entitlement or a federal mandate to the states and why?

If, as I understand, the small business, early retiree, and low-income subsidies provided by the federal government to state health alliances are capped under the President's plan.

Answer

Under the President's plan, the minimum benefits package is not a federal entitlement or a federal mandate to the states. The standard benefits package is a National standard and without it market fragmentation would lead to "cherry picking," and the dilution of competition in the health care industry. Health plans will compete for customers on their ability to provide the best quality and most efficient care. It would also be difficult or impossible for consumers to compare the cost and quality of available plans if they were not standardized. They would be comparing "apples to oranges." Risk adjustment would be difficult or impossible and a standard set of benefits is necessary to calculate risk adjusted payments. Where benefits differ today, there can be no valid actuarial comparison of risk.

Is it your understanding that these subsidies will not be characterized as federal entitlements?

Answer

They will be characterized as federal entitlements, but as capped federal entitlements.

Perhaps you can help me understand exactly how the President's plan can promise a fixed package of benefits and say it can never be taken away when the primary source of federal financing is subject to limits and when the total amount of employer mandated contributions is subject to unpredictable fluctuations year-by-year and alliance by alliance? What mechanisms are available to the states and health alliances to meet premium commitments, if the combined state, federal, employer and individual contributions prove insufficient?

Answer

OMB to supply answer.

- #5 Under the Clinton plan, it is possible that the weighted average premium for an alliance will increase by more than the 5.2 or other percentage premium cap allowable under the Health Security Act. How will the Administration ensure that the alliance lowers its rate of increase if it is greater than the cap? It is possible that there could be an increase greater than 5.2% in weighted average premium without an increase in costs. If enough individuals choose a higher cost plan in the second year, the weighted average premium will increase by a number greater than the premium cap. Will the National Health Board or HHS force regional alliances to reduce the choices offered to individuals by eliminating some of the high cost plans in order to keep

5

premium cost increases in line with the premium caps? Could that result in the elimination of all fee-for-service plans?

Answer

OMB to supply answer.

#6 Who is regional alliance eligible? Section 1571 of the Health Security Act defines the duties of the Secretary of HHS. One of the duties that HHS must perform is the auditing of alliance performance by ensuring all regional alliance eligible individuals are enrolled in the health plan. My question is, who exactly is considered eligible? Are resident aliens considered eligible? How will illegal aliens who request health care be treated under the President's plan? Will they be enrolled at the time of their hospital or doctor visit? In fact, how will aliens be identified as illegal - by health providers or by whom?

Answer

Eligibility

An eligible individual is any person who resides in the U.S. and who is a citizen or a national of the U.S., an alien lawfully admitted for permanent residence in the U.S. or a long-term nonimmigrant. Aliens lawfully admitted for permanent residence in the U.S. are defined as an alien who is admitted as a refugee, granted asylum, admitted for residence under the amnesty programs under the INA, one whose deportation is withheld, an alien who has been paroled indefinitely into the U.S. or who has been granted an extended voluntary departure, an alien who is the spouse or unmarried child under the age of 21 of a citizen or the parent of a citizen over age 21 and has applied for permanent residence, and any other classes of permanent resident aliens as the NHB recognizes. Long-term nonimmigrants include: aliens entering under a treaty of commerce or trade and their families and certain temporary workers and trainees.

Medicare-eligible individuals are entitled to benefits through the Medicare program rather than through the HSA unless they are qualified employees or spouses of qualified employees. Prisoners (who are imprisoned by Federal, state or local authorities following conviction as an adult) are not entitled to coverage under the Act during the term of imprisonment.

Individuals will have the opportunity to register for particular health plans. If they fail to do so, they will be required to pick a health plan at the point of service.

JAN 21 '94 18:19 SBA CONGRESSIONAL AFF.

P.7/16

6

Emergency care for anyone in need will be available through emergency rooms and community and migrant health centers paid for through the existing Medicaid programs. Primary and preventive care services will continue to be provided through the Public Health Service programs. These services will be available since it is necessary to protect the public's health. For example, it is important that all children are vaccinated and that all persons with active TB receive medical treatment.

When the Department of Health and Human Services finds a regional alliance eligible individual who is not enrolled in the plan, what recourse will HHS have to force individuals into the regional alliance?

Enrollment

The Department of HHS will not be involved in this area. When an individual needs service and has not joined a health plan through a regional alliance, that individual will need to join a health plan at the point of service.

- #7 It was recently stated in the New York Times that "what you pay would no longer depend so much on what you get. Instead, it would be determined even more by where you live and who you are grouped with."

I suppose the article was referring to the distribution among regional alliances of the various high cost populations -- some who may now be uninsured or insured under government programs.

My question is whether this kind of high cost concentration and cost-shifting could result in businesses in alliances that cover areas like inner cities paying more than businesses in alliances that cover suburban areas? Would you agree or disagree that these artificial boundaries will create new disincentives for business location and favor the employment of residents of low-cost areas?

Answer

Generally, today businesses in inner cities have a higher cost of doing business than businesses in suburban areas. Under the regional alliances, the cost differential is not going to bury any more dramatically than is already experienced.

We disagree that regional alliances will create disincentives for businesses to locate in low cost areas and favor the employment residents from low-cost areas. Community rating would make this practice illegal. Under the Health Security Act the disincentives to relocate should decrease. The Health Security

JAN 21 '94 18:13 SBA CONGRESSIONAL AFF.

P.8/16

7

Act will not change economic realities such as East and West coast cost of living differentials. But the Health Security Act will tackle the problem of cost-shifting and the spiraling costs of health care on many different levels. Through reform we will see overall costs decrease, thereby leveling out the playing field.

#8 The President's plan is quite complex and stretches over 1,342 pages. I presume that small employers who are required to pay into regional alliances will continue to have various recordkeeping and other obligations. Exactly what is the extent of the employer's responsibility? What kinds of records, reports, and so forth would have to be maintained and to whom would they be forwarded?

Answer

The employer under the HSA must maintain records, as is done today, on the total number of employees who work full-time, part-time, their hours worked, the employer premium contributions made for each employee and each employee's family status. On a monthly basis the employer must send this information to the regional alliance and any changes in qualifying employee status. On a yearly basis, the employer premium payment must be reconciled to take into account employer/employee discounts and any other discrepancies.

Would employers also be responsible to disseminate information on the myriads of health plans offered in, say, a state-wide alliance?

Answer

No, an employer does not disseminate information on the variety of health plans. It is the regional alliance that provides that information.

#9 In general, small business is the major source of new jobs in this country. My first question is whether or not your agency (SBA) has determined the number of small businesses and employees who are now engaged in the health insurance and health care industry?

Answer

According to the 1991 U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings, 4,324,000 individuals were employed in small businesses relating to the health services

JAN 21 '94 18:20 SEA CONGRESSIONAL HPF.

P.0/10

8

industry. These industries include physician offices, dental offices, nursing/personnel, medical dental labs, and outpatient care facilities.

secondly, what is the magnitude of effect of the President's plan on those existing businesses?

Answer

OMB to supply answer.

#10 Under the President's plan, there appears to be great emphasis placed on so-called "subsidies"--that is, subsidies for small employers, for early retirees, for employers whose payroll costs exceed 7.94, and so forth. My question is, if those receiving these subsidies are not paying their own way, who then will pick up the costs for these being subsidized? Please quantify the amount and source of financing for each subsidy type.

Answer

First, everyone will pay something, even if it is just nominal cost-sharing. There will not be one particular group which must pick up the costs of those who will be subsidized. Funding will come primarily from the incorporation of the acute portion of Medicaid into the overall system. Slower growth in tax-exempt health spending, excluding health insurance from cafeteria plans, tax changes and corporate retiree assessments, a reduction in debt service and increasing the federal excise tax on cigarettes will assist in the contribution to those needing to be subsidized. The discounts are a Federal guarantee and it is a capped entitlement.

#11 Members of your staff recently held a meeting with approximately 40 small business owners to analyze the effect of President Clinton's health care plan on small companies. The business men and women were led through a computer program that prepared various calculations based on their total number of employees, average wages, their anticipated costs of insurance and the value of the government subsidies proposed by the Administration. Because many Members of this committee have substantial contact with small business each and every day, would you please share with us the methodology used to prepare this small business analysis? Would you also provide the members of this Committee a copy of the program used to prepare the analysis?

Answer

The methodology used to prepare the small business analysis in which we invited small business owners to analyze the cost under

JAN 21 '94 18:21 SBA CONGRESSIONAL AFF.

P.10/16

9

the President's plan looked at the fundamental components of the plan that were available at that given date. We have produced a worksheet which can be followed to help estimate costs. A copy is enclosed.

Did the SBA prepare a report regarding the impact of the President's plan on small businesses as a result of this meeting, if so would you please provide us a copy of those findings?

Answer

The SBA has not yet prepared any studies regarding the impact of the President's plan on small businesses. However, because of the considerable stake that our nation's small businesses have in the resolution of the current health care crisis, the SBA's Office of Advocacy has been very involved in the SBA's efforts to educate policy makers and small businesses about health care cost and coverage. Advocacy currently is working on two studies that are relevant to the debate. The first, recently received in draft from the University of Kentucky by the Office of Advocacy, "Measuring the Uninsured by Firm Size and Employment Status," uses 1992 Census Data to contrast the level of insurance offered by firms of differing sizes with percentages of employees in those firms that are covered by health insurance from some source.

The second study, to be conducted by Lewin-VHI, will examine differences in cost and coverage of benefits offered to employees by firms of differing sizes. The questionnaire for this study is about to be field tested and, if the field test is successful, will be sent to approximately 6000 firms to gather nationally representative data by firm size and demographic characteristics (such as employee age, marital status, gender as well as employer data by industry and geographic region).

These two studies will provide information that will be vital to the ability of the Office of Advocacy to play a very active role in representing the small business point of view in health care reform as it moves through the Congress.

#12 Many employers, particularly the self-insured, have been developing innovative ways of containing health care costs. Many have successfully cut their costs below 7.9 percent of payroll. What provisions in the President's plan will encourage employers under regional alliances to promote good health habits and contain health spending?

Answer

10

Cost sharing by employees under the plan will encourage employees to make informed health choices.

#13 The Small Business Administration, along with the Department of Commerce, spent approximately \$21,000 to prepare and publish 200,000 copies of a glossy brochure which outlines the Administration's health care plan. In response to congressional criticism, members of your staff have called the brochure "educational," yet no mention was made of the five other health care plans presently being considered by Congress. Does the SBA plan to produce similar "educational" brochures for the five other health care plans?

Answer

Unfortunately, due to the lack of resources at this time, the SBA does not plan to produce any additional health care brochures. Within the limits of our resources, we are willing to analyze competing plans and disseminate information about them to small business owners.

#14 Mr. Bowles, it is my understanding that the latest version of the President's plan still excludes any employer with less than 5,000 full-time employees from establishing a corporate alliance. Can you explain why an employer with 4,000, 3,000 or even 500 employees should be prohibited from forming a corporate alliance and self-insuring? What is "magic" about the 5,000 employee threshold? Even allowing for such a high threshold, would the Administration consider allowing employers who might share a common association (i.e. a local chamber of Commerce, an industry association, etc.) and, together, have 5,000 employees, to form a corporate alliance and self-insure? If not, why not?

I also understand the President's plan would require corporate alliances to: (1) pay up to a 1% payroll tax; (2) establish trust funds and reserves; (3) contribute to a newly established federal guarantee fund; and (4) meet cost controls and other reporting requirements. In addition, neither the companies nor their employees would be eligible for the premium cap, early retiree, and other individual subsidies which are made available only under the regional alliances.

Answer

The question of the size of the alliances has been a difficult issue. It is important to spread risk so that small employers (firms of 100 or less), do not have to absorb the total cost of insuring Medicaid enrollees, the unemployed, the disabled, and high cost individuals who have previously been denied insurance

JAN 21 '94 18:22 SBA CONGRESSIONAL AFF.

P.12/16

11

because of preexisting conditions. In particular, we need to design regional alliances with sufficient critical mass to achieve effective community rating. We also need to ensure that the alliances are not victims of adverse selection. We fear this would happen if companies were allowed freely to opt in or out of the system. Largely for these reasons, we have chosen to require all smaller employers to participate in the regional alliances. We firmly believe that the benefits of the regional alliances as effective purchasers of health care will work to the advantage of its corporate participants.

Can you please explain why the Administration would erect these kinds of disincentives to the formation of corporate alliances?

Answer

The HSA would require corporate alliances to pay a 1.5% corporate assessment, not a 1% payroll tax. It is important to distinguish between micromanaging -- as the Federal government perhaps has done with the Medicare program -- and setting guidelines within which states and regional alliances can carry out the day-to-day operation of the system. The regional alliances do not add an additional level of bureaucracy; rather they are "purchasing pools" which will increase buying power of consumers and small businesses by banding them together in groups which purchase quality health insurance at discounted prices. These alliances also can be thought of as large risk pools, pooling individuals together to bring down the costs for all.

Is this an attempt to force everyone into the government run health alliances?

Answer

No, most definitely not. If the President had intended to run a government system, then he would have chosen the single payer system over the employer based system.

#15 According to recent press reports, the SBA gave 10,000 copies of the health care brochure directly to the Democratic National Committee for it to distribute as a part of its grass-roots lobbying efforts. Can you provide for the Committee how the decision made to provide the 10,000 copies to the DNC, and whether as of today the DNC has reimbursed the American taxpayers for its 10,000 copies?

Answer

The SBA did not give 10,000 copies to the DNC. The DNC will pay the costs of their 10,000 copies of the brochure.

JAN 21 '94 18:22 SBR CONGRESSIONAL AFF.

P.13/16

12

#16 It seems to me that President Clinton's Health Security Act discriminates against larger employers and higher wage employers. The plan includes many disincentives for large companies to continue their self-insured health plans. A one percent payroll tax, establishing and paying into a reserve, and meeting cost controls and other reporting requirements are just a few of the disincentives inherent in the plan.

The plan also discriminates against higher wage employers. They are not given the subsidies that lower wage employers are offered. This appears to be an incentive that keeps average wages down.

Why does the Health Security Act treat less favorably those employers who offer higher average wages and who may already offer good health benefits?

ANSWER

The Health Security Act does not treat employers who pay higher wages and offer good health benefits less favorably. There are many incentives for small and large employers. Large employers (with less than 5,000 employees) who now see an ever increasing percentage of their payroll going toward health care insurance will see it drop to 7.9% if they join the regional alliance and will also see lower premiums in general. Those employers will see the burden of early retiree health care costs reduced. Standardized benefits and a single insurance form will dramatically lower business costs and a more equitable distribution of the costs of retiree health care will help American business to be more competitive. The discounts offered to lower wage employers will only be offered to small business, which would be seriously hurt if they did not receive assistance. Under the HSA, small businesses will be able to get the same coverage at the price that most large businesses do today.

#17 My concern is over the increased obligation of small employers under the plan. Can you give me an estimate of the number and percentage of small business with less than 100 employees who will have new or increased contribution obligations under the President's health plan?

Answer

According to the 1991 ICF/Lewin Retirement Plan Survey, 93% of firms with employees between 25-99 provide health insurance for their employees. 50.6% of the employers with employees between 1-24 provide health insurance. The percentage of small businesses which will have an increase in contribution obligations under the President's plan will vary depending on

13

whether the firm currently does or does not offer insurance and how much they are paying for that insurance. It is obvious that those firms that currently do not offer health insurance will have a new obligation. The final result, however, will be that the many small firms that currently do provide insurance will be able to offer a comprehensive plan at a more affordable rate.

#18 My question involves the subsidy in regional alliances for early retirees who are age 55 or older but not eligible for Medicare. First, what is the criteria used to define "early retirees" -- does this include the individuals eligible for a pension or could anyone age 55 quit working and receive the government subsidy equal to 80% of the cost of an average health plan? Could this include the self-employed and small business employees who would be laid off?

ANSWER

The American Health Security Act defines a retiree eligible for a government payment for the 80% employer share of premium as an individual who: 1) is at least 55, but less than 65 years of age; 2) is not employed on a full time basis; 3) would be eligible (under section 226(a) of the Social Security Act) for hospital insurance benefits under Part A if the individual were 65 years of age based solely on the employment of the individual; and 4) is not a Medicare eligible individual. Employers who currently provide a retiree health benefits package must pay the 20% family share of the premium for their former workers.

What kind of price tag does the Administration place on this early retirement subsidy and what will be the source of financing?

ANSWER

The early retirement benefits are now estimated to cost approximately \$12 billion over the 1995-2000 period. All non-workers, regardless of age, are eligible for subsidies on the eighty percent (or employer) share if their non-wage income is less than or equal to 250 percent of poverty. The \$12 billion dollars noted here reflects the extra cost of subsidizing early-retirees beyond the regular subsidy to non-working families. In addition, government subsidies are offset somewhat by individuals aged 55-64 who work part-time or who have employed spouses. For example, a 58 year old man who is working half time will have fifty percent of the employer share paid by his employer and fifty percent by the government. No government subsidy is necessary when a retiree has a full-time working spouse. These factors combine to limit the costs to the government of this provision.

14

Will employers who currently have an obligation to pay for early retirees health coverage be excused of this obligation under the President's plan? If so, please provide year by year estimates of current employer obligation and the reduced obligations under the President's plan.

Answer

We do not yet have an industry-by-industry estimate of who will receive the \$12 billion in fiscal relief. This would require detailed information, not currently available, on current retirees health provisions in each industry.

#19 My concern relates to the basis on which employers will have to pay into regional health alliances. My understanding is that employer premium costs will be determined solely by the bidding process and by the structure of the alliance their employees are assigned to -- rather than the health care choices of their employees. There seems to be numerous factors establishing the "weighted average premium" of which employers may pay 80%. Some of these factors in the 1342 page document include: the demographics of the alliance, the "uniform per capita conversion factor", "reinsurance methodology", "premium class factors", "risk-adjustment factors", AFDC, SSI, administrative costs, penalty adjustments for exceeding the premium target, and so forth.

Could you please explain what role these factors have in establishing a small employer's contribution?

Answer

The employer premium costs will be determined by the bidding process between the health plan and the regional alliance. The bidding process is something that health plans (groups of doctors and insurance companies) must negotiate with their regional alliance. Employees are not "assigned" but will join the regional alliance closest to where they live and choose the health plan they would like to join. The various factors: demographics; "uniform per capita conversion factor;" reinsurance methodology; premium class factors; risk-adjustment factors; administrative costs; etc. all will factor into the health insurance premium costs within regional alliances.

Since these factors are not specific to each employer's workforce, on what basis would you agree or disagree that this employer mandate is anything other than a tax set by each alliance?

Answer

JAN 21 '94 18:24 SBA CONGRESSIONAL AFF.

P.16/16

15

The employer mandate is not a tax. The 1967 Report to the President's Commission on Budget Concepts clearly states what a tax is and is not. According to the Commission, an item is not a tax if it has a price that is used by the consumer to purchase a service. As an example, mandatory auto insurance is not considered a tax because the individual is paying for goods and services received.

In what respect do you think that regional alliances build on the present employer-based system?

ANSWER

The President's system of regional alliances builds upon the current employer-based system, but is superior because it puts the choice of health care plans where it should be -- with the consumer. The regional alliance system gives individuals information, and empowers them, unencumbered by employer limits on the number or type of plan they select, to make decisions about their health coverage.

OUTLINE OF TESTIMONY

BY

ARTHUR S. FLEMMING

Former Secretary of Health, Education and Welfare

BEFORE THE

SENATE COMMITTEE ON FINANCE

September 14, 1993

I. Introduction

- A. I am honored by the opportunity to appear before the Committee on Finance to discuss Senator Moynahan's proposal to make the Social Security Administration a separate agency.
- B. First of all, I would like to express my deep appreciation for the creative leadership which Senator Moynihan has provided the Social Security system.
 - 1. He has shown his deep interest in improving the system.
 - 2. In doing so, however, he has always demonstrated that his primary interest is in the individual--how he can help him in his journey through this life.
 - 3. I would like to apply his test by asking: Would his proposal make it possible for the national community do a better job in helping the individual deal with some of the hazards and vicissitudes of life?

II. Body

- A. The Save Our Security coalition (SOS) which I represent today, has been led in their consideration of this issue, by two men who were closely associated with the development and implementation of the system.
- B. I refer first of all to the late Wilbur Cohen who founded SOS in 1979. In testimony on behalf of SOS on July 30, 1984 he said:

"We believe the policy and administration of the agency should be under a Board. This was the majority view of the National Commission on Social Security (1981) on which Robert J. Myers and I served. It was the view also of a substantial number of the members of the National Commission on Social Security Reform (1983).

"I was the Technical Advisor to the Social Security Board for the entire duration of its existence (1935-1946) and subsequently Technical Advisor to three Commissioners of Social Security (1946-1955). Then as Assistant Secretary, Under Secretary and Secretary for eight years (1961-1969). During this time, I worked closely with two Commissioners.

"Thus, I had nearly thirty years of close working association with several different organizational structures in Social Security. From my experience, I strongly favor removing SSA from HHS and restoring it to the independent status of a Board as it was from 1935-1946. It worked well then and I believe would work even better now."

2. It would be difficult for me to over-emphasize the support for his position that Secretary Cohen received from the members of SOS.
3. In my judgment the events of the late 80s would simply reinforce his conviction that a three-member independent board "would work even better now."

C. In the second place I refer to the testimony of former Commissioner Robert Ball.

1. In testimony before the Subcommittee on Social Security and Family policy of the Finance Committee he said:

"I was Commissioner of Social Security from 1962 to 1973. Prior to my appointment by President Kennedy I was a civil service employee of the Social Security Administration for some twenty years. Since leaving the government in 1973, I have continued to write and speak about Social Security and related programs.

"I am testifying today as the Chair of the Independent Agency and Administration Committee of the Save Our Security (SOS) Coalition.

"SOS believes it would add significantly to public understanding of the trustee character of Social Security as a retirement and group insurance plan if the program were administered by a Board directly under the President.xxx

"Just about every American has a major stake in protecting the long-term commitments of the Social Security program from fluctuations in politics and policy. The administration of Social Security by a separate Board would strengthen public confidence in the security of the long-run commitments of the program and in the freedom of the administrative operations from short-run political influence. It would give emphasis to the fact that in this program the government is acting as trustee for those who have built up rights under the system."

D. Why did the late Wilbur Cohen and Robert Ball state, and re-state before the appropriate committees of the Senate and House of Representatives that Social Security should be handled by a bi-partisan independent board?

1. They saw Social Security as the greatest contributor to the prevention of poverty that has been made by any program in world history.
2. They lost confidence in the arrangement for the leadership of Social Security because they saw that the leadership could not prevent the infiltration of a belief that you could promise the people of this country certain benefits and then tell them you could not provide those benefits promptly because of lack of money.
3. They saw the system, under the leadership provided by present law, sharply deteriorate.
4. They saw that leadership in the 1980s unable to prevent an arbitrary and capricious downsizing of the Social Security Administration from 80,000 to 63,000.
5. They saw the leadership of the 80s unable to deal with a growing backlog of disability cases which the budget says will reach 1,320,000 by the end of 1994.
 - a. This means that persons who file an application for disability will wait an average of 7 or 8 months before they get a reply.
 - b. Persons who file an appeal will wait for an average of two years for action.

E. Here is the testimony of the two leaders who actually devoted the best years of their lives to the Social Security system:

1. Wilbur Cohen's:

"I sincerely believe that if there had been a Board administering the disability provisions of the Social Security program in 1981, we would not have had the unfortunate recent experience with the administration of the disability program. With a bi-partisan Board, there very likely would have been a "whistle blower" on the Board who would have prevented or moderated the precipitate and uncompassionate implementation of the 1980 amendments.

"Moreover, I also believe a Board would never have unanimously opposed the House-passed disability amendments in the Senate this year. Nor in my opinion would a Board have defied the Courts as has the present Department and Administration.

2. Robert Ball's:

"It seems unlikely that under a Board form of organization we would have had the major shifts in the administration of the disability program that has characterized the last several years. A Board with a minority member would have been unlikely to remove hundreds of thousands of people from the disability rolls and later restore benefits to a large percentage of them through the appeals process. Nor would a Board have adopted a policy stance that caused many Governors under contract with Social Security to refuse to carry out Social Security's directions. And a Board would have been unlikely to pursue a course overturned by the courts in literally hundreds of cases.

"I believe, too, a bi-partisan Board would have looked at some of the less visible operations of Social Security--the selection of representative payees and an accounting of their trusteeship, the reinvestigation of disability recipients diaried for possible recovery, post-entitlement work generally and the administration of the Supplemental Security Insurance program, including the vigor of the outreach program.

F. Personally, I would like to see the law worded so that a President would be encouraged to include the Chair of the Social Security Board as a member of his Cabinet.

1. I would like to see the chairmanship of the Board serve a term which parallels the term of the President.

2. I would like the Chair to be a person of outstanding qualifications.

- a. Such a person could assist the President and the Cabinet in their discussion of major Social Security policies.

- b. Such a person could also assist the President as a general adviser.

III. Conclusion

A. I have concluded that when dealing with a people's program—and certainly Social Security is a people's program—it is imperative to keep the authority to act as close to the grass roots as possible.

1. It is only as we do so that the field official will be able to meet promptly the individual's need.

2. We should not, by layering, create a situation where action to meet human need is delayed indefinitely while clearances are obtained from a higher authority.

B. I was a member of President Eisenhower's committee on government organization for eight years--the other two members were Nelson Rockefeller and Milton Eisenhower. Don Price became a member when Nelson Rockefeller became Governor of New York.

1. I was given the responsibility of representing the committee in developing a reorganization plan for creating what became the Department of Health, Education and Welfare.
 2. We made a mistake. Instead of providing for layering above the Social Security agency we should have recommended that Social Security be established as a department with a mandate to delegate authority to act, whenever possible, to the field official who comes in contact with the needs of a member of the system.
 3. By the same token Congress makes a mistake of layering when it requires departments to clear all kinds of administrative action with the Office of Management and Budget, or some other central agencies.
- C. We create layers above the point where the Federal official comes into contact with human need in order to prevent mistakes.
1. Yes, mistakes will be made.
 2. Often times the regulations we promulgate calling for review at higher levels cost far more in dollars and cents and certainly far more in the morale of federal employees at the grass roots.
- D. Finally, Mr. Chairman, I know that your bill calls for a single administrator.
1. Social Security is for all the people.
 2. I feel that when the Republicans are in power it is wise to provide a Democratic voice, and likewise when the Democrats are in power it is wise to provide for a Republican voice.
 3. As a Republican I ask that you give this careful consideration.