THE RISING COST OF HEALTH CARE: HOW ARE EMPLOYERS AND EMPLOYEES RESPONDING?

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

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HEARING ON THE RISING COST OF HEALTH CARE:

HOW ARE EMPLOYERS AND EMPLOYEES RESPONDING?

Tuesday, June 18, 2002

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

U.S. House of Representatives

Washington, D.C.

The Subcommittee met, pursuant to notice, at 11:30 a.m. in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives DeMint, McKeon, Tiberi, Wilson, Andrews, Kildee, Rivers, McCarthy, and Tierney.

Staff Present: Kristin Fitzgerald, Professional Staff Member; David Connolly, Professional Staff Member; Dave Thomas, Legislative Assistant; Ed Gilroy, Director of Workforce Policy; Christine Roth, Professional Staff Member; Kevin Smith, Senior Communications Counselor; Patrick Lyden, Professional Staff Member; Deborah Samantar, Committee Clerk/Intern Coordinator.

Mark Zuckerman, Minority General Counsel; Michele Varnhagen, Minority Labor Counsel/Coordinator; Camille Donald, Minority Counsel, Employer-Employee Relations; and, Dan Rawlins, Minority Staff Assistant/Labor.

Chairman Johnson. Good morning. A quorum being present, the Subcommittee on Employer-Employee Relations will come to order.

I appreciate you being here. Today the Subcommittee is going to hear testimony on the factors that contribute to rapidly increasing health care costs, as well as responses from employers and employees. I am eager to get to our witnesses today, so I am going to limit the opening statements to the Chairman and Ranking Minority Member of the Subcommittee. If other Members have statements, they will be included in the record.

With that, I ask unanimous consent for the hearing record to remain open 14 days to allow member statements and other extraneous material referenced during the hearing to be submitted in the official hearing record. Hearing no objection, so ordered.

Good morning again and I extend a warm welcome to all of you, as well as to Mr. Andrews and my other colleague, Mr. Wilson. I also want to thank everyone for being so flexible and understanding about the time change for today's hearing. I appreciate you responding.

I would also like to apologize in advance, for I may have to leave this Committee hearing. Ways and Means, my other Committee, is holding a Mark-up to make prescription drugs less expensive. After I leave, I will hand the gavel to Vice Chairman Jim DeMint. Thank you for understanding.

OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Today's hearing is going to focus on rising health care costs, and employer and employee responses. This is our first hearing on the critical issue of rising health care costs, and though the committee has heard about the rising cost of retiree health care, we have yet to hear about the growing cost that all employees face.

Last year, employers' cost for health care benefits increased an average of 13 percent. This alarming trend is expected to continue for some time, and the increases will or could be larger. For example, the California Public Employees Retirement System, also known as CALPERS, recently announced a 25 percent increase in health care premiums for the next year.

This hearing is designed to answer two questions: One, why are costs increasing so dramatically, and, two, what do the increases mean for employers and employees, and how will they respond.

We will hear testimony regarding various reasons behind big dollar increases for health insurance. As you may know, a study in the next edition of *Health Affairs* details issues facing employers looking to increase cost sharing or reduce benefits because of rising health care costs. Experts will tell us today about rising prescription drug costs, higher costs for doctors and

hospitals, and the costs that malpractice lawsuits and other litigation bring to the system. Knowing this, we want to strike while the iron is hot.

Another factor that many states are focusing on is how state mandates contribute to increased costs. Governors and legislators in many states are starting to require cost reviews of mandates before enacting new legislation. When these reviews are unsuccessful in stopping harmful new mandates, some governors are vetoing them, as Maine Governor Angus King did with an overreaching and burdensome expanded mental health parity law.

Another critical factor of rising health care costs is patients themselves. Because patients are usually only responsible for a fraction of their care, they are more likely to demand the latest Cadillac treatment or prescription.

How do employers and employees respond to these increasing costs? The first line of defense for many employers has been to increase co-payments to share the growing burden and ensure that employees are fiscally aware. Some employers also have shifted dollars from fringe coverage, such as dental or vision coverage, to medical and surgical care to ensure that needs are met.

We will also hear testimony about some innovative responses by employers. These employers are making changes in their health plans to give their employees the tools they need to make good decisions about their own medical care. While some of these innovative changes help employers reduce costs, they also empower employees with more control over health care dollars to help them meet their specific needs.

As I have said many times before, employers voluntarily provide health care for workers. Unfortunately, as health plan costs make up a greater and greater share of company resources, many employers are being forced to reevaluate the size of their health benefit packages.

Employers, especially those who own small businesses, are more likely to see dramatic increases. They are concerned about issues such as the Patients' Bill of Rights or coverage mandates, like mental health parity. Especially in this time of high health care inflation, many employers fear that additional cost spikes may force them to drop health care altogether. With that in mind, later we will hear testimony about the problem of the uninsured. We will also hear about solutions that will provide access to health care coverage for those without health insurance.

Health care costs are a serious issue. Private employers provide access to health care for 128 million Americans, and the health of this employer-based system could be in jeopardy. It is extremely important that we understand why costs are rising, and I look forward to working with my colleagues on the Subcommittee as we examine the issue.

OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Chairman Johnson. Right now, I would like to ask Mr. Andrews if he has an opening statement. Sir?

Mr. Andrews. Thank you, Mr. Chairman. I also appreciate the flexibility of the witnesses in rescheduling the hearing, and we appreciate your efforts to be here, and I very much look forward to hearing what you have to say.

OPENING STATEMENT OF RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

I'm glad that this hearing is taking place out of the arena of partisan conflict, because I think this is an analytical problem, not a partisan one. Solutions may well lead to partisan differences, but the purpose of this hearing is to state the problem so that we can all begin to understand it.

I have heard about the problem of exploding health care premiums from employers and individuals throughout my state and my district. Commonly, small employers are coming to my office and telling me they are experiencing 20 to 30 percent increases in premiums. Large employers are experiencing increases which are less severe than that, but still double digits in an environment where general inflation is barely measurable, 1 or 2 percent.

Obviously, I have a very large share of that uninsured group that is mentioned in several of the statements in my District. Probably one out of every six adults in my District does not have health insurance, and this cost spiral makes the problem of providing those families with health insurance that much more difficult and that much more expensive.

I also find that what is interesting about this topic is that health insurance is such an anomaly in the American insurance market. In many other areas of insurance, the real cost of insurance has gone down in the last couple of decades. Most of my constituents are paying less for homeowner's and property and casualty insurance than they were 15 or 20 years ago in real dollar terms. Although it is not true in New Jersey, where auto insurance is a perennial source of great explosiveness, it is true throughout the country that auto insurance rates have moderated in many cases, and there has been success in that area. Health insurance really stands out as an anomaly in an otherwise functioning insurance market.

One of the things I'm interested in hearing about from the panelists today is what the shape and structure of that market is. I'm inclined to think that one of our root problems is that we do not have a national insurance market. Because of the way we have set up the regulation of health insurance, we, in effect, have 51 balkanized markets around the country. As a point of departure I think we should take a look at whether the absence of a seamless and powerful national market, as we have in many other areas, is one of the contributing causes to this very difficult problem that we are all facing.

So I am very appreciative of the quality of the panel that has been put together. I want the panelists to know that the relatively small attendance from the Members is in no way an expression of disinterest. Congress is sort of working a two-and-a-half day week lately, and everything gets crammed into a few precious hours, but we are very interested in what you have to say and very grateful that you are here to provide us with your testimony this morning.

Chairman Johnson. Thank you, Mr. Andrews. You are absolutely correct, and I appreciate the camaraderie with which we are approaching this hearing. This is an important issue, and he is right that there is a lot of business going on in the House right now that everybody is tied up with, and that's why you are seeing a smaller number of Members today.

We have two panels of witnesses, and I will begin by introducing the first panel. Our first witness is Dr. Paul Ginsburg. Dr. Ginsburg is President of the Center for Studying Health System Change (HSC). Our next witness will be Dr. Henry Simmons. He is President of the National Coalition on Health Care. And our last witness is Ms. Catherine Longley who is the Commissioner of Professional and Financial Regulation for the state of Maine.

Before the witnesses begin their testimony, I would like to remind Members we will be asking questions after the complete panel has testified. In addition, Committee Rule 2 imposes a five-minute limit on all questions, and we would like to impose the same limit on your testimony.

With that, I thank you all for being here. Dr. Ginsburg, you may begin your testimony.

STATEMENT OF DR. PAUL GINSBURG, PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (HSC), WASHINGTON, D.C.

Thank you, Mr. Chairman and Members of the Subcommittee, for inviting me to testify. The Center for Studying Health System Change is an independent, non-partisan policy research organization, funded solely by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. Although we seek to inform policy with timely and objective analyses, we do not lobby or advocate for any particular policy position.

Although the most reliable studies of employers' 2002 premium increases have not yet been released, the increase is likely to be in the area of 13 percent, up from 11 percent for 2001. This figure probably understates the size of the increase because it does not reflect the increases in patient cost-sharing employers incorporated into their benefit plans in 2002. These double-digit increases come at a time when corporate profits are down and the average hourly wage rates are rising by only 4 percent. You can see the magnitude of the problems this creates for both employers and employees.

Insurance premium trends often diverge from trends in what insurers actually pay out in benefits, what I refer to as “underlying costs.” For example, in 2001, premiums for employment-based coverage increased by 11 percent, while the underlying costs or spending on care increased

by only 8.7 percent. However, five years ago, the reverse was the case, with premium increases trending below the underlying costs.

Economists refer to this as the "health insurance underwriting cycle." This divergence offers a prospect for some limited relief in the short run. The trend in underlying costs, not as high as the trend in premiums, means that over time premium trends will get closer to the trends in costs.

Turning to the major component of health care costs, increases in hospital costs have replaced prescription drugs as the most important driver of overall cost growth, only because a much higher share of health spending is for hospital care. Prescription drugs are still the most rapidly increasing component. In 2001, per capita in-patient hospital spending increased by 5.6 percent, an enormous turnabout from the 5.3 percent spending decrease in 1997.

This turnabout reflects both higher prices for hospital care and higher utilization of hospital services. Of the 9.5 percent increase for all hospital spending in 2001, 38 percent is due to higher prices for care and 62 percent is due to higher utilization of services. The service use component has been growing particularly rapidly in recent years. The use of physician services is also increasing, but physician price trends have been level.

Important drivers of health care costs at this time include advances in technology, increases in per capita income, the retreat from tightly managed care, provider consolidation and shortages of nurses and other skilled personnel. In my oral remarks, I will focus on the retreat from tightly managed care.

HSC's site visit research has documented a pronounced trend away from tightly managed care. Health plans have dropped authorization requirements for hospital admissions, referrals to specialists, and the use of expensive diagnostic procedures. Many patients can now see a specialist without first going to a primary care physician.

Provider networks are now much broader, giving enrollees a much wider choice of hospitals and physicians. Plans are less likely to contract with providers on a capitated basis, a method that gives providers incentives to economize on service use. Although some of these changes came from mandates, much of it happened in response to demands by employers and consumers for a less restrictive insurance product.

Fees changes have added to costs. Many believe that the aging of the American population is an important driver of health care costs. We have been analyzing this and find that while a driver, aging is a relatively small one. Preliminary estimates suggest that at this time, aging of the working age or under 65 population contributes about seven-tenths of a percentage point to the cost trend. Viewed in relation to the 2001 cost increase of almost 9 percent, aging is a relatively small driver.

While I have reviewed many of the drivers contributing to the largest jump in health care costs in a decade, I want to close by touching on a core factor that is behind much of this. In the United States, our culture emphasizes that people should get all beneficial medical care regardless of cost. This works against attempts to discourage the development of treatments in which the

benefits are uncertain or known to be small. Until the public becomes more aware of the cost-quality tradeoffs, rising health care costs will continue to strain the resources of government purchasers, employers, and consumers.

STATEMENT OF DR. PAUL GINSBURG, PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (HSC), WASHINGTON, D.C. – SEE APPENDIX B

Chairman Johnson. Thank you, Dr. Ginsburg. We appreciate your testimony.

Dr. Simmons, you may begin.

STATEMENT OF DR. HENRY SIMMONS, PRESIDENT, NATIONAL COALITION ON HEALTH CARE, WASHINGTON, D.C.

Mr. Chairman and Members of the Subcommittee, I am Dr. Henry Simmons, the President of the nation's largest and most broadly representative alliance, the National Coalition on Health Care. The coalition was founded a decade ago, is non-profit, and is rigorously non-partisan. Our honorary Co-chairs are former Presidents Bush, Carter, and Ford, and our working Co-chairs are former Iowa Republican Governor Bob Ray and former Democratic Congressman Paul Rogers, who, for a decade, chaired the Health Subcommittee of the Energy and Commerce Committee. Our members include major corporations, the nation's largest consumer, provider, religious and labor groups, and very interestingly, the nation's largest health and pension funds, including CALPERS. Collectively, these members represent or employ over a hundred million Americans. The American Cancer Society is our newest member.

As you have already heard, national health care spending is rising very rapidly and this year will exceed $1.54 trillion, and is scheduled to double by the turn of the decade. Our per capita costs are far higher than any other developed nations in the world, and our health outcomes are no better.

The premiums that employers, employees, and individuals pay for health care are rising today at the fastest rate in our history. Those huge increases are coming at a time of low general inflation. The question is why is this so? Why should you and employers and the public be concerned? Before answering that question, I, again, want to briefly review the major causes of rising costs.

There are two major forces at work. There are old forces and there are new forces. Together, they have come together to create what we have termed “A perfect storm” in health care.

The first set of traditional drivers include an aging population, increasing intensity of care, and one which has been mentioned, poor quality, waste, inefficiency, and a structurally flawed system, which experts have suggested are currently wasting $500 billion every year and harming

unnecessarily millions of our fellow Americans.

Now, to those sets of forces, including high administrative costs, and state mandates, have been added a new set of forces, or emerging cost drivers, which include the underwriting cycle that Dr. Ginsburg talked about, pressure from Wall Street on for-profit health plans to increase profits, drug cost and utilization escalation, diminished competition in the system, 77 million baby boomers, medical malpractice increases, and international terrorism.

In answer to your question as to how employers and employees are responding to this, the answer is very poorly. In fact, in our judgment, after many years of work in the absence of major national policy changes and system restructuring as Secretary Thompson called for recently, we believe they will be unable to deal with this problem, nor will you. And certainly all our members have unanimously come to that conclusion.

Why should Congress, employers, and the public be concerned? Five reasons:

First, we have not one, but three serious interrelated systemic problems - rising costs, decreasing coverage, and pervasive, destructive, and extremely expensive quality problems. To successfully deal with any one of those problems, you must deal with them all. Whatever employers and private sector payers, including our members, have been doing to this point to control costs is not working and will not work, in our judgment.

Second, what is especially worrisome is that we are seeing these startling increases at a time of low general inflation and even though major employers have become very sophisticated and concerned about their costs, premiums for even the largest and smartest employers are out of control. Costs for small business and individuals are rising even more rapidly, as Congressman Andrews said.

Third, increasing health care costs for employers and sharply rising premiums are going to dramatically increase the number of Americans without insurance.

Fourth, the new wave of ostensible cost containment tactics that employers are edging towards, such as increased cost-sharing and defined contributions are, in fact, ways to shift costs not contain them.

And last, all these problems are growing worse and after much reflection, we have concluded that present policies and procedures, including those being debated on this Hill today, will not be powerful enough to enable employers, employees, or the American people to address those problems.

So in summary, we believe that we will need a major new public policy initiative to respond to the issue of surging health insurance premiums. Our members are working to encourage a renewed national debate about these far-flung issues facing our system and about the options for system-wide reforms that will be necessary to contain costs, achieve universal coverage, and improve the quality of care, while assuring equitable and sustainable financing, and simplifying the

most non-user-friendly, complex system on the face of the earth.

We sincerely commend the Subcommittee for beginning this dialogue on an issue that has received so little attention to this point.

STATEMENT OF DR. HENRY SIMMONS, PRESIDENT, NATIONAL COALITION ON HEALTH CARE, WASHINGTON, D.C. – SEE APPENDIX C

Chairman Johnson. Thank you, sir. I hope you are not correct that we can't fix the problem either here or with the appropriate structure.

Dr. Simmons. I think we can, just not with the tools we have been using.

Chairman Johnson. Thank you for your testimony, Dr. Simmons.

Commissioner Longley, you may begin your testimony now.

STATEMENT OF S. CATHERINE LONGLEY, COMMISSIONER, PROFESSIONAL AND FINANCIAL REGULATION, STATE OF MAINE, AGUSTA, ME

Thank you, Chairman Johnson, Congressman Andrews, and Members of the Subcommittee. I am pleased to be here today to give you information I hope you will find helpful from one state's experience and perspective on the private health insurance market. In Maine, as in other states, we are facing a health care cost crisis. Let me put in context where Maine stands.

We spend about $5 billion a year on health care, or $3,900 per capita a year. We spend about 14 percent of our gross state product on health care, and in a recent study, we were ranked third highest among all states in health care spending. Between 1990 and 1998, our medical inflation increased 80.4 percent compared to 53.3 percent nationally.

Now, several factors exacerbate our situation. First, geographically we are a relatively large and rural state. We have a small population of 1.2 million people. We are ranked fourth among states as having the oldest population. We have a high level of chronic disease and we have a lack of competition among health care providers and insurance carriers.

We thought it might be helpful to explain our private health insurance market to you. We have about 22,000 people who are covered by individual health insurance, which is insurance that is not covered by employers. We are now experiencing a “death spiral” and that, in insurance terms, means that the pool of insureds is getting smaller and smaller, because those that are staying in are the sickest, therefore, the most costly. Therefore, premiums go up. Right now, those

premiums are approaching absolute unaffordability. In my handouts, tab two, page nine, you will see that an HMO policy for a family of four can now cost upwards of $2,000 a month, or over $24,000 a year. We expect, without some reversal in policy, that that market might be eliminated. We would have no individual health insurance market in approximately five years.

The cost issues are not unique to our individual market. We face these same cost pressures in our small group market, and the difficult choice for employers is do you continue coverage, do you purchase higher deductibles, do you shift more costs to the employee, or as someone said, since it's a voluntary market, do you drop coverage altogether? Our highest selling policies in the state of Maine are the $5,000 high deductible policies. While it's easy to look at insurance premiums and realize they are too high, the more difficult question is why, and we commend the Committee today for focusing on costs.

I'll just take a minute to share with you a few examples of what we are doing in Maine.

As discussed, Maine has 24 insurance mandates. A mandate is required coverage for any insurer selling a state-insured plan. We have a process to review mandates with our legislature. Health insurance mandates are tricky. First, they differ on a state-by-state basis. Second, they don't apply to everyone. They don't apply to ERISA-exempt plans. And to show you what has happened in Maine, we have had a mental health parity mandate since 1995, and we are proud of it. It's a progressive mandate that covers seven biologically based diseases.

But since that time, we have grown more concerned about costs, and this year a bill was introduced which would have substantially expanded that mandate to cover over 40 additional mental health disorders. Although well-intentioned and certainly a laudable proposal, Governor King did veto that legislation and in his veto message, which is in your materials, he stated that when you are in a hole, the first rule is not to dig any deeper.

One of the things we're trying to do to get a handle on costs is to have better quantitative information on our state's underlying costs. In that respect, we have formed a performance council, funded initially by Robert Wood Johnson. The underlying goal of the group is to formulate tangible and objective measures of our health care system in Maine. There's a lot of national data, but what we seem to be lacking is knowledge about what the cost drivers in the state are and why. Some of the measures we are exploring are how we compare to other states in terms of insurance premiums, and numbers of hospitals.

Finally, let me speak about consumer education. We believe that in an era of higher deductible policies with citizens paying more out of pocket, consumer education is extremely critical. To that end, we have recently published a brochure, which is in your materials under tab three that describes much of how our health care system is paid for, and how hospitals, doctors and other providers are broken down. It's a primer on cost pressures created by cost shifting, utilization and other issues, and with it we hope to encourage people to become better-informed consumers.

Let me wrap up here. Our present focus is to better understand why health care costs and corresponding insurance costs are increasing so dramatically. I would end by saying it is important in any health care debate not only to focus on who pays, but also to scrutinize the underlying costs

and the components of such costs. States can't solve the crisis alone and individuals and the Federal Government must assist.

I am happy to answer any questions. Thank you.

STATEMENT OF S. CATHERINE LONGLEY, COMMISSIONER, PROFESSIONAL AND FINANCIAL REGULATION, STATE OF MAINE, AGUSTA, ME - SEE APPENDIX D

Chairman Johnson. Thank you, Commissioner. We appreciate your testimony. We'll begin the question session.

You talk about looking for ways to address rising costs. Everybody talks about rising costs. But how do we address them? You also say that states alone cannot solve the crisis. Individual citizens and the Federal Government must assist. What do you mean by that?

Commissioner Longley. In answer to the first question as to what is driving costs, it is the work of our Health Care Performance Council, to see where we may be outliers in terms of our delivery system and where we stack up against other states and other regions. We're looking, for instance, at our prescription drug premiums compared to other states.

I think another reason why we are a high cost state is our Medicare reimbursement levels. That is an area our hospitals have been actively looking at. I think we tend to rank pretty low on the totem pole. We were 49th out of 50 but after the Balanced Budget Amendment, we are now more towards the middle of the pack.

With regard to your second question about individuals and the Federal Government, I think there is a fundamental disconnect between consumers and their health care. The way our health insurance system is set up, the individual doesn't always know what something costs or doesn't have any incentive to know what something costs. So with respect to solutions, we would hope that policy goals would be tied to incentives, so that we don't have over utilization and so there is some cognizance or recognition by the consumer of where his or her health care dollar is being spent.

I think Representative Andrews mentioned before that the health insurance market is really quite different than other areas of insurance, because you have first dollar coverage. But the third party payment mechanism disconnects the consumer or the patient oftentimes from the cost implications.

Dr. Simmons. Mr. Chairman, could I also answer your question as to how we would contain costs?

Chairman Johnson. Go ahead.

Dr. Simmons. Two observations. First of all, this is a task that is doable, but not with any of the partial patches that we've been trying to use for the past 45 years, and there is no one approach that would do it. When you have a systemic problem that has interrelations among it, you have to fix

all the problems. If you just patch one, your problem just shifts elsewhere. If Medicare takes care of its problem, it shifts to the private sector, to the employers, to the employees, to the American people. So we need a systemic approach, because we have a systemic problem.

Now, what are the main elements of that? Secretary Thompson in his speech at Chicago Medical School just last week hit on one of them very hard. He said the way we deliver care in this country today approaches the point of being archaic. He said our system doesn't have as good quality controls as does a grocery store. That's a very serious problem. Part of the solution of controlling costs has to be restructuring our health care system. It's not bad health care professionals. We health professionals are working in a very flawed system that's got to be addressed as part of the cost containment problem.

Another major way to do it would be to work very hard on the quality problem. When Secretary O'Neill of the Treasury testified before a Senate committee and was asked how much waste he thinks we have in the system, he, having studied the health care system extremely well, judged that probably 30 to 50 percent of our entire $1.5 trillion dollar budget is wasted every year because of our lack of attention to quality.

We will never contain costs unless we get serious about the quality problem. And do you know what emphasis the Congress has put on the quality issue to this point? Virtually zero. We are spending $1.5 trillion dollars as a society. We put virtually zero into improving its quality. That's not very good public policy.

So in our judgment, there are four things that the nation would have to achieve to solve these interrelated problems. We must achieve universal coverage. We must institute a major national quality improvement program. We must put in a system that contains costs for the entire system and stops the national shell game of cost shifting, which is not working for anybody. Finally, we obviously need a fairer, more equitable and sustainable mechanism for financing the system, because many employers right now are not playing on a level field which they cannot long sustain. They will drop out and the death spiral of the employment-based system will grow larger.

Chairman Johnson. Dr. Ginsburg?

Dr. Ginsburg. Let me add to what has been said. I think a very key element in containing costs is that we need to inform consumers and physicians about what care costs and what the benefits of care are. I think it is the latter area that government can contribute a lot more information about regarding which new technologies work, where the benefits are small, and where the benefits are large. Even though it can't be the cornerstone of it, unless consumers are more aware of what it costs to get different services and incentives to make trade-offs, we are not going to get very far.

Chairman Johnson. Don't you think it's hard to educate consumers, for example, about insurance and what they are getting with Medicare? Are you all having that problem in Maine?

Commissioner Longley. I think there is more interest now as we shift away from managed care to a higher deductible policy. We have an example of an individual whose daughter was scheduled for elective surgery and he was trying to compare costs and called four hospitals. Not one would give

him even a range of prices, because they're concerned about malpractice and complications.

So I think there is a growing concern. But I share your wonder at how much it will help. For instance, in our state employee health plan, which is the largest plan in the state, only 50 percent of state employees get their annual wellness exam, which doesn't cost anything except a co-pay. You can lead a horse to water. We really do believe that consumer education is important. Whether consumers take advantage of it I guess is the $64,000 dollar question.

Chairman Johnson. Your horses don't drink the water up there! Thank you. Those are good answers. I appreciate it.

Mr. Andrews, would you care to question?

Mr. Andrews. I would. I thank the panel for their testimony.

Dr. Simmons, I listened to your very articulate analysis of the systemic flaws in the system and I am reminded that nine years ago, another witness sat precisely where you are sitting and gave almost word for word the same assessment of the systemic failures.She is now the junior Senator from New York, Hillary Clinton, and she was pilloried and criticized for proposals that she made to fix the problem. I would submit that the analysis that she had of the problem is truer today than it was nine years ago. I, frankly, just heard it from you.

Commissioner Longley, I want to ask you a question. If I were a businessperson in Maine today and I wanted to buy health insurance for my employees and their families; let's say there were 75 of them. How many underwriters do I have to choose from to buy the coverage in Maine?

Commissioner Longley. Well, we have only four active insurance carriers in the state right now, and the largest of them is our Blue Cross plan, acquired by Anthem a couple of years ago. So there's not a lot of choice. We have some smaller companies, but predominantly four companies.

Mr. Andrews. Do you know, and you can supplement the record, if you need to, how much of the market share the two top insurers of those four have? What percentage of the coverage do they have?

Commissioner Longley. I believe Anthem has about 50 percent of the market.

Mr. Andrews. The top two have 50 percent. In the metropolitan area I live in, in the Philadelphia metropolitan area, the most recent data I have seen suggests that the two leading underwriters have 83 percent of the covered lives, and I think that number is reflective.

If Horizon Blue Cross and Blue Shield of New Jersey or Kaiser Permanente, based in California, wanted to compete in the Maine market and sell health insurance, what would they have to do?

Commissioner Longley. Well, as with any state, you have to become an authorized insurer under state regulation. You have to meet capitalization and solvency standards that are fairly uniform

throughout the states through the National Association of Insurance Commissioners (NAIC).

Maine has that same model. One of the drawbacks in anyone coming, and we don't see a flurry of carriers coming into the state, is we don't have that many covered lives. So just from a population standpoint, we have about 600,000 insured people. It's not a huge market.

Mr. Andrews. When was the last time that someone of any size applied to get into the market?

Commissioner Longley. Not for a while. We had Tufts exit the market with their insolvency. We had Harvard exit the market. So we basically have Cigna, Aetna, and Anthem.

Mr. Andrews. What would your opinion be of a proposal to pass a Federal law that said here is a set of uniform national standards for fiduciary protection of financial resources and for protection of health care consumers? If you meet these standards, you can do business in Maine or California or Michigan or New Jersey or anywhere in the country you want to do business. What would you think about that proposal?

Commissioner Longley. Obviously, I would have to look at it, but I think the NAIC has formulated pretty seamless financial standards for carriers doing business in other states.

Mr. Andrews. But the difference is, of course, they would still require you to apply 51 separate times under 51 separate bureaucracies. What if you had to do it just once?

Dr. Simmons, what do you think of that idea?

Dr. Simmons. It would certainly be simpler than what currently goes on today.

Mr. Andrews. Dr. Ginsburg, what do you think?

Dr. Ginsburg. I would say that traditionally, insurers having to qualify in each state that they want to operate in has been a nuisance and costs something, but I don't think it has been a real barrier.

I believe it is more difficult today for insurers to enter new markets because of what is required to function as a managed care provider. One needs networks of providers, and one needs management techniques in place. So in a sense, there is probably somewhat less of a threat to entry from out of state for existing insurers.

Mr. Andrews. But wasn't the balkanization that I characterized also present before managed care took such a big piece of the market when it was fee for service? Wasn't the same pattern really in existence then?

Dr. Ginsburg. I think we had national insurers then, as we do today, and we have always had a combination of national insurers and Blue Cross/Blue Shield plans serving local or regional territory.

Mr. Andrews. Let me ask you one other quick question, because my time is up. You make reference to 2001, where premiums increased by 11 percent and spending on care increased by 8.7 percent, and you say that in some years, the opposite was true. Could you provide the Committee with some aggregate data on the increase in premiums and the increase in costs over a ten-year period?

Dr. Ginsburg. Yes. I do have a table and would be glad to supply it to the Committee.

Mr. Andrews. Could you tell us quickly what the increase in premiums to costs ratio would be for, say, a 10-year period?

Dr. Ginsburg. Sure. Actually, in the mid-1990s there was a time when premium increases were virtually down to zero. Cost trends were also very low, but they were running about 2 or 3 percent a year. What was happening then is that insurers were very profitable and they were very aggressive in getting into additional markets, and I don't know if it happened in Maine, but that was the time when insurers did get into new markets.

In a sense, they competed with each other, competed away their additional profits, and the underwriting cycle turned. In the last few years, we have witnessed insurers withdrawing from markets that they weren't doing very well in, raising their premiums to restore their profit margins, and willing to give up market share. This cycle will turn soon, although, of course, we don't know when.

Mr. Andrews. I appreciate that. And if you could supplement with the statistics, I'd appreciate that.

Dr. Ginsburg. Glad to do that.

Chairman Johnson. Thank you, Mr. Andrews.

Mr. DeMint, do you care to question?

Mr. DeMint. I think what we are hearing is a debate between universal, free care for everyone, or a different type of systemic change. You folks have done a good job talking about some of the symptoms of our problems and recognizing we need systemic change, and there are really two ways to go. It's either more towards free, universal care or more towards a free enterprise type market.

I, frankly, think we need to consider the fact that most health problems are caused by bad habits and poor behavior. This means that free or nearly free health care services are probably the major contributors to poor health and the high cost of health care in this country because people are more willing to treat the problem than to read the information, or develop the discipline to prevent the poor health.

We are not talking about insurance now. We are talking about pre-paid health care. We have danced around the fact that maybe consumers are insulated from the costs, but it really doesn't

make any difference how much information we give them about the costs if they don't have to care about how much it costs or if they don't have to care about preventing health problems.

I like the idea of looking at systemic changes, but if consumers and health care providers are not concerned about the costs to the consumer, it is going to be very difficult for us to centrally manage what we are talking about. That's cost containment and quality control. I've had the opportunity in my professional life to work in both of these fields. We talk about quality problems, Dr. Simmons, but continuous quality improvement, which has proven to work in so many other industries, cannot work in health care as long as there is a third party payer mechanism, where new technologies and new ways to do things can't be tried because they can't be paid for.

It is my belief that we do need to look at systemic changes, but also recognize that we have to have something that is more consumer directed, and that the one who is seeking health care has to care what it costs. The one who is providing it cares what it costs, and the one to whom it is provided has to have the flexibility and the ability to use technology and new protocols that continuously improve care. Now it can take two or three years to get approval from Medicare or even third party private payers for a new type of treatment protocol. We've got the system tied up with this third party concept. We are not looking at ways to systemically change the system that might move it towards a more accountable market.

Frankly, I expected to hear a little more about that. Through defined contribution plans we have employers looking at ways to help employees develop accounts that have money in them that can be used to shop for part of their health care. So that when they call hospitals and ask for prices, they can demand to know those prices. And while we need to continue to offer a safety net in insurance, I am frankly surprised to hear all of you talking more about symptoms. Although we have talked about the need for systemic changes, the dialogue has been more about universal health care, free health care, and things that are creating the problems that we are talking about. So I don't know who to address my questions to, but I would certainly like to hear more about innovation.

Dr. Simmons. I'd like to start, Mr. DeMint.

I don't think it's a matter of either/or. First of all, universal coverage does not imply a government-controlled system. It doesn't require central administration. You could have universal coverage without either of those things. And it's not whether you have a market or whether you don't have a market. Ideally, we should have as much competition in the system as we can, but if we are going to do that, then we've got to understand what is necessary to make a system competitive.

Now, if you read the original papers of the Jackson Hole group who hypothesized managed competition, and read the papers from the New England Journal of Medicine a decade ago, they very honestly pointed out that markets will not work in health care unless you have universal coverage. That is the necessary precursor, because otherwise insurers compete on risk selection. That's one thing. The second thing you need is competitive systems. We are moving exactly away from that with system consolidation. The third thing we need is good information for the buyer and the seller, neither of which is currently present. And the fourth thing you need is government

oversight. Markets don't work without that.

So I don't think it's a matter of should our system have market-based competition. We should, but we can't have it unless we recognize that we've got to put in some of the necessary prerequisites. I think that's the issue.

Mr. DeMint. Those are good points, but consumers aren't going to seek information unless they need it, and right now they don't need it. It's meaningless.

Universal coverage does not have to mean dollar insurance coverage or prepaid health care. We need to recognize that we can help people get access to health care and actually get better coverage for catastrophic events. We can help them get the resources to shop for health care, which would force the markets to come to them. That type of thing has happened in other markets, where years ago consumers couldn't buy computers. But once they started to, the markets came to them, and I think we can do that.

I just think in our dialogue, it's a matter of semantics. Universal coverage to some means free health care for everybody. To me, it means making sure that everyone has access to good health care, with the incentive to shop and to care about what it costs.

Dr. Ginsburg. Could I add something? Because health care is so expensive, everyone needs some type of insurance to have access to care they need.

Mr. DeMint. But part of the reason it's expensive is because people have insurance that covers it. You can see what has happened with laser surgery, where the costs started high and the consumers paid for it. Now they shop, there is advertising, the technology has improved, the setting has become more convenient, and the quality has gone up. I would at least like to interject that thought into this debate.

Dr. Ginsburg. Yes. I agree with that. The other point I wanted to make is that we, in a sense, are somewhat behind in providing various financial incentives to consumers to make good choices, and this is because of our experience with the managed care revolution.

When managed care became the norm, a lot of the cost sharing that we had in health insurance policies went away. Then we succeeded in loosening up managed care and we are just now starting to get back some of the cost sharing we had before, let alone thinking of new designs. And there is a lot going on with employer-based plans that put cost sharing into policies in ways that are productive. However, we have a long way to go.

Mr. DeMint. Thank you.

Chairman Johnson. The gentleman's time has expired.

We recognize the gentlelady from New York, Mrs. McCarthy.

Mrs. McCarthy. Thank you, Mr. Chairman. I have a couple questions.

I spent 30 years of my life as a nurse, so I think I have a different outlook than a lot of my colleagues. When I look at health care today, it has become extremely expensive. Take the example of laser eye surgery. It's performed and you're out within 25 minutes to an hour, depending on what you're having done, versus surgery 20 years ago when you spent three days in the hospital. So no one is looking at how much we are actually saving on the other end.

I am 58 years old. At 52 years old, they put me on Lipitol, not because of my health care needs. I eat well, but there was a hereditary factor. Hopefully Lipitol is going to prevent me from having heart attacks and strokes. No one is taking that into account, where 10 to 15 years ago someone who is 58 would end up having a heart attack or a stroke, and be placed in a nursing home. No one does a cost analysis on that. But I know that's another debate.

I happen to agree with you, Dr. Simmons, that we have to look at the whole system. If we fix one part this week, prescription drugs for example, that's not going to help the whole system. I'm curious about what you had said, though, when you talked about $500 billion in waste. Could you give me some examples of where you see waste?

Dr. Simmons. Sure. There are quite a few in fact. In 1970, I was Deputy Assistant Secretary for Health in the Nixon Administration and the Ford Administration. One of the first jobs handed to me was when Republican Senator Wallace Bennett passed the Professional Standards Review legislation, and we had to look at the quality of care in this country. As a physician, I thought it was excellent before I was really forced to look at it.

There are huge numbers of examples of waste. One is giving care that will not produce any known benefit. There is a tremendous amount of that in many different ways. The other is making mistakes which are very costly, can take your life, can certainly prolong your illness and can be very expensive to take care of.

In fact, the National Association of Chain Drug Stores is one of our members. They have shared a study done by the University of Arizona School of Pharmacy with us that shows that it costs more in this country to take care of the preventable side effects of prescription drugs than it costs to buy prescription drugs. It costs $171 billion to fix the errors and $150 billion to buy the drugs.

So there are hundreds of examples. There are some real heroes from my profession that have been virtually ignored in this country, pioneers like Dr. Don Berwick and Jack Winburg and Bob Brook, who have been telling us we have a serious problem that we have to address.

Mrs. McCarthy. I agree with that, especially in hospitals. Going back a number of years ago, it was quite hard to do but we as nurses had to know all our medications, know what the side effects were, and doctors would prescribe the medication.

Then we changed the system. What the doctors prescribed had to be okayed by the pharmacists, because there could be five doctors on a case all ordering medication, with no one

looking to see how one drug was interacting with other drugs. Of course it's easier today with computers. So we are slowly making strides in fixing that problem, but we can do a better job.

Obviously, I think mistakes are made. On the hospital floor we have less nurses because people aren't going into nursing. My sister, who was a nurse, just left the profession. She is now a school nurse, mainly, because on her day off she couldn't answer the phone because she knew darn well they were calling her to go in and work. You get tired. Nursing is a stressful job. We all love it. We went into it because we loved nursing. But you can't keep working 12-hour shifts without making a mistake. You can't.

Dr. Simmons. Congresswoman McCarthy, I know that you are a nurse and the sad thing is that we're at the point in this system where the overwhelming majority of nurses working in this country would not recommend that somebody use their hospital. Now, that's pretty sad. That's really troublesome. And what are we doing about it? Virtually zero.

Mrs. McCarthy. On Long Island we have started a magnet hospital. I'm going to see if we can experiment here and sponsor a bill where everyone is part of the quality of care in the hospital. Through the magnet hospitals that we have studied, we have seen the quality of care increase tremendously and we have also seen the nurses stay an average of eight years, because they have become part of the system. I think that was always the frustration with a nurse. They're with the patient the majority of the time, and yet they had absolutely no say in the quality of care. Now, I'm not taking this away from doctors, but a hospital is a team. If one part of that team isn't working together, the whole team falls apart. So I agree with you that we have to start looking differently at how we provide our health care, but in the end the bottom line is people should be involved.

I was just saying to my colleague, for all the years that I have paid for health care insurance, and I mean this sincerely, I think the first time I ever used it was when I was about 48 years old. I went to the HMO and I got a $10 physical. Now, the problem is my physical was totally different from my husband's, because I'm a woman. I didn't get an EKG, I didn't get a rectal exam, and I didn't get half the tests he did. But I had never used it. Most people, thank God, are healthy up to a certain point.

At 58, every time I go to the doctor's now, well, your blood pressure is a little bit higher. I say that's the job. I'm fine on weekends. But in all seriousness, we are facing different health care issues only because we are getting older. That's normal health care. The final three months of costs are probably the most expensive. We have to start looking at those issues.

But I agree with you, people misunderstand universal health care. It is not a free health care system. Everybody pays into it. I have insurance, but if I went into the hospital tomorrow, I would be paying an extra $450 just to walk through Admissions to help care for someone that doesn't have health care insurance. We're already paying for this.

Thank you.

Mr. DeMint [presiding]. Thank you.

Mr. Wilson?

Mr. Wilson. Thank you, Mr. DeMint.

Dr. Ginsburg, you mentioned that prescription drug prices have been the most rapidly growing component of health care costs since 1995. Why this increase in cost?

Dr. Ginsburg. I think there are a few key reasons. One is that a lot of new drugs have come out that are valuable, but they are expensive. Another thing that concerns many in the field is that the very extensive direct consumer advertising and actually large expenditures on marketing to physicians are probably driving spending up.

You know, marketing prescription drugs is a little different from marketing other goods and services in the economy, because you are convincing someone they want something, but a third party is going to pay for it. So it's a method that has been a particularly effective form of marketing, and that is one of the reasons why drug spending has been increasing so much.

Mr. Wilson. When you mention new drugs, obviously, people think of research and the cost of research. But has there been any study indicating price gouging or differentials that indicate an abuse of the economic power that a company may have?

Dr. Ginsburg. With prescription drugs, the patent system is very important and as an incentive to do research, we confer a patent. So in a sense, each drug over the patent period is a monopoly and they can charge whatever they want. It is very difficult to second guess whether the price is appropriate because of the fact that for each drug that comes to market successfully, a lot of research and development efforts on other drugs just does not pan out. A successful drug has to gain revenue not just to justify its R&D cost, but the R&D costs of drugs that didn't make it.

You know, one of the aspects of managed care is that people became a lot more extensively covered for prescription drugs. Initially, the out of pocket costs of prescription drugs for consumers fell. In fact, I should add that to the list. That has probably been another factor why drug spending has risen very rapidly since 1995.

Mr. Wilson. But what is the bottom line?

Dr. Simmons. Mr. Wilson, could I add an answer to your question? I had the privilege of spending three years as the Director of the Bureau of Drugs in the Food and Drug Administration. So I have some idea of the public safety hurdles that the Congress requires drugs to go through.

New drugs are always going to be expensive. It's not an inexpensive process and unless those research costs are borne among other nations, somebody bears them all. Maybe they should be more fairly shared, but that's another issue. But the one area where there could be very substantial improvements in the public interest, without sacrificing safety, is a more rapid availability of generic drugs, and I think that is an area where the Congress has a real opportunity to serve the American people. It is in no way a compromise to safety to provide these drugs, which are every bit as good and safe, to the American people at a substantially lower cost. However, there

are barriers to that now, as you know.

Mr. Wilson. Well, are there any efforts to reduce the barriers? Is there any legislation or regulation?

Dr. Simmons. Not that I know of, but I wouldn't pretend to know all those bills that might have been introduced here.

Dr. Ginsburg. Actually, there has been a lot of activity to re-think this. I guess it's called the Hatch-Waxman Act that sets up procedures for what happens when a patent expires and a drug becomes available for generic manufacturers. There's been a lot of concern about steps that drug companies can take that are just delaying tactics that put off for a couple of years a very valuable drug becoming available in generic form at a much lower price for patients.

Mr. Wilson. Also, Dr. Ginsburg, you indicated that there was a 38 percent increase in hospital spending in 2001 due to higher prices for care. Why are the hospital prices going up?

Dr. Ginsburg. Hospital prices are going up for two reasons. One is that hospitals are experiencing higher costs, and a very important driver is that hospitals have to raise wages substantially for nurses and other skilled personnel to deal with the shortage.

But another factor is that hospitals that have gained more leverage vis-à-vis managed care plans are able to charge higher prices and indeed increase their profit margins. A lot of this is due to the loosening of managed care as employers, not very cost-conscious, have responded to employees' complaints about choice and demanded broad networks. This has meant that managed care plans no longer have the ability to constrain hospitals by the threat of excluding them from a network.

Dr. Simmons. Congressman, I would like to add an answer to your question. One of the major reasons hospital costs are rising rapidly is the quality issue, and that concerns the technology war that is going on in institutions. If somebody has a CAT scan or the latest laser surgery equipment, everybody has to have it, resulting in either underutilization by everybody or over utilization because they've got to pay for it.

Dr. Winburg of Dartmouth has pointed this out in the regional variation phenomenon that is so troublesome. It demonstrates that where there is more equipment and more professionals and more beds, people get more care. It costs $50,000 more per lifetime for a Medicare beneficiary in Miami than it does in Sun City, Arizona. There is no difference in outcome, but a huge difference in cost, and it is because of the different practice patterns and greater availability of resources that get overused.

Mr. Wilson. I appreciate it very much.

Thank you, Mr. Chairman.

Mr. DeMint. Ms. Rivers.

Ms. Rivers. Thank you, Mr. Chairman. I understand the arguments that you are putting forward about the current system, but I guess I would ask each of you to contemplate the premise that underpins the system, which is the idea that alone in the industrialized world, we make a determination on who will have health care based on who they work for. Do you think that's a good paradigm?

Dr. Simmons. Do I think that's the best way to do it? No. And I think if we were starting from scratch, we probably would not pick the present way that we provide the bulk of private sector care. But that's the one system we have now and, of course, you have to figure out what is doable in a democracy and in the political process. Is it the simplest, most efficient way to do it given that people leave jobs?

Ms. Rivers. Most ethical?

Dr. Simmons. No. It just isn't.

Ms. Rivers. You don't think we could retreat from that simply because it is now entrenched? We couldn't move from that?

Dr. Simmons. I think that is a political judgment and no, I don't think it is impossible. In fact, I suspect that employers now are saying, look, either we're all in this business of providing health insurance or I'm getting out, because I cannot compete with the guy next door who is not bearing that cost. He's eating my lunch in market share and I'm trying to be a good guy and provide insurance, and it's unfair.

So that uneven playing field is a very serious phenomenon. You take some huge supermarkets on the west coast who are competing with the largest supermarkets in the United States, who don't provide as much insurance, and it's not a sustainable phenomenon.

Commissioner Longley. I guess what I would say is if it was a clean slate, you might direct it differently. But we do have an employer-based system and we do have a system of private insurance. In Maine, it's 60 percent insurance, 40 percent public. So I think what people underestimate is that a transition, if we did go to a publicly paid system, is not going to be easy. There are no simple answers.

But, again, it gets back to the premise of my testimony. It is not who pays. You can shift it to make it a completely public payer system, as we have with Medicare and other systems, but it's what we are paying and can we control the underlying costs. I think closing hospitals are tough decisions at the local level and they are very hard to face. Those questions need to be answered.

Ms. Rivers. But that is my question. We have jumped to a debate on how the current system should be altered without examining whether or not the current system is the right way to deal with it. What do you say to somebody who works for CVS and makes $6 an hour and doesn't get health care? Someone else, however, works for Ford Motor Company and makes $18 an hour, and does.

Both have little kids with ear infections. How do we justify that, as a nation, other than saying it's entrenched. That's the system we are used to and it's going to cost money to change.

Commissioner Longley. We do have safety nets for care, as well. I think we've done a good job in Medicaid and Medicare and other areas. So I'm not sure if it's completely broken.

Ms. Rivers. But those systems are in trouble because of the cost sharing which is what Dr. Simmons was talking about.

Commissioner Longley. Absolutely. And Medicaid budgets across the country are the highest they've ever been and their rates of inflation are reflective of what is happening in the private market.

Ms. Rivers. Dr. Ginsburg.

Dr. Ginsburg. I agree with much of what has been said. I think one of the virtues of an employment-based system is that there has been innovation by some of the better employers. Have we gotten enough innovation to deal with the downside of the system? Probably not.

I think, as Henry Simmons mentioned, the big political obstacle to major change from the employment-based system is not the employers, but it's really the people who have good insurance through their employers and getting them to feel comfortable that they won't be big losers in the transition.

Ms. Rivers. I want to talk about the costs going up, because I represent and live in Ann Arbor, Michigan, which of course, as you were talking about, is a high care center. There are lots of practitioners. But it doesn't matter which group I talk to in the delivery system, all of them feel that they are underpaid, over-utilized, and hamstrung to a certain degree from providing good care.

As I look at doctors, nurses, physical therapists, and occupational therapists at the outset it does not look like any of them, except the doctors, are doing well. Certainly the nurses and the other technicians are not getting rich doing this. So when we talk about rising salaries, are expectations reasonable for what we think professionals in these areas should actually be paid? Can we actually save costs by paying nurses and technicians and other kinds of medical personnel less?

Dr. Ginsburg. No. I don't think there is much hope of that. Historically, workers in health care did actually get paid more than their counterparts in other industries, but then when cost pressures were brought to bear on the health care system beginning in the early '90s, that changed. In fact, during the mid-1990s and later, you saw that rates of increase of wages in health care, traditionally leading the rest of the economy, started lagging behind it.

I would say, in the very recent data, they have crept up again in response to the shortages. So I think, for the most part, wage rates are pretty much determined by either tough collective bargaining when it's unionized, or otherwise the marketplace. I think whatever happens, happens,

but I don't see that as a major opportunity to lower costs.

Dr. Simmons. Congressman, it is true though if you look at Canada. When corrected for the cost of doing business my fellow physicians there charge substantially less than do my peers in this country. They make substantially less and provide, to the best of our ability to determine it, every bit as good care. So you can function with a different system. I'm not advocating that.

To go back to your first question, whether the employment-based system is the ideal way to do it, I think that is the big question that this country will face. I think to us it's a fact that we have to achieve universal coverage. You can't fix the system unless you do it. But there is more than one way to do it, but it's not an infinite number. There are only three that we can see.

One is to build on the employment-based system and have a tax structure to which we all contribute that pays for those too poor to pay, who are unemployed and that possibly subsidizes small businesses. The second is an individual mandate, such as Congressman Thomas is proposing, and the third is a system like Medicare, where everybody is in and it's a mandatory, tax-based system.

Ms. Rivers. Thank you. Thank you, Mr. Chairman.

Mr. DeMint. Thank you, Ms. Rivers.

Thank you all. We do have a challenge, with 160 million Americans insured in an employer-based system. There are some serious questions about third parties, but these employees are happy and it's going to be hard to switch them to something else. I appreciate your taking the time to give us this input today, and certainly your testimony will be used a number of times after this.

We will dismiss this first panel, and I would ask the second panel to step up.

Welcome. I want to thank our second panel for being here today. Our first witness on the panel is Mr. Patrick McGinnis. Mr. McGinnis is the Chairman and CEO of Trover Solutions in Louisville, Kentucky. Our second witness is Ms. Carol Miller. She is from the Frontier Education Center in Santa Fe, New Mexico. Our final witness for the day is Ms. Cathy Streker. She is the Director of Employee Benefits and Planning for Textron, Inc., at the Providence, Rhode Island site.

I would also like to welcome you on behalf of our Chairman, a fellow Texan, Sam Johnson, because Textron and Bell Helicopter are based in Fort Worth, Texas. He made me say that.

You probably have seen the lights here. Five minutes. They will be green, then yellow, then red when your time is up.

We will begin with you, Mr. McGinnis.

STATEMENT OF PATRICK B. McGINNIS, CHAIRMAN AND CEO, TROVER SOLUTIONS INC., LOUISVILLE, KY

Mr. Chairman and Members of the Subcommittee, my name is Patrick B. McGinnis, Chairman and CEO of Trover Solutions. We are the leading provider of claims recovery services for health care payers and property and casualty insurers in the United States. We employ 670 people, about 80 percent of who reside in our home city of Louisville, Kentucky. I am here today to discuss employer-sponsored health insurance and what we are doing to involve our employees as consumers in the health care system.

Trover Solutions was forced to take a new direction in providing health benefits to our employees due to rapidly rising health insurance premiums. We had four choices: drop coverage, increase employee premiums, increase co-insurance, or reduce benefits. Each of these options carried unacceptable consequences. Some of our employees may not have been able to afford insurance coverage at all.

Working with our health insurer, Humana, Inc., we made a more innovative choice. Involve our employees in the process and use technology to drive a solution that gives employees more plan choices and the information to make better decisions about what care is right for them and at what cost. We wanted to help our employees to become better health care consumers instead of continuing as passive health care system users. Humana helped us develop technology-driven plan choices and educational resources that would enable our employees to navigate the system.

This year our employees chose from six plans, including an HMO, PPO, and a flexible contribution option. This last option pays for all services up to $500, since we want employees to adopt wellness as a way to reduce long-term costs. After this first dollar coverage, the employee has a $1,000 dollar deductible and a 20 percent co-insurance requirement for in-network services, which is capped at $2,000 per person. Providing these choices meant that our health insurance premiums would be less and employees could choose the plan that best met their needs. Getting our employees to make their own decisions about what type of health plan they wanted and the cost of that plan made good health care sense.

Today, most employees believe the cost of an office visit is $10 and the cost of a prescription is $20. Those are just their co-payments. The real cost of an office visit to a specialist in Louisville is about $75. The real cost of a month's supply of Prilosec averages $120. Our new program gives consumers a real understanding of the cost of health care.

These plans offer essential coverage and provide insurance against major medical events. All the plans cover routine and preventative services and catastrophic costs, and all these plan options are offered to all employees within our group and they can make their own decision about how much, what, and which plan they want. When the enrollment results were in, it didn't surprise us that two-thirds of the employees chose the least costly plan, called Coverage First. The young, the not so young, male and female, and I chose this plan for myself and for my family.

Today, this hearing is exploring what the marketplace is doing toward the development of consumer-driven health plans. It's time to make the market work for consumers like you and me.

Employees want more choice and they need more information about health care options. They need to be in control of their health care expenditures and they need protection from major medical events. Employees need accurate, accessible information about the health care system and about their personal consumption of health care services. This will allow them and their families to make informed choices about their health care budget.

Today we ask the Congress to assist employees in driving the trend toward consumer-driven health benefits.Congress can help by passing legislation that permits a rollover of funds and flexible spending accounts and other health spending account options to encourage employees to use their dollars wisely and to save the remaining balance as appropriate for future need. Congressman Fletcher, Congressman DeMint, and others have introduced and co-sponsored legislation to permit $500 to be rolled over each year. We urge you to pass this legislation.

In conclusion, consumer-driven health benefits like the ones we are offering our employees represent the future health benefits model, helping individuals be better health care consumers by becoming actively involved in their health care purchasing decisions. In doing so, employers will be able to continue to provide their workforce with affordable benefits.

Your support and legislative action will encourage employers across the country to adopt similar consumer-driven benefits. Failure to support these initiatives will mean the continued rise in health care costs and consequent increase in the number of uninsured Americans.

Thank you for permitting me the opportunity to share our testimony with you today.

STATEMENT OF PATRICK B. McGINNIS, CHAIRMAN AND CEO, TROVER SOLUTIONS INC., LOUISVILLE, KY – SEE APPENDIX E

Mr. DeMint. Thank you, Mr. McGinnis.

Our second witness is Carol Miller.

STATEMENT OF CAROL MILLER, THE FRONTIER EDUCATION CENTER, SANTA FE, NM

Mr. Chairman and Members of the Committee, thank you very much for having me here to testify. I have been fiercely going through my testimony trying to keep it within the five-minute limit, because I am here representing a consumer point of view, which is somewhat different.

I live in a county in northern New Mexico with one of the highest rates of non-insurance in the United States. New Mexico hovers at about 22 to 32 percent uninsured, and in my county it is between 46 and 60 percent. This impacts the behaviors of my neighbors, who don't take advantage of even the most minimal level of services that most Americans take for granted.

Weekends in northern New Mexico are filled with car washes, enchilada dinners, pancake breakfasts, and the buying and selling of raffle tickets to raise money for neighbors needing help paying for cancer treatments or other medical care for members of their families. Donation jars with a photo of a sick child and a plea for donations are a familiar sight at gas stations and local stores. I believe my community is not alone in coming together in these informal ways to pay for health services. In many of these cases, at least one parent of the child is employed and often at more than one job, and I believe this is not an acceptable way to pay for health services.

One of the interesting factors that people haven't talked about is that most uninsured people are employed. A study by the Commonwealth Fund showed that 19 million full-time workers, that's 16.4 percent of all full-time workers, are uninsured, and certain occupation groups are more likely to be uninsured. Three of these occupational groups are primarily located in rural areas, agriculture, forestry and fisheries, which contributes to the high rate of rural non-insurance. These are not only rural occupations, but also seasonal. That doubles the risk that workers in these industries will be uninsured. And I would just note that most of the people who are out fighting forest fires right now, really risking life and limb, are seasonal employees and the majority of them, once the fire season ends, will join the ranks of the uninsured.

I wanted to talk a little bit about what that means, because we have heard about cost shifts. Wherever you have seasonal employees, people in the temporary employment industry that are not getting benefits, they are still getting care, but it's not primary care and it's not preventive care. It's often acute care, which is the most expensive way to enter the health care system.

Lack of health insurance, even covered people who do not have adequate health insurance, is the leading cause of personal bankruptcies; 79 percent of the families filing for bankruptcy had at least some health insurance coverage. And 326,000 families identified illness/injury as the main cause of bankruptcy. An additional 270,000 had large medical debts at the time of bankruptcy. This should provide a cautionary note against reducing the cost of health insurance to employers by shifting more of the cost to employees. The unintended consequences of more cost shifting will hurt both the health of the employees and the health of the economy, which is hurt by these bankruptcies.

A tragic study, in my opinion, was released by the Institute of Medicine last month called Care Without Coverage: Too Little, Too Late, which has documented that people without health insurance or with inadequate health insurance are sicker and die earlier than people with insurance. They receive less frequent or no cancer screening, resulting in delayed diagnosis and treatment, and premature mortality. For example, uninsured women with breast cancer have a 30 to 50 percent higher risk of dying than women with private health insurance. People without insurance or with inadequate insurance go without care for managing chronic diseases. For example, eye and foot exams in the case of people with diabetes could prevent serious problems.

One other thing I want to talk about is the whole issue about educated decision-making, which is very expensive. There was a stunning finding, 93 percent of individuals with employment based insurance, 14 percent with Medicare, and 54 percent Medicaid are enrolled in a type of managed care, but 58 percent claim that they have *never* been enrolled in managed care! Some of that might be related to the incredibly high functional illiteracy rates in this country, which we

estimate occur with 42 to 90 million Americans.

If we are to have informed consumers, it is going to be a very expensive process. Once you get out of middle class communities, you need to work one on one with people to understand health care choices.

Thank you.

STATEMENT OF CAROL MILLER, THE FRONTIER EDUCATION CENTER, SANTA FE, NM – SEE APPENDIX F

Mr. DeMint. Thank you, Ms. Miller.

Ms. Streker.

STATEMENT OF CATHY STREKER, DIRECTOR, EMPLOYEE BENEFITS AND PLANNING, TEXTRON, INC., PROVIDENCE, RI

Thank you, Mr. Chairman and Members of the Subcommittee. My name is Cathy Streker, and I am the Director of Employee Benefits and Planning for Textron. In addition, I have been working with the Business Roundtable's Health and Retirement Task Force on formulating policies for consumer-driven health care and other issues. The Business Roundtable is an association of chief executive officers of leading corporations. Textron's Chairman, President, and CEO, Lewis Campbell, chairs the Health and Retirement Task Force.

Textron is a $12 billion, global, multi-industry company. We employ more than 51,000 employees, of which 36,000 are based in the United States. More than 75 percent of our U.S. employees receive their health care coverage through Textron. By early 2001, Textron recognized that the cost of employer-provided health care plans was forecast to double within the next five years.

Several factors are putting upward pressure on health care costs. First, the baby boom generation is reaching the age where they will begin to place greater demands on the health care system. Second, new drugs and new medical technologies continue to hit the market. These drugs are life saving, but also costly. And, finally, in today's litigious climate, employers are exposed to an increasing risk of liability for the decisions of managed care providers.

With managed care responding to these factors by raising their costs to double-digit rates of inflation, it was clear to us that Textron's future competitiveness, our ability to meet the expectation of our shareholders, and the job security of our employees was at stake. We determined that we needed a solution that did not simply shift the cost of additional health care to our employees. Our goal was to identify an innovative solution that provided continued access to quality health care,

while providing incentives for employees to become active consumers.

For Textron, the solution is consumer-driven health care, a partnership between the company and its employees, that slows the rising cost of health care without cutting benefits, and gives employees financial incentives and educational support to help them make better informed health care decisions.

Employees are already treated like health care consumers by pharmaceutical companies and other providers of health care products and services. Yet, after years of being insulated from the true cost of health care, most employees don't have the knowledge or motivation to make informed purchasing decisions. The consumer-driven model provides employees with the critical information to help them navigate the health care maze.

After extensive research and market analysis, Textron chose to implement Affinity Health as our new benefit plan. Key features of the plan include: (1) 100 percent coverage for preventative care services, such as annual exams, well baby, and immunization, (2) Personal care accounts, which are funded by Textron and used by our employees help pay for their health care services, (3) “Carry forwards” for amounts credited to their personal care accounts that can be used for future health care expenses, including retiree medical (4) Financial protection in the event of a serious illness, and (5) Credible health care information, plus education and health care advocate resources to meet the employees' needs.

The consumer-driven model supports our commitment to consumer advocacy by arming employees with tools to make educated purchasing decisions. On January 1, 2001, Textron offered Affinity Health to approximately 1,600 employees. An extensive communication and education campaign accompanied this organizational shift from a culture of benefit entitlement to one of employee responsibility and empowerment. Our buy-in success was evident through employees' responses to a post-enrollment survey. Eighty-three percent understood Textron's business case for this change, 82 percent understood how the plan works, and 63 percent believes that the new program will help manage the increase in health care costs. Going forward, we plan to expand the consumer-driven health care plan to more of our U.S.-based employees next year.

Although consumer-driven health plans are relatively new, it is important that a collaborative effort continues among government, employers, and the health care industry. In particular, we at Textron offer the following recommendations. Federal legislation and regulations should provide a framework to support employer-funded personal care accounts and employee-funded flexible spending accounts.

To cite two examples, first, Textron and others in the business community are hopeful that the IRS will issue a ruling this summer to clarify that the current law allows employees to roll over unspent money in their employer-funded personal care accounts without tax liability. Second, Textron and other employers welcome the bill introduced by Congressman Jim DeMint of this Committee and Congressman David Phelps, that would permit rollover of employee-funded flexible spending accounts, giving American workers more options to save money for health care or retirement. In addition, health care providers must embrace collaboration with patients and make a commitment to follow evidence-based best practices. And, finally, employers need to work

together with providers to implement long-term and financing strategies.

Once again, thank you for this opportunity to testify before the Subcommittee. I welcome any questions.

STATEMENT OF CATHY STREKER, DIRECTOR, EMPLOYEE BENEFITS AND PLANNING, TEXTRON, INC., PROVIDENCE, RI – SEE APPENDIX G

Mr. DeMint. Thank you. Just a couple of questions myself.

Mr. McGinnis, let me make sure I understand the flexible plan that you talked about. You actually give your employees the first $500?

Mr. McGinnis. We don't give it to them outright, but they have a $500 dollar spending account funded by us that pays for all covered benefits, subject to any co-payments or deductibles on a particular benefit.

For example, our pharmacy benefit requires a $10, $15, or $25 dollar co-payment, and the employee still would be required to pay that, but the rest of that cost would be covered by their flexible spending account.

Mr. DeMint. Once they spend that, then they have another $1,000?

Mr. McGinnis. Then they are exposed for a $1,000 dollar deductible and up to a $2,500 dollar co-insurance payment, and then at that point they are capped out.

Mr. DeMint. When they shop for health care with that first $500, go to a doctor or whatever, can they go to a doctor that is a network provider that your insurance covers? In other words, do they get a break on their prices or do they just shop the top retail dollar?

Mr. McGinnis. They have an incentive to use in-network providers, yes.

Mr. DeMint. They have an incentive to ask for the costs. Thank you.

Ms. Streker, with your plan, when you talk about preventative care, does that come out of their personal care account or is that a kind of first dollar insurance coverage?

Ms. Streker. It does not come out of their personal care account. It is first dollar.

Mr. DeMint. And are there indications so far that it is working and that they are out shopping for their health care? Have problems come up as far as getting price quotes from providers? Because I know that's the next step. The first step is to get employers to help facilitate these savings accounts and to help fund them and then encourage employees to fund their own through FSAs. But then when they go shopping for information and prices we need to make sure that information is

available. What is happening there?

Ms. Streker. We have been watching closely. We have been implemented now for six months. Certainly one of the key things that we have been watching for are employees actually reaching out to the facilities that we're providing to them to get the education that they need to make the right choices? We have seen an increase of Internet usage. Also, there is a nurse line that we used to offer which had a very low usage at that time. Now under our current plan there has been an increase in usage of the nurse line.

And regarding the pricing for the providers, one of the things Affinity Health does, when it does contract with a provider network, is to allow the pricing to be available to the participants. So that is available today, as well. Not as robust as we would eventually like it to be, but it is there.

Mr. DeMint. Okay.

I'm not familiar with electronic selection Mr. McGinnis or an Internet wizard that walks employees through key decisions. Just tell us a little bit more about that.

Mr. McGinnis. Sure. A big part of the process of making this change in benefit structure was to explain to our employees, first of all, the inherent costs and what would occur if we continued to do what we were going to do. And we were looking at premium increases that, for our employees, would have been north of 20 percent had we continued the same benefit structure.

We use an employee committee for educational purposes. As we moved towards the choice product, our employees had the opportunity to decide which of the six benefits structures they wanted to choose by going on the internet and providing some demographic information about the health care needs of themselves and their family members. Then this information was analyzed and the wizard would suggest two or three logical selections that would provide the best choice of economy and coverage for them.

Mr. DeMint. Great. These are exciting ideas. I could ask questions all day, but I will yield to Mr. Andrews.

Mr. Andrews. Thank you. I would like to thank the panelists for their very thoughtful testimony.

Mr. McGinnis, your company has been hit with very severe increases in health insurance premiums, and you outlined the problems that you've had. How many choices in health insurance writers do you have in the Louisville market?

Mr. McGinnis. I couldn't quote a figure, but my perception would be a reasonably large number. The Kentucky market is not nearly as concentrated as the statistics I heard on Maine.

Mr. Andrews. Do you buy through a broker or do you buy directly?

Mr. McGinnis. This year, in conjunction with making the structural change, we also went to a self-funded process. So we are, in effect, our own insurance company now. We have enough

employees and enough expenditure that we self-insure our health care risks, and then purchase through a broker a policy that is referred to as a reinsurance policy, if you're familiar with that term.

Mr. Andrews. Right. I am.

Ms. Miller, what does it cost for a family health insurance policy in northern New Mexico?

Ms. Miller. Actually, I have been working on looking at some of those policies for the organization I work with, and the lowest we've found for a young, single worker is about $500 a month just for a single.

Mr. Andrews. One person?

Ms. Miller. One person, that's correct.

Mr. Andrews. So if this person has a couple of children, I would assume it would be well beyond that.

Ms. Miller. It would be quite a bit higher than that.

Mr. Andrews. Five hundred dollars a month is $6,000 a year.

Ms. Miller. Six thousand dollars a year, and it is affecting the fringe rate that employers are using. People used to figure between 17 and 22 percent. I know that the other small employers in New Mexico, if they provided insurance, said their fringe rate would be closer to 50 percent.

Mr. Andrews. I know, Mr. McGinnis and Ms. Streker, that you are concerned with finding ways to keep your own employees insured and moderating the costs. We support that and we appreciate that. I want to ask if you could both give us some advice on what we should do about the people Ms. Miller is talking about.

There are nearly 40 million of them in the country, and it is our observation that you are paying for them too, because when they go to the hospital, the hospitals do not turn them away. The emergency rooms provide care; sometimes other parts of the hospital provide care. Most states have some kind of uncompensated care system. In New Jersey it is funded through the payroll tax; unemployment tax pays for that care.

What do you think we ought to do about the people that Ms. Miller is talking about, Ms. Streker?

Ms. Streker. One of the things we need to do, whether it is employer-provided health care, or government-provided health care is get the consumers involved. When health care is free, people do not take an active role in purchasing health care service.

Mr. Andrews. You would agree, wouldn't you that it's hard to be involved if you have no money, or if you have a job that pays $6 an hour and it costs $8,000 a year for a policy. How do you get involved?

Ms. Streker. By educating somebody about the cost of health care, rather than running to an emergency room.

Mr. Andrews. Well, of course, people shouldn't do that. They wouldn't run to the emergency room if they had a heath insurance policy. So if they have none, the only place they can see a doctor is the emergency room. So what should we do?

Ms. Streker. My point about going to the emergency room is in some cases, and this happens today even if people are covered under health care insurance, they will go to an emergency room versus treating it otherwise.

Mr. Andrews. Versus what? If you have no health insurance, you can't go see your doctor unless you have enough money in your pocket to pay him or her.

Mr. McGinnis, did you want to say something?

Mr. McGinnis. Yes, I do. I think these are two important issues that are related, but often confused. One issue is access, and that's the problem you're talking about. The other issue is price.

Now, I can't do anything about access, but I can engage my employees and their dependents in the purchase of health care to change the marketplace dynamics. I do agree with some of the former witnesses that we have to create a mechanism that requires healthy people to pay into the system before they get sick, because if healthy people don't have to be involved, then everything is shifted to sick people.

Mr. Andrews. Of course, one of the reasons why the price that you pay is so high is because so many people do not have access. When the 15 to 20 percent of people nationwide who have no insurance get sick they are cared for, and the bill is then shifted back to you. We do have to deal with access. Do you have any suggestions?

Mr. McGinnis. Well, I do believe that if we are going to have a system in which the distribution of health care benefits is through employers, all employers have to be part of the system.

Mr. Andrews. I appreciate that. I think Ms. Miller would like to say something.

Ms. Miller. I would like to mention one thing we're looking at in New Mexico at the state government level and that is creating a single risk pool for everybody. As for the delivery system, we're trying to keep the private delivery system that we have.

In some states, and I believe the Commissioner from Maine referred to this, such as New Mexico and Alaska, most of the health care is actually paid for by the government right now through Medicare, Medicaid, state and Federal employees, VA and military benefits. There is a

very small private insurance market in a number of states. Many of them are primarily rural and are impacted by Federal land ownership and the military and other Federal economic effects.

But I think we need to look at getting everyone into the same system. Since costs are going up and so many people are uninsured, they are not accessing care when it would be affordable. Recent studies of emergency room use actually showed that it really is the proper place for a huge percentage to be taking their sick child, because they didn't get the primary care that they needed which might have made a lower acuity situation.

So I think we need to be careful about assuming that we are not all paying for it. We working people are paying for all the care. I pay three taxes in my county, one property tax and two gross receipts taxes that are levied on top of what I am paying for my own health insurance to cover the uninsured in my county.

Mr. DeMint. Mr. Andrews asked an excellent question, and I agree our goal should be for every American to have funds to access health care. How the insurance component of that works is something we need to think about. My hope, regarding his question about the uninsured, is that some of the models that are being created by employers that recognize that engaging consumers with funds of their own as shoppers are models that the government can also use to set up similar accounts and provide insurance coverage at higher levels rather than first dollar free care.

I am hoping that some of you, as employers, can put those prototypes in place and that Medicare can recognize that we can provide dollars for the poor to access care in a type of personal health account. We can encourage them to access information and not go to the emergency room. While many will say that at this point maybe they're not capable of managing those funds properly, moving folks in that direction is certainly a desirable goal.

As we watch what you do in the marketplace, we need to apply those same principles of consumer-directed care to every American, and not use our government programs to provide free health care where there is no consumer responsibility.

Mr. Andrews. Will the Chairman yield for just one second?

Mr. DeMint. I sure will.

Mr. Andrews. I do appreciate his point about consumer education and choice. Of course, you can't be a consumer if you have no income to spend, and the problem for a huge percentage of the uninsured is that after they pay their rent and their utility bills and their grocery bills and their other expenses, there is essentially no income left to spend. This model may work well when people have disposable income, but getting people to the point where they have disposable income is the threshold you have to reach.

Mr. DeMint. That is an excellent point. But Textron, for instance, gives the first $500 to the individual, which is not something they have to have an income for. My thought is we need to look at this type of model. I think Textron actually gives employees an account to spend from, and there is no reason why the government can't consider the same incentives for all the uninsured people

Ms. Miller was talking about. Instead of first dollar coverage, we could create accounts that they can draw from, and they could become consumers.

Mr. McGinnis?

Mr. McGinnis. Our experience with these new plans was that even our employees who have more modest incomes are able to budget their finances and afford coverage through these mechanisms. The average compensation in our company of some 700 people is probably high $30s, low $40s. But probably 15 to 20 percent of our employees are in positions that are more clerical in nature, and their average compensation would be low $20s. We had very few fall off the table by changing these mechanisms.

My primary concern with the way our premiums were going up was the fact that I was going to end up with more employees who could no longer afford insurance, and that is one of the main reasons why we made this change, and it was successful. If people know what to expect, they will budget accordingly.

Mr. DeMint. Ms. Miller? One more comment.

Ms. Miller. I just want to clarify the record. The people I am talking about are not the poor, per se. They are low wage workers or they are in the temp industry or they are contract employees or they are seasonal employees, and they have no access to the health insurance market.

We are actually doing a very good job in this country providing coverage for low-income people through some of the Medicaid expansions and other programs, but not this group of people who get up every day and go to work. Because of the kind of industry or the kind of employment category they are in, they cannot get access to health insurance.

Mr. DeMint. Our next hearing will consider the uninsured, and hopefully we can use some of the ideas we have heard today to arrive at some new ideas for the uninsured.

I want to thank the panel again, and Mr. Andrews, and all the staff that helped us with this hearing. We are now dismissed.

Whereupon, at 1:24 p.m., the Subcommittee was adjourned

APPENDIX A - OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Opening Statement of Chairman Sam Johnson

Subcommittee on Employer-Employee Relations

June 18, 2002

GOOD MORNING. LET ME EXTEND A WARM WELCOME TO ALL OF YOU, THE RANKING MEMBER, MR. ANDREWS, AND TO MY OTHER COLLEAGUES.

BEFORE I BEGIN, I WOULD LIKE TO APOLOGIZE IN ADVANCE FOR HAVING TO LEAVE TODAY'S HEARING. WAYS AND MEANS – MY OTHER COMMITTEE – WILL MARK UP THE MEDICARE BILL. AFTER I LEAVE, I'LL HAND THE GAVEL TO VICE-CHAIR JIM DE MINT. THANK YOU FOR YOUR UNDERSTANDING.

TODAY'S HEARING WILL FOCUS ON RISING HEALTH CARE COSTS AND EMPLOYER AND EMPLOYEE RESPONSES.

THIS IS OUR FIRST HEARING ON THE CRITICAL ISSUE OF RISING HEALTH CARE COSTS.

THOUGH THE COMMITTEE HAS HEARD ABOUT THE RISING COSTS OF RETIREE HEALTH CARE, WE HAVE YET TO HEAR ABOUT THE GROWING COSTS THAT ALL EMPLOYEES FACE.

LAST YEAR, EMPLOYERS' COSTS FOR HEALTH CARE BENEFITS INCREASED BY AN AVERAGE OF THIRTEEN PERCENT.

THIS ALARMING TREND IS EXPECTED TO CONTINUE – AND, FOR SOME, THE INCREASES WILL BE MUCH LARGER.

FOR EXAMPLE, THE CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM, ALSO KNOWN AS CALPERS, RECENTLY ANNOUNCED A TWENTY FIVE PERCENT INCREASE IN HEALTH CARE PREMIUMS FOR NEXT YEAR.

TODAY'S HEARING IS DESIGNED TO ANSWER TWO QUESTIONS:

NUMBER ONE, WHY ARE COSTS INCREASING SO DRAMATICALLY?

AND NUMBER TWO, WHAT DO THE INCREASES MEAN FOR EMPLOYERS AND EMPLOYEES AND HOW WILL THEY RESPOND?

WE'LL HEAR TESTIMONY REGARDING VARIOUS REASONS BEHIND BIG DOLLAR INCREASES FOR HEALTH INSURANCE.

AS YOU MAY KNOW, A STUDY IN THE NEXT EDITION OF *HEALTH AFFAIRS* DETAILS ISSUES FACING EMPLOYERS LOOKING TO INCREASE COST SHARING OR REDUCE BENEFITS BECAUSE OF RISING HEALTH CARE COSTS. KNOWING THIS, WE WANT TO STRIKE WHILE THE IRON IS HOT.

EXPERTS WILL TELL US ABOUT RISING PRESCRIPTION DRUG COSTS, HIGHER COSTS FOR DOCTORS AND HOSPITALS AND THE COST THAT MALPRACTICE LAWSUITS AND OTHER LITIGATION BRINGS TO THE SYSTEM.

ANOTHER FACTOR THAT MANY STATES ARE FOCUSING ON IS HOW STATE MANDATES CONTRIBUTE TO INCREASED COSTS.

GOVERNORS AND LEGISLATORS IN MANY STATES ARE STARTING TO REQUIRE COST REVIEWS OF MANDATES BEFORE ENACTING NEW LEGISLATION.

WHEN THESE REVIEWS ARE UNSUCCESSFUL IN STOPPING HARMFUL NEW MANDATES, SOME GOVERNORS ARE VETOING THEM – AS MAINE GOVERNOR ANGUS KING DID WITH AN OVER-REACHING AND BURDENSOME EXPANDED MENTAL HEALTH PARITY LAW.

ANOTHER CRITICAL FACTOR OF RISING HEALTH CARE COSTS IS PATIENTS THEMSELVES.

BECAUSE PATIENTS ARE USUALLY ONLY RESPONSIBLE FOR A FRACTION OF THE COST OF THEIR CARE, THEY ARE MORE LIKELY TO DEMAND THE LATEST 'CADILLAC' TREATMENT OR PRESCRIPTION.

HOW DO EMPLOYERS AND EMPLOYEES RESPOND TO THESE INCREASING COSTS?

THE FIRST LINE OF DEFENSE FOR MANY EMPLOYERS HAS BEEN TO INCREASE CO-PAYMENTS FOR EMPLOYEES TO SHARE THE GROWING BURDEN AND ENSURE THAT EMPLOYEES ARE FISCALLY AWARE.

SOME EMPLOYERS ALSO HAVE SHIFTED DOLLARS FROM FRINGE COVERAGE, SUCH AS DENTAL OR VISION COVERAGE, TO MEDICAL AND SURGICAL CARE TO ENSURE THAT NEEDS ARE MET.

WE'LL ALSO HEAR TESTIMONY ABOUT SOME INNOVATIVE RESPONSES BY EMPLOYERS. THESE EMPLOYERS ARE MAKING CHANGES IN THEIR HEALTH PLANS TO GIVE THEIR EMPLOYEES THE

TOOLS THEY NEED TO MAKE GOOD DECISIONS ABOUT THEIR OWN MEDICAL CARE.

WHILE SOME OF THESE INNOVATIVE CHANGES HELP EMPLOYERS REDUCE COSTS, THEY ALSO EMPOWER EMPLOYEES WITH MORE CONTROL OVER HEALTH CARE DOLLARS TO HELP THEM MEET THEIR SPECIFIC HEALTH CARE NEEDS.

AS I HAVE SAID MANY TIMES BEFORE, EMPLOYERS VOLUNTARILY PROVIDE HEALTH CARE FOR WORKERS. UNFORTUNATELY, AS HEALTH PLAN COSTS MAKE UP A GREATER AND GREATER SHARE OF COMPANY RESOURCES, MANY EMPLOYERS ARE BEING FORCED TO RE-EVALUATE THE SIZE OF THEIR HEALTH BENEFIT PACKAGES.

EMPLOYERS -- ESPECIALLY THOSE WHO OWN SMALL BUSINESSES WHO ARE MORE LIKELY TO SEE DRAMATIC INCREASES IN COSTS – ARE URGING CONGRESS TO CAREFULLY CONSIDER HEALTH CARE POLICIES.

SMALL BUSINESS OWNERS ARE CONCERNED ABOUT ISSUES SUCH AS THE PATIENTS' BILL OF RIGHTS OR COVERAGE MANDATES, LIKE MENTAL HEALTH PARITY, WHICH WILL INCREASE COSTS EVEN FURTHER. ESPECIALLY IN THIS TIME OF HIGH HEALTH CARE INFLATION, MANY EMPLOYERS FEAR THAT ADDITIONAL COST SPIKES MAY FORCE THEM TO DROP HEALTH INSURANCE ALTOGETHER, WHICH WILL DRAMATICALLY INCREASE THE NUMBER OF UNINSURED AMERICANS.

WITH THAT IN MIND, LATER WE'LL HEAR TESTIMONY ABOUT THE PROBLEM OF THE UNINSURED, PARTICULARLY IN SMALL BUSINESSES.

WE'LL ALSO HEAR ABOUT SOLUTIONS THAT WILL PROVIDE ACCESS TO HEALTH CARE COVERAGE FOR THOSE WITHOUT HEALTH INSURANCE.

HEALTH CARE COSTS ARE A SERIOUS ISSUE. PRIVATE EMPLOYERS PROVIDE ACCESS TO HEALTH CARE FOR 128 MILLION AMERICANS. THE HEALTH OF THIS EMPLOYER-BASED SYSTEM COULD BE IN JEOPARDY.

IT IS EXTREMELY IMPORTANT THAT WE UNDERSTAND WHY COSTS ARE RISING AND HOW OUR OWN LEGISLATIVE ACTIONS CONTRIBUTE TO THIS PROBLEM.

I LOOK FORWARD TO WORKING WITH MY COLLEAGUES ON THE SUBCOMMITTEE AS WE EXAMINE THIS ISSUE.

APPENDIX B - STATEMENT OF DR. PAUL GINSBURG, PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (HSC), WASHINGTON, D.C.

Testimony of Dr. Paul B. Ginsburg, Ph.D.

President, Center for Studying Health System Change

June 18, 2002

Thank you Mr. Chairman, Congressman Andrews and members of the subcommittee for inviting me to testify about rising costs in employer-sponsored health insurance. I am Paul B. Ginsburg, President of the Center for Studying Health System Change (HSC). HSC is an independent nonpartisan policy research organization funded solely by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research. Our longitudinal, nationally representative surveys of households and physicians and site visits to 12 U.S. communities provide a unique perspective on developments in the private health care markets and their impacts on people. Although we seek to inform policy with timely and objective analyses, we do not lobby or advocate for any particular policy position.

As an economist, I have personally studied health care cost trends since the late 1960s. At HSC, I have published an article each year since 1996 in the journal *Health Affairs* synthesizing various cost trend data to help policymakers understand the underlying dynamics in the U.S. health care system. The 1996 article convinced many people that the decline in cost trends at the time was a real one. Later articles documented the return of rapidly rising costs. In recent years, information collected by HSC's site visit team has been an important complement to the quantitative data to provide insight into the factors behind rising costs. I will draw heavily on that information in this testimony.

Although the most reliable surveys of employers' 2002 premium increases have not yet been released, the increase is likely to be in the area of 13 percent, up from 11 percent for 2001. This figure probably understates the size of the increase, because it does not reflect the increases in patient cost sharing employers incorporated into their benefit plans in 2002. These double-digit increases come at a time when corporate profits are down and the average hourly wage is rising by only 4 percent. So you can see the magnitude of the problems this creates for both employers and employees.

To help you understand these cost trends and what is behind them, I will cover three areas in this testimony:

- Differences between underlying cost trends and premium trends;
- The key components of the cost trend; and
- The factors that are driving the cost trend.

Cost Trends and Premium Trends: The Insurance Underwriting Cycle

Insurance premium trends often diverge from the trends in what insurers actually pay out in benefits, what I refer to as "underlying costs." For example, in 2001, premiums for employment-based coverage increased by 11 percent, while the underlying costs, or spending on care, increased by only 8.7 percent. However, five years ago, the reverse was the case, with premium increases trending below the underlying costs.

Economists refer to this as the "health insurance underwriting cycle." The differences between premium and cost trends are the result of two factors. First, the inevitable errors insurers make in projecting future costs at the time that premiums are set, and second, the cyclical expansion and contraction by health insurers in response to the industry's profitability. When the insurance business is unusually profitable, companies move to expand market share by competing on price, recognizing that they may lose money in the short-run but make it up later with a larger market share. When business is unprofitable, companies raise premiums faster than costs even if it means losing some market share.

For the last few years, premium increases have exceeded cost increases as the insurance industry moves to restore profitability. We have seen many examples of insurers exiting unprofitable markets but have not yet seen entry into new markets, which would be a sign of a turn in the underwriting cycle. Inevitably, such a turn will occur, probably within a year or two. Such a change will provide some relief to employers and employees, who will no longer face premium increases exceeding cost trends.

Key Components of the Cost Trend

To better understand the trend in underlying costs, it is useful to examine the various spending components, including inpatient hospital care, outpatient hospital care, physician services and prescription drugs. We can also look at changes in prices paid to health care providers and changes in the quantity of services provided per covered person.

Since 1995, prescription drugs have been the most rapidly growing component of health care costs. By 1999, drugs were the most important contributor to overall cost growth, with the rate of growth in drug spending per person reaching more than 18 percent. Since then, the rate of growth has slowed somewhat, but it is still in the mid-teens. More recently, increases in hospital costs have replaced prescription drugs as the most important driver of overall cost growth because a much higher share of health spending is for hospital care.

Spending trends for inpatient hospital care have made a remarkable turnabout in recent years. Each year from 1994 to 1998, inpatient hospital spending per insured person actually declined. In 1999, however, this ended and inpatient spending trends have increased each year since. For 2001, per capita inpatient hospital

spending increased by 5.6 percent, an enormous turnabout from a 5.3 percent spending decrease in 1997. Hospital outpatient spending and physician spending trends followed similar patterns, although spending levels for these services never went into negative territory like inpatient spending. Overall, cost trends declined in the mid-1990s and then began to increase in 1997. When inpatient and outpatient hospital spending are combined, they now account for almost half of the increase in overall health care spending.

The pattern of spending trends slowing through the mid-1990s and then accelerating starting in 1997 is seen in both prices and quantities. Using the hospital component of the Producer Price Index as the measure of price, we have estimated that 38 percent of the hospital spending increase for 2001 is due to higher prices for care and 62 percent is due to higher utilization of services. The service use component has been growing particularly rapidly in recent years. The use of physician services is also increasing, but physician price trends have been level.

Factors Behind the Cost Trends

Important drivers of health care costs at this time include advances in technology, increases in per capita income, the retreat from tightly managed care, provider consolidation, and shortages of nurses and other skilled personnel. Surprisingly, the aging of the population is a relatively small driver of cost trends.

Medical Technology. Advancing medical technology is far and away the most important driver of costs. This includes not only the introduction of new services or equipment, but also new applications of existing services and equipment made possible because of advances in medical science. Prominent academic studies estimate that over the long run, advances in technology explain between one-half and two-thirds of the increase in costs in excess of general inflation. Much of this provides important benefits to patients, saving lives and avoiding disability. But together with valuable technologies, we also get technologies that turn out to do patients more harm than good and some where the benefits are very small in relation to the additional cost. Although advances in technology have different impacts on costs at different times, I am unaware of any evidence that technology advances are contributing more or less to costs than in the past.

Income Growth. Income growth is another important driver. Over the long run, as societies' incomes grow, they tend to spend a disproportionate amount of the income increase on medical care. Studies have shown that in the short run, changes in per capita income affect trends in health costs, but with a substantial lag. Thus, the very rapid growth in incomes during the late 1990s is likely to be contributing to today's high health care cost growth. And these cost increases come at a time when the economy is sluggish.

Less-Restrictive Managed Care. HSC's site visit research has documented a pronounced trend away from tightly managed care. Health plans have dropped authorization requirements for hospital admissions, referrals to specialists and the

use of expensive diagnostic procedures. Many patients can now see a specialist without first going to a primary care physician. Provider networks are now much broader, giving enrollees a much wider choice of hospitals and physicians. Plans are less likely to contract with providers on a capitated basis, a method that gives providers incentives to economize on service use. External review mechanisms have been made available to enrollees who disagree with plan decisions about medical necessity. Although some of these changes came from mandates, much if it happened in response to demands by employers and consumers for a less restrictive insurance product.

These changes have added to costs. Reduction of authorization requirements has probably led to more utilization of services. Many observers believe that authorization requirements had a sentinel effect, with physicians not requesting authorizations for services that they expected would be turned down. We have seen anecdotal evidence of sharp increases in the number of MRI screens after health plans dropped requirements for authorization.

Broader provider networks are likely to have contributed to a shift in negotiating power away from health plans and toward hospitals. Today, plans feel compelled to have all of the prominent hospitals in a community in their networks. As hospitals figured this out, they were able to demand substantial increases in payment rates from health plans.

Other Factors. Hospitals consolidated a great deal during the 1990s. As a result, most communities now have fewer hospital systems, with many smaller communities now having only one or two. This, in turn, increased hospitals' leverage with health plans. Although we have not seen quantitative estimates of the impact of consolidation, its potential to raise costs is clear.

Shortages of nurses and other skilled personnel also are driving up costs through higher wage rates. According to data from the Bureau of Labor Statistics, average hourly wages in hospitals increased by 5.9 percent in 2001, compared to 3.2 percent in 2000. This is higher than the 4 percent average wage increase in all industries.

Many analysts believe that the aging of the American population is an important driver of health care costs. We have been analyzing this and find that while a driver, aging is a relatively small one. Using data on health care spending per capita by people of different ages and data on the changing age distribution of the population, preliminary estimates suggest that at this time, aging of the working-age population contributes about 0.7 percentage points to the cost trend. Viewed in relation to the 2001 cost increase of almost 9 percent, aging is a relatively small driver. I would note, however, that aging contributes more to the cost trend than it did 10 years ago, when it contributed only 0.1 percentage points. Per capita spending rises sharply around age 55, and the leading edge of the baby boom generation is now reaching this age.

Implications of Rapidly Rising Health Care Costs

When spending rises for most goods and services, policymakers' attitude toward it is neutral because of our belief in consumer sovereignty. But health care is quite different because most health care is financed through health insurance because of the uncertainty about when someone will need very expensive care. This reliance on third-party payment blunts consumer incentives to economize on the use of care. And rising premiums cause problems for the employers and governments that pay for health insurance. So, policymakers have good reason to be concerned about rising health care costs.

Unlike a housing purchase, for example, where a consumer can tailor the purchase to what they are willing to spend and can afford, consumers have much less ability to adjust their health spending to their ability to pay. For the most part, we have a single standard of what should be done for people who have various illnesses. This means that if we want people with lower incomes to have access to care, they need to be subsidized, either through pools that employers establish (where the employer makes the same contribution regardless of the worker's earnings) or through government programs.

Rising health costs affect people's ability to afford health insurance. When insurance premiums rise faster than workers' wages, fewer people obtain employment-based health insurance. This happens through small employers deciding not to provide coverage to their employees and employees deciding not to take up employer coverage because the employee contribution is too high. If health care cost trends continue to exceed increases in wage rates by a large margin, this could result in substantial loss of employer-based health insurance.

Finally, rising health care costs also pose a problem for the federal and state governments, which finance 45 percent of national health expenditures, mostly through Medicare and Medicaid. With public revenues staying at a relatively constant percentage of national income, growth in outlays for these programs in excess of growth in income that is taxed poses particular strains on public budgets. States are facing these strains now in an acute manner, as Medicaid outlay growth exceeds the trend in state revenues by a large margin. The strain will become acute for the federal government when the baby boom generation begins to become eligible for Medicare.

While I have reviewed many of the drivers contributing to the largest jump in health care costs in a decade, I want to close by touching on a core factor that is behind much of this. In the United States, our culture emphasizes that people should get all beneficial medical care, regardless of cost. This works against attempts to discourage the development of treatments in which the benefits are uncertain or known to be small. Until the public becomes more aware of cost-quality trade-offs, rising health care costs will continue to strain the resources of government purchasers, employers and consumers.

APPENDIX C - STATEMENT OF DR. HENRY SIMMONS, PRESIDENT, NATIONAL COALITION ON HEALTH CARE, WASHINGTON, D.C.

Testimony of Dr. Henry E. Simmons, M.D, M.P.H, F.A.C.P.

President, National Coalition on Health Care

June 18, 2002

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to testify before the Subcommittee on rising health care costs and how employers and employees are responding to those increases. I am Dr. Henry Simmons, President of the National Coalition on Health Care. The Coalition is the nation's largest and most broadly representative alliance working to improve America's health care. The Coalition was founded in 1990 and is non-profit and rigorously non-partisan. Former Presidents Bush, Carter, and Ford are our honorary Co-chairs and our working Co-chairs are former Iowa Republican Governor Robert D. Ray and former Democratic Congressman Paul G. Rogers of Florida. Our members include major corporations and unions, the nation's largest consumer, religious and labor groups, as well as health care provider groups and large health and pension funds. Collectively, our 80 members employ or represent more than 100 million Americans. Our membership list is attached to my written statement.

The Rising Costs of Health Insurance

National health care spending is rising rapidly and this year will exceed $1.54 trillion – more than $5,400 per capita. That is four times what we spent on health care in 1980, and the total bill is expected to almost double to $2.8 trillion by 2011. Our per capita health care costs are far higher than any other industrialized nation and our health outcomes are no better.

The premiums that employers, employees, and individuals pay for health insurance are rising at the fastest rate in history. On average, premiums jumped 12 percent last year and – depending on plan type – are projected to increase 12 to 16 percent this year. Hewitt Associates recently reported that preliminary HMO increases for 2003 are averaging 22 percent – nearly 7 percent higher than the increases Hewitt found for this year. Out-of-pocket costs are also rising rapidly.

These huge increases are occurring at a time of low general inflation. Why? And why should Congress, employers and the public be concerned?

Causes of Rapidly Rising Health Insurance Premiums

The recent and ongoing surges in health insurance premiums are being driven by a confluence of two sets of forces, old and new – which have come together to create the equivalent of "A perfect storm" in health care.

The first set – traditional cost drivers – includes a mix of:

- Poor quality, waste and inefficiency due to inadequate quality control, inadequate science and a structurally flawed health care system
- Advances in medical technology
- Increasing service intensity
- The high costs of end-of-life care
- High administrative costs
- Cost-shifting to cover the costs of emergency care for the uninsured and underinsured
- Fraud and abuse
- General inflation, and
- State mandates

To these have now been added a new set of forces – emerging cost drivers, which include:

- A longer and deeper insurance underwriting cycle, designed to help insurers and health plans make up for premium shortfalls in recent years
- Increased use of medical technology
- Pressures from Wall Street on for-profit health plans to raise premiums in order to increase profits
- Escalating prescription drug costs and utilization
- Diminished competition due to provider consolidations and tougher negotiations with health plans for higher reimbursements
- The medical needs and demands of 77 million baby boomers
- Soaring medical malpractice insurance premiums and, with them, an increased tendency for physicians to order extra tests and make treatment decisions that limit their risks

- Consumer demands for easier and broader access to care, and
- International terrorism.

How Are Employers and Employees Responding?

In answer to the subcommittee's question as to how employers and employees are responding to rapidly rising costs, the answer is very poorly. In fact, in the absence of major national policy changes and system restructuring, they will be unable to deal with the problem.

Why Should Congress Employers And The Public Be Concerned?

First, we have not one, but three systematic problems – rising costs, decreasing coverage, and pervasive, destructive, and expensive quality problems. These problems are interrelated and growing worse. To successfully deal with one you must deal with them all. Whatever employers and other private sector payers have been doing to contain costs isn't working.

Second, what is especially worrisome is that we are seeing startling premium increases at a time of low general inflation and even though employers, especially big companies, have become more serious and sophisticated about health care purchasing. Health care premiums for even the largest and smartest employers are out of control. Costs for small businesses and individuals are rising even more rapidly.

Third, increasing health care costs for employees – and sharply rising premiums in the non-group market – will produce dramatic increases in the number of Americans without health insurance. The Coalition estimated in its recent report, "A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage," that due to cost increases the number of uninsured Americans may have increased, just in 2001 and 2002, by 6 million. A summary of our report is included in my written testimony.

Fourth, many of the new wave of ostensible cost containment tactics that employers are edging towards – increased cost-sharing, defined contributions – are in fact ways to shift costs, not contain them. If and as more companies move in this direction, we will see the employee share of health care spending continue to rise. The effect would be the equivalent of a wage decrease – with some added disadvantages.

With increased cost sharing through higher deductibles and co-payments, more and more employees would put off needed health care for financial reasons – the very scenario that health insurance is meant to protect against. And with defined contributions, many would drop coverage altogether because of sharp increases in the costs of maintaining it.

Fifth, we have created a perpetual motion machine in health care, which is headed in the wrong direction. All our problems are growing worse and present policies and procedures will not be powerful enough to enable employers and employees to address these problems.

Summary

The Coalition believes that we will need a major new public policy initiative to respond to surging health insurance premiums. Our members are working to encourage a renewed national debate about the large-scale issues facing American health care – and about the options for system-wide reforms that will be necessary to contain costs, achieve universal coverage, improve the quality of care, assure equitable and sustainable financing, and simplify administration.

APPENDIX D - STATEMENT OF S. CATHERINE LONGLEY, COMMISSIONER, PROFESSIONAL AND FINANCIAL REGULATION, STATE OF MAINE, AGUSTA, ME

Testimony of Ms. S. Catherine Longley

Commissioner, Maine Department of Professional and Financial Regulation

June 18, 2002

Introduction

Good afternoon Representative Johnson, Representative Andrews, and Members of the Subcommittee on Employer-Employee Relations, thank you for inviting me to appear before you today. My name is S. Catherine Longley. I am the Commissioner of Professional and Financial Regulation for the State of Maine and my department includes the State's Bureau of Insurance. My goal today is to share with you information regarding one state's experience and what is happening in our private health insurance market from a cost perspective.

Health Insurance and Health Care Costs in the State of Maine

In the State of Maine, we are facing a health care cost crisis. Although health care costs have increased dramatically across the country, they have increased even faster in Maine. Nationally, from 1990—1998, the per capita expenditures for personal health care increased an average of 53.3%; in Maine, the increase was 80.4% for the same period of time. In 1999, the citizens of Maine spent almost $5 billion dollars per year for personal health care. This is an average of $3,901 per person and represents nearly 14% of Maine's entire gross state product. By 2010, the number is expected to be approximately $9 billion per year.

Several factors contribute to or exacerbate our current situation. We are a relatively large state geographically with a small population, and one which is aging and which has a high level of chronic disease. There is a lack of competition, both among health care providers and health insurance carriers.

Maine's individual health insurance market is in what is commonly referred to in the insurance industry as a "death spiral." A death spiral occurs when rate increases cause individuals (usually younger and healthier individuals) to purchase policies with very high deductibles or to drop coverage altogether, causing a deterioration in the average health of the remaining risk pool (those with health problems and who utilize the insurance benefits are less likely to drop coverage). The deterioration of the pool causes further increases in the cost of health insurance, leading more people to drop coverage, etc., etc. This can, and in fact is likely to, result in the ultimate collapse of the individual health insurance market in Maine within the next five years. To illustrate the costs in this market, a monthly premium for an individual (non-group) HMO policy for a family of 4 in Maine can cost upwards of

$2,000 a month or $24,000 a year!

These issues are not unique to the individual health insurance market—although its condition is not quite as severe, the small group market in Maine is experiencing many of the same issues and pressures. Maine employers are faced with difficult choices—do they continue existing policies at a significant increase in cost and shift more of the cost of the health insurance to employees; do they retain coverage but offer higher deductible policies; do they forego increasing employee salaries to maintain coverage; or do they drop coverage altogether? Clearly, these issues have implications on a state's economy as well. While it is easy to look at insurance premiums and recognize that they are high, the more difficult issue is examining the underlying health care costs and cost drivers. Maine has embarked on several paths to examine costs, but I will limit my testimony to a few areas.

Cost Containment—Mandated Benefit Review and Evaluation

The first area is cost-containment. There are many significant factors that contribute to cost increases, many of which are beyond our control. Mandated benefit proposals attempt to address the issue of "who pays" for health care services—they do not and cannot address the underlying costs. They are, however, one area over which the State can exercise some control.

In Maine, there are currently 24 health insurance benefits mandated by state law. The estimated cumulative cost of these mandates, shown in Table 1, ranges from 4.33% to 8.44%, depending upon the type of plan involved:

Table 1—Cumulative Cost of Mandated Benefits in Maine

	Indemnity Plan	**HMO Plan**
Total cost for groups larger than 20:	**8.44%**	**7.36%**
Total cost for groups of 20 or fewer:	**4.34%**	**4.46%**
Total cost for individual contracts:	**4.33%**	**4.36%**

In Maine, before any legislative proposal to mandate health insurance coverage for specific health services can be enacted it must undergo a review and evaluation by the Bureau of Insurance. The legislative committee considering the proposal must hold a public hearing to determine the level of support for the proposal. If a majority of the committee members support the proposal, it may be referred to the Bureau of Insurance for the required review. Once the review has been completed,

the Bureau reports its findings to the committee. The review and evaluation by the Bureau of Insurance must address four major categories of information: (1) the social impacts of mandating the benefit; (2) the financial impacts of mandating the benefit; (3) the medical efficacy of mandating the benefit and (4) the effects of balancing the social, economic and medical efficacy considerations. A copy of statute governing the review and evaluation of mandated benefit proposals (24-A Me. Rev. Stat. Ann. § 2752) is included in the presentation materials under Tab # 4, and a copy of a recent report may be accessed via the Internet (the Internet address for accessing the report is included in the presentation materials under Tab #7, "Additional Resources").

Health insurance mandates on the state level are a tricky proposition. First, laws can differ on a state-by-state basis placing a burden on insurers to design separate products and, arguably, making it difficult for employers who do business in other states. Secondly, mandate laws only apply to insured plans subject to state law—they do not apply to federally insured or ERISA-exempt plan. This also creates a dichotomy of plan offerings and plan benefits available to Maine citizens. That being said, several health insurance mandates have been enacted by the Maine Legislature, each having its own merits but also having associated costs.

For example, in 1995, Governor King signed a progressive mental health parity law that required health insurance coverage for 7 specific biologically based mental illnesses in policies held by employer groups of 20 or more. Since that time, the King Administration has grown more and more concerned about the dramatic increases in health care costs and effect of public policy on those increases. As a result, in 2002 the Administration adopted a presumption against further mandates, which only the most compelling of arguments should overturn. Given the circumstances this year, Governor King felt that he could no longer support additional mandates, and accordingly, vetoed LD 1627, "An Act to Ensure Equality in Mental Health Coverage," the only health insurance mandate vetoed during his nearly eight years as governor. L.D. 1627 sought to expand the mandated coverage to 11 categories of mental illness as defined in the Diagnostic & Statistical Manual of Mental Disorders (increasing the number of potentially covered disorders to over 40). Although the proposal was unquestionably well intentioned and would have benefited a number of Maine's citizens, it was felt that Maine could ill afford any new mandate that would further increase costs. As Governor King stated in his April 11, 2002 veto message to the Maine Legislature, "When you are in a hole, the first rule is not to dig any deeper." A copy of Governor King's veto message is included in the presentation materials under Tab #5.

State Specific Information on Cost, Quality & Participation: Maine Health Care Performance Council

Another innovative step taken by the State is the recent formation of the Maine Health Performance Council. In February 2001, Governor King established the council to prepare and maintain a long-range vision, goals, objectives, and performance measures for the health care delivery system in Maine, in order to

inform decisions by citizens, health care professionals, and policy makers. Its work is supported initially by a grant from the Robert Wood Johnson Foundation.

The Council serves in an advisory capacity and is comprised of up to thirteen employers and consumers appointed by the Governor and 2 state officials. No providers, hospitals or insurers serve on the group.

The Council's functions include:

- Preparing a vision and principles for health care in Maine;
- Developing health care goals and objectives to achieve the vision, in the areas of access, cost, efficiency, quality, status, service capacity and distribution of Maine's health care system, and other issues; and
- Reporting annually on Maine health care performance to the Governor, Legislature and the citizens of Maine. The council will monitor progress in achieving the goals on a regular basis.

The underlying goal of the group is to formulate tangible and objective measures of Maine's health care system so that policy makers have credible data upon which to base decisions. For instance, how do our monthly insurance premiums compare to rates in other states and regions? How are these rates trending? What are the underlying cost drivers of care and how can we evaluate them both in-state and in comparison to other states? The more difficult step will be determining the benchmarks on where we want Maine to be. Certainly we don't want our health inflation to be the highest in the nation! We understand that the work of the Council is unique in that no state – that we know of – is attempting to measure and quantify its health care costs and develop corresponding benchmarks.

Additional information about the Maine Health Care Performance Council and its work can be found in the presentation materials under Tab #6, or on its website: http://mdf.org/mhcpc.

Consumer Education: "How Your Health Insurance Dollar is Spent"

As more and more individuals and employers move toward high deductible policies, and citizens are paying more out of their own pockets for health care, consumer education and information become extremely important. To that end, Maine's Bureau of Insurance recently developed a brochure entitled "How Your Health Insurance Dollar is Spent." (A copy of the brochure is included in the presentation materials under Tab # 3.)

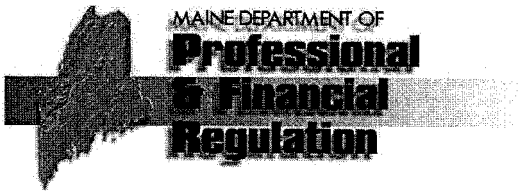
The brochure describes how much of each health care dollar currently goes to hospitals, physicians and other providers, to prescription drugs, and to administrative costs. It also provides a primer on the cost pressures created by cost-

shifting, increased utilization, under-pricing of insurance, improved but more costly new technologies, and by state and federal regulation. The brochure's primary purpose is to educate consumers about the steps they can take to slow the rate at which health care spending increases.

We hope to encourage people to become better informed consumers—to "shop around," to ask questions, to get second opinions when surgery is suggested, to find out why tests, procedures or treatments are important, how much they cost, and whether there are other alternatives available. It also encourages individuals to live healthier lifestyles. According to the State's Bureau of Health, four chronic diseases (cardiovascular disease, cancer, chronic lung disease, and diabetes) kill three-quarters of all Mainers and cause over one-third of all disabilities. Yet, most cases of these four diseases are preventable—the major risk factors include tobacco addiction, physical inactivity, poor nutrition, elevated blood pressure, and elevated cholesterol. Publication of the brochure will hopefully encourage consumers to become more engaged in their health care decisions—from daily lifestyle choices to a more active and pro-active role in the health care decision making process. Too often insurance or the availability of insurance disconnects the consumer from the cost implications of their health care.

Conclusion

We are facing a crisis in health care costs, both on the state level and nationally. Maine has taken a number of innovative steps to address and examine the rising costs of health care and health insurance, only a few of which have I outlined for you here today. Our present focus in Maine is to better understand why health care costs, and corresponding insurance costs, are increasing so dramatically—because only when we fully understand the issue and have reliable information can we adequately address the problem. It is also important not to limit the discussion on health care to "who pays" but rather to examine underlying costs and the components of such costs. Finally, although we are looking for ways to address the rising costs of health care, the states alone cannot solve this crisis—individual citizens and the federal government must also assist in this endeavor.



COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

"The Rising Cost of Health Care: How Are Employers and Employees Responding?"

JUNE 18, 2002

Presentation by
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Commissioner

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5. Veto Message to L.D. 1627, "An Act to Ensure Equality in Mental Health Coverage"

6. Maine Health Care Performance Council Information

7. Additional Resources

Tab #1

Biography of S. Catherine Longley

S. Catherine Longley is the Commissioner of the Maine Department of Professional and Financial Regulation. She was appointed to the post by Maine's Independent Governor, Angus S. King, Jr. in February, 1995. As Commissioner she acts as the chief administrative officer of the Department which regulates banks, credit unions, HMO's, insurance companies, investment advisors, broker-dealers, mortgage companies and licenses numerous professions and occupational trades.

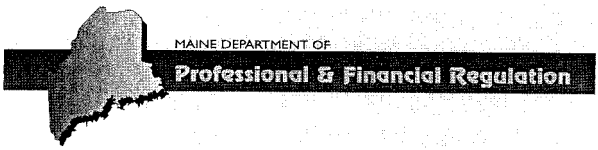
A member of Governor King's cabinet, Commissioner Longley is responsible for developing executive policy in the areas of financial services, health insurance, workers' compensation and professional licensing. The Department's $15 million annual budget encompasses the Bureau of Banking, the Bureau of Insurance, the Office of Consumer Credit Regulation, the Office of Securities, thirty-six professional/occupational licensing boards, and six licensing boards affiliated with the Department. The Department employs approximately 200 people.

Catherine has played a leadership role on several task forces and commissions, including chairing the Governor's Economic Development Subcommittee on Financial Services, the Governor's Interstate Banking/Branching Advisory Committee and serving on the Prescription Drug Advisory Committee and the Productivity Realization Task Force. She is a graduate of the Leadership Maine Program (Epsilon) Class and the 1997 recipient of the Dirigo Award from the Maine Chamber and Business Alliance for achievements in public service. Ms. Longley currently serves as a director of the Maine Development Foundation and as a member of the Maine Health Care Performance Council.

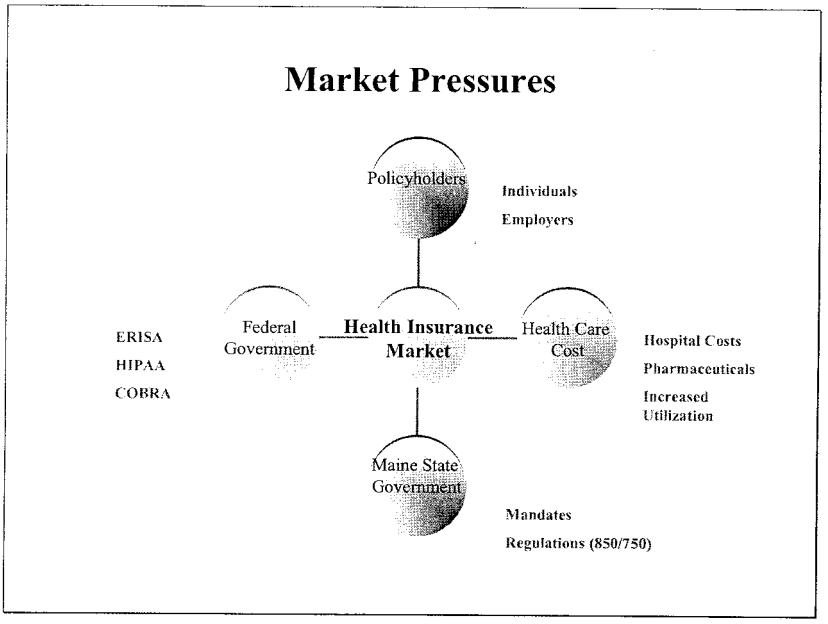
Prior to her appointment to Maine state government, Ms. Longley, who holds a J.D. degree cum laude from Suffolk University Law School and an A.B. degree in history from Bowdoin College, was a partner at the Portland, Maine law firm of Verrill & Dana, where she practiced corporate and public finance law. During her twelve years with Verrill & Dana, she also co-chaired the firm's corporate law department.

Tab #2

Characteristics of Maine's Health Insurance Market



Characteristics of Maine's Health Insurance Market

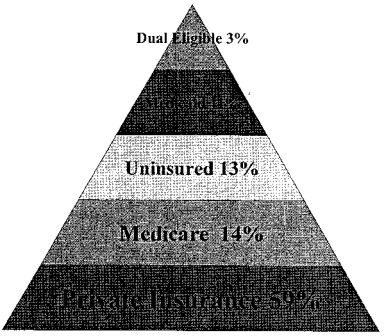

Market Pressures
Policyholders
Individuals
Employers
ERISA
HIPAA
COBRA
Federal Government
Health Insurance Market
Health Care Cost
Hospital Costs
Pharmaceuticals
Increased Utilization
Maine State Government
Mandates
Regulations (850/750)

Health Care Costs in Maine

- In 1999, the citizens of Maine spent almost $5 billion dollars per year for personal health
- This is an average of $3,901 per person and represents nearly 14% of Maine's gross state product (Nationally, the 3rd highest percentage of GSP in 1998)[1]
- Between 1990—1998, Maine's health care costs increased at the fastest rate in the United States: ↑ 80.4% in Maine compared to 53.3% nationally[2]
- By 2010, the number is expected to be approximately $9 billion, with the largest increases coming in home health care and prescription drugs, and the smallest in hospital and physician services

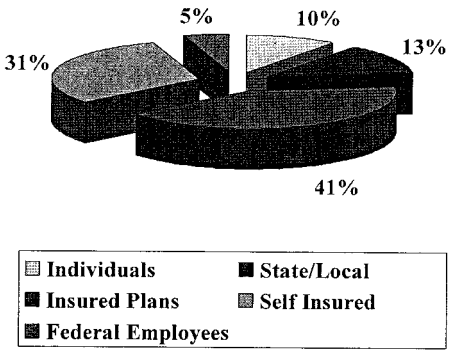
[1] Source: US DHHS, CMS, State Health Expenditures [2] Source: Morgan Quinto's Health Care State Rankings 2002

Health Care Cost Allocation
(by Percent of Maine Population)



Source: Final Report of the Year 2000 Blue Ribbon Commission (Nov 2000)

The 59% in Private Insurance is Fragmented Into this Breakdown



The 38% of the Market the Maine Bureau of Insurance Regulates:

The fully insured population is further segmented:

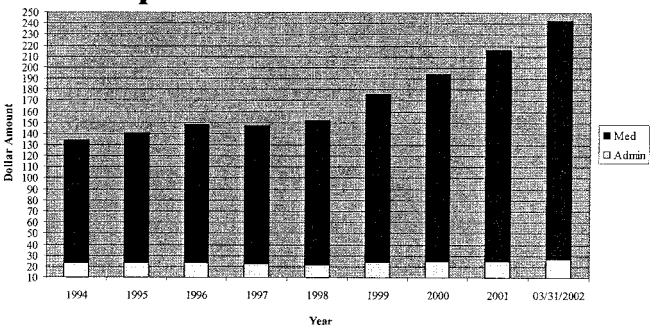
- Employer Sponsored
  - Large Group (51 & greater) (68% of market)[1]
  - Small Group (1-50) (26% of market) [1]
- Individual policies (6% of market) [1]
  - Health Insurance
  - Medicare Supplement

[1] Percentage of market is calculated from the 1999 premium written.

Characteristics of the Insurance Market:

- Double digit premium increases
- 20%-30% increase in pharmaceutical costs
- Hospital costs make up approximately 40% of medical costs
- Number of employees offered coverage over the last 10 years has declined
- Number of employees accepting coverage has declined
- Number of persons with individual health insurance coverage has decreased dramatically. This portion of market in "death spiral."

Medical and Administrative Expenses of Maine HMO's



Medical and Administrative Expenses Per Member Per Month are the total of all medical, hospital, and administrative expenditures for the Maine domestic HMO's as reported in their financial statements divided by the total member months as reported in their financial statements, except that HMO Maine's financial information is based on gross amounts (exclusive of quota share reinsurance).

Source: Maine Bureau of Insurance, 2002

Current Maine Health Insurance Rates for a Family of 4

Market	Plan[1]	Rate Range/Month[2]
Small Group	HMO	$947 - $1,394
Small Group	HMO Point-of-Service	$1,029 - $1,556
Small Group	PPO	$795 - $1,160
Small Group	Indemnity	$936 - $1,409
Individual	HMO	$1,905 - $2,307
Individual	Indemnity ($500 deductible)	$1,369
Individual	Indemnity ($5,000 deductible)	$ 433

[1] Plan Design Assumptions:

Small Group HMO plan assumes $20 office co-pay, $100 hospital co-pay, $10/$20/$30 drug co-pays (Generic/Formulary/Brand)
Small Group HMO Point-of-Service plan same as HMO plus out-of-network services are covered after a deductible and coinsurance
Small Group PPO In-Network assumes $250 deductible, 80/20 coinsurance, $750 out-of-pocket limit, Out-of-Network assumes $500 deductible, 60/40 coinsurance, $1,500 out-of-pocket limit
Small Group Indemnity assumes $250 deductible, 80/20 coinsurance, $750 out-of-pocket limit
Individual HMO assumes $10 office co-pay, $250 hospital co-pay, $10/$20 drug co-pays (Generic/Brand)
Individual Indemnity ($500 deductible) assumes 80/20 coinsurance, $700 out-of-pocket limit
Individual Indemnity ($5,000 deductible) assumes no coinsurance

[2] Rates shown are community rates for a two-adult family with children. Rates may vary 20% up or down based on age, industry, and geographic area.
Small group rates assume a ten-employee group. The range of rates shown is for insurers for which data is available. Other insurers may be outside this range.

Results for HMO Business & Blue Cross Business in Maine
1997 - 6/30/01

06/30/2001		
Pre-tax Income(Loss)	$	(10,598,130)
Provision for Fed Taxes	$	(3,297,183)
Net Income(Loss)	$	(7,300,947)
2000		
Pre-tax Income(Loss)	$	(32,460,634)
Provision for Fed Taxes	$	(5,650,867)
Net Income(Loss)	$	(26,809,767)
1999		
Pre-tax Income(Loss)	$	(64,914,531)
Provision for Fed Taxes	$	(2,968,906)
Net Income(Loss)	$	(61,945,625)
1998		
Pre-tax Income(Loss)	$	(33,587,917)
Provision for Fed Taxes	$	(7,226,448)
Net Income(Loss)	$	(26,361,469)
1997		
Pre-tax Income(Loss)	$	(54,887,205)
Provision for Fed Taxes	$	(1,078,579)
Net Income(Loss)	$	(53,808,626)
Grand Totals for 1997 - 6/30/01		
Pre-tax Income(Loss)	**$**	**(196,448,417)**
Provision for Fed Taxes	**$**	**(20,221,983)**
Net Income(Loss)	**$**	**(176,226,434)**

Tufts NE Net Loss numbers for 1997 - 1999 have been provided by Tufts Management. Pre-tax numbers are assumed to be the same as post-tax, and the Provision for Federal taxes is assumed to be 0.

Harvard numbers for 1997 - 1999 are estimated based on ME premiums compared to total premiums.

Harvard numbers for 2000 are based on estimates HPHC management has for Maine losses for 2000 (entire year).

Harvard numbers for 1/1/01 - 6/30/01 have been estimated.

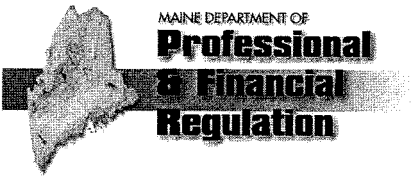
It is highly likely that Harvard losses through 1999 in Maine are in excess of estimates used here.

Contributing Factors to Health Care Cost "Crisis"

- Aging population
- High level of chronic disease
- Lack of provider competition
- Disconnect between costs and consumer
- Rural demographics
- Unintended consequences of regulation; mandated benefits
- Medical errors
- High cost impacting access to care/insurance
- Cost shifting among public/private programs *i.e.*, Medicaid and Medicare
- Consumer expectations

Tab # 3

“How Your Health Insurance Dollar is Spent”



How Your Health Insurance Dollar Is Spent

January 2002

Angus S. King, Jr.
Governor

S. Catherine Longley
Commissioner

Alessandro A. Iuppa
Superintendent

How Your Health Insurance Dollar Is Spent

In Maine, as in many other parts of the country, health insurance premiums are experiencing their biggest increases since the early 1990s. Health care expenses continue to grow faster than spending for other goods and services. Nationwide, average annual increases of 13% or more are projected for insurance plans over the next year.[1]

In 1999, health insurance bought by Maine employers cost an average of about $2,400 per year per employee, and an average of about $6,200 to cover both employees and their families.[2] These rates have since seen double-digit increases, with increases as high as 50% for some businesses . According to one national estimate, the health insurance cost for each employee will increase an average of $746 this year.[3] Maine can expect to see double-digit increases for at least several more years.

Who's affected?

Everyone's affected by increases in health care spending, but small businesses and individuals in Maine face particular challenges.

Small businesses - In 2001, small businesses across the country experienced higher increases in health insurance premiums than larger firms. This trend is predicted to continue into 2002.

Fewer than half of Maine businesses offer health insurance to their workers, but those that do provide coverage for almost 60% of Maine people.[4] Most Maine businesses are small. In national surveys, significant numbers of small employers say they may drop their health insurance if rates rise by 10% in the coming year.[5]

Nationally, of the employers that offer health insurance, fewer than half pay the full cost of that insurance.[6] The weakening economy has put more economic pressure on employers, so they are shifting more of the health care costs to their workers. Employees across the country will probably pay between $186 and $463 more annually for health insurance over the course of 2002 than they did in 2001.[7] Many workers refuse health insurance for themselves or their families because of the costs.

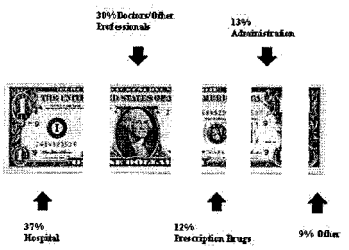
Individuals - Individuals who buy their own health insurance have an even tougher time maintaining coverage. Many healthy self-employed Mainers, or Mainers whose employers don't provide insurance, have dropped coverage because it is too expensive, leaving those with the greatest medical need in this market. The very small size of this market and the high medical needs of the people remaining in this market have resulted in significant premium increases since 1998.

Everyone faces greater out-of-pocket costs. In addition to paying a larger health insurance premium cost, people must pay greater copayments and deductibles, as well as higher costs for prescription drugs. In 1999, the average Mainer paid between $1,000 and $2,000 out-of-pocket for personal health care expenditures.[8]

Where does the money go?

Private health insurance rates are based on several costs, including those for hospitals, doctors and other health care professionals, and prescription drugs. The following graphic illustrates where healthcare dollars went in 1999.

How Maine Health Care Dollars Are Spent (1999)



Hospital care: 34%
Doctors/other professionals: 22%
Nursing home care: 11%
Prescription drugs: 10%
Administration: 8%
Other (including home health & durable medical equipment): 15%

Source: Year 2000 Blue Ribbon Commission on Health Care

Hospitals

In 1999, approximately 37¢ of every insurance dollar spent on medical costs in Maine paid for hospital costs.[9] In 2000, HMOs in Maine paid approximately 40% of their medical costs for in- and out-patient hospital services.[10] And in 2001, 10 hospital systems are among Maine's top 100 revenue-producing firms; two are in the top 10.[11] On a national level, increases in hospital

costs account for nearly half of the overall health care spending increase in the past year.[12] Reasons for these increases include: more bargaining power with insurers (especially in rural areas, where a hospital may be the only choice), labor shortages, and making up for shortfalls because Maine Care (Medicaid) and Medicare don't pay their full costs (more on this in "cost-shifting," on page 7).

Doctors, other health care professionals

In 1999, approximately 30¢ of every insurance dollar spent on medical costs in Maine paid for services provided by Maine doctors or other health care professionals.[13] Nationally, increases in spending for doctors and other professionals accounted for one-quarter of the overall increase in health care spending in the past year.[14] Specialty physician salaries in particular have jumped as a result of greater patient demand and the fact that residency training in the 1990s stressed primary care.[15]

Many doctors have joined with hospitals to create physician-hospital organizations. These organizations may be patients' only choice, especially in rural areas, so insurance companies are compelled to include them in their networks. This means these organizations have greater leverage in negotiating fees to participate in these networks.

Shortages among health care professionals – such as nurses and pharmacists – also lead to increased costs for medical services both in hospitals and through other health care providers.

- In Maine hospitals, nearly 10% of nursing positions are unfilled.[16]
- In hospitals across the country, 21% of pharmacist positions are unfilled.[17] In retail pharmacies across the country, the number of unfilled pharmacist positions rose to 7,000 in the year 2000 from 2,700 two years earlier.[18]

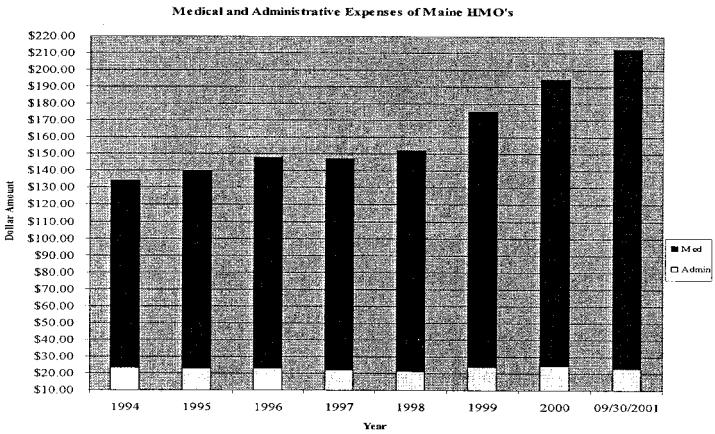
Because these professionals are scarce, attracting qualified individuals means offering signing bonuses or higher wages. Facilities may also be paying increased overtime to existing workers to maintain adequate staffing levels.

Prescription drugs

In 1999, approximately 12¢ of every insurance dollar spent in Maine on medical costs paid for prescription drugs.[19] Nationally, increases in spending for drugs made up more than one quarter of the overall increase in health care spending in the past year.[20] Drug spending could increase by 20% in the coming year.[21] This higher spending is due to three things: higher prices for existing drugs, changes in the types of drugs used (as newer and more expensive drugs replace older drugs), and – most importantly – more people using more drugs. Direct advertising to consumers on TV and in magazines has contributed to more people demanding the latest prescription drug.

Administrative costs

In 1999, approximately 13¢ of every insurance dollar spent in Maine on medical costs paid for insurers' administrative services.[22] As the chart on the following page shows, the administrative costs for Maine HMOs – which often have higher administrative costs than other insurers – are dropping as a percentage of their total costs.



Source: Maine Bureau of Insurance, 2001 Medical and Administrative Expenses Per Member Per Month are the total of all medical, hospital, and administrative expenditures for the Maine domestic HMO's as reported in their financial statements divided by the total member months as reported in their financial statements, except that HMO Maine's financial information is based on gross amounts (exclusive of quota share reinsurance).

Other cost pressures

Cost-shifting - Different people pay different prices for medical services, which may or may not reflect the costs of these services. For example, about one-third of Mainers receive health care coverage from Medicare and Maine Care (Medicaid).[23] However, Maine Care (Medicaid) and Medicare often pay health care providers less than the cost of the service. Maine hospital administrators say that Medicare underpays a total of $100 million per year.[24] These uncompensated costs are borne by Mainers who have health insurance or self fund their health care expenses.

Greater use of health care services - Elderly people tend to use more medical services than younger people, and Maine has the 16th highest percentage of residents age 65 or older in the country.[25] We'll soon have more people over 65 than under 18, a first in Maine's history.[26]

Mainers also tend to be less healthy than people in other states. Lifestyle choices account for a significant portion of health care problems in Maine, resulting in high usage of health care services.

- Nearly one-quarter of the population of Maine smokes.[27] In 1993, over $343 million were spent on medical costs related to smoking.[28]

- Over half the population in Maine is considered overweight or obese.[29] If coronary bypass surgery and angioplasty – which are often connected with obesity – were reduced by 20%, the health care system would save $38.3 million a year.[30]

Insurance underwriting cycle - In the mid-1990s, insurance companies offered premiums lower than their expected cost in order to attract more enrollees. After years of financial losses (over $176 million in Maine since 1997),[31] most are trying to play "catch-up."

More expensive medical technologies - Many new medical technologies have resulted in improvements in health care. However, these new technologies frequently cost much more than the tools they replace. Demand for the newest treatments increases overall health care spending.

Regulation - State and federal mandates, aimed at protecting insured people, can also drive up costs. In Maine, mandated benefits are estimated to have increased insurance rates for businesses with more than 20 people by up to 8%, and for businesses with 20 or fewer people or for individuals by up to 4%.[32] Maine's regulations that require health plans to provide access to a hospital within one hour's drive have resulted in insurance companies having to keep most hospitals in their networks, giving hospitals the power to negotiate tough financial terms.

What you can do

You can do several things to slow down the rate at which health care spending is increasing:

- Become an educated health care consumer and learn the real cost of medical services, as well as the best ways to get the care you need to stay healthy.
    - If you're choosing a doctor, look for one who encourages you to ask questions and explains things clearly. You may want to ask family, friends, coworkers, or even the doctor's office staff for recommendations on a new doctor.
    - Write down questions before your visit, and don't be afraid to "bother" your doctor with those questions. If you have questions after leaving the doctor's office, call.
    - Before you have a test, ask the doctor to explain why it's important, whether it's the only way to get the needed information, the benefits and risks, and what it will cost.
    - If you're diagnosed with a medical condition and your doctor suggests a treatment, find out what it will or will not do, how much it will cost, and whether other treatments are available that would have the same results.
    - If your doctor suggests that you have surgery, get a second opinion on the need for the operation and other possible ways to treat your condition. Check if your health insurance will pay for both the second opinion and the operation. If you decide to have the operation, ask what your surgeon's fee is and what it covers, including whether it covers visits after the operation.[33] If the operation will be performed in a hospital, call the hospital beforehand to find out the related costs, such as anesthesia.

- If you're an employer, build a culture among your employees that promotes education about health care and health care consumption.

- Think about your prescription drug choices, and talk to your doctor and pharmacist. In general, the average price of brand name drugs is about three times the price of generic drugs. The Bureau of Elder and Adult Services has a website (www.state.me.us/dhs/beas/drugs/drug_survey.htm) that lists the prices across the state for 15 commonly used prescription drugs . You can use the "drug pricing calculator" on the site to determine the total price for the prescriptions you use. You can also ask your doctor about the cost of the drug he or she is prescribing, and about lower cost drugs you could try instead.

- If your health plan has a nurse hotline, and you get sick at night or on a weekend but are not sure if you need to go to the emergency room, call the nurse hotline for help.

- Talk to providers, including members of hospital boards, about their costs and need for the newest technology.

- Stop smoking. The Partnership for a Tobacco–Free Maine runs the Maine Tobacco HelpLine, which offers free and confidential telephone counseling to anyone who wants to stop using tobacco. The HelpLine number is 1-800-207-1230. You can also visit their website at: www.tobaccofreemaine.org/default.asp.

- Live a healthier lifestyle. The federal Agency for Healthcare Research and Quality can give you some ideas on taking charge of your health. Their guides include:

  - *Personal Health Guide: Put Prevention into Practice*, which will help you make sure that you get the tests, immunizations (shots), and guidance you need to stay healthy[34]
  - *Child Health Guide: Put Prevention into Practice*, which will help you become an active member of your child's health care team[35]
  - Staying Healthy at 50+: Put Prevention into *Practice,* which gives information on living habits that have been proven to help prevent certain diseases and conditions[36]

  The above listed guides are free from the Agency's website: www.ahrq.gov – or Publications Clearinghouse – 800-358-9295.

- If you're an employer, start or encourage your employees to participate in wellness programs promoting smart eating choices, exercise, or smoking cessation.

For more information...

The Maine Bureau of Insurance has many publications available to help consumers and small business owners. These can be requested from the Bureau by calling 1-800-300-5000 or can be downloaded from the Bureau's web site at: www.MaineInsuranceReg.org.

- *Health Insurance Complaint Ratios - 2000*
- *Consumer's Guide to Health Insurers Doing Business in Maine (Internet brochure)*

- *A Consumer's Guide to Individual Health Insurance*
- *What Can I Do If I Lose My Group Health Insurance?*
- *What Maine Small Employers Should Know About Health Insurance*

Many state and national data sources were used in compiling this brochure. If you'd like more information, the following may be particularly helpful:

www.healthweb.state.me.us – a website developed by the Maine Health Data Organization — includes information on how much was charged for various medical procedures in hospitals.

The Cost of Health Care in Maine: Report of the Year 2000 Blue Ribbon Commission on Health Care, www.mdf.org (under "Publications Available")

The Henry J. Kaiser Family Foundation State Health Facts Online, www.statehealthfacts.kff.org

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, www.ahrq.gov

Footnotes

[1] The Segal Company. 2002 Segal Health Plan Cost Trend Survey. October 2001.

[2] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 1999 Medical Expenditure Panel Survey – Insurance Component. Reported in: The Henry J. Kaiser Family Foundation. State Health Facts Online. www.statehealthfacts.kff.org.

[3] "Health insurance costs set to soar/U.S. health care costs/Why health insurance costs are rising," Omaha World – Herald. November 4, 2001.

[4] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys. Reported in: The Henry J. Kaiser Family Foundation. State Health Facts Online. www.statehealthfacts.kff.org.

[5] Healthcare Leadership Council. HLC Small Business Health Insurance Survey. Survey of 500 employers with 150 or fewer employees conducted June 27-July 13, 2000 by American Viewpoint, Inc.

[6] Data from the 2001 Cost Management Group Annual Compensation and Benefits Survey. Reported in: "Health plans top list of employee fringe benefits, with PPO and POS plans finding favor," Cost Management Update. October 1, 2001.

[7] Perrault, Michael. "Hewitt Associates study predicts employer health costs will rise 13% to 16% in 2002," Denver Rocky Mountain News. October 30, 2001.

[8] Market Decisions. Citizen Perceptions of Health Care Issues. July 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[9] Year 2000 Blue Ribbon Commission on Health Care. The Cost of Health Care in Maine: An Analysis of Health Care Costs, Factors that Contribute to Rising Costs, and Some Potential Approaches to Stabilize Costs. Report to Governor Angus S. King, Jr. November 2000.

[10] Maine Bureau of Insurance. Expenditure Composition for Domestic HMOs 2000.

[11] Willard, John. "Views from the top: The Maine 100," Portland Monthly Magazine. October 2001.

[12] Strunk, Bradley C., Ginsburg, Paul B., Gabel, Jon R. "Tracking health care costs: Hospital care surpasses drugs as key cost driver," Health Affairs (Web Exclusive). Data Bulletin No. 21, September 26, 2001. www.healthaffairs.org.

[13] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[14] Strunk, Ginsburg, Gabel (See note 12).

[15] Greene, Jay. "Surging demand for specialists spurs salary hikes: Practices and groups are having to pay, as well as deliver higher perks," AMNews. October 22-29, 2001 (based on data by Merritt, Hawkins & Associates 2001 Recruiting Incentive Study).

[16] Maine Hospital Association. Maine's Healthcare Workforce: Examining the Implications of a Growing Labor Shortage on Access to Hospital Care. September 2001.

[17] American Hospital Association data reported in: Wiebe, Christine. "Pharmacist shortage reflects profession's struggles," Medscape Money & Medicine. 2001.

[18] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists (Report to Congress). December 2000.

[19] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[20] Strunk, Ginsburg, Gabel (See note 12).

[21] The Segal Company (See note 1).

[22] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[23] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[24] Critical Insights. Attitudes Toward Administrative Inefficiencies in Health Care. 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[25] Urban Institute and Kaiser Commission on Medicaid and the Uninsured (See note 4).

[26] Year 2000 Blue Ribbon Commission on Health Care (See note 9).

[27] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death. December 1999. Reported in: The Henry J. Kaiser Family Foundation, State Health Facts Online. www.statehealthfacts.kff.org.

[28] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. CDC's Tobacco Info – State & National Tobacco Control Highlights – Maine. www.cdc.gov/tobacco/statehi/htmltext/me_sh.htm.

[29] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (See note 27).

[30] Maine Turning Point. "Survey shows Mainers willing to pay for better health" (press release). May 8, 2000. Reported in: Year 2000 Blue Ribbon Commission on Health Care.

[31] Maine Bureau of Insurance. Results for HMO Business & Blue Cross Business in Maine, 1997-9/30/01.

[32] Maine Bureau of Insurance. A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature: Review and Evaluation of LD 403, An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons. May 9, 2001.

[33] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Be Informed: Questions to Ask your Doctor Before You Have Surgery. Pub. No. 95-0027. January 1995. www.ahrq.gov/consumer/surgery.htm.

[34] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Personal Health Guide: Put Prevention into Practice. Pub. No. APPIP 98-0027. Consumer Information, April 1998. www.ahrq.gov/ppip/ppadult.htm.

[35] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Child Health Guide: Put Prevention into Practice. Pub. No. APPIP 98-0026. www.ahrq.gov/ppip/ppchild.htm.

[36] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Staying Healthy at 50+: Put Prevention into Practice. Pub. No. 00-0002. January 2000. www.ahrq.gov/ppip/50plus/index.html.

Maine Bureau of Insurance's Consumer Assistance Hotline can help with questions and with problems with insurance companies.

Call 1-800-300-5000 or visit www.MaineInsuranceReg.org for help.

The Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates the insurance industry for solvency and consumer protection. It does so through its examining and licensing procedures of insurance companies, by licensing producers, by reviewing rates and coverage forms, by conducting audits, and by sponsoring programs that enhance awareness of and compliance with State laws. The Bureau has statutory authority to enforce the State's laws and rules pertaining to insurance, and it initiates investigations and holds hearings concerning possible infractions of them.

Alessandro A. Iuppa
Superintendent

Printed under Appropriation Number 014 02A 3041 012
January 2002

Tab #4

Maine's Mandated Benefit Review and Evaluation Law

(24-A ME. REV. STAT. ANN. § 2752)

MAINE REVISED STATUTES
Title 24-A, MAINE INSURANCE CODE
CHAPTER 33. HEALTH INSURANCE CONTRACTS

§ 2752. Mandated health legislation procedures

1. **Mandated health benefits proposals.** For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

2. **Procedures before legislative committees.** Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the Bureau of Insurance for review and evaluation pursuant to subsection 3. Once a review and evaluation has been completed, the committee shall review the findings of the bureau. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

3. **Review and evaluation.** Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

(1) The extent to which the treatment or service is utilized by a significant portion of the population;

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

(4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered;

(15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(16) The impact of making the benefit applicable to the state employee health insurance program;

B. The financial impact of mandating the benefit, including:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

(6) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(9) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(10) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State;

C. The medical efficacy of mandating the benefit, including:

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of practitioners:

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(b) The methods of the appropriate professional organization that assure clinical proficiency; and

D. The effects of balancing the social, economic and medical efficacy considerations, including:

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

Tab #5

Veto Message of Governor Angus S. King, Jr.

L.D. 1627, "An Act to Ensure Equality in Mental Health Coverag

April 11, 2002

To the Honorable Members of the 120th Legislature:

Enclosed please find H.P. 1205, L.D. 1627, "An Act to Ensure Equality in Mental Health Coverage," which I am returning without my signature or approval.

In 1995, I signed a progressive mental health parity law that required health insurance coverage for 7 specific biologically based mental illnesses in policies held by employer groups of 20 or more. This new bill goes considerably beyond the 1995 act to expand mandated coverage to 11 categories of mental illness as defined in the Diagnostic & Statistical Manual of Mental Disorders (increasing the number of potentially covered disorders to over 40); to include licensed clinical professional counselors in the definition of providers eligible to treat mental illness and receive reimbursement for those services; and to require coverage for residential treatment services and home support services. The addition of anxiety disorders, personality disorders, attention-deficit/disruptive behavior disorders and the substance abuse aspects of those illnesses already covered under the 1995 law inevitably will increase health insurance costs.

While the bill before me is well intentioned, it is offered in a period of dramatically escalating health care and insurance costs. As we look for ways to reduce the costs of health care, we must not exacerbate the problem by adding new mandates. When you are in a hole, the first rule is not to dig any deeper. This bill would serve to make the hole deeper, because the addition of another mandated benefit virtually guarantees that the cost of health insurance for employer groups of 20 or more will increase. I realize that cost estimates in connection with this bill are in the range of .5% of current premiums; but in the current climate, <u>any</u> increase mandated by the state is unacceptable, particularly in an area where significant growth can be expected.

We already know that more and more employers are being presented with increases in health insurance renewal premiums that range from 25% to 50% and more. According to one national estimate, the health insurance cost for each employee will increase an average of $746 this year. During the first session of the 120th Legislature, we heard testimony about specific businesses and their premium increases. For example, a retail tire business with 31 employees saw its health insurance rates increase over 42% from 1998-2000, and a physician practice with 32 employees saw its rates increase over 20% from 1999 to 2001. These and other Maine businesses are forced to confront difficult choices: do they continue existing policies at a significant increase in cost and shift more of the cost of the health insurance to employees; do they retain coverage but offer higher deductible policies; do they forego increasing employee salaries to maintain coverage; or do they drop coverage altogether? All of these options translate into less money in the pockets of Maine citizens.

Proposals to try to make health insurance more affordable, such as those brought forward by Speaker Saxl and President Bennett, have dominated this Legislative session. It is worthy of note that L.D. 1627 will have exactly the opposite effect and will serve to make

health insurance more expensive. The bill itself recognizes this fact, by including an appropriation to the general fund to cover the increased costs to the state employee health plan. Many other Maine employers that provide health insurance will have to do the same thing if L.D. 1627 takes effect.

The bill also anticipates savings to the general fund, reflected in a deappropriation of funding for the Departments of Behavioral and Developmental Services and Human Services. These deappropriations are predicated upon expected savings to state programs to be gained by shifting these costs to employers and employees in the private insurance market. I am reluctant, however, to accept these "anticipated savings" because is not clear to what extent employers or employees are likely to drop coverage due to increasing health insurance premiums.

We are facing a health insurance crisis in this state, and accordingly, it is a particularly bad time to add costs, regardless of how big or small. As we face expected double-digit increases in health insurance costs for at least several more years, we cannot ask people who can barely afford what they have now to pay more. While expanding mental health care is a worthy goal, we cannot allow the best (comprehensive coverage including full mental health benefits) to become the enemy of the good (any coverage at all).

Because of the objections outlined above, I am in firm opposition to L.D. 1627 and I respectfully urge you to sustain my veto.

Sincerely,
S/Angus S. King, Jr.
Governor

Tab # 6

Maine Health Care Performance Council

The Maine Health Care Performance Council envisions that all Maine citizens will participate in a health care system that is integrated, affordable, accountable and accessible.

Goal Statements

The health care system should be structured to promote appropriate participation by consumers, providers and payers.

The health care system should be cost-effective and financed to ensure its long-term sustainability.

The health care system should produce quality outcomes and information to improve the health of Maine citizens.

Subgoals

Physical Participation
Does the system promote appropriate participation by consumers and providers?

Financial Participation
Does the system's payment system support the vision?

Other Issues
Are there issues related to culture, disability or education that inhibit access?

Distribution of Payer Cost
Who pays and how much? Who doesn't pay? Where do the dollars go?

Provider Costs
How much does it cost to deliver the services being bought?

Unit and Utilization Costs
What is the service delivery cost per unit? How is it related to utilization?

Other Cost Areas
What are cost implications of public health? What are cost drivers in the system?

Cost Shifting
Where/who are costs being shifted from? And where/who are costs being shifted to?

Structural Quality
Does the system's infrastructure support the collection, analysis and dissemination of information to its users?

Treatment Quality
Does the infrastructure promote and support the provision of quality treatment?

Quality of Outcomes
What are the health care results of interventions, and how does the system affect them?

Tab # 7

Additional Resources

Additional Resources

Characteristics of Maine's Health Insurance Market (Tab 2):

White Paper: Maine's Individual Health Insurance Market (January 2001):

http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.htm (HTML)
http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.doc (MS Word)
http://www.state.me.us/pfr/120_Legis/reports/ins_Indiv_health_2001.pdf (Adobe PDF)

"The Cost of Health Care in Maine," Report of the Year 2000 Blue Ribbon Commission on Health Care (November 2000):

http://mdf.org/chc/

LD 1627, "An Act to Ensure Equality in Mental Health Coverage" (Tab 5):

Review and Evaluation of LD 1627, An Act to Ensure Equality in Mental Health Coverage:

http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.htm (HTML)
http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.doc (Word)
http://www.state.me.us/pfr/120_Legis/reports/ins_LD1627.pdf (Adobe PDF)

Maine Health Care Performance Council (Tab 6):

http://www.mdf.org/mhcpc

APPENDIX E - STATEMENT OF PATRICK B. McGINNIS, CHAIRMAN AND CEO, TROVER SOLUTIONS INC., LOUISVILLE, KY

Testimony of Mr. Patrick B. McGinnis

Chairman & CEO, Trover Solutions, Inc.

June 18, 2002

Good Morning. My name is Patrick B. McGinnis, Chairman & CEO of Trover Solutions, Inc., the leading provider of recovery services for healthcare payers and property and casualty insurers in the United States. We offer subrogation, overpayment recoveries, bill auditing, and other related services for all types of insurers, as well as technology solutions for these types of business processes. We employ 670 people, about 80 percent of whom reside in our home city of Louisville, Kentucky.

Rising Costs forced us to Change

Trover Solutions was facing unusually high increases in premiums, largely as a result of extremely high claim costs for a small number of employees over the last few years. Premium increases of 17% in 2000 and 15% in 2001, large by normal standards, pale in comparison to the whopping 76% increase we faced in 2002. These increases had their roots in a small number of very large claims for a few employees. In 2000, seven claims amounted to about half a million dollars. Twelve claims in 2001 totaled over $600,000 dollars. A few sick people with catastrophic health care needs and relentlessly rising underlying health care costs combined to drive our premiums through the roof.

In the face of such proposed increases, we had very few choices. We could drop coverage, reduce our contributions, and/or force our employees to pay more toward their benefits, or significantly increase their cost share at the point-of-service. None of these options was attractive from an employer's perspective. A big concern we had was that our younger, healthier employees would leave the company if their health care contributions were too high. Another major concern was that employees with lower levels of compensation would be forced to drop coverage.

We decided to bet on consumer choice

We turned to Humana Inc., our long-standing health benefits company, for a solution. Humana, one of the largest health benefits companies in the country, had recently introduced a new approach to health benefits offering more choice to employees and giving employees more opportunity and incentive to manage their own costs.

The challenge facing Humana – as it was for its business customers like us – was

how to create some predictability around the management of costs while retaining choice and flexibility for the employee. Humana saw the solution in the development of new products and services that would expand consumer choices, help its members understand the financial implications of their health care decisions including balancing the trade-offs between coverage and costs, and engage them as consumers in better using health care services.

These were the ideas behind the suite of benefits options that Humana designed for Trover Solutions. In past years we had offered our employees only a single plan; this time around our employees were offered a range of six health benefit options that included HMO and PPO options as well as two new "CoverageFirst" flexible contribution options. These low-cost options provide an open $500 medical services benefit allowance for preventive or routine services then an expenditure window of either a $1000 deductible with 80/20 insurance coverage in network or $2500 deductible with 100% coverage in network, both capping employee out-of-pocket expenses. While the cost of the rich-benefit HMO increased by over 45 percent, the lowest-cost CoverageFirst option increased premiums by only 15 percent.

The CoverageFirst options allowed employees who expected to have low health care expenditures to significantly lower their payroll deduction premium payments. While they took on the risk of either $1000 or $2500 deductibles, they retained insurance protection from catastrophic loss as well as coverage for routine and preventive services. These sorts of options are being considered by other carriers, but have been criticized for siphoning off the good insurance risks and creating an imbalance in the risk pool. However, by offering these choices in a suite of benefit options from the same carrier, Humana allowed us to protect the integrity of our insurance pool while giving employees a chance to choose a plan based on their own evaluation of their health care needs. As it turned out, in our case, nearly two-thirds of our employees chose these low-cost plans— male and female, young and not-so-young – myself and my family included.

How are these benefit designs expected to control utilization and claim costs? We expect our employees to exercise more fiscal restraint in response to their own financial exposure. Specifically, the $500 benefit allowance begins to engage the employee as a consumer—allowing them to make decisions on how to spend what they perceive to be "their" money. Offering a flexible contribution strategy option creates predictability for us and transparency for our employees with respect to the relative cost of benefit options. Increased cost-sharing during episodes of care will create badly needed price sensitivity to the individual health care decisions our employees face. The SmartSuite™ bundle of products for one large employee group has been performing better than expected. Through a combination of increased member awareness of the cost of health services, choice of appropriate health plan options, and plan changes, the employer has been able to hold premium increases to single digit levels.

In addition, to reduce our administrative costs, enrollment was managed entirely on-line. This also created opportunities for us to better educate our employees about

their choices.

For example, we have been putting a great deal of effort into engaging our employees in thinking about the cost and the value of their health benefits and to promote more health consciousness, too. We have instituted several work-site health programs, including a women's health program and an antibiotic awareness program, and are in the process of implementing a pilot program to conduct health risk assessments of employees both on-line and through the telephone in order to better focus and design future wellness programs. In addition, our Human Resources Department provides our employees with consumer-oriented healthcare information on a daily basis via e-mail.

Education and communication with employees is key to success

A well-informed and well-prepared consumer, armed with the right tools, is essential to creating a system that works for everybody. But change in health benefits has to be handled carefully because health benefits are highly valued, yet poorly understood. To compound this difficulty, employees have a tendency to spend little time thinking about the cost of care, the cost of insurance, and how they want to balance those costs in their health benefits. If you think about this in comparison to how much time consumers spend deciding what kind of car, stereo system, or computer they want to buy...the differences are truly astonishing. A recent Watson Wyatt & Company survey found that employees underestimate the total cost of health benefit premiums as well as their share of that cost, and tend to see health benefit coverage as an entitlement. Most employees believe the cost of an office visit is $10 and the cost of prescriptions is $20. They believe this because that is what they pay at the point of service out of their own pocket. The real cost of an office visit to a specialist in Louisville averages $75. The real cost of a month's supply of a prescription for Prilosec averages $120.

In anticipation of the benefit changes, we went to great effort, with Humana's help, to educate our employees about the new plan options and help them make their plan choices. We launched a pre-enrollment communications plan raising awareness of rising health costs and growing consumerism in health care. We met with employees and created an employee advisory committee to make sure we got good feedback.

To help our employees make a plan selection that best fit their needs, Humana created an electronic selection "wizard" that walks employees through key decisions and rank-ordered the plan options based on the employee's estimate of their health care use. A follow-up survey showed that employees liked the wizard and felt well prepared to make their health care selection.

According to our health benefits administrator, employees found that the Wizard confirmed their choice for the plan that would best suit their needs. The Wizard helped employees feel better informed about their financial risks, and gave them more peace of mind about their choices. Also, the Wizard is designed to make

employees think about their health care.

All these factors have also made the Flexible Spending Account program at Trover Solutions a preferred option. It had not been as successful until employees themselves could evaluate what was best for them. By using the Wizard, employees saw how health care costs add up--reinforcing the need to plan for medical expenses. This increased our employees' use of Flexible Spending Accounts for 2002.

Employee Response

Most employees found the educational materials understandable, and 80 percent said they felt they had received the right amount of information prior to enrollment. About sixty percent of our employees used the enrollment Wizard to help them choose, and although not all of them chose the plan selected by the Wizard, they did feel that it helped them make their decision. Ours is a pretty technology-savvy company, so the use of information technology for decision support and enrollment was well accepted by our employees.

Our benefit administrator Vanetta Ladesma summarized this way:

> *I would tell my colleagues that SmartSuite™ is the way of the future in health plans, especially the CoverageFirst plans. This package gives our employees options from a broad range of plans, from traditional HMOs and PPOs to the innovative CoverageFirst plans. This also forces the employees to actually look at their health care utilization and how that impacts costs. I think it is a good way to lower claims; people won't go running to the emergency room when a trip to their doctor would suffice, and they won't go running to their doctor unless they feel they really need to. The program really makes employees think about what they are doing because they are shouldering more of the cost.*

What Can Congress Do

The rising tide of health costs can not be held back with regulation. We've tried regulating prices and it hasn't worked. We've tried regulating supply and it hasn't worked. We've tried regulating the product, and premiums have increased. We've tried regulating consumer health care use, and the public has pushed back.

It's time we tried to make the market work for consumers like you and me. We've been told that employees want more choice. We need to encourage health benefit designs that encourage employees to use health care services judiciously, and that give them greater freedom to manage their health care expenditures, while still protecting them from catastrophic financial consequences to illness. These products have to be introduced carefully. If these options are allowed to siphon off the healthy and isolate the sick few in the insurance pool, private, employer-sponsored health insurance coverage will soon become unaffordable. And, employees need good information to make these decisions – about providers, wellness programs, and

the cost of care. Our own experience revealed that implementing these new products heightened awareness of the opportunity in flexible spending accounts and personal care accounts to help employees manage their health care expenses and save themselves money. We were able to boost participation in these programs through the CoverageFirst benefits designed for us by Humana. Congress should take steps to increase the flexibility in the management of these accounts so that they will be more attractive to employees. I encourage Congress to pass legislation that permits a rollover of funds in Flexible Spending Accounts or other Health Spending Account options to encourage employees to use their dollars wisely and save balances as appropriate for future needs. Congressman Fletcher and Congressman DeMint—as well as many others--have introduced legislation to permit $500 to be rolled over each year – I urge you to cosponsor and see this legislation enacted.

Conclusion

This was not just a new product or benefit design – it was a full solution for us so we could provide affordable health benefits to all of our employees. And it was not intended to add to the financial burden of employees – they remained protected – but it created more opportunity for willing employees to handle a portion of their own health care expenses. It was developed so the new product options did not degrade our risk pool. And, given the migration of employees to the new products, it allowed for cost savings by capitalizing on the desire of many of our employees to take more control over the management of their health care finances.

We believe that we have to begin to engage our employees in decisions affecting the cost and effectiveness of health care. We believe that by giving consumers more choice and more control, and better information to help them make the choices that are right for them, consistent with their own values and preferences and resources, we'll help to create more affordable, more efficient, and more desirable health system for everybody.

We need some laws changed, like permitting a rollover of funds from year to year in the Flexible Spending Accounts to be passed to fully achieve the positive benefits of this consumer-driven health journey we should all follow.

APPENDIX F - STATEMENT OF CAROL MILLER, THE FRONTIER EDUCATION CENTER, SANTA FE, N M

Testimony of Ms. Carol Miller

The Frontier Education Center

June 18, 2002

Mr. Chairman and Members of the Committee,

Thank you very much for inviting me to testify about how the rising costs of health care are affecting both employers and employees. You are to be commended for taking action on this issue of critical importance to tens of millions of hard working Americans who are counting on you. We look forward to the Congress providing leadership to assure that health insurance coverage not only remains available and affordable to those who are currently covered, but that millions of uninsured and underinsured workers will be also have access to affordable health insurance.

Although I have previously worked in the health care field, my current work is focused on broader issues, primarily the inter-relationship between community economies, education, health status and health services in the smallest and most isolated rural communities, the enduring American frontier.

Communities With Low Rates of Insurance Are In Crisis

I am here today speaking as a consumer very concerned with the changing face of employment in the United States and how those changes impact employment-based benefits. Because this issue affects my family in a very personal way, I have done my best to become well-informed on the issue not only as a professional, but as an informed consumer.

I live in Rio Arriba County New Mexico which has one of the highest rates of uninsurance in the United States. While New Mexico hovers between 22 and 30 percent uninsured, Rio Arriba, depending on the study, is somewhere between 46 and 60% uninsured. This impacts the behaviors of my neighbors, most of whom do not access even the most minimal level of services most Americans take for granted.

Weekends in northern New Mexico are filled with car washes, enchilada dinners, pancake breakfasts, and the buying and selling of raffle tickets to raise money for neighbors needing help paying for cancer or other medical care for members of their family. Donation jars with a photo of a sick child and a plea for donations are a familiar sight at gas stations and local stores. I believe my community is not alone in coming together in these informal ways to help pay for life-and-death health services. In almost every case, at least one parent of these children is employed, and often at more than one job, trying to support their family.

This is not an acceptable way to pay for health services in this great nation. While people are as

generous as possible and want to help, it is always too little, too late. We need systemic improvements to guarantee access to health coverage by working people.

Uninsured Americans Work

Research by the Commonwealth Fund documented that most uninsured people are employed. This study found that 19 million full-time workers (16.4% of all full-time workers) are uninsured and 5.2 million part-time workers (22.4% of all part-time workers) are uninsured. (Commonwealth Fund, March 2000) Census data tells us that people in certain occupation groups are most likely to be uninsured with agriculture, construction, and household services leading and the next tier including retail, repair services, personal services, entertainment, forestry and fisheries (CPS, Census Bureau).

Three of these occupational groups are primarily located in rural areas, agriculture, forestry and fisheries, which contributes to the high rate of rural uninsurance. These are not only rural occupations, but are all also seasonal which doubles the risk that workers in these industries will be uninsured. In this spring of tremendous forest fires, including one which burned within five miles of my community, it is important to note that most of the brave men and women hacking fire breaks around the flames are seasonal employees and do not have year round health insurance coverage for themselves and their families.

Affordable Health Insurance Is Good for Business

As you know, the US system of health insurance developed as an employment based system during and immediately after World War II. The costs of providing this insurance have grown tremendously and small employers who provide insurance benefits to their employees are struggling to continue to provide the benefit. A recent study by the Employee Benefit Research Institute (EBRI) learned that for small firms:

> "offering health benefits helps with recruitment and retention, and keeps workers healthy, which ultimately reduces absenteeism and increases productivity. ... there is real business value in providing health care coverage to their workers."

(Fronstin and Helman, EBRI, 2000)

Sixty-five percent of workers in a recent survey rated health benefits as the most important employee benefit. (Salisbury and Ostuw, EBRI, 2000)

Increasing Costs of Health Insurance Transform the Workplace

One way that employers have responded to the rising costs of health insurance is to change the structure of the workforce as demonstrated by the dramatic rise in the use of temporary workers since the 1980's. In 1980, less than 500,000 people worked as temps every day. Since then, the number has doubled several times. Through the 1980's, employment growth in the temporary help industry grew annually by 20% For the last seven years annual growth has remained high at 10%. Why? The answer is obviously complex, but one significant factor has been the rising

costs of health care and health insurance. Using temps allows companies to avoid the costs of benefits. Although many temp agencies claim to offer benefits, there is little data on how many of their employees actually receive those benefits. Anecdotal evidence suggests that very few do. Prior to the 1980's temps were used mostly on an ad-hoc basis. Then, more and more companies started to plan for the "strategic" use of temps, meaning that they budgeted to use temps to cover a portion of their normal workload. This represents a significant change in "workplace culture" from just a generation ago. As employers respond to the rising costs of maintaining a workforce, and health costs are a big part of the increased costs, a consistently growing percentage of the American workforce is experiencing less job security and fewer employee benefits, including health insurance, pensions, paid vacations and sick leave.

Growth of Temporary Workers,
Average Daily Employees 1975-2000

Chart showing the Growth of Temporary Workers, Average Daily Employees 1975-2000

Sources: US Bureau of Labor Statistics (prior to 1990) and National Association of Temporary and Staffing Services (after 1990)..

Refundable Tax Credits Won't Work for Most of the Uninsured

Another idea being debated in the Congress is the provision of refundable tax credits to individuals who buy their own health insurance. These tax credits will not solve the problem of uninsurance and underinsurance because even if these tax credits were initially high enough to purchase insurance, it is unlikely that the credits would increase at the same rate as the annual increase in the cost of insurance. In many insurance markets, an individual policy is around $500 a month ($6000 a year) and much more for family coverage. I doubt the Congress will provide a tax credit sufficient to cover that cost when other existing federal programs are already providing access and/or coverage at a lower pre capita annual cost.

No Health Insurance: The Leading Cause of Personal Bankruptcies

Nearly half of all personal bankruptcies are caused by health problems or a large medical debt - even though 79% of the families filing for bankruptcy had at least some health insurance coverage. This staggering statistic provides some indication of the high failure rate of the current insurance system to cover a catastrophic illness. The numbers are quite large; 326,000

families identified illness/injury as the main cause of bankruptcy and an additional 270,000 had large medical debts at the time of bankruptcy. (Norton's Bankruptcy Advisor, May 2000)

This should provide a cautionary note against reducing the costs of health insurance to employers by shifting even more of the costs to employees. The unintended consequences of more cost shifting to employees will hurt both the health of the employees and the health of the economy which is hurt by bankruptcies.

No Health Insurance: A Health Hazard

Last month, the Institute of Medicine (IOM) released *Care Without Coverage: Too Little, Too Late*, a groundbreaking report which for the first time documented that people without health insurance are sicker and die earlier than people with insurance. The IOM Committee on the Consequences of Uninsurance reviewed 130 research studies which compared health status and outcomes or working age adults with and without health insurance. The clear results of each of the studies was similar, lack of health insurance is a serious health risk. There are approximately 30 million working-age adults without health insurance.

The IOM study identified four primary causes of the uninsurance health risk. Adults without health insurance:

- Receive less frequent or no cancer screening, resulting in delayed diagnosis and treatment and premature mortality for cancer patients. For example, uninsured women with breast cancer have a 30 - 50 percent higher risk of dying than women with private health insurance.
- Go without care that meets professionally recommended standards for managing chronic diseases, like timely eye and foot exams to prevent blindness and amputations in persons with diabetes.
- Lack regular access to medications needed to manage conditions like hypertension or HIV infection.
- Obtain fewer diagnostic and treatment services after a traumatic injury or a heart attack, resulting in an increased risk of death even when in the hospital.

(*Care Without Coverage: Too Little, Too Late,* IOM, May 2002)

Congressional action is needed now to end the downward spiral of more people without health insurance which leads to more sick people with higher health care costs which leads to more increases in the cost of health insurance which leads to even more people without insurance and on and on.

Insuring all Americans will be good for the economy and that will be good for employers and for employees.

APPENDIX G - STATEMENT OF CATHY STREKER, DIRECTOR, EMPLOYEE BENEFITS AND PLANNING, TEXTRON, INC., PROVIDENCE, RI

Testimony of Ms. Cathy Streker

Director Employee Benefits and Planning, Textron Inc.

June 18, 2002

Good afternoon, Mr. Chairman and members of the Employer-Employee Relations Subcommittee. My name is Cathy Streker, and I am the Director of Employee Benefits and Planning for Textron Inc. In addition, I have been working with The Business Roundtable's Health and Retirement Task Force in formulating policy on consumer health care programs and related issues. The Roundtable is an association of chief executive officers of leading corporations. Textron's Chairman, President and CEO, Lewis Campbell, chairs the Health and Retirement Task Force.

Textron Inc. is a $12 billion global multi-industry company with market-leading businesses in aircraft, fastening systems, industrial products and components and finance. We employ more than 51,000 people in 40 countries, some 36,000 of them in the United States. Of our U.S. employees, about three-quarters receive their health care coverage through managed care plans provided by Textron.

By early 2001, Textron management recognized that the cost of employer-provided health care plans was forecast to double within five years. Several factors are putting upward pressure on health care costs. The large number of people in the "baby boom" generation are reaching the age where they will begin to place greater demands on the health care system. New drugs and new medical technologies continue to come on line that are life saving but also costly. Finally, in today's litigious climate, employers see themselves at increasing risk of liability for the decisions of managed care providers. With managed care responding to these factors by accelerating their cost of services at double digit rates of inflation , it was clear to us at Textron that our company's future competitiveness, our ability to meet the expectations of our shareholders, and the long-term job security of many of our employees were at stake.

However, we needed a sustainable answer that did not merely shift the burden of additional health care costs onto the shoulders of our employees. Further, we sought to ensure continued access to quality care and to provide incentives for employees to become active consumers. For Textron, the solution is consumer-driven health care – a partnership between the company and our employees that slows the rising cost of providing health care without cutting benefits and gives employees financial incentives and educational support to help them make better-informed health care decisions.

Employees are already treated like health care consumers by pharmaceutical companies and other providers of health care products and services. Yet after years

of being insulated from the true cost and value of health care, most employees don't have the knowledge or motivation to make informed purchasing decisions. The consumer-driven model provides employees with the critical information to help them navigate the health care maze.

After extensive research and market analysis, Textron chose to implement Definity Health as our new benefit plan and administrator. Key features of the plan include:

- 100% coverage for preventive care services, such as annual examinations, well-baby care and immunizations.
- Personal Care Accounts (PCAs) funded by Textron. Participants can use their PCA benefit dollars to pay for health care expenses, including health care services not covered by the plan today.
- Carry forward for amounts credited to PCAs, which may be used by employees for future medical expenses, such as retiree medical.
- Financial protection in case of a serious illness.
- Credible health care information, plus educational and health care advocate resources to meet employees' needs.

The consumer-driven model supports our commitment to consumer advocacy and arming employees with tools to make educated purchasing decisions that take into consideration the quality of care provided as well as the cost of obtaining that care. Our employees need to have good comparative information about providers and treatment options. The better information employees have, the more initiative they have in working with employers to contain the rising cost of health care.

On January 1, 2002, Textron offered Definity Health to a subset group of approximately 1,600 employees. An extensive communication and education campaign accompanied this organizational shift – from a culture of benefit entitlement to one of employee responsibility and empowerment. Our success was evident through employees' responses to a post-enrollment survey:

- 83% understood Textron's business case for the change
- 82% understood how the plan works
- 63% believe that the new program will help manage the increase in health care costs

Going forward, we plan to expand the consumer-driven health care plan to more of our U.S. based employees next year.

Although consumer-driven health plans are in their relative infancy, it is important that a collaborative effort continues among government, employers, and the health care industry. In particular, we at Textron would offer the following recommendations:

- Federal legislation and regulations should provide a framework

to support employer-funded Personal Care Accounts and employee-funded Flexible Spending Accounts. To cite two examples, Textron and others in the business community are hopeful that the IRS will issue a ruling this summer that current law allows employees to roll over unspent money in their employer-funded Personal Care Accounts without tax liability. Second, Textron and other employers welcome the bill introduced by Congressman Jim DeMint of this committee and Congressman David Phelps (H.R. 4804) that would permit rollover of employee-funded Flexible Spending Accounts – giving American workers more options to save money for health care or retirement. Congressman Ernie Fletcher, also of this committee, has introduced a similar bill. Other bills have been introduced by Representatives David Dreier, Ed Royce and James Ramstad.

- In addition, health care providers must embrace collaboration with patients and make a commitment to follow evidence-based best practices.
- Finally, employers need to work together with providers to implement long-term financing strategies.

Once again, thank you for giving me this opportunity to testify before the Employer-Employee Relations Subcommittee. I will be pleased to answer any questions you may have about how we at Textron are working to contain the rising cost of providing top-quality health care to our employees.

APPENDIX H – SUBMITTED FOR THE RECORD, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, DATA BULLETIN, RESULTS FROM HSC RESEARCH, TRACKING HEALTH CARE COSTS: HOSPITAL CARE KEY COST DRIVER IN 2000, NUMBER 21 REVISED, SEPTEMBER 2001

Data Bulletin

Results from HSC Research

TRACKING HEALTH CARE COSTS:

Hospital Care Key Cost Driver in 2000

This Data Bulletin is based on data from the Milliman USA Health Cost Index ($0 deductible), which is designed to reflect claims increases faced by private insurers; the Kaiser Family Foundation/Health Research and Educational Trust survey of employer-based health plans for 1999-2001; the KPMG survey of employer-based plans for 1991-98; the U.S. Bureau of Labor Statistics Employment, Hours and Earnings series to track payroll costs; and Center for Studying Health System Change 2000-01 site visits (see www.hschange.org*). The bulletin is adapted from "Tracking Health Care Costs," by Bradley C. Strunk, Paul B. Ginsburg and Jon R. Gabel,* Health Affairs, *Web-exclusive publication, Sept. 26, 2001,* www.healthaffairs.org.

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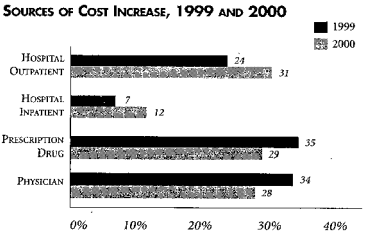
President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group

CENTER *for* STUDYING HEALTH SYSTEM CHANGE

FIGURE 1
SOURCES OF COST INCREASE, 1999 AND 2000



Note: 1999 sources of cost increase reflect August 2001 revision in spending data by Milliman USA.

Source: Milliman USA Health Cost Index ($0 deductible)

Hospital spending accounted for the largest portion—43 percent—of medical cost increases in 2000 (see Figure 1). Overall, health care spending growth per privately insured person increased 7.2 percent in 2000—the largest year-to-year increase since 1990 (see Table 1).

Rapid rises in underlying medical costs, double-digit premium increases and the slowing economy could create a volatile combination that may increase consumers' out-of-pocket costs and the ranks of the uninsured.

Underlying Cost Trends

In 2000, health care spending reflected significant shifts in growth of underlying cost components, particularly for hospital services (see Figure 1).

- Spending for outpatient care increased 11.2 percent in 2000, accounting for 31 percent of the overall increase. The 2000 outpatient spending increase was the largest since 1992.
- Spending for inpatient care increased 2.8 percent in 2000, accounting for 12 percent of the overall increase. The inpatient increase signals a dramatic departure from the 1994-98 trend, when inpatient spending actually declined year-to-year by as much as 5.3 percent.

Consumer demand for broad networks of hospitals and physicians and the retreat from tightly managed care—coupled with hospital consolidation and reduction in excess capacity—have increased some hospitals' bargaining leverage with health plans. Growing numbers of contract showdowns between providers and health plans are occurring as providers use their clout to gain higher payments.

Health care payroll growth also is a key driver of overall costs. Payroll costs for all health services increased 4.7 percent in 2000, compared to 3.1 percent in 1999, while hospital payroll costs increased 3.7 percent in 2000, compared to 2.6 percent in 1999. The higher payroll growth in 2000 is largely accounted for by increased growth in hours worked rather than faster-growing average hourly wages. But during the first five months of 2001, average hourly wage growth increased sharply, particularly for hospitals, perhaps because of nursing and other staff shortages.

Other underlying cost trends include:

- Spending growth for prescription drugs—while still very high—slowed, dropping to 14.5 percent and accounting for 29 percent of the overall increase in 2000. Two factors likely caused the reduction: a lack of new "blockbuster" drugs and the shift to three-tier pharmacy benefits.
- Spending growth for physician services slowed in 2000 to 4.8 percent, accounting for 28 percent of the overall increase.

Implications for Consumers

In 2001, employer-based insurance premiums increased 11 percent—the fifth straight year of rising premiums and the highest increase since 1993.

The large difference between the 2001 premium increase and the underlying cost increase in 2000—11 percent vs. 7.2 percent—reflects both expectations of higher costs and the health insurance underwriting cycle, or the pattern of premium trends diverging from expected costs. The expectation of higher costs is reflected in the 9.5 percent premium increase for self-insured plans in 2001. The underwriting cycle is reflected by the much higher premium increase of 12.3 percent for fully insured plans in 2001, signaling insurers' willingness to sacrifice market share to restore profit margins.

Insured consumers generally have been sheltered from cost increases in recent years because employers have paid a disproportionate share of higher premiums in past years. In 2001, the employee share of premiums remained stable at 15 percent for single coverage and 27 percent for family coverage. But, with a slowing economy, this could change. Indeed, employers have increased patient cost sharing already for pharmaceuticals and are expected to do the same for hospital and physician services. In contrast to the last time cost trends were this high—in the early 1990s—the cost-containment strategies of managed care are now in retreat, leaving few ways to stem the rising cost tide. ●

Table 1
Annual Spending and Premium Trends, 1991-2001

	Annual Change per Capita in Health Care Spending, by Component					Annual Increase in Employer-Based Insurance Premiums	
Year	Hospital Inpatient	Hospital Outpatient	Physician	Prescription Drugs	All Services	Large Firms[b]	All Firms
1991	*3.5%*	*16.8%*	*5.4%*	*12.4%*	*6.9%*	*11.5%*	c
1992	*2.8*	*13.9*	*5.9*	*11.7*	*6.6*	*10.9*	c
1993	*4.8*	*8.9*	*3.3*	*7.1*	*5.0*	*8.0*	*8.5%*
1994	*-2.0*	*8.7*	*1.7*	*5.2*	*2.1*	*4.8*	c
1995	*-3.5*	*7.9*	*1.9*	*10.6*	*2.2*	*2.1*	*2.3*
1996	*-4.4*	*7.7*	*1.6*	*11.0*	*2.0*	*0.5*	*0.8*
1997	*-5.3*	*9.5*	*3.4*	*11.5*	*3.3*	*2.1*	c
1998	*-0.6*	*7.9*	*4.8*	*14.1*	*5.3*	*3.3*	*3.7*
1999	*1.6*	*8.9*	*5.7*	*18.4*	*7.1*	*4.1*	*4.8*
2000	*2.8*	*11.2*	*4.8*	*14.5*	*7.2*	*7.5*	*8.3*
2001	*3.5[a]*	*12.5[a]*	*4.8[a]*	*15.2[a]*	*7.7[a]*	*10.2*	*11.0*

[a] Data through March 2001, change from corresponding months in 2000. [b] Firms with 200 or more workers. [c] Not available.

Note: Spending data for 1998 and 1999 reflect August 2001 revision by Milliman USA.

Source: Milliman USA Health Cost Index ($0 deductible), Kaiser/HRET survey of employer-based health plans for 1999-2001 and KPMG survey for 1991-98

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Tracking Health Care Costs

Hospital care surpasses drugs as the key cost driver.

by Bradley C. Strunk, Paul B. Ginsburg, and Jon R. Gabel

ABSTRACT: This paper provides an update on trends in health care costs since 1999. Although the growth rate in overall costs has been stable since 1999, the trend in costs for hospital services rose, while that for prescription drugs declined, although it remains extremely high. Increased growth in hospital costs reflects the retreat from tightly managed care and labor shortages. The discrepancy between premium trends and cost trends has increased, which reflects the health insurance underwriting cycle. If these trends continue, likely responses by employers would lead to consumers' facing higher out-of-pocket costs and an increase in the number of uninsured persons.

LAST YEAR IN THIS JOURNAL we documented the return in 1999 to higher rates of growth in the health care costs that underlie private health insurance premiums.[1] Growth in these costs largely determines long-run premium trends. It affects decisions on health insurance product types, benefit design, and out-of-pocket costs borne by workers. Moreover, it is an important determinant of employers' decisions to offer any insurance at all and employees' decisions to take up coverage. Also, a high rate of growth could affect consumers' ability to pay for health care and could lead to higher outlays for public programs. In contrast to 1999, the U.S. economy recently has been slowing, which threatens to exacerbate these adverse consequences of high health cost inflation.

We use the most recent data available to update prior analyses of trends in health care costs and private insurance premiums. Although overall growth in health care costs is similar to that in 1999, we document an important shift in its composition. Moreover, evidence from local communities across the country suggests that much of this shift is associated with a retreat from tightly managed care. This has profound implications for future cost trends.

Bradley Strunk is a health analyst and Paul Ginsburg is president of the Center for Studying Health System Change, in Washington, D.C. Jon Gabel is vice-president of the Health Research and Educational Trust, also in Washington.

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Data Sources

This analysis draws on a variety of data sources to provide insight into trends in health care costs, as well as their implications for private health insurance premiums and consumers' out-of-pocket spending. Our choices of data were guided by the ability of a given source to provide reliable estimates with a short time lag.

■ **Cost trend data.** To gain insight into recent cost trends, we used the Milliman USA Health Cost Index (HCI), which measures the health care spending increases underlying changes in private health insurance premiums.[2] This index, based on provider revenues (a proxy for spending on services), is designed to reflect claims expenses experienced by private insurers for a typical policy.[3] The HCI draws its data from surveys of providers, some widely available and some proprietary. The index is limited to measuring health services that tend to be insured: inpatient and outpatient hospital services, physician services, and prescription drugs. Because provider revenue data tend to cover all patients, Medicare payments to providers are removed in an effort to arrive at a series that more closely reflects the population covered by private health insurance. Inability to remove revenues from Medicaid and uninsured patients is a limitation in the HCI's ability to track spending for privately insured patients. When expanded to include Medicare expenditures, the HCI closely tracks the National Health Accounts (NHA) maintained by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), which is widely considered the "gold standard" for tracking health spending.[4] The HCI, however, is available with a shorter time lag.

We used data on payroll costs for health services establishments collectively, and for hospitals specifically, to gain insight into changes in what amounts to the largest cost factor faced by providers.[5] These data, compiled monthly by the U.S. Department of Labor's Bureau of Labor Statistics (BLS) and known as the Employment, Hours, and Earnings (EHE) series, is useful for its reliability and very short time lag. The sample includes both private and public employers but excludes nonsalaried health professionals. Payroll costs are calculated as the product of total production (that is, nonsupervisory) workers, average weekly hours per worker, and average hourly wage. BLS payroll data are reported on a per capita basis. This is the most relevant measure for policymakers and is directly comparable to the HCI data and to data on premiums, which reflect what is charged to cover an individual or a family.[6]

We drew on data from the 2000–2001 Community Tracking Study (CTS) site visits by the Center for Studying Health System

Change (HSC) to twelve representative communities for additional insights into cost trends. Third-round CTS site visits occurred between June 2000 and March 2001. Researchers conducted forty-five to ninety interviews per site with leaders of local hospitals, health plans, physician organizations, employers, and policymakers.[7]

■ **Premiums and out-of-pocket spending.** Data on premiums for employment-based health insurance come from the Kaiser Family Foundation/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits and its predecessor surveys. The 2001 Kaiser/HRET survey is based on a stratified random sample of 1,907 employers with three or more workers selected from Dun and Bradstreet's listing of private and public businesses that have entered the credit market. The survey collected data through telephone interviews with employee benefit managers from January to May 2001. The survey continues the health benefits survey first conducted by the Health Insurance Association of America (HIAA) from 1987 to 1991 and then by KPMG Peat Marwick from 1991 to 1998. The core questions in these surveys are virtually identical. For the years 1991, 1992, 1994, and 1997 KPMG sampled only firms with 200 or more workers.

To track trends in consumers' out-of-pocket spending, we used data from the Consumer Expenditure Survey (CES) conducted by the BLS. This national survey is the basis for constructing the market basket of goods that urban households consume. The BLS requests participating households to enter their spending, including medical care expenses, into logs that it provides. These logs also include information on reimbursements from public and private insurance plans, which are netted out from direct out-of-pocket payments for medical care.[8] Data from the CES are available with a longer time lag compared with other data sources discussed here, with the most recent data being for 1999.

Underlying Health Care Spending Trends

Health care spending per privately insured person increased 7.2 percent in 2000, which represents the largest year-to-year increase since 1990 and marks the third straight year of significantly high growth (Exhibit 1). This recent acceleration in growth follows the period 1994–1997, when health care spending per capita grew at record-low levels and, in fact, grew more slowly than did gross domestic product (GDP) per capita (Exhibit 1). That trend reversed itself in 1998, and growth in health care spending has since continued to top growth in GDP per capita, outpacing it by 1.6 percentage points in 2000. Although growth in overall spending changed little between 1999 and 2000, early indications from 2001 are that growth

EXHIBIT 1
Annual Percentage Change Per Capita In Health Care Spending And Gross Domestic Product, 1991–2001

	Spending on type of health care service					
Year	All services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs	Gross domestic product
1991	6.9%	3.5%	16.8%	5.4%	12.4%	2.1%
1992	6.6	2.8	13.9	5.9	11.7	4.4
1993	5.0	4.8	8.9	3.3	7.1	4.0
1994	2.1	−2.0	8.7	1.7	5.2	5.2
1995	2.2	−3.5	7.9	1.9	10.6	3.9
1996	2.0	−4.4	7.7	1.6	11.0	4.6
1997	3.3	−5.3	9.5	3.4	11.5	5.4
1998	5.3	−0.6	7.9	4.8	14.1	4.6
1999	7.1	1.6	8.9	5.7	18.4	4.6
2000	7.2	2.8	11.2	4.8	14.5	5.6
2001[a]	7.7	3.5	12.5	4.8	15.2	3.7

SOURCES: Health care spending data are from the Milliman USA Health Cost Index ($0 deductible). Gross domestic product (GDP) data are from the U.S. Department of Commerce, Bureau of Economic Analysis.
NOTES: GDP is in nominal dollars. Milliman USA Health Cost Index (HCI) data reflect the 7 August 2001 revision.
[a] Data through March 2001, compared with corresponding months in 2000.

is accelerating once again, as has appeared in recent earnings reports by health plans.

Despite the stability of overall health care spending growth from 1999 to 2000, an examination of the individual components of spending unmasks important underlying trends. The Milliman HCI reveals a shift in the composition of health care spending growth: The rate of increase in prescription drug spending decelerated while hospital spending accelerated.

■ **Hospital spending.** Hospital inpatient spending increased at a rate of 2.8 percent in 2000—a 1.2 percentage point increase over 1999. More importantly, however, this finding signals a dramatic departure from the trend in 1994–1998, when hospital inpatient spending was actually declining year to year by as much as 5.3 percent. Growth in hospital outpatient spending also accelerated in 2000, increasing 11.2 percent compared with 8.9 percent in 1999 and 7.9 percent in 1998. Although this category has been growing at high rates throughout the 1990s, the 2000 increase represents the largest increase in hospital outpatient spending since 1992. Taken together, spending on inpatient and outpatient hospital services accounted for 43 percent of the growth in overall spending, substantially higher than its share of the 1999 increase. Growth in spending on both types of services is also accelerating further in 2001.

■ **Prescription drug spending.** Growth in per capita spending on prescription drugs decelerated in 2000 compared with 1999 but nonetheless remained very high. This reverses a six-year trend in

which spending growth rose steadily from 5.2 percent to 18.4 percent.[9] Two factors may be behind this reversal: (1) a decline in the number of "blockbuster" drugs being introduced; and (2) the rapid spread of three-tier drug copayment structures in health benefits offerings.[10] However, the trend turned upward again in the first quarter of 2001.

■ **Spending for physician services** Growth in spending for physician services also decelerated in 2000. Following a period in the mid-1990s when private insurers reduced physician payment rates, physician payments from insurers have risen steadily during the past few years. However, this trend clearly leveled off in 2000, and together with the decreasing spending rate on prescription drugs, it offset the impact of higher hospital spending growth, thus explaining the relative stability of overall spending growth from 1999 to 2000.

■ **Payroll costs.** Data on payroll costs from the BLS (which, unlike the Milliman HCI, reflect services for patients covered by all payers including Medicare) illustrate that payroll growth is a key driver of both overall health care cost trends and rising trends within the hospital sector (Exhibit 2). For all health services establishments, payroll costs grew at a rate of 4.7 percent in 2000—a 1.6-percentage-point increase over 1999. Hospital payroll growth, specifically, rose from 2.6 percent in 1999 to 3.7 percent in 2000.

EXHIBIT 2
Annual Percentage Change Per Capita In Payroll And Underlying Wage Costs, 1991–2001

	Payroll[a]		Average hourly wage		
Year	All health services establishments	Hospitals	All health services establishments	Hospitals	All industries
1991	9.0%	8.2%	5.3%	4.8%	3.1%
1992	7.3	6.4	3.9	3.0	2.4
1993	5.5	3.4	3.4	2.3	2.5
1994	4.4	1.2	2.7	1.8	2.7
1995	4.5	2.4	2.9	2.4	2.8
1996	4.8	2.4	3.2	1.8	3.4
1997	5.7	4.2	3.2	1.3	3.9
1998	4.3	4.1	3.5	1.9	4.1
1999	3.1	2.6	3.4	2.3	3.6
2000	4.7	3.7	3.8	2.3	3.8
2001[b]	7.0	7.6	5.2	4.6	4.1

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Employment, Hours, and Earnings series. Data accessed 30 July 2001.
[a] Product of average hourly wage and total hours worked per capita (which is not shown). Total hours worked per capita is a product of number of production workers (excludes executives and managers) and average hours per week, adjusted for changes in the U.S. population.
[b] Data through May 2001, compared with corresponding months in 2000.

"Data suggest that the retreat from tightly managed care has played an important role in rising cost trends."

More significantly, early indications from 2001 data suggest that these trends are accelerating even further to levels not seen since the early 1990s. These trends do not appear for payroll at physicians' offices.

For both health services establishments in general and hospitals in particular, the higher payroll growth rate in 2000 than in 1999 is largely accounted for by increased growth in hours worked rather than an increase in average hourly wages (data on hours worked not shown here). Nonetheless, the increase in the 2000 average hourly wage for all health services establishments—3.8 percent—was somewhat higher than in 1999 and higher than any increase since 1992. The year 2000 marked the first time since 1995 that growth in the wage rate for health services establishments was not below the wage rate growth for all industries combined. This may foreshadow a return to a long-standing earlier pattern in which wage rates rise more rapidly in the health care sector than in other industries. Interestingly, average hourly wage growth for both health services establishments collectively and hospitals specifically rose substantially in the first five months of 2001, perhaps as a result of severe nursing and other staff shortages throughout the system.[11] These trends are strongly supported by another measure of wage costs, the Employer Cost Index (ECI).[12]

Role Of Looser Managed Care

Data from the third round of CTS site visits suggest that the retreat from tightly managed care has played an important role in rising cost trends.[13] Most notable has been the strengthening of providers' bargaining power, especially that of hospitals, in relation to that of health plans. With the emphasis on broad choice of providers in managed care, health plans need to keep most hospital systems in their networks. This power has been reinforced by the increased consolidation of hospitals during the 1990s and the reduction in excess capacity since the mid-1990s. The latter has encouraged hospitals to take the risk of not having a managed care contract with a major health plan, something unthinkable only a few years ago. The inability to staff some beds as a result of severe nursing and other staff shortages—and the higher payroll costs needed to address these shortages—has left hospitals more willing to forgo a contract with a managed care plan if the payment rates are unfavorable. This

shift in bargaining power has been reflected in highly public showdowns in many communities between hospitals or specialty medical groups and plans over payment rates.[14] Facing critical shortages of workers, employers often have responded to the prospect of instability of their plan's provider network by pressing the plan to meet providers' demands. This, in turn, has further strengthened providers' bargaining position.

Other developments related to the retreat from tightly managed care also may have contributed to higher cost trends, but the evidence is softer. For example, reductions in required authorizations for services and more direct access to specialists may be leading to more hospitalizations and procedures. Fewer providers are willing to accept capitated payment for their services, which also is leading to less control over service use. Furthermore, when providers did not succeed in controlling costs under capitation, the fee-for-service contracts that replaced capitated ones increased payments substantially.[15]

The retreat from tightly managed care is vividly illustrated by enrollment trends by product type. Data from the Kaiser/HRET annual survey show that enrollment in health maintenance organizations (HMOs)—the most tightly managed product type in the managed care arsenal—experienced a sharp and unprecedented decline between 2000 and 2001, falling from 29 percent to 23 percent of enrollment. In contrast, enrollment in preferred provider organizations (PPOs)—a more loosely managed product type—increased from 41 percent to 48 percent of total enrollment.[16]

Insurance Premium Trends

Premiums for employment-based insurance policies increased 11.0 percent from 2000 to 2001, the highest rate of increase since 1993 (Exhibit 3).[17] This was the fifth consecutive year of accelerating premium increases since 1996, a year when they reached a record low of 0.8 percent. The pattern of small firms facing larger increases than large firms continued, with firms of 200 or fewer employees experiencing a 12.5 percent increase. Increases by plan type were similar in magnitude.

In addition to the trend in underlying health care costs, the health insurance underwriting cycle contributed to premium increases. In 2000 Blue Cross Blue Shield plans realized underwriting profits (preinvestment income) of 0.6 percent of revenue, up from 0.1 percent in 1999. Throughout much of the 1990s health plans' prevailing strategy was to increase their local market share by underpricing their competitors; this strategy ultimately resulted in insurers' suffering underwriting losses during 1995–1998. Responding to these financial losses, many insurers pulled out of selected markets and

EXHIBIT 3
Annual Percentage Change In Employment-Based Insurance Premiums And Underlying Health Care Spending, 1991–2001

Year	Premium increases		Underlying health care spending
	Large firms[a]	All firms	
1991	11.5%	–[b]	6.9%
1992	10.9	–[b]	6.6
1993	8.0	8.5%	5.0
1994	4.8	–[b]	2.1
1995	2.1	2.3	2.2
1996	0.5	0.8	2.0
1997	2.1	–[b]	3.3
1998	3.3	3.7	5.3
1999	4.1	4.8	7.1
2000	7.5	8.3	7.2
2001	10.2	11.0	7.7[c]

SOURCES: Health care spending data are from the Milliman USA Health Cost Index ($0 deductible). Premiums are from the Kaiser/ Health Research and Educational Trust (HRET) survey of employer-based health plans for 1998–2001 and the KPMG survey for 1991–1998.
NOTE: Milliman USA Health Cost Index (HCI) data reflect the 7 August 2001 revision.
[a] Firms with 200 or more workers.
[b] Survey only covered firms with 200 or more workers in this year.
[c] Data through March 2001, compared with corresponding months in 2000.

were willing to risk loss of market share to restore profitability through larger premium increases. The particularly large difference between premium increases for 2001 and underlying cost increases for 2000 (Exhibit 3) reflects both an expectation that cost increases will accelerate further in 2001 and a stronger effort by health plans to increase their profit margins. The 0.6 percent underwriting profits earned in 2000 may well have been lower than insurers had planned on. HSC site visits continue to record instances of health plan exits from local markets but few, if any, instances of new entry. This suggests that the "hard" phase of the underwriting cycle, characterized by rising premiums for employers and rising profitability for insurers, is likely to continue.

One proxy measure for underlying trends in claims expenses is annual changes in premium equivalents for self-insured firms. Employers set premium-equivalent increases at projected increases in expenses. According to the Kaiser/HRET data, overall premium increases for self-insured plans surged from 3.7 percent in 1999 to 7.1 percent in 2000 to 9.5 percent in 2001. Yet in 2001 premiums for fully insured plans increased 12.3 percent—a difference of 2.8 percentage points compared with self-insured plans.

Implications For Consumers

Despite the rapid rise in the cost of health care, a robust economy

has insulated consumers from much of that increase. Data from the CES indicate that in 1999 households spent 4.5 percent of their income on health care expenses out of pocket, down from 4.6 percent in 1998 and 5.1 percent in 1993 and equal to the 4.5 percent in 1985. Facing a shortage of qualified workers, employers have competed for scarce workers by keeping increases in employee contributions for health insurance down and, to a lesser extent, increases in deductibles, coinsurance, and copayments down as well.

Data from the Kaiser/HRET annual survey show little change in the share of workers' contributions for health insurance premiums between 2000 and 2001. Employees pay 15 percent of the cost of single coverage and 27 percent of the cost of family coverage, figures that are statistically unchanged from 2000. The fact that workers contribute less (in nominal dollars) for single coverage in 2001 than they did in 1993 is a vivid illustration of how they have been spared the consequences of rising premiums so far.

Workers are, however, bearing greater financial risk for the cost of prescription drugs. From 2000 to 2001 employers continued to adopt three-tier cost-sharing arrangements. Under these arrangements, workers face one copayment (or coinsurance) level when using generic drugs, a higher one when using brand-name drugs on a preferred list, and the highest payment level for use of other brand-name drugs. The Kaiser/HRET survey reports that 36 percent of workers with job-based insurance are enrolled in a plan using such arrangements, up from 33 percent in 2000.

Discussion And Forecasts

Data presented here add empirical credence to what has been heralded as "the end of managed care" as we knew it in the 1990s.[18] As the third round of CTS site visits makes clear, hospitals are enjoying new bargaining power vis-à-vis health plans as enrollment shifts to less restrictive and more loosely managed products and hospitals become "must-have" providers in plans' networks. Meanwhile, health plans, in an effort to quell the managed care backlash, are reducing their reliance on other cost-control mechanisms such as gatekeepers, preauthorization requirements, and capitation. As these developments unfold, their combined effect on costs is appearing as a major shift in the composition of underlying spending growth, as growth in spending on hospital services is increasingly responsible for overall spending growth.

■ **Health care affordability.** In light of these trends and early indications from 2001, health care affordability will likely deteriorate further in the near future. Health plan–provider showdowns over payment rates continue across the country and make it likely

that sharp increases in provider payment rates will continue. Although the rate of growth in spending on prescription drugs fell in 2000 compared with 1999, the unrelenting pace of technological innovation and promotion of drugs all but assure a rate of drug spending growth that will stress those who pay for care.[19] Also, early indications from 2001 payroll data suggest that labor shortages in the hospital industry are causing an acceleration in wage increases. In contrast to the last time cost trends were this high—in the early 1990s—the cost containment strategies of managed care are now in retreat, and there are no longer alternative approaches to address these pressures.

■ **Out-of-pocket spending** Although the most recent consumer spending data (for 1999) suggest that consumers have remained protected from the growth in health care costs and insurance premiums, the changes under way in the health care system and the softening of labor markets due to a slowing economy will likely lead to greater out-of-pocket spending in the future. This development is already under way for prescription drugs, as three-tier cost-sharing strategies become more prevalent and as average copayments rise. As managed care companies continue to contend with demand for broad choice and rising payments to providers, higher costs may increasingly be passed on to consumers in the form of higher deductibles, coinsurance, and copayments. Meanwhile, employers may be driven to reduce their contribution rates and leave consumers to pick up more of the rising premium bill.

■ **Insurance coverage.** Ultimately, the combination of higher growth in health care costs, through its effect on premiums, and a slowing economy threaten a major increase in the number of people who are uninsured.[20] Evidence is already appearing that small employers are dropping coverage in response to sharp premium increases. When employers shield workers less from premium increases, rates of employee take-up will continue to fall. At a time when national policymakers are giving renewed attention to the problem of the uninsured—debating the merits of tax credits versus expansions of public programs—rising costs and premiums could undercut their efforts greatly. Indeed, health care cost containment will begin to permeate the health policy agenda again.

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NOTES

1. C. Hogan, P.B. Ginsburg, and J.R. Gabel, "Tracking Health Care Costs: Inflation Returns," *Health Affairs* (Nov/Dec 2000): 217–223.
2. Often the terms *costs* and *spending* are used interchangeably. Conceptually, the primary interest is in costs, which reflect the resources devoted to health care that are not available to produce other goods and services. Practically, most available data, including the HCI, reflect spending, or what is paid for health services by those who purchase them (or received by providers of health services). Costs and spending differ when the payment is greater or less than the resources that go into providing the services.
3. The index that Milliman USA provides to its clients is intended to assist insurers in forecasting their claims payments and comparing them with those of others. It simulates trends in claims for a "standard" private health insurance policy with a $250 deductible. The trend in such an index would slightly overstate the trend in spending underlying private insurance because the standard policy would pay for a slightly higher proportion of expenditures each year. Milliman has provided us with a version of the index that reflects a hypothetical policy with no deductible.
4. P.B. Ginsburg and J.D. Pickreign, "Tracking Health Care Costs," *Health Affairs* (Fall 1996): 140–149.
5. Health services establishments include offices and clinics of medical doctors, dentists, and other health practitioners; nursing and personal care facilities; intermediate care facilities; hospitals; and home health care services.
6. For additional discussion of this point, see Ginsburg and Pickreign, "Tracking Health Care Costs."
7. For more information about the CTS, see P. Kemper et al., "The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People," *Inquiry* (Summer 1996): 195–206. For more information about CTS site visit methodology, see P.B. Ginsburg et al., "The Community Tracking Study Analyses of Market Change: Introduction," *Health Services Research* (April 2000): 7–16.
8. BLS analysts indicate that payments from Internal Revenue Service (IRS) Section 125 accounts, commonly referred to as cafeteria plans or reimbursement accounts, are not treated consistently in the study. In the majority of cases, these payments are regarded as insurance payments, but in some cases, households may not report these payments in their logs.
9. In contrast, a recent study by the National Institute for Health Care Management (NIHCM) reported that prescription drug spending grew by 18.8 percent in 2000, a difference of 4.3 percentage points with the Milliman USA data. However, the NIHCM data were not adjusted for growth in population and therefore are not directly comparable to the data presented here. An adjustment of this nature would result in a slightly lower rate of growth. Furthermore, a recent study by Merck-Medco Managed Care reported that growth in drug spending among its clients grew by 14 percent in 2000, which is more in line with the Milliman data. The Merck-Medco report was based on the spending habits of sixty-five million insured persons. See "Spending on Drugs Seen Doubling by '06," *New York Times*, 7 June 2001.
10. F. Teitelbaum et al., *Express Scripts 2000 Drug Trend Report* (St. Louis: Express Scripts, June 2001), 21–24. Because the HCI focuses on aggregate spending per person rather than costs borne by insurers or employers only, three-tier copayment structures would be expected to affect the growth rate of prescription drug spending only if they induce less use of drugs, switching to cheaper drugs, or lower prices based on purchasers' greater ability to shift demand to

preferred drugs. Cost shifting to consumers alone would not be expected to affect the HCI.

11. *The Hospital Workforce Shortage: Immediate and Future*, TrendWatch, vol. 3, no. 2 (Washington: American Hospital Association, June 2001).
12. The ECI, a series compiled quarterly by the U.S. Department of Labor, measures the average cost of an employee per hour worked. Federal employees are excluded from the index. Although trends in the ECI and the BLS average hourly wage data did not match up exactly—because the ECI holds skill-mix constant and includes all workers, not just nonsupervisory workers—both measures grew in similar patterns.
13. C.S. Lesser and P.B. Ginsburg, *Back to the Future? New Cost and Access Challenges Emerge: Initial Findings from HSC's Recent Site Visits*, Issue Brief no. 35 (Washington: Center for Studying Health System Change, February 2001).
14. B.C. Strunk, K. Devers, and R.H. Hurley, *Health Plan–Provider Showdowns on the Rise*, Issue Brief no. 40 (Washington: HSC, June 2001).
15. D.A. Draper et al., "The Changing Face of Managed Care" (Unpublished paper, Mathematica Policy Research, September 2001).
16. J. Gabel et al., "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs* (Sep/Oct 2001): 180–186.
17. Ibid.
18. J.C. Robinson, "The End of Managed Care," *Journal of the American Medical Association* (23/30 May 2001): 2622–2628.
19. See "Spending on Drugs Seen Doubling by '06."
20. See R. Kronick and T. Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979–1995," *Health Affairs* (Mar/Apr 1999): 30–47. Also, in a letter to Greg Crist, House Committee on Ways and Means, John Shiels described research that calculated the price elasticity for health coverage to be −0.203 (Falls Church, Va.: Lewin Group, 7 October 1999). This means that a 1 percent real increase in premiums would be associated with a net coverage loss of approximately 293,000 persons, according to these results.

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