Statement of Joan Simmons
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Good morning. My name is Joan Simmons. I am the vice president of the Healthcare Leadership Council. The BLC is a group of nearly 50 CEOs from the health care industry. It originated almost five years ago from discussions among its founding members after the 1988 Presidential election. They realized then a crisis was facing our health care system, that as a nation we weren't prepared to face up to that crisis and that as leaders in the industry they had a responsibility to provide leadership toward reform. And so, the BLC was created with the sole purpose of developing and advocating action on consensus solutions to health care.

Our members are not protectors of the status quo. Quite the opposite. They are the risk takers, the entrepreneurs, the ones who seek change, who shake up the status quo. Whether it's consolidation of hospitals and the creation of doctor and hospital networks, the targeting of R&D and manufacturing on new cost-effective technology, or the recognition by our insurance members that the future for them was not merely to process claims or manage risk, but to manage health care — our members have been in the forefront of the market place revolution that is now the hallmark of the best of American health care. Just as importantly, our members are committed to working for legislative reforms.

We applaud the commitment of President Clinton and Members of Congress have made to health care reform and their efforts to advance a national discussion. Unlike five years ago, the debate this year is no longer over the need for reform, or even the goals. On both these points all Americans agree. Rather, the debate will now focus on how to achieve our shared vision without compromising the quality, choice and innovation that characterizes our nation's health care system at its best.

A Revolution in Progress

Reform of the health care system is already in progress. In recent decades, there has been a revolution in the delivery system. Treatments that once were cutting edge, like coronary bypass surgery, have become commonplace. High tech medical devices like diagnostic imaging and cardiac pacemakers are now widely available. And more investment in research and development has produced a wealth of new life-saving drugs. These advances have made our population healthier. Infant mortality is down and life-expectancy is up. People from across the globe come to the United States to receive the highest quality care. In this respect, our health care system is the envy of the world. It is proof that our system does more for its patients.

There has also been a radical change in the way we buy health care coverage. Responding to signals from the market place, more and more of us are covered through managed care. A recent report prepared by Lewin-VFH for the National Committee for Quality Health Care found that 95 percent of employed workers were participating in some kind of managed care plan by 1990.

This move toward managed care has helped to contain costs. Average premium increases from HMOs declined from 10.6 percent in 1992 to 8.1 percent in 1993 and are expected to drop to 5.6 percent this year. Some BLC members have even reported negative premium increases in the past year. Consistent with these reports, a U. S. Chamber of Commerce survey of 1,100 corporations found that the average employer's costs for medical and dental coverage decreased between 1991 and 1992 — from $2,811 to $2,754 a worker.

Recent studies demonstrate the market is responding in other ways to demands for lower costs. Demands by employers and other payers for lower prices have caused increases in health care prices to drop from 9.6 percent in 1990 to 7.9 percent in 1991 to 6.6 percent in 1992. According to the Labor Department, health care prices increased only 5.5 percent between November 1992 and November 1993. This is the smallest increase since 1973 — when health care was subject to wage and price controls. This cost containment is not due to the fear of reform. It is part of a steady and on-going trend toward using and providing care more efficiently.

These reforms were initiated even before the impetus of health care reform legislation. They have been driven by employers, who pay most of the nation's private health care bill. Employers are turning to providers who offer low-cost, high-quality care to their employees. And providers are responding by becoming more efficient and innovative. The market is proving it can reform itself National reform should build on this success, not short circuit it.

The Delivery System

It's important to remember there are two aspects to the health care system: the delivery system and the financing system. The issues that need to be addressed in the delivery system are access and quality of care. The issues driving the financing crisis are ones of coverage and cost. We must make sure everybody can get the quality care they need at a reasonable price.

Our delivery system is undoubtedly the best in the world. It is constantly renewing itself in response to market forces, consumer demand and innovation. Policy makers may find that the delivery of health care is changing so fast that they will soon be trying to reform a system that no longer exists in many parts of the United States.

The new National Committee for Quality Health Care report points out that while we are paying more for health care, we also are receiving greater care. The health care product — the package of services we receive when we seek medical treatment — is far superior than it was only a decade ago. As a result, mortality from heart disease, stroke and unintended injures has declined substantially since 1980. Death from heart disease, for example, dropped by 27 percent.

The health care delivery system is also becoming more efficient. Both technological advances and changes in reimbursement have lead to an increase in more cost-effective outpatient services. Investment in R&D, for example, has produced cost-saving therapies like laser surgery for cataract removal. This technological advance has saved money by shifting the procedure from an inpatient to an outpatient setting.

The National Committee for Quality Health Care report also demonstrates that the health care delivery system is dynamic. It is able to respond to unanticipated events. Hospitals, for instance, were able to respond to a shortage of registered nurses that began in the late 1970s. They increased the supply and lowered the demand for registered nurses by raising the salaries of RNs and relieving them of certain tasks like making beds and delivering meals. The health care system also was able to respond to the AIDS crisis by marshaling important resources to cope with prevention and treatment.

These are just a few examples of how the delivery system is effectively responding to demand. Reform legislation must not interfere with these market mechanisms. We fear that premium caps and government regulations may have the unintended consequence of lower investment in R&D. As a result, innovative new procedures like cataract laser surgery may not be developed. We are also concerned that premium caps would prevent hospitals from responding appropriately to future nursing shortages. Imposing price controls on the health care industry could force hospitals and other health care employers to freeze wages. But by imposing price controls exclusively on the health care industry, skilled health care workers would be given an incentive to leave for better-paying jobs in other industries. Price controls also could handcuff the health care system's ability to respond quickly to unexpected demands for services, as it did with AIDS. Even more important, price controls would freeze in place the status quo.

Instead, reform should build on what is working by providing incentives for higher quality and greater choice and innovation. By arming consumers with needed information, providers would have to compete on objective standards of quality.

The Financing System

Yet the financing system does require swift legislative reform. The incentives in the current system need to be reversed. Today, insurers too often seek to minimize risk by excluding high-risk populations. Patients and providers have little incentive to be cost conscious because the insurance company will pick up the tab. And often they don't know the true cost of their health care choices. This system results in the exclusion of many from health coverage and an inflation in health care costs. This must be changed now.

Insurers must be prohibited from excluding people with pre-existing conditions and dropping people when they become sick or change jobs. Providers and consumers must become aware of the true cost of the health care services they dispense and receive. The only way to contain costs without risking quality is to give consumers an incentive to choose the lowest-cost, highest-quality health plan and to force providers to compete on the basis on price and quality.

Congress must pass and the President must sign a bill that contains health care costs and makes coverage affordable and accessible to all — but without jeopardizing the high-quality, choice and innovation that Americans have come to expect from their health care system. Reform should build on the positive market reforms we are now witnessing — not replace them with government regulations and price controls.

Principles of Reform

The Healthcare Leadership Council believes there are five fundamental principles of reform. They are:

- Access: Everyone must have available to them the right treatments and facilities — where and when they need them.

- Coverage: Everyone should have the ability to pay for their health care services. No American should ever lose sleep over the possibility their coverage may be dropped if they become sick or change jobs.

- Choice: People should have the option to choose the kind of coverage and the kind of providers that meet their particular needs.

- Quality: Everyone should have care and treatment by the best health care professionals — selected on the basis of need, not cost.

- Innovation: We believe developing innovative new cost- effective technologies and treatments is critical to increasing the quality of care and to reducing costs.

Access vs. Coverage

The distinction between access and coverage is an important one. Access means having quality care available at an affordable price. Coverage means you have insurance and the peace of mind of knowing you can pay for health care. The goal of reform should be to promote both. In the idealized health care system, they go hand in hand. Coverage is meaningless if you cannot find a doctor to treat you or if the quality of care is poor. Similarly, access to the best health care system in the world doesn't offer much if you cannot afford it.

We must make sure that health care reform doesn't sacrifice one for the other. The President has said he wants reform to guarantee everyone private health insurance that can never be taken away. In order to achieve this goal without a broad-based tax, the Clinton plan relies on price controls and government regulations. But if these controls and regulations put at risk our high quality care, universal coverage would be a Pyrrhic victory at best. In too many places, particularly inner city and rural areas, people who have coverage are still unable to see a doctor. What good is insurance coverage if there are inadequate facilities in the community or if there are long waits for treatment?

We do not believe an employer mandate combined with regulatory alliances is a good solution. It would allow government to dictate how businesses and individuals spend their resources and it could force businesses with small profit margins to freeze wages or lay-off workers. Another Lewin-VHI study, prepared for the HLC, found that an employer mandate is a clumsy way of

providing universal coverage because it would provide subsidies to companies that already are able to afford coverage on their own.

Increasing the Value of the Health Care Dollar

Cost containment is vitally important. For too many people, health care is becoming too expensive. It is depleting family savings, driving up business expenses and increasing government budget deficits. But cost containment is ultimately about value. It is inaccurate for some to suggest we are paying more and more for less and less care. We are paying more and more for greater and greater care.

The question is not just how much we pay but whether we are getting our money's worth. The United States spends a lot on health care — 14 percent of GDP. But would the American people rather spend half that amount if the quality of care was similarly cut in half? How much is too much? And how quickly can we reduce our national health spending without negatively impacting quality?

The goal of cost containment should be to get the most value out of every health care dollar spent. This means increasing efficiency by reducing administrative costs, eliminating unnecessary procedures, reforming the malpractice system and revising anti-trust regulations.

A Look at the Michel Bill

We believe Minority Leader Bob Michel's "Affordable Health Care Now Act" (HR 3080) contains many provisions consistent with the principles of the Healthcare Leadership Council.

The Healthcare Leadership Council advocates insurance reforms. Mr. Michel's bill would make coverage portable and prohibit insurers from denying coverage to those with pre-existing conditions or dropping coverage when you become sick. It also would require insurers to accept every small employer and every eligible employee of a small employer who applies for coverage.

The BLC advocates market competition, not government regulations, to contain costs. We believe the Michel bill adheres to this philosophy. It would achieve health care savings through malpractice and administrative reforms. States would be given more flexibility to enroll Medicaid beneficiaries into managed care plans. Medical Savings Accounts also would make consumers more cost conscious.

The HLC believes health care coverage can be affordable and accessible to all without an employer mandate. Michel agrees. His bill would require employers to offer, but not pay for, insurance for their workers. It also would allow states to establish a sliding-scale subsidy for those earning up to 200 percent of the federal poverty level.

The HLC endorses small group purchasing pools. Purchasing pools give small businesses and individuals the same purchasing power larger businesses now enjoy. The Michel bill would encourage the formation of multiple employer health plans by removing burdensome government regulations.

Areas of Consensus

A look at the Michel bill and the other reform proposals under consideration reveals a remarkable degree of agreement. Everyone agrees health costs need to be contained and access to care expanded. There is also agreement on many of the ways of achieving these goals. Virtually all plans advocate insurance reforms, a basic benefits package, purchasing pools, consumer information, administrative and malpractice reform, subsidies and changes in the tax code.

As we debate the differences in these proposals, we must keep in mind there are more areas of agreement than disagreement. The BLC believes a bipartisan consensus can be forged. It is essential for successful passage and implementation of reform that support comes from both parties. We hope members of Congress will be able to tell their constituents next fall that they passed legislation that makes health care affordable and accessible to all while maintaining the quality, choice and innovation people expect.

Thank you for giving me the opportunity to speak with you.