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Committee on Energy and Commerce
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Mr. Chairman and Members of the Committee: I am pleased to be here today to discuss with you the cost containment provisions of the President's Health Security Act.

First, I will discuss the reasons why a strong cost containment strategy is critical to the success of comprehensive health care reform plan. Second, I will provide you with the details of the cost containment provisions in the President's plan.

The Costs of Doing Nothing

Why must we remain committed to a strong cost containment strategy? Because the total costs of health care are high and rising.

In 1992, the United States devoted 14 percent of GDP to health care. In 1980, the share was 9 percent. No other country in the world spends more than 10 percent of GDP on health care. It is estimated that health care spending will consume 19 percent of GDP in the United States by the year 2000.

Over forty percent of the growth of real per capita GDP between 1993 and 1996 will be accounted for by health care spending. While some of this growth is warranted, this unusually high rate crowds out other items of consumption.

Health care cost growth will continue to outpace growth in other segments of the economy. While the annual growth in the non-health care sectors of the economy for the rest of the decade is projected to be between 4 and 6 percent:

- Private health care costs will grow at a rate between 7 and 8 percent.
- Medicare growth will be 11 percent, and
- Federal Medicaid growth is expected to be over 16 percent in 1994, and to slow to only 12 percent over the remainder of the decade.

The rising costs of the current system harm businesses, government, and households.

The Cost to Business

Businesses pay for health care primarily through premium contributions for health coverage and workers' compensation.

- Real business spending on health care has risen from $774 per employee (in 1992 dollars) in 1970 to $2,345 in 1992, a 200 percent increase.

- Real workers' compensation premiums per employee have more than doubled since 1970, rising from $149 (in $1987) in 1970 to $326 in 1992. Health care costs are the fastest growing component of workers' compensation premiums.

- On average, the uninsured currently pay for just 20 percent of the care that they use. The other 80 percent is shifted to people who are privately insured, resulting in higher premiums for businesses and families.

- High health care costs tie up money that would have been use for wage and salary increases, capital expansion, profits, and payments to shareholders.

The Cost to Government

In addition, our current health care system is a growing burden on all levels of government, and is the greatest barrier to deficit reduction.

- Government spending accounts for 44 percent of health care spending in this country. This includes the costs of Medicare and Medicaid and the costs of providing health care for government workers.

- Almost two-thirds of the growth in all federal spending between 1993 and 1996 will be accounted for by health care spending.

- As health care continues to consume a larger share of the federal budget, Federal spending other goods, such as education, training, employment, and social services will actually decline as a share of total federal spending over the next 5 years.

The Cost to Families

The bottom line for workers under the current system is that they ultimately pay for the growth in health care spending.

- One of the reasons that real wages have barely grown for the past 20 years is the increased costs of health care for businesses.

- If employer contributions to health insurance remained at their same share of employee compensation between 1992 and the year 2000, and employers passed these savings on to workers, real wages per worker would be $566 higher in 2000 than they are currently projected to be.

What has become clear is that we cannot achieve meaningful cost containment without comprehensive reform. Cost containment efforts over the last twenty years, public and private, have done little to reduce the spiralling rate of growth in the health care sector of our economy. In today's system, cost containment efforts by one payer often just shift costs to another. Employers and other payers, faced with uncontrollable health care expenses, are being forced to reduce benefits, limit choice and increase the share of expenses paid by their employees. Without the guarantee of a universal system, including a comprehensive cost containment strategy, the unrestrained growth of health care costs will threaten health security for us all.

Even with health care reform, health spending will continue to grow. The important differences, however, are that with reform, the increase in spending will be accompanied by (1) universal access; (2) enhanced benefits for millions of Americans, including older Americans; and (3) a coherent cost containment strategy that assures affordable levels of growth into the future.

The President's Cost Containment Plan

The President has a three pronged approach to cost containment. First, the plan restructures the health care market place, permitting consumers to make informed choices regarding their health plan. In this reformed marketplace, plans will compete on price and quality. Second, as a back-up strategy, the plan includes caps on the permissible rate of growth of health plan premiums. Third, the plan achieves substantial savings through reduction in the rate of growth in the Medicare program and through Medicaid savings.

1. Increasing Market Competitiveness

To facilitate competition, the Health Security Act creates regional health alliances. These alliances will act as the purchasing agents for workers in firms with less than 5000 workers, for those who are self-employed, and for those who have no attachment to the workforce. In addition, some large firms may opt into the regional alliances. Alliances will provide consumers with even greater choices than those enjoyed by employees in large corporations in today's market.

Under the current system, large firms can promise substantial market shares to insurance plans in return for lower premiums. However, those in small or moderately sized firms are often unable to obtain reasonably priced premiums because insurers view each firm as being relatively unimportant to their market share. Individuals attempting to purchase insurance outside of an employer group have an even more difficult time in their attempts to purchase independent policies.

Health alliances act as buying cooperatives to organize the health insurance market on behalf of their members. Health plans that want to participate in the market place will have to compete honestly over price, quality, and service. By eliminating the ability of insurers to discriminate based on health status and age, the President's plan moves the health care environment in the direction of a more competitive market, which will reduce waste in the system and drive premium prices downward.

The President's plan also provides incentives for consumers to make cost conscious decisions about their health care coverage. Consumers who choose to enroll in higher cost plans will pay more for their insurance than consumers who opt for lower cost plans.

An example of how such incentives to consumers will work under the reform plan is the experience in the State of Minnesota. In the mid 80s, Minnesota changed its contribution for the state's employees from 100 percent of the state high cost plan to 100% of the low-cost plan serving a given county. Between 1988 and 1990, the percentage enrolling in the state high cost plan fell from 43 percent to 12 percent. Those enrolling in the low cost plan increased from 25 percent to 45 percent during that period. System expenditures in the Minneapolis region were 6 percent lower than they would have been if no plan switching had occurred between 1988 and 1989.

Alliances have another negotiating tool -- information. Data about practice patterns, price and quality differentials from one plan to another and from one metropolitan area to another allow alliances to compare plan and area performance. The current lack of information hampers competition. By expanding the information base, competition drives high-cost, high utilization areas to bring their performance more in line with other areas. As utilization and costs decrease, this translates to lower prices to consumers.

An example of how this information can help to drive costs down is the case of the new California Health Insurance Plan Cooperative (HIPC). California HIPC, a voluntary pool for firms between 5 and 50 employers, informed high and low bidders (health plans) of the relationship of their first bid to the average. Among those who were informed that their bid was above average, close to 30 percent gave second bids that were lower by an average of nearly 10 percent. No bidder, even those whose bids were below average, raised its bids. Initial evidence in Florida is similar to that in California.

The Health Security Act also contains costs by reducing administrative expenses, both for health plans and for health care providers. Administrative expenses for individual and small group insurance can amount to up to 40 percent of premiums. Health care providers spend millions of dollars on inefficient claims processing systems, including the time costs involved in filling out multiple forms. Through alliances, administrative costs for insurance will be far lower than they are today. In addition, the President's plan simplifies claims administration by developing a uniform claims form and electronic billing system.

The Health Security Act also saves money by taking aggressive steps to combat health care fraud, increasing penalties for those who cheat the system and expanding enforcement activities.

It imposes new prohibitions against kickbacks and conflicts of interest, such as doctors who refer patients to laboratories in which they have a financial stake. And health care providers convicted of fraud and related crimes will be excluded from participation in health plans.

2. Caps on the permissible rate of growth of health plan premiums

Through these changes in the competitive market, the Health Security Act restrains the growth in health care spending. To ensure that these changes achieve savings, we create a backup system of enforceable premium caps. These caps will still allow spending to increase, but by a much more reasonable amount — one much closer to the rise in other consumer prices. These premium caps are not designed to restrain the marketplace, but only to act as a backstop, guaranteeing reasonable and defensible expectations for savings. The caps are based upon projections of savings in administrative costs and from increased price competition in the alliances. We believe insurers and providers can achieve these savings, and hold premium growth closer to price increases in the rest of the economy.

Premiums caps are enforced through an automatic mechanism written into the legislation. If premiums in an alliance exceed the cap, alliances may negotiate with health plans to bring premiums in line. If premiums cannot be reduced through negotiations, automatic premium reductions are triggered, and provider payments from plans are similarly reduced (with adjustments for expected increases in volume of services).

3. Reductions in the rate of growth in the Medicare program — $123 billion.

Medicare has been growing at a rate of almost 11 percent per year. We have identified a set of approximately 25 policy changes that will achieve $123 billion in savings. These policy changes include "reconciliation-type" reductions that affect the payment rates to providers, as well as new proposals to control utilization. We have also included a proposal to income-relate the Part B premium for high-income Medicare beneficiaries — singles with income of $100,000+ and couples with incomes of $125,000+. These spending reductions produce a moderate decline in the extremely rapid baseline growth of the Medicare program. Under our plan, by FY 2000 we will have reduced the rate of growth in Medicare from its current annual rate of 11 percent per year to around 8.4 percent -- even while adding new coverage for prescription drugs.

4. Medicaid savings — $65 billion.

The Medicaid savings counted here result from two sources. The Health Security Act will provide all Americans with health coverage, and therefore it will nearly eliminate uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat large numbers of low-income populations, including undocumented persons. In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because under our plan, Medicaid recipients will be receiving health care services in alliance health plans, like other Americans with private insurance.

The President is committed to bringing the rate of increase in health care spending in line with the rate of growth in the rest of the economy. The Health Security Act proposes a market-based mechanism for controlling health care costs, backed by enforceable premium caps and fee schedules for fee-for-service plans. We understand that controlling costs requires tough choices, but the consequence of doing nothing means that health care spending will continue to rise unrestrained, threatening health security for us all.