Public Hearing

before

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

"Presentation by Joy Johnson Wilson, concerning the major legislative proposals currently pending in the U.S. Congress with regard to health care reform"

LOCATION: Legislative Office Building
Committee Room 8
Trenton, New Jersey

DATE: March 30, 1992
3:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Nicholas R. Felice, Vice-Chairman
Assemblyman Stephen A. Mikulak
Assemblyman Thomas S. Smith
Assemblywoman Barbara W. Wright
Assemblywoman Stephanie R. Bush
Assemblyman Louis A. Romano

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and
Human Services Committee

Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, 162 W. State St., CN 068, Trenton, New Jersey 08625-0068

New Jersey State Legislature
ASSEMBLY HEALTH AND HUMAN
SERVICES COMMITTEE
Legislative Office Building, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 292-1646

COMMITTEE NOTICE

TO: MEMBERS OF THE ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

FROM: ASSEMBLYMAN HAROLD L. COLBURN, JR., CHAIRMAN

SUBJECT: **COMMITTEE MEETING - March 30, 1992**

The public may address comments and questions to David Price, Committee Aide, or make bill status and scheduling inquiries to Felice Astor, secretary, at (609) 292-1646.

The Assembly Health and Human Services Committee will meet on **Monday, March 30, 1992 at 2:00 P.M., in Committee Room 8, First Floor, Legislative Office Building, 135 West Hanover Street, Trenton.**

The agenda will be as follows:

The committee will hear a presentation by Joy Wilson, Director of the Health Committee for the National Conference of State Legislatures in Washington, D.C., concerning the major legislative proposals currently pending in the U.S. Congress with regard to health care reform, as well as a comparative analysis of selected health care systems in other countries and their potential for replication in the United States.

A-1144 Sosa/Mikulak	Delays effective date of State Health plan until January 1, 1993.

Issued 3/23/92

TABLE OF CONTENTS

* * * * * * * * * * * *

tca: 1-35

ASSEMBLYMAN HAROLD L. COLBURN, JR. (Chairman): If everyone could, please, be seated. We wish to proceed. Dave has written some comments for me here, and I'm going to use some of them. Dave, uh-- Dave, what's your last name?

MR. PRICE (Committee Aide): Price. (laughter)

ASSEMBLYMAN COLBURN: I've lost everything in that last-- At least you could put your name on here. (laughter) David Price is our number one, nonpartisan, staff member. He made some nice little comments so that I could introduce the real reason why we're here this afternoon.

Last year, when the State, overwhelmingly, passed this question on the ballot having to do with national health insurance-- And while I voted to put it on the ballot, I must say that the wording was so wonderful I think it almost said you didn't have to pay for it, or something like that. It seemed to me it would be useful to have a better grasp of just what the building blocks were of such a program, and as we tried to find somebody who wouldn't have a vested interest, here in New Jersey, my gosh, we came upon somebody who had lived in Mount Holly, which used to be my district and in which I have a medical office even now. We found her through the National Conference of State Legislatures. Is that what we call that?

J O Y J O H N S O N W I L S O N: That's right.

ASSEMBLYMAN COLBURN: Okay. I think we pay dues to that.

MS. WILSON: You do.

ASSEMBLYMAN COLBURN: We invited Joy Wilson up here and she accepted with alacrity, and I didn't realize that she was operating-- Her speed is slightly reduced as far as locomotion is concerned right now (referring to her advanced stage of pregnancy), but she agreed to come, and then she agreed to let all of this other go ahead of her (referring to Committee meeting held prior), which I thought was especially gracious.

She has been a staff member of the Pepper Commission. Is that right? (affirmative response) That means that she's been exposed to a tremendous variety of opinions. We would like her to give us some ideas about the building blocks for a possible national health insurance plan, and she was going to discuss some of the foreign plans as well. Without further ado, I would like to thank you, again, for coming here.

MS. WILSON: Thank you for inviting me. It's really a pleasure to be here, back in New Jersey, where I spent a good deal of my life. I'm a military brat -- Air Force brat. We were stationed at McGuire for two terms, and then my father retired in Mount Holly. I consider New Jersey my home State, so, it's kind of fun to be back in Trenton.

I was asked to kind of give an overview on what the Congress is contemplating in terms of health care reform, and to also talk a little bit about some of the international systems and how they differ from what we have and the possibilities of using some of that information in our efforts to reform our system. That's a pretty broad mandate. What I've decided to do was try to give a broad overview, identify the major reform models, and talk a little bit about Canada, Japan, and West Germany, as the foreign models that we might look at.

In terms of the handouts: The handouts will provide you a little bit of detail on a number of Congressional proposals. I can't give you something on all of them, because my guess is that by May or June every member of Congress will have his or her health care reform proposal which may be a little bit different than their neighbor's but not too much -- something that they can write about prior to the election in November. I'd say we're pretty close-- There are probably over 100 bills that have been introduced so far, and they represent a broad range of models. So, I will touch on the major models and tell you the different bells and whistles that

you can attach to each to make it a little different, and talk about some of the pros and cons.

I should probably tell you a little bit about what I do, so that you know where I'm coming from. I am the staff person for the Health Committee of the National Conference of State Legislatures. That is the Conference's policy-making Committee, and we deal with all health care issues including health care reform.

The Conference is a bipartisan organization. Each State pays dues to our organization, and we represent the 50 states, the territories, Puerto Rico, and the District of Columbia, most recently. So, I lobby on behalf of state legislatures. I lobby to Congress, and the Administration on health care issues. That's my job. I took a leave of absence for a year and was on the staff of the Pepper Commission, which, as you probably know, was a Congressional effort to get health care reform. As you probably know, the Pepper Commission recommended -- not unanimously, but did recommend by majority -- a play or pay model. I will talk a little bit about play or pay in a few minutes.

I think in order to start talking about health care reform, we've got to look a little bit at what we've got now. I think, probably -- as models go -- our model is probably the most difficult to explain. If I were a foreigner I'm not sure I would understand what it is Americans do. If I had to read how we operate our health care system, I think I would leave very confused.

Basically, we have an employer-based system. Most people who are insured get their insurance through their employer. If your employer is a large employer you get group coverage. If you are employed by a small employer you get group coverage, but it's a little bit different, and it's very important to note that the insurance that is available to small employers is different in many ways than those products that

are available to larger employers. Then, for the self-employed, there is the individual insurance market, where you as an individual go to an agent and obtain insurance coverage, and that is different than either the group coverage or the small group coverage. It's important to note that those differences exist.

In addition to the private insurance market we have Medicaid, which -- contrary to what many people believe -- is not the health care program for all poor people. It is a health care program for certain categories of poor people. When it was initiated it was pretty much limited to women and their dependents, and the disabled. We have, through a series of Federal mandates and state options, expanded coverage under the Medicaid program so that it now covers a somewhat broader group of the poor. However, it is not a health care program for poor people. It is a health care program for poor people who receive Aid to Families with Dependent Children, or SSI, primarily. There are some other additional groups, but those are the main ones.

We also have Medicare, which is for qualifying disabled people and people over age 65. It is an acute care program. It is not a long-term care program. We also have, and this is almost never mentioned, a whole separate system for veterans and military people. It is a huge system that operates autonomously from the rest of the system. Then we have people that don't qualify for any of those things, and those are the 37 million people who are uninsured in America.

I think it's important to note that the 37 million, or however many -- that's a number in dispute, but the one that's most often used -- is not a static group. Because our coverage is tied to employment, as people become employed and unemployed they become insured and uninsured. So, the 37 million people are not the same 37 million today as it was yesterday, and it will be a different group tomorrow. I think that's important

to note. In any given year, someone may have coverage for two months, three months, or six months, but they might not have coverage when they're sick. This is not a new problem.

The working poor has always had this problem of rolling insurance coverage. I think spiralling costs, and the fact of our changing employment demographics have made the health insurance situation more noticeable. As we move towards a small employer economy we're downsizing, and our growth is in small employers -- small businesses -- as opposed to major manufacturing.

If you look at what kinds of employers are least likely to provide health insurance you will find that it is small employers that are least likely. So, as that sector grows, you have a growing number of people who are falling outside of our covered categories. The other thing is that, we are unions, and a lot of the major manufacturing where unions were concentrated are downsizing, and those unionized employees that had very nice benefits under the union plan are finding that those benefits were because they were part of a union plan and benefits outside of that are not the same or maybe nonexistent, if they go and work for a small employer. So, people are beginning to find that what they thought everybody had--

As long as you have health care coverage-- If you work in a large group, you think everybody must have what you have. We're finding that it's not that simple. The other things is that as health care costs spiral, all employers are ratcheting down on health benefits. So, what you see, and many of us have experienced this, is larger deductibles, larger copays, higher premiums, and what I call disappearing coverages.

As open season rolls around, once a year, it behooves you to look very closely at the materials they send you, because oftentimes you will see that either they have eliminated benefits, or cut back on benefits in terms of

numbers of days or parts of the coverages. And as that happens, people become less satisfied with their health care coverage.

I don't know that we've reached a crisis yet, but we are at least reading about health care reform more in the papers, magazines, and we're hearing about it on TV and on radio. I think it is clear that we as a nation have not reached a consensus on what to do yet. We all seem to agree that everyone should have coverage. We all seem to agree that somebody else should pay for it, and therein lies the rub.

While I was on the staff of the Pepper Commission, which is a homogeneous group compared to the group that I'm working for now, I think as a staff we all felt that if we get a bunch of really smart people together, and well connected politicians -- which certainly was represented on the Pepper Commission -- that surely we could come up with a health care plan that would pass muster, and would get everybody's support. I was, certainly, optimistic as a staff person.

I thought I was pretty pragmatic. I'd been in politics a pretty long time. I can tell you now that I'm a lot smarter now than when I went in, and this is a tough, tough, issue. There are hard, hard, questions, and there's no silver bullet here.

I think what I'd like to do is talk about the different ways that we can approach health care reform, and tell you flat out that they all have pros and cons that are very serious ones. You can't do health care reform on the cheap, and you can't do it without making somebody cry, "Ouch." I think, ultimately, we'll all have to hold our noses and dive in and take our loss, but I've not seen any indication that we're ready to do that yet. But in preparation, let me talk a little bit about the different ways of approaching health care reform in light of our current system.

I think one of the things-- A key area where people don't agree is whether we need to approach cost first, or access first. It's something of a chicken and an egg situation, really, but it's a major area where people split off. I am of the opinion that as long as we have 37 million people outside of the system -- that come into the system at the absolute highest cost when they enter the system, we cannot have cost containment. Therefore, unless we address access we cannot address cost.

There are people that don't feel that way, and they feel that we must first try to rein in cost. I'm not sure how you do that and not deal with all of those people out there who are coming into the emergency room requiring surgery. Perhaps, if they had had coverage, some medication or a physician visit, it might have sufficed. That is a key issue that we have to deal with as a country, and it has some bearing on the approach that one takes towards health care reform.

There are other issues other than the fact that there are 37 million people that are uninsured, that impact on cost. Among them are technology. We are very technology strong in the United States. We spend a lot of money on research and development, and we have, probably, more technology than-- I'll remember that acronym in a minute. I know what you're asking.

ASSEMBLYMAN ROMANO: No, no, I wasn't asking you. I thought that he might have known. I pointed toward the APPWP. I couldn't find it anywhere here. I wasn't trying to disturb your session. I asked him if he knew.

MS. WILSON: It's on the handout. He wants to know who wrote it, and I wrote it down in--

ASSEMBLYMAN ROMANO: No. What's APPWP?

UNIDENTIFIED SPEAKER FROM THE COMMITTEE: That's who did it.

MS. WILSON: Right. It's a private pension organization--

ASSEMBLYMAN ROMANO: Okay. Okay.

MS. WILSON: --that put this handy-dandy together.

ASSEMBLYMAN ROMANO: I didn't know what the acronym--

MS. WILSON: I'll get the full name of it for you, or it will come to me -- one or the other.

So, we are high users of technology. We use more technology than any other country in the world. We develop more technology, and that does add to the cost. We also have an aging society. Although our demographics are not necessarily-- We're not aging any more quickly than, say, the Japanese, but our costs are higher. We do have to deal with AIDS. It will be a major impact on health care costs over time.

Clearly, our malpractice system puts stresses on our system that don't exist in other countries, and I'll talk a little bit about that. Often mentioned are the poor health habits that Americans have, in terms of smoking, drinking, nutrition, and the fact that we have not really put a lot of effort into preventive health. We've been primarily an acute care based society. Finally, we have -- because of our mixed system -- very high administrative costs compared to other countries. These are all things that contribute to our spiralling health care costs.

In looking at different ways of reforming our system, there are three major ways of looking at it:

* There is the slash and burn and build from scratch, which is the single payer Canadian system that you hear about.

* There is play or pay, which is really keep our current system, but make it quasi mandatory.

* Then there is the finger in the dike approach, which is the incremental approach where you try and take our current system with all of its worts and fine-tune it.

Right now in Congress there have been several single payer bills that have been introduced. The major bills are considered to be the play and pay ones. Senator Mitchell, Senator Rockefeller, Congressman Waxman, and Congressman Rostenkowski have all introduced play or pay proposals. Then, finally, there has been a hodgepodge of incremental step bills. Among the incremental steps that one can take it would include small group insurance reform.

You remember, I mentioned how the insurance that is provided to small employers is different in nature than that larger groups receive, and there is a lot of effort, right now, being concentrated on trying to correct some the problems in that area. Malpractice reforms, practice parameters for physicians, Medicaid expansions, and tax credits are all incremental approaches to expand access under the current system.

Then, finally, there's state experimentation that, basically, involves states doing their own thing, trying to develop a statewide comprehensive approach to health care reform. Now, on a single payer system, there are lots of ways you can do it. I think the most common model that people think about is the Canadian model, where the Federal government sets broad guidelines. The health care program is administered by the provinces -- which are states for us -- and hospitals work under a global budget, and physicians work under a fee schedule. That's kind of the broad confines of it. Basically, there is one rate, one payer. There's no price competition kinds of things. Everybody is eligible for health insurance, and they don't pay per visit. They pay in taxes. The Canadian system is tax funded, both from Federal taxes and then local taxes.

That's the gist of a single payer system, and in America it would be-- Some people have said, it's like expanding Medicare to all of the people, as opposed to just

people age 65 and older. Now, anybody that's dealt with Medicare-- A lot of elderly people have said, "Gee, that makes me nervous, to think that you'd want to expand Medicare to the rest of the folks."

I do my parents' Medicare claims, and I can tell you that it's pretty complex. Under the single payer system you wouldn't have all of the forms, which is the other main advantage to a single payer system. You don't have to file the claims and all of that stuff. The doctor files the claims with the Federal government and receives payment, and he knows what the payment will be, because it's according to a fee schedule. So, it's very simplified.

The political problem with the single payer system is that it pretty much eliminates private health insurance, because the benefit is nationally drawn and the only role for private health insurance are for benefits that would not be part of the national plan. So, private insurance would provide wraparound coverage. For instance: The national plan may cover a semiprivate room. You could buy coverage that would pay for the private room. Perhaps, the national plan doesn't cover prescription drugs, and you could buy coverage for prescription drugs. That would be the role of private insurance under most single payer systems.

Consequently, private insurers are not particularly favorable to that kind of a system. Physicians, typically, oppose national fee schedules, and consequently, have not been favorably disposed towards single payer systems that would establish some sort of national fee schedule. In terms of being able to work in the United States, I think politically it would be very difficult to make that happen. It's not what we typically do when we reform something. We usually build on existing. We don't usually start from scratch, but we'll see. That is one approach that could be taken.

I think it's important to note that under a single payer system it could either be Federally administered or state administered. There is nothing that says it has to be one way or the other. There are different concerns from different people depending on how they feel about the ability of the states or the Federal government to administer health care programs. So, that's a bell or whistle you might add on a single payer system: Who would be the administrating agency?

The other rub -- and this is particularly interesting to state legislators -- is who pays, and what is the role of the state in paying towards a single payer system? That always makes for interesting discussions.

Under a play or pay, there are kinds of gradations. Play or pay could almost be an employer mandate, depending on where you put the penalty. Basically, under a play or pay model, employers are suppose to either cover their employees or pay a tax. Now, depending on where the tax is set, that determines whether an employer is going to opt to seek coverage on his own or pay the tax.

Of course, there is a point at which you could put the tax so high that it's a mandate, or you could put it so low that employers will go, "Why should I bother? I'll pay the tax." That's the concern that you often hear about play or pay being national health insurance: Because, to the extent that the tax is low and everybody's part of the public plan, you have a Federally funded health care program for everybody. To the extent that the tax is very high, you're requiring, basically, an employer to provide coverage. So, it's critical where the tax is set. That is an issue. The other is, because it is building on our current employer based system, by its definition it means that there will be people outside the system.

People who are unemployed automatically are outside of play or pay. So, there has to be a residual public program to

cover people who fall outside of the employer based system. Of course, there's a lot of concern about what that public plan might look like. Many legislators are concerned it might look like Medicaid, and we all are very familiar with the shortfalls of Medicaid. It is a major concern; how we can construct a public program that serves the people who fall outside the system, but does not look terribly much like Medicaid and does not have the problems that Medicaid has.

Clearly, there has to be a public program, and depending on where the tax is set, that will determine the size of the public program. There is also the concern about how an employer mandate -- play or pay -- effort would affect small businesses. It is clear that small businesses will be more impacted than larger businesses because they're less able to shift additional cost onto the consumer, for competitive reasons. Consequently, most play or pay models have some sort of special section for small businesses where they try to lessen the burden on small businesses either by phasing the tax in over a longer period of time, providing tax credits or some sort of government subsidy to small businesses. That is clearly a very important issue if you're going to look at a play or pay type model.

Then there are the incremental approaches, and they are numerous. I will run through a series of them and talk a little bit about the pros and cons, and how they fit into the universal scheme of things. The one that I think is most likely -- we may actually get some legislation this year -- would be small group reform. I'll spend a little bit of time talking about that. I think it's very important, given that small employers are a growth industry in the United States.

I think that-- An interesting thing, when I was on the Pepper Commission staff, was that the Commissioners didn't agree 100 percent on a whole lot of things, but they all agreed that the small group market was nonfunctional, and that's very

important. We had bipartisan agreement that health insurance for small employers was broke, and something needed to be done. I think that's important because a lot of the ways to fix it do not cost the Federal government a dime.

So, here we are in an election year, and we have very little consensus on big picture health care reform. We have a lot of consensus on this piece, and it's budget neutral. So, if I had to handicap any of these proposals I'm talking about, I would say small group reform is above the 50/50. It has some problems, and I'll go through some of those. I think, politically, it is the most likely first step if Congress is going to do anything on health care reform in the near term.

Now, what is broke about the small group market? One of the things-- If you work for a large company you have a benefits manager. The benefits manager goes out and negotiates your benefits for you, basically.

If you worked for Mabel's Yarn Shop, Mabel is the benefits manager. She's the proprietor. She does everything. She will see a series of insurance agents who will try to sell her a policy. Of course Mabel's Yarn Shop-- She would probably have to go find them. Let's say we've got Joe's Plumbing. Joe is the proprietor. He's got five, 23-year-old guys -- hunks -- very healthy. They'll come to him. It will be a series of insurance agents that will come and see Joe. Mabel has three ladies all over 50, and they all have high blood pressure. She has to go and find the agents.

Now, one of the things that's different is, in a large group, they do not medically underwrite. They take everybody. If your group is large, you're negotiating on money, mostly: deductibles, copays, premiums -- that kind of thing. Mabel and Joe are going to be negotiating on whether the insurance company is willing to cover all the people or not because when you work for a large company, you typically -- at least up until now; things are changing -- did not have to take a

physical to get your health care coverage. You picked whether you wanted the HMO, the fee for service, or whatever, and you signed a form and you were covered. Not so in the small group market.

In the small group market they can require not only that the employees take physicals, but their dependents as well. This is called medical underwriting, and the insurance company can decide whether or not they wish to cover all of the people that work in any given entity. Now, what typically happens in businesses like Joe's Plumbing that has the hunks, the insurance agents are beating each other down trying to find these places and cover these folks, because unless they have a motorcycle and ride around with no helmet, they're probably not going to get sick. So, you've got high probability that you're going to get premiums in, and not pay out.

They run from people like Mabel, because nine times out of 10 you're at least going to have to pay for high blood pressure medicine or something connected with their health conditions. So, what happens is, in order to get Joe to sign on with you, you offer him below market rates, because you want to get Joe locked in. When you get to Mabel, you'll say, "Gee, Mabel, you caught me. I'm going to have to talk to you, and I will offer you some insurance, but I want your arm and your leg, and I don't want to cover Mrs. Brown." So, as a proprietor, you have to then decide whether you want to take that coverage and not cover one of your employees. In a small business that's more difficult than even a large business, because you have to look at this person every day, or you're going to have to go find some other insurance company that will provide that coverage. That is a major problem in the small group market.

There are some businesses who just can't find anybody that's interested in their business, period. Then you have some who get coverage-- Let's say, in Mabel's Yarn Shop none

of them had high blood pressure to start with, but sometimes during the year of coverage, one of them developed high blood pressure. When renewal time comes around, they double the premium and go, "Well, you can stay with us, but you'll have to pay twice as much." This creaming of small business has been a major problem in the small group market, and something that everybody has wanted to do something about. The other thing is that there's a lot of turnover in small businesses, and the benefits are not portable, which means that if you were so lucky to work for a small company and get insured, if you leave that company and go work for another small company, there is a fairly decent likelihood that you may not get coverage at the new employer. So, that has been another major problem.

Now, in order to deal with these problems there are a number of things you can do: One, forbid insurance companies from underwriting. That sounds like a good thing to do, but on the other hand the insurance company will say, "You're making us take people who we know are going to be sick. That's not insurance." There's that tension there. Who's going to pay for these high cost people? How are we going to spread that risk? We know these people are sick. This does not make sense. This does not make business sense for us as an insurer. The only way that they will do that is if everybody has to take sick people.

Then they say, "If you make us all spread this risk, we think that the really sick people should be put in a different category, then we'll spread that risk around again. Oftentimes they want that risk management to be underwritten by government. So, it's just something to think about.

The other things that happens is that-- What you want to do is equalize the market, so that people who are getting below market rates will be brought up to market, and people that were paying far above market rates will come closer to market, so that Mabel's premiums will go down, but Joe's

premiums will go up under insurance reform, and that, too, creates a problem. There will be a significant number of businesses that will see premium increases under insurance reform.

So, insurance reform, on its face, impacts availability, not affordability. To address affordability you're talking about some subsidization either for the business owner or for the employee on the premium side, to help as this adjustment takes place. The other impact is that you may have companies, that were providing insurance, drop out because of rising premiums. We don't know very much about exactly where that point is, because we don't have much experience. We do know that in this recession it is very unlikely that businesses will be picking up new benefits regardless of availability, just because small businesses are disproportionately affected by recession, as they are in any other business costs.

So, in terms of timing, this may not be a very good time for small group reform -- in terms of increasing access -- but it probably is very important and something that must be done. But people have to understand what it will do, and that there will be some displacements that are caused as we equalize that market and take care of some of the abuses in that market. So, I give that a 60-40 chance this year in the Congress, mainly because in the Federal budget it's zero.

Now, there will be costs at the state level, and let me just flag that for you. You will accrue some costs, both in terms of possibly people falling out of their insured status and then becoming uninsured, which you pick up somewhere along the line. There's also the issue of this reinsurance: Taking the very high risk people and covering them in some way. That will probably end up being a cost to the state in one way or another. So, I throw that out as something that I think--

A lot of states are looking at, and have adopted, small group reform. Unfortunately, most of them are just

nderway, and we've not evaluated them yet. We don't the full impact is. One of the things we have found here hasn't been a large increase in enrollments. So, done a whole lot on the access side, but in terms of out the market, I think that's something that has yet luated.

Malpractice reform: Certainly at the state level een a number of cycles of malpractice reform, which is to lessen the amount of defensive medicine that's by physicians. I could probably argue both sides of ne, it would make absolutely no difference, and the t would be a tremendous help. And I could find tion to back up either.

There are a lot of people that feel very strongly and for that reason, actually, in Congress they've not e to move malpractice reform legislation very far. , it comes down to a war between the trial lawyers and ors, and everybody gets very bloody, and nothing At the state level there's some evidence that ce reforms do lower premiums for physicians, but not dence that it lessens the amount of defensive medicine .. That's very hard to measure, so I'm not quite sure evaluate the effect on the practice of defensive but that is a major effort. It is part of the 's package, as a small group reform.

The other thing is practice parameters. One of the hat comes up is that physicians do too many procedures ny people, that are unneccessary. So, the development tice guidelines and effectiveness measures would -- Some people call it cookbook medicine, where for gnosis there would be prescribed treatments. It also ate to malpractice, in that, if a physician-- If you h a sore throat and the physician does five things in tice guidelines that they say you're supposed to do --

if someone comes in with a sore throat and it turns out that you had throat cancer and not strep throat -- he can say, "I followed the correct procedures," and that's a reputable presumption against malpractice. That's a very bad example, but that's kind of what is envisioned.

The other thing is to rein in unnecessary testing -- diagnostic testing. Under these practice parameters, if a physician wanted to use test that were outside of the guidelines, he would have to go to some other level of authority and appeal to do those diagnostic tests, where today he might just -- he or she -- go ahead and perform those tests. There is a fairly large contingent, and a lot of business people think the answer is to expand Medicaid, which for the legislators here, it means you all pick up the costs. The people I work for don't really seem to like that idea a whole lot.

Clearly, if not Medicaid -- under anything that retains an employer based system -- there will be a public program of some sort, and states will probably have some role in that. So, whether it's a Medicaid expansion or if we rename it and change some of the bells and whistles-- If we retain an employer based system, something will exist: Some of Medicaid will exist, and we'll have to deal with that.

Finally, there's a whole series of proposals that deal with the tax code. Some of them would provide tax credits at the back end. Some would be refundable tax credits that you could get up front. The President's proposal is refundable tax credits that would really be vouchers, and you could then use that voucher to purchase private health insurance. There are different bells and whistles you could put on that, where the refundable tax credit would be a mandatory thing, and you would be required to purchase insurance. Others: It's a voluntary thing, and you might get insurance if you felt like it. The others have to do with--

There are tax proposals about whether or not you can deduct medical expenses or whether you would pay taxes on what they would call excess medical benefits. So, if your employer were particularly gracious in medical care and provided you with a Cadillac health care plan, you may end up paying taxes on the dollar value above a certain level.

Finally, something everybody seems to agree on every year but because of its Federal budget impact it never gets enacted: If you are self-employed, you can only deduct 25 percent of your health insurance premiums. Everybody agrees that they should be able to deduct 100 percent, but that costs a bundle. So, every year there are probably 20 bills that go in to fix that problem, and they never get enacted. They've been discussed again this year, and, ultimately, I suppose, when we do a more comprehensive reform, that particular tax issue will get settled and will be added into the costs of the overall program.

Then, there's state experimentation. A lot has been said about: Let states be the laboratory for health care reform. We can see what states do and use that information in developing a national plan. Certainly, NCSL supports that notion, and we are pursuing that. However, I must say that we have some major barriers to state experimentation: Number one being, the Federal ERISA Law, which precludes states from regulating self-insured companies. States cannot access premium taxes, nor can they regulate the benefit packages of companies that are self-insured.

In some states self-insured companies represent 60 percent of the companies in their state. It is difficult to envision the state doing comprehensive health care with 60 percent of their employers outside of their regulatory purview. ERISA is really a pension law. It's a tome size thing. Most of it deals with private pension plans. The health part of it is very small, but it's very important,

because without getting some sort of exemption under ERISA a state could not do, for instance, a state play or pay approach, because they would not be able to require employers that are self-insured to cover their employees, for instance, nor can they charge them a premium tax or do anything related to their provision of health care coverage to their employees.

The other barriers are Medicaid and Medicare, where states would almost certainly need waivers to the provisions of those two programs. They would also, probably, need waivers to the Federal tax code. Finally, a large barrier for state experimentation is the fact that state budgets are in such trouble right now. All of these things work against states being effective as laboratories. However, I must say that we have a number of states that are moving forward with very innovative approaches, and there are some very exciting ideas out there that are being put into legislation.

Minnesota is about ready to pass a major health care reform proposal, sometime in the next week or two. The California Insurance Commissioner has come up with a very innovative plan that includes not just health insurance but workers comp and automobile insurance -- all noncontroversial issues (laughter) -- into one unified program. So, there are a lot of ideas out there.

Like I said, a lot of states have passed small group reform. We're just not sure what it will do. We need to make sure that when states do get something on board, and access it, that there are evaluations done so that we know what these programs do and whether or not they warrant replication at the national level.

Now, quickly, to talk a little bit about the programs in other countries: I think one of the major differences-- The major differences between us and Canada, West Germany, and Japan, is that they cover everybody, and we don't. I think it's very important. It's a fundamental difference, and in

some respects I think that it grows out of how our system started. Our system started as-- It was connected to the workplace. We were giving health benefits instead of wage increases during a time when you couldn't increase wages.

In most of these other countries, their health insurance program was developed to provide coverage for health so that they had a healthy work force, and that's why there's some commitment towards this whole idea of the healthy individuals, a healthy work force. Health was the centerpiece of why they have a program. I'm not sure that that's where we started, and perhaps that's why we're having some difficulty in getting there now. I think that's very important. They do cover everybody.

In West Germany and Japan, they are employer based systems, and I think that's why you're increasingly seeing more reference to, particularly, West Germany; because it's an employer based plan like we have an employer based system. I think that we relate to that. One of the key differences is that insurance is compulsory in both West Germany and Japan, and it didn't seem to be controversial, as best I can tell. I think we still have a problem making health insurance compulsory, either on an employer or on an individual. Just like we have a problem making it compulsory to wear seatbelts or helmets.

We believe in personal freedom. It's American.

Whether or not you want to be insured with health insurance is a personal decision in our minds. I think that we've not-- While we say we want everybody covered, I'm not sure we're at the point where we want to require everybody to have health insurance. It was not an issue, apparently, in West Germany or Japan, where everybody is required to have insurance, and they do.

I have provided a briefing paper that gives you some background on the Canadian system. I think it's interesting

that they were establishing their provincial system when we were doing Medicaid. So, I think it's important to note that the Canadian system didn't just start yesterday, and they've got this universal system, and all systems are go. This system developed over a span of years, just like our system has developed over a span of years. They took a different approach than we did. We can't expect that we could take any system and overnight it looks like it does in that country, because all of the systems developed over time.

I gave a little chronology of the Canadian system. I think it's important to note that in Canada, Japan, and West Germany, they all are experiencing health care inflation that's spiraling out of sight, so they don't have the silver bullet. Their expenditures are below ours, and I have charts in the back of the paper that show how their expenditures as a percentage of GNP compare to ours. I also have some data on health indicators, infant mortality, and life expectancy; male and female, and you can see that although we spend more money, we are not number one.

So, there are clearly things we can do better. It's not to say that our system is not good. We have a very good system if you're covered, but I think it's important, in terms of our health indicators, that when you factor in the 37 million people who are not getting good care, it pulls down our key health indicators.

I will run through any of the systems that you want me to, or I can just leave the-- I think the summaries are pretty good. I tried to make them as short as possible. I think that in terms of things that are similar: They cover everybody, they have fee schedules, global budgets. There's some constraint on expenditures that way, and most of them cover medically necessary physician and hospital services.

In Japan they do not cover maternity services, which is kind of interesting. However, they provide cash to women

who go on maternity leave, as does West Germany which requires an employer to give a woman 14 weeks of maternity leave with full pay. So, again, they are ahead of us on some family issues. I think those are probably the most interesting. The other big difference is the amount of taxes they pay for their system, which gets us down to where we started, money. You can't do it cheap, and I've got to tell you that the tax effort that's put forth in Canada, West Germany, and Japan, would make us all pale.

I have addressed what the payroll tax looks like in West Germany and Japan, where it can be as high as 16 percent. They are paying through their taxes for this coverage, but I have to tell you that they've got very good coverage, and it's not something that you lose if you get a pink slip. That's the trade-off. I don't know if people in the United States are ready, yet, to make those trade-offs, and that's where we come back to, "Why is Congress not doing anything?" I think the biggest--

Probably, the biggest single thing that's happened in recent years that has had an effect on health care reform, and is very seldom mentioned, is catastrophic health insurance. Anytime you go and talk to a member of Congress, they bring this up. So, they're still feeling the pain from catastrophic health insurance, although that was a couple of years ago. They thought they were doing good, and they thought they were enacting something people wanted, and they didn't want it. They're not going to do that with comprehensive health care reform. They're going to go, "Is this it?" And unless you say, "Yes," they're going to sit on it. I think, they have not been able to put anything up yet, that people have said, "Yes, this is what we want." I think that until that happens, like I said, we may get small group reform; we may get some little things around the edges; but we won't get anything comprehensive.

I think that this time around it will have to be grass roots from the bottom: "We want something to happen, and this is what we want to happen." As you know, that's difficult on some things as complex as health care reform. Well, I think I'll stop there and take questions. I tried to cover the waterfront.

ASSEMBLYMAN COLBURN: You carried out your assignment perfectly. I just wanted to say, I hope all of you know that this was primarily a session to educate the Committee members and others, and any other interested people were invited. The questions are expected to come from the Committee first and then if there's time, if our speaker doesn't have to jump on the train and get back to Washington-- I hate to exclude the audience, but this really was educational for the members here. Assemblywoman Wright.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Ms. Wilson. It was very enlightening. I wanted to raise a question about the Canadian system, and maybe to the others, as it relates-- What we've been advised is that the technology is not as open and advanced in, say, the Japanese, the German, or the Canadian, particularly the Canadian, I understand. I noticed I didn't see anything, in my brief look at your notes. Do you want to address that?

I think technology in this country has become both a salvation and a curse, in one sense. We want the highest technology because that may drive some of the costs down, and we hear that the other programs may not be addressing technology but using ours.

MS. WILSON: In Canada, one of the big differences is, the block grant that goes from the Federal government to the provinces is for services and not for capital, which is where technology development and machinery -- purchase of technology -- is dealt with. The purchase and development of technology is provincial. It's done by, I guess what would be in our

country, a health planning agency at the province level, and they decide where the technology is located, how much is spent, and they pay for it. They have to raise the funds. Consequently, you don't have so much, because it's totally raised by the State. The State has to come up with the money.

ASSEMBLYWOMAN WRIGHT: Public funding versus private funding.

MS. WILSON: That's right. So, it's very political as well. It's dealt with under capital expenditures.

ASSEMBLYWOMAN WRIGHT: How about Japan and West Germany?

MS. WILSON: In Japan they also have local health planning. In West Germany, I'm not sure how that's done. Actually, in West Germany they do a significant amount of technology development, particularly in pharmaceuticals. I'm not sure how that's funded. You're absolutely right, Canada has much less technology than we do. I think that often people will say that that is one of the major weaknesses in their system; that they did not build in a way of supporting capital that's sufficient. Although, I have had Canadians say that their feeling is that they have a sufficient amount and when they need more they can send people to the United States--

ASSEMBLYWOMAN WRIGHT: That's my point.

MS. WILSON: --and it's cost-effective to do so. (laughter)

ASSEMBLYWOMAN WRIGHT: It sure is.

UNIDENTIFIED SPEAKER FROM THE COMMITTEE: Seventeen points.

MS. WILSON: They said, we've got more than we need.

ASSEMBLYMAN COLBURN: I'm going to show the Chairman's personal reform and ask Assemblywoman Bush, if she would like to ask a question.

ASSEMBLYWOMAN BUSH: Thank you, Mr. Chairman. I'd like to thank you also, for bringing Ms. Wilson in -- for you

to be here, because it's really an education. I've been taking notes galore here.

ASSEMBLYMAN COLBURN: I see. I expect lots of trouble over this.

ASSEMBLYWOMAN BUSH: No, no, no, I think it's good.

ASSEMBLYMAN COLBURN: No, I'm kidding.

ASSEMBLYWOMAN BUSH: I'm really hoping to come from information, which I think this has truly provided. So many plans have been brought forth. I know even in the last legislative term, plans about the Canadian plan, etc., etc.-- I would have one question, and it may be in here already -- which I couldn't take notes, read it at the same time, and listen to you. It's my understanding that with, possibly, the Canadian plan, there may be some social decisions that have been made, such as withholding treatment depending upon age and things like that. Is that true? If it is, does it also apply to these other two?

MS. WILSON: That is more connected to the British system, where they clearly ration. I think the example that's most often used is dialysis, where they typically do not provide hemodialysis to people over age 55, which would not be tolerated here, because you can certainly live many years after age 55 if you receive dialysis. If you don't receive dialysis, you die. That is more connected with the United Kingdom.

I think in Canada, there are certainly cues for elective procedures, but they argue that when people really need surgery, they get it. I've heard differing views on that. Their key health indicators don't seem to indicate that they have excess mortality, so I can't really say for certain.

ASSEMBLYMAN COLBURN: Could I just interject there? Does it make any difference that they probably have -- and do they have -- a more homogeneous population than we do? Does that make a difference, do you think?

MS. WILSON: Well, now, I've heard that argued, and I heard last week a Canadian physician said, "That is not true that they are a homogeneous group." They said that they have indigenous populations that--

ASSEMBLYMAN COLBURN: Lots of different kinds of people. Okay.

MS. WILSON: And he argued that that was bunk.

ASSEMBLYMAN COLBURN: I'll withdraw that bunk. (laughter) I can't use bunk around here. I can see that. (laughter)

ASSEMBLYWOMAN BUSH: The Japanese plan, do they have any, sort of, decision like that?

MS. WILSON: I am not aware of the Japanese plan-- They cover medically necessary physician and hospital services. Apparently, in Japan they are much more dependent on prescription drugs -- which I understand is a cultural thing -- where they believe in using drug therapy to a higher extent than in other countries, but I'm not aware that they ration, and I've not heard that associated with the West German plan either.

ASSEMBLYWOMAN BUSH: Thank you.

ASSEMBLYMAN COLBURN: Mr. Mikulak.

ASSEMBLYMAN MIKULAK: I don't know, I think you kind of answered it. I was going to ask you about rationing in the Canadian plan. Do you know anything about fiscal problems that the provinces are having right now?

MS. WILSON: Major ones.

ASSEMBLYMAN MIKULAK: Major ones.

MS. WILSON: They're in deficit.

ASSEMBLYMAN MIKULAK: Could you give us a little--

MS. WILSON: One of the things that happened-- The Canadian plan started out as a 50/50 matching grant with the Federal government, just like we've had here. As the Federal government deficit went up, they decided to change from a matching grant to block grant, and you know what that means.

ASSEMBLYMAN MIKULAK: Less.

MS. WILSON: Right. So, I think, now, the Federal contribution is about 28 percent. It started at 50 percent. The Federal contribution is now 28 percent. The provincial is 42 percent, and the private sector kicks in 24 percent.

ASSEMBLYMAN COLBURN: By what method?

MS. WILSON: The private sector?

ASSEMBLYMAN COLBURN: Yes.

MS. WILSON: Through fees, and surcharges, and things of that nature.

ASSEMBLYMAN COLBURN: Okay. Members--

MS. WILSON: I was just going to say that Canada is having something of a recession, like we are, and their provinces are having a hard time raising funds. So, they've got budget deficits similar to ours.

ASSEMBLYMAN COLBURN: Ms. Wright.

ASSEMBLYWOMAN WRIGHT: Through the Chairman, the other thing I think that's very significant about the difference with Canada is that Canada's industry is very publicly based. There is a minimum amount of private enterprise. I was in Canada the summer before last and there's just every thrust-- The queen was in that year -- on TV -- saying, what we need to do is maximize our private enterprise. So, it's interesting that-- I'm sure that that will have an impact on their health care delivery system as well.

ASSEMBLYMAN FELICE: Dr. Colburn?

ASSEMBLYMAN COLBURN: Yes, sir.

ASSEMBLYMAN FELICE: I apologize for running in and out, although I promise to look at the rest of the notes that are here, because I they're interesting things that you're saying.

Recently, they had a survey that showed all of the countries that had some form of a national health program: United Kingdom, France, Germany, Japan, and the United States.

It was interesting -- this was only this last month -- that in the last 18 years, all of the countries had a greater percentage of increase in health cost starting with the United Kingdom who had 12.7, France was 11.2, Germany was 9.8, Canada was 8.75, and the United States had only an increase of 8.1 in health care costs in the last 18 years. So, it's interesting where you say, "What we need is a national health reform plan." It's not as cheap as people think it is.

It's a lot to be looked into. We talked about some -- Canada, with their rationing; about 17 percent of the people coming to the United States. They get specialized health care under Canada. So, it's not cracked up to what it's meant to be, and like you say, you would have one heck of a fight to have some of these paid people paying 16 percent, 20 percent, and 30 percent of their salaries or more, to be part of mandatory national health care program.

So, you have to look at all of ins and outs, what you're getting for your buck, and, I, quite honestly -- even though I was one of the sponsors for the bill to have the Governor look into the program -- think it would have to be completely different than anything that we've seen in any other country in the world for it to work here. It's something to look into the future, but I have some very strong reservations that's it's more on Federal government helping the states to initiate programs for small business involvement and other programs, to help those people make more people eligible under different programs whether it's Medicaid eligibility or others. I think those are the answers that we've been looking at the last few years.

What you said today verifies a lot of things that we have to look towards ourselves, with some assistance from the Federal government. The rest of it has got to come on the State level, because geographically and everything else, every state is different, as every country is.

ASSEMBLYMAN COLBURN: I have a whole bunch of questions. Didn't Massachusetts go to a pay or play? Was that what they did?

MS. WILSON: Yes, they did. They delayed the implementation--

ASSEMBLYMAN COLBURN: Oh, have they?

MS. WILSON: --of the employer mandate until 1995, at which point the Restaurant Association will sue the state under ERISA and stop the program.

ASSEMBLYMAN COLBURN: Okay. So, that's not in effect. I thought it was in effect.

MS. WILSON: Well, they are implementing pieces of it that are not associated with ERISA.

ASSEMBLYMAN COLBURN: Okay.

MS. WILSON: And Oregon has a play or pay with, also, a delayed implementation. They will be sued as well.

ASSEMBLYMAN COLBURN: Did they require Federal waivers for their plan, Oregon?

MS. WILSON: That was on a separate portion of their plan. They have an employer mandate that nobody really knows very much about, because it's been overshadowed by the Medicaid rationing plan.

ASSEMBLYMAN COLBURN: Okay.

MS. WILSON: The Medicaid plan is pending a Federal waiver. We should hear something in the next month or two, on whether the Federal government will approve Oregon's waiver, but on the play or pay option, it's based on number of employees of small businesses. I believe the trigger date is 1994. If the number hasn't reached 150,000 additional small employees covered, then an employer mandate would go into effect, and then they will be sued.

ASSEMBLYMAN COLBURN: Thanks. I wanted to ask you about the present financing of the United States Medicare plan. What do the participants pay for hospital insurance? How do they pay for that, or do they?

MS. WILSON: Under Medicare, it's a payroll tax.

ASSEMBLYMAN COLBURN: Okay. So, the Medicare participant doesn't pay for their hospital insurance, or do they?

MS. WILSON: They pay a deductible. There is a deductible.

ASSEMBLYMAN COLBURN: On their hospital insurance? I know they pay some money up front when they go in the hospital.

MS. WILSON: Right.

ASSEMBLYMAN COLBURN: Is that what you're speaking about?

MS. WILSON: Right. But they don't pay-- Yes, and there is a premium.

ASSEMBLYMAN COLBURN: Is there? I wasn't sure what part of it they were currently paying.

MS. WILSON: Right. Yes, it's automatically deducted from their Social Security checks.

ASSEMBLYMAN COLBURN: Oh, okay.

MS. WILSON: And it's set in statute. The amount of the premium is set in statute.

ASSEMBLYMAN COLBURN: Okay. And the physician part is -- they pay a premium for that, then pay deductibles and copays?

MS. WILSON: Right.

ASSEMBLYMAN COLBURN: Do they pay the entire cost of the physician program, do you think? I was told they pay 25 percent, by a consultant that I was attending a course to learn how to participate in this darn, new Medicare program, and I don't know.

MS. WILSON: Well, the premium is set at 25 percent of the cost of the program, which they keep trying to raise. The copay is 20 percent.

ASSEMBLYMAN COLBURN: Twenty percent. Right. The deductible is $100.

MS. WILSON: Right. That goes up by a schedule that's statutory as well, and I can't remember now what the--

ASSEMBLYMAN COLBURN: I don't think they pay the whole premium--

MS. WILSON: No, they don't.

ASSEMBLYMAN COLBURN: --the whole cost of the system.

MS. WILSON: No, they don't.

ASSEMBLYMAN COLBURN: That's what I was trying to get at.

MS. WILSON: No.

ASSEMBLYMAN COLBURN: Okay. Then, finally-- Not finally, two more questions. How much do the foreign programs rely on managed care?

MS. WILSON: They don't.

ASSEMBLYMAN COLBURN: They do not?

MS. WILSON: No.

ASSEMBLYMAN COLBURN: How about that. I didn't know that.

MS. WILSON: It's all fee for service.

ASSEMBLYMAN COLBURN: Well, can the patient go to the physician -- the specialist -- without a referral?

MS. WILSON: In West Germany you cannot go to a hospital without referral. You can go to any physician that is licensed under their sickness fund. In Japan, I think you can go to anybody.

ASSEMBLYMAN COLBURN: Okay.

MS. WILSON: There's no referral requirement. In Canada, you have a primary physician, and I think there are referrals after that. I'm not sure that it's mandatory, but there is no managed care. In fact, Canada is very interested in the managed care model, and they're sending people here to look at that. But in Canada, West Germany, and Japan, right now, it's fee for service with a fee schedule.

ASSEMBLYMAN COLBURN: My medical school newspaper -- the chief of medicine wrote a letter to the editor and said, "If we get national health insurance, I hope the" -- how did he put this? -- "private sector won't cost shift to the government," and I wrote him a letter back and I said, "Gee, right now the problem seems to be the reverse." The government is cost shifting under Medicare to the payers down here. What would you like to say about cost shifting, anything at all?

MS. WILSON: Well, under our current system, it's the name of the game. It's the only way to survive. I think that in terms of managed care there is a limit. If you take managed care to its ultimate, managed care really is a cost shift as well, because basically what you have are people getting together negotiating lower fees from a provider who then raises those cost to payers who are outside of the managed care system.

Presumably, if everyone were to become part of a managed care system, then everybody's rates would go up. We'd be back where we are now. So, I guess I, personally, am not totally sold on managed care because I think if you take it to the ultimate, it levels off. The benefit levels out.

ASSEMBLYMAN COLBURN: You lose the benefit.

MS. WILSON: That's right. The benefit for managed care is if you get in quick, you get in big, and you negotiate, and you're a great negotiator, then you get good prices, but somebody else is paying for it. So, I think what we're seeing is managed care saving certain groups a lot of money right now, but I'm not sure how long that can be maintained.

ASSEMBLYMAN COLBURN: Are there varying definitions of managed care in the minds of many of us? Do you think-- Frankly, I wasn't aware, even, of what you said about that part of the definition. I thought of it as, I guess, your primary doctor controlling your referrals,--

MS. WILSON: Oh, your access to specialists.

ASSEMBLYMAN COLBURN: --your tests, your hospitalization, and all of that kind of business. I can see that it appears to be more to it, just on the financial side.

MS. WILSON: I guess I'm use to hearing from the business people.

ASSEMBLYMAN COLBURN: Yes, but I think there are different definitions.

MS. WILSON: Well, that's right. The business people look at managed care as a way of containing cost. I think there are others that look at it as a way of managed health care.

ASSEMBLYMAN COLBURN: Okay.

MS. WILSON: Sometimes, never the twain shall meet, which is unfortunate. I think that there are a lot of people that would like to see more done in terms of managing health care, in terms of not having people just go out, because we're not good purchasers of health care, because most of us don't know what we're doing. We just go out there. If we don't feel good, we go about trying to fix ourselves as best we can.

I think that from that perspective, that part of managed care is very different than what most business people are talking about, which is restraining access, and negotiating fees to reduce costs; costs being the focal point.

ASSEMBLYMAN COLBURN: For the survivors in the audience, our speaker graciously has said she would answer a question or two if you have any. (no response) Gee whiz.

MS. WILSON: We wore them out.

ASSEMBLYMAN COLBURN: Thank a lot. Yes, Mr. Romano?

ASSEMBLYMAN ROMANO: With everything that you know, what should be the State plan for New Jersey?

MS. WILSON: Oh, God. I'm taking the 5th. (laughter)

ASSEMBLYMAN ROMANO: I figured we get a free one.

ASSEMBLYMAN COLBURN: We already did get a free one. Thanks. Thanks very much. We certainly appreciate what you've told us.

MS. WILSON: Thank you. (applause)

(HEARING CONCLUDED)

APPENDIX

NATIONAL CONFERENCE OF STATE LEGISLATURES

444 NORTH CAPITOL STREET, N.W. SUITE 500 WASHINGTON, D.C. 20001
202-624-5400 FAX: 202-737-1069

BRIEFING MATERIALS

COMPARISON OF CANADIAN, WEST GERMAN AND JAPANESE HEALTH CARE SYSTEMS

Prepared by: Joy Johnson Wilson, Senior Committee Director, National Conference of State Legislatures, Washington Office

Presented to: The Assembly Health and Human Services Committee, New Jersey State Legislature

March 30, 1992

Denver Office 1560 BROADWAY SUITE 700 DENVER COLORADO 80202 303-830-2200 FAX 303-863-8003

CANADA

CHRONOLOGY OF EVENTS

1957 **Hospital Insurance Diagnostic Services Act**

The federal government established a 50 percent matching grants program to the provinces for hospital services.

1966 **Medical Care Act**

The federal government established a matching grant program, similar to the Hospital Insurance Diagnostic Services Act, for physician services.

1971 All provinces had established qualifying plans

1977 **The Extended Health Care Services Act**

The federal government established a block grant program for long term care services (nursing home, home care, and ambulatory care). The federal government provides 50 percent matching funds for services to low income citizens.

The federal government replaced the matching grant program for hospital and physician service with a block grant to the provinces, limiting annual increases to a percentage of the growth in GNP.

1984 **Canada Health Act**

The federal government established policy of reducing aid to provinces that permit physicians to "balance bill," or charge patients the difference between the negotiated fee for the service and the physicians charge. All provinces adopted a policy prohibiting balanced billing.

CANADA

Structure

Provinces run the program under federally established guidelines. Each province must guarantee: (a) universal coverage; (b) reasonable access, without cost-sharing; (c) comprehensive coverage; and (d) portability.

Financing

The federal government provides block grants to the provinces for health services. The provinces raise funds through taxes, premiums and fees. Currently, the provinces pay approximately 42 percent of the costs, the federal government 28 percent and private sources 24 percent. Health care costs account for approximately one-third of provincial budget expenditures.

Administration

Each provincial program must be administered by a public, non-profit agency that is accountable to the provincial government.

Benefits

In general, all medically necessary physician and hospital services. Other services vary by province.

Provider Reimbursement/Cost Containment/Patient Out-of-Pocket

Hospitals - Hospitals receive global budgets for operating expenses. Provincial health planning agencies provide separate grants for capital costs.

Physicians - Physicians are paid on a fee-for-service basis. Fees are based on a fee schedule negotiated between the province and the provincial medical society. Physicians are not permitted to balance bill. Physicians that work in hospitals are salaried.

Patients - Patients can obtain "wrap around" private insurance coverage to cover services not covered in the national benefit package. Patients are not required to pay premiums, co-pays or deductibles for services provided under the provincial plan.

Employers - Employers can sponsor supplemental insurance to cover services not provided in the provincial plan. Approximately 95 percent of the private employers provide such insurance. Many of them provide the coverage at not cost to their employees. Typical services covered under these supplemental plans are: prescription drugs, dental services and coverage for a semi-private hospital room.

WEST GERMANY

Structure

Every individual is eligible for and approximately 75 percent of the population is required to participate in the Statutory Health Insurance (SHI) program. Wage earners with incomes between $2,740 and $26,000, their spouses and dependents, students, some disabled individuals, and retirees that were covered through SHI during their working years, are required to participate in a "sickness fund," organized by locality, occupation, or firm, and joined into national or state federations. There are approximately 1,200 sickness funds.

Soldiers, prisoners and the poor are provided care through other federally subsidized programs. Approximately 8.7 percent of the West German population receive coverage through private insurance. Private carriers provide coverage primarily to high income individuals who opt out of the Statutory Health Insurance program (SHI). Over four million individuals purchase supplemental insurance for benefits not covered under the national plan.

Financing

Employers and employees share the cost through payroll and wage taxes. The employee share equals approximately 12 percent of wages, however; the range is 8-16 percent and varies substantially by fund. The federal government subsidizes the premiums of the unemployed and the disabled.

Administration

The sickness funds administer the program.

Benefits

Inpatient and out-patient physician and hospital services, diagnostic and therapeutic services, maternity services, lab tests, medical appliances, dental services. The benefits are established by federal law.

Provider Reimbursement/Cost Containment/Patient Out-of-Pocket

Hospitals - Reimbursed by sickness funds at negotiated per diem rates. Hospitals have non-binding global budgets. Capital costs are paid by a combination of federal, state and local funds, subject to statewide planning.

Physicians - Physicians are required to join an association of sickness fund physicians. These associations set care standards, establish staffing priorities, and represent its members in negotiations with sickness funds. Since 1986, the federal government has set binding expenditure caps on physicians. Physicians negotiate with sickness funds for annual lump-sum payments which are apportioned to physicians on a fee-for-services basis. When expenditures exceed the government established cap, fees are reduced. Physicians are not permitted to balance bill. Hospital physicians are salaried.

Patients - The government has established nominal copayment requirements for prescription drugs and the first 14 days of inpatient hospital care. The government recently established a 40 percent copayment requirement on dental services. Individuals can purchase private supplemental insurance for benefits not covered in national benefit plan. Wealthy individuals can purchase private health insurance in lieu of participating in a sickness fund. Once an individual has opted out of the national program, he cannot reenter.

Employers - Employers are required to pay full earnings to individuals for the first 6 weeks of illness or disability. After that period, the government will pay 80 percent of wages for up to 78 weeks of missed work in a three year period. Employers are also required to provide 14 weeks of paid maternity leave at full salary.

Variance in the Payroll-Tax Rate Across West German Sickness Funds, 1988

Type of Fund	Payroll-Tax Rates*	
	Range	Average
Local Sickness Funds	10.8 - 16.0%	13.5%
Company-based Funds	7.5 - 15.0%	11.5%
Craft-based Funds	9.8 - 15.8%	12.8%
Substitute Funds		
• blue collar	10.2 - 14.8%	11.9%
• white collar	18.8 - 12.9%	12.7%
ALL STATUTORY FUNDS	7.5 - 16.0%	12.9%

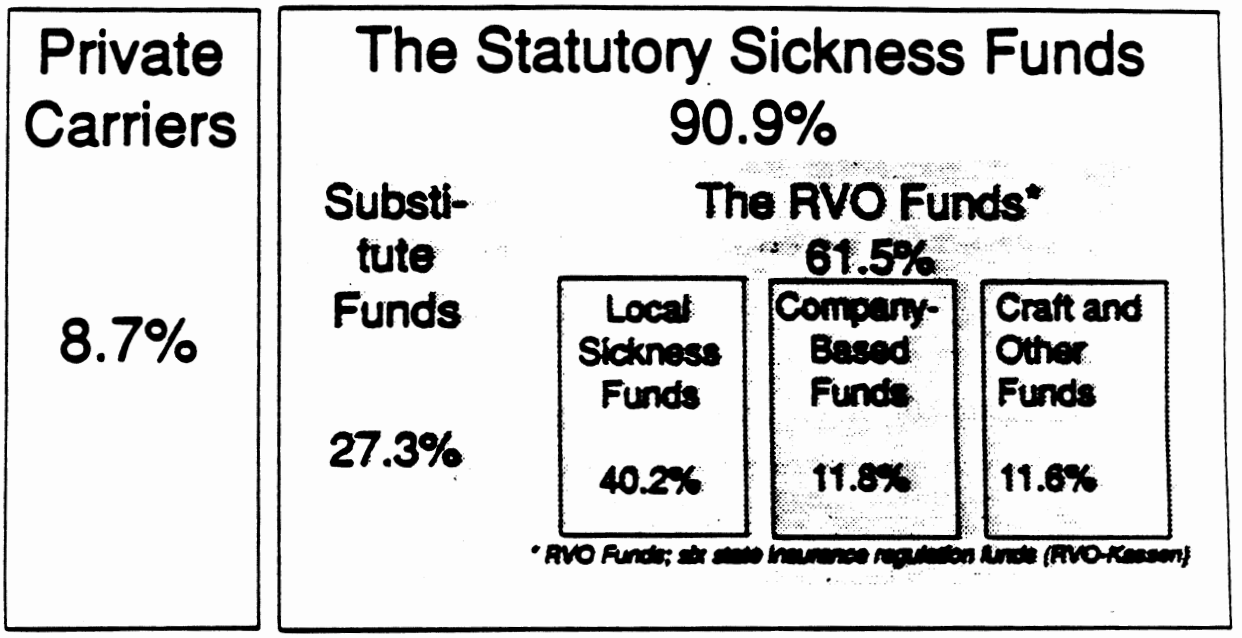
* *Employer's and employee's contribution to sickness fund, as a percentage of gross compensation (including fringes).*

Sources: Guntram Bauer and Franz Schoenhofen, "Risikostrukturen und Beitragssatzunterschiede in der GKV," *DieOrtskrankenkasse*, vol. 22, November 15, 1988, Table 1, p. 650.

West Germany's Health-Care and Health-Insurance System: Combining Access with Cost Control, by Dr. Uwe E. Reinhardt.

The Structure of the West German Health-Insurance System

(The Number of the Percentages of the Population in Each Type of Fund, 1986)



Sources: *Verband der Privaten Krankenversicherungen e.V.* Die Private Krankenversicherungen, Zahlenbericht 1987/99, p.13.

West Germany's Health-Care and Health-Insurance System: Combining Access with Cost Control, by Dr. Uwe E. Reinhardt.

6X

JAPAN

Structure

In 1961, the Japanese government enacted the National Health Insurance Law, requiring employers to provide health insurance coverage to their employees. Government and private employees are covered under this law. The unemployed, retirees, small employers, the self-employed and farmers are covered under the National Health Insurance program, a public, government subsidized, program.

Financing

The employer-based program is funded by payroll and wage taxes. The payroll tax averages 3.5 percent and the wage tax averages 4.5 percent. The National Health Insurance program is financed through premiums based on income up to an annual ceiling $2, 740 per household plus national and local government subsidies.

Administration

The private program is administered by either the government (for government employees) or health insurance societies that represent large employers or specialized groups of workers. The National Health Insurance Plan is administered by local governments.

Benefits

Physician, dental and hospital services, prescription drugs. The plan does not cover maternity care or preventive health services.

Provider Reimbursement/Cost Containment/Patient Out-of-Pocket

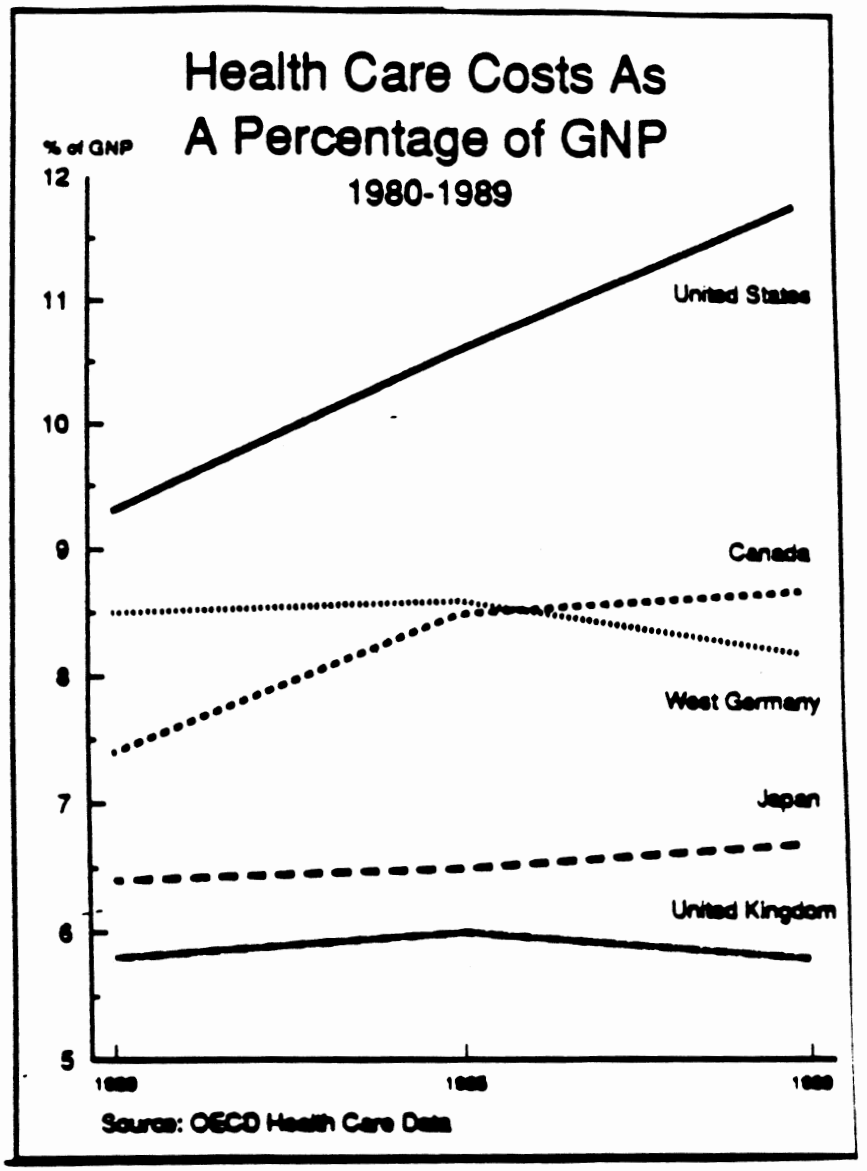
Hospitals - Hospitals are paid on a fee-for-service basis based on federally established fee schedule. Some government grants available for capital expenditures.

Physicians - Physicians are paid on a fee-for-service basis, based on federally established fee schedule.

Patients - Individuals in the employer-based program are required to pay 10 percent coinsurance and their dependents pay 20 percent coinsurance for inpatient care and 30 percent for outpatient care. Individuals in the National Health Insurance Program are required to pay 30 percent coinsurance. Under both programs, individuals are limited to $400 per month in out-of-pocket expenditures.

COMPARISON OF HEALTH CARE EXPENDITURES

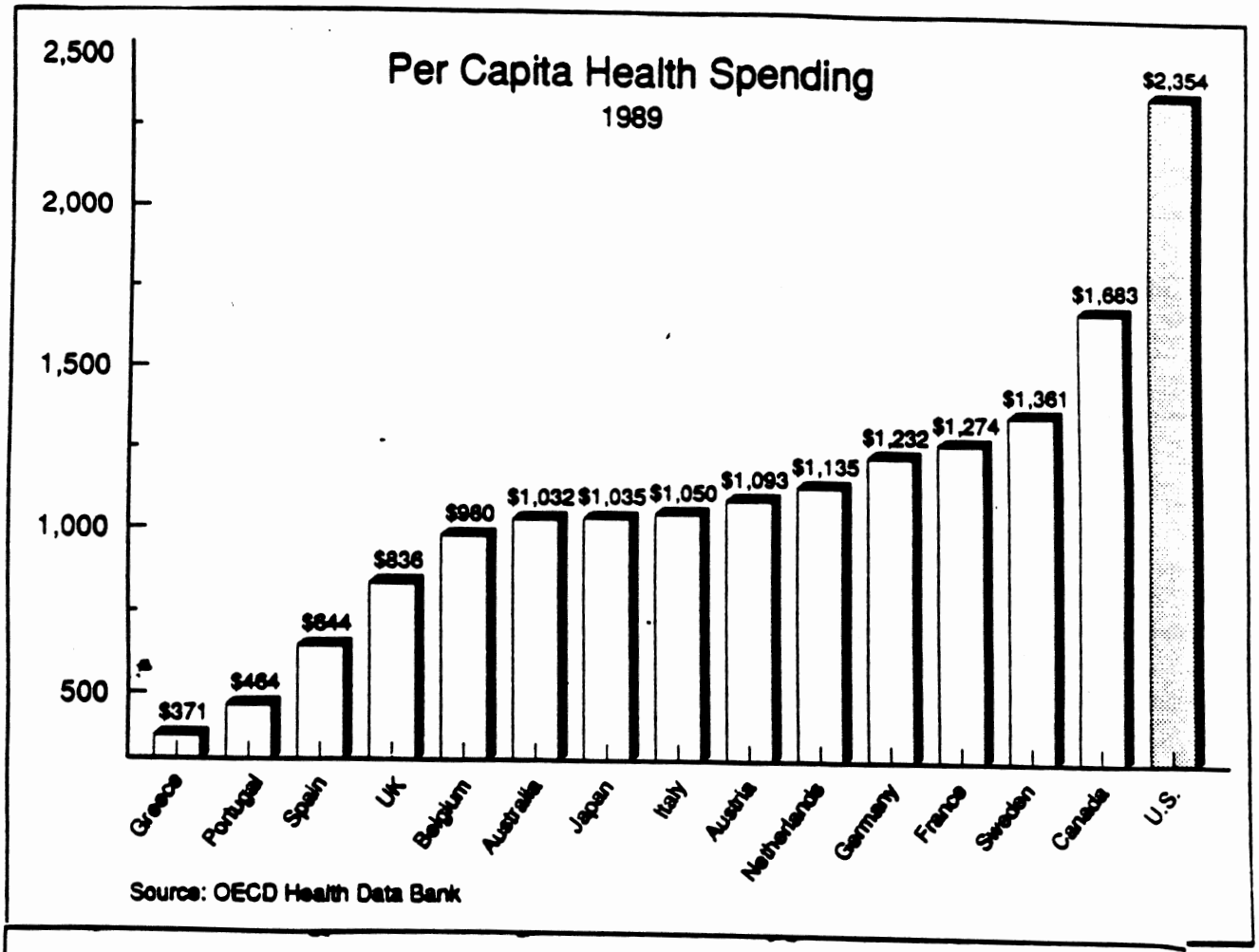
8 X

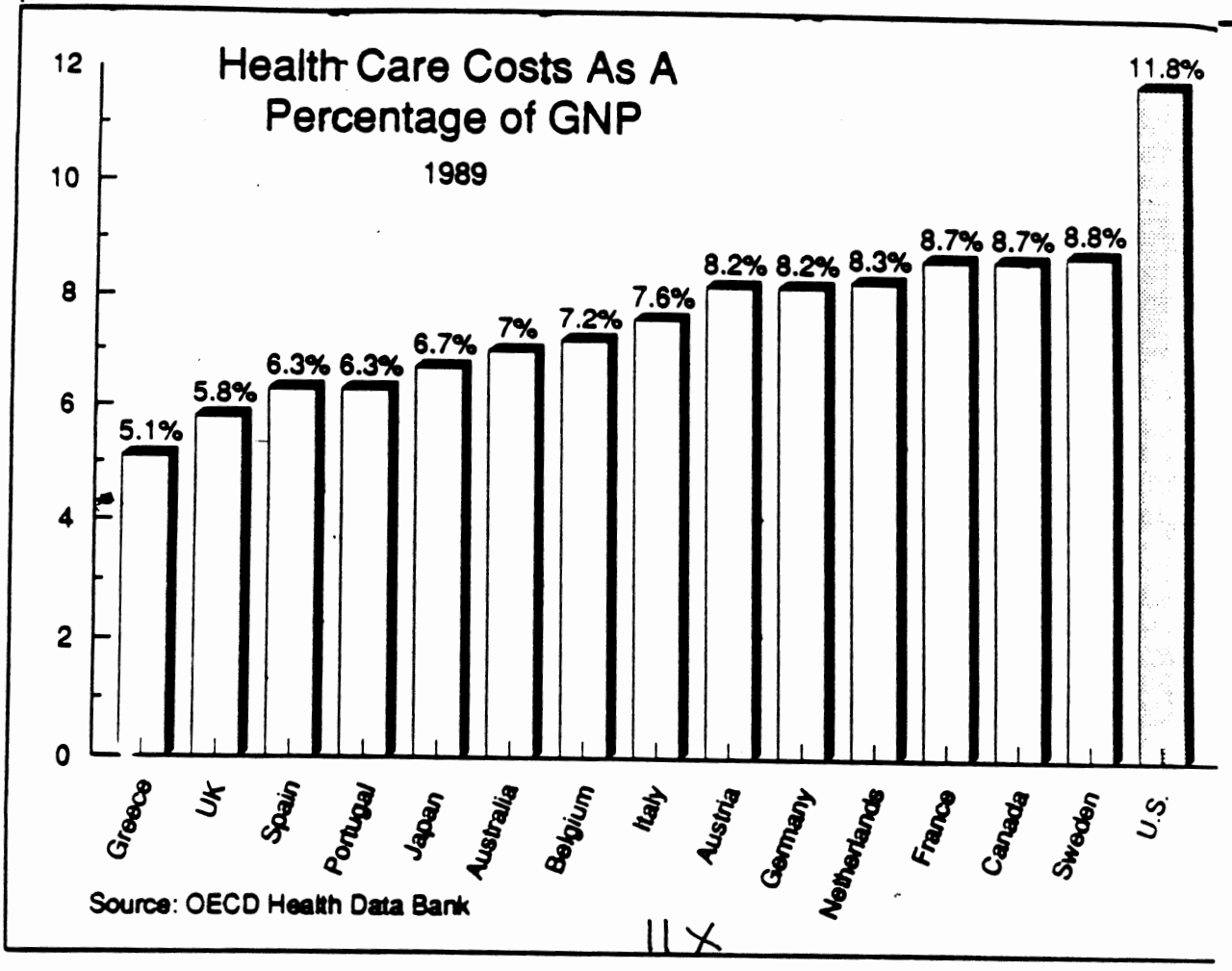

Health Care Costs As
A Percentage of GNP
1980-1989
% of GNP
12
11
10
9
8
7
6
5
United States
Canada
West Germany
Japan
United Kingdom
Source: OECD Health Care Data

Health Care Costs As A Percentage of GNP

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Australia	4.6	4.9	4.9	5.5	6.5	7.0	7.1	7.1	6.9	7.0
Austria	4.6	5.0	5.4	7.3	7.9	7.6	8.3	8.4	8.3	8.2
Belgium	3.4	3.9	4.1	5.9	6.3	6.9	7.2	7.3	7.3	7.2
Canada	5.5	6.1	7.1	7.2	7.4	8.5	8.8	8.8	8.6	8.7
Denmark	3.6	4.8	6.1	6.5	6.8	6.3	6.0	6.3	6.4	6.3
Finland	3.9	4.9	5.7	6.3	6.5	7.2	7.4	7.4	7.2	7.1
France	4.2	5.2	5.8	7.0	7.6	8.5	8.5	8.5	8.6	8.7
West Germany	4.7	5.1	5.9	8.2	8.5	8.6	8.5	8.6	8.9	8.2
Greece	3.2	3.6	4.0	4.1	4.3	4.9	5.4	5.2	5.1	5.1
Iceland	3.5	4.2	5.2	6.2	6.5	7.4	7.8	7.9	8.5	8.6
Ireland	4.0	4.4	5.6	7.6	9.0	8.3	8.3	8.0	7.9	7.3
Italy	3.3	4.0	5.2	6.1	6.8	7.0	6.9	7.3	7.6	7.6
Japan	2.9	4.3	4.4	5.5	6.4	6.5	6.7	6.8	6.7	6.7
Luxembourg	-	-	4.1	5.6	6.8	6.8	6.7	7.2	7.3	7.4
Netherlands	3.9	4.4	6.0	7.7	8.2	8.2	8.1	8.5	8.4	8.3
New Zealand	4.4	4.5	5.2	6.7	7.2	6.6	6.9	7.3	7.4	7.1
Norway	3.3	3.9	5.0	6.7	6.6	6.4	7.1	7.5	7.4	7.6
Portugal	-	-	-	6.4	5.9	7.0	6.6	6.4	6.5	6.3
Spain	2.3	2.7	3.7	4.8	5.6	5.7	5.6	5.7	6.0	6.3
Sweden	4.7	5.6	7.2	7.9	9.5	9.3	9.0	9.0	9.0	8.8
Switzerland	3.3	3.8	5.2	7.0	7.3	7.6	7.6	7.9	8.0	7.8
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.0	6.0	5.9	5.9	5.8
United States	5.2	6.0	7.4	8.4	9.3	10.6	10.8	11.1	11.3	11.8
Average	3.9	4.5	5.4	6.5	7.1	7.3	7.4	7.6	7.6	7.6

Source: George Schieber and Jean-Pierre Poullier, "International Health Spending: Issues and Trends," Health Affairs (Spring 1991)


Per Capita Health Spending
1989
2,500
2,000
1,500
1,000
500
$371
$464
$644
$836
$960
$1,032
$1,035
$1,050
$1,093
$1,135
$1,232
$1,274
$1,361
$1,683
$2,354
Greece
Portugal
Spain
UK
Belgium
Australia
Japan
Italy
Austria
Netherlands
Germany
France
Sweden
Canada
U.S.
Source: OECD Health Data Bank


Health Care Costs As A
Percentage of GNP
1989
12
10
8
6
4
2
0
5.1%
5.8%
6.3%
6.3%
6.7%
7%
7.2%
7.6%
8.2%
8.2%
8.3%
8.7%
8.7%
8.8%
11.8%
Greece
UK
Spain
Portugal
Japan
Australia
Belgium
Italy
Austria
Germany
Netherlands
France
Canada
Sweden
U.S.
Source: OECD Health Data Bank

11 X

Health Care Inflation
Compared To General Inflation

Year	Consumer Price Indexes*		Year-To-Year Percent Changes	
	All Items	Medical Care	All Items	Medical Care
1951	26.0	15.9	7.9%	5.3%
1952	26.5	16.7	1.9%	5.0%
1953	26.7	17.3	0.8%	3.6%
1954	26.9	17.8	0.7%	2.9%
1955	26.8	18.2	-0.4%	2.2%
1956	27.2	18.9	1.5%	3.8%
1957	28.1	19.7	3.3%	4.2%
1958	28.9	20.6	2.8%	4.6%
1959	29.1	21.5	0.7%	4.4%
1960	29.6	22.3	1.7%	3.7%
1961	29.9	22.9	1.0%	2.7%
1962	30.2	23.5	1.0%	2.6%
1963	30.6	24.1	1.3%	2.6%
1964	31.0	24.6	1.3%	2.1%
1965	31.5	25.2	1.6%	2.4%
1966	32.4	26.3	2.9%	4.4%
1967	33.4	28.2	3.1%	7.2%
1968	34.8	29.9	4.2%	6.0%
1969	36.7	31.9	5.5%	6.7%
1970	38.8	34.0	5.7%	6.6%
1971	40.5	36.1	4.4%	6.2%
1972	41.8	37.3	3.2%	3.3%
1973	44.4	38.8	6.2%	4.0%
1974	49.3	42.4	11.0%	9.3%
1975	53.8	47.5	9.1%	12.0%
1976	56.9	52.0	5.8%	9.5%
1977	60.6	57.0	6.5%	9.6%
1978	65.2	61.8	7.6%	8.4%
1979	72.6	67.5	11.3%	9.2%
1980	82.4	74.9	13.5%	11.0%
Average, 1951 - 1980			***4.2%***	***5.5%***
1981	90.9	82.9	10.3%	10.7%
1982	96.5	92.5	6.2%	11.6%
1983	99.6	100.6	3.2%	8.8%
1984	103.9	106.8	4.3%	6.2%
1985	107.6	113.5	3.6%	6.3%
1986	109.6	122.0	1.9%	7.5%
1987	113.6	130.1	3.6%	6.6%
1988	118.3	138.6	4.1%	6.5%
1989	124.0	149.3	4.8%	7.7%
1990	130.7	162.8	5.4%	9.0%
Average, 1981 - 1990			***4.7%***	***8.1%***

Source: Bureau of Labor Statistics

Relationship Between Health Care Costs And Average Wages

(Dollar Amounts In Constant 1990 Dollars)

Year	Annual Earnings (per worker)*	Household Health Care Costs (per worker)**	Health Costs As Percent Of Earnings	Weeks of Work Needed To Pay Health Costs
1965	$20,414	$1,348	6.6%	3.3
1970	21,761	1,439	6.6%	3.3
1975	22,010	1,511	6.9%	3.4
1980	21,128	1,390	6.6%	3.3
1985	20,820	1,714	8.2%	4.1
1989	20,364	1,937	9.5%	4.8
	[Projections, Based on Trends During 1980–89]			
1990	20,060	2,042	10.2%	5.1
1995	19,544	2,572	13.2%	6.6
2000	19,060	3,266	17.1%	8.6
2005	18,579	4,189	22.5%	11.3
2010	18,110	5,387	29.7%	14.9
2015	17,653	7,013	39.7%	19.9
2020	17,207	9,128	53.0%	26.5
2025	16,773	11,882	70.8%	35.4
2030	16,350	15,466	94.6%	47.3
2035	15,937	20,132	126.3%	63.2

* Annual earnings for someone working year-round, full-time, at the average hourly wage for production and nonsupervisory workers.

** Annual health care costs paid by households, divided by the number of workers for each year.

COMPARISION OF KEY HEALTH INDICATORS

Infant Mortality
(Infant Deaths Per 1,000 Live Births)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	20.1	18.5	17.9	14.3	10.7	10.0	10.3	9.6	9.2	9.9	8.8	8.7
Austria	37.5	28.3	25.9	20.5	14.3	12.7	12.8	11.9	11.4	11.2	10.3	9.8
Belgium	31.2	23.7	21.1	16.1	12.1	11.5	11.1	10.5	10.0	9.4	9.7	9.7
Canada	27.3	23.6	18.8	14.3	10.4	9.6	9.1	8.5	8.1	8.0	7.9	7.3
Denmark	21.5	18.7	14.2	10.4	8.4	7.9	8.2	7.7	7.7	7.8	8.2	8.3
Finland	21.0	17.6	13.2	10.0	7.6	6.6	6.1	6.1	6.3	6.3	5.9	6.2
France	27.4	21.9	18.2	13.6	10.1	9.6	9.3	8.9	8.3	8.1	8.0	7.6
West Germany	33.8	23.8	23.4	19.7	12.7	11.6	10.9	10.2	9.6	8.9	8.7	8.3
Greece	40.1	34.3	29.6	24.0	17.9	16.3	15.1	14.6	14.3	14.1	12.2	11.7
Iceland	13.0	15.0	13.2	12.5	7.7	6.0	7.1	6.2	6.1	5.7	5.4	7.2
Ireland	29.3	25.3	19.5	17.5	11.1	10.6	10.5	9.8	10.1	8.9	8.7	7.4
Italy	43.9	36.0	29.6	22.2	14.3	14.1	12.9	12.4	11.7	10.9	9.8	9.6
Japan	30.7	18.5	13.1	10.0	7.5	7.1	6.6	6.2	6.0	5.5	5.2	5.0
Luxembourg	31.5	24.0	24.9	14.8	11.5	13.8	12.1	11.2	11.7	9.0	8.0	9.3
Netherlands	17.9	14.4	12.7	10.6	8.6	8.3	8.3	8.4	7.0	6.9	6.4	7.6
New Zealand	22.6	-	16.8	-	12.9	11.7	11.7	12.5	11.6	10.8	11.2	9.8
Norway	18.9	-	12.7	11.1	8.1	7.5	8.1	7.9	8.3	8.5	7.8	8.4
Portugal	77.5	64.9	55.1	38.9	24.3	21.8	19.8	19.2	16.7	17.8	15.8	14.2
Spain	43.7	37.8	28.1	18.9	12.3	12.5	11.3	10.9	9.4	9.0	8.7	8.7
Sweden	16.6	13.3	11.0	8.6	6.9	6.9	6.8	7.0	6.4	6.8	5.9	6.1
Switzerland	21.1	17.8	14.4	10.7	9.1	7.6	7.7	7.6	7.1	6.9	6.8	6.8
United Kingdom	22.5	19.6	18.5	16.0	12.1	11.2	11.0	10.1	9.6	9.4	9.5	9.1
United States	26.0	24.7	20.0	16.1	12.6	11.9	11.2	10.9	10.7	10.6	10.4	10.1
Average	29.4	24.8	20.5	15.9	11.4	10.7	10.3	9.9	9.4	8.8	8.7	7.5

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1987 data for certain countries, World Health Organization, World Health Statistics Annual, 1989.

Female Life Expectancy

(At Birth; In Years)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	74.0	–	74.2	76.2	78.0	78.4	78.2	78.7	78.9	78.8	79.6	79.8
Austria	71.9	73.0	73.4	74.7	76.1	76.4	76.6	76.6	77.2	77.4	77.8	78.2
Belgium	72.7	–	74.2	75.1	76.8	76.8	76.8	–	–	–	78.2	–
Canada	–	–	–	–	–	78.9	–	–	79.8	–	79.9	80.2
Denmark	74.1	–	76.1	76.8	77.6	77.4	77.5	77.5	77.5	77.5	77.8	78.0
Finland	72.4	–	74.5	75.9	77.6	77.8	78.1	78.0	78.8	78.5	78.9	78.9
France	73.6	75.0	76.1	76.9	78.4	78.5	78.9	78.8	79.3	79.4	80.0	81.1
West Germany	71.9	–	73.6	75.2	76.5	76.9	77.2	77.5	77.8	–	78.5	78.9
Greece	70.4	–	73.6	–	76.6	–	–	–	–	–	78.9	–
Iceland	75.0	–	–	–	79.7	–	79.4	–	80.2	80.2	80.4	80.0
Ireland	71.8	–	73.2	–	75.0	75.6	75.6	–	–	–	76.4	77.3
Italy	71.8	–	74.6	75.9	77.4	77.8	78.2	78.1	78.1	–	79.2	–
Japan	70.3	73.0	74.7	77.0	78.7	79.1	79.7	79.8	80.2	80.5	81.6	82.1
Luxembourg	71.9	–	73.9	–	75.1	76.7	–	–	–	–	77.9	–
Netherlands	75.5	–	76.6	77.6	79.2	79.3	79.4	79.5	79.5	79.6	79.8	80.3
New Zealand	73.9	–	74.4	–	76.4	76.9	76.9	76.9	77.7	–	77.5	77.3
Norway	75.9	–	77.5	78.1	79.0	79.4	79.4	79.6	79.5	79.4	79.9	79.8
Portugal	67.2	69.3	71.0	–	–	76.6	–	76.2	–	76.7	77.1	77.5
Spain	72.2	–	75.1	76.2	78.6	75.8	79.3	79.1	79.7	80.0	–	–
Sweden	74.9	76.1	77.1	77.9	78.8	79.1	79.4	79.6	79.9	79.7	80.2	80.4
Switzerland	74.2	–	76.3	78.2	79.1	79.0	79.2	79.5	79.7	80.0	80.6	81.0
United Kingdom	74.2	–	75.2	–	75.9	76.2	–	77.2	77.4	77.4	77.5	78.3
United States	73.3	73.7	74.7	76.6	76.7	77.9	78.2	78.3	78.3	78.2	78.3	78.4
Average	72.9	73.4	74.8	76.6	77.5	77.6	78.2	78.3	78.9	78.9	78.9	79.3

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1986 and 1987 data, World Health Organization, World Health Statistics Annuals, 1988 and 1989.

Male Life Expectancy

(At Birth; In Years)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	67.9	-	67.4	69.2	70.9	71.4	71.2	72.1	72.4	72.3	73.0	73.2
Austria	65.4	66.6	66.5	67.7	69.0	69.3	69.4	69.4	70.1	70.4	71.0	71.6
Belgium	66.7	-	67.8	68.6	70.0	70.0	70.0	-	-	-	71.4	-
Canada	-	-	-	-	-	71.9	-	-	73.0	-	73.1	73.3
Denmark	72.3	-	71.0	71.1	71.4	71.4	71.5	71.5	71.6	71.6	71.9	71.9
Finland	65.4	-	66.2	67.4	69.2	69.5	70.1	70.2	70.4	70.1	70.6	70.7
France	67.0	67.8	68.6	69.0	70.2	70.4	70.7	70.7	71.2	71.3	71.8	72.6
West Germany	66.5	-	67.3	68.6	69.7	70.2	70.5	70.8	71.2	-	71.9	72.2
Greece	67.3	-	70.1	-	72.2	-	-	-	-	-	74.1	-
Iceland	70.7	-	-	-	73.7	-	73.9	-	74.0	74.7	75.0	75.1
Ireland	68.5	-	68.5	-	69.5	70.1	70.1	-	-	-	70.8	71.6
Italy	66.8	-	68.6	69.7	70.7	71.1	71.5	71.4	71.6	-	72.7	-
Japan	65.4	67.7	69.3	71.8	73.3	73.8	74.2	74.2	74.5	74.8	75.5	75.9
Luxembourg	66.1	-	67.0	-	68.0	70.0	-	-	-	-	70.6	-
Netherlands	71.6	-	70.9	71.4	72.4	72.7	72.7	72.8	73.0	73.1	73.1	73.6
New Zealand	68.7	-	68.1	-	69.7	70.5	70.7	70.8	71.2	-	71.1	71.0
Norway	71.4	-	71.0	71.9	72.2	72.6	72.7	72.9	72.8	72.7	72.9	72.8
Portugal	61.7	65.3	65.3	-	-	68.9	-	69.3	-	69.7	70.2	70.6
Spain	67.4	-	69.6	70.4	72.5	72.6	73.2	73.0	73.2	74.0	-	-
Sweden	71.2	71.7	72.2	72.1	72.8	73.1	73.4	73.6	73.8	73.8	74.0	74.2
Switzerland	68.7	-	70.1	71.8	72.4	72.5	72.7	72.8	73.1	73.5	73.8	74.0
United Kingdom	68.3	-	68.8	-	70.2	69.8	-	71.4	71.5	71.5	71.7	72.6
United States	66.7	66.8	67.2	68.8	69.6	70.4	70.9	71.0	71.1	71.2	71.3	71.5
Average	67.8	67.7	68.6	70.0	70.9	71.1	71.6	71.6	72.2	72.3	72.3	72.7

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1986 and 1987 data, World Health Organization, World Health Statistics Annuals, 1988 and 1989.

WEST GERMANY

Structure

Every individual is eligible for and approximately 75 percent of the population is required to participate in the Statutory Health Insurance (SHI) program. Wage earners with incomes between $2,740 and $26,000, their spouses and dependents, students, some disabled individuals, and retirees that were covered through SHI during their working years, are required to participate in a "sickness fund," organized by locality, occupation, or firm, and joined into national or state federations. There are approximately 1,200 sickness funds.

Soldiers, prisoners and the poor are provided care through other federally subsidized programs. Approximately 8.7 percent of the West German population receive coverage through private insurance. Private carriers provide coverage primarily to high income individuals who opt out of the Statutory Health Insurance program (SHI). Over four million individuals purchase supplemental insurance for benefits not covered under the national plan.

Financing

Employers and employees share the cost through payroll and wage taxes. The employee share equals approximately 12 percent of wages, however; the range is 8-16 percent and varies substantially by fund. The federal government subsidizes the premiums of the unemployed and the disabled.

Administration

The sickness funds administer the program.

Benefits

Inpatient and out-patient physician and hospital services, diagnostic and therapeutic services, maternity services, lab tests, medical appliances, dental services. The benefits are established by federal law.

Provider Reimbursement/Cost Containment/Patient Out-of-Pocket

Hospitals - Reimbursed by sickness funds at negotiated per diem rates. Hospitals have non-binding global budgets. Capital costs are paid by a combination of federal, state and local funds, subject to statewide planning.

Physicians - Physicians are required to join an association of sickness fund physicians. These associations set care standards, establish staffing priorities, and represent its members in negotiations with sickness funds. Since 1986, the federal government has set binding expenditure caps on physicians. Physicians negotiate with sickness funds for annual lump-sum payments which are apportioned to physicians on a fee-for-services basis. When expenditures exceed the government established cap, fees are reduced. Physicians are not permitted to balance bill. Hospital physicians are salaried.

Patients - The government has established nominal copayment requirements for prescription drugs and the first 14 days of inpatient hospital care. The government recently established a 40 percent copayment requirement on dental services. Individuals can purchase private supplemental insurance for benefits not covered in national benefit plan. Wealthy individuals can purchase private health insurance in lieu of participating in a sickness fund. Once an individual has opted out of the national program, he cannot reenter.

Employers - Employers are required to pay full earnings to individuals for the first 6 weeks of illness or disability. After that period, the government will pay 80 percent of wages for up to 78 weeks of missed work in a three year period. Employers are also required to provide 14 weeks of paid maternity leave at full salary.

Variance in the Payroll-Tax Rate Across West German Sickness Funds, 1988

Type of Fund	Payroll-Tax Rates*	
	Range	Average
Local Sickness Funds	10.8 - 16.0%	13.8%
Company-based Funds	7.5 - 15.0%	11.8%
Craft-based Funds	9.8 - 15.8%	12.8%
Substitute Funds		
• blue collar	10.2 - 14.6%	11.9%
• white collar	16.8 - 12.9%	12.7%
ALL STATUTORY FUNDS	7.5 - 16.0%	12.9%

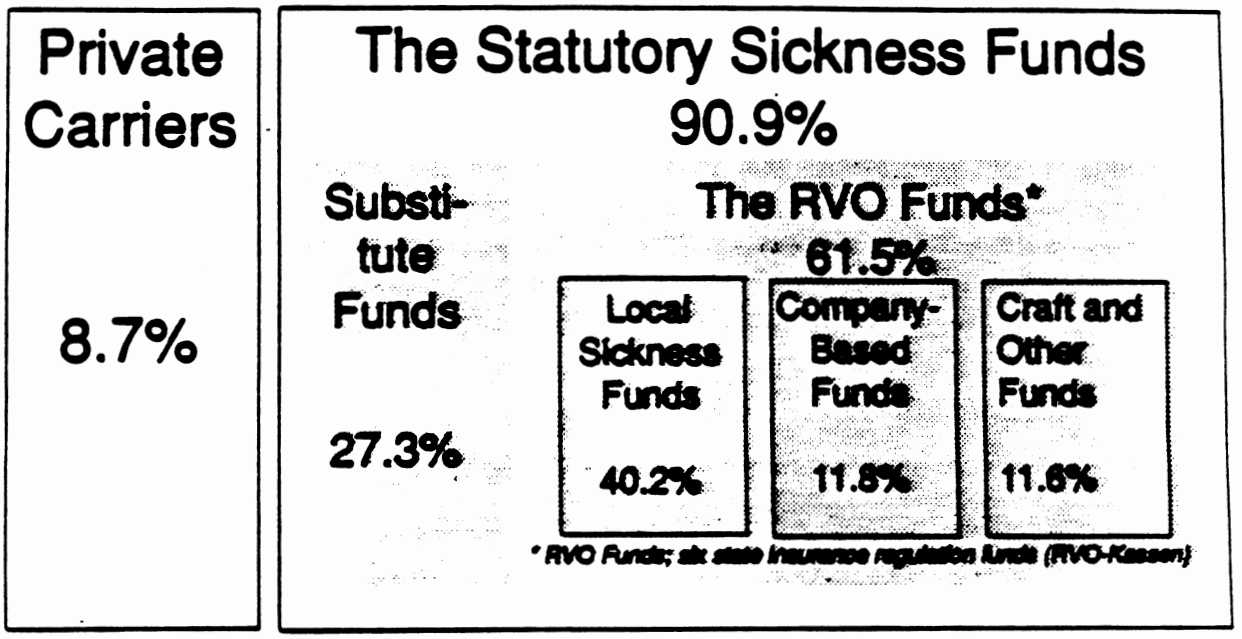
* *Employer's and employee's contribution to sickness fund, as a percentage of gross compensation (including fringes).*

Sources: Guntram Bauer and Franz Schoenhofen, "Risikostrukturen und Beitragssatzunterschiede in der GKV," *Die Ortskrankenkasse*, vol. 22, November 15, 1988, Table 1, p. 650.

West Germany's Health-Care and Health-Insurance System: Combining Access with Cost Control, by Dr. Uwe E. Reinhardt.

The Structure of the West German Health-Insurance System

(The Number of the Percentages of the Population in Each Type of Fund, 1986)



Sources: *Verband der Privaten Krankenversicherungen e.V.*
Die Private Krankenversicherungen, Zahlenbericht 1987/99, p.13.

West Germany's Health-Care and Health-Insurance System: Combining Access with Cost Control, by Dr. Uwe E. Reinhardt.

20X

JAPAN

Structure

In 1961, the Japanese government enacted the National Health Insurance Law, requiring employers to provide health insurance coverage to their employees. Government and private employees are covered under this law. The unemployed, retirees, small employers, the self-employed and farmers are covered under the National Health Insurance program, a public, government subsidized, program.

Financing

The employer-based program is funded by payroll and wage taxes. The payroll tax averages 3.5 percent and the wage tax averages 4.5 percent. The National Health Insurance program is financed through premiums based on income up to an annual ceiling $2, 740 per household plus national and local government subsidies.

Administration

The private program is administered by either the government (for government employees) or health insurance societies that represent large employers or specialized groups of workers. The National Health Insurance Plan is administered by local governments.

Benefits

Physician, dental and hospital services, prescription drugs. The plan does not cover maternity care or preventive health services.

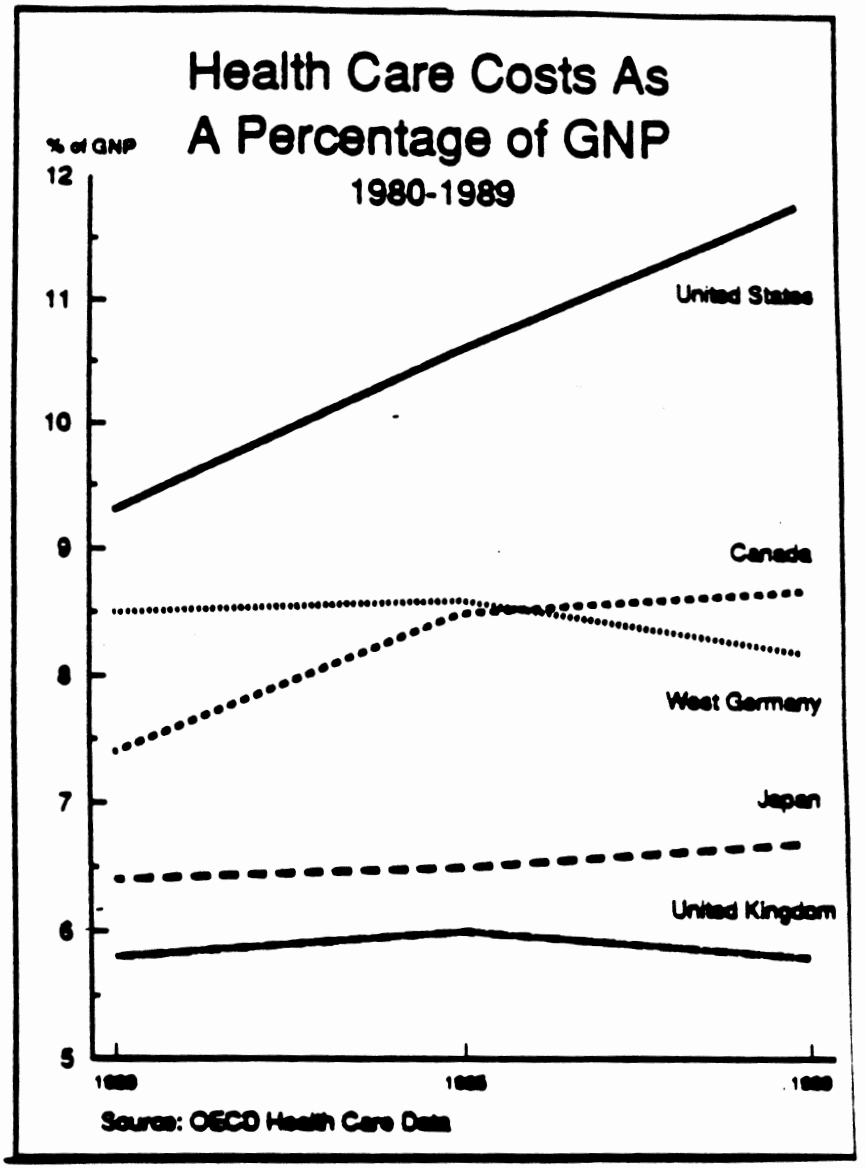
Provider Reimbursement/Cost Containment/Patient Out-of-Pocket

Hospitals - Hospitals are paid on a fee-for-service basis based on federally established fee schedule. Some government grants available for capital expenditures.

Physicians - Physicians are paid on a fee-for-service basis, based on federally established fee schedule.

Patients - Individuals in the employer-based program are required to pay 10 percent coinsurance and their dependents pay 20 percent coinsurance for inpatient care and 30 percent for outpatient care. Individuals in the National Health Insurance Program are required to pay 30 percent coinsurance. Under both programs, individuals are limited to $400 per month in out-of-pocket expenditures.

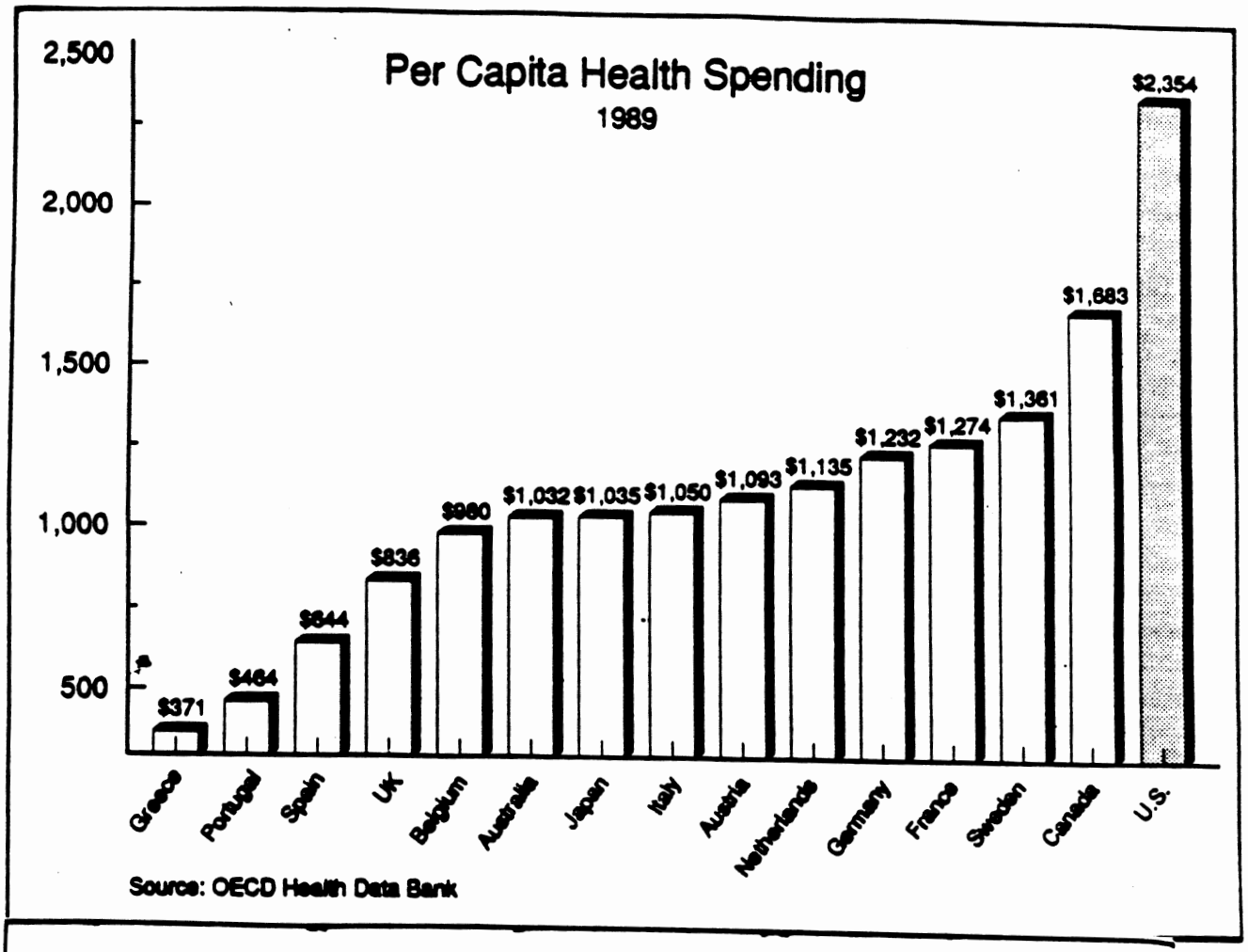
COMPARISON OF HEALTH CARE EXPENDITURES

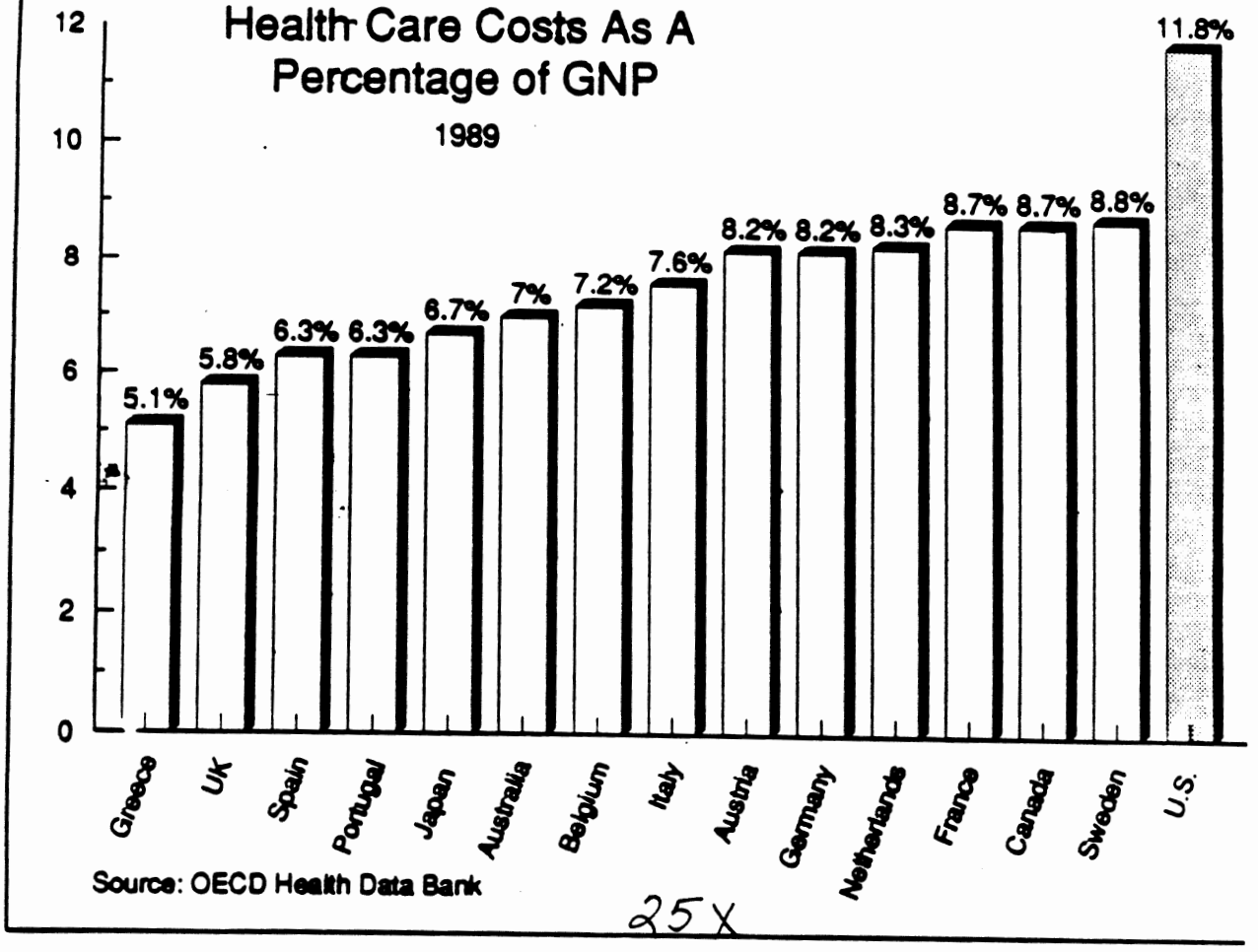

Health Care Costs As
A Percentage of GNP
1980-1989
% of GNP
12
11
10
9
8
7
6
5
United States
Canada
West Germany
Japan
United Kingdom
Source: OECD Health Care Data

Health Care Costs As A Percentage of GNP

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989
Australia	4.6	4.9	4.9	5.5	6.5	7.0	7.1	7.1	6.9	7.0
Austria	4.6	5.0	5.4	7.3	7.9	7.6	8.3	8.4	8.3	8.2
Belgium	3.4	3.9	4.1	5.9	6.3	6.9	7.2	7.3	7.3	7.2
Canada	5.5	6.1	7.1	7.2	7.4	8.5	8.8	8.8	8.6	8.7
Denmark	3.6	4.8	6.1	6.5	6.8	6.3	6.0	6.3	6.4	6.3
Finland	3.9	4.9	5.7	6.3	6.5	7.2	7.4	7.4	7.2	7.1
France	4.2	5.2	5.8	7.0	7.6	8.5	8.5	8.5	8.6	8.7
West Germany	4.7	5.1	5.9	8.2	8.5	8.6	8.5	8.6	8.9	8.2
Greece	3.2	3.6	4.0	4.1	4.3	4.9	5.4	5.2	5.1	5.1
Iceland	3.5	4.2	5.2	6.2	6.5	7.4	7.8	7.9	8.5	8.6
Ireland	4.0	4.4	5.6	7.6	9.0	8.3	8.3	8.0	7.9	7.3
Italy	3.3	4.0	5.2	6.1	6.8	7.0	6.9	7.3	7.6	7.6
Japan	2.9	4.3	4.4	5.5	6.4	6.5	6.7	6.8	6.7	6.7
Luxembourg	-	-	4.1	5.6	6.8	6.8	6.7	7.2	7.3	7.4
Netherlands	3.9	4.4	6.0	7.7	8.2	8.2	8.1	8.5	8.4	8.3
New Zealand	4.4	4.5	5.2	6.7	7.2	6.6	6.9	7.3	7.4	7.1
Norway	3.3	3.9	5.0	6.7	6.6	6.4	7.1	7.5	7.4	7.6
Portugal	-	-	-	6.4	5.9	7.0	6.6	6.4	6.5	6.3
Spain	2.3	2.7	3.7	4.8	5.6	5.7	5.6	5.7	6.0	6.3
Sweden	4.7	5.6	7.2	7.9	9.5	9.3	9.0	9.0	9.0	8.8
Switzerland	3.3	3.8	5.2	7.0	7.3	7.6	7.6	7.9	8.0	7.8
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.0	6.0	5.9	5.9	5.8
United States	5.2	6.0	7.4	8.4	9.3	10.6	10.8	11.1	11.3	11.8
Average	3.9	4.5	5.4	6.5	7.1	7.3	7.4	7.6	7.6	7.6

Source: George Schieber and Jean-Pierre Poullier, "International Health Spending: Issues and Trends," Health Affairs (Spring 1991)


Per Capita Health Spending
1989
2,500
2,000
1,500
1,000
500
$371
$464
$644
$836
$980
$1,032
$1,035
$1,050
$1,093
$1,135
$1,232
$1,274
$1,361
$1,683
$2,354
Greece
Portugal
Spain
UK
Belgium
Australia
Japan
Italy
Austria
Netherlands
Germany
France
Sweden
Canada
U.S.
Source: OECD Health Data Bank


Health Care Costs As A Percentage of GNP
1989
12
10
8
6
4
2
0
5.1%
5.8%
6.3%
6.3%
6.7%
7%
7.2%
7.6%
8.2%
8.2%
8.3%
8.7%
8.7%
8.8%
11.8%
Greece
UK
Spain
Portugal
Japan
Australia
Belgium
Italy
Austria
Germany
Netherlands
France
Canada
Sweden
U.S.
Source: OECD Health Data Bank

25X

Health Care Inflation
Compared To General Inflation

Year	Consumer Price Indexes*		Year-To-Year Percent Changes	
	All Items	Medical Care	All Items	Medical Care
1951	26.0	15.9	7.9%	5.3%
1952	26.5	16.7	1.9%	5.0%
1953	26.7	17.3	0.8%	3.6%
1954	26.9	17.8	0.7%	2.9%
1955	26.8	18.2	-0.4%	2.2%
1956	27.2	18.9	1.5%	3.8%
1957	28.1	19.7	3.3%	4.2%
1958	28.9	20.6	2.8%	4.6%
1959	29.1	21.5	0.7%	4.4%
1960	29.6	22.3	1.7%	3.7%
1961	29.9	22.9	1.0%	2.7%
1962	30.2	23.5	1.0%	2.6%
1963	30.6	24.1	1.3%	2.6%
1964	31.0	24.6	1.3%	2.1%
1965	31.5	25.2	1.6%	2.4%
1966	32.4	26.3	2.9%	4.4%
1967	33.4	28.2	3.1%	7.2%
1968	34.8	29.9	4.2%	6.0%
1969	36.7	31.9	5.5%	6.7%
1970	38.8	34.0	5.7%	6.6%
1971	40.5	36.1	4.4%	6.2%
1972	41.8	37.3	3.2%	3.3%
1973	44.4	38.8	6.2%	4.0%
1974	49.3	42.4	11.0%	9.3%
1975	53.8	47.5	9.1%	12.0%
1976	56.9	52.0	5.8%	9.5%
1977	60.6	57.0	6.5%	9.6%
1978	65.2	61.8	7.6%	8.4%
1979	72.6	67.5	11.3%	9.2%
1980	82.4	74.9	13.5%	11.0%
Average, 1951 - 1980			*4.2%*	*5.5%*
1981	90.9	82.9	10.3%	10.7%
1982	96.5	92.5	6.2%	11.6%
1983	99.6	100.6	3.2%	8.8%
1984	103.9	106.8	4.3%	6.2%
1985	107.6	113.5	3.6%	6.3%
1986	109.6	122.0	1.9%	7.5%
1987	113.6	130.1	3.6%	6.6%
1988	118.3	138.6	4.1%	6.5%
1989	124.0	149.3	4.8%	7.7%
1990	130.7	162.8	5.4%	9.0%
Average, 1981 - 1990			*4.7%*	*8.1%*

Source: Bureau of Labor Statistics

Relationship Between Health Care Costs And Average Wages

(Dollar Amounts In Constant 1990 Dollars)

Year	Annual Earnings (per worker)*	Household Health Care Costs (per worker)**	Health Costs As Percent Of Earnings	Weeks of Work Needed To Pay Health Costs
1965	$20,414	$1,348	6.6%	3.3
1970	21,761	1,439	6.6%	3.3
1975	22,010	1,511	6.9%	3.4
1980	21,128	1,390	6.6%	3.3
1985	20,820	1,714	8.2%	4.1
1989	20,364	1,937	9.5%	4.8
	[Projections, Based on Trends During 1980–89]			
1990	20,060	2,042	10.2%	5.1
1995	19,544	2,572	13.2%	6.6
2000	19,060	3,266	17.1%	8.6
2005	18,579	4,189	22.5%	11.3
2010	18,110	5,387	29.7%	14.9
2015	17,653	7,013	39.7%	19.9
2020	17,207	9,128	53.0%	26.5
2025	16,773	11,882	70.8%	35.4
2030	16,350	15,466	94.6%	47.3
2035	15,937	20,132	126.3%	63.2

* Annual earnings for someone working year-round, full-time, at the average hourly wage for production and nonsupervisory workers.

** Annual health care costs paid by households, divided by the number of workers for each year.

COMPARISION OF KEY HEALTH INDICATORS

Infant Mortality

(Infant Deaths Per 1,000 Live Births)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	20.1	18.5	17.9	14.3	10.7	10.0	10.3	9.6	9.2	9.9	8.8	8.7
Austria	37.5	28.3	25.9	20.5	14.3	12.7	12.8	11.9	11.4	11.2	10.3	9.8
Belgium	31.2	23.7	21.1	16.1	12.1	11.5	11.1	10.5	10.0	9.4	9.7	9.7
Canada	27.3	23.6	18.8	14.3	10.4	9.6	9.1	8.5	8.1	8.0	7.9	7.3
Denmark	21.5	18.7	14.2	10.4	8.4	7.9	8.2	7.7	7.7	7.8	8.2	8.3
Finland	21.0	17.6	13.2	10.0	7.6	6.6	6.1	6.1	6.3	6.3	5.9	6.2
France	27.4	21.9	18.2	13.6	10.1	9.6	9.3	8.9	8.3	8.1	8.0	7.6
West Germany	33.8	23.8	23.4	19.7	12.7	11.6	10.9	10.2	9.6	8.9	8.7	8.3
Greece	40.1	34.3	29.6	24.0	17.9	16.3	15.1	14.6	14.3	14.1	12.2	11.7
Iceland	13.0	15.0	13.2	12.5	7.7	6.0	7.1	6.2	6.1	5.7	5.4	7.2
Ireland	29.3	25.3	19.5	17.5	11.1	10.6	10.5	9.8	10.1	8.9	8.7	7.4
Italy	43.9	36.0	29.6	22.2	14.3	14.1	12.9	12.4	11.7	10.9	9.8	9.6
Japan	30.7	18.5	13.1	10.0	7.5	7.1	6.6	6.2	6.0	5.5	5.2	5.0
Luxembourg	31.5	24.0	24.9	14.8	11.5	13.8	12.1	11.2	11.7	9.0	8.0	9.3
Netherlands	17.9	14.4	12.7	10.6	8.6	8.3	8.3	8.4	7.0	6.9	6.4	7.6
New Zealand	22.6	-	16.8	-	12.9	11.7	11.7	12.5	11.6	10.8	11.2	9.8
Norway	18.9	-	12.7	11.1	8.1	7.5	8.1	7.9	8.3	8.5	7.8	8.4
Portugal	77.5	64.9	55.1	38.9	24.3	21.8	19.8	19.2	16.7	17.8	15.8	14.2
Spain	43.7	37.8	28.1	18.9	12.3	12.5	11.3	10.9	9.4	9.0	8.7	8.7
Sweden	16.6	13.3	11.0	8.6	6.9	6.9	6.8	7.0	6.4	6.8	5.9	6.1
Switzerland	21.1	17.8	14.4	10.7	9.1	7.6	7.7	7.6	7.1	6.9	6.8	6.8
United Kingdom	22.5	19.6	18.5	16.0	12.1	11.2	11.0	10.1	9.6	9.4	9.5	9.1
United States	26.0	24.7	20.0	16.1	12.6	11.9	11.2	10.9	10.7	10.6	10.4	10.1
Average	29.4	24.8	20.5	15.9	11.4	10.7	10.3	9.9	9.4	8.8	8.7	7.5

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1987 data for certain countries, World Health Organization, World Health Statistics Annual, 1989.

Female Life Expectancy

(At Birth; In Years)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	74.0	–	74.2	76.2	78.0	78.4	78.2	78.7	78.9	78.8	79.6	79.8
Austria	71.9	73.0	73.4	74.7	76.1	76.4	76.6	76.6	77.2	77.4	77.8	78.2
Belgium	72.7	–	74.2	75.1	76.8	76.8	76.8	–	–	–	78.2	–
Canada	–	–	–	–	–	78.9	–	–	79.8	–	79.9	80.2
Denmark	74.1	–	76.1	76.8	77.6	77.4	77.5	77.5	77.5	77.5	77.8	78.0
Finland	72.4	–	74.5	75.9	77.6	77.8	78.1	78.0	78.8	78.5	78.9	78.9
France	73.6	75.0	76.1	76.9	78.4	78.5	78.9	78.8	79.3	79.4	80.0	81.1
West Germany	71.9	–	73.6	75.2	76.5	76.9	77.2	77.5	77.8	–	78.5	78.9
Greece	70.4	–	73.6	–	76.6	–	–	–	–	–	78.9	–
Iceland	75.0	–	–	–	79.7	–	79.4	–	80.2	80.2	80.4	80.0
Ireland	71.8	–	73.2	–	75.0	75.6	75.6	–	–	–	76.4	77.3
Italy	71.8	–	74.6	75.9	77.4	77.8	78.2	78.1	78.1	–	79.2	–
Japan	70.3	73.0	74.7	77.0	78.7	79.1	79.7	79.8	80.2	80.5	81.6	82.1
Luxembourg	71.9	–	73.9	–	75.1	76.7	–	–	–	–	77.9	–
Netherlands	75.5	–	76.6	77.6	79.2	79.3	79.4	79.5	79.5	79.6	79.8	80.3
New Zealand	73.9	–	74.4	–	76.4	76.9	76.9	76.9	77.7	–	77.5	77.3
Norway	75.9	–	77.5	78.1	79.0	79.4	79.4	79.6	79.5	79.4	79.9	79.8
Portugal	67.2	69.3	71.0	–	–	76.6	–	76.2	–	76.7	77.1	77.5
Spain	72.2	–	75.1	76.2	78.6	75.8	79.3	79.1	79.7	80.0	–	–
Sweden	74.9	76.1	77.1	77.9	78.8	79.1	79.4	79.6	79.9	79.7	80.2	80.4
Switzerland	74.2	–	76.3	78.2	79.1	79.0	79.2	79.5	79.7	80.0	80.6	81.0
United Kingdom	74.2	–	75.2	–	75.9	76.2	–	77.2	77.4	77.4	77.5	78.3
United States	73.3	73.7	74.7	76.6	76.7	77.9	78.2	78.3	78.3	78.2	78.3	78.4
Average	72.9	73.4	74.8	76.6	77.5	77.6	78.2	78.3	78.9	78.9	78.9	79.3

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1986 and 1987 data, World Health Organization, World Health Statistics Annuals, 1988 and 1989.

30 X

Male Life Expectancy

(At Birth; In Years)

	1960	1965	1970	1975	1980	1981	1982	1983	1984	1985	1986	1987
Australia	67.9	-	67.4	69.2	70.9	71.4	71.2	72.1	72.4	72.3	73.0	73.2
Austria	65.4	66.6	66.5	67.7	69.0	69.3	69.4	69.4	70.1	70.4	71.0	71.6
Belgium	66.7	-	67.8	68.6	70.0	70.0	70.0	-	-	-	71.4	-
Canada	-	-	-	-	-	71.9	-	-	73.0	-	73.1	73.3
Denmark	72.3	-	71.0	71.1	71.4	71.4	71.5	71.5	71.6	71.6	71.9	71.9
Finland	65.4	-	66.2	67.4	69.2	69.5	70.1	70.2	70.4	70.1	70.6	70.7
France	67.0	67.8	68.6	69.0	70.2	70.4	70.7	70.7	71.2	71.3	71.8	72.6
West Germany	66.5	-	67.3	68.6	69.7	70.2	70.5	70.8	71.2	-	71.9	72.2
Greece	67.3	-	70.1	-	72.2	-	-	-	-	-	74.1	-
Iceland	70.7	-	-	-	73.7	-	73.9	-	74.0	74.7	75.0	75.1
Ireland	68.5	-	68.5	-	69.5	70.1	70.1	-	-	-	70.8	71.6
Italy	66.8	-	68.6	69.7	70.7	71.1	71.5	71.4	71.6	-	72.7	-
Japan	65.4	67.7	69.3	71.8	73.3	73.8	74.2	74.2	74.5	74.8	75.5	75.9
Luxembourg	66.1	-	67.0	-	68.0	70.0	-	-	-	-	70.6	-
Netherlands	71.6	-	70.9	71.4	72.4	72.7	72.7	72.8	73.0	73.1	73.1	73.6
New Zealand	68.7	-	68.1	-	69.7	70.5	70.7	70.8	71.2	-	71.1	71.0
Norway	71.4	-	71.0	71.9	72.2	72.6	72.7	72.9	72.8	72.7	72.9	72.8
Portugal	61.7	65.3	65.3	-	-	68.9	-	69.3	-	69.7	70.2	70.6
Spain	67.4	-	69.6	70.4	72.5	72.6	73.2	73.0	73.2	74.0	-	-
Sweden	71.2	71.7	72.2	72.1	72.8	73.1	73.4	73.6	73.8	73.8	74.0	74.2
Switzerland	68.7	-	70.1	71.8	72.4	72.5	72.7	72.8	73.1	73.5	73.8	74.0
United Kingdom	68.3	-	68.8	-	70.2	69.8	-	71.4	71.5	71.5	71.7	72.6
United States	66.7	66.8	67.2	68.8	69.6	70.4	70.9	71.0	71.1	71.2	71.3	71.5
Average	67.8	67.7	68.6	70.0	70.9	71.1	71.6	71.6	72.2	72.3	72.3	72.7

Sources: "International Comparison of Health Care Financing and Delivery," Health Care Financing Review (Annual Supplement 1989); 1986 and 1987 data, World Health Organization, World Health Statistics Annuals, 1988 and 1989.

A P P W P

Side-by-Side Comparison

of

Health Care Reform Proposals

March 1992

APPWP

PART I - ONE-PAYOR REFORM PROPOSALS

BILL/PROPOSAL	SCOPE OF COVERAGE	FINANCING	COST CONTAINMENT	OTHER FEATURES	COMMENTS
H.R. 1300 Universal Health Act of 1991 Rep. Marty Russo (D-IL)	Universal coverage provided by U.S. Government. Basic benefits include all "medically necessary physician and hospital care" (includes mental, dental, prescription drugs, preventive & home care).	No coinsurance or deductibles. New 6% employer payroll tax, increase corporate and personal income tax. Special Medicare Part B fee for long-term care, increase in taxable Social Security wage base, and other "federal contributions," all to National Health Trust Fund, administered by the states.	Prospective global budget and fee schedules for providers - (paid monthly) through federal/state commissions or negotiations, and HHS. Separate budgets for capital and medical education. Adjusted annually by GNP and inflation growth. Would apply Medicare outcomes research and practice guidelines to entire system.	Claims processing contracts - one per state. Individual choice of provider.	Has 66 co sponsors (2 92). Assumes savings from reduction in unnecessary care and administrative costs.
H.R. 5300 Mediplan Rep. Pete Stark (D-CA)	Alters and provides Medicare coverage for all Americans. Adds to Medicare benefits: well-child, preventive care and long term care. Basic single deductible $500; $2,500 out-of pocket limit, (except for well child and preventive care). Low income benefits also include unlimited hospital, outpatient drugs, glasses & hearing aids.	$1,000 annual premium paid by payroll tax - employer 80%/employee 20%; adjusted for low income. Additional 4% income tax per family.	Applies Medicare features: DRGs, RVRBS, volume performance standards; no balanced billing	Individual choice of provider.	Rep. Stark was a key dissenter on the Pepper Commission, and is Chairman of House Ways & Means Subcommittee on Health.
S. 1446 Health USA Act of 1991 Sen. Bob Kerrey (D-NE)	Universal coverage for hospital, physician, preventive, mental health, nursing home, home health, and prescription services, as well as long-term care, all provided through state-operated or supported FFS and private health plans. Replaces all other public health plans and not tied to employment. No limits on scope and duration. Experimental treatments to be approved by national board. Private plans reimbursed by States and must include no underwriting restrictions; annual open enrollment.	Creates National Health Care Trust Fund: 5% payroll tax (4% employers, 1% employees), exemption for first $30,000 of payroll. New excise taxes (cigarettes and alcohol), increases corporate and personal income taxes, 2% tax on nonwage income, increases Social Security wage base to $125,000, increases amount of Social Security benefits subject to tax to 85%. Annual deductible of $100, 20% co-pay, $5 per visit, $1,000/$1,500 2,000 cap individual/family. No cost sharing for preventive, hospital or nursing home care (for first 3 months)	National Health Commission to recommend annual global budget and compute national per capita cost (with adjustments) to determine federal contribution to states. State budgets would include separate accounts for prevention, capital spending and medical education. States would pay providers negotiated rates using RBRVS and expenditure targets.	New Independent National Health Care Commission and advisory board to administer. State plans could be HMOs, managed care networks, etc.	Sen. Kerrey is a presidential candidate. Estimates cost savings $11 billion the first year, and $150 billion over five years.

n.b. Other One-Payor Proposals:

H.R. 1777 "Medicare Universal Coverage Expansion Act of 1991," Rep. Sam Gibbons (D-FL), which would also expand and extend Medicare to all Americans, permit a private Medigap market, and be paid for through increased payroll taxes.

H.R. 8 Rep. Mary Rose Oakar (D-OH) - Canadian-style universal health coverage program with long-term care that combines public finance with private insurance. Federal commission would establish quality standards, capital budgets, and technology assessment; all-payor rate setting, modest cost-sharing, and state administration. Rep. Oakar was member of the Pepper Commission.

H.R. 16 Rep. John Dingell (D-MI) - a national health insurance program financed by a 5% VAT and run by a new federal board that would allocate funds to states and devise cost containment strategies; state administration. Similar NHI legislation introduced by Rep. Dingell, and his father, for many years.

33X

APPWP

PART II - EMPLOYER COMPREHENSIVE COVERAGE MANDATES/"PLAY OR PAY"

BILL/PROPOSAL	COVERAGE MANDATE/ACCESS	PUBLIC PLAN	FINANCING/CO PAYS	COST CONTAINMENT	OTHER FEATURES	COMMENTS
S. 1227 Affordable Heath Care for All Americans Sens. George Mitchell (D-ME) Edward Kennedy (D-MA), Jay Rockefeller (D-WV), and Don Reigle (D-MI)	Employer mandate to provide basic health plan (hospital & physician services, mental health, prenatal, well-baby and preventive care), or actuarial equivalent, to all employees who work 17.5 or more hours per week. "front-end COBRA" for start-up employees, (102% premium during waiting period). Phased-in for small business over four to five years.	Creates AmeriCare as new public plan for employees of employers who don't "play," also to include Medicaid population. Benefits as for employer mandate. Administered by states with federal standards and contributions; Medicare rates.	Cost-sharing: 80%/20% premium, $250/$500 individual/family deductible, $3,000 out-of-pocket limit. Adjusted for low income. "AmeriCare" financed by "non-playing" employers through tax based on percent of payroll, to be determined by HHS Secretary.	Managed care encouraged but not mandatory for AmeriCare. New federal Health Expenditure Board (HEB) to establish spending targets and negotiate "recommended" provider rates. Also, increased spending for outcomes research and protocols, pre-emption of state laws, and malpractice reform. State consortia regulate rates, provider supply, capital allocation and consumer information.	Small market reforms: State purchasing consortia, prohibits underwriting restrictions, managed care access, community rating. Tax credit to soften mandate for certain small businesses; mandate phased in over 4-5 years; exempts new businesses for first 2 years; permission to use Medicare provider reimbursement rates. Deduction for self-employed increased.	10 co-sponsors (2-92) No benefits taxation or tax code changes. Encourages "paperless" claims system. First year cost - $6 billion. Committee marked up bill and deleted tax sections to avoid finance jurisdiction. Also, Board rate recommendations would be binding, and States would be permitted to adopt Canadian style plans, (1-92)
H.R. 3205 Health Insurance Coverage and Cost Containment Act of 1991" Rep. Dan Rostenkowski(D-IL)	Employer mandate similar to above. Provides benefit coordination for dual coverage households. Mandate phased-in over 4 years.	Similar to Medicare, with additional benefits for younger population. Medicaid to continue and reimbursements would increase overtime to Medicare levels.	For nonparticipating employers: 9% payroll tax (initially), personal and corporate income surtax (9% after 3 years), and increased payroll tax. Assistance for low-income individuals. Co-pays similar to above.	Similar to above but mandatory global spending targets, capital spending, and rate-setting determined by National Health Care Cost Containment Commission Increases tied to GNP growth, with adjustments.	Group health plans must meet certain federal standards (eg. no underwriting) or pay hefty tax. Lowers Medicare eligibility age to 60. Prohibits self-insurance for firms with fewer than 100 workers. COBRA repealed. Deductions for self-insured increased to 100%.	Ways & Means Chairman not giving full weight to this bill; may push incremental bill (H.R 3626) described following.
Excellent Health Care National Leadership Coalition (Henry Simmons)	Universal coverage through employer mandate or public plan. "Play" mandates standard package that includes hospital, home health, surgical, mental health, routine preventive, well-child care and other care and services.	Firms that don't "play" pay a 7% payroll tax to support enrollments in new Pro-Health plan that would subsume Medicaid population. Employees to pay 1.75% payroll tax.	All firms and individuals to pay 0.5% payroll tax for Pro-Health, up to Medicare cap. Estimated premium: 80%/20% ($1,432/3,720, individual/family) Co-pays: $200/$400 individual/family; out-of-pocket limit: $1,500/$3,000; 80%/20% all services except well-child-100%	National Health Review Board sets global budget and spending targets, and would reduce spending 2% each year until it matches growth in GNP. Also sets provider reimbursement rates for use system-wide. National Board on Health Care Quality would issue practice guidelines, conduct technology assessment and outcomes research, and improve health system efficiency.	Small market reforms that would prohibit underwriting, and require guaranteed issue and community rating. Malpractice reform and incentives for development of organized delivery systems included.	

34x

c.)	Other Employer Mandate Proposals
H.R. 2535	Pepper Commission Health Care Access & Reform Act of 1991, Rep. Henry Waxman (D-CA) - Follows Commission recommendation for employer play or pay mandate and long term care. (Companion bill, S. 1227, introduced in Senate by Sen. Jay Rockefeller (D-WV), Commission Chairman, but he has put most of his weight behind Senate Democratic bill, S. 1227, which incorporates many Pepper recommendations.) Uses Medicare rates system wide and includes small market reforms; no other cost containment features, silent on managed care; no financing mechanism.
S. 2114	Comprehensive Health Insurance Plan of 1991, Sen. Bob Packwood (R-OR) - Mandates all employers to provide coverage, regardless of size, no play or pay. Tax credits provided to low income individuals, and firms depending on ratio of premium costs to wages. Preserves Medicare and expands Medicaid to all non elderly non employed. Encourages "coordinated care," uniform electronic billing, and requires dissemination of cost data. Similar to 1974 CHIP legislation.
H.R. 3393	Rep. Robert Matsui, (September 1991) - Proposes a targeted play-or-pay mandate on employers to cover employees' children, up to age 22, or pay a 4.2% payroll tax. These revenues would be used to create a new public plan for children.
1990	Consumer Choice Plan, or managed competition - Dr. Alain Enthoven, Stanford University, et.al.: Near universal coverage through employer mandate to cover all full-time employees and their dependents, or employer pays 8% payroll tax on first $22,500 of individual wages; small business subsidy if costs exceed 8% of payroll. Employees would be taxed on benefits exceeding 80% of the average cost of a qualified plan. Establishes at least one public sponsor in each state to serve as insurance purchasing agent for those not covered by employer plans, and to broker most cost-effective plan. The plan would, overtime, force all sponsors to bid for competitive, low-cost plans and shift greater cost sharing to beneficiaries who opt for richer plans or services.
1989	The Basic Benefits for All Americans Act, Sen. Edward Kennedy and Rep. Henry Waxman, mandated employers to provide a specific package of benefits for all employees; no play or pay. Non employed individuals would be covered by an expanded Medicaid, which would also provide subsidy to low-income workers (to 18.5% of poverty line) to purchase private coverage. Provided regional insurance purchasing consortia for pooling small groups. Limited cost-sharing and no change in tax status of benefits. Small business subsidy to cover 75% of premiums in excess of 5% of gross income; small market reforms.
1974	Comprehensive Health Insurance Program (CHIP) - proposed by Pres. Richard Nixon, mandated employers to cover all employees, with modest deductible and 25% co-pay, up to maximum annual liability.

APPWP

PART III - INCREMENTAL REFORM PROPOSALS

Bill/Proposal	Small Market Reforms/ Access	Benefit Requirements	Cost Containment and Managed Care	Other Provisions	Comments
S. 1872 Better Access to Affordable Health Care Act of 1991 Sen. Lloyd Bentsen (D-TX)	Covers groups 2-50 employees; full-time @ 30hrs/wk. Underwriting reforms: guaranteed enrollment and renewal, limits pre-existing conditions to 6-month waiting period, 3-month look back (ie. portability). Premium rate limitations and disclosure, (base rate variance to 20%, annual rise: trend + 5%, rating band limits, GAO to study premium rates). 15-state demonstration grants for small employer purchasing groups. State may adopt reinsurance pool or risk allocation. Carriers must register with state. Federal excise tax of 25% of premium for non-compliance.	Minimum package based on Medicare plus prevention and well-child benefits. Single deductible: $400+CPI (or 1% of wages); families $700+CPI (or 2% of wages); 20% co-payment to $3,000+CPI stop-loss level. Premium contribution for employees capped at 200% (50% for part-time).	Establishes federal Health Care Cost Containment Commission to advise on cost containment; State mandates and anti-managed care laws pre-empted. Establishes federal certification of managed care and UR programs. Increases funds for outcomes research.	Raises tax deduction for self-employed to 100%. Adds colorectal and mammography screening and flu shots to Medicare package. NAIC to develop model state statutes and regulations	9 co-sponsors, bi-partisan. Cost estimated at $10 billion over five years.
H.R. 3626 The Health Insurance Reform and Cost Control Act of 1991 Rep. Dan Rostenkowski (D-IL)	Similar, but: full-time @ 17.5hrs/wk, imposes community rating with age and gender adjustments of plus or minus 25% allowed; full disclosure required. No provision for purchasing groups. Carriers to register with state and HHS. federal excise tax for non-compliance.	Similar benefit package. Single deductible: $250, family: $500. No co-payments for preventive services or inpatient care for children. Co-payments limited to $2,500/individual, $3,000/families. Silent on employee premium contribution.	Same commission. Small group standards to be established by HHS with HHS and Treasury enforcement; states may be permitted to certify and supervise small plans. HHS to develop uniform claims processing.	Raises self employed deduction to 100% deduction over four years. Similar Medicare enhancement. HHS to establish payment rates for hospital and physician services based on Medicare RBRVS and DRGs, to be approved by Commission. Small employers would be prohibited from self-insuring.	12 Co sponsors Cost estimated at $7 9 billion.
H.R. 1565 The Health Equity and Access Reform Today (HEART) Act Reps. Nancy Johnson (R-CT) and Rod Chandler (R-WA) 36 X	Covers firms with 2-50 employees working 17.5 hrs/wk. Similar enrollment, renewal, and pre-existing condition as H.R. 3626. Rating requirements similar to S. 1872, except NAIC will develop standards for premium increases for renewals and reinsurance. (States may impose charges on insurers or self-insured employers to pay for reinsurance.) All plans to register with state. Silent on purchasing groups. States must adopt NAIC models, or be regulated by federal government. Federal excise tax for non-compliance by insurers and employers.	"MedAccess" minimum package, with basic hospital, medical, surgical, and some preventive services. MedAccess plans pre-empt state mandates.	Tax disincentives provided for plans lacking managed care and "responsible co-payment plan" (ie. employee pays 30% of benefits costs). Safe-harbor plans require employer contribution of $160/300 per individual/family. Non-cost-controlled plans taxed at 25% of costs. Restrictive state anti-managed care laws pre-empted for five years.	Employers mandated to offer MedAccess plans one year after enactment. Self-employed tax deduction increased to 100% over 5 year period for managed care plans, or for plans with 30% co-payment. Tort reform for community health centers, and $1.5 billion in grants to expand services. HHS to develop inpatient clinical data standards, and all hospitals must maintain such data within 8 years. $10 million in grants for data/quality monitoring systems.	10 co sponsors

Bill/Proposal	Small Market Reform / Access	Benefit Requirements	Cost Containment and Managed Care	Other Provisions	Comments
S. 1936 The Health Equity and Access Improvement Act of 1991 Sen. John Chafee (R-RI)	Covers firms with 3-99 employees; full time @ 20hrs/wk. Same enrollment, renewal and pre-existing condition reforms. States may follow NAIC models for reforms and risk-sharing if approved by HHS. Rate variance 20%; annual increases: demographic changes + trend + 5%. Carriers must register, full disclosure. Non-profit purchasing groups (minimum 100 employees), to be approved by HHS, would receive tax credit. Tax credits for first-time small business coverage for employees, and for dependent coverage, at 25% of costs, phased-out over 5 years. Non-complying insurers cannot deduct for tax purposes reserves set aside for future liabilities.	NAIC to develop. No language on deductibles or co-pays. Preventive care tax credit up to $250 per individual for such services not covered, eg. well-child, cancer screening, immunizations.	Institute of Medicine to establish federal standards for managed care. Approved plans pre-empt state laws and receive tax credits, at 25% of costs, phased out over 5 years. Malpractice reforms and ADRs. Establishes federal Managed Care Advisory Committee.	Raises self-employed deduction to 100%. Tax credits for uninsured family ($1200) and individual ($600) toward purchase of insurance and medical care. Phased out at incomes over $32,000/family and $16,000/individual. Expands funding for Community Health Centers and National Health Service Corps. Creates new federal/state Basicare program for low income (below 200% poverty line) who are ineligible for Medicaid. State flexibility in design and administration of this and other existing programs, with federal quality assurance monitoring program. Expanded rural health initiatives.	22 Co-sponsors (2 92) Cost estimated at $150 billion. Very different scope and intent than S. 1872 and H.R. 3626.
S. 700 The American Health Security Act of 1991 Sen. Dave Durenberger (R-MN)	Covers firms 1-50 employees; similar enrollment, renewal, and pre-existing condition reforms. Rate limitations: premiums with 80-120% of average rate, or 20% plus/minus average rate; annual increases capped at level of rates charged to new contracts, with adjustments. Full disclosure, filed yearly with HHS. State laws may govern, with HHS approval. (Small insurers, ie. less than $1 million in gross premium income, excepted.) Non-complying insurers liable for federal excise tax equal to 20% of gross premium income.	Insurers must make available two tier MEDPLANS, exempt from state mandates. Both plans provide 20% co-pay for hospital, surgical, physician, and screening services; pre-natal care with no co-pay. Standard MEDPLAN also offers mental health and drug treatment coverage. Both Core and Standard plan require single/family deductible: $500/1,000; out-of-pocket cap: $3,000/6,000.	No Provision		S. 700 strictly small market reform. Sen. Durenberger is developing further legislation that would create tax incentives for small market financed by tax cap on <u>all</u> employer plans. S. 700 estimates core MEDPLAN costs to be $900-1200 for individuals per year, standard plan @ $1,200 1,600/year.

Bill/Proposal	Small Market Reforms/ Access	Benefit Requirements	Cost Containment and Managed Care	Other Provisions	Comment
The President's Comprehensive Health Reform Program, 1992	Eliminates pre existing condition exclusions; other underwriting reforms similar to above. Premium limitations during "transition period" for firms with fewer than 100 employees, and would be phased out upon implementation of risk pool system that would equalize risk among insurers. Premiums could vary up to 20% across blocks of business, and 50% in a single block of business. States to establish HINs - Health Insurance Networks - to act as insurance purchasing agents for small groups and individuals. HINs could operate in more than one state and would be exempted from state mandates and anti-managed care laws. All employers required to provide information on available basic health plans. Colleges mandated to cover recent graduates for six months. Reforms to be implemented by states; federal intervention if necessary.	States would work with insurers to develop basic plans equal to value of maximum tax credit. No specifics required; one HMO and six FFS examples provided, with differing coverage and co-pays.	Managed care (here called coordinated care) encouraged for Medicaid and Medicare and for private plans. Assumes tax credit and state basic plan, and perhaps including Medicaid and Medicare provider reforms and reductions, will together force greater economies and drive greater use of managed care. Also, malpractice reform, uniform claims processing, provider cost and outcomes data requirements for consumers.	Transferable tax credits and tax deductions for poor, uninsured and middle class provided: maximum $1,250/2,500/3,750 for individuals/married couples/ families at the poverty line. Adjusted downward for individual/family incomes of $50,000/80,000. Minimum credit would be $125/375. Tax deduction for self-employed increased to 100%.	Administration estimates access will expand by 29 million over five years; tax credits will cost $100 billion over five years, and that savings to the system by 1997 will be 6 to 14%; premium savings for small group market as much as $20 million. Legislative plans for 1992: perhaps only HINs and small market reforms; malpractice previously introduced. Incorporates some principles of "free market" proposals, (see following).

n.b. Other Incremental Reform Proposals:

H.R. 3410, "The Health Access and Affordability Act of 1991," by Rep. Barbara Kennelly, (D-CT), among other things would require that all employers offer health insurance to all their employees, if made available to any; for part-time employees (working less than 30hrs/wk), employers may charge full cost. Non-complying employers face excise tax equal to 25% of all health premiums. Reforms and expands Medicaid eligibility and coverage, would assign Medicare and Medicaid patients to providers, and increases Medicaid reimbursement rates to Medicare levels. Pre-empts state mandates. Expands managed care in Medicare and creates national outcomes data base. Increases federal Medicaid share if states enact market and malpractice reforms, Medicaid managed care networks, and risk pools. (The Blue Cross-Blue Shield Association also recommends an employer mandate to offer.)

H.R. 2121, "The Health Insurance Reform Act of 1991," by Rep. Pete Stark (D-CA), would require insurance reforms, a minimum benefit package based on Medicare, and co-payment limitations. Non complying insurers would be assessed a federal excise tax equal to 100% of gross premiums collected during taxable year.

H.R. 1230, "Health Empowerment and Access Legislation," (HEAL) Rep. Fred Grandy, (R-IA) would offer incentives for employers to offer coverage, and provide for small market reforms. If coverage did not expand significantly in a certain time-period, employers would then be obligated to offer, and encouraged to help fund, a basic health package.

PART IV - FREE MARKET

Bill/Proposal	Tax Treatment of Health Plans	Affordability & Cost Containment	Public Plan Reforms	Other Provisions	Comment
Heritage Foundation	Complete tax equity: Removes current federal tax subsidies for group/individual health benefits and replaces with individual tax credits; 20% open-ended credit provided for all insurance purchases that meet minimum requirements, plus steeply rising credit for out-of-pocket expenses, based on family income. Credit for dependent coverage would include older children and grandchildren.	Assumes more careful and cost effective individual purchase of coverage and care, greater competition among carriers and providers. Envisions state risk pools for high-risk and uninsurables.	Expands Medicaid eligibility to income level, and encourages state managed care plans for Medicaid. Would increase Medicare deductibles to offset assistance for low income elderly. Encourages Medicare funds to be used for individual vouchers to purchase private plans.	Individual mandate - All Americans would have to acquire coverage. Long-term care: allows use of retirement funds to purchase long-term care insurance; encourages conversion of life insurance into LTC policies; promotes home equity lump-sum conversion to purchase LTC policies; provides tax incentives for LTC policy purchases.	Decouples coverage from employment; promotes maximum portability.
H.R. 3084 The Affordable Health Insurance Act of 1991 Rep. William Dannemeyer (R CA)	Caps deduction/exclusion at $3,695 per employee for family and $1,478 for individual coverage. Provides each uninsured a 33% tax credit for premiums, up to a limit based on age ($350 for under age 29 to $2000 for over 65) for purchase of federally qualified "no-frills" plans. Adjusted annually according to rise in CPI.	Qualified plans exempt from state mandates, state premium taxes, risk pool assessments, and rate regulations.	Not addressed	Tax credits available for establishment of medical care savings account to pay for medical expenses. Minimum balances required.	Not considered major legislative proposal, but incorporates principles of "free market."
Responsible National Health Insurance Mark V. Pauly, University of Pennsylvania, et.al. (American Enterprise Inst.)	Similar tax credit as Heritage, except Congress would chose fixed levels for each income level, and would be used to purchase <u>basic</u> coverage. Deductibles and out-of-pocket limits geared to income. Credits would be refundable. Vouchers for low-income, set at zero for very high income. Employers could still <u>offer</u> group coverage (and get the deduction). Employee tax liability depends on income level, level of benefits offered, and tax credit offset.	Assumes more competitive, cost-conscious market would result.	Local welfare agency would facilitate refundable credit/voucher for low income. Medicaid would be replaced by voucher system, the eligibility would be expanded based on income. Similar approach would be applied to Medicare over time.	Like Heritage, individual mandate to purchase basic coverage. Government would negotiate with insurers in different areas to serve as "fall back" coverage for those unable to obtain it otherwise. Balance billing negotiable.	Adverse selection eliminated, but high cost of high risk premiums could be offset by further credit. Also, community rating could be tried, as well as high risk pools. Flexibility, and most current arrangements, would continue.

PART V - INTERNATIONAL PROGRAMS

Country	Access/Benefits	Administration	Financing	Cost Containment	Comment
Canada	Universal coverage includes all basic and medically necessary hospital and medical services. Other levels and types of services -- eg. dental -- optional per province. Completely portable across country. Free choice of providers.	Provincial budgets and fee-setting; providers remain private. Only role for private insurance or employer-provided benefits limited to offering auxiliary services or non-ward accommodations	Government financing: approx. 60% regional, 40% federal; some provinces also use revenues from payroll tax. Health care costs consume approx. one-third of provincial budgets.	No cost-sharing except for certain auxiliary services. Provincial budgets act as relatively effective spending targets. Regional health planning councils allocate capital spending and resource allocation. No managed care or capitated arrangements. Very low administrative costs.	9% GNP devoted to health care, but actual spending rising faster than U.S. (4.28% vs 3.93%). Queues and equipment shortages reported.
Germany	Universal coverage; compulsory enrollment in national, decentralized program for all but highest income ($50,000+); about 9% opt out for private coverage. Guaranteed free benefits: ambulatory and hospital care preventive care, family planning, rehabilitation, and maternity, including necessary household help. Co-pays for auxiliary services such as dental, drug, vision care, etc.	System consists of approx. 1,200 self-governed sickness funds that serve different regions, trade or employment groups.	Payroll tax divided equally between employee and employer; varies 8-16% (i.e. 4-8% employer/employee) among the funds. Retirees also contribute tax on social security pensions and on private pensions. Revenue transfers pay for poor, disabled and unemployed.	$6/day hospital co-pay for first two weeks only; co-pays for auxiliary care as high as 50%. All-payor negotiations with government catalyst on provider reimbursements, plus RBRVS determined FFS. Some variance among funds. System-wide cap negotiated by government and physicians' organization. Physician peer utilization monitoring system; hospital physicians salaried.	Overall growth tied to growth in wages. 8% GNP, steady since 1975. Utilization rates and population aging more rapidly than U.S.
Japan	Universal coverage through two government plans: NHI and NIE (see next column). Most medically necessary services covered, except physical exams, and normal pregnancy and delivery.	NIE - Health Insurance for Employees covers all workers and dependents; (companies with over 700 employees can establish own plan.) Version of play-or-pay. NHI - National Health Insurance covers all disabled, unemployed, elderly and some workers not under NIE, through many local or trade plans. Federal government pays administrative and claims handling costs for both NHI and NIE.	NIE: 4.5% payroll tax approx. for employee and employer. NHI: Half funding from federal and local taxes, and half from individual premiums, adjusted according to income, to maximum of $2,700/year.	Cost-sharing significant. NIE: co-pays of 10% to out-of-pocket maximum of $400/month; dependent co-pays 20%/30% for inpatient/outpatient.	6.8% GNP (1987), rising faster than U.S. Japanese culturally prefer prescription drugs (28% vs 8% U.S. of all NCE) over intrusive procedures; hospital stays also higher. Population aging faster than U.S.

APPENDIX - OTHER PROPOSALS

Dec., 1991	Feb, 1991	March, 1990	Aug., 1991	States to note:
Social Security Advisory Council; Deborah Steelman, Chairman - Quadrennial federal commission recommended school-based clinics and medical insurance, expansion of Community and Migrant Health Center Programs, small market insurance reforms, preemption of state mandates and anti-managed care laws, promotion of prevention and healthy lifestyles, malpractice reforms, Medicare selective contracting and centers of excellence, merging Medicare Parts A and B, health claim standardization, technology assessment and data pooling, medical practice guidelines, and citizen involvement in developing reform systems. Council deeply divided on broad-scale, long-term system reforms and strategies.	AFL-CIO - Recommended a national health insurance program for those without employer-provided health care, to include Medicare and Medicaid, global budget to cap expenditures and allocate capital and resources, insurance underwriting and claims filing reforms, lowering Medicare eligibility age to 60, guaranteed core benefit package, and long-term care. Acknowledged that Labor long-term goal of government-financed social insurance would have to come about gradually. Labor was divided in developing proposal between those unions wanting immediate establishment of a Canadian-style system, and those who did not.	American Medical Association, "Health Access America" - Would mandate employers to cover all full-time employees and their families, reform and expand Medicaid, create state risk pools, create tax incentives for long-term care coverage, malpractice reform, alter tax subsidy for private plans to create incentives for more cost-effective choices, ERISA reform so that self-insured plans contribute to state risk pools, repeal state benefit mandates, small market reforms, and create larger risk-spreading groups.	National Governors Association, Gov. Booth Gardner (D-WA), Chairman - Rather than recommending a central plan, the Governors opted for state experimentation -- and the necessary waivers from the federal government to design individual access and cost containment programs, including Canadian-style plans to more modest reforms. They also pledged to pass uniform small market reforms, and to enact stronger prevention programs, especially for vulnerable groups. (n.b. New York, Minnesota, California, Colorado, and Vermont already considering major state-organized universal health care proposals.)	<u>Oregon</u> Its plan to ration care for the State's Medicaid population, while also expanding coverage to all Oregonians below the poverty line, has gotten much attention. Less attention has been focussed on the employer mandate, set to become effective in 1995, to provide employees with a benefit package similar to the new Medicaid package. <u>Hawaii</u> Since 1974, employers have been required to provide employees working more than 20 hours per week with health benefits; others covered by state-subsidized plan. Employee co-pay up to 1.5% of monthly wages or half the premium, whichever is less. 98% coverage; community rating, costs lower than rest of the country. State has been seeking ERISA waiver in order to add preventive and other services to its mandate. <u>Massachusetts</u> Proposed and passed under administration of Gov. Dukakis, the Massachusetts Universal Health Care Law has survived attempts to derail it but its implementation has been delayed by three years to 1995. The play-or-pay program would require employers with more than six workers to either cover their employees, or contribute to a state fund from which the uninsured could purchase coverage.

X 14