

**GAO**

**Testimony**

Before the Committee on Government Operations  
House of Representatives

For Release on Delivery  
Expected at 9:00 a.m. EST  
Friday, March 27, 1992

**HEALTH CARE**



146315

**Problems and Potential  
Lessons for Reform**

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053985/146315

SUMMARY OF TESTIMONY  
BY  
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BEFORE THE  
HOUSE COMMITTEE ON GOVERNMENT OPERATIONS  
ROCHESTER, N.Y.  
March 27, 1992

The rapidly growing costs of health care and the fact that access to health care is not available to a growing share of our population have generated a consensus that the U.S. health care system needs significant change. Our challenge is to find a better way to manage and finance our health care system while preserving the high-quality, innovative medical care we have achieved.

The United States is projected to spend over 16 percent of its GNP on health care by the year 2000--far more than any industrialized country. These growing costs are being shared by individuals and the business community as well as federal and state government programs. It is essential that individuals, business, and the government work together to tame the rising cost spiral for health care.

Despite having the highest costs in the industrialized world, our health care system is not serving large portions of our population very well. Nearly 34 million Americans are uninsured, and millions more are underinsured or fear that they might lose coverage if they develop a serious medical condition or change their employment status.

With concerns about health care costs and access growing, the Congress has asked GAO to review approaches developed in American communities as well as foreign systems that might help us address these issues. Our reviews of these programs suggest that there are some common themes that emerge in successful domestic and foreign programs, including: (1) universal coverage, (2) a uniform system for managing payment of providers, and (3) expenditure targets or caps for major categories of providers and services.

The Rochester community appears to have been more successful than most in controlling the twin problems of rapidly rising costs and constricting access to health insurance. GAO is beginning a detailed study of the Rochester health care system at the request of Congressman Horton. GAO will be looking at the lessons to be learned about the role of community rating and the role of health planning systems, which are important features of the Rochester health care system.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss problems in our health care system and potential lessons for reform. I would like to thank you and Mr. Horton for inviting me to Rochester for this field hearing on health care. The Government Operations Committee has taken a leadership role in the national debate on health care reform. I am particularly pleased to have an opportunity to participate in this hearing where the Committee brings the debate out of Washington to incorporate the views and experiences of health care leaders in the Rochester community.

The United States can be justifiably proud of the achievements of U.S. medicine. Our teaching hospitals and medical schools are setting the pace for advances in medical procedures that are emulated in the rest of the world. American citizens benefit from the range of sophisticated medical treatments and equipment available to them and generally express satisfaction with the quality of care that they receive.

However, there is a growing consensus that our health care system needs significant change. The demands for reform are directed at the rapidly growing cost of health care and the fact that access to care is not available to a growing share of our population. The challenge facing the United States is to find a

better way to manage and finance its health care system while preserving the high quality and innovation we have achieved.

RISING HEALTH CARE COSTS ARE A MAJOR PROBLEM  
FOR INDIVIDUALS, GOVERNMENT, AND BUSINESS

The costs of American health care are escalating. Between 1980 and 1990, health care costs rose from 9.1 to 12.2 percent of GNP. At this rate of increase, it is estimated that we will be spending over 16 percent of GNP on health care by the year 2000. If these trends continue, the increase in spending between 1990 and 2000 will be \$300 billion--this increase alone would equal our total defense budget for last year.

The burgeoning costs of health care are affecting all sectors of our economy. The 1980s saw the share of the federal government's budget devoted to health care spending increase by over 30 percent. If we could have held the growth in federal health care spending to the average increase for all federal outlays, total federal spending would have been \$50 billion less in 1990. If we hope to resolve our persistent federal budget deficit problem, we must stem the long-term growth in health care costs.

The rapid increases in government spending on health care in the last decade did not translate into a break for business or

consumers. For American households, the share of their income spent on health care also increased by more than 30 percent during the last decade. The business community experienced the same phenomenon, with the share of their total wage bill going to health care increasing by over 35 percent. Individuals, government, and the business community have all searched for ways to stem these increases. In many cases these efforts have meant shifting costs among each other. These pressures can be expected to intensify if health care costs continue to soar as projected.

#### GROWING CONCERNS ABOUT ACCESS TO HEALTH CARE

Despite our high health care expenditures--the highest in the industrialized world--our health care system does not serve large portions of our population very well. Nearly 34 million people, more than half of them working adults or their dependents, lack health insurance. Millions more are underinsured, and many others fear that they may lose their insurance coverage if they change jobs, they lose their jobs, or someone in their family develops a serious illness. Unfortunately, technical insurance terms, like medical underwriting and preexisting medical conditions, have now become common topics of conversation for the American public.

Most working Americans have traditionally relied on employment-based health insurance coverage, but recent trends in

the health insurance market have generated greater uncertainty about the guaranteed availability and continuity of such coverage. In the past, companies selling health insurance ensured that premiums they collected covered claims they paid by placing all their beneficiaries in one very large group and actuarially projecting their claims. Insured persons or families would be charged the same rates across the entire group to cover the costs of future claims and administration. This process is called community rating.

Community rating has declined for two principal reasons. First, insurance companies, faced with rapidly rising health care costs, have competed to attract business by offering lower rates to employers with relatively low-risk employees and minimizing coverage of high-risk groups or employees. Second, most large employers found that they could lower their health insurance costs by self-insuring, rather than paying an insurance company to perform this role. Thus, employers too small to self-insure, and with high-risk employees, often found health insurance very costly. The result has been declining availability of health insurance for employees of small businesses.

In most American communities--with Rochester a notable exception--the process of "community rating" has been supplanted by a number of competitive rating practices. These practices

have resulted in denied coverage or unaffordable rates for individuals or firms expected to have high medical care costs.

As insurers compete for better health risks in the population, risk pools have narrowed. This has meant that employees within particular industries (including foundries, barber and beauty shops, restaurants, and bars) are being denied coverage because the workers' current or future health status is judged too costly. An individual firm may drop coverage for its employees because one worker or a covered family member develops a costly medical condition. Health conditions such as cancer or diabetes are often excluded from coverage as preexisting conditions or may serve as a basis for denial of health insurance whenever an employed person loses a job or changes jobs, or if their employer decides to change insurance carriers. These insurance practices, coupled with our inability to control health care costs, are resulting in more and more of our workers and their families being added to the ranks of the uninsured.

#### LESSONS LEARNED FROM SUCCESSFUL FOREIGN AND STATE MODELS

With concerns about health care costs and access growing, the Congress has asked us to review approaches being taken by states or foreign countries that might help us to address these issues. We have examined the experience of Canada, Germany, France, and Japan, as well as the U.S. experience with federal

programs and state initiatives, to gain a better understanding of the root causes of our health care problems and possible solutions.

If the United States is to broaden access and contain health cost spending, we need to integrate features common to successful systems we have observed in other countries and within our own borders. A reformed U.S. system should retain and build upon the strengths of U.S. health care. The strong U.S. research establishment, the continuing development of technology, and the capacity to evolve new and potentially more efficient service delivery mechanisms are among the characteristics of the U.S. system that should be preserved as we search for models to help us overcome our problems.

In looking at some of the more successful domestic and foreign systems, we have found several common elements:

- universal coverage,
- a uniform system for managing payment of providers,  
and
- expenditure targets or caps for major categories of  
providers and services.



All of the major industrialized countries we have visited provide health insurance coverage for all of their citizens, yet spend a considerably smaller share of their national resources on health care. In our review of state programs, we find that Hawaii comes closest to universal coverage, yet it has had more success than other states in controlling the growth in health care costs. One clear lesson emerges: Universal health insurance coverage is a goal that can be achieved while keeping costs under control.

The foreign countries we have examined use varying approaches to managing the payment process, but they all set uniform payment rules that establish who is eligible for insurance, what services are included in benefit packages, what rates of payment are allowed for providers, and which procedures are used to file claims. The systems range from a single government payer in Canada to a system of more than 1,000 sickness funds in Germany.

Finally, the successful foreign models make explicit decisions about the amount they will spend in major health care sectors. They have used combinations of techniques--including global budgets for hospitals, fee schedules for physicians and other providers, and explicit constraints on the diffusion of technology--to constrain or cap the flow of income to hospitals and physicians.

THE ROCHESTER HEALTH CARE SYSTEM MAY PROVIDE  
VALUABLE INSIGHTS FOR REFORM

Examples employing many of these same elements to address cost and access problems also exist within the United States. The Rochester community, for example, appears to have been more successful than most in controlling the twin problems of rapidly rising costs and constricting access to health insurance. Health planning, a community ethic of cooperation among health care providers, and community rating appear to have helped to keep the area's health care costs more affordable to large and small employers. As a result:

- Health insurance premiums in Rochester are about two-thirds the national average even though per capita health care expenditures in the state of New York are among the highest in the nation.
- Health insurance coverage is more widely available in the Rochester area. Local estimates place the percentage of uninsured at 7 to 9 percent compared with 12 percent for New York State and 15 percent for the nation.
- Rochester's long-term commitment to health planning appears to have controlled the growth of hospital

beds and costly procedures and technologies. As a result, the Rochester area's supply of hospital beds, rates of admission, and hospital costs per capita have remained well below, and hospital occupancy rates above, the national average.

One unique feature in Rochester appears to be the structure of its insurance industry. The Rochester insurance market has not followed the national trends we have observed toward fragmentation and segmentation. In large part this has been due to Rochester's large employers, who have resisted the incentives to abandon community rating for self-insurance and experience rating. As a result, small employers and even individuals can purchase traditional health insurance or health maintenance organization (HMO) membership for the same price per employee as large employers. A 1987 study performed for the Commission on Health Futures for Rochester estimated that if the Rochester area abandoned community rating, more than 11,000 people would lose health insurance coverage because of the resulting large cost increases for small group coverage.

A single insurer--Blue Cross/Blue Shield--covers nearly three-quarters of Rochester's population. Yet the Rochester area has not only been a participant but also a leader in the movement to managed care programs. More than half of the participants in the Blue Cross program participate in their two HMOs. The second

largest insurer in the area, Preferred Care, is an HMO that serves about 14 percent of the population. We find it interesting to note that the state with the lowest rate of uninsured, Hawaii, also has an insurance market dominated by two private insurers.

We believe that studying the experiences of communities like Rochester can help us better understand how to adapt successful features of foreign systems while still preserving the advantages of our own. We are particularly pleased that Congressman Horton has asked us to review in detail the Rochester experience. We will be looking at the lessons to be learned about community rating and the role of health planning systems. We also intend to explore whether the structure of the insurance market in Rochester contributes to a more uniform payment system and lower administrative costs.

Mr. Chairman, I cannot overemphasize how important it is for government, the business community and individuals to work together to find a solution to the problems of escalating health care costs and deteriorating access. We owe it to all of our citizens to work to assure the availability of high-quality, affordable health care. Moreover, the effects of these problems extend beyond the health care system. We must control health costs if we are to control budget deficits and maintain a competitive position in an increasingly global economy. I am

confident that the experience here in Rochester will help all of us address these problems.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.