STRUCTURAL PROBLEMS IN THE INCREMENTAL APPROACH
DRAFT: prepared by Walter Zelman with assistance from Rick Kronick and Pam Short

INTRODUCTION

As the national discussion of health care reform enters its final stages the focus remains on the issue of universal coverage. The President's original proposal and those offered by three Congressional committees would achieve that goal largely by implementation of a shared requirement on employers, families and government (via subsidy payments to employers and families), to purchase insurance for all Americans.

A number of other proposals espouse the goal of universal coverage but suggest an incremental, or step by step approach. The short term goal of such approaches is to gradually reduce the numbers of the uninsured from approximately 15% to between 5-10% of the population. The means of achieving that short term goal include insurance reforms and government subsidies to low-income individuals who purchase insurance policies.

Included for the purpose of this analysis in the incremental category are proposals offered by: Senator Robert Dole, Congressman Jim Cooper and Senator John Breaux, and the bill produced by the Senate Finance Committee.

Such proposals appear to offer a less expensive and less controversial route to universal coverage. Unfortunately, careful analysis indicates that they will fall far short even of the more modest goals they appear to offer. They would do so for two primary reasons: first, they tend to be either poorly funded or underfunded (i.e. they offer too little in subsidies or don't adequately fund the subsidies proposed), and without fully funded and subsidies the expansion of coverage is likely to be minimal.

Second, and perhaps more important, these subsidy-without-mandate-proposals suffer from fundamental, structural flaws which would prevent them --even if subsidy dollars were made available-- from approaching universal coverage.

Specifically, some of these approaches, if fully funded, might lead to a noticeable increases in the numbers of insured individuals below the poverty line. (This is because individuals under the poverty line receive the most generous subsidies -- usually 100% of premium-- and have first call on those subsidies).

But none of the incremental proposals hold out much hope of generating substantial increases in the numbers of the insured above the poverty line.

Under some of these proposals, fully funded, a decrease in the numbers of the insured in 1999 from 15% to 9-11% of the population is possible. A decrease of greater amounts is very unlikely, under any of the proposals. A decrease in the numbers of the insured to the sometimes-stated goal of 5% is virtually inconceivable.

This, it should emphasized, may be the case even if the subsidy schemes in the incremental proposals are made considerably more generous. As subsidies are expanded increasing amounts of subsidy dollars flow to those who are already insured, as more employers drop coverage of already insured individuals. As a result, in the absence of an employer requirement to purchase insurance, substantial increases in subsidies produce only very modest gains in the numbers of insured, and at very high costs.

THE INCREMENTAL APPROACH

At the heart of the incremental proposals is the assumption that before mandates to purchase insurance are imposed, a reformed insurance marketplace featuring greater access to insurance should be given a chance to work --i.e., reduce insurance costs and increase the numbers of the insured.

While they differ in many significant respects, these measures feature:

- Reform of the insurance market, including: limitations on the imposition of pre-existing condition exclusions; a requirement that all insurers sell to all who wish to purchase their product; restrictions on the dropping of groups; some movement away from premiums based on health experience and occupation (experience rating) and towards rating based only on family size, age, and regional costs (modified community rating).

- Availability of some federal government monies for subsidies of low-income individuals.

- The possibility --in some cases the mandated establishment of-- purchasing cooperatives for small employers.

Some incremental approaches would limit the tax advantages associated with employer purchased health insurance, or widen the tax advantages on individually purchased insurance. Others would not. Additionally, some would create and impose a standardized benefits package whereas others would leave insurers and employers free to set benefits as they saw fit.

MARKET REFORMS AND THE REDUCTION OF INSURANCE COSTS

Advocates of such measures believe that the reforms proposed can significantly reduce the costs of insurance, especially for small groups. As a result, they assert, even without significant subsidies, reform will lead more employers and individuals to purchase insurance.

No doubt this is true with regard to at least one group -- those high risk individuals who have the funds to purchase insurance but cannot find an insurer willing to cover them. But the numbers of this group is small (most analysts estimate it to be less than 1 million individuals). And there simply isn't much reason to believe that market reforms, in the absence of universal coverage, will do much make insurance more affordable and thus to reduce the ranks of the uninsured.

- As indicated in a recent analysis by Lewin-VHI,[1] market reforms, especially in the absence of universal coverage, will exert upward pressure on premiums. As higher risk individuals benefit from reduced premiums, the overall level of risk in the insured pool will rise. As the Lewin-VHI analysis concludes, "In general, we find that average premiums would increase if coverage were expanded through insurance market reforms and premium subsidies."

- To the extent a ban on experience rating assists some small employers by lowering their rates it will increase rates on others. Even if some rating based on age is tolerated, rates are most likely to rise for younger workers, those most likely to decline the option to purchase insurance.

- While purchasing pools and market reforms may reduce costs (or, more likely, rates of growth) for some, other factors --such as bringing in many of the unemployed and the "uninsurables" -- will drive costs up. This will be particularly true if the community rated pool is small.

- If proposals rely on Medicare and/or Medicaid savings to finance subsidies there may well be an additional cost shift to private insurance, negating what reductions might have been achieved by market reforms and pooling efforts.

- As a result of these and other factors, few anticipate that market reforms alone will significantly reduce the costs of insurance. If properly implemented they might slow the rate of growth in those costs. But a slightly slower rate of growth will not be enough to produce a significant increase.

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[1] "Coverage, Premium, and Household Spending Implications of Health Reform," July 18, 1994.

in the employer or family purchase of insurance. As a number of studies have concluded, the great majority of the uninsured have no insurance because they or their employers cannot afford it or because they choose not to buy it. Market reforms, which cannot in and of themselves, substantially reduce insurance costs, won't change this.

POORLY OR UNDERFUNDED SUBSIDIES

If market reforms alone will not significantly reduce costs or increase the numbers of the insured, offering subsidies to low-income individuals may help to achieve the latter goal.

But the nature of subsidy schemes in incremental approaches raise serious questions about the willingness of their backers to fund the subsidies required to produce even modest gains in coverage. Proposals offered by Cooper and Breaux and by the Senate Finance Committee appear to be underfunded --e.g. the revenues and savings generated may not produce the subsidies promised. The proposal by Senator Dole, while perhaps fully funded, offers far too little subsidy to far too few individuals to make a significant impact on the numbers of the uninsured.

Cooper/Breaux

The Cooper/Breaux plan proposes that premiums for families under 100% of poverty be fully subsidized by the federal government. Subsidies would be phased out between 100% and 200% of poverty.

The Congressional Budget Office (CBO)[2] suggests that, with such subsidies, the Cooper bill could reduce the numbers of the uninsured from about 40 million to about 25 million in 1999, or from 15% to 9% of the population. (An analysis by Lewin yields similar conclusions).[3]

But the CBO report also notes that the measure is sorely underfunded. Given a benefits package equal to that proposed in the President's Health Security Act, the subsidy dollars generated by the sources designated in the Cooper proposal will be, according to CBO, about $35 billion a year short of what

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[2]"An Analysis of the Managed Competition Act," Congressional Budget Office, May 4, 1994.

[3]"Expanding Insurance Coverage Without a Mandate," Lewin-VHI, Inc., May 18, 1994. This report actually anticipates a slightly greater increase in the numbers of the uninsured than does the CBO report.

would be necessary to fully fund the proposed subsidy levels.

The Cooper plan would force health plans, including the self-insured to absorb these subsidy shortfalls, or to pass the underpayment by subsidy-eligible individuals on to those paying full cost.

The CBO concludes that such a process "would be extremely complicated; its feasibility is doubtful." Failure to adequately fund the subsidies, the CBO argues, "could result in an upward spiral of health insurance premiums, declines in health insurance coverage, and, potentially, the collapse of the HPPC system.[4]

Even if subsidies are fully funded, CBO concludes, the Cooper plan would do little to increase the numbers of insured who are above poverty levels. As indicated in Chart I, virtually all the gains, in terms of increased coverage, (11 million more insured individuals) would come at the under 100% of poverty level. Only 2 million of the 18 million Americans above the poverty line would gain insurance. (chart p. 29).

The Senate Finance Proposal

If fully funded, Senate Finance would increase coverage by a bit more than the Cooper bill in the year 2000, but a bit less in the early years. The bill offers a full premium subsidy to those below poverty in 1996, and increases the phase out of this subsidy to 200% of poverty by the year 2000. In this it is like Cooper/Breaux, although a bit less generous until 2000. In addition, Finance proposal provides full premium subsidies to otherwise uninsured children and pregnant women in families with income below 185% of poverty, and a phase out of this special subsidy up to 240% of poverty. These special additional subsidies might decrease the number of insured individuals by approximately 3 million (to 22 million) below the estimates for Cooper.

Such an estimate, of course, assumes that subsidies are fully funded. Press reports, however, have suggested that the Senate Finance proposal is significantly underfunded. Definitive estimates from the CBO or OMB are not yet available.

The Dole Proposal

Senator Dole proposes, initially, to subsidize 75% of insurance costs for families up to 90% of poverty. Fully subsidized persons with family income below 90% of poverty would be required to pay 25% of the premium if they wanted to become

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[4]CBO analysis, p. 19.

insured. In subsequent years (unspecified by Dole) this "full" subsidy would be available to those below 100% of poverty. The subsidy would phase out (available funds permitting) at 150% of poverty.

Such an approach is likely to have almost no effect on increasing health insurance coverage. A family of four at 50% of poverty ($7,500 per year) would be required to pay $1,250 to $1,500 for a health insurance policy. Analysis by both Lewin and CBO suggest that no more than 30% of families made such an offer are likely to accept it. An optimistic assessment is that the subsidies offered by Senator Dole's proposal would increase coverage by at most 8-9 million people, and leave approximately 32 million uninsured at any point in time.

STRUCTURAL FLAWS IN INCREMENTAL REFORMS

Even if they were to be fully funded, an analysis of such incremental reforms suggests that all may --at least in terms of achieving universal coverage-- be structurally flawed. Admittedly, they can (if fully funded) reduce the numbers of the uninsured at or below the poverty line; but they have little capacity to reduce the numbers of uninsured above the poverty line. If they attempted to do so they would become increasingly inefficient, producing ever higher costs for very marginal gains.

As more subsidies become available more employers reduce the coverage they now offer and increasing numbers of subsidy funds go to individuals that formerly had employer-based insurance.

As noted above, analyses of the Cooper-Breaux Managed Competition Act conclude that almost all of the gains in the numbers of insured under that Act come as fully subsidized individuals below the poverty level purchase insurance. As subsidies phase out between 100 and 200% of poverty relatively few uninsured individuals in this income range purchase insurance. This conclusion reflects what studies have revealed for some time --that even substantial subsidies (say 25-50% of premium at 150% of poverty) are not enough to get large numbers of low-income people to buy insurance they don't have to buy.

Theoretically, the willingness to purchase insurance might be increased if subsidies are made more generous, and phased out over a broader income range than the 100-200% of poverty applied in the Cooper-Breaux proposal. Subsidies might, for example, be phased out between 100 and 300% of poverty. This would both offer subsidies to greater numbers of individuals and offer more generous subsidies to those between 100-200% of poverty. However, in the absence of a mandate, such more generous

subsidies are likely to produce effects on the purchase of employer-sponsored insurance which limit the capacity of the extra subsidy dollars to produce substantial net gains in the numbers of the insured. It is these offer effects that reveal the inherent flaws in the incremental approach.

ASSESSING THE IMPACT OF VARIOUS SUBSIDY PROPOSALS

Table I presents an overview of coverage of the Under 65 population, projected to 1999. Over 11 million of uninsured have family incomes below poverty. Almost 19 million of the uninsured have family incomes between 100 and 300% of poverty. Another 10.4 million uninsured (about 25% of the total uninsured population) have incomes of over 300% of poverty.

As the above analysis would suggest, fully subsidizing individuals under 100% of poverty, is likely to produce significant increases in this class of the uninsured. On the other extreme, no subsidy scheme contemplated would reduce the numbers of the uninsured above 300% of poverty (although community rating and insurance reform might reduce those numbers somewhat).

In the absence of a mandate, then, additional progress toward universal coverage, will hinge largely on the impact of a subsidy scheme on the 18.8 million (44% of the uninsured) between 100 and 300% of poverty.

To estimate that impact we attempted to assess the increases in the numbers of insured persons that might result from subsidies of different magnitudes. Additionally, we sought to project; (1) the numbers of individuals (newly insured and already insured) that might get subsidies under each model; (2) the total dollars in subsidies that would go to newly insured and already insured individuals; and (3) and the costs per newly insured at various subsidy levels.

The methodology for this analysis is discussed in the Appendix, but two assumptions are outlined here.

First, we assume that any proposal offering subsidies to individuals while imposing no requirement on employers to purchase insurance would include a provision that employers who offer to pay for coverage of some employees must offer to pay for coverage of all employees (perhaps just full-time employees). Without such a requirement, incentives would be strong for employers (and employees) to drop coverage of subsidy-eligible employees. These employees could then accept slightly higher wages or other benefits, and accept government subsidized coverage. Employers and employees might both gain from such an arrangement, while government subsidy costs would rise. Forcing

the employer to offer coverage to all (if coverage is offered to any) reduces the probability that the employer will drop coverages.

The question then becomes, under what circumstances will employers drop coverage of all employees? That decision may depend largely on the salary mix in any given place of employment. (See Appendix). The higher the percentage of low-income, subsidy-eligible individuals, the greater the likelihood that an employer (and its employees) might benefit from the dropping of coverage for all. (Such a decision would not seem so unlikely as might now be expected. In a reformed insurance market all individuals would have access to policies at community, or modified community rates. Under such circumstances higher wages in exchange for dropped coverage might seem a reasonable exchange for many middle and upper middle income employees).

The second assumption made here relates to the tax deductibility of insurance. The decision on whether an employer covers all or drops all will hinge, in part, on this issue. If those benefits are deductible for individuals, as they are for group purchased insurance -- and as is the case in most insurance reform/subsidy proposals-- there is less incentive for employers and employees to arrange for group purchased insurance, and more incentive for them to look for the most profitable insurance arrangement. Such an arrangement could include dropping employer-sponsored insurance for all, raising wages, and taking advantage of government subsidized insurance. (Again, the pain to employees, of such a result would be minimized by market reforms that would guarantee all access to non-experience rated insurance policies).

For the purpose of this analysis we assume that --as is the case in most market reform proposals-- individually purchased as well as group purchased insurance will be tax deductible.

Results

The impact of various subsidy proposals can be seen in Tables II and III. As shown in Table II, subsidies that phase out between 100 and 150% of poverty result in subsidies going to 19.8 million individuals, 10.9 million of whom move from uninsured to insured status. However, at subsidies up to 200% of poverty the numbers of subsided individuals rises by almost 10 million people with less than two million of them newly insured. And at subsidy levels up to 300% of poverty the numbers of individuals subsidized rises by 26 million while producing a net gain of only 4.5 million in newly insured individuals. Subsidizing to 150% of poverty moves the percentage of insured individuals from 82.6% of the non-elderly population to 87%; subsidies up to 200% of poverty would raise that percentage by

just one point to 88%; subsidies of up to 300% of poverty would increase the percentage of the non-elderly insured by 2 more points, to 90%.

Thus, as subsidies levels increase, the numbers of subsidized individuals rises much faster than the numbers of the newly insured. To produce an increase of insured individuals from 10.8 million to 17 million, an additional 36 million already insured individuals are subsidized.

The same phenomena can be seen in Table III, which details the costs in total subsidies of increasing the numbers of insured individuals. With a subsidy level of 150% of poverty, total subsidies are estimated at $37.8 billion in 1999, $23.1 billion of which goes to the previously uninsured. Subsidizing individuals to 200% of poverty raises subsidy costs by an additional $10.8 billion, only $2.9 billion of which goes to the newly insured. Subsidizing individuals up to 300% of poverty increases total subsidy costs by another $39.2 billion, only $6.9 billion of which goes to the newly insured.

In terms of dollars per newly insured, a subsidy level of 150% of poverty produces a subsidy cost of $3,468 per newly insured individual. At 200% of poverty the comparable figure is $3,827. At 300% of poverty the figure rises to $4,523.

Thus, an effort to increase the numbers of insured by increasing subsidy payments produces only modest gains for very high and increasing costs. Thus the inherent flaw in the subsidies-without-mandates approach to universal coverage.

The efficiency of a subsidy approach, of course, might increase if subsidies could be more specifically directed or targeted to the uninsured population. That is not generally the approach taken by incremental proposals. An analysis of the potential of more targeted subsidies is not undertaken here.

Millions of people receiving premium subsidies (1999)

Family income as a percent of poverty	Newly insured	Formerly employer coverage	Other private	Total with subsidies	
Subsidies extend to 150% of poverty					
Total	10.9	5.5	3.4	19.8	Percent of population with coverage:
0 - 99	8.3	1.9	1.9	12.1	
100 - 124	1.7	1.6	0.7	4.0	87% of nonelderly
125 - 150	1.0	2.0	0.7	3.7	89% of total
Subsidies extend to 200% of poverty					
Total	12.7	11.6	4.8	29.1	Percent of the population with coverage:
0 - 99	8.3	1.9	1.9	12.2	
100 - 124	1.7	1.7	0.7	4.1	88% of nonelderly
125 - 149	1.5	2.0	0.7	4.3	90% of total
150 - 200	1.2	5.9	1.4	8.6	
Subsidies extend to 300% of poverty					
Total	17.2	30.5	7.3	55.0	Percent of population with coverage:
0 - 99	8.3	2.2	1.9	12.4	
100 - 124	2.2	1.9	0.7	4.8	90% of nonelderly
125 - 149	1.6	2.3	0.7	4.6	91% of elderly
150 - 199	2.7	6.6	1.4	10.7	
200 - 299	2.3	17.6	2.5	22.5	

Note: Employs CBO methodology for determining willingness to apply for subsidies and pay for insurance. Percent of persons who drop employer-sponsored insurance to receive subsidies increases from 50 percent as the proportion of insured workers eligible for subsidies increases.

Unofficial staff estimates. 7/18/94

Government expenditures on premium subsidies, billions of dollars (1999)

Family income as a percent of poverty	Newly insured	Formerly employer coverage	Other private	Total subsidies	
Subsidies extend to 150% of poverty					
Total	23.1	8.5	6.2	37.8	Dollars per newly insured: $3468
0 - 99	19.6	4.5	4.6	28.6	
100 - 124	3.0	2.9	1.2	7.1	
125 - 150	0.6	1.2	0.4	2.2	
Subsidies extend to 200% of poverty					
Total	26.0	14.7	7.9	48.6	Dollars per newly insured: $3827
0 - 99	19.6	4.7	4.6	28.8	
100 - 124	3.5	3.5	1.4	8.4	
125 - 149	2.2	3.1	1.1	6.3	
150 - 200	0.7	3.5	0.8	5.0	
Subsidies extend to 300% of poverty					
Total	32.9	33.8	11.1	77.8	Dollars per newly insured: $4523
0 - 99	19.6	5.2	4.6	29.3	
100 - 124	4.9	4.1	1.6	10.6	
125 - 149	3.1	4.4	1.4	8.9	
150 - 199	4.0	9.7	2.1	15.8	
200 - 299	1.4	10.4	1.5	13.3	

Note: Employs CBO methodology for determining willingness to apply for subsidies and pay for insurance. Percent of persons who drop employer-sponsored insurance to receive subsidies increases from 50 percent as the proportion of insured workers eligible for subsidies increases.

Unofficial staff estimates. 7/18/94

Coverage of the U.S. population under 65, current law (1999)

Family income as a percent of poverty	Total population (Millions)	Employer-sponsored coverage	Other private coverage	Uninsured
		Percent of income group with specified coverage		
Total	232.8	62.7	8.5	17.4
0 - 99	34.8	11.2	7.6	32.6
100 - 124	10.3	31.7	9.3	35.5
125 - 150	10.1	39.2	9.9	35.2
151 - 199	21.3	53.5	9.1	27.6
200 - 299	41.0	74.6	8.5	13.9
300 - 399	37.7	74.6	8.5	13.9
400+	77.5	83.5	8.5	6.7
		Millions with specified coverage		
Total	34.8	145.6	19.8	40.4
0 - 99	34.8	3.8	2.6	11.3
100 - 124	10.3	3.2	1.0	3.7
125 - 149	10.1	3.9	1.0	3.5
150 - 199	21.3	11.3	1.9	5.9
200 - 299	41.0	30.6	3.5	5.7
300 - 399	37.7	28.1	3.2	5.2
400+	77.5	64.6	6.6	5.2

Note: Medicaid and other public coverage is not shown. EBRI tabulations of insurance coverage by income from the March 1993 Current Population Survey were projected to match CBO's projection of the number of uninsured in 1999.

Unofficial staff estimates. 7/18/94

Methodology for Estimating Alternative Premium Subsidies
under a Voluntary System

P. Short (7/19/94)

Assumptions about current law coverage

(1) Apply EBRI's income distribution of the uninsured (from the March 1993 CPS) to CBO's 1999 number of uninsured (40.4 million). After adjusting for population growth between 1993 and 1999 in the EBRI estimate, the totals are very similar. Rounding to one decimal, the percent of the nonelderly population that is uninsured is identical (17.4%).

(2) The percent of the nonelderly population with other types of coverage by income also come from EBRI. Counts are adjusted for population growth.

Assumptions about premiums (actuarial value = 92% of HSA)

(1) Start with the 1994 CBO per-capita premium for the HSA ($1774).

(2) Apply CPI growth (about 3% a year) to OMB's Chafee premium path factor for 1999 (1.1556). The per-capita premium in 1999 is $2364.

Assumptions about take-up rates

(1) Assume that 73% of the uninsured with free coverage (the poor) will apply for subsidies.

(2) Also assume that 73% of those with private insurance that is not through an employer who are eligible for subsidies will apply (regardless of the amount of the subsidy).

(3) For those uninsured who qualify for subsidized, but not free coverage, calculate the share of income that a single person would pay and apply the Lewin take-up rates. For categories of income, these calculations are made at the mid-point of the income interval (rather than the endpoint).

(4) For those with employer-sponsored insurance who qualify for subsidies, assume that a maximum of 73% would switch to subsidized individual coverage and apply for subsidies. When the proportion with employer-sponsored insurance who are eligible for subsidies is small in proportion to the total (the case with subsidies only up to 150% of poverty), only 50% of eligibles are assumed to switch to subsidized coverage. The difference between 73% and 50% is phased out linearly with the proportion of those currently holding employer-sponsored coverage who are eligible

for subsidies under the different schemes.

The presumption here is that employers are subject to all-or-nothing rules, so not every employee who'd like to drop employer coverage can.

I am also assuming that individuals get the tax break that is now available to employers--so eligible workers are always better off with the subsidy than staying with their employers, and upper-income workers don't lose much (except the advantage of experience rating) if the employer increases everyone's wages and drops the plan.

Other notes/comments

(1) Current Medicaid recipients are entirely left out of the calculations. In particular, the cost of premium subsidies for current Medicaid recipients is not included in the total.

(2) Only changes in coverage that are attributable to the subsidy scheme are considered. Insurance reforms alone might encourage some additional enrollment among upper income groups who are eligible for the subsidies.

(3) If a lot of employers do drop their plans as the proportion of insured workers who are eligible for subsidies increases, some of their covered employees may not purchase insurance on an individual basis. This would contribute to an offsetting decline in coverage that is not considered in the estimates.

(4) Comparison to CBO: The estimates for subsidies going up to 200% of poverty should be similar to CBO's estimate for Cooper (except for the difference in the benefit package). CBO's estimate of non-Medicare premium subsidies for Cooper in 1999 is $113 billion. This figure includes all of Medicaid, so subtract the number of Medicaid recipients (24 million, after 2 million who have to pay premiums under Cooper drop out according to CBO) and multiply by the per-capita premium ($2364 inflated by 8% to adjust for the benefit package) to get an estimate of premium subsidies for Medicaid ($61 billion). Subtracting $61 from $113, subsidies in the CBO estimate for the non-Medicaid population are about $52 billion. Ninety-two percent of that figure (adjusting for the benefit package) is $48 billion. The estimate, shown here, using the methodology described above, is $48.6 billion.

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Department of Justice

CHRIS
Bob Brink asked for clearance. This statement is IDENTICAL to that previously cleared + given by Hubbell before Energy + Commerce. Any reason not to clear? Bob is anxious to get statement to Finance
thanks
Bob
(5-4871)

STATEMENT OF

WILLIAM C. BRYSON

ACTING ASSOCIATE ATTORNEY GENERAL

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

CONCERNING

MEDICAL MALPRACTICE ISSUES IN HEALTH CARE REFORM

PRESENTED ON

MAY 12, 1994

* I cleared this to Bob Brink yesterday (5/19) -- checked with Jennifer.

Bob

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I am pleased to submit this testimony regarding the Health Security Act and the Administration's proposals relating to medical malpractice reform. The President is grateful for the priority you have given this legislation. Every member of this Administration stands ready and willing to assist you and your colleagues, so that we may realize the prompt enactment of this historic proposal by the Congress.

The President's health care reform plan is the most detailed and comprehensive health care reform proposal ever offered. As with other parts of the plan, the President has committed his views to legislation, and my testimony is part of a continuing dialogue on those views.

There are many things wrong with the medical malpractice system as we know it today. Some who are injured are perceived to be overcompensated; others are undercompensated or shut out of the system altogether. There is little empirical evidence that the malpractice system deters substandard care or promotes the practice of quality medicine. We all know that the civil litigation system can be inefficient and expensive. We know that doctors practice defensive medicine which, at least in part, is related to malpractice litigation. While the costs may be hard

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to quantify, we do know that such practices have contributed to the soaring costs of our national health care bill.

The President's proposal attempts to address the problems with the current malpractice system, while recognizing that medical malpractice litigation is a fundamental aspect of basic state tort law and jurisprudence. We know that virtually every state has adopted specific malpractice reforms since the malpractice liability insurance crises of the 1970's and 1980's. Each of those reforms has been tailored to the unique circumstances of the respective state court and civil justice system involved. We strongly believe that medical malpractice cases should continue to be litigated primarily in the state courts and that medical malpractice reform should respect the fundamental nature of state practice and procedure.

Before I describe the specific reforms contained in the Health Security Act, I want to refer to the conclusions of several of the best studies of medical malpractice. Some of these are probably familiar to you, but they are worth repeating. However, one of the frustrations about this whole issue is the lack of good empirical data to guide our deliberations. For a problem of this importance, the scarcity of reliable research data is astonishing. I am hopeful that we might address the need for top-quality empirical research through this legislation and an increased emphasis on federal funding for such research.

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The Harvard Medical Practice Study of hospital discharges in New York in the mid-1980's found that 3.7% of all people discharged from the hospital suffered adverse medical events. Over 25% of those, or 1% of discharges overall, were due to provider negligence.

Only one out of eight patients injured as a result of negligence filed a malpractice claim, and only one out of sixteen received any compensation from the tort system.

In New York, the average delay between initial claim and eventual payment was six years, and over ten years for the more serious injuries.

A different study found that many injured parties are frequently undercompensated, particularly those suffering permanent, serious injuries. Because payment typically comes so long after injury, funds for early rehabilitation are not available.

For every patient who does not receive fair compensation, there is a doctor who feels financially threatened by potential lawsuits, the unpredictability of jury verdicts, and high liability insurance premiums. In one major study, over 80% of patients who filed suits had not in fact been negligently injured. Physicians view the malpractice system as haphazard,

unpredictable, and personally traumatic, exposing them to the attendant costs and delays of our troubled civil justice system.

Striking the proper balance of competing concerns in this environment is not an easy task. There is no simple solution. There are strongly held views on all sides, and some truth on all sides.

The President's proposal provides two new mechanisms for a more sensible and cost-effective approach to resolving medical malpractice disputes. First, it encourages consumers and providers to settle malpractice claims outside of court. Every health plan will be required to develop and have in place at least one alternative dispute resolution mechanism, and every claim against a doctor or other provider must first be referred for alternative dispute resolution before it can be litigated.

While ADR is not binding, meaning that consumers dissatisfied with the outcome can go to court, it is mandatory. Attempting to settle malpractice claims before they get to court has rewards for both patients and providers. Parties suffering real injuries will be compensated sooner and claimants with smaller claims will have increased access to a dispute resolution mechanism. The plan administrators will be aware of those providers with a track record of claims against them, and

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physicians may be spared the expense and distraction of defending groundless claims.

Second, the Health Security Act provides that the National Practitioner Data Bank will make available to the public the names of practitioners who have a pattern of malpractice payouts or sanctions. Under the Health Care Quality Improvement Act, malpractice payouts and sanctions are reported to the National Practitioner Data Bank and are made available to states or accrediting bodies, but not to the general public.

For the first time, the names of licensed health care practitioners with repeated numbers of malpractice payments or sanctions will be available to the public. Combined with the quality measures in the proposal, the public can make more informed choices about the practitioners they choose. With adequate information, consumers can improve the quality of the health care they receive by their choice of practitioners.

The Health Security Act also contains certain proposed reforms to discourage the filing of frivolous lawsuits and to provide fair, uniform national rules for malpractice awards.

First, the proposed Act limits the amount of a lawyer's fee to no more than one-third of the amount recovered in a malpractice case. However, states may impose lower limits.

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While some have challenged this proposal as unfair to plaintiffs' trial lawyers, it is a change which has already been implemented in some form in the majority of states. In fact, the Federal Tort Claims Act, under which medical malpractice suits are brought against federally-employed health care providers, establishes even lower attorneys' fee limits.

Second, under the Administration's proposal, before a lawyer can file a medical malpractice lawsuit, he or she has to first consult a qualified medical specialist, and prepare an affidavit including a written report by the medical specialist. The written report must contain the specialist's determination that the specialist has reviewed the medical records, and believes there is a "reasonable and meritorious" claim. Courts can impose sanctions against a plaintiff or attorney for affidavits submitted without reasonable cause.

Third, double recoveries are eliminated by abolishing the collateral source rule in both federal and state medical malpractice cases. The proposal reduces the amount of recovery by any amount recovered from another source, such as private disability insurance. Again, this is simple fairness. If a health plan already provides for the health coverage needed by an injured patient, there is no reason that a malpractice award should include this amount.

DRAFT

Fourth, the proposal allows either party to request that an award be paid periodically rather than in a lump sum. The judge would determine the schedule based on the needs of the injured party. This proposal, which is consistent with the recommendations of the National Conference of Commissioners on Uniform State Laws, is important for both injured parties and defendants so that damages will compensate people at the time they need the money.

Over the past months, we have examined many different options. I know that distinguished Members of the Committee may have different ways of addressing the same problems we have identified. We hope to discuss how best to accomplish our common goal.

One of the issues that has been debated is consideration of caps on damages in malpractice cases. Many urge that a limit be placed on non-economic damages, such as pain and suffering.

We have examined that issue in detail, and heard every opinion. It was decided not to recommend caps on damages, and let me explain briefly why that decision was made. First, we have designed a series of changes intended to address specific problems with the malpractice system. If we address the problems of frivolous lawsuits and the lack of effective quality measures,

DRAFT

and if we place limits on double recoveries, there is no reason to place arbitrary limits on damages.

Second, as I mentioned earlier, studies have shown, and it is obvious, that those affected by caps on damages are those most severely injured who are likely to get large awards. It is those same individuals who need the money to allow them to get on with their lives. No one wants to tell persons who have been severely injured through the negligence of others that they will not get compensation because there is an arbitrary limit, and that they are simply out of luck.

Third, the states have enacted various limits on damages, and a few states have even held a cap on damages to be unconstitutional under their respective state Constitutions. It would disrupt those state initiatives to impose limits at the federal level. The state limits vary widely. For example, California has a cap on non-economic damages of $250,000; Indiana has an overall limit of $750,000 for all damages.

The Health Security Act attempts to strike a balance between the needs of those who are injured and those working diligently to provide high quality health care. We believe we have done that. We recognize that this is a controversial area, with strongly held views on all sides.

DRAFT

Let me also add that the problems of the medical malpractice system are exemplary of the many difficulties confronting our civil justice system at both the state and federal levels. The Justice Department has undertaken a major access to justice study, aimed at reducing the costs and delays of civil litigation, increasing access to our justice system for all litigants, and restoring public confidence in a system which is fundamental to our concepts of law and liberty. I am hopeful that we will soon formulate proposals that will address the problems inherent in medical malpractice and other kinds of civil litigation.

I appreciate the opportunity to discuss our views and I look forward to working with all of the Members of this Committee in the months ahead as we move forward in our historic effort to guarantee health security for all Americans.