

THE INSTABILITY OF HEALTH COVERAGE IN AMERICA

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED TENTH CONGRESS SECOND SESSION

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THE INSTABILITY OF HEALTH COVERAGE IN AMERICA

TUESDAY, APRIL 15, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m. in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee) presiding.
[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 08, 2008
HL-23

CONTACT: (202) 225-3943

The Instability of Health Coverage in America

House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) announced today that the Subcommittee on Health will hold a hearing on the instability of health coverage in America. **The hearing will take place at 10:00 a.m. on Tuesday, April 15, 2008, in the main committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

There are nearly 47 million uninsured people in this country and their ranks have been growing rapidly in recent years. Those without health insurance have worse health outcomes than those with insurance, often pay more out-of-pocket for services when they do seek care, and increase costs to the entire health care system. Additionally, there are millions of people who have private health insurance but have trouble affording and accessing care.

The inadequacy of current coverage options forces many people to forgo needed medical care because of the costs associated with seeking care. A 2005 study by *The Commonwealth Fund*¹ estimated that nearly 16 million non-elderly individuals (12 percent of the insured population) were “underinsured” in 2003. Despite the fact that they have insurance coverage, underinsured individuals can be exposed to significant out-of-pocket costs in the form of higher premiums, deductibles and co-pays relative to more adequately insured individuals. They also can have trouble accessing doctors, obtaining prescription drugs and getting their insurance to pay for needed care because the insurance that they can afford does not cover the treatment that they need.

In announcing the hearing Chairman Stark said, **“America’s health system is broken. Every year more and more people join the ranks of the uninsured. Even those who have insurance are discovering the inadequacy of their coverage, all the while their premiums and cost sharing continue to rise. I am pleased to hold this hearing. It is important we understand the problems of today’s system as we prepare to embark on health care reform.”**

FOCUS OF THE HEARING:

The hearing will focus on the instability of health coverage in America, examining the problems facing those with and without health insurance.

¹ http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=280812.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "110th Congress" from the menu entitled, "Committee Hearings" (<http://waysandmeans.house.gov/Hearings.asp?congress=118>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Follow the online instructions, completing all informational forms and clicking "submit". Attach your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, April 29, 2008**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*Chairman STARK. The Subcommittee will begin its hearing, and the Chairman will make outstanding introductory remarks, if he can find them.

Thank you for attending today and I hope to be brief.

We are going to depart a little from our standard procedure. We'll show a short video that deals with the issues many Americans who are uninsured and are underinsured are facing. We know that there's a lot of discussion in the campaign and in the press, and everywhere else, about healthcare reform.

It's been some years since the last large attempt at system-wide reform and the failure to be able to come to a conclusion with it. In this election year, candidates on all sides are talking about healthcare with different approaches and philosophies, but I think each candidate recognizes that there have to be some changes in the system of delivery of medical care.

The number of uninsured is increasing. Middle class Americans are having trouble paying their premiums, paying their cost-sharing. They just announced the other day they're going to charge us more for expensive drugs; and, we all know, I think, that the medical care delivery system is in need of change; and, before we rush into solutions, I think we should develop an understanding of where we are. What is the problem? Can we identify the problem we are trying to fix?

Hopefully, Mr. Camp and I can come to some kind of agreement on that. We may not agree on what the fix ought to be, but hopefully, we don't have to argue about what the problem is, and that's the purpose of today's hearing.

I'd like to defer on mentioning our first witness for a moment, but after we do hear from our first witness, we will hear from a panel of witnesses who will describe the instability of health coverage and the availability. After a second, I am going to recognize Mr. Camp. We will then go off the record and view a ten- or twelve-minute clip that comes out of a sixty-minute program in February; and, it features the work of one of the witnesses that we will hear from later today.

I want to thank the witnesses and my colleagues for being here as we try to lay some groundwork for what may face us in the coming months and years ahead.

Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. I want to thank our witnesses for being here today as well. The laws and regulations governing the U.S. health system can prevent from between 25 to 45 million Americans from having health insurance, and that's wrong. Every American should have access to quality healthcare.

Before we can solve the problem, we need to ask why so many Americans lack health insurance. One of the most immediate causes has to be the skyrocketing cost of healthcare and health insurance. Since 2000, employer-based insurance premiums have increased by about 100 percent, and that's four times the rate of inflation. These spiraling costs are driving increasing numbers of employers to drop health insurance coverage for their employees. At the same time, over-regulated state insurance markets are failing to provide affordable health insurance for many American families.

We also need to identify who is uninsured. Approximately two-thirds of the uninsured are in families with incomes below 200 percent of poverty, or about \$40,000 a year. In the current, difficult, economic times, it shouldn't come as a surprise that these individuals do not have the resources to purchase private health insurance. That does not mean, however, that they cannot have private health insurance. Every uninsured person in this country shares one common characteristic: they receive no assistance under the Federal Tax Code to help them purchase health insurance.

At the same time that costs for health insurance are soaring, our Tax Code affirmatively discriminates against the uninsured. If we were to simply equalize the tax subsidies that we provide, millions more Americans would be able to get health insurance.

The generosity of the American taxpayer should not only go to those with employer-purchased health insurance, it should apply to individuals, small businesses, and large corporations alike. To do that, we must make sure those Americans who already have insurance keep it, and we must help those who don't have coverage get it.

I want to thank Mr. Stark for calling this hearing to give us all the opportunity to examine this issue. I hope that in exploring this issue, we can begin to identify solutions to reducing the number of uninsured without further burdening existing entitlement programs that are already facing insolvency.

Thank you, Mr. Chairman, and I yield back.

[The prepared statement of Mr. Camp follows:]

**Hearing on the Instability of Health Coverage in America
Opening Statement of Subcommittee Ranking Member Dave Camp
April 15, 2008**

The laws and regulations governing the U.S. health care system prevent anywhere from 25 to 45 million Americans from having health insurance. That is wrong. Every American should have access to quality healthcare.

Before we can solve this problem, we need to ask why so many Americans lack health insurance. One of the most immediate causes has to be the skyrocketing costs of health care and health insurance. Since 2000, employer based health insurance premiums have increased by approximately 100 percent, or four times the rate of inflation.

These spiraling costs are driving increasing numbers of employers to drop health insurance coverage for their employees. At the same time, over-regulated state insurance markets are failing to provide affordable health insurance for many American families.

We also need to identify who is uninsured. Approximately two-thirds of the uninsured are in families with incomes below 200 percent of poverty, or about \$40,000 per year.

In the current difficult economic times, it should hardly come as a surprise to anyone that these individuals do not have the resources to purchase private health insurance. That does not mean, however, that these individuals cannot have private health insurance.

Every uninsured person in this country shares one common characteristic – they receive no assistance under the federal tax code to help them purchase health insurance. At the same time that costs for health insurance are soaring, our tax code affirmatively discriminates against the uninsured. If we were simply to equalize the tax subsidies that we provide, millions of more Americans would be able to get health insurance.

The generosity of the American taxpayers should not go only to those with employer purchased health insurance; it should apply to individuals, small businesses and large corporations alike. To do that, we must make sure those Americans who already have insurance keep it and we must help those who don't have coverage get it.

I appreciate Chairman Stark for calling this hearing to give us all the opportunity to examine this issue. I hope that in exploring this issue, we can begin to identify solutions to reducing the number of the uninsured without further burdening existing entitlement programs that are already facing insolvency.

Thank you Mr. Chairman, I yield back my time.

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*Chairman STARK. Well, as the Committee knows, when it comes to introducing witnesses we draw straws; and, this morning, Mr. Ramstad, our colleague from Minneapolis drew the short straw, and I'd like to recognize him at this point.

Mr. RAMSTAD. Well, thank you very much, Mr. Chairman, and I'm very pleased today that our Subcommittee will hear from one

of our country's most respected leaders in healthcare policy, former Minnesota Senator, Dave Durenberger.

I would also like to recognize another distinguished Minnesotan in the audience, Hennepin County Commissioner, Randy Johnson, who at the county level has worked long and hard on extending access to healthcare for Hennepin County residents.

My good friend, Dave Durenberger, served as Minnesota Senior Senator from 1978 to his retirement in 1995. In the Senate he was highly respected for his mastery of healthcare policy and his ability to work with people from both sides of the aisle to find solutions. He brought some of Minnesota's most innovative and successful ideas to Washington.

Dave Durenberger served on the two Senate Committees with jurisdiction over health policy, the Finance Committee and Labor Committee, and also chaired the Finance Health Subcommittee. Senator Durenberger left his mark on every major piece of healthcare legislation through the 1980s and into the 90s. He also authored "Prescription for Change," a book on healthcare reform through consumer choice.

Since his retirement, I know firsthand, Senator Durenberger has not slowed down one iota. In addition to teaching graduate-level courses in health policy, and I understand his graduate students from St. Thomas University are here today with him, he formed the National Institute on Health Policy, a joint effort between the University of St. Thomas and the University of Minnesota.

Senator Durenberger also started the Medical Technology Leadership Forum, and also serves on the Medicare Payment Advisory Commission. Of course, most significant to me personally, Senator Dave Durenberger has been a close friend, mentor, confidant for 30 years.

We would be here all day if I listed all of Dave Durenberger's credentials, but let me just say I deeply appreciated your expertise, David, and your friendship over the years. This Subcommittee certainly looks forward to your testimony. We appreciate your collaboration on what I believe is one of America's most pressing problems. Thank you again for being here, and thank you to all the witnesses.

I yield back, Mr. Chairman, thank you.

*Chairman STARK. Thank you, and I'd like to join you.

It is my pleasure to welcome Dave here. He and I worked together since, I guess, 1985, on issues with Medicare and other issues on healthcare and look forward to your testimony, following which we will view the video.

Go ahead and enlighten us.

*Mr. DURENBERGER. Thank you, Mr. Chairman, Mr. Camp, Members of the Committee, but especially Jim Ramstad, because as Jim said he has been a very close friend for a long period of time. I had mixed feelings when Jim announced that he was retiring, as many of you had too. On the one hand, I was happy for him. On the other hand, I was unhappy for the rest of you, because of the contribution that he has made to not just good health policy, but a good policy in so, so many ways.

Each of us is reflective in a way of the people that we represented, the places we were raised, how we were educated, and so

forth. Jim did this better than most people. As I see from some of the people that I know here like Mr. Camp and his part of Michigan, and Mr. Kind and his part of Wisconsin, we much more alike than we differ.

That certainly is true of health policy as well. It was an honor for me to serve Minnesota for three terms in the Senate. It was always a challenge, I must say, to go to conference near the end of each of those 16 years with the chair of this Subcommittee and the chair of the energy and Commerce Committee, because they always insisted on winning. I'm really honored, Mr. Chairman, to have been asked to testify here today.

I do so in the spirit that for most of those years characterized our relationships and our effort to make national health policy; and, particularly, to improve the health system of this country by changing the financing incentives for providers in the Medicare Program. One of the things you learn fairly early on in this process is we don't have a national health system; and, Mr. Camp alluded to that, I think, in his comment.

But, what we do have, because we know this from our personal experiences in the communities we represent, we have a series of systems and the work at Dartmouth explains that to us quite clearly. But my job is not to talk to you about the health system or the specific challenge of the uninsured. I was asked to reflect on my experience in doing health policy. First, let me say that not since the Presidential campaign 1992 have Americans been as concerned about their financial well-being as they are this year.

Most Americans know they can't afford the rapid rise of health insurance premiums, especially when it is currently accompanied by the escalation and the cost of so many other of their basic needs; so it's a big challenge. But it isn't just health policy; and, you know this better than I. Public opinion polls reflect this in strong support for proposals to guarantee access for all, the health and medical services for all Americans through some system of health insurance.

But, clearly, the same polls will tell you that there's no consensus on how to do it as both of you have pointed out. The debate, as it always has been, is between universal coverage and cost containment; and, it's also between social insurance systems and private insurance. For example, Senator Clinton advocates a universal coverage path that can utilize a form of what we might call Medicare for persons under 65.

Senator Obama, same party, advocates using the model of the Federal employee health benefits plan. Senator McCain advocates cost containment through greater tax subsidies for private, major medical insurance. Interestingly, each advocates similar cost containment measures through realigning financial incentives to produce better quality, outcomes, effectiveness and efficiency from the delivery system. Similar battles, as we know only too well, are being waged at the state level—in part, coverage; in part, quality and value.

So it has always been. Unfortunately, critics of the Democratic proposals characterize them as socialized medicine; and, critics of the Republican proposal criticize them as doing nothing to meet the

issue of affordability which was driving up the numbers of uninsured and underinsured. That will probably get us nowhere.

As policymakers, we have always followed a two-path course to universal coverage. It is most obvious in the Medicare Program, where we have been making most national health insurance policy, since I became active in health policy reform in the early 1970s. We have used both social insurance and private insurance in our financing policy changes, aiming ourselves at expanding access coverage and cost containment. The test for high value health insurance is how well it does for people when they are sick, seriously injured, or chronically ill. It's the 80-20 problem.

Twenty percent of the people present us with 80 plus percent of the cost challenge. So the real test, choosing an insurance course to universal coverage is how well does the plan do in that regard. How many benefits a plan has or how little people use a deductible is not the measure. The value test for both social insurance and private insurance is how well each does to consistently pay for quality, for outcomes, for effectiveness, and for efficiency.

That has been our challenge since I started doing this sort of thing. How do you move both social and private insurance in that direction? For example, the Federal F benefit plan has always been a model for consumer choice of private health plans, and the impact of that choice was important in creating health insurance competition, community by community, using Federal employees and retirees to accomplish that.

My first health legislation proposal was the Consumer Choice Health Plan of 1979, when some of you were born, probably. The purpose of it was to require choices similar to the HBP in the private employment in exchange for the employer tax subsidy.

So, Medicare always used private insurance: first in its benefit design and its implementation through Blue Cross/Blue Shield carriers and intermediaries, and then, on my watch in cost have HMOs, and in a major national test of HMO, in HMO risk contracting starting in 1985. These were hugely successful in areas of the country where they were tried and where medical practice in relations with community and state-based health insurance guaranteed their success.

For example, in our part of the country which always brags about being the low cost area, we were one of the high cost areas. We were in the upper quartile in the Hennepin County, St. Paul area, and in North Dakota and places like that. Within two and a half years of the start of this experiment with private HMOs, we went to the bottom quartile; and, unfortunately, we're still there; principally because we didn't share there savings.

We in the Medicare Program did not share the savings with the people that made them possible, who are the physicians, the hospitals, and the local health plans. The rest of the country chose to follow the path of hospital DRGs which we instituted at the same time, but on another vehicle. By 1989, of necessity we adopted the prospect we payment system to physician position payment and created lots of other problems, none of which I endorse that you repeat.

The mistake we made, of course, was not to leaving more of the financial savings, for changing the overuse of medical services with

the care professionals, and the hospitals, and the plans that were responsible for doing it. The mistake the medical industry made was to take these community-based examples of physician-hospital cooperation national, and to take the local managed care organization national as well.

For example, United Health Group in our own community became the largest health insurer in the country through merger and acquisition of lots of local HMOs all over America. Likewise, Wellpoint became the largest insurer in the country through the conversion of lots of local and state blues plans to for-profits, and their subsequent merger and acquisition. This new national private insurance phenomenon was very successful for a while in driving down healthcare costs, and their premiums and profits made them Wall Street darling.

But, by the end of the 1990s, the same plans were in national industry playing by either state rules or no rules in the employer self-insured market because of ERISA. Congress in 1997 authorized private plans to do what markets are supposed to do, determine through price competition for basic benefits, what's the real cost of a basic set of medical services in a community-by-community across the country.

The industry refused to play. The managed care industry, slowly but surely, adopted itself to the realities of consumer demand for freedom of choice, access, innovation and expectations. This is unfortunate. They did that particularly in areas in which physician groups and hospitals had the power to make sure that sort of thing happened. So, in effect, we've lost some of the benefit and the potential that exists in private insurance. That's the point I'd like to make. Not that it's wrong—it's very right—it's been our course from the beginning. The question is what are we trying to achieve?

At the Medicare Payment Advisory Commission, on which I served until last week, we simply asked the public policy question that Members of Congress like me have been asking since 1982 when Senator John Hines put the privatization amendment on the tougher risk contract. If traditional Medicare is less effective in achieving performance improvement than private insurance, then how do we structure the value proposition in the relationship between Medicare and private health insurance?

Paying financial bonuses to Medicare Advantage Insurance plans for simply adding service benefits to the Medicare Program is probably something you could do as a congress. But it's not the right thing to do without clear evidence that those services have value added over existing insured services, this makes us to issues around comparative effectiveness, which I won't dwell on, because you've heard plenty of that.

So, let me conclude by saying there are many reasons why universal coverage is important. Many of them relate to the vastly improved economics of reducing or eliminating cross-subsidies from paying to non-paying services in hospitals especially. I have now lived long enough with the consequences of our National failures to secure financial access to needed healthcare services for all Americans that I believe a commitment of the next president to this goal is important to my vote. I do not believe it is possible in a Federal

system for each of the 50 states to accomplish this goal on their own. Their fiscal capacity, their populations are just too disparate.

This is a matter of income security policy for the nation of which we are all citizens. We have no income security policy and we have a bunch of aging entitlement programs, and Mr. Camp pointed this out. We have a bunch of aging entitlement programs, which are bending and sometimes breaking under the weight of population health and aging and the cost of medical technology and providers.

It would be an appropriate challenge for this Committee, the full Committee, to take the lead in going beyond reforming programs that were enacted in the 1930s for the 30s and the 60s for the 60s in developing an income security policy in this country. A good place to start would be as we recommended in the Pepper Commission, get long-term care out of the welfare program and convert it into a combination social and private insurance program. That would make your challenges a lot more simple.

I have no reason to believe that as Republicans or Democrats we have much disagreement about the need to agree quickly on how to do the work of data gathering, measuring performance, motivating better outcomes, and rewarding the first-rate performers in the business of an informed consumer in as many communities as possible. I am also pleased to have been afforded this opportunity.

Much is expected of each of you in an area that is too complex to be understood by any one of you, but challenging circumstances always bring out the best. I hope that I may continue to serve whatever interest you may take in health coverage and reform.

*Chairman STARK. Thank you, Senator. Dave, thank you very much. As you know, you and I have a great difference in this problem of the underpayment of the Minnesota, North Dakota Wisconsin area, representing a district that is drastically in your opinion overpaid. I've always said, swell, let's just cut the payments to California down to the level that we're paying in Minnesota and think of all the money we'll save.

I'm not so sure that that's the most popular approach to this solution in your part of the country, and it sure wouldn't be very popular in mine. But it occurs to me that that's one way to do it. I just want to ask one question, and that is one of the issues that we are going to be faced with—and I'm not sure any of us as yet have an answer in the reimbursement program for physician services—is what we do about volume. I'm sure that in redesigning that system as I think we all agree it must be redesigned.

We are going to have to deal with that issue, and my question is will you come back and help us with it?

*Mr. DURENBERGER. Well, I'd be glad to, and I'm going to connect the two, just very, very briefly. The disparities exist in payment across the country, but it is largely because there are disparities in performance, and whether you look in Mr. Camp's district, or you look in my district, or you look at La Crosse, Wisconsin.

By the way, Congressman Kind is a doctor from Gunderson out here in the MBA class as well. If you compare measurable, quality outcomes performance for the dollars that are spent in your district, in his district, in my district, and so forth, it is a bargain for the rest of the country. But it's also a model for the rest of the country to be followed. Unless you can design a payment system

that begins to reward high performance in some way appropriately, we are going to continue to have these problems. The key to that is physician payment reform.

We've talked about accountable care organizations. We talk about bundling. We talk about a variety of approaches, and I would be happy to come back and be helpful.

*Chairman STARK. Look forward to it.

Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman, and thank you, Senator Durenberger.

*Mr. DURENBERGER. You are welcome.

Mr. CAMP. You made a number of good points.

I appreciate you outlining really sort of the background on Medicare that it always has had a private insurance component to it. Tell me, what do you think of some of the proposals that have been introduced either in the Senate or the House that are attempting to use the Tax Code, either a tax credit or a tax deduction, or a combination thereof to really create an individual insurance market.

Tell me, and also what you might think about the question of mandates, if you have time.

*Mr. DURENBERGER. I'll again try to be brief. Number one, we just had the benefit yesterday of having both Ron White and Bob Bennett speak to our class. So, I'm fresh from the ideas that are out there.

First, with regard to the proposal for the tax subsidy, they have this increase. Everybody pays, like \$10,000, and then make them pay with their insurance. That, like President Bush's proposal, has been needed for the 35 years that I've been involved with this. It's the question of getting from here to there that is always the challenge. So, I think on the appropriateness of the tax subsidy for individuals, that is so much better than any other approach that has been taken.

The challenge, I think, in this concept that we can blend the universal coverage of the Democrats with the market ideas of the Republicans is whether have real markets. I will start with something simple, like insurance.

You will not have real markets in health insurance until you have national rules by which all health plans have to pay. The idea that we should just stay with 50-state regulation and you can go shopping around the country for a good deal just will not work. It won't protect consumers. But the idea of having a set of national rules by which both national and state plans can truly compete is really a great idea, and that's been presented as value-based benefits. It's been presented as a guaranteed issue and renewal, and some of the other things that I know that this Committee is familiar with, but I think that is critical to getting the best out of private insurance.

After that, the issue becomes the same with regard to doctors and hospitals and we talked about that in terms of what's quality, what's good outcome, how do you measure it, how do you get consensus, and a lot of progress is being made on that. But, again, and like the secretary's ideas on value exchanges and things like that,

focusing on local communities and finding out who are the people that are already ahead of the curve is critically important.

When you get the market working, you've got all the information you need. People are informed and they are getting their information from reliable sources. They've curbed their own expectations about having the sun and the moon and the stars and everything else. Then the only way a national system works most effectively is through everyone having an ownership of that insurance. Long term care insurance, as we've analyzed many times, is basically supportive services for elderly people. If we were able to sell disability insurance to everybody in this country when they were young, you know, you wouldn't have to worry about meeting long-term care insurance, because people can use it at various times through this system. Same thing applies to health insurance.

Mr. CAMP. Just quickly before my time, what do you think of the individual mandate, some proposals think that's essential. Others don't.

*Mr. DURENBERGER. Yeah, again, you have to tie it together with the insurance reform in my book before you even consider it. You also have to tie it together with some other reforms. I think in the end at some point you are going to need it. I would not start with an individual mandate on whether it's at the state level or the Federal level.

There are other ways, I think, to explore the problem that's created by freeloaders or whatever the economists call it, the free somebody or others on the system.

Mr. CAMP. All right. Thank you very much.

*Mr. DURENBERGER. You are welcome.

*Chairman STARK. Mr. Doggett, would you like to inquire?

Mr. DOGETT. Thank you very much for your testimony.

Does any other country provide us a model of any aspect of what we should be striving for here, or is our predicament so unique that we have to strike out on our own?

*Mr. DURENBERGER. The policy models have been tried in one form or another, although we've had some discussion about what's the appropriate policy model to get from here to there.

One of the challenges that you face as a Subcommittee and the larger Committee on Ways and Means is there's already by most people's assumptions a lot of money in the system, and a lot of it is being spent on tax subsidies that are not doing. I mean, they are benefiting wealthy people rather than lower income people. However, you might consider this. Long term care going into a welfare system rather than being in it's an insurable event and we ought to be having insurance for it.

There's all kinds of money out there, the inside buildup on tax subsidized savings and things like that, so there's plenty of money in the system, but there's no policy to guide you as a Committee. There's no policy to guide you to get from here to there, which is why I made the argument about income security. Thinking about it as income security policy, and I know along time ago, I think it was the 25th anniversary of Medicare or something, I made the statement that Medicare and Medicaid are not health programs. They aren't. They are income security programs.

If you think about that long enough, you realize we've got this whole series of programs built for various purposes at various times that are not working today for the benefit of the people that need them the most. That is an enormous challenge for you in terms of cost reduction or cost containment. Let's take Medicare Advantage, because I just heard this yesterday from Abbey Block who runs the Medicare Advantage program at CMS.

She didn't know there was going to be somebody in the audience from La Crosse, Wisconsin, so she says the difference in the value to a Medicare beneficiary in Dade County, Florida, and the amount of money that you are spending on her services in Miami, Florida, versus La Crosse, Wisconsin, and this is what I heard from her, is 248 percent. More money being spent on the same beneficiary in Dade County for no reason, you know, other than part of the policy design and the practice design.

Mr. DOGGETT. I certainly agree with you that these tax credits by their very nature are very blunt instruments and they are very costly for what they produced. They are not the most efficient way, sometimes, of getting health coverage where we need it, and I certainly concur in your comments about how costly some of them are for what they produce.

Do you believe that it's possible for some type of government insurance program to co-exist with private insurance to address this problem?

*Mr. DURENBERGER. It does now to the potential advantage of both. This is America. We're a pluralistic society and we ought to build on that and that's why I made the point, that we've always followed two paths. The question is have you set the goals correctly?

I mean, is the goal to be paying for the sick, the severely injured?

I mean is that the purpose of insurance?

Also, is part of the purpose of insurance to facilitate the rewards for quality outcomes and efficiency and things like that?

So, if you set the policy goals right, there might be some circumstances, some populations, for which social insurance works much better and others for which private insurance works better.

Mr. DOGGETT. Thank you so much.

*Mr. DURENBERGER. Thank you, Lloyd.

*Chairman STARK. Mr. Thompson? You pass?

I think Ms. Tubbs Jones. Would you like to inquire?

Ms. TUBBS JONES. Thank you Mr. Chairman.

Good morning, Senator. I don't think I have ever had the chance to meet you, and it is my pleasure.

*Mr. DURENBERGER. It has been my pleasure.

Ms. TUBBS JONES. I would like to focus for a moment and ask you about healthcare disparities.

Today, the Congressional Black Caucus is hosting their annual healthcare disparity conference at a hotel here in Washington, D.C., and I had to choose between which I could attend. So, I decided to be here with you. I wondered that in the work that you have done around healthcare, have you had any focus in on health disparities as it involves the delivery of healthcare to minorities and majority. If so, what your experience has been and what your recommendation would be to this Committee as we walk down the

road of trying to repair the healthcare delivery system in this country.

*Mr. DURENBERGER. Thank you very much for the question, and I will give you two brief reactions.

There are communities in this country where because of state efforts to provide universal coverage. Mine is one. You have heard about Massachusetts. You can see a group of states in this country that have gone the extra mile to finance access for as close to 100 percent of their population as you possibly can; and, so, in varying ways we, have relied traditionally on the states to provide the initiative for financing access for people who are disadvantaged by income, by education, for whatever reason. Those states are on most charts of health, access and so forth are going to be ahead of states that have taken different courses, and have not chosen either through the way they practice healthcare deliver or the way they organize their systems or the way they finance them to accomplish it.

One of the ways you can consider to broaden access to the financial insurance side of this, of course, is to think about it in terms of income related subsidies for either private insurance or for some other form of access. The transition to getting from here to there would involve taking long-term care out of Medicaid particular thing. But, the second, and maybe more important comment to make, is about a hearing on cultural and other disparities, economic and other disparities today.

That same discussion is taking place in every community in this country, and the link that organized medicine broke between public health and medicine 80 years ago is now being reattached in many of our communities. In Texas, for example, I can point to Parkland Hospital in Dallas and some of the leadership there to involve the communities. When the legislature is unwilling to provide the financing of access, the leadership at that very public, very challenged hospital, is out in the community, reaching out to the gang leaders and other leaders to try to bring the community into the delivery system.

One of the values of not-for-profit hospitals is the community benefit tax exemption for contributing to bringing in the access, not just through insurance, but access to services. It is happening in many communities around this country and it is a wonderful thing that it's happening. We reconnect public health, personal responsibility and, you know, the insurance programs for medical care services and fostering that in some appropriate way.

Ms. TUBBS JONES. Thank you.

I would just put on the record another question about how do we increase the availability of healthcare delivery personnel, nursing being one of the huge things that one of the areas professions that we were in such deep need for. One idea is that you don't have time to give me the answer today, but I would be interested in what you might think how we might address that issue.

*Mr. DURENBERGER. Well, in 28 seconds, I am going to tell you to start financing the students, and stop financing the institutions that educate them. I mean, you look at where all the Medicare money is going, for example. It is going to large academic

medical centers and they are overpaying for indirect medical education, benefits, and so forth.

My sort of conservative side says I'd rather finance the consumer of education than to continue to finance the establishment.

You are welcome.

Ms. TUBBS JONES. Thank you.

*Chairman STARK. Thank you.

Mr. Ramstad, would you like to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman.

Thank you for your excellent testimony, Senator. Thank you Mr. Chairman for inviting this witness to lead off this important hearing. I don't think anybody frames the issues better than Senator Durenberger.

Senator, you have often pointed out that Minnesota does a lot of things right when it comes to healthcare delivery. We all know that. We were recently ranked as the healthiest state in the nation. We have the lowest rate of uninsured. We have a long history of delivering high quality, efficient care at a low cost. Yet, as you pointed out, as we all know on this Subcommittee, every Federal program seems to punish Minnesota for doing the right thing.

We get low Medicare fee for service and Medicare Advantage reimbursement because of our history of low cost. I don't know how many times I have copied your illustration comparing Dade County vis-a-vis Hennepin County in my district. We can't use SCHIP funds to cover children because we were already covering kids through Minnesota Care before SCHIP was ever created. Our state high risk pool for the uninsurable gets low Federal funding, because our state has done a good job of covering the uninsured.

How in your judgment can Federal incentives be realigned so we are actually paying for quality and value instead of inefficiency and utilization as you put it?

*Mr. DURENBERGER. Well, thank you for the question and thank you for the self-serving comments about Minnesota. We could say the same thing about Mr. McDermott's constituency, and I've said that about Mr. Kind and Mr. Camp. There's probably others on this Committee that I am not aware of. The short answer is we tried it already.

I mean we tried using what was then called the HMO and managed care to do our work for us, basically to identify all of the poor quality areas that were just costing us a lot of money, and they performed well. They continue to perform well.

The Virginia Mason Clinic, for example, in Seattle, is one of the leaders in this country on efficiency and effectiveness, and issues like that. Inter Mountain Healthcare is probably one of the best places to go to get healthcare in this country. There are places in the Chairman's district as we know, some of the Kaiser programs, and so forth.

So, it isn't possible, I'd say, for the Committee or the Subcommittee to start designating who do you like and who do you not like. You almost need an intermediary to do that for you, and that's why I make an argument for changing the rules and changing the goals and the requirements for both public and private.

If you are going to pay extra money for private insurance to go out there and find the most effective places to spend money, then

you ought to do the same thing for traditional Medicare and enable the doctors and the hospitals to be regarded for their outcomes and their quality as well.

Mr. RAMSTAD. Well, first of all, I should thank you for being less parochial than I am.

*Mr. DURENBERGER. That's because I'm here and you are there.

Mr. RAMSTAD. Yeah, but I am not running for re-election, either.

[Laughter.]

*Mr. DURENBERGER. Somebody you'll be just like me.

Mr. RAMSTAD. I mean don't we really have to get rid of—I mean, there's not enough money in the system or the Federal treasury for that matter to equalize things through the AAPCC formula. I mean, we really need a new system. Don't you agree?

*Mr. DURENBERGER. Yes. But the design of that system will probably vary from one place to the other. I mean your task is to reward quality. This is where Med-Pac was going, you know, with bundling payments, with defining accountable care organizations. That's where some of the people in the professions are going with the concept of medical home.

We had a regional medical home application under the 646 demonstration program. We had the entire region from Montana to Wisconsin. The medical group at the University of Wisconsin was part of it and a six-doctor group out in Western South Dakota was part of it, just to demonstrate, if we had the authority to demonstrate it, from CMS, to demonstrate that paying for quality saves money. There's a variety of those ways that can be chosen, most of which are going to relate to physicians.

Mr. RAMSTAD. Those criteria are much more important than geographic criteria. Some have suggested moving to a regional system, but wouldn't we still have some of those same geographic inequities?

*Mr. DURENBERGER. You have the same problems within some of our systems that you have nationally. I mean, you can go to one of the Fairview hospitals, or whatever it is in Minneapolis-St. Paul area, and you are going to find disparities there. That's why the physician becomes so important. Physician payment becomes important, and the Chairman has already pointed that out.

Mr. RAMSTAD. Thank you, Senator. Thank you, Mr. Chairman.

*Chairman STARK. Thank you.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Mr. Chairman, other than to acknowledge the Senator for all his work and to thank him for taking the time to be here, I very much appreciate it and with that Mr. Chairman I will yield back and say that I hope we are able to move forward with some of the ideas that the senator has articulated and more importantly just recognize it. More and more people are saying that it is time to do something.

So, thank you for your testimony and thanks for being here.

*Mr. DURENBERGER. You are very welcome.

*Chairman STARK. Mr. Kind?

Mr. KIND. Thank you, Mr. Chairman.

Just for the record, Senator Durenberger's testimony today is not a paid advertisement on behalf of myself, Mr. Ramstad and Mr. Camp. Although I'm sure we are all nodding in strong agreement with the statements and it is good to have you back, and it is good to hear from you again.

I really appreciate the effort you have made too in reaching out with so many of the providers in my own congressional district to have this type of conversation ongoing. I couldn't agree with you more that there is going to be tremendous savings had within the Medicare system if we can get to out outcome or performance-based type of reimbursement system. But that, of course, will follow the huge investment in HIT which will be important in establishing the standards and interoperability and everything that is taking place right now.

I don't know if you have had an opportunity to pick up Shannon Bromley's book, "Overtreated," at all. If you have read that, many people have. Her basic thesis is that there is huge disparity, obviously, in utilization, and that is backed up with the Dartmouth Atlas study every year. If we look at how the utilization is taking place from region to region, there could be tremendous cost savings.

One of the points that she made, I had a chance to talk to her a little bit more about, is the crucial, six-months, end of life care, and the tremendous spending that goes on there. Her point was if we get back to listening to the patient a little more closely, because again there is vast differences in utilization and what type of hospital stay is recommended or tests that are ordered in those final months or weeks of life.

There could be tremendous cost savings there, not through a major reform with healthcare treatment, but just by listening to the patient. She says, invariably, patients don't want to be in the ICU for weeks and weeks and weeks and having multiple tests ordered and multiple drugs administered, and that generally patients are more conservative than a typical provider and they just like pain management and have a chance to be at home in those final days of life.

If we get back to that, listening to the patient, there could be not only greater satisfaction with the patient and the family but also a tremendous change in the healthcare system. One of the bills that I've been working on through a period of years, and you know it modeled closely what you were advocating when you were still serving in the Senate, is trying to set up that national purchasing pool.

Of course, we have had the ongoing debate about associated health plans and Federal preemption of State mandates; but, I also agree with you that we do need a set of national rules, national standards.

My question to you is how do we get there? What would the process look like? One of the things I have been toying with in the legislation would be a small business and family farm health act modeled after the Federal employee purchasing pool concept, because when you look at the 47 million uninsured, most of them are working Americans, either in small business or on farms, who just can't afford to provide any healthcare coverage.

But part of the key to the success, obviously, is getting away from the 50 different rules and mandates that are established from state-to-state, which would make it easier for the plans to come in that and be able to compete in the national pool. One of the ideas I had forming this commission perhaps represented strongly by the various state health insurance commissioners to see if they can reach some type of agreement on what minimal standards should look like and therefore have a national template.

I don't know if you have any thoughts, or I'm sure you do.

*Mr. DURENBERGER. Right. Just two comments on what you said: first with regard to the role of the patient in the last 6, 12, and 24 months of life, which Dr. Wennberg has demonstrated for us. Jack Wennberg has always been focused on the relationship between the doctor and the patient. He started with shared dialog. He moved to all of this data that Dartmouth grinds out; and, today, he sent a recommendation to you to consider changing the legal standard for liability in healthcare to informed patient choice.

Informed patient choice means there is an obligation on the doctor to access all available information that relates to that patient's condition, to provide that to the patient, and then have the patient make the choice and take the responsibility for that choice. On the second point, Jeff Bingaman from New Mexico, and I think it was '91 or '92 introduced the health insurance purchasing cooperative bill.

Unfortunately for us that got picked up in Mrs. Clinton's health plan, and like so many good things that were in Mrs. Clinton's health plan, it died an unfortunate death. Nobody brings it up anymore except folks who want to talk about association health plans, which is a very different approach. So, I would recommend to you to look at that, Health Insurance Purchasing Cooperative, because it is basically a local way in which to do large group purchasing and it serves the individual and the small group market as well.

Mr. KIND. Just to stop you there, real quick. In fact, we've got some pilot programs taking place in Wisconsin right now targeting family farmers throughout the state. It was the health insurance cooperative, and allowing them to pool together, and it has been tremendously popular and just a backlog of waiting lists developed right now. May just decided to participate. There are like six or seven plans right now participating in this program, and may just decided to participate as well.

Thank you, Senator. It was good to hear from you.

*Mr. DURENBERGER. You are welcome. Thank you, very much.

Mr. KIND. Thank you, Mr. Chairman.

*Chairman STARK. I want to thank the gentleman from Wisconsin, but I do want to suggest a political implication.

When he starts talking about this end of life savings, you've got to remember that Senator Durenberger and I are very concerned about turned indicators, satellite radio, two-tone paint, little motorized scooters; and, if I thought you were going to take that away from us.

Mr. KIND. It's a dangerous subject, Mr. Chairman.

*Chairman STARK. I'd tread carefully there.

Mr. Johnson, would you like to weigh in on that issue?

Mr. JOHNSON. Yeah, I'd love to have one of those motorized deals.

[Laughter.]

Mr. JOHNSON. Thank you for being here Senator.

Let me just ask one thing. It seems to me the companies that provide insurance for their employees do it with pre-tax dollars, and yet individuals or small companies that can't provide insurance have to buy it with after-tax dollars. This Committee has an opportunity to fix that, and I wonder what your thoughts are on that subject.

*Mr. DURENBERGER. I think you ought to fix it and there are proposals around.

We talked earlier in the morning about the proposal that Senator Wyden and Senator Bennett had put forward. We talked about President Bush's proposal, which is an excellent one. Thirty years I've been asking the same question you've been asking and we haven't gotten to the point of changing it. I think in my opinion, these are two good ways to change it.

One of the things I don't agree with in some of the proposals is getting rid of the employer. I think the employer is a vital part of the purchase and whole lot of other things. This whole effort to go to health fitness and health management and helping people become more productive persons, and so forth, is really being driven by employer involvement in the healthcare system.

You know, everybody walks around with no contribution from their employer. It's too expensive to get any kind of coverage unless you can keep those people involved.

Mr. JOHNSON. No, I think you are on target.

Thank you sir, I appreciate you being here.

Thank you, Mr. Chairman. I yield back.

*Chairman STARK. Thank you.

Mr. Emanuel, would you like to inquire?

Mr. EMANUEL. Thank you, Senator.

*Chairman STARK. You are welcome.

Mr. EMANUEL. That's all I got to say. Actually, I do want to pick up with Ron and on the end of life.

I mean, if you look at healthcare, five Presidents have tried universal care: Truman, Johnson, Nixon, Carter, and Clinton. We're 0 for 5, but we've universalized care for segments of the population: Medicare, Medicaid, Veterans. SCHIP was an attempt at that.

You are always torn between trying to just do the system and get it right, because I want to associate it myself with what your comment is. There's a lot of money in the system. We spent \$2 Trillion on 300 million people and have life expectancy of 73. The EU, which is similar population, spends a trillion dollars yes and has life expectancy of 75.

If you were doing this smartly, you would just say "we ain't gettin' our bang for the buck", if that's one measurement. I'm always torn between just doing the whole thing, hopin' for hope, that the six times a magic number, we are then taking steps here that you have outlined. One is the end of life. We do spend a preponderance of dollars on the last six months of life.

Two, something Dave and I are working on, which is getting people earlier in life, that is early retiree, 55, 65, participating in a

chronic illness management before they get into Medicare, and they get reduced co-pays for every illness or year they spend, whether it's smoking, diabetes, heart blood, etcetera.

So, you reward the right type of behavior, and that's one option to look at. The other thing is to invest in the IT and get to the national standards you talked about and then allowing people to compete once that kind of floor and boundaries were set up.

Based on what you've seen in the history of reform where it has succeeded and where it hasn't, what would guidance be given the next congress and the next presidents. Go for the whole thing, or try to make significant reforms, kind of early retiree buy-in to Medicare and then alter that? I mean, take kind of the piece-meal approach, or go for the "Hail Mary" pass and see if this time is different than the last 50 years.

*Mr. DURENBERGER. Back in 1988 long-term care financing was the big political issue, and Claude Pepper wanted to create a commission to deal with long-term care. Danny Rostenkowski said right after we lost the Medicare Catastrophic Act, a step in the direction of making some sense out of the Medicare program, "No. It's got to be a commission for long-term care and everything else."

Out of that came the employer mandate. It did not come to the answer to your question. We came with a solution. The Republicans voted against it, but the AMA person and the Democrats including Pete voted for it. Excuse me, Mr. Chairman. Out of it came the employer mandate, which was, you know, it was a solution or an answer, but it wasn't the answer to your question.

We've always had this kind of debate between cost containment. What belief about 2009 is the importance of the President. It doesn't make any difference whether its Republican, Democrat, or which Democrat. It is critical that the President begin by giving all Americans a view of what is possible in a country as rich as ours, as varied as ours, with the entrepreneurship that we see in healthcare and medicine.

With a vision like that, people like you all can accomplish a lot. Because with no vision, the status quo, you have, the old business of what is one person's income is somebody else's cost, or the reverse of that. So, I think leadership right now is the biggest factor in getting to all this other stuff.

There's a lot of things we can talk about, but unless the people are on board this thing, you know. You aren't going to make it or you are going to lose it at some point, so that leadership issue is my answer.

Mr. EMANUEL. I'd add one point and then I'll end, Mr. Chairman.

The difference between the 90s and now, vis-a-vis household income, where we saw a \$6,000 rise in the nineties and an \$1,100 drop in median household income, all related to healthcare. In fact, Americans got a raise in the last six years. The problem is it all went to the health insurance industry.

When you get healthcare costs for a family of four going from 6,000 to 12,000, median income is dropping by 11,000. They got a raise; it just went to the healthcare system. It didn't go to their bottom line to meet other needs. Unless we do something about this, we just double it again.

Thank you.

*Mr. DURENBERGER. You're welcome.

*Chairman STARK. Again, Dave, thank you very much. We are going to take you up on your generous offer to help us as we grind through this next year.

I appreciate you sharing your thoughts with us today.

*Mr. DURENBERGER. Thanks to all of you, Mr. Chairman.

*Chairman STARK. We will now in just a moment, we'll go off the record for about 10 or 12 minutes and observe a video. Perhaps while we are doing that, if the second panel would like to come on up, I think you will be able to see the video from the witness stand. Why don't we just start the video.

[Video.]

*Chairman STARK. Without, we will go back on the record. We have a print script of that, and without objection, I ask that we put the script in the record.

[A transcript of the video follows:]

One of the decisive issues in the presidential campaign is likely to be health care. Some 47 million Americans have no health insurance, and that's just the start: millions more are underinsured, unable to pay their deductibles or get access to dental care.

Recently, *60 Minutes* heard about an American relief organization that airdrops doctors and medicine into the jungles of the Amazon. It's called Remote Area Medical, or "RAM" for short.

Remote Area Medical sets up emergency clinics where the needs are greatest. But these days that's not the Amazon. This charity founded to help people who can't reach medical care finds itself throwing America a lifeline.

In a matter of hours, Remote Area Medical set up its massive clinic, for a weekend, in an exhibit hall in Knoxville, Tenn. Tools for dentists were laid out by the yard, optometrists prepared to make hundreds of pairs of glasses, general medical doctors set up for whatever might come through the door. Nearly everything is donated, and everyone is a volunteer. The care is free. But no one could say how many patients might show up.

The first clue came a little before midnight, when Stan Brock, the founder of Remote Area Medical, opened the gate outside. The clinic wouldn't open for seven hours, but people in pain didn't want to chance being left out. State guardsmen came in for crowd control. They handed out what would become precious slips of paper - numbered tickets to board what amounted to a medical lifeboat.

It was 27 degrees. The young and the old would spend the night in their cars, running the engine for heat, but not much - not at \$3 a gallon. At 5 a.m., Pelley took a walk through the parking lot.

"We got up at three o'clock this morning and we got here about four. We've been out where a little while it's cold," Margaret Walls, a hopeful patient from Tennessee, told Pelley.

"Why did you come so early?" Pelley asked.

"Cause we wanted to be seen," Walls replied.

Marty Tankersley came with his wife and his daughter, asleep behind the front seats. Tankersley says he drove some 200 miles to get to the clinic and slept in the parking lot for hours.

"Just to have this done?" Pelley asked.

"Yes, sir. I've been in some very excruciating pain," he replied.

Tankersley had an infected tooth that had been killing him for weeks. Most of the people who filled the lot heard about the clinic on the news or by word of mouth, and they came by the hundreds.

Stan Brock calls RAM clinics "medical expeditions." He takes all comers, but just for the weekend.

Brock says he was surprised at the number of people who came when he set up the first "expedition" in the U.S. "And the numbers are getting higher. And I don't know if it's because we're getting better known, or that the healthcare in this country is getting worse," he told Pelley.

On Saturday at 6 a.m. they entered by the numbers. Inside, 276 volunteers from 11 states were waiting.

For those who were diagnosed with cancer on that particular day, or other ailments like diabetes and heart disease, RAM will try to find a volunteer doctor who will follow up.

Ross Isaacs is one of the doctors. Asked who these patients are, Dr. Isaacs - an internal medicine specialist at the University of Virginia -- told Pelley, "It's the working poor middle of their lives most with families, most not substance abusers and employed without adequate insurance."

Isaacs saw Marty Tankersley, the man Pelley had met in the parking lot who'd driven 200 miles. It turned out Tankersley had two heart attacks and heart surgery a few years back, but almost no follow up since.

The Tankersleys live in Dalton, Ga., and fall into the underinsured category. Marty's a truck driver and has major medical insurance through his employer. But the deductible is \$500, really unaffordable. And the dental insurance costs too much.

No one really knows how many Americans are underinsured like the Tankersleys.

"He's the lucky one he could drive the 200 miles. He's the lucky one who got to see people today and get hooked in. There are tens of hundreds of thousands of people like him," Isaacs said.

Tankersley, his wife and daughter were seen for checkups, glasses, mammograms, and the yanking of that agonizing tooth. "This has truly been a Godsend to us. To me and my family. And to all the hundreds of people that's here. I see the faces. The relief in the faces. This has been a wonderful thing," he commented.

This was RAM's 524th expedition. RAM took off in 1992, airlifting relief to Latin America. And at age 72, Stan Brock still flies the antique fleet. One of their planes, a C-47, flew on D-Day.

Brock is British by birth, and an adventurer at heart. He was a cowboy in the Amazon and then, incredibly, he was discovered by TV's "Wild Kingdom." Brock was a star - sort of a naturalist daredevil - for the program in the late 1960s and early 1970s.

Today Brock is devoted to RAM - completely devoted. He has no family, takes no salary, and has no home. Brock lives in an abandoned school that the city of Knoxville leases to RAM for \$1. Until recently, he took showers in the courtyard with a hose.

How does he pay for all the care and supplies?

"In the first place we really know how to stretch the dollar. We operate entirely on the generosity of the American people. I'd like to say that we had big corporate support in America but we don't. So it's the little checks from those people who send in the \$5 and \$10," Brock explained.

RAM operates on a shoestring budget of about \$250,000 a year. Yet, last year, it treated 17,000 patients. On the Saturday *60 Minutes* stopped by, there was no sign of a let up.

"What have you accomplished today?" Pelley asked.

"Approximately 600 people actually showed up here and we were able to do just about everybody I think we turned away about 15 people who are going to come back tomorrow anyway," Brock said.

The next day, Sunday, there were hundreds more. Tickets started again with number one. But now, the doctors were racing time. In hours they'd be heading home.

Nurse practitioner Teresa Gardner, who brought in a portable women's health clinic from Wise, Va., was worried about Rebecca McWilliams. McWilliams had surgery for cervical cancer in 2005, but without the recommended follow up.

"It's been two, about two years since I've had my last pap smear and I was supposed to have every six months and I've only had it once since that surgery," McWilliams told Pelley.

"I think many doctors would say you've taken a terrible risk waiting this long," Pelley remarked.

"I've really have. But it's just, like I said, it's very hard to afford it. I have three kids. And my husband lost his job this past summer," McWilliams, 28, explained.

McWilliams' pap smear came back clear, but in her exam Gardner found reason to worry. "I think just from the clinical inspection of the cervix that, you know, possibly, there is a possibility that cancer, you know, still being there," Gardner explained.

"You created this medical organization designed to go into Third World countries to go

into remote places, and now doing 60 percent of your work in urban and rural America, what are we supposed to make of that?" Pelley asked Brock.

"For the 50 million or so people in this country, the one thing that is on their mind is 'What if I have a catastrophic event, a car crash, a heart attack,'" he replied. "Because I either have no health insurance or I'm underinsured.' And, so this is a very, very weighty thing to be thinking about, knowing that your family is in great jeopardy."

Late Sunday, Joanne Ford's number was among the last. Pelley found her sitting by a stairwell. She's retired, living on disability with no insurance, and her glasses don't work anymore. She got in only to find out the vision care line had closed.

Asked what she was going to do, Ford told Pelley, "I don't know. I have a lot of friends and I have a lot of church support. I was very active in my church and I have a lot of friends in church. I just hate to ask. I've worked all my life. I hate to ask. That's why things like this are so wonderful."

"There is no shame in seeking healthcare," Pelley remarked.

"No. You're right. You know, it really, I am sad that we are the wealthiest nation in the world, and we don't take care of our own. So. But it will be okay," she said.

And it did turn out okay after all. Someone at RAM noticed Ford's situation. They put her in the vision care line and examined her for a new pair of glasses.

But at the gate, many were waiting when the weekend ended.

In the expedition to Knoxville, RAM saw 920 patients, made 500 pairs of glasses, did 94 mammograms, extracted 1,066 teeth and did 567 fillings. But when Stan Brock called the last number, 400 people were turned away.

"What's going through your mind when you're reading off the last two or three numbers and you see so many more people at the gate than are going to be able to come in?" Pelley asked.

"Yeah, you know, that's the lousy part of this job. I mean, it's nice to be able to know that you've helped a bunch of people. But the reality is that we can't do everybody. At the moment, we're just seeing the thousands and thousands of people that we can, and the rest of them, unfortunately, have got to do the best they can without us," Brock said.

*Chairman STARK. We will proceed with our second panel, and they include Dr. Diane Rowland, who is familiar to all of us. Diane has testified many times. She is vice president of the Kaiser Family Foundation, which I am told to remind people has nothing to do with Kaiser Permanente in my district, which provides hundreds of thousands of people with medical care.

Dr. Ayanian, who is a professor of medicine and healthcare policy at the Harvard Medical School.

Dr. Michael J. O'Grady, who is a senior fellow of the National Opinion Research Center at the University of Chicago.

Stan Brock, who we saw displayed just a few minutes ago; and Stephen Finan, the associate director of policy for the American Cancer Society.

Each of you have submitted testimony which will without objection appear in the record in its entirety and we will ask you each to summarize or expand upon your testimony in any manner that you are comfortable.

We will start with Dr. Rowland.

**STATEMENT OF DIANE ROWLAND, SC.D., EXECUTIVE VICE
PRESIDENT, KAISER FAMILY FOUNDATION**

*Ms. ROWLAND. Thank you, Mr. Chairman, and Members of the Subcommittee.

I am pleased to be here today and will try to put some numbers to go with the very human experience you just saw in the video.

Health insurance coverage can provide a valuable lever to help gain access to primary and preventive healthcare services, as well as piece of mind and financial security for many facing serious healthcare problems. Yet, our latest statistics show that nearly 47 million Americans were without health insurance coverage in 2006.

Whether or not one receives healthcare coverage in the U.S. today depends on a variety of factors: age, income, workplace, and state of residence. For those over age 65 and those with permanent disabilities, Medicare provides health insurance protection. Slightly more than half of all Americans receive employer-based coverage and about five percent purchase coverage through the non-group or individual market.

Together, Medicaid and SCHIP play a critical role for the low income population covering 29 million children and 24 million non-elderly adults and people with disabilities. This leaves, however, one in six Americans, 16 percent of our population, uninsured.

The 47 million uninsured Americans include 9 million children primarily coming from low-wage, working families. 80 percent of the uninsured are from families with a full- or part-time worker and two-thirds have incomes below 200 percent of poverty or roughly \$40,000 for a family of four.

Most work in places where health insurance is not offered through their job, and the rising cost of health insurance premiums, now over \$12,000 for a family, means that if coverage is offered, the employee's share of the premium is becoming more and more unaffordable for working families.

Take for example one of the families participating in our study on family budgets. Sam is uninsured and has just gotten a job in a home improvement store. His wife, Carmen, is at home with their three children. Once he becomes eligible for employer-sponsored coverage, he will be required to pay \$400 per month in his share of the insurance premium, which is a quarter of his \$1600 monthly take-home pay. Today, nearly 90 percent of the family spending already goes to basic necessities, leaving little room in their budget, roughly \$150 a month, for additional spending that could be used for healthcare or to pay deductibles and cost sharing for the health plan.

Yet, having health insurance matters. It affects how and when people use the health system, and ultimately their health and financial well being. The uninsured are much more likely to postpone or forego care due to costs than those with coverage. When they seek care, they are often billed full charge and left to pay what they can, sometimes accumulating large medical debts that can lead to bankruptcy.

Leaving 47 million Americans without health coverage affects not only the uninsured, but also puts a growing burden on our healthcare system and adds additional strain on the economy. In 2006 it is estimated that some 22,000 Americans died prematurely as a consequence of being uninsured, and the lost productivity of the uninsured had an annualized, economic cost of between 100 and 200 billion dollars.

As the availability, affordability, and scope of insurance decrease, both insured and uninsured Americans are now dealing with budget-consuming medical bills and debt. In 2004 some 45 million Americans were in families that had a high financial burden for healthcare, i.e. spending more than 10 percent of disposable family income on healthcare services and insurance premiums. This financial burden provides a measure of underinsurance.

Individuals at high risk for these levels of financial burden include those 55 to 64 who are not yet eligible for Medicare, those in fair or poor health, and especially those with diabetes, stroke, heart disease, and other chronic illnesses. It is clear that for many health insurance alone is no longer a guarantee of financial protection from the cost of healthcare and financial stress when illness strikes.

Health insurance is an important source of financial security for families when illness strikes and helps to promote access to healthcare services that can often stave off more serious illness.

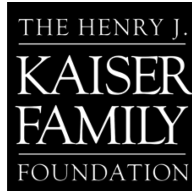
As Congress moves forward to address the growing uninsured population and the impact of rising healthcare costs for America's families, promoting improved access to affordable healthcare and adequate health coverage for all Americans, will be an important but challenging objective.

I appreciate the opportunity to testify before you today and will welcome your questions at the conclusion of the panel.

Thank you.

[The prepared statement of Diane Rowland follows:]

**Prepared Statement of Diane Rowland, Sc.D., Executive Vice President,
Kaiser Family Foundation**



Health Care Affordability and the Uninsured

Testimony of Diane Rowland, Sc.D.

**Executive Vice President, Henry J. Kaiser Family Foundation
and
Executive Director, Kaiser Commission on Medicaid and the Uninsured**

For Hearing on the Instability of Health Coverage

**Before the Congress of the United States
House of Representatives
Committee on Ways and Means
Health Subcommittee**

April 15, 2008

SUMMARY OF TESTIMONY BY DIANE ROWLAND, SC.D.

- The patchwork health insurance system in the United States left nearly 47 million people without health coverage in 2006—two thirds of the uninsured are low-income and eight in ten come from families with a full- or part-time worker. Uninsured workers are more likely to work for small firms and in industries such as agriculture, construction, and services where fewer employers offer coverage.
- For low-income families, Medicaid and the companion State Children’s Health Insurance Program (SCHIP) play a critical role in providing coverage. However, the reach of Medicaid and SCHIP is limited and leaves many of the poor and low-income population without health coverage.
- Having health insurance makes a difference in whether, when, and where people get needed care and how well that coverage promotes access to preventive and primary care services and protects them from medical expenses when illness strikes. The uninsured are more likely to postpone or forego needed care and preventive services than the insured.
- As a society, we bear a substantial cost for leaving so many of our fellow Americans without health coverage—it is estimated that in 2006 some 22,000 Americans died prematurely as a consequence of being uninsured, and the lost productivity due to the diminished health and shorter life span of the uninsured had an annualized economic cost of \$102-\$204 billion.
- Rising health care costs are exacting a financial toll on both insured and uninsured families. In 2007, the average total premium for a family policy was \$12,106—about the same amount as the annual earnings of a full-time minimum wage worker.
- Low- and moderate-income families face greater financial strain from both increasing premium costs and more limited coverage that increases out-of-pocket costs for care.
- The increasing costs and limits on the scope of medical care covered by insurance are impacting families. For a family earning \$1,600 per month, basic necessities consume 90% of income—making a \$400 monthly premium or \$500 deductible unaffordable.
- As the availability, affordability and scope of insurance decrease, both insured and uninsured Americans are now dealing with budget-consuming medical bills and debt. In 2004, 45 million Americans were in families that spent more than 10 percent of family income on health care, and those at higher risk include the near-elderly and those with chronic illnesses.
- It is clear that for many, health insurance alone is no longer a guarantee of financial protection from the costs of health care and financial stress when illness strikes. As Congress moves forward to address the growing uninsured population and the impact of rising health care costs on America’s families, promoting improved access to affordable health care and adequate health coverage for all Americans is an important but challenging objective.

Mr. Chairman and Members of the Subcommittee on Health, thank you for the opportunity to testify today on the growing share of Americans who are uninsured and without adequate health insurance coverage. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. I also hold an appointment as an Adjunct Professor in the Bloomberg School of Public Health at the Johns Hopkins University.

Health insurance coverage can provide a valuable lever to help gain access to primary and preventive health care services as well as peace of mind and financial security for many facing serious health care problems. Yet, our latest statistics show nearly 47 million Americans, including 9 million children, were without health insurance coverage in 2006. Our growing uninsured population gets care later, if at all, and ends up sicker than those with coverage. For the one in six Americans under age 65 who are uninsured, lack of affordable coverage can both compromise health and leave families with substantial medical debt.

The continued growth in our uninsured population also takes a toll on society. Based on work of the Institute of Medicine, it is estimated that in 2006 some 22,000 Americans died prematurely as a consequence of being uninsured, and the lost productivity due to the diminished health and shorter life span of the uninsured had an annualized economic cost of \$102-\$204 billion. Leaving 47 million Americans without health coverage affects not only the uninsured but also puts a growing burden on our health care system and adds additional strain on the economy.

And, even for those with health insurance coverage, rising insurance premiums, the increasing out-of-pocket costs from more limited coverage, and the decreasing availability of employer-based coverage make obtaining and paying for health care an increasing financial burden. For many, health insurance coverage through the workplace now has higher deductibles and more cost-sharing as well as higher premiums that can put health coverage out of reach for low-wage workers. As a result, even those who have health coverage find health care increasingly unaffordable, leading many analysts to conclude America has both a growing uninsured and underinsured population.

My testimony today will highlight the key characteristics and issues with regard to the uninsured as well as assess the financial burdens for medical care faced by America's families.

The Uninsured

Whether or not one has health insurance coverage in the U.S. today depends on a variety of factors: age, income, workplace, and state of residence all affect whether health insurance is available and affordable. For those over age 65 and those with permanent disabilities who qualify for Social Security, Medicare provides health insurance protection, keeping them from the ranks of the uninsured (*Figure 1*). Slightly more than half (54%) of all Americans receive employer-sponsored health coverage and 5% purchase coverage through the non-group or individual market. Medicaid and other public programs assist 12% of individuals primarily from low-income families. The remaining 16% of Americans are uninsured. The likelihood of being uninsured is higher in some states due to the nature of their economy and the scope of public programs, with over 20% of the nonelderly population uninsured in 10 states (*Figure 2*).

The 47 million uninsured Americans in 2006 included 9 million children, but the uninsured population is primarily composed of low- and moderate-income adults under age 65 (*Figure 3*). The uninsured primarily come from working families – 80% of the uninsured come from families with a full or part time worker, but most work in places where health insurance is not a benefit offered through their job. Many, but not all, employers voluntarily offer health coverage to their workers and are encouraged by the federal tax system to do so. In 2007, 60% of firms offered health benefits to workers, down from 69% in 2000. Even if a firm offers health benefits, some employees (about 15% of all employees) are ineligible because they work part-time, are recent hires, or do not meet other eligibility criteria.

Only three in ten poor workers have coverage through their own or a spouse's employer, compared to 92% of higher-income workers (*Figure 4*). More than half of poor workers are not offered coverage through their own or a spouse's employer. Another 15% of poor workers decline coverage when offered, most likely due to the cost of their share of the health insurance premium. For a worker earning \$30,000 per year, the employee share (\$3,281) of the average 2007 family premium would be more than 10% of their income.

The rising cost of health insurance premiums also means that for low wage workers, if coverage is offered, the employee share of premiums is becoming more and more unaffordable—or in some cases, the scant coverage provided makes the premium share a poor investment. As a result, the uninsured tend to be in families with lower wage workers. Almost two-thirds (65%) of the uninsured are from families with incomes below twice the poverty level (about \$40,000 a year in income for a family of four in 2006 (*Figure 5*). Uninsured workers are more likely to work for small firms and in industries such as agriculture, construction, and services where fewer employers offer coverage.

For low-income families, Medicaid and the companion State Children’s Health Insurance Program (SCHIP) play a critical role in covering 29 million children and 30 million nonelderly adults, including 8 million low-income adults with severe disabilities for whom private insurance is not a viable option. However, the reach of Medicaid and SCHIP is limited and leaves many of the poor and low-income population without health coverage.

Most low-income children qualify for Medicaid or SCHIP, but low-income adults can only qualify for Medicaid if they are disabled, pregnant, or have dependent children. Beyond the categorical exclusions from Medicaid coverage, income eligibility levels are generally much lower—well below the poverty level—for adults compared to children. Most states (45 total) have authorized Medicaid and SCHIP eligibility levels for children at 200% of poverty or higher (*Figure 6*). In contrast, eligibility for parents is below 50% of poverty in 12 states (*Figure 7*). In 29 states, a parent working full-time at minimum wage has an income too high to qualify for Medicaid. As a result, adults are more likely to be uninsured than children, making up eight in ten of our uninsured population.

While young adults have the highest likelihood of being uninsured, adults age 55-64 are a particularly vulnerable group. They are not yet eligible for Medicare or, in some cases, are the spouse of someone on Medicare who lost employer-based coverage when their spouse retired. Because of their age, coverage from the individual market is likely to be very expensive because policy premiums are age-rated and likely to exclude coverage for many pre-existing health problems. Public coverage through Medicaid is mostly unavailable unless then can qualify as the parent of a dependent child or as disabled.

Minorities are also much more likely to be uninsured than Whites. About one-third of the nonelderly Hispanic population and 22% of African Americans are uninsured, compared to 13% of Whites. This disparity reflects the fact that minorities are more likely to have lower incomes than Whites and less likely to have health insurance offered through their jobs, to be eligible for benefits, and to be able to afford their share of premiums. However, public programs play a particularly important role for minorities – 44% percent of African American children and 14% of nonelderly African American adults count Medicaid or SCHIP as their health coverage. In the absence of public coverage, millions more would join the ranks of the uninsured.

While there is much discussion and debate about the role of immigrants in our society, the uninsured population is largely comprised of native or naturalized citizens. Immigrants have high rates of uninsurance (47% vs. 15% for citizens) due to their lower-wage job base and ineligibility for public coverage. Although immigrants, especially recent immigrants, are likely to be uninsured, they are not the driving force behind America's growing uninsured problem because they comprise only a small share of the U.S population. Our uninsured problem is created by the nature and fragmentation of our health insurance system—not the presence of an immigrant population in the U.S.

The Consequences of Inadequate Health Coverage

The uninsured tend to be in worse health than our nation's privately insured population (though better off than those who qualify for Medicaid). One in ten (11%) uninsured report being in fair or poor health compared to one in twenty (5%) of those with private insurance. Almost half of all uninsured adults have a chronic condition. Those with health problems are likely to find private non-group coverage unavailable or unaffordable if job-based coverage is not an option. Policies sold in the non-group or individual market can be more expensive than employer-sponsored coverage because insurers can vary the premium based on age and health status. Insurers in the non-group or individual market can also deny coverage or exclude pre-existing conditions and charge higher premiums for older adults, putting such policies out of reach for many of the uninsured.

Without insurance to cover health care costs, access to health care and ultimately health suffers. Having health insurance makes a difference in whether, when, and where people get

needed care and how well that coverage promotes access to preventive and primary care services and protects them from medical expenses when illness strikes. The uninsured are much more likely to postpone or forego care due to cost than those with coverage (*Figure 8*). More than half of uninsured adults do not have a place where they regularly go when they are sick. As a result, they are less likely than those with insurance to receive preventive care and even standard treatment for chronic conditions.

Limited access puts the uninsured at risk for worse health outcomes. Lack of access to early and ongoing medical care leaves the uninsured more likely to be hospitalized for avoidable health problems and to risk being diagnosed at a later disease stage, leading to poorer health outcomes. When they are hospitalized, the uninsured are less likely to receive diagnostic and therapeutic services and are more likely to die in the hospital than insured patients. Being uninsured has been correlated with a 10-25% increased risk of mortality and an estimated 22,000 excess deaths in 2006 were linked to lack of health insurance coverage.

As a society, we also bear a substantial cost for leaving so many of our fellow Americans without health coverage. Children who are uninsured are more likely not to receive early and preventive care, to miss school due to illness, and not to get the healthy start in life our children deserve. Uninsured adults compromise our nation's productivity when work is missed due to unattended health problems, and financial burdens for health care strain family resources. It is estimated that in 2006, the diminished health and shortened lifespan of the uninsured had an economic cost of between \$102 and \$204 billion due to the lost productivity of uninsured individuals.

Financial Burden and Health Care

Health care is not free, even for the poorest among the uninsured. High health care costs and fear of medical debt result in many of the uninsured going without care. Their annual medical costs are about half as much as those who are privately insured. Most of the uninsured do not receive health services for free or at reduced cost, nor do they benefit from the discounted rates negotiated by insurance companies. They are often billed at full charge and left to pay what they can—sometimes accumulating large medical debts and notices from collection agencies.

However, rising health care costs are also exacting a financial toll on families with health insurance and their employers. The cost of employer-sponsored health coverage increased 78% from 2001 to 2007, rising faster than wages and inflation. In 2007, the average total premium for a family policy was \$12,106—about the same amount as the annual earnings of a full-time minimum wage worker (*Figure 9*). Employees have seen their average share of annual premiums for a family policy double from \$1,619 in 2000 to \$3,281 in 2007. As premiums rise, firms may find it difficult to maintain the level of health benefits they offer workers, particularly in times of economic downturn and slowed profits. In response, employers have attempted to increase efficiency and limit expenditures, shifted more costs to employees, or elected not to offer coverage. Thus, low- and moderate-income families face greater financial strain from both increasing premium costs and more limited coverage that increases out-of-pocket costs for care.

In interviews the Foundation is currently conducting, we see the impact the inadequate health system is having on family finances. Paying for health coverage and care is challenging for families, especially in light of rising gas prices and increased costs for other basic necessities. For example, one family in Houston demonstrates the gaps in coverage that exist. Sam works at a home improvement store and his wife Carmen is at home with their three children. Though the children qualify for public coverage, the parents are uninsured—they are not eligible for Medicaid, and Sam cannot yet enroll in coverage through his job. Once he does become eligible for employer-sponsored coverage, he will be required to pay a \$400 per month insurance premium, which is a quarter of his \$1,600 monthly take-home income. Nearly 90% of the family's spending already goes toward basic necessities other than medical care, leaving little room in their budget for additional spending on health care.

Even if the uninsured may be able to afford lower premiums by enrolling in high deductible health plans, the high level of required cost sharing is likely to be out of reach for most of the uninsured. Three quarters of the uninsured population come from families with incomes below 300% of poverty (\$63,600 for a family of four in 2008). A new study by Kaiser researchers found that the lower-income uninsured population (below 300% of poverty) had very limited (median was \$300) liquid financial resources that could be tapped to help pay deductibles and other out-of-pocket expenses. In contrast, higher-income uninsured workers had median financial assets of \$2,560—a level still inadequate to meet the cost-sharing requirements that

would accompany a hospital stay or other catastrophic health event. Only about one in five uninsured households had enough net financial assets to meet the minimum deductibles in health savings account-qualified high deductible plans.

The growing limits on the scope of medical care costs covered by insurance are impacting families. Health insurance policies do not provide complete “100 percent” coverage for health care needs. Depending on their policy, individuals with insurance can face deductibles for physician or hospital services, co-payments or cost-sharing for physician visits and other medical services, and pay additional amounts for using providers outside a plan’s network. Even people who are insured can face significant out-of-pocket costs. Our Kaiser/HRET Annual Employer Health Benefits Survey for 2007 found that 11% of workers in employer-sponsored Preferred Provider Organizations (PPOs) who have deductibles are in plans with a deductible for single coverage of \$1,000 or more and about half of all covered workers are in plans that have cost-sharing in addition to a hospital deductible.

As the availability, affordability and scope of insurance decrease, both insured and uninsured Americans are now dealing with budget-consuming medical bills and debt. Researchers from AHRQ in the Department of Health and Human Services estimate that in 2004, 45 million Americans were in families that spent more than 10 percent of family income on health care (*Figure 10*). Financial burden, defined as having out-of-pocket expenses for health care service and insurance premiums that exceeded 10 percent of a family’s disposable (after tax) income, provides a measure of “underinsurance” faced by many families whose health coverage leaves them without protection for catastrophic level health costs. Sadly, individuals at high risk for these levels of financial burden include those age 55-64 who are not yet eligible for Medicare, those in fair or poor health, and especially those with diabetes, stroke, heart disease and other chronic illnesses (*Figure 11*).

Financial burden also varied considerably depending on the type of health insurance a person had. About one in ten (11%) individuals with a high health care financial burden were from uninsured families, but two-thirds were individuals in families with employer-sponsored coverage reflecting their larger share of the population. People with private, non-group coverage were the most at risk for high financial burden—more than half spent 10% or more of their

family income on health care. This group also experienced the highest percentage point increase in high financial burden from 2001-2004. Without a subsidy from their employer, individuals are exposed to the full cost of the premium. With insurers' ability to deny coverage and exclude pre-existing conditions, finding coverage can be difficult for those who have health conditions. In 2005, nearly three in five adults who sought coverage in the non-group market had difficulty finding a plan they could afford, and one in five were denied coverage, charged a higher price, or had a specific health condition excluded from coverage.

It is clear that for many, health insurance alone is no longer a guarantee of financial protection from the costs of health care and financial stress when illness strikes. Today's higher premiums, deductibles, and co-payments can create a substantial financial burden for families, and many learn only through an unexpected serious injury or illness that they are not well-protected financially. A 2005 Kaiser Family Foundation report examined the privately insured who have had problems paying medical bills, comparing their access to care to those who did not have medical bill problems as well as those with no health coverage at all. Those with medical debt were in worse health and reported having fewer benefits in their health plans than others with private coverage. Perhaps not surprising, the majority of those with medical debt reported underestimating what their health plan would pay towards their medical bills and nearly half said their plan had not paid anything for care they thought was covered.

Having medical debt was associated with a substantial decrease in access to health care. While those with medical debt were just as likely as other privately insured adults to have a medical home, decisions to seek health care were markedly different, including their decisions to postpone and forgo care as well as to skip treatments and prescriptions. In many ways, care-seeking patterns among those with private coverage who had problems paying their medical bills resembled those of the uninsured.

The Challenge Ahead

Health insurance coverage is closely tied to the strength of the nation's economy. Given the current slowdown in the economy after a brief period of recovery and the challenge that creates for employers and states to maintain their coverage programs, the number of uninsured Americans is likely to continue to grow in the near future. Even in good economic times, however, it can be difficult to reverse the rise in the uninsured. Employer-sponsored coverage is not likely to increase again until the growth in health insurance premiums is checked or competition for workers again becomes intense. In the current economic environment especially, the costs of health insurance premiums are a major impediment to improving health coverage.

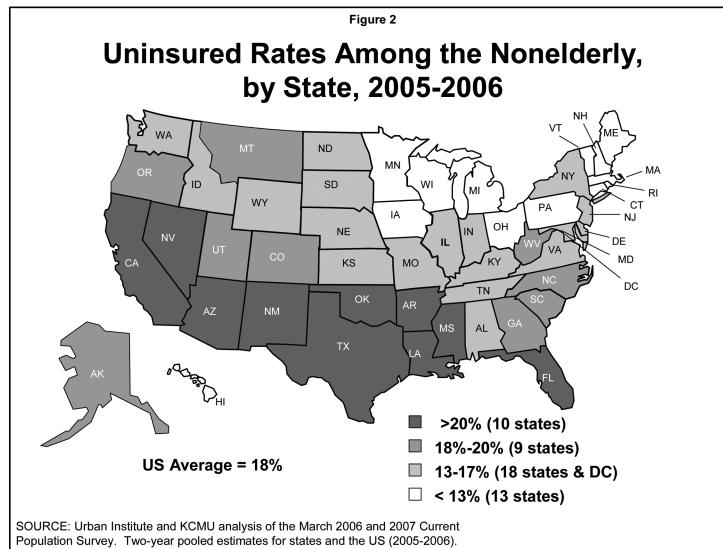
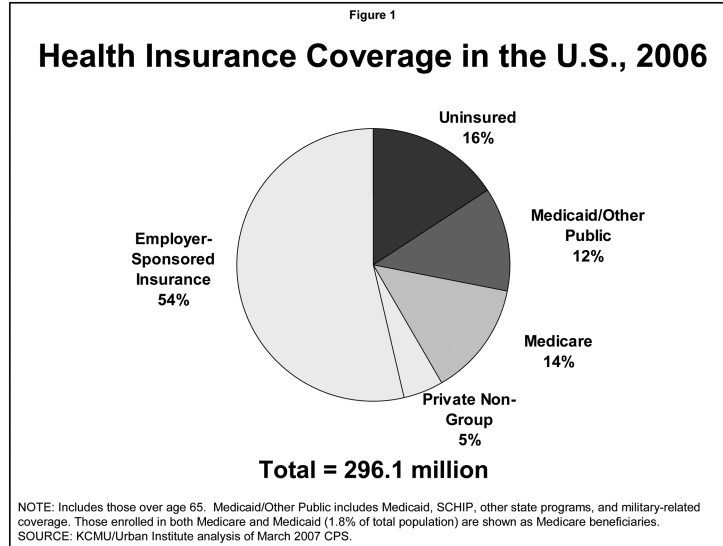
During the economic downturn from 2000-2004, Medicaid and SCHIP were an essential safety-net as unemployment grew and median household incomes fell. The number of uninsured people increased by 6 million during this time, primarily as a result of declines in employer-sponsored coverage, but enrollment growth in Medicaid—assisted by Congress' temporary increase in the federal matching rate—counteracted additional growth in the uninsured. However, the continued ability of Medicaid and SCHIP to absorb all the losses from employer-sponsored coverage is strained by growing demand and limited resources, as evidenced by an increase in the number of uninsured—including children—during the economic recovery from 2004-2006. The current economic downturn is likely to mean more substantial increases in America's uninsured population, especially if Medicaid and SCHIP are limited in their ability to meet the rising demand for coverage from the declining economy. In the absence of additional federal assistance, the fiscal crises in the states are likely to compromise further their ability even to maintain coverage through the Medicaid and SCHIP programs, much less expand coverage.

Health insurance provides families with an important source of financial security when illness strikes and helps to promote access to health care services that can often stave off more serious illness. Although the majority of nonelderly Americans receive health care coverage through their employer today, the availability and affordability of employer-based coverage is declining—putting more and more middle- and low-income working families at risk of being uninsured and without coverage for their health needs. For those with coverage, the value of that

coverage has begun to erode as limits on the scope of coverage leave more and more insured Americans to face increased out-of-pocket costs when they seek care.

Rising costs for both health care services and insurance coverage are placing a heavy load on family budgets, businesses, and public programs. The financial burden resulting from these growing costs is already squeezing out good health practices, leading many to defer care due to costs and contributing to increases in the uninsured. As Congress moves forward to address the growing uninsured population and the impact of rising health care costs on America's families, promoting improved access to affordable health care and adequate health coverage for all Americans will be an important but challenging objective.

I appreciate the opportunity to testify before the Committee today and welcome your questions. Thank you.



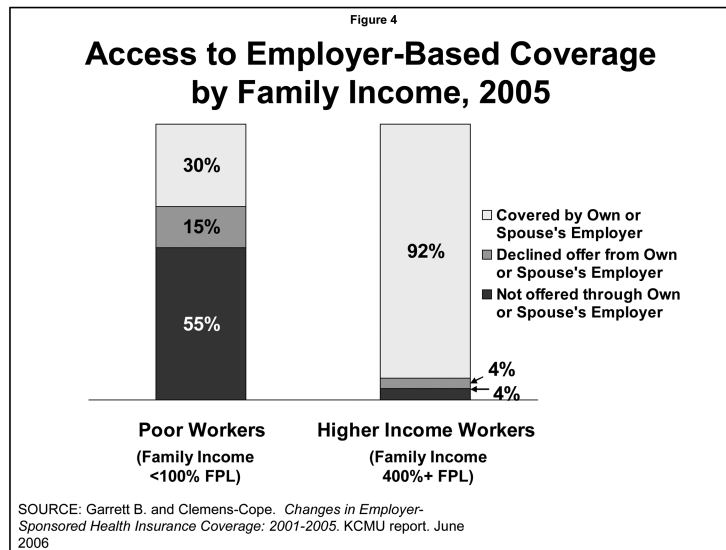
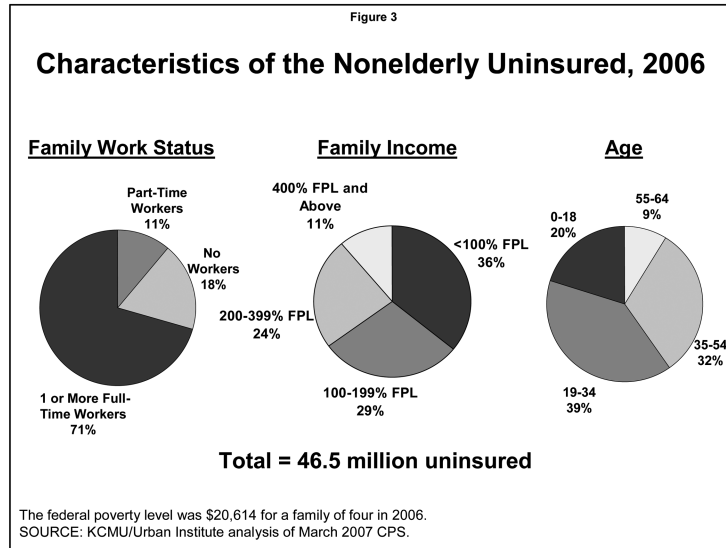
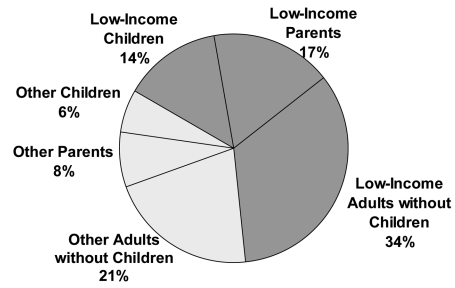


Figure 5

The Nonelderly Uninsured, by Age and Income Groups, 2006

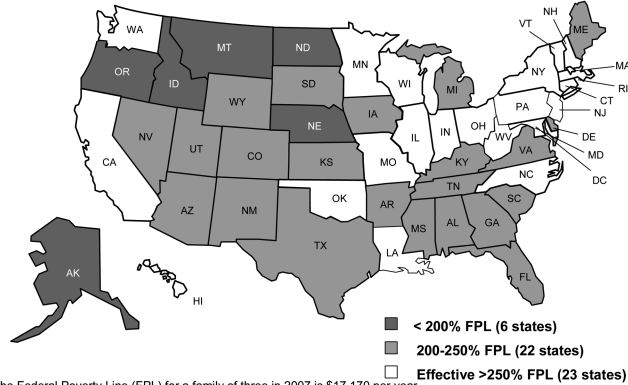


Total = 46.5 million uninsured

Low-income includes those with family incomes less than 200% FPL.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Figure 6

State Authorized Children's Eligibility for Medicaid/SCHIP by Income, January 2008

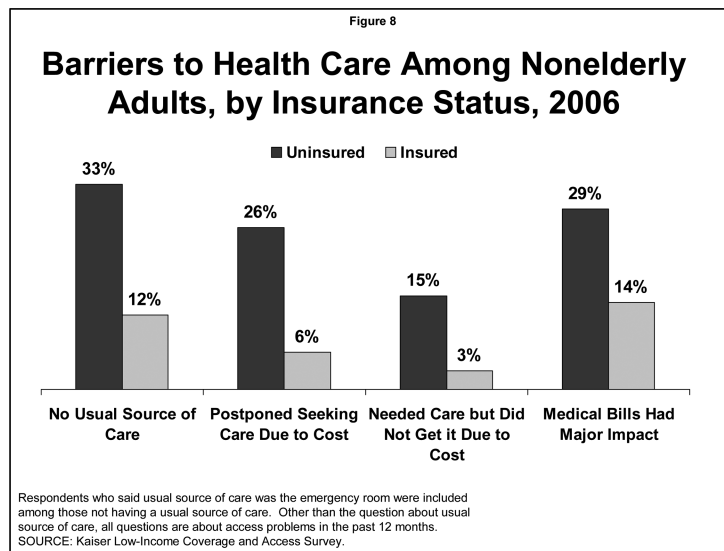
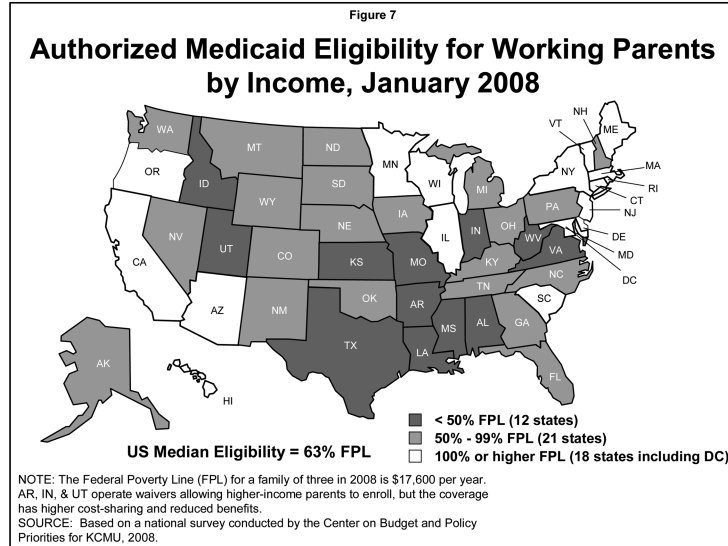


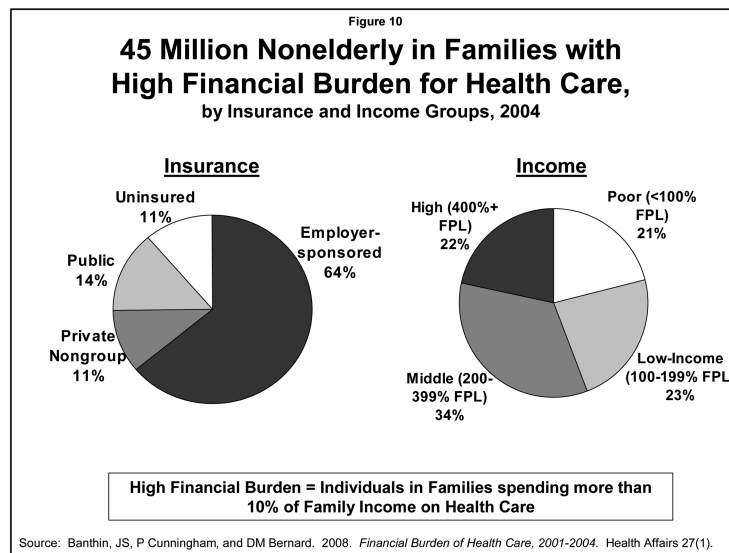
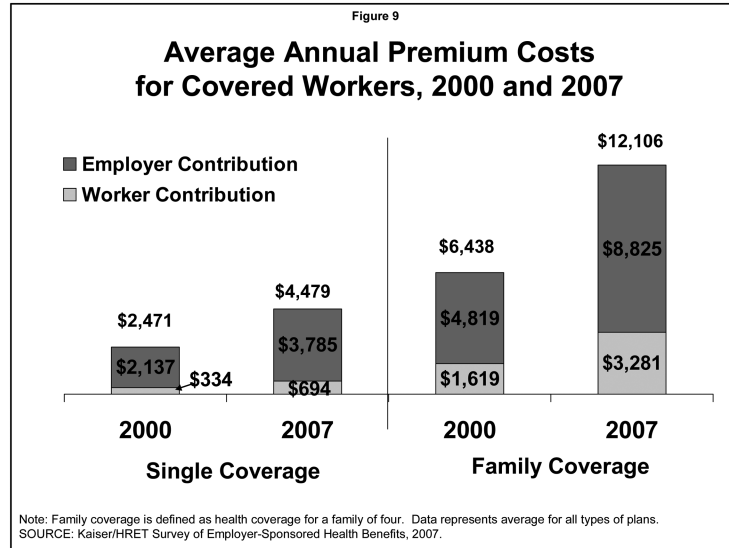
*The Federal Poverty Line (FPL) for a family of three in 2007 is \$17,170 per year.

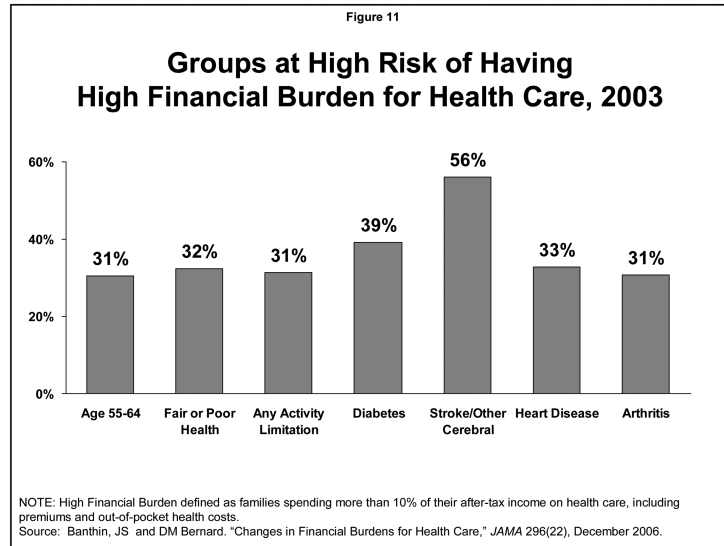
**Effective eligibility higher than 250% FPL accounts for earnings disregards.

***IL uses state funds to cover children above 200% FPL.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.







*Chairman STARK. Dr. Ayanian?

STATEMENT OF JOHN Z. AYANIAN, M.D., PROFESSOR OF MEDICINE AND HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

*Dr. AYANIAN. Thank you, Chairman Stark, Representative Camp, and the Members of the Subcommittee on health for inviting me to testify on the health consequences for Americans who lack insurance and on the persistent problem of racial and ethnic disparities in the U.S. healthcare system. These topics are of vital importance to our Nation.

My name is John Ayanian, and I am a professor of medicine and health care policy at Harvard Medical School. Over the past 16 years, I have studied the adverse effects Americans experience when they lack health insurance, as well as racial and ethnic disparities in healthcare.

From 2000 to 2004 I served on the Institute of Medicine Committee on the Consequences of Uninsurance. I am also a practicing physician at Brigham and Young Women's Hospital in Boston, where I have seen first-hand how patients lives are affected when they lose their insurance.

Uninsured Americans are much more likely than insured Americans to avoid seeing a doctor because of the cost. Among those in poor health, 50 to 70 percent of uninsured adults go without needed medical care, compared with only about 20 percent of insured adults in poor health. Uninsured adults are less likely to receive high quality primary care and important preventive services, such as cholesterol testing and mammograms. As a result, they are often unaware of their major health risks, such as high blood pressure, high cholesterol, and those with curable cancers such as breast cancer or colon cancer, are diagnosed at a more severe stage of disease.

Because of their unstable and sporadic medical care, uninsured adults have a much greater risk of dying at younger ages than insured adults. The Institute of Medicine has estimated that 18,000 Americans died prematurely in 2000 because they lacked health insurance. Sadly, many of these premature deaths occur among people with conditions that are readily treatable, including high blood pressure, HIV infection, and breast cancer.

The instability of insurance coverage in the United States has especially harsh effects for adults who are uninsured or erratically insured between ages 55 and 64. About four million adults in this age group were uninsured in 2006. For those who have lost their coverage, finding insurance in the individual market is often prohibitively expensive, if not impossible, when they have pre-existing medical conditions.

As a physician, I see that people who receive good medical care in their 50s and early 60s live longer and healthier lives; however, recent research by our group and others has shown that the health of uninsured adults declines more rapidly in middle age than the health of insured adults. These declines in health are associated with a 40 percent greater risk of death for uninsured adults. This risk is concentrated among uninsured adults with high blood pres-

sure, diabetes or heart disease, precisely the conditions for which we know good medical care makes a difference.

But the evidence on this topic is not all grim. If uninsured adults survive to age 65, Medicare improves their access to physicians, medical tests and effective treatments. In our most recent research, we have found that differences in health between uninsured and insured adults with cardiovascular disease or diabetes at age 65 are reduced by half after five years of Medicare coverage. Our research also shows that after these uninsured adults gain Medicare coverage, they experience fewer heart attacks, less heart failure, and less severe chest pain.

The status quo masks hidden cost to the Medicare Program when millions of uninsured adults enroll in Medicare. Uninsured adults, particularly those with chronic medical conditions, have fewer visits to physicians and fewer hospitalizations than insured adults in similar health before age 65. After becoming eligible for Medicare, uninsured adults have a rapid increase in physician visits and hospitalizations that persists for at least seven years after age 65.

Their care in the Medicare Program is thus more costly, because they reach age 65 in worse health and have more immediate and expensive medical needs than if they had been insured and well-treated in their fifties and sixties. If all adults in this age group had insurance coverage, the cost of covering them could be off-set by better health and potential savings for the Medicare program.

The instability of insurance coverage in the U.S. is also an important factor contributing to racial and ethnic disparities in healthcare and health outcomes. Rates of coverage vary widely across racial and ethnic groups in the United States with the highest rates of uninsurance among African Americans, American Indians, and Hispanic Americans. Without consistent insurance coverage, many minority Americans receive fewer preventive services and less effective treatment for many medical conditions.

In the latest national healthcare disparities report, three key themes have emerged since 2001. First, overall disparities in healthcare quality and access are not getting smaller. Second, some progress is being made, but many of the biggest gaps in quality and access have not been reduced. Third, the problem of persistent uninsurance is a major barrier to reducing disparities.

In conclusion, as you consider the instability of health coverage in the United States, the financial challenge of achieving universal coverage may appear daunting, but the human and economic consequences of the status quo are substantial. To put it bluntly, uninsured Americans live sicker and die quicker because they receive too little medical care that often comes too late to prevent avoidable complications and death.

Thank you for inviting me to speak with you today about this important problem for our Nation.

[The prepared statement of John Ayanian, M.D. follows:]

**Prepared Statement of John Z. Ayanian, MD, Professor of Medicine and
Health Care Policy, Harvard Medical School, Boston, Massachusetts**

**Health Consequences for Uninsured Americans
and Racial and Ethnic Disparities in Health Care**

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Invited Testimony
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Hearing on "The Instability of Health Coverage in the United States"

April 15, 2008

Thank you, Chairman Stark, Representative Camp, and the members of the House Ways and Means Subcommittee on Health, for inviting me to testify on the health consequences for Americans who lack insurance and on the persistent problem of racial and ethnic disparities in the U.S. health care system. These topics are of vital importance to our nation. Too many Americans live in worse health and face an increased risk of death because effective medical care is not accessible and affordable without health insurance. Even when people are insured, the benefits of good health care are not consistently available to Americans of all racial and ethnic groups.

As a researcher and faculty member at Harvard Medical School over the past 16 years, I have studied with colleagues the adverse effects that Americans experience when they lack health insurance, as well as pervasive racial and ethnic disparities in health care and health outcomes across a wide range of medical conditions and services. From 2000 through 2004, I served on the Institute of Medicine Committee on the Consequences of Uninsurance. Our committee issued a series of six comprehensive reports on the cascade of medical, social and economic consequences of uninsurance for adults, children, families, communities, and our country.¹⁻⁶ As a physician at Brigham and Women's Hospital in Boston, I also care for patients with high blood pressure, heart disease, diabetes, cancer, and other serious conditions. I have seen first-hand how patients' lives are affected when they lose their insurance, causing them to miss appointments and forego treatments that could keep them in better health.

Health Consequences of Lacking Insurance

As you consider in this hearing the instability of health coverage in the United States, I would like to share insights from my research and clinical experience and from the findings of the Institute of Medicine. The financial challenge of achieving universal coverage may appear daunting, but the human and economic consequences of inaction are substantial. To put it bluntly, uninsured Americans "live sicker and die quicker" because they receive too little medical care that often comes too late to prevent avoidable complications and death.

Uninsured Americans are much more likely than insured Americans to avoid seeing a doctor because of the cost. Among those in poor health, 50 to 70 percent of uninsured adults go without needed medical care, compared with only about 20 percent of insured adults in poor health (Figure 1).⁷ Uninsured adults are less likely to receive high-quality primary care and important preventive services, such as cholesterol testing and mammograms. As a result, they

are often unaware of their major health risks, such as high blood pressure or high cholesterol,⁸ and those with curable cancers, such as breast cancer or colon cancer, are diagnosed at a more severe stage of disease.⁹⁻¹¹

Because of their unstable and sporadic medical care, uninsured adults have a much greater risk of dying at younger ages than insured adults.¹²⁻¹⁵ In 2002, the Institute of Medicine estimated that 18,000 Americans died prematurely in 2000 because they lacked health insurance.² A recent update from the Urban Institute estimated this number has risen to 22,000 to 27,000 excess deaths among uninsured adults in 2006.¹⁶ Sadly, many of these premature deaths occur among people with conditions that are readily treatable, including high blood pressure, HIV infection, and breast cancer.^{9, 17}

Uninsured Near-Elderly Adults: A Particularly High-Risk Group

The instability of insurance coverage in the United States has especially harsh effects for near-elderly adults who are uninsured or erratically insured between the ages of 55 and 64. About 4 million adults in this age group were uninsured in 2006.¹⁸ For those who have lost their insurance coverage because they've lost their job, become disabled, or had an older spouse retire, finding insurance in the individual market is often prohibitively expensive – if not impossible – when they have pre-existing medical conditions.

As a physician, I see that people who receive good medical care in their 50's and early 60's live longer and healthier lives. Medical advances over the past 40 years have done much to improve the outcomes of high blood pressure, heart disease, diabetes and cancer, particularly for middle-aged adults who have much to gain from early detection and effective treatment of these conditions. However, recent research by our group and others has shown that the health of uninsured middle-aged adults declines more rapidly than the health of comparable insured adults.^{19, 20} These declines in health are associated with a 40% greater risk of death for uninsured adults.¹⁴ This risk is concentrated among uninsured adults with high blood pressure, diabetes or heart disease (Figure 2), precisely the medical conditions for which we know good medical care makes a difference.

Health Benefits of Gaining Insurance Coverage

The evidence on this topic is not all grim. Universal Medicare coverage at age 65 offers real benefits to individuals and society. If uninsured adults survive to age 65, Medicare provides improved access to physicians, appropriate medical tests, and effective treatments (Figure 3).²¹

In our most recent research, my colleagues and I have found that the differences in health between uninsured and insured adults with cardiovascular disease or diabetes at age 65 are reduced by half after 5 years of Medicare coverage (Figure 4).²⁰ Our research also shows that after these uninsured adults gain Medicare coverage, they experience fewer heart attacks, less heart failure, and less severe chest pain.

Hidden Costs When Uninsured Adults Enroll in Medicare

The status quo masks hidden costs to the Medicare program when millions of uninsured adults enroll in Medicare. Uninsured adults, particularly those with chronic medical conditions, have fewer visits to physicians and fewer hospitalizations than insured adults in similar health before age 65. After becoming eligible for Medicare, uninsured adults have a rapid increase in physician visits and hospitalizations that exceeds the use of services by insured adults and persists for at least 7 years after age 65 (Figure 5).²² Their care in the Medicare program is thus more costly because uninsured adults reach age 65 in worse health and have more immediate and expensive medical needs than if they had been insured and well treated in their 50's and early 60's. If all near-elderly adults had insurance coverage, the costs of covering this high-risk group could be offset by better health and potential savings for the Medicare program.

Racial and Ethnic Disparities in Health Care and Health Outcomes

To obtain high-quality care, Americans must overcome seven potential barriers: 1) having health insurance available; 2) getting enrolled in insurance; 3) having coverage for effective providers and appropriate services; 4) becoming well informed about treatment options; 5) having a consistent source of primary care; 6) getting referred for needed specialty care; and 7) having providers deliver high-quality care.²³ Disparities in medical care and health outcomes arise when people from disadvantaged racial, ethnic or socioeconomic groups experience barriers in any one of these seven steps.

The instability of health insurance coverage in the United States is an important factor contributing to racial and ethnic disparities in health care and health outcomes. Rates of coverage vary widely across racial and ethnic groups in the United States (Figure 6). Whereas 13 percent of white Americans under age 65 were uninsured in 2006, rates of uninsurance were considerably higher for other racial and ethnic groups: 17 percent for Asian Americans and Pacific Islanders, 22 percent for African Americans, 33 percent for American Indians and Alaska Natives, and 36 percent for Hispanic Americans.¹⁸ Without consistent insurance coverage, many

minority Americans receive fewer preventive services and less effective treatment for heart disease, high blood pressure, diabetes, cancer and other major conditions. In the latest National Healthcare Disparities Report, three key themes have emerged since 2001:

- “Overall, disparities in health care quality and access are not getting smaller.
- Progress is being made, but many of the biggest gaps in quality and access have not been reduced.
- The problem of persistent uninsurance is a major barrier to reducing disparities.”²⁴

Even when minority Americans have insurance coverage, the health system often does not perform as well for them as for white Americans. The landmark Institute of Medicine report, *Unequal Treatment*, has dissected the many ways in which the quality of health care is uneven across racial and ethnic groups.²⁵ Some disparities arise from biases and discrimination by health care providers, while other disparities occur because safety-net organizations that disproportionately serve poor minority patients are often underfunded and isolated from the best features of American health care.

Fragmented systems of care in the United States are a major contributor to disparities in care. Our health-care systems are complex and often difficult to navigate for all members of society. However, deficits related to fragmented care are most likely to affect patients who are disadvantaged because of their race, ethnicity, language, immigrant status, income, education, or lack of insurance coverage. These patients fall through the cracks in complex systems of care. In multi-step processes of evaluation and treatment, such as cardiac procedures, kidney transplants, or cancer care, small disparities at each step in the process can yield a moderate to large disparity in the overall pattern of care.²⁶

Racial and ethnic disparities in health outcomes have deep roots in American history. These disparities also result from persistent poverty, discrimination, and unequal opportunities in contemporary American society. Stable and affordable health insurance that provides access to high-quality primary and specialty care is an essential part of the foundation for eliminating these disparities and improving the health of all Americans.

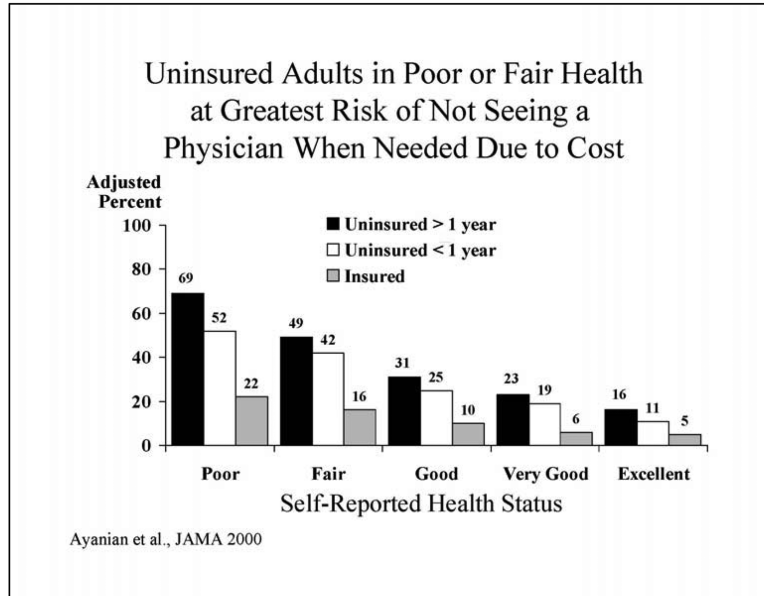


Figure 1

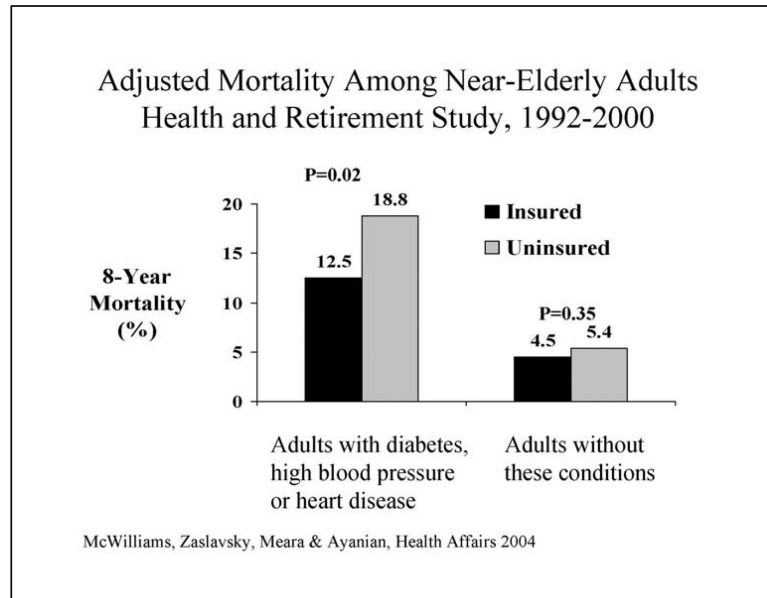


Figure 2

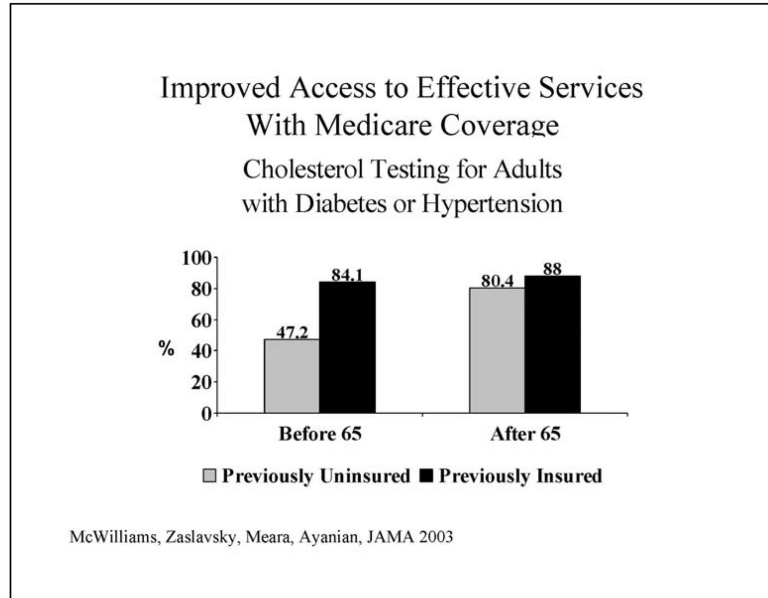


Figure 3

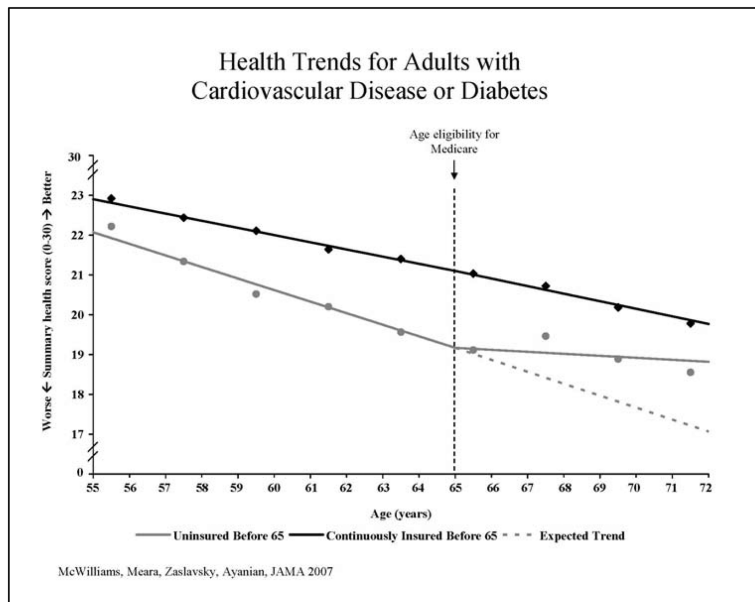


Figure 4

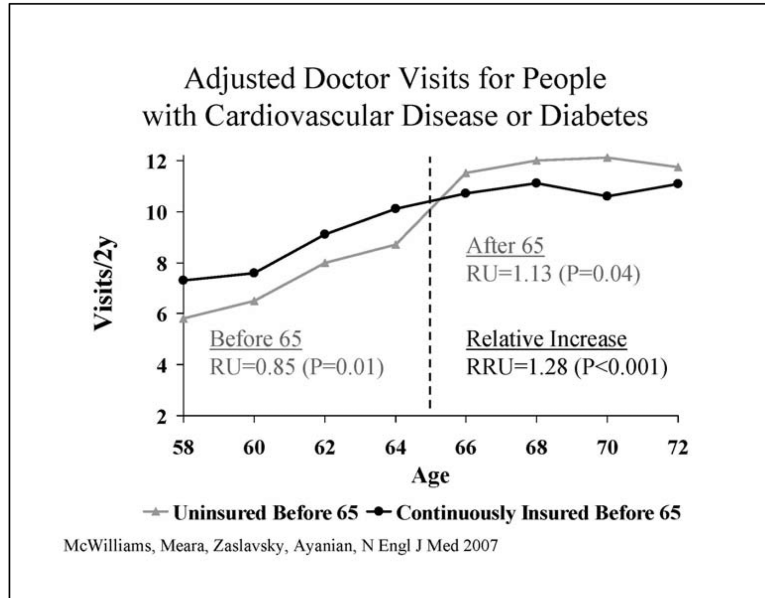


Figure 5

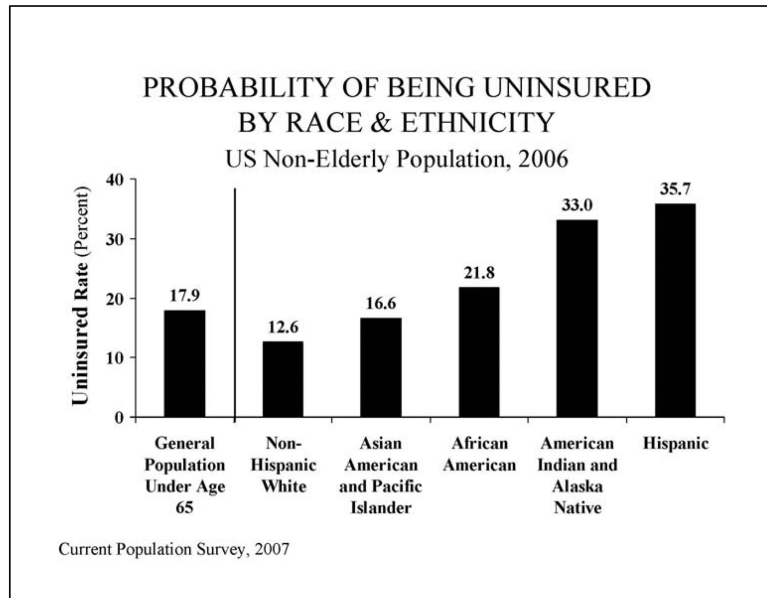


Figure 6

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*Chairman STARK. Thank you.
Dr. O'Grady?

**STATEMENT OF MICHAEL J. O'GRADY, PH.D., SENIOR FELLOW,
NATIONAL OPINION RESEARCH CENTER, UNIVERSITY OF
CHICAGO**

*Mr. O'GRADY. Mr. Chairman, Members of the Subcommittee, my name is Michael O'Grady, and I am a senior fellow at the National Opinion Research Center at the University of Chicago.

Previously, I was the assistant secretary for planning and evaluation at the Department of Health and Human Services. I have also served on the professional staff of the Senate Finance Committee, the Joint Economic Committee, and the Congressional Research Service. In all of those roles I have studied the problem of the uninsured.

First slide, please?

[Slide.]

*Mr. O'GRADY. An important point I urge you to keep in mind is the uninsured are not one single population. Consider the following: more than half of the uninsured who are of working age are full-time workers. It is not only the unemployed who lack insurance.

Second, those who work in small firms are far less likely to have coverage than those in the larger firms.

Third, the uninsured are found at all income levels, but most notably the poor and the near poor.

Four, the uninsured are found at all ages, except for seniors, because of Medicare. Youth, 18 to 24, are the least likely to be insured, and sometimes by their own choice.

Hispanics are the last likely to have insurance, followed by blacks, Asians, and then whites. About 20 percent or 10 million people of the uninsured living in the United States are not U.S. citizens.

Other than being uninsured, these individuals often have very little else in common. Designing and evaluating proposals to expand health insurance coverage is remarkably complex. It is made even more difficult in the event that budget constraints require tough choices about who will be assisted in what way.

I offer two suggestions. First, consider coverage options along several key policy dimensions. Second, consider the mix of coverage tools for providing coverage to this very diverse population.

Next slide please.

[Slide.]

*Mr. O'GRADY. The first dimension I recommend is the desire for coverage. It can be broken down into at least three groups. First, people who are desperate for coverage, such as the chronically ill and are willing to pay almost any price if it was only available. Second, those who seek coverage, but are priced out of the market. They just can't afford it. Third, people who do not seek coverage, even if it is available and affordable.

Traditional definitions of universal coverage: provide coverage to everyone, regardless of an individual's desire to be covered. For example, the single, healthy, young adult who isn't interested in health coverage at this point in life. On the other hand, those following a phased approach might rank some groups of the uninsured as a higher priority than others. For example, they may be

more concerned about an uninsured, 55-year-old diabetic with complications than a young, healthy, recent college graduate.

The second dimension I'd suggest is time without coverage. The data on coverage indicates that the longer a person is uninsured, the longer the potential gap in needed services. In this example, higher priority might be given to those uninsured for the longest period of time. For example, more than two years.

The third dimension is citizenship status. There may be neither the political consensus nor the budget to extend coverage to all the people living in the United States. A likely scenario might have coverage first off to citizens before coverage would be considered for non-citizens, either legally or illegally in the country. This chart provides a visual way to think about the interactions among the three policy dimensions I've just outlined.

People falling into the highest priority on all three dimensions are assigned the highest overall priority of one. While policymakers may differ on the assignment of priorities or on the dimensions they wish to consider, this provides a common framework on which to base decisions. In addition to those policy dimensions, different policy tools may be needed to meet the needs of these very different subpopulations.

For small business with moderate income employees, the successful solution might include access to both purchasing pools, so they have the same options as larger firms, and an improved tax advantage to help them offset the cost of coverage. For the uninsured without employment-based coverage, it could be made more affordable if they had access to the same tax advantages as employer-based coverage.

For immigrants, legal or illegal, that same combination of incentives would probably not be as nearly as effective. Also, especially for the illegal immigrants, it would seem unlikely that expanded government programs would prove effective, asking illegal immigrants to interact with government intake and eligibility officials is unlikely to generate much trust or compliance.

This subpopulation may be better served through a clinic approach, which insures care, if not coverage, and is closer to the model of care found in many of their home countries. Policymakers will need to carefully consider the circumstances of the subpopulation involved to judge which type of design will be the most successful. The systematic examination of the composition of the uninsured, a prioritization of those who receive insurance assistance, and a review of the mix of tools available to help the uninsured gain access to health care will prove useful in shaping a scientifically sound and viable policy for the future. Thank you.

[The prepared statement of Michael J. O'Grady follows:]

**Prepared Statement of Michael O'Grady, Senior Fellow, National Opinion
Research Center, University of Chicago, Chicago, Illinois**

A Systematic Approach to Expanding Health Insurance Coverage

Michael J. O'Grady, Ph.D.
Senior Fellow,
National Opinion Research Center (NORC)
at the University of Chicago

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

Tuesday, April 15, 2008

Mr. Chairman and members of the Subcommittee, my name is Michael J. O'Grady and I am a Senior Fellow at the National Opinion Research Center at the University of Chicago. Previously I was the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS). I have also served on the professional staff of the Senate Finance Committee, the Joint Economic Committee and the Congressional Research Service. In those various roles I have had a chance to extensively study the problem of the uninsured and a number of different approaches to reducing the number of uninsured. Thank you for giving me an opportunity to speak with you about this critical subject today.

Background:

The United States faces a serious problem: between 10 percent and 15 percent of the population lacks access to health care, except for limited emergency services. Those without health insurance are significantly restricted to routine health care, screenings, immunizations and preventive services. Providing health insurance to those who do not have it is a vital goal.

This testimony examines who the uninsured really are, provides three policy dimensions to help prioritize government efforts to reduce the number of uninsured, and then reviews the mix of tools that can be used to make insurance available to as many people as possible.

A few key points upfront.

First, the uninsured are not one population -- they are employed and unemployed, poor and middle class, young and middle age, citizens and non-citizens.

Second, there are several policy dimensions for triaging government efforts to help the uninsured. These include desire and affordability of insurance, length of time without insurance, and citizenship status.

Third, there are different ways to make health care more accessible to the uninsured. These include tax credits and/or tax deductions; government subsidies for needy populations; employer and/or individual mandates; as well as the availability of free or subsidized clinics.

1. Who Are the Uninsured?

The key point to understand here is that the uninsured are not one population.

- ◆ More than half of the uninsured who are of working age are full-time workers.

- ◆ Those who work in small firms are far less likely to have coverage than those in large firms.
- ◆ The uninsured are found at all income levels, but most notably the poor and near-poor.
- ◆ The uninsured are found at all ages, except seniors because of Medicare.
- ◆ Hispanics are the least likely to be insured, followed by Blacks, Asians and Whites.
- ◆ About 20 percent of the uninsured live in the U.S. but are not U.S. citizens.

Let me provide statistics on each of these areas.

Employment Status: Most of the population obtains its health insurance through a current or former employer. Employment-based health insurance is somewhat unique to the United State, having developed as a response to wage controls during World War II.¹ The Census Bureau estimates that 60 percent of the population is covered through employment-based health insurance.²

Somewhat surprisingly, however, a large percentage of the uninsured also are involved in the workplace, either as full-time or part-time workers.

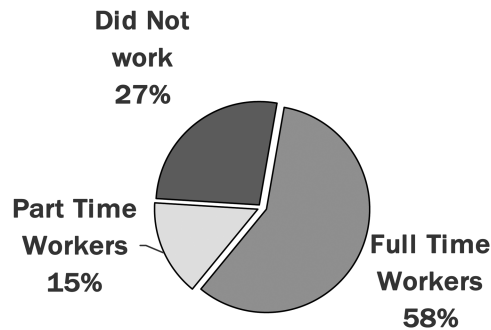
Chart 1 illustrates that the majority of the uninsured has a significant attachment to the labor force. Although part-time and part-year workers have had difficulties obtaining coverage for much of the post-war period, in recent years full-time, full-year workers increasingly have faced a lack of health insurance. This is due in part by the trend in which insurance costs are growing faster than employers' ability to pay.³

¹Employers trying to attract scarce skill labor were not allowed to offer higher wages, so they added extra benefits, such as hospitalization and other health care benefits. Offering health insurance became a regular tool by employers to recruit and retain the best workers. In Europe after the war much of the infrastructure was destroyed and the government was the only effective means of offering coverage. The differences between the American and European approaches are sometimes argued on ideological grounds today, but their inception was driven more by practical necessity.

² http://pubdb3.census.gov/macro/032007/health/h09_000.htm.

³ Health insurance is just one component of the total compensation package an employer offers. Depending on the needs and preferences of the workers they are trying to attract, other components, in particular wages, may be more effective at attracting talent. As the new jobs in the American economy are more likely to be in the service sector than in the manufacturing sector, employers have not had to offer the same mix of benefits to attract and keep the workers they need.

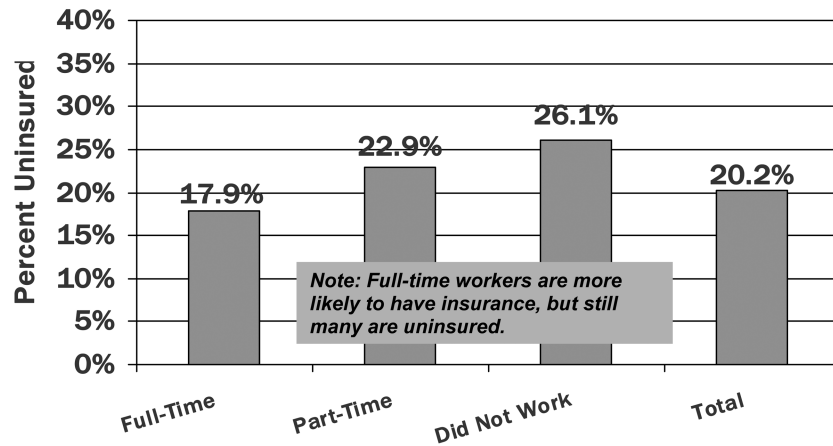
Chart 1
The Percent Of Uninsured by Attachment To The Labor Force,
Ages 18 To 64, 2006
 (e.g., 58% of working age uninsured are full-time workers)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Chart 2 provides further evidence of the relationship between work and health insurance coverage. It shows that full time workers are much less likely to be uninsured than either part time worker or people out of the labor force. For this overall group of working age adults 20.2 percent report no health insurance during 2006. Full time workers fare better with 17.9 percent reporting no health insurance, but not substantially better and not as well as many observers might have expected.

Chart 2
The Percentage Without Health Insurance by Attachment To The
Labor Force, Ages 18 to 64, 2006
 (e.g., 17.9% of full time workers are uninsured)

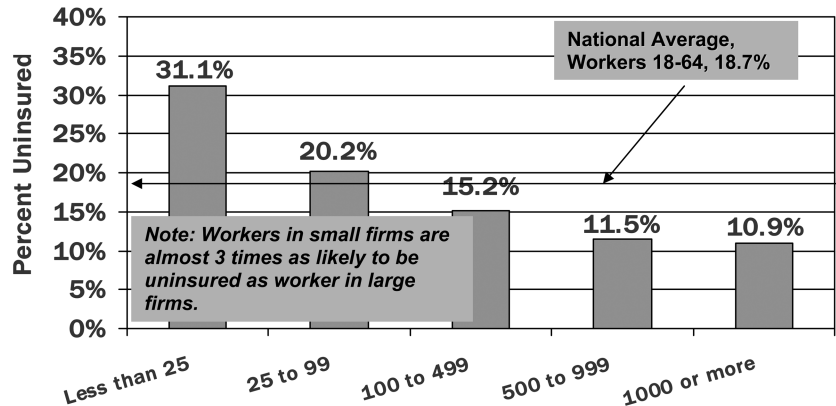


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Chart 3 illustrates the relationship between firm size and insurance coverage. Larger firms are much more likely to offer their workers and retirees coverage. They are in a much stronger position to negotiate lower premiums, and almost all are self-insured. Also, once they have enough workers, retirees and dependents, they can in effect create their own insurance pool. These result in lower costs in two ways:

1. The firm only pays the insurance company to administer benefits, rather than hold insurance risk. Insurance companies can calculate the dollar value of the risk they are asked to take and add that amount to the price of the premium.
2. They avoid state benefit mandates and state premium taxes. Self-insured employers are regulated by the U.S. Labor Department and state mandates and taxes are preempted.

Chart 3
The Percentage Of Workers Without Health Insurance Based On
Different Firm Sizes, 2006
 (e.g., 31.1% of workers in firms less than 25 are uninsured)

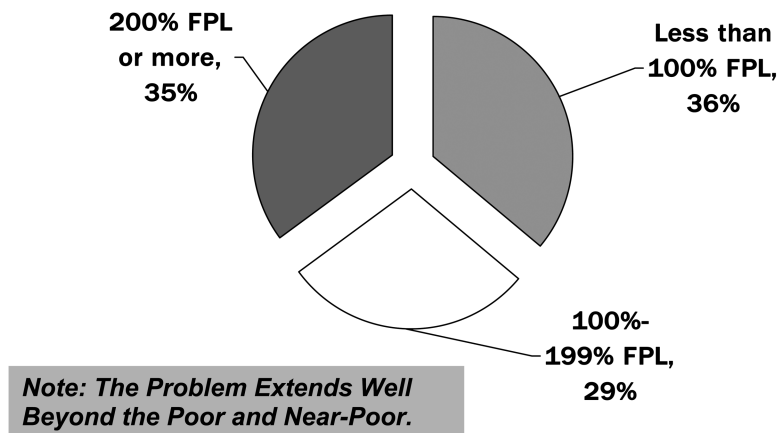


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

The size of the firm is an important predictor of whether a worker or retiree will have health insurance coverage and how affordable that coverage will be. Large firms (those with at least 500 workers) almost undoubtedly offer coverage and have negotiated the lowest premiums. Still, as Chart 3 shows, about one in 10 workers in large firms have no coverage - either these workers do not believe that they need the coverage or that they cannot afford the premiums. The former view is sometimes held by single, healthy, young workers; the latter held by those at the lower income brackets.

Income and Coverage: Being uninsured is not limited to the poor or the near-poor. Chart 4 illustrates the income distribution of the uninsured. People with 200 percent or more of the federal poverty level made up 35 percent of the uninsured in 2006. The federal poverty line was \$20,614 for a family of four in 2006, so these could be families making \$41,228 or more. It is unclear whether this is a problem in which coverage is offered and is still unaffordable even for people at this income level or if it is a problem of access to coverage for small businesses or the self-employed or any number of other possibilities.

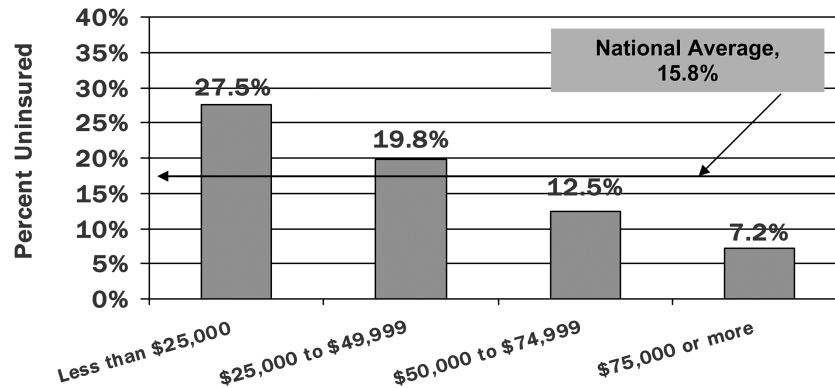
Chart 4
The Percent of the Uninsured by Family Income in 2006
 (e.g., 35% of the uninsured have incomes 200% or above the federal poverty line)



The federal poverty level (FPL) was \$20,614 for a family of four in 2006.
 Source: KCMU/Urban Institute analysis of March 2007 CPS.

Chart 5 below illustrates what percentage of each income group went without coverage in 2006. The previous chart showed that more than a third of the uninsured can be considered moderate to high income. Chart 5 also shows that while the lack of insurance extends beyond the poor and near-poor, the rate of those without insurance is highly correlated with income. More than one in four of those who make less than \$25,000 do not have insurance compared with about one in 14 who make \$75,000 or more.

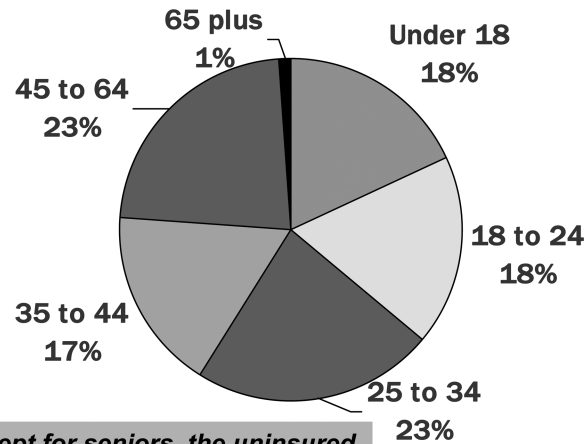
Chart 5
The Percentage without Health Insurance by
Family Income, 2006
 (e.g., among those who make less than \$25,000, 27.5% are uninsured)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Age and Coverage: Age is another important factor to examine in considering the problems of the uninsured. The uninsured are found among all age groups, with the clear exception of the elderly. Medicare's close to universal coverage means the problems of the uninsured are problems on the non-elderly subpopulation. Among the non-elderly, the distribution of the uninsured is fairly evenly balanced with the uninsured being found in all age categories.

Chart 6
Percentage of the Uninsured by Age, 2006
 (e.g., 18% of the uninsured are between 18 - 24)

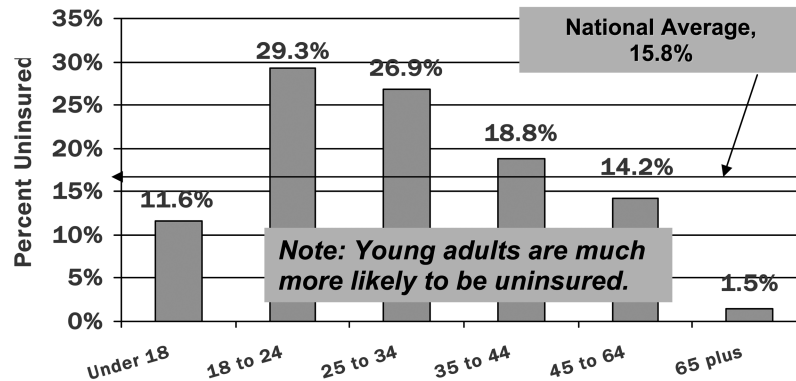


Note: Except for seniors, the uninsured are found among all age groups.

Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table H102. U.S. Bureau of the Census.

While the uninsured may be found in all the non-elderly age categories, some age categories have a much higher likelihood of being uninsured. Chart 7 illustrates the strong correlation between age and insurance coverage. Young adults 18 - 24 are at least twice as likely to be uninsured as those between 45 and 64. These young adults may have aged out of coverage on their parents' plans, they may not be in the work force, and/or they may have an employer that does not offer coverage. Additionally, some members of this age group do not see the same need for coverage. This is a relatively healthy age group and they may not yet have family obligations that would encourage them to purchase coverage for a spouse and children.

Chart 7
The Percentage without Health Insurance
for Different Age Groups, 2006
 (e.g., 29.3% of 18 to 24 year olds are uninsured)

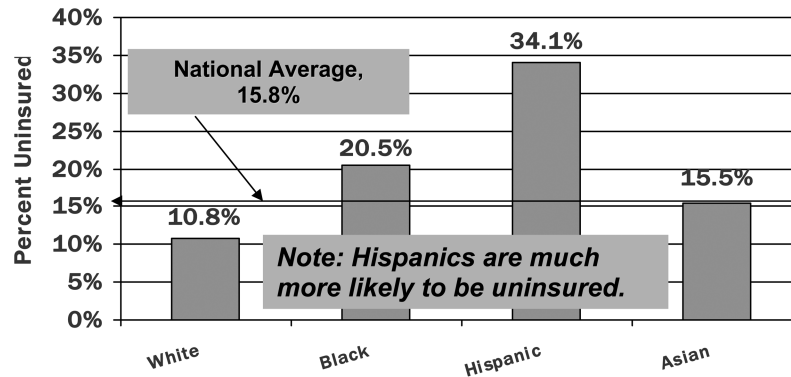


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Race/Ethnicity and Coverage: There are clear differences in health insurance coverage between the different racial and ethnic groups in the country. Chart 8 displays the coverage rates for the four largest racial/ethnic groups in the country. For this analysis the Census Bureau counted only people who identified themselves as fully “White, not Hispanic”; “Black, not Hispanic”; “Hispanic” or “Asian”. People of different racial/ethnic groups and mixed racial/ethnic backgrounds were not included in this particular analysis.

Hispanics have the highest percentage without health insurance - 34.1 percent in 2006. Blacks have the next highest with 20.5 percent in 2006. Asians had 15.5 percent uninsured and whites had 10.8 percent uninsured in 2006. How race/ethnicity interacts with the other factors is an open question. What part of the higher rate for Hispanic is really associated with a higher percentage of immigrants within the Hispanic subpopulation? Is this a problem for immigrants no matter what racial/ethnic group they come from or is there some aspect of this problem that is specifically severe for the Hispanic subpopulation unrelated to immigration? Many of these questions need much further and more rigorous research to help inform the policy discussion.

Chart 8
The Percentage without Health Insurance for
Different Racial/Ethnic Groups, 2006
 (e.g., 34.1% of Hispanics do not have insurance)



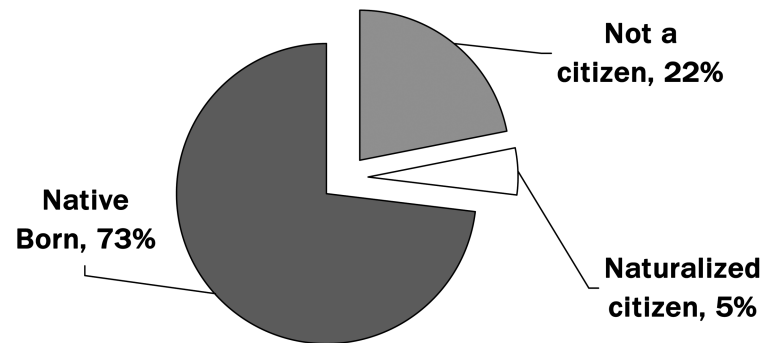
Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI01. U.S. Bureau of the Census.

Immigration and Coverage: The interaction between immigration status and coverage status poses very challenging policy choices. Chart 9 shows the distribution of the uninsured by citizenship and immigration status. The latest data from the Census Bureau estimates that while non-citizens comprise about 8 percent of the population they comprise 22 percent of the uninsured or about 10.2 million people.⁴

There is no reliable way to accurately estimate how many of these non-citizens are in the country legally or illegally. Understandably, immigrants here illegally are not particularly forthcoming about their status when interviewed by Census Bureau interviewers. However, based on the types of jobs and benefits available to illegal immigrants, it is reasonable to deduce that illegal immigrants are more likely to be uninsured than legal immigrants.

⁴ U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. http://pubdb3.census.gov/macro/032007/health/h09_000.htm. Table HI09. US Bureau of the Census.

Chart 9 -
Percentage of the Uninsured by Immigration Status, 2006
 (22% of those uninsured are not citizens)



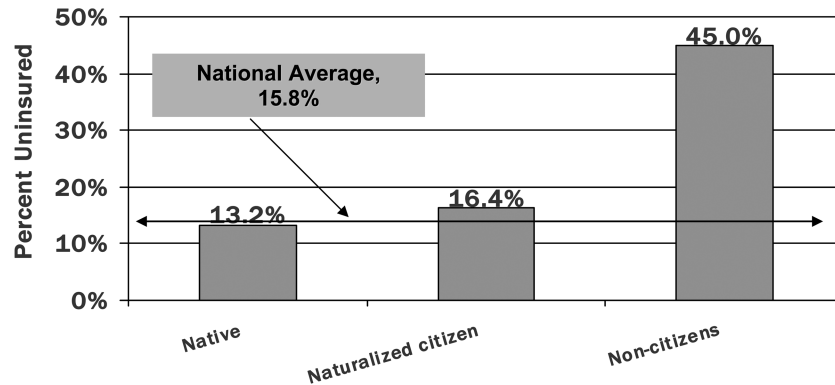
Note: Non-Citizens make up only 8% of the population, but 22% of the uninsured.

Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI09. US Bureau of the Census.

Even among those immigrants that are here legally, restrictions are placed on some forms of government-based coverage. For example, legal immigrants are ineligible for Medicaid or SCHIP until they have been legal permanent residents for five years. In addition, when an immigrant is sponsored for immigration by an American citizen, the resources of an immigrant's sponsor are counted in addition to those of the immigrant's family.

If nothing else, it is important to note that the Census Bureau's estimate of 47 million uninsured in 2006 is not 47 million Americans; it is 47 million people living in the United States. The Census Bureau's estimate of uninsured Americans is 37 million in 2006.

Chart 10
The Percentage Without Health Insurance
By Immigration Status, 2006
 (45% of non-citizens do not have insurance)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table H109. U.S. Bureau of the Census.

Like age, citizenship correlates strongly with insurance coverage. Non-citizens are approximately three times more likely to be uninsured than are native or naturalized citizens.

This section has illustrated how diverse the different subpopulations of the uninsured can be. Other than being uninsured, they often have little else in common.

2. Policy Dimensions

Designing and assessing proposals to provide health care access to those without insurance is remarkably complex.

Affordability of coverage becomes a necessary policy dynamic when considering proposals that expand coverage either through voluntary or mandatory measures directed at individuals, firms, or insurance pools.

Assuming that the goal of providing coverage for everyone in this country is achievable, it is unnecessary to triage subpopulations of the uninsured to determine when and in what order they should be included.

However, in the event that policy makers have to make some hard choices about who will be assisted in gaining coverage due to budget constraints or the realities of political compromise, a conceptual framework to help make such decisions is provided below.

Chart 11 illustrates the conceptual framework. Three dimensions are chosen here representing three of the more common concerns:

- Desire for coverage
- Time without coverage
- Citizenship

Desire for coverage

A key dimension is desire for coverage, which can be broken down as follows:

- Those who do not seek coverage, even if it is available and affordable.
- Those who seek coverage but cannot afford it.
- Those desperate for coverage, willing to pay almost any price if it were only available, e.g., some groups of the chronically ill.

Those favoring universal coverage in its broadest sense have sought coverage regardless of an individual's desire for coverage. This would include the single, healthy, young adult who doesn't see a need for health insurance at this point in life.

Those favoring a phased-approach to health coverage may have a greater policy concern for the uninsured 55 year-old diabetic with complications than the new, healthy, college graduate.

Time without coverage

A second dimension is time without coverage. The somewhat limited data on coverage indicates a range in the number of people uninsured for brief periods of time versus those uninsured for an entire year or more. We know that at a minimum the longer the person is uninsured the longer the potential gap in screenings and other preventive services. In this example, if a policymaker were looking to phase-in insurance, the highest priority might be given to the people uninsured for the longest period of time, e.g., over two years.

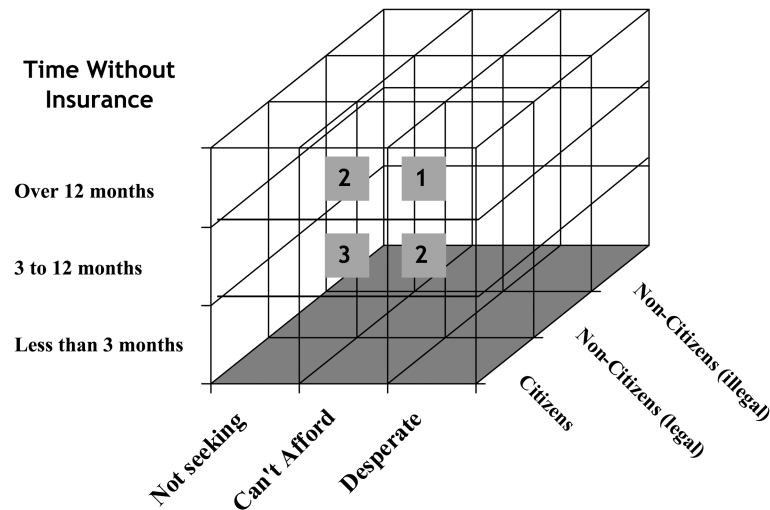
Citizenship status

The third key dimension is citizenship status. As noted above more than 20 percent of the uninsured are not U.S. citizens. There may be neither a

political consensus nor the budget to extend coverage to all people living in the United States. A likely scenario would have coverage first offered to citizens, either native or naturalized. There may be a further consensus over coverage to legal immigrants. Gaining the political consensus necessary to offer coverage to illegal immigrants seems unlikely.

Chart 11 below provides a visual way to think about the interactions among the three policy dimensions outline above. For example, people falling in the high priority on all three dimensions are assigned an overall priority of 1. The assignment of priorities will vary from policymaker to policymaker and person to person based on their individually held judgments.

Chart 11
Conceptual Tool for Thinking about the Uninsured



Other dimensions

Age may provide yet another dimension on which to prioritize coverage. Children are a vulnerable population as well as a relatively inexpensive

population to insure. Medical need may provide another dimension although it may be difficult to determine who is most medically needy.

3. Matching the Right Policy to the Right Population:

It is unlikely that only one option would meet the needs of all these different subpopulations. For small businesses with moderate income employees, a successful solution might include access to both purchasing pools, so they have options similar to larger firms, and an improved tax advantage to help offset the cost of coverage.

For the uninsured without employment-based coverage, it could be made much more affordable if they had access to the same tax advantages as employer-based coverage.

For immigrants, legal or illegal that same combination of incentives would probably not be anywhere near as effective. Also, especially for the illegal immigrants, it seems unlikely that expanded government programs would prove effective. Asking illegal immigrants to interact with government intake and eligibility officials is unlikely to generate much trust and compliance. This subpopulation may be better served through a clinic approach which ensures care, if not coverage, and is closer to the model of care found in many of their home countries.

The various policy tools that could be brought to bear to best meet the needs of these different subpopulations all have ideological implications for policymakers. It is not unusual that when confronted with a challenging policy problem many Democrats are more comfortable trying government-based approaches and many Republicans are more comfortable trying market-based approaches. These preferences were apparent in the design options for a Medicare drug benefit.

In crafting a solution to the problem as complex as the uninsured, there will be ample opportunities to try both market-based and government-based solutions. Policymakers will need to carefully consider the circumstances of the subpopulation involved to judge which type of design will be the most successful. A systematic examination of the composition of the uninsured, a prioritization of those to receive insurance assistance, and identification and review of the mix of tools available to help the uninsured gain access to healthcare will help shape a scientifically sound and viable policy in the future.

*Chairman STARK. Thank you very much, doctor.
 Mr. Brock, what can you add to the wonderful program, which we just viewed? Please.

STATEMENT OF STAN BROCK, FOUNDER AND VOLUNTEER DIRECTOR OF OPERATIONS, REMOTE AREA MEDICAL, KNOXVILLE, TENNESSEE

*Mr. BROCK. I'll try. Thank you, sir.

Remote Area of Medical, often referred to the acronym, RAM, was formed in 1985 as a tax-exempt 501(c)(3) publicly supported organization headquartered in Knoxville, Tennessee. Its intent was to provide airborne medical and veterinary relief for the Wapishana Indians, with whom I had lived for many years in a remote area over the upper Amazon. However, observations at our U.S. base in the heart of Appalachia revealed a substantial need for RAM free services here at home. The need is massive and it touches all regions of America, both rural and urban. It's not limited to the homeless, unemployed, and uninsured. It affects the working class and those who have insurance. Health care in America has become a privilege of the wealthy and well-insured.

More than 15 percent of America's population are uninsured, and there are millions more who have insurance inadequate to meet the needs of a catastrophic medical event or visits to the dentist or eye doctor.

The RAM experience in hundreds of thousands of cases proves huge numbers of Americans cannot afford routine dental care and simply neglect their teeth. RAM data showed that our volunteer dentists extract an overwhelming number of teeth that are beyond repair. People tell us they face thousands of dollars of dental work, and when we look in their mouths, we see cases as bad as any discovered among the Amazonian tribal groups.

The state of vision care among those who visit RAM clinics is no better. They can't afford an eye exam and if they had one, can't afford the prescription glasses. No wonder hundreds, sometimes a thousand people line up throughout the night before a RAM-free clinic in an effort to get their teeth fixed and obtain a free pair of glasses from us.

Services for children under the age of 18 usually are covered by state programs, but access can be difficult. Topping the list of reasons is government reimbursements are too low, and paperwork too cumbersome to make it worthwhile.

Once people transition into adulthood, they are on their own for dental and vision care, unless they're able to pay large insurance premiums. I received a call last Sunday from a 38-year-old working mother of four in Kentucky. All five of the family have serious dental problems. She has insurance through her employer, but it has a \$50 deductible, and when the plan pays, she has to cover an unaffordable 20 percent co-payment. Her 17-year-old needs his wisdom teeth extracted, but the plan does not cover the \$700 for the anesthesia. The mother needs her own teeth extracted so she can get dentures. Oh, and the family cat needs to be spayed. I told her to come to the RAM clinic at Lincoln Memorial University at the end of May and would fix everybody's teeth, and a RAM volunteer vet would spay the cat, all free.

Why does the United States, the richest country on our planet, have a health care system ranked No. 37 out 190 countries by the World Health Organization? We have the most advanced technology accessible only to those who can afford it.

America's poor and the not-so-poor, who have some type of insurance are suffering debilitating pain and health risk from diseased teeth and are handicapped with vision problems that are correctable, but not affordable.

When Britain was at war in 1941 the government realized that they needed a national health care system, and in 1944 gave the minister of health and Aneurin Bevan a mandate to develop it. I'm not advocating that the United States follow Britain, France, Canada, Germany, or any other developed country which has some form of national health care system; however, I am convinced that the RAM experience with the hundreds of thousands of patients we have seen that America does need to provide free care for the millions who cannot afford it, and free dental and vision care for the adults must be included.

In closing, I would like to stress that a great impediment to providing free care in this country is that willing volunteer health care providers holding licenses in one state are not allowed to provide free care in another.

Tennessee changed this in 1995 with the enactment of the Volunteer Health Care Services Act. Under that law, any charitable organization can bring volunteer medical workers and vets licensed anywhere in the U.S. into Tennessee to provide free care. House concurrent resolution No. 69 was introduced to Congress in 1997 to encourage national adoption of the Tennessee model. To our knowledge, it never got out of Committee. If practitioners were allowed to cross state lines to provide free care for those in need and had protection from frivolous malpractice suits, the system of free care that RAM has developed and proven throughout all these years, could be replicated throughout America.

I'd like to thank the Committee for inviting me today, and thank you, CBS, 60 Minutes, for dramatically focusing on this national problem.

[The prepared statement of Stan Brock follows:]

Prepared Statement of Stan Brock, Founder and Volunteer Director of Operations, Remote Area Medical, Knoxville, Tennessee

Remote Area Medical, often referred to by the acronym, "RAM," was formed in 1985 as a tax exempt 501c3 publicly supported organization headquartered in Knoxville, TN. Its intent was to provide airborne medical and veterinary relief for Wapishana Indians with whom I had lived for many years in a remote area of the upper Amazon.

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If practitioners were allowed to cross state lines to provide free care for those in need, *and* had protection from frivolous malpractice suits, the system of free care that RAM has developed and proven throughout all these years could be replicated throughout America.

*Chairman STARK. Thank you, Mr. Brock.
Mr. Finan, would you?

**STATEMENT OF STEPHEN FINAN, ASSOCIATE DIRECTOR OF
POLICY, AMERICAN CANCER SOCIETY**

*Mr. FINAN. Good morning, Mr. Chairman, Mr. Camp, and distinguished Members of the Committee. Thank you for inviting the American Cancer Society year to testify today. The American Cancer Society is a nation-wide, community-based voluntary health organization dedicated to eliminating cancer. The Society and its sister advocacy organization, the American Cancer Society Cancer Action Network, are working together to elevate the issue of access to care and its impact on cancer patients and their families.

I would like to begin my discussion of inadequate health insurance by sharing Doreen's story with you. Doreen, a 57-year-old former medical office receptionist, was diagnosed with stage IV breast cancer in the fall of 2005. The cancer spread to her spinal column, liver, lungs, and left femur.

Doreen's husband is a retired New York policeman, and she has health insurance through his retirement plan. Her plan limited her to thirty outpatient visits a year, a number Doreen quickly exceeded. Her plan had other restrictions as well, including a limit that initially prevented her from getting a stent for her chemotherapy. She was ultimately allowed to have the procedure for the stent, but only after a delay. She also learned of some of these restrictions from her plan, only after she had exceeded them. As a result, in less than a year Doreen and her husband owed more than \$100,000 to the hospital for various treatments. These significant restrictions resulted in delays in treatment and great emotional stress that further jeopardized her health.

As defined by the Society, adequate health insurance insures timely access to the full range of evidence-based health care services necessary to maintain health, avoid disease, overcome acute illness, and live with a chronic condition. These services include the complete continuum of evidence-based cancer care for preventing treatment and support needs, including clinical trials.

Doreen is one of 16,000 people who have called the American Cancer Society because she had problems with her private health insurance. The primary problems we have identified among those with inadequate health insurance include annular life-time dollar limits or restrictions on necessary services, like Doreen experienced; no or limited coverage within the plan for out-of-network specialists, limiting the patient's ability to access care; no or limited coverage within the plan for prescription drugs.

But the biggest single issue we see is related to cost sharing. Nearly two-thirds have trouble meeting deductibles, paying their co-insurance for prescription drugs and treatment, and covering costs for necessary services not covered by their plan.

Let me illustrate the cost-sharing problem with Martha's story. Martha, a 63-year old retired woman, was diagnosed with stage I breast cancer in November of 2007. Martha's cancer treatment included surgery followed by radiation. Martha has health insurance but the policy is inadequate. For example, the insurance paid \$100,000 of a \$10,000 hospital bill for her surgery. Her accumulated deductibles and co-pays for various medical services have left her with \$28,000 in medical debt and the hospital is threatening her with a collection agency.

Co-pays and deductibles may be reasonable or routine care, but when a person has a serious medical condition like cancer, the accumulated expenses can become very significant. Today Martha is struggling with keeping her head above water financially.

Some of the most disheartening kinds of stories we hear are from people who have had to interrupt their treatment because of inadequate coverage. We logged nearly 900 such cases last year. Please think about this for a minute. These are people who have stopped treatment for a deadly disease because they cannot afford to pay for additional necessary care.

For them a decision to delay treatment is often a life-or-death decision, but if they proceed, they risk breaking themselves and their families financially.

More formal studies support our experience. For example, nearly 1 in 3 cancer patients who are insured have out-of-pocket costs that exceed 10 percent of their family income. More than 1 in 9 cancer patients with insurance have out-of-pocket health costs that exceed 20 percent of their family income. Twenty percent of cancer patients with insurance use all or most of their savings when dealing with their financial costs of cancer. And 10 percent of medical bankruptcies are from people who have had a cancer diagnosis.

The problem of under-insurance is very difficult to measure, but we know the problem is very real for many cancer patients. This should be a concern to everyone, because cancer can touch us all. Slightly less than 1 in 2 men will have cancer in their lifetime, and slightly more than 1 in 3 women will.

Although I've focused on the issue of adequacy of insurance, the American Cancer Society is also greatly concerned about the problems of the uninsured which the other witnesses this morning have addressed. We believe that the science and the knowledge exist to provide quality care for all Americans, but we must work together to restructure our coverage and delivery systems to achieve that goal. Your hearing today is a valuable contribution to that discussion.

Thank you, Mr. Chairman.

[The prepared statement of Stephen Finan follows:]

**Prepared Statement of Stephen Finan, Associate Director of Policy,
American Cancer Society**

Good morning, Mr. Chairman and distinguished Members of the Committee. My name is Stephen Finan, Associate Director of Policy for the American Cancer Society. The American Cancer Society is a nationwide, community-based, voluntary health organization, dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

Thank you for inviting the American Cancer Society to testify. As you may know, ACS, and its sister advocacy organization the American Cancer Society Cancer Action Network (ACS CAN) are working together to elevate the issue of access to care and its impact on cancer patients and their families by educating the public and policymakers about problems in the health care system and the need for change. We look forward to working with this Subcommittee as you work toward solutions to improve and expand access to quality care.

This morning you are listening to other speakers on the panel describe the problem of availability of health insurance. Although we fully share that concern, I would like to take this time to shed light on the under-appreciated, and at times overlooked, problem of adequacy of insurance. I would like to paint a picture—all too common in America—of how cancer patients and survivors with inadequate insurance face barriers and financial burdens in getting the quality health care they need to fight their dreadful disease.

Doreen's Struggle With Inadequate Insurance Coverage

Let me begin our discussion of inadequate insured by sharing Doreen's story with you. Doreen, a 57-year-old former medical office receptionist, was diagnosed with Stage IV breast cancer in the fall of 2005. The cancer metastasized to her spinal column, liver, lungs, and left femur. Doreen and her husband, a retired New York City police officer, have health insurance through his retirement plan. The insurance covers 30 outpatient visits a year, a number Doreen quickly exceeded after beginning treatment for her cancer. After she reached this annual limit, she was billed \$5,000 a week for chemotherapy treatments. In less than a year, Doreen and her husband owed more than \$100,000 to the hospital for her treatment. By the time

Doreen's insurance company informed her that she had exceeded her maximum number of outpatient visits, she had already made additional visits the plan would not cover. Fortunately for Doreen, she spoke at an American Cancer Society event about her inadequate insurance and the story ran in the Long Island *Newsday*. Upon reading the article, the insurer reversed the decision and paid Doreen's medical bills in full. While Doreen's story turned out well, countless others are not as fortunate to have a platform to share their story.

It was stories like Doreen's and the countless stories of uninsured Americans' struggle with this dreadful disease that brought the American Cancer Society to the conclusion that we had to enter the broader national debate about access to care.

Defining Adequate Health Insurance

As defined by the Society, adequate health insurance ensures timely access to the full range of evidence-based health care services (i.e., rational, science-based, patient-centered)—including prevention and primary care—necessary to maintain health, avoid disease, overcome acute illness, and live with chronic illness. These services include the complete continuum of evidence-based cancer care for treatment and support needs including clinical trials. Coverage should be comprehensive and protect the individual from incurring catastrophic expenditures.

Little Help Available for Those With Inadequate Insurance

The stories we are giving you come from our Health Insurance Assistance Service (HIAS), which is a service offered through the American Cancer Society's National Cancer Information Center (NCIC). HIAS is a free resource that connects callers with health insurance specialists who work to address their needs. The specialists at NCIC handle inquiries about health insurance, coverage dynamics, and state programs—all specific to the caller's needs. To date HIAS has captured almost 16,000 cases from 32 states, with plans to expand the program to other states.

The volume and type of calls received are captured as part of an internal database that allows for analysis of trends and emerging issues. While the database is not systematic or representative of all Americans, the volume and type of calls we receive identify serious problems that exist in our insurance system today. A recent analysis of the cases in the database revealed interesting information about cancer patients who have inadequate health insurance. In general, the Society is able to assist 1 in 6 cancer patients who contact HIAS about their health insurance problems. In the cases where we were unable to help the cancer patient, we can identify barriers in the current health insurance system facing cancer patients.

HIAS receives calls from individuals who are uninsured, those who are transitioning between plans, and cancer patients who are currently insured. Many of these callers are people who have been recently diagnosed or who are in treatment for cancer.

The problems we have specifically identified among those with inadequate insurance include:

- Annual or lifetime benefit limits within the plan that results in the patient not being able to access further cancer care without incurring medical debt.
- No or limited coverage within the plan for out-of-network specialists, limiting the patient's ability to access quality cancer care.
- No or limited coverage within the plan for prescription drugs or treatments.
- Mounting, affordable co-pays or co-insurance.

For these callers, there is seldom help available to solve their problems. Unfortunately, there are few safety net options for the under-insured.

The biggest single issue is related to cost-sharing being too high. Nearly two-thirds (63 percent) stated cost-sharing as their primary reason to call HIAS. These callers had trouble meeting deductibles, paying their co-insurance for prescription drugs and treatment, and covering costs for physician visits and non-network specialty care.

Martha's Financial Struggle With High Cost-Sharing

I would like to share a story from HIAS of a cancer patient who was insured and struggled financially because of the high cost-sharing for covered benefits. Martha, a 63-year-old retired woman, was diagnosed with Stage I breast cancer in November 2007. For her cancer treatment, Martha had surgery followed by radiation. Martha is now post-treatment, but still needs periodic follow-up visits to her oncologist to monitor for recurrence. Martha has a health insurance policy, but the policy is inadequate for her needs. For example, the insurance paid \$1,000 of a \$10,000 hospital bill for her surgery. Martha said she is \$28,000 in medical debt due to her cancer diagnosis, and the hospital is threatening her with a collection agency. Martha lives in a state that has a medically underwritten individual insurance market, so it is

unlikely she would be offered another policy. Martha beat her cancer, but now she is struggling with keeping her head above water financially.

Patients Interrupting Treatment Because of Inadequate Coverage

Some of the most disheartening kind of stories we hear come from people who have had to interrupt their treatment because of inadequate coverage. Nearly 900 of the cases logged in the last year have involved cancer patients interrupting their treatment, meaning they elect to stop their treatment before it has been completed. Please think about this for a moment—these are people who stop treatment for a deadly disease because they cannot afford to pay. The consequences of this decision could be detrimental to their health and may very well be a life or death situation.

Another common problem we see involves pre-existing condition restrictions on coverage. Although this is an access problem, it can also be viewed as an adequacy issue. If the caller has a current cancer diagnosis or a history of cancer, insurers may limit their coverage by imposing a pre-existing exclusion period. These exclusions eliminate all coverage for cancer-related health care for the duration of the exclusion period—usually 6–12 months, but sometimes permanently, depending on the coverage type. Pre-existing condition exclusion periods are a leading reason why HIAS callers do not enroll in coverage options available to them. They cannot afford to pay for premiums without receiving coverage for their cancer.

Let me share a story illustrating the adequacy problems related to the exclusion of pre-existing conditions. Thomas, a 35-year-old married father of three, was diagnosed with testicular cancer in March 2004. At the time, he was insured and able to get the appropriate care to successfully treat his cancer with surgery and radiation. Thomas' wife called HIAS because Thomas was without insurance and needed follow-up care to ensure his cancer remained in remission. Thomas could not receive the follow-up tests, which cost more than \$2,500, without insurance or a means to pay. Since his remission, Thomas started his own business and lost his previous coverage. He attempted to get coverage in the individual market, but due to medically underwriting he was denied several insurance policies. Thomas was eligible for the state high risk pool; however, Thomas said the 12-month pre-existing exclusion period renders this option not viable. Thomas remains uninsured and unable to access the follow-up care to monitor his health.

Cancer and the “Under-Insured”

The problem of paying costly medical bills affects middle-class families, particularly those with chronic diseases such as cancer. Often insurance policy deductibles, co-payments and limits on health services may leave cancer patients without access to the timely, lifesaving treatment they need. Cancer patients may have to deal with major financial burdens because of out-of-pocket costs in addition to their cancer diagnosis. We receive calls everyday from cancer patients with these problems and published research is available that supports these problems of inadequate and unaffordable insurance as illustrated through the HIAS stories.

A recent study analyzing data from the Medical Expenditures Panel Survey (MEPS) shows the breadth of this kind of financial problem.¹ The MEPS household survey, sponsored by the Agency for Health Care Research and Quality (AHRQ), collects information from the non-elderly, non-institutionalized U.S. population. The survey asks American families questions about health insurance coverage, health care utilization, and health care expenditures. In this study, the researchers defined “under-insured” as people with insurance spending 10 percent or more of their tax-adjusted family income on health care services, including insurance premiums. Nearly 1 in 3 (28.8 percent) cancer patients who are insured have an out-of-pocket health care burden that exceeds 10 percent of their family income. More than 1 in 9 cancer patients with insurance have out-of-pocket health care burdens exceeding 20 percent of their family income in health care expenditures.

Cancer patients who have inadequate coverage have higher medical costs and must deal with the additional stress of financial instability. A survey of cancer patients and their families found that one in five cancer patients with insurance uses all or most of their savings when dealing with the financial costs of cancer.² Another study found that more than one in five people with chronic conditions have problems paying medical bills. Furthermore, the incidence of burdensome out-of-pocket spend-

¹ Banthoin JS, Bernard DM. Changes in financial burdens for health care: National estimates for the population younger than 65 years, 1996 to 2003. *JAMA* 2006; 296: 2712–19.

² *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1–September 14, 2006.

ing among low-income, privately insured people with chronic conditions is rising dramatically.³

Medical debt has been an important cause of bankruptcy filing in the U.S. An analysis of national survey data found nearly six of ten adults who had current-year difficulty paying medical bills and 70 percent of those reporting medical debt said they were insured at the time their problems began.⁴ Another study examined the causes of bankruptcy and found that 1.9–2.2 million Americans experienced bankruptcy related to medical problems in 2001.⁵ Among those with illnesses that led to bankruptcy, their out-of-pocket costs average \$11,854 and three-quarters had insurance at the time of their diagnosis.

Despite having insurance, many cancer patients and survivors experience major financial burdens. The situation of the “under-insured” is difficult to measure because wide variation exists among health insurance plans and people do not realize they are “under-insured” until they have a health crisis such as cancer. Furthermore, studies like the one I previously mentioned use a narrow definition to measure the number of “under-insured”—that is, they do not include those who stop or delay treatment because they will not be able to afford it. While we use these studies to talk about the “under-insured,” they do not fully capture the nature and extent of the problem.

American Cancer Society’s Commitment to Access to Care

Our testimony this morning focused on the issue of adequacy, but the American Cancer Society is also greatly concerned about the problems of the uninsured, which the other witnesses this morning are addressing.

We have made significant progress in recent years in addressing the cancer problem. Cancer death rates have decreased by 18.4 percent among men and 10.5 percent among women since the early 1990s. Despite this significant progress, the American Cancer Society realizes that its long-term goals of reducing the incidence and mortality of cancer cannot be achieved unless the gaps that exist within the current health care system are addressed. The challenge lies in the fact that our health care system is not up to the task.

A recent American Cancer Society study of 12 types of cancer among more than 3.5 million cancer patients dramatically demonstrates the problem of access today for uninsured cancer patients.⁶ The study found uninsured patients were significantly more likely to present with advanced stage cancer compared to patients with private insurance. The study found consistent associations between insurance status and stage at diagnosis across multiple cancer sites. Compared to patients with private insurance, uninsured patients had significantly increased likelihoods of being diagnosed with cancer at more advanced stages. The greatest risk for diagnosis with moderately advanced cancer (stage II) instead of the earliest stage (stage I) was in colorectal cancer, while the highest risk for diagnosis at the most advanced stage of cancer (stage III/IV) was in breast cancer. The study shows that too many cancer patients are being diagnosed too late, when treatment is more difficult, more expensive, and has less chance of saving lives.

We know that individuals and families who are uninsured or have inadequate insurance often go without preventive care despite research showing that early detection and timely treatment are effective in improving outcomes.

We know that cancer patients who are uninsured or have inadequate insurance often do not receive necessary and appropriate treatment in a timely manner, and that they have worse health because of these problems.

And we know we cannot meet the American Cancer Society’s goals of reducing cancer mortality by 25 percent and cancer incidence by 50 percent by 2015 if we don’t achieve greater improvements in our nation’s coverage and health care delivery systems.

The recognition of these problems for cancer patients led the American Cancer Society to decide to enter the broader national debate on health care reform. Last year, the Society developed evidence-based principles defining meaningful health insurance to be adequate, available, affordable, and administratively simple without re-

³Tu HT. Rising health costs, medical debt, and chronic conditions. Center for Studying Health System Change Issue Brief No. 88, September 2004.

⁴Doty MM, Edwards JN, Holgren AL. Seeing red: Americans driven into debt by medical bills. The Commonwealth Fund, August 2005.

⁵Himmelstein DB, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff* 2005; Web exclusive: 63–73.

⁶Halpern MT, Ward EM, Pavluck AL, Schrag NM, Bian J, et al. Association of Insurance Status and Ethnicity with Cancer Stage at Diagnosis for 12 Cancer Sites: A Retrospective Analysis. *Lancet Oncology* 2008; 9:222–31.

gard to health status or risk. These guiding principles, known as the 4As, are essential to any health care reform. (The principles are attached as Appendix A.)

Conclusion

Cancer death rates are decreasing and we know what we must do as a nation to defeat cancer. Much of the public debate today is about the need to cover the 47 million uninsured, and the American Cancer Society fully shares that concern. However, we need to recognize more fully the very significant problem of underinsurance. Health plans vary enormously in their deductibles, co-pays, benefits covered, and exceptions. Insurance plans are written in very detailed legalistic language that very few lay people can begin to comprehend, and the summary plan documents that are provided to enrollees almost never begin to convey the adequacy of coverage. Put another way, if you were to look at an array of plans that might be available to you as a consumer, and you were to ask, what would be the adequacy of your coverage if you were to be diagnosed with cancer or some other serious disease, you would probably conclude that you have no idea whether the plan would be adequate. As we see all too often in our HIAS cases, people often discover after their diagnosis what their plan really means—and that is a point where for most patients it is virtually impossible to change coverage. As an appendix to my testimony, I am including additional stories that highlight the problems of the inadequately insured. (The stories are attached as Appendix B.)

In adopting our principles for meaningful health insurance—our 4As—we said that adequacy should cover the full array of necessary services, from early detection through treatment and survivorship, but we did not attempt to define the specifics of an adequate plan. Rather, our goal is to stimulate a public discussion that will lead to a broad consensus. We want to raise the issues through the campaigns this year and carry the discussion forward at the Federal and State level as legislative reform efforts are developed. We believe the science and the knowledge exist to provide quality health care for all Americans, but we must work together to restructure our coverage and delivery systems to achieve that goal. Your hearing today is a valuable contribution to that discussion.

Thank you.

Appendix A:

American Cancer Society Statement of Principles on What Constitutes Meaningful Health Insurance

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society has set ambitious goals for significantly reducing the rates of cancer incidence and mortality along with measurably improving the quality of life for all people with cancer.

“The ultimate conquest of cancer in America is as much a public policy aspiration as it is a scientific and medical challenge. There are many stakeholders in the cancer fight actively doing their part to defeat this disease, but it cannot be done without the sustained leadership and strong commitment of government. We are poised to make gains so substantial that we now can talk about a time when cancer is no longer a killer and is instead just a chronic condition, or even better, a disease for which a cure is a realistic, frequently achieved goal. Our nation’s current health care system is not up to this challenge. If we are to ultimately conquer cancer our system must ensure that all Americans have access to high quality care.”⁷

Improving the nation’s health care system requires a new partnership for the nation that will facilitate the coverage and delivery of quality evidence-based cancer care and work to eliminate disparities and inequities in the current system. This will require a commitment from the private, public, and not-for-profit sectors and individuals. Stakeholders in the health care system, from doctors, hospitals, and insurers, to employers, and not-for-profit organizations, all have critical roles to play. All Americans have an obligation, as well, to take responsibility for their own health to the extent possible, by pursuing healthy lifestyles, and educating themselves about their health needs, including ways to prevent and detect cancer.

A critical aspect of improving the health care system is to define and ensure access to meaningful public or private insurance. This includes adequate financing. Our nation has had much conversation on the insured and uninsured and less on what it means to be meaningfully insured. Below is the statement of the American Cancer Society on what constitutes meaningful health insurance.

⁷Dr. John Seffrin, American Cancer Society CEO, Statement to ACS Board of Directors during January 2006 meeting.

Statement of Principles

It is a fundamental principle of the American Cancer Society that everyone should have meaningful public or private health insurance.

Meaningful health insurance is adequate, affordable, available and administratively simple.

Adequate health insurance means:

- *timely access and coverage of the complete continuum of quality, evidence-based healthcare services (i.e., rational, science-based, patient-centered), including prevention and early detection, diagnosis, and treatment*
- *supportive services should be available as appropriate, including access to clinical trials, chronic disease management, and palliative care*
- *coverage with sufficient annual and lifetime benefits to cover catastrophic expenditures*

Available health insurance means:

- *coverage will be available regardless of health status, or claims history*
- *policies are renewable*
- *coverage is continuous*

Affordable health insurance means:

- *costs, including premiums, deductibles, co-pays, and total out-of-pocket expenditure limits, are not excessive and are based on the family's or individual's ability to pay*
- *premium pricing is not based on health status or claims experience*

Administratively simple health insurance means:

- *clear, up-front explanations of covered benefits, financial liability, billing procedures, and processes for filing claims, grievances, and appeals are easily understood and timely, and required forms are readily comprehensible by consumers, providers and regulators*
- *consumers can reasonably compare and contrast the different health insurance plans available and can navigate health insurance transactions and transitions*

Appendix B: Stories from Cancer Patients on the Adequacy of Health Insurance

Since 2005, the Society has documented real stories from cancer patients who have had trouble accessing adequate coverage. These case studies reflect actual cases of cancer patients who called the American Cancer Society National Cancer Information Center for advice navigating the health care system and solving coverage problems.

Randy, 63 years old, Pennsylvania

Following his diagnosis with Stage IV esophageal cancer, Randy had surgery to remove his esophagus and stomach. Radiation and intense chemotherapy followed. Randy quickly reached the \$100,000 lifetime cap on his major medical coverage and now receives no further benefits. He has paid out of pocket for follow-up scans and labs to monitor his condition. Because he had 18 months of continuous, creditable coverage, Randy would've been eligible by Federal law for a policy with no pre-exclusionary period. However, he wasn't aware of the option until after it had expired. Meanwhile, Randy and his wife are ineligible for AdultBasic or Medicaid, and he is unlikely to get private insurance due to medical underwriting. Randy's only option, a guaranteed issue policy, includes a pre-existing condition exclusionary period of up to three years. The policy allows for riders that could modify the benefits and conditions of his coverage. Ultimately, Randy will have to wait two years to become Medicare eligible. He has no other choice.

Valerie, 34 years old, Georgia

Valerie, a mother and wife, is a contract worker for a small staffing agency. Her husband, Jeff, is a car salesman. The family's income fluctuates based on her workload and his commission. Valerie was recently diagnosed with Stage IV breast cancer and is currently undergoing treatment. She has employee-sponsored insurance through the staffing agency, but she quickly met the plan's \$10,000 yearly maximum benefit. She now owes \$6,000 in bills to her oncologist's office and is responsible for the cost of her treatments moving forward. Those treatments include three more rounds of chemotherapy and potentially radiation or surgery. Valerie doesn't

want to change insurance, largely because the other members of her family are covered under her plan. Jeff doesn't have access to employee-sponsored insurance at his job. Valerie will likely be denied insurance in the individual market because of medical underwriting. Therefore, she can't buy a supplemental policy to cover her chemotherapy. She will continue paying her considerable treatment costs out of pocket.

Kay, 61 years old, Florida

Kay works part time at a large department store earning \$13,000 per year. She has insurance through her employer but quickly exceeded the plan's \$25,000 annual maximum following her diagnosis with Stage II breast cancer. She has received eight cycles of pre-operative chemotherapy, had a lumpectomy with auxiliary lymph node dissection, and now needs radiation. Kay already has \$40,000 in outstanding medical bills from various diagnostic tests that were not covered. Now she's been told that she cannot begin radiation unless she plans to bring \$115,000 with her to the first appointment. Kay's Medicaid application is pending; it will take months before she learns if help is available. Meanwhile, she will likely be denied private insurance because of medical underwriting. Kay has no adequate insurance options.

Bettie, 57 years old, Florida

Bettie works at a toll both in Florida. She exceeded the \$50,000 annual maximum on her employer-sponsored insurance within six weeks of her breast cancer diagnosis. Bettie had a lumpectomy followed by auxiliary dissection of her underarm lymph nodes. She has been unable to start radiation treatments and is now uninsured; her plan was terminated when her employer changed parent companies. Bettie has been told that she cannot enroll in the new employee-sponsored plan until she returns from short-term disability. She is currently caring for her husband, a double amputee, and spending many hours searching for a way to afford her radiation treatments.

Andrew, 19 years old, Rhode Island

Andrew was recently diagnosed with Hodgkin lymphoma. He is on leave from his landscaping job and receives \$641 per month in unemployment compensation. Andrew's outstanding medical bills currently total between \$15,000 and \$20,000. He has private insurance but his treatments sometimes exceed the policy's limit of \$1,000 per day for chemotherapy. The insurance also does not cover many of his hospital costs. Andrew's boss has offered him a different insurance policy once he returns to work. Andrew will elect the new coverage option when the time comes. However, his medical debt will remain.

Donna, 45 years old, Ohio

Donna has two children. She works full time, and her annual income is \$27,000. She was recently diagnosed with breast cancer. Donna does have health insurance, a major medical individual policy that she purchased after her company ended its group plan. However, she quickly met the \$10,000 limit on outpatient services under her new plan. Donna's treatment, including 15 chemotherapy sessions, has left her with more than \$100,000 in outstanding medical bills. Donna is uncertain how she is going to pay the debt and handle future out-of-pocket costs. She had been supplementing her income through a second, part-time job but had to give that up once her chemotherapy began. Donna's hoping she can get one of Ohio's guaranteed issue policies, which are limited by enrollment caps. The plans are only available during an annual 30-day open enrollment period, so Donna will wait to see what happens. She has no insurance options otherwise.

*Chairman STARK. Thank you. I had agreed that I would yield my first chance to inquire to Mr. Thompson. Would you like to inquire, Mr. Thompson?

Mr. THOMPSON. Thank you very much, Mr. Chairman. I appreciate your generosity, and thank you to all of the witnesses who are here today. Mr. Finan, I'd like to pick up where you left off. I'm a huge proponent of preventive care, an area where I see there is a huge problem is the barriers that seniors face in regard to getting preventive care in the form of cancer screenings and such. It seems to me that someone's a senior in many instances their disposable

income numbers are going down, and right now sadly at the same time that the costs for food and gasoline and energy and everything else is going up, I'm concerned that copayments and co-insurance payments are having an impact, a negative impact, in providing a barrier to these preventive services. That's had an impact on things like cancer screening, which costs us more money in the long run. Anything you want to add to that? Push your button, please.

*Chairman STARK. Your mike please, Mr. Finan?

*Mr. FINAN. Yes, I would. First of all I want to thank you very much for your continued support on this issue. We totally agree with you that it is a significant problem, and we are totally supportive of your legislative efforts in this area.

I'd like to point out that there was an article recently in the New England Journal of Medicine that looked at the issue of co-pays and preventive services among the Medicare population; and they found that even a co-pay as little as \$10 resulted in about an 8 percent decline in the number of women who sought mammograms. So, it does suggest that there's enormous price sensitivity among the elderly to these kinds of services.

Mr. THOMPSON. Then we pay for it at the other end, when it becomes an acute problem.

*Mr. FINAN. Exactly. Here for \$10 we see a decline in women getting the mammograms, and yet, as you just point out, the cost if they're not getting them could be extraordinarily high.

Mr. THOMPSON. Thank you. Dr. Ayanian? Thanks. On the other end of the spectrum, on the other end of the age spectrum, the issue of preventive care for children. When I was in the state legislature, I had success with legislation that required all providers to provide health care for kids, preventive health care for kids from birth to 18 years of age. One loophole in that legislation was the ERISA loophole. It's my feeling that that is, in fact, a true loophole, and I know we can save a lot of money and a lot of lives and a lot of anguish if we can catch problems early in kids. It's everything from keeping kids out of the hospital and hospitalization for kids is more expensive than adults, and it's longer than adults. Then also if we can deal with these things when they're preventable, rather than when they're acute, we're building a more healthy Medicare population in the future, should we close that ERISA loophole.

*Dr. AYANIAN. It's clear that investing in the health of children is a very worthwhile endeavor, and anything we can do in a cost-effective manner to achieve that goal is very important. We this at the issue Institute of Medicine regarding the consequences of uninsurance and the importance of consistent coverage for children as well as their parents. It was clear that the evidence is that children are more likely to get the care they need when they have coverage and it's consistent across different plans; and particularly also when their parents are covered the parents use the health system more effectively for their children. We get long-term benefits from that. So, yes.

Mr. THOMPSON. Then, lastly, Mr. Brock, thank you for being here and thank you for all of the work that you're doing. That's pretty fascinating.

Ten percent of the doctors practice in rural areas, and I'm told about 25 percent of the patients are in rural areas, so there's a real disparity. Representing one of those rural areas, I hear all the time about the trouble that we get to attract physicians to our areas and keep physicians in our areas, and we share the same health care problems as under-served areas, be they rural, urban, or otherwise.

How much of the lack of access to health care in rural areas can be attributed to the lack of providers?

*Mr. BROCK. Well, thank you for asking that question. A lot of the problems do stem from the fact that there are programs to help some of these people, but the paperwork requirements and the reimbursement rates unfortunately are not attractive enough for many of the providers to be willing to accept the patients.

The other problem that we are continually faced with and actually it doesn't matter whether we're in a very, very rural area of Appalachia or whether we're in a downtown urban area, the number of patients that are going to show up for our services are about the same. As a small turnout, there are going to be 5 or 6 hundred patients turn out. At a large RAM event, there are going to be several thousand that turn up. It doesn't matter whether they're living in an urban area or a rural area.

The biggest problem really in providing this kind of care for these people is that we have found over many, many years now that the local physicians, dentists, and eye doctors really don't want to deliver the care to these people in their hometown. Those same doctors are very, very willing to travel hundreds of miles with us, perhaps to Eagle Butte, South Dakota, to provide the care, but they're really not interested in providing the care in their own home districts. For that reason, we are strongly hoping that rules will change, so that doctors can cross state lines from all over the country and alleviate this very, very serious problem.

Mr. THOMPSON. Thank you. Mr. Chairman, Mr. Doggett, thank you both for yielding me the time.

*Chairman STARK. Mr. Camp?

Mr. CAMP. Thank you, Mr. Chairman. Dr. O'Grady, you testified that of the uninsured population that 22 percent are non-citizens. What percentage of the total uninsured population are eligible for Medicaid and other programs, but are not enrolled?

*Mr. O'GRADY. I don't have that figure right off the top of my head, but I can certainly get it for. Although it is one that is under some considerable kind of discussion of figuring out what the right figure is—and part of it has to do with the interactions between these eligibility questions—so if some of these kids, given immigration laws, would not be eligible as is true for the legal immigrants, that you're not eligible in the first five years for either Medicaid or S-CHIP, exactly who's eligible or not is certainly somewhat of a bone of contention. Although one of the nation's best experts in this is right across the street at the Congressional Research Service. So, candidly, I'm going to go and pull that, and get back to you on it.

Mr. CAMP. All right. If you could get back to the Committee with your—

Mr. Rowland. Mr. Camp, if I could—

Mr. CAMP. I just have a short time. I'm not done with him yet.

Mr. Rowland. I was going to just answer——

Mr. CAMP. All right. If you could submit that in writing, that answer, I'd appreciate that.

What percentage of the uninsured lack coverage for just a short period of time, say less than three months or less than six months?

*Mr. O'GRADY. Well, we tend to see this pattern. Again, I'll get back to you with the exact figure. But what we see is we see there's points in your life where you are more vulnerable. Some of these vulnerabilities we worry about more than others. So, you do—I gave the example in the oral testimony about the kid who leaves college, and before they start that first real job and get coverage, that is, certainly they're uninsured, we would certainly prefer to have them insured, but we don't really worry about them quite as much as we do about the chronically ill and these people who have been uninsured for years.

So, it is this idea of where I've tried to introduce this idea of thinking about how you might triage this problem, because the likelihood of having enough money and political consensus to do everything for everybody might just not be there, in reality.

Mr. CAMP. Do you know, and can you tell us what percentage of the uninsured elect not to purchase health insurance, even if it's offered to them?

*Mr. O'GRADY. There are certain ways we sort of back into that question. There is not good data. What we do know and you'll see in the written testimony is we know that the offering rates, especially among once you're over about 500 or a thousand employees in a firm, that almost all those firms offer. But you still see perhaps 10 percent in both those categories as being uninsured.

Now we know they're offered. We don't know exactly whether they are, like I said, what we tend to jokingly call the young immortals, who sort of as long as they don't fall off their motorcycle, they really don't see much need for insurance. Is it that category?, or is it someone who is in a position where, you know, coverage is being offered, but whatever their share of the premium, their share of the cost-sharing going on makes it unaffordable for them. Splitting those two kinds of groups is—I don't know anyone who's done it well yet.

Mr. CAMP. Difficult to do?

*Mr. O'GRADY. Yeah.

Mr. CAMP. There's been a lot of debate around the question of an individual mandate to buying health insurance. Do you have any opinion on whether there should be a mandate, and what would be the pros and cons of imposing a requirement that an individual is to buy insurance, even if they feel they don't need it.

*Mr. O'GRADY. Yeah. An individual mandate is a tough issue in terms of you have these situations in the last generation of these sort of proposals we heard an awful lot about employer mandates, and in some today we hear about matching of employer and individual. The individual mandate does get to the point of where we talked about before, my young immortals. The idea of should you be in a position where you in effect force them to have coverage? Now that's much of the discussion that's gone on, on the campaign trail between Mrs. Clinton and Mr. Obama. Mr. Obama sort of wondering once you're out of children, once you're at a certain age,

you want to make it as affordable as possible; do you actually want to take that extra step to mandate?

Mr. CAMP. Okay.

*Mr. O'GRADY. It is true, the term that the Senator was searching for before is "free rider." So, when these folks do fall off their motorcycle and all of a sudden need the health care system, they are going as bad debt on the rest of us; there's no doubt about that.

Mr. CAMP. All right. I noticed in the tape we saw that—well, let me just say there are 23 federally qualified health centers in Tennessee, and from what I understand, they have a list of services that are required, including emergency medical and dental services, among a list of other services. Can you tell me why individuals would not be able to be also attending the federally-qualified health centers that have a mandate to see anyone who comes in?

*Mr. O'GRADY. Right. They do have a mandate, they certainly serve the uninsured. They serve the underinsured, Medicaid population, and even a few, just because of locale, regular insurance people. All the evaluations I've seen is they scored very high on what they do; they have—this was brought up before about health information technology—they have one of the best systems in the country right now—whether it's poor outreach or just a nod of allowing them to know, but I know of no structural barrier of why folks can't seek out those clinics.

As you may have remembered, the President a few state of the unions ago, made the push to have a clinic in every poor county, and from what I saw when I was at the Department of Health and Human Services, they took that seriously. Especially in those areas like in the, you know where Katrina hit, especially poor.

Mr. CAMP. All right. Thank you very much. Thank you, Mr. Chairman.

*Chairman STARK. Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman and thanks to each of you for your insightful remarks. Of course, Mr. Brock, what we've seen that you've accomplished is incredibly impressive, and yet it is an indictment of the failings of our public health system in this country that those serious needs are there, demanding the extraordinary effort you've undertaken.

One of the issues that I noted from the 60 Minutes clip is the difference between providing a one-stop or a periodic kind of service like eyeglasses or dental care versus the need for continuing treatment, continuing care, like the young woman who had had cervical cancer. Is there any way through your program that you can provide someone a primary health care home for that type of continuing care?, or what happens to the person who requires the periodic checkup, whether it's for cervical cancer or for maintaining their blood pressure or their cholesterol, or whatever, on a repeat visit basis?

*Mr. BROCK. Well, I think that that question is admirably demonstrated at our clinic that we do every year in Wise County, Virginia. In Wise County, Virginia, for 2½ days, people come at the rate of twelve hundred people a day, and they wait eight, ten, fifteen hours for the service.

Now we provide all of the services that you've just mentioned. Not only do we have about a hundred dentists there and dozens

and dozens of eye doctors, but we also have cardiologists and we have cancer experts, we do mammograms and we do Pap smears. The whole gamut. The interesting thing is—and again this goes back to the fact that so few of these state and Federal programs address the dentistry and the vision care—so here you have twelve hundred people who arrive at one of our clinics, and wait many, many hours. When they get in the door, they want to see the dentist so bad because their teeth are just in agony and they want a pair of eyeglasses because they can't see to read the paper or they can't qualify to get a job. We are constantly, with the hundreds of other practitioners that we've got there, saying, "Save your place in line. You need to come down here and you need to have a diabetic check-up. You need to have a check-up for high blood pressure", and so on and so forth.

It is extremely difficult to get those people motivated to do that. So, if some of these programs were addressing and enabling people to get their teeth fixed, those immediate problems, then we would find it easier to get them to see the other specialties that they need.

When you look at the cross-section of the thousands of people that we see, it's largely self-induced problems. They're all smoking and they're all eating the wrong things; they're largely overweight, and of course there's an educational factor in there too.

But the services are there, but they're so hung up on the teeth and the eyes, that's it's very difficult to get them to take advantage of the rest of it.

Mr. DOGGETT. Thank you. Dr. Rowland, and Dr. Ayanian, you've touched on this issue, but really the lack of insurance is a matter of life and death, and I have seen one recent study in the state of Texas, which is notable for having more uninsured children proportionally than any other state in the nation, tragically, that about seven working-aged Texans die each day because of a lack of health insurance. I suppose if the death certificate were amended to show the true cause of death along with the physical cause as being a societal disability, that we would see lack of health insurance on that death certificate on a pretty regular basis. It would be up perhaps as high as deaths from diabetes.

Could you just comment again on what you see as the life and death cost of the failings of this Congress and this administration to see that there is access to health insurance for more of our citizens?

*Ms. ROWLAND. Well, clearly we see from all of the research that when you don't have health insurance, you make decisions that are contrary to your health. So, as we saw in the film so graphically, people delay care, and as a result of delaying care they come at a later stage of diagnosis, where treatment options are fewer and where the outcomes are worse therefore mean this means that on their death certificate they may die from a cancer, but the cancer could have been treated if caught in an earlier stage.

Dr. Ayanian's work has really helped to really the impact of lack of insurance by looking at specific conditions, so I'll let him comment in addition.

*Dr. AYANIAN. I would just add that we all know that effective insurance coverage is the gateway to the health care system for most people in our country, and when people lack that, they don't have the good primary and specialty care that we know makes a difference. In many ways we just defer the costs. Effective primary care can be very cost-effective. Preventive care screening tests, and care of chronic diseases like high blood pressure and diabetes. If we don't take measures to provide coverage and provide access to care for people at those early stages of disease, then we end up with more costly complications of heart attacks, kidney failure, advanced cancer.

*Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman. For any of you first three over there, you know, I believe one way to increase access to health care for more Americans in this country is to decrease the cost, and if there's one thing America has proven, that it's competition is the best way to drive down the cost. Health care is no different.

There's two initiatives I think are critical in achieving this goal: Health savings accounts, and association health plans. You know, over 4.5 million Americans have chosen HSA type insurance, and some studies show that as many as one-third of them were previously uninsured, and almost half have incomes below \$50,000.

Concerning HPs, estimates indicate that at least 60 percent of the working uninsured work for small businesses. I think we can't have a conversation about the uninsured in this country without talking about a way to allow small businesses to pool their resources in order to provide health insurance for their employees. Would you all discuss that for me?

*Ms. ROWLAND. When you look at the problems facing our health care system, rising costs from the increases that we've seen in premiums over the last few years have taken a real toll on both employers' ability to offer coverage as well as on employees' ability to pay their share of those premiums.

However, I think one of the things that's important when you look at the low-income, uninsured population, is that two-thirds of the uninsured come from families with incomes below \$40,000 a year. How much they can they afford for the premium, how much would you subsidize that premium, and also how much they are able to pay out of pocket. One of the concerns we have stems from some of the research we've done is looking at the liquid assets of individuals at these lower income levels. We see that they have relatively few savings. As a result, if they have a health care policy that requires a fairly high deductible, they may not have the resources to be able to pay those co-payments and deductibles, which in the end could end up having them behave more in their interaction with the health system, like an uninsured person rather than like someone with health insurance coverage.

So, I think one really needs to look at the availability of income and the availability of assets to be able to meet obligations as one assesses the adequacy of health insurance coverage. Work that the Department of Health and Human Services has done, looking at financial burden, finds many families, especially those with higher deductible plans, as end up spending much more of a share of their

income on health insurance coverage than people with more comprehensive plans, especially those offered now through the employer sector.

*Mr. O'GRADY. Yes. There are a couple of things you brought up which were very good. One thing to keep in mind is that making this more affordable is essential. At the same time it is that value proposition that was being discussed earlier about we have the baby boomer retiring, we have these other pressures that are coming, so it's more spending smarter, not more, not—and how we're going to control that, and how we're going to determine whether we're really getting—most of us don't mind spending more if we think we're getting that breakthrough drug or that breakthrough device that's going to really make a difference. But we mind spending more for something that seems wasteful and is just nicer cars for physicians. That sort of thing.

So, when the chief actuary came in, I assume a week or two ago, and showed those trends in Medicare, those same trends exist for employers trying to offer coverage, Medicaid. They just don't have a trustee's report that you get every year.

So, all that money being absorbed there is more money being taken off the table for the uninsured. So the notion of how you ease up on that cost pressure to give yourself enough leeway to start to think about expansion and doing it in a fiscally responsible way is vital.

There was a piece done a few years ago by a researcher at the University of San Diego, that looked at those small firms, and in years when premiums were going up very fast, they either had to drop their coverage, or for the firms that were looking to add coverage, not in a 10 percent premium increase here. In the slower years, that's when people either held their own in terms of offering coverage, or were able to expand. So, it's very important. HSAs fill a niche, a very important niche in terms of affordability. Because by changing the structure of the health benefit, moving it to the more serious, more catastrophic things, they definitely lower the premium.

Now I have one personally. I've had it for about three years now. I like it very much. I have a chronic illness. It works because it means also that account I can go to whatever provider I want to, whether they're in the network or not, or participating with my plan or not.

So, it works very well on the affordability, but certainly it is putting financial pressures on folks for that up-front cost. There's no denying that. Again, none of these particular solutions that people put forth, me or anyone else you'll hear from, are going to be totally pain-free. Also, you'll help on affordability but you'll hurt on cost-sharings on the beneficiary.

But back to your first notion about bringing down this overall growth in spending, you know, that's where you can have it cost less for both the employer and the worker, for the government and the beneficiary is by slowing that growth in overall spending.

Mr. JOHNSON. Yeah. They get to pick their hospital. That's important.

Thank you, Mr. Chairman.

*Mr. BROCK. Is it possible that I can just in the half-minute light on unemployment insurance thing from a statistic that we came up with last Saturday?

*Chairman STARK. Certainly, Mr. Brock.

*Mr. BROCK. Two hundred and fifty people showed up at a rural area in Tennessee and 124 of them were prepared to answer the following questions. It turned out that 73 percent of them were unemployed; 18 percent were employed part time; and 10 percent were employed full time. Of the full-time employed, only 18 percent had any kind of insurance. Of those employed part time, 58 percent of them had insurance; and of the unemployed of which there were 73 percent of them were unemployed, 46 percent of them had insurance. So, from this non-scientific but carefully done study last Saturday, if you were unemployed you were more likely to have some kind of insurance.

*Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. I don't know if I should be more depressed now after hearing that.

[Laughter.]

Mr. BECERRA. Thank you all for your testimony. I think you are reiterating much of what we've heard or experienced. I wish we knew how to crack this nut that keeps us from having universal coverage; but perhaps I can try to whittle my thoughts here down to a couple of questions.

I was wondering, Mr. Brock, if you'd give me just a quick sense of what your understanding or what your sense is of an individual mandate, the proposals to require that individuals purchase insurance in order to obtain access to health care that rather than require an employer, or rather than do it through a system like Medicare, which is government-financed, that we put the burden of obtaining the insurance on the individual and by requiring everyone in the country to have insurance, then we will end up having that universal coverage that we need.

*Mr. BROCK. I think—

Mr. BECERRA. Your microphone. You need to turn your microphone on.

*Mr. BROCK. I think that in light of the fact that 73 percent of the people that show up are unemployed, this would demonstrate that those people could not afford to buy insurance. So, that presents us with a very difficult problem.

Mr. BECERRA. Another question. Give us again a very quick sense, because I know my time is limited—what are some of the comments you hear from some of the caregivers, the doctors, the dentists, the other providers, that volunteer to be part of these clinics that you set up? What's their sense? They obviously go back to their paying job later on, where they're providing health care, but what's their sense of where we have to go, where a solution lies?

*Mr. BROCK. Well, they want coverage for malpractice. The first question that doctors ask us when they volunteer is, "Am I covered for malpractice?" The answer unfortunately is not, they are not. So, that's something that needs to be fixed. Again, going back to—we really need to allow these doctors and dentists who are willing to provide the service to cross state lines and provide free care anywhere in the country as long as they can prove that they are a doc-

tor in good standing. The Tennessee Volunteer Health Care Services Act, it's as simple as this: The doctor shows up, even without any notice. "Hey, I heard you're holding a clinic. I'm from Iowa, here's my license, I'm not under any judicial review." "Sign that statement, roll your sleeves up, and go to work."

Mr. BECERRA. Let me ask—my question is more—I imagine the doctor from Iowa who goes to Tennessee can only do that once in a while. My question goes more to the point of: What do they see as a longer-term solution to this crisis that causes hundreds if not thousands of people to show up on a weekend to try to receive the care you offer?

*Mr. BROCK. Well, I think that they would like to see some type of national coverage for people who are in a certain economic strata, whether it's twice the poverty line or three times the poverty line, that people in that group need some kind of national health care coverage, and people who are above that economic group let's not mess with the system that we've already got, which is fabulous as long as you can afford it.

Mr. BECERRA. Dr. Rowland, let me see I can ask you something. I find what Mr. Brock does inspiring and demoralizing at the same time: inspiring because you have people who are willing to volunteer, the good Samaritans who go out there, professionals who provide this care; demoralizing because hundreds and thousands of people have to rely on a weekend opportunity to get a tooth taken care of.

In all these studies that have been done, in all the work that we've had come before us for presentation, I still don't see that the American public is any more angry and prepared to take us to a place where we, then, as policy-makers feel that we could go and provide that type of coverage that gets the universality that I think most of us would like to see for the American public.

So I guess my question to you is: Do you see any further movement in the eyes of the American public—not so much the policy-makers, but the American public, in having the outrage to having their policy-makers move in a universal direction?

*Ms. ROWLAND. As we do our work in public opinion, we ask the public about the uninsured and about their access to care, and one of the startling things from our research is that people say, "Well, the uninsured get the care they need; they just may get it a little later." I think we still have a real burden of educating the public on the facts. I think things like the 60 Minute documentary is very important about to show that if you're uninsured, you make different choices and you may not get the care you need. As John and others' work shows, the consequences on your health and on our society's health are really monumental.

But I think it really is a lack of understanding—we think that we have the best medical care system in the world, and that if anyone really gets sick, they can show up at an emergency room and they can get the care they need. Yet we know they don't even show up often at the emergency room, and the consequences of not getting preventive and primary care are overwhelming.

Mr. BECERRA. Thank you. I appreciate your testimony, all of you, and look forward to having you back again. Thank you very much. Mr. Chairman, thank you.

*Chairman STARK. Ms. Tubbs Jones, would you like to inquire?

Ms. TUBBS JONES. Mr. Chairman, thank you very much, and to all the witnesses, thank you for appearing here today.

I think the public is actually saying to policy makers like us and legislators that they do want and need health care. I think the dilemma is that the United States has been so reluctant to focus on preventive care that we tend to be a country that focuses on acute and chronic care versus preventive care. That's my little piece of it.

But I want to focus for a moment, if I can, with you, Dr. Ayanian, if I'm saying your name appropriately. As I said earlier before this panel came, the Congressional Black Caucus Foundation is doing a health disparities session at a hotel here yesterday and today, and I'm hoping to get over there this afternoon. But I see that in your report—and I don't recall that you had enough time in your 5 minutes to really delve into what we need to focus in around disparities. There were seven things that I just had in front of me, and I lost them. So, why don't you go back through that again for me, and if you had to prioritize the 1 through 7 factors around health care disparities, would you give them to me in that order?

*Dr. AYANIAN. Sure. You're referring to a set of what have been described as voltage drops in the health care system from the basic essential of having insurance coverage to ending up with high-quality care and the seven steps in which we can lose voltage, and people not get the care and the quality of health outcomes that we're looking for.

Clearly insurance coverage is an important part of the health care disparities we see for different racial and ethnic groups and economic groups in this country, and so that's one of the most important factors. We have a safety net. In many areas safety net providers are doing very important and effective work. But it leaves too many people outside the boundaries of our health care system, who are not coming in until their illnesses are too far advanced.

We also know that health care providers that serve predominantly minority communities, low-income communities tend to be less well-supported, and less access to appropriate specialty care. If primary care is available, it's not consistently available to all in the community.

So, I think we also need to focus on the providers, the health care organizations, hospitals, community health centers, and medical groups, that care for disproportionate shares of minority patients, and make sure that they're well supported, that their staff are highly qualified, that they have the services that are needed, and relationships within their communities.

I think one of the points that was touched on in the first panel discussion was the need for communities and states to understand the presence of health care disparities in their midst and develop their own local and state plans. We're seeing some promising evidence about this work in Chicago, trying to address racial disparities between African American women and white women, and breast cancer mortality, where community health centers, breast cancer survivors, community leaders, leaders of the major medical

centers, are coming together and really working on access to mammography, access to effective treatment, and then the quality of care that people get.

So, I think those are some of the highest priority areas, and I think it's very important at a national level through tools like the National Health Care Disparities Report, to pay close attention to what progress or lack of progress we have on this front; and then also to use data and resources to support local communities in addressing the health care needs, where they're well understood.

Ms. TUBBS JONES. I remember that as a kid in the public school systems, there were at least a school nurse and a dentist that fell through at least every once in a while. I can't understand why we can't get back to some of that service. There's less schools, there are less students in many of the schools. Because to me it would be the broker for other services for folks at every level, and hopefully begin a process of working with young people with the vision of what prevention really means, because that is what's ultimately going to be the concept.

I don't have time to allow the rest of you to respond to that particular issue, but I think it's something we need to think about, how do we marry an education and then an education about preventive care within the system?

Mr. Brock, I want to applaud you for the work you're doing, and I think I'm going to be in Knoxville on Friday, and depending on my schedule, I may try to catch up with you, if I can get a number or an address.

*Mr. BROCK. I'd be delighted to see you, madame.

Ms. TUBBS JONES. Thank you. Mr. Chairman?

*Chairman STARK. Thank you. Dr. Rowland, you were going to add an answer or a comment to Mr. Camp's question relative to the make-up of the uninsured. Would you like to?

*Ms. ROWLAND. It's roughly 20 percent of our uninsured population are children. When we look at uninsured children, we think that about two-thirds of those children are actually eligible today for either the Medicaid or the S-CHIP program, but have not been enrolled, partially because they may be unaware of their eligibility or their family may not have taken them in. About half a million children who are uninsured have an immigration status that prohibits them from being eligible for either Medicaid or S-CHIP, although their incomes are below the 300 percent of poverty.

*Chairman STARK. Thank you. Further, can you comment on what's happening to the projections of the growth in uninsured Americans, and this question of citizenship or documentation unhappily will come up and for those who are more xenophobic than others, it's a great political stance to suggest that—I don't know of other countries that deny coverage to people who happen not to be citizens—but how big a part of our problem is that?

*Ms. ROWLAND. Well currently, about 22 percent of our 47 million uninsured are non-citizens; however, the majority of them are legal and not illegal, and we estimate that about 10 million people therefore out of the 47 million are non-citizens, many of them waiting for eligibility for citizenship. About 4 million are from the illegal immigration population and therefore currently ineligible for anything except for emergency care in the U.S.

*Chairman STARK. So, can I infer from that, that if we think there are 12 million undocumented workers here and there are only 4 million of the 12, at least with about 8 million who have some form of insurance, even though they are not documented, is that fair?

*Ms. ROWLAND. Correct.

*Chairman STARK. Okay.

*Ms. ROWLAND. In fact most of the growth we see in our uninsured population comes growth among citizens, who makes up about 80 percent of the growth each year, since the number of illegals is still small in comparison to the total population.

*Chairman STARK. Okay.

I want to ask both you and Dr. Ayanian, in your testimony, doctor, and I think Diane as well, you've talked about hidden costs. Dr. Ayanian points out that if—I think if I remember correctly—if I'm uninsured before I mature into Medicare for the next 7 years, 65–72, I'm apt to be more expensive than those who have a continuum of medical—which one presumes means they were insured.

Then there's the issue of the local emergency room. I'd like to think, although I'm not positive, that we don't let people bleed to death on the streets, so if they end up in an emergency room, they're at least stabilized if they're treated, somebody pays for that, either those of us who are paying for insurance pay through higher premiums, or the local community pays through taxes to subsidize care.

Then there is the issue of benefit caps, in other words, whether it's the people who sell these association plans that generally don't meet decent standards in terms of providing care that is covered by most insurance commissioners or other reasons—can we get—I think Commonwealth did a study that deals with the social costs. Productivity is kind of an elusive issue. You know, is General Motors going to make less money because of productivity, or is the dry cleaner in the shopping going to make less money because their workers may be absent more than others—are there many studies, and any of you I'd appreciate the answer, seriously—it's kind of hard for us to quantify that. I mean how much more do we spend on Medicare?, can we find out?, because of the uninsured who mature into Medicare? Is there a number out there that would available to us without extensive research?

*Dr. AYANIAN. I'd have to say at this point there is not a definitive number, but it's something that we're actively working on, and working with Medicare data to try to understand that better. From some of the work that I discussed earlier, we found that people in their late fifties and early sixties who are uninsured use 15 percent lower levels of services in the presence of heart disease and diabetes, so this is a group clearly that should be in care and where we know health care makes a difference.

Then almost immediately after they turn 65, we see a sort of flipping of that, and the people who are previously uninsured use about 15 percent more services after they enter the Medicare Program. So, we're now moving forward to try and understand exactly what services. Some of them may be fairly expensive, like people needing coronary bypass surgery. Other aspects may be fairly basic, like seeing primary care physician for diabetes care. Another

issue that we're pursuing is to what extent might those savings be available to the Medicare Program if we did a better job of covering people in their 50s and 60s before their conditions became more severe.

*Chairman STARK. Okay. It would be helpful, I'm sure to all of us if we could, at least as we have to wind our way through this, we could in fact quantify those areas, because there are a lot of people who on both sides of the aisle that unless we can assure them that we're not wasting a lot of money, we're going to have trouble. It's one thing to talk in generalities; it's another thing to say, "Hey, this costs X bucks" to Medicare. That makes our job a bit easier.

Mr. Brock, I just want to commend you as well for the efforts of your organization, and I hope you'll keep it up. I'm concerned that many of the services that you suggest are not insurable, insofar as I know, the American Dental Society is not very anxious to see dental insurance made available by any kind of mandate, and so without their help, I'm not sure it will ever happen.

Speaking of mandates, which is an issue that was brought up, I'd be remiss if I didn't suggest that Governor Romney and Governor Schwarzenegger, whom I have not ever seen at any of our progressive caucuses, or any other liberal groups, both suggested mandates as part of their state plans, and I don't think to their political disadvantage. I think they both felt, as I feel, that there was no way they were going to get universal coverage without somehow "mandating" it. I just don't think that whether it's the youngsters who think they're invincible, who won't buy it if they're not told to, but at some point I think mandate—if we would like to see universal coverage, I don't know how we're going to avoid that.

My commentary on that. I appreciate, Mr. Finan, the work that American Cancer Society does to try and save us from ourselves, and what happens the somebody diagnosed with cancer with no insurance, no money? You're a male and when you get prostate cancer, if you're uninsured you go to the emergency room. Prostate cancer generally doesn't present itself except for maybe an urgency to go to the bathroom that you can't satisfy, but other than that. What happens to that person? What happens to the woman who says, "Oh, oh, I've got a lump, but I don't know whether that's breast cancer or not."—and they virtually don't have access to a systematic medical protocol—what do they do?

*Mr. FINAN. Well, you're correct, Mr. Chairman. These people in those situations typically show up at the emergency room. At that point they probably have an advanced stage of a cancer. It obviously becomes much more expensive to treat at that point. That cost is being borne more widely by society because they're uninsured.

*Chairman STARK. Do they get treated, though? I mean if they show up, do they get surgery or radiology or chemo, which could be a long and expensive procedure. Is that—

*Mr. FINAN. It depends on the state of the condition, actually. Where they happen to go into the emergency room. I think it varies considerably by the facility and where they are, and what kind of charity is available. But the fact is we know that some recent research was done by some of my colleagues in the Society shows

that for those who are uninsured, they tend to be diagnosed much later and are much less likely to survive, or they have less chances of survivorship for the uninsured.

So, insurance makes a huge difference.

*Chairman STARK. Okay. Well, I can't conclude this hearing without commenting that the one thing—and Dr. O'Grady, I hate to tell you, but you failed me—I know coming from the “Let them eat cake” school of social consciousness that you'd like to find ways to provide care like public clinics, but with all your perspicuity and intellectual curiosity, you blew it. The Stark solution for these people who are truly uninsured, be they citizens with document or people without documentation—how you could have missed the chance that I have suggested for every uninsured American, who under the Constitution, all they have to do is walk out of this room, step out there on the corner, and kick a cop. You'll end up in jail, where the Constitution will require us with the medical care you deserve. So I've always suggested, if you don't have medical care any place else, go hit a cop, you'll get all the medical care—you'll probably need a little extra when you're done—but please add that to your testimony because you really haven't done the job that I think your position requires.

[Laughter.]

*Mr. O'GRADY. I stand corrected.

*Chairman STARK. Having said that, I want to thank the witnesses and the Members for starting at least on this road to seeing whether we can identify the problem that faces us.

Thank you all very much for being with us today.

*Mr. BROCK. Can I just add a 10-second thing—that comment that you made a moment ago?

*Chairman STARK. Certainly, Mr. Brock, you may.

*Mr. BROCK. About the state of Massachusetts. I have here as a result of the 60 Minutes piece a request from the Campaign for a Better Tomorrow in Massachusetts, saying to us, “We are proposing a convoy of 300 southeastern Massachusetts residents via school bus for treatment by Remote Area of Medical in Tennessee.” Does this mean, then, that one of the richest states in the Union is going to be sending patients to us, at one of the poorest states in the Union? But I found it rather interesting. If they show up, we'll treat them.

*Chairman STARK. You're very kind. Thank you very much, and the hearing is adjourned.

[Whereupon, at 12:37 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of American College of Physicians

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 125,000 doctors of internal medicine, residents and medical students. ACP commends Chairman Pete Stark for holding this hearing to better understand the problems of today's health care system so that we may achieve effective health care reform. The College advocates that all Americans should have affordable health insurance coverage.

To determine how to achieve a high performance health care system with universal health insurance coverage, the College examined the U.S. health care system

and compared it to health care systems in other countries.ⁱ The analysis revealed lessons that could be learned from high performance health care systems in other industrialized countries. Based on these lessons, ACP proposes recommendations to achieve a more efficient, better functioning health care system in the USA with health insurance coverage for all.

The U.S. health care system spends far more on health care than any other country. Costs continue to rise at a faster pace than spending in the rest of the U.S. economy. Yet, an estimated 47 million Americans (15.8 percent) lack health insurance protection.ⁱⁱ These Americans are much less likely than those with insurance to receive recommended preventive services and medications, are less likely to have access to regular care by a personal physician and are less able to obtain needed health care services. People without health insurance live sicker and die younger.ⁱⁱⁱ Even among those with health insurance coverage, wide variations exist in terms of cost, utilization, quality and access to health care services. Rising costs are creating financial burdens for individuals, government and employers, resulting in reduced access to care, and adding to the number of uninsured.^{iv}

Additional problems in the U.S. include disparities in health care based on race, ethnicity and geography; an insufficient supply of primary care physicians for an aging society; a dysfunctional system for paying physicians; and excessive administrative and regulatory costs.

Our analysis of health care systems in twelve other industrialized countries included an overview of each country's healthcare system, its advantages and disadvantages, and possible lessons to be learned for the USA. Criteria developed by the Commonwealth Fund were used for measuring the performance of health care systems.

Although many individuals in the United States receive exemplary health care, international comparisons on most key indicators of the public's health have shown that the United States has poorer health outcomes in the aggregate than many other industrialized countries. Major improvements are needed in the health care system in the United States to achieve performance levels attained by health systems in other countries.

The following lessons and recommendations were identified for improving health care in the United States:

Lesson: Well-functioning health systems guarantee that all residents have access to affordable health care. Some countries achieve universal coverage with a system funded solely by the government. Most, however, have opted for models that include a mix of public and private sources of funding.

Lesson: Global budgets can help restrain health care costs but do not provide incentives for improved efficiency unless they are set reasonably and targeted to small enough groups.

Lesson: The use of government power to negotiate prices can achieve cost savings but may result in shortages of services subject to price controls, delays in obtaining elective procedures, cost-shifting, and creation of parallel private sector markets.

Recommendation: Provide universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers. Health insurance coverage and benefits should be continuous and not dependent on place of residence or employment status. ACP calls on policymakers to consider adopting one of the following two pathways to achieve universal coverage:

A single-payer system in which one government entity is the sole third-party payer of health care costs. The advantages of single-payer systems are that they generally are more equitable, have lower administrative costs, have lower per capita health care expenditures, have high levels of patient satisfaction, and have high performance on measures of quality and access than systems using private health insurance. The disadvantages of this system include potential shortages of services subject to price controls and delays in obtaining elective procedures.

ⁱAmerican College of Physicians. Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. *Annals of Internal Medicine*. 2008;148:55-75 (accessible at <http://www.annals.org/cgi/content/full/0000605-200801010-00196v1>)

ⁱⁱOrganization for Economic Co-operation and Development. Total Expenditures Per Capita, June 2006.

ⁱⁱⁱU.S. Bureau of the Census. Income, poverty, and health insurance coverage in the United States: 2006. U.S. Department of Commerce (P60-233). August 2007.

^{iv}American College of Physicians—American Society of Internal Medicine. No health insurance? It's enough to make you sick. Philadelphia: American College of Physicians—American Society of Internal Medicine; November 1999.

A pluralistic system in which government entities as well as for-profit and not-for-profit organizations ensure universal access while allowing individuals the freedom to purchase private supplemental coverage. The disadvantages of this system are that it is more likely to result in inequalities in coverage and higher administrative costs. Pluralistic financing models must provide a legal guarantee that all individuals have access to coverage and sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector.

Lesson: Cost-sharing designed so that low-income individuals pay no or nominal amounts can help restrain costs while assuring that poorer individuals are still able to access services.

Recommendation: Create incentives to encourage patients to be prudent purchasers and to participate in their health care. Patients should have ready access to health information necessary for informed decision-making. Cost-sharing should be designed to encourage patient cost-consciousness without deterring patients from receiving needed and appropriate services or participating in their care.

Lesson: Societal investment in professional medical education can help achieve a health care workforce that is balanced, well-trained, and in sufficient supply. Investment in primary and preventive care can result in better health outcomes, reduce costs, and may better assure an adequate supply of primary care physicians.

Recommendation: Develop a national health workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs. To meet this goal, the nation's workforce policy must focus on ensuring an adequate supply of primary and principal care physicians trained to manage care for the whole patient. The Federal Government must intervene to avert the impending shortage of primary care physicians. A key element of workforce policy is setting specific targets for producing generalists and specialists and enacting policy to achieve these targets.

Lesson: Effective physician payment systems include support for the role of primary care physicians, incentives for quality improvement and reporting, and incentives for care coordination. Establishment of performance measures, financial incentives, and active monitoring of performance can encourage higher quality of care. Countries that organize care around the relationship between a primary care physician and the patient through a patient-centered medical home have better outcomes at lower cost.

Recommendation: Provide financial incentives for physicians to achieve evidence-based performance standards. The United States should revise existing volume-based payment systems to create care coordination payments for physicians working with health care teams to provide patient care management and maintain a fee-for-service component for separately identifiable visits. Redirect Federal health care policy toward supporting patient-centered care and the patient-centered medical home.

Lesson: Uniform billing systems and electronic processing of claims improve efficiency and reduce administrative expenses.

Recommendation: Support with Federal funds an inter-operable health information technology infrastructure, create a uniform billing system for all services, and reduce regulatory burdens.

Lesson: Insufficient investments in research and medical technology result in reliance on outdated technologies and medical equipment, and delay patients' access to advances in medical science.

Recommendation: Encourage public and private investment in medical research and assessments of the comparative effectiveness of different medical treatments.

Conclusion

The American College of Physicians appreciates the opportunity to provide the Health Subcommittee with this summary of our views on health system reform. We recognized that although we can learn much from other health care systems, any solution for the United States must be unique to our political and social culture, demographics, and form of government. Many factors make it unlikely that we can simply adopt systems used by other nations, particularly those that involve a substantial expansion of the power of the Federal Government to regulate health care. Nevertheless, we believe our examination of the evidence identified several approaches that are more likely than others to be effective in achieving a well-functioning health system that could be adapted to the unique circumstances in the U.S.

Additional information on ACP's analysis and proposals for improving access to health care can be found on our website at: http://www.acponline.org/advocacy/where_we_stand/access/#access.

The American College of Physicians would welcome an opportunity to provide further details of our findings and recommendations or to answer any questions.

Statement of Edward M. Burke

Hello, my name is Edward M. Burke and I am a 49-year-old individual with hemophilia. I want to share my concern with you about the increasingly unobtainable and unaffordable health insurance coverage for Americans, especially the unemployed, the disabled and vulnerable youth. Therefore I am submitting for the record the following statistics:

Health insurance costs continue to climb and will probably rise again next year according to the survey released by the Kaiser Family Foundation, a health care research organization that annually tracks the cost of health insurance.⁽¹⁾ Traditionally health care premiums rises between 9–14 percent per year, challenging the standard of income increase. Although health insurance is a priority issue in American lives and amongst political candidates no new significant advance or major change has been applied in years.

The largest uninsured population of the U.S. are the young people between 19–30. The reason they do not have health insurance is because most have jobs that do not offer it or because they only make average annual incomes of less than \$26,000. If they were to pay premiums they would require approximately \$3,600 which would be 13 percent of their income before taxes and other expenses.

Here is an example at \$26,000 (\$2,166 monthly):

Monthly Income:

\$2,166 per month

Monthly Expenses:

\$375 per month	4,500 Taxes 15% of income
\$300 per month	3,600 Health Premiums 13% of income
\$900 per month	Rent 38% of income
\$400 per month	Transportation—18% of income
\$250 per month	Food—11% of income
\$150 per month	Utilities—7% of income
\$100 per month	Debt—4.5% of income
\$2,475 per month	

(\$309) Monthly Debt with health insurance⁽²⁾

It is clearly evident from an economic standpoint that the younger uninsured population cannot afford health insurance. There is nothing to scale down unless you expect this population to live in section 8 housing, ride bicycles to work, live off of soup and crackers, and heat their homes with dangerous space heaters. Many in this population would rather “roll the dice” of chances than live in debt, given the fact that they are already living from “hand to mouth”. The strategy for this population is, “if I need medical attention, I will just go to an emergency room and either the state or government will pay for it. . . . not me.”

Now that we have looked at the livelihood of a relatively health young adult population, let's assume there is a small population within this population who have expensive chronic illnesses. Suddenly the \$309 monthly debt would significantly increase to an additional \$500 to \$1,000 per month in co-payments. Me, having hemophilia and being one of these young people would have to not only incur a debt of \$300 per month so I can stay insured, but I would have to incur an additional monthly debt of \$2500 per month until my out-of-pocket was met or it would be a recurrent monthly debt for all 12 months if I were on Medicare totaling \$30,000. And you wonder why people who are uninsured flock to the emergency rooms?!

Our health care system does not provide affordable coverage, plummets working tax-paying citizens into public assistance programs (which incurs cost to the govern-

⁽¹⁾ Health Insurance Costs Climb; Workers Pay ¼ of Premiums Emily Fredrix, The Associated Press, Page 9

⁽²⁾ UCLA Center for Health Policy Research, California Budget Project, August 2007, “What Does It Take For a Family to Afford to Pay for Health Care”, David Carroll, Dylan H. Roby, Jean Ross, Michael Snavey, E. Richard Brown, and Gerald F. Kominski

ment), and removes any incentive to better oneself or even maintain a work environment. Why not just live off the State and Federal Governments?

In all due respect, many legislators are not understanding the economics livelihoods and capabilities of their constituents. There seems to be a loss of reality between those making the laws and those trying to live the laws.

The Factor Foundation would like to propose two solutions to provide an incentive for helping young people afford health insurance and helping people maintain health insurance. The first is simply to negotiate with health plans to offer more affordable premiums that would provide at least catastrophic coverage for injuries, hospitalizations, and necessary tests and surgeries. The second would be the elimination of lifetime health insurance caps.

"Sixty (60) percent of all individuals affected by hemophilia have private health insurance and approximately 3,000 people in the U.S. exceed their lifetime cap each year,"⁽³⁾

"The average cap for hemophilia A is around \$1.4 million."⁽⁴⁾ Since this chronic disease state can incur from \$100,000 to \$2,000,000 per patient per year health insurance coverage is a constant concern for families with hemophilia. In 1970, the cap of 1 million dollars was set by the insurance industry. "The same coverage today would equal \$18 million."⁽⁵⁾

Eliminating or raising lifetime caps would be of the utmost benefit to chronic disease states such as hemophilia. Other disease states like Cancer, Cystic Fibrosis, Fabry Disease, Parkinson's and Multiple Sclerosis as well as so many others would also benefit.

"In 1995 Price Waterhouse found that eliminating the lifetime cap would save the Medicaid program alone more than \$7 billion over seven years. These savings are likely more in today's dollars. A study from the American Academy of Actuaries, also in 1995, found that eliminating the lifetime cap would increase premiums as little as \$8 a year. Eliminating lifetime caps would allow individuals with manageable, but high costs such as those with bleeding disorders to maintain their private insurance."⁽⁶⁾

Further, as per the research of Mr. Jack Rodgers, then Director of Health Policy Economics at Price Waterhouse in 1995, Mr. Rodgers stated, "based on our preliminary calculations, we estimate that removing lifetime insurance caps on medical care would result in an annual savings of \$440 million to the entire Medicaid program for 1995 and increasing to roughly \$1.3 billion in year 2002. The cumulative estimated Medicaid savings for Federal and State/local governments for years 1995 to 2002 is approximately \$7 billion. Of the \$440 million Medicaid savings in 1995, we estimate that approximately \$250 million would go towards Federal Medicaid savings and \$190 million would go towards State/local Medicaid savings."⁽⁷⁾

In 2001 Price Waterhouse estimated about 2,500 patients per year reached their insurance cap. The Price Waterhouse report prepared in 1995 as Congress was considering legislation to require higher lifetime caps, estimated that State and Federal health programs could save \$1.3 billion in 2002 if lifetime caps were completely removed.

Eliminating lifetime caps would allow the Federal Government and State governments to experience cost savings to ever increasing challenged budgets, and avoid costly utilization of emergency rooms and hospitalizations due to the chronically ill being uninsured and limited by lifetime caps. Making health insurance minimal and more affordable to fit a young persons budget illustrated above would also provide cost savings to the Federal Government.

I thank you for the opportunity to present this information to you and would be willing to provide you with the documented resources that support this statement. Thank you for your interest and concern.

Additional information provided by Dana Kuhn, PhD, President and Founder of Patient Services Incorporated.

⁽³⁾ www.HemophiliaGalaxy. About Lifetime Caps, Page 1

⁽⁴⁾ www.HemophiliaGalaxy. About Lifetime Caps, Page 1

⁽⁵⁾ www.hemophilia.org, Lifetime Insurance Caps, Page 1

⁽⁶⁾ www.hemophilia.org, Lifetime Insurance Caps, Page 2

⁽⁷⁾ Jack Rodgers, November 8, 1995, Research Letter, Page 7

Statement of George Stone

Thank you for looking into the rising cost of health insurance in this country. I retired about 6 years ago and since that time the cost of my health insurance has gone up dramatically while my income has not.

Without help controlling those health care costs I will be joining the ranks of the uninsured.

Retired Firefighter/Paramedic

Statement of Jonathan B. Weisbuch

Thank you for the opportunity to submit a statement to your informational hearing, Health Subcommittee Advisory No. HL-23. Since my graduation from NYU Medical School in 1963, this country has struggled to provide health care to all its residents. Medicare and Medicaid were initial steps, but continue to leave huge gaps that have not been closed. Now is the time to make the major changes that will set the system right.

Plans currently promoted by Senators Clinton and Obama are insufficient. Their plans rely on an insurance industry which profits by denying care, and a Medicaid program for "medically indigent" that promotes the myth that a health system for the poor can be separate, but equal.

Preserving a profit system continues the benighted notion that medicine operates under the rules of Adam Smith, Milton Friedman and the economics of the market place. This cultural error produces waste, inefficiency, and unnecessary human morbidity and mortality. It encourages the outright greed we now find in hospitals, physician practices, the medical equipment and pharmaceutical sectors, and the insurance industry. The business model is driven by profits and competition; a medical system should focus on preventing disease, using science to diagnosis and treat patients, and providing humane care when cure is no longer possible. Profit does not enter the equation. Quality care and profits frequently conflict; nothing in the business vocabulary speaks to serving human needs where no economic benefit accrue to the corporation. The cultural misconception that medicine is a business, not a profession, must be eliminated from any reform.

Similarly, Medicaid, focused on serving the "medically indigent," has produced 50 state systems, all of which are different. Eligibility is variable, coverage is not transportable; individuals are subject to means tests, and may lose coverage for themselves or their children when income exceeds a minimal level. States invariably have difficulty covering their medical costs, reducing eligibility, services, and the fee schedule. A special system for the poor must be eliminated. Congress must adopt a universal program that assures that everyone has coverage that is equitable and accessible in every region of the country; is based on common standards of care, practice and quality; and is reimbursed by fees agreed upon by all parties. Administration costs should be a low percentage of total expenditures.

The one program in the United States that could meet these objectives, if expanded and modified, is Medicare. It is true that the VA system provides the highest quality care at the lowest cost of any large system in this country; but proposing a program, fully owned by government, is inconsistent with the independent nature of medical practice. The VA should be preserved until the new health reform achieves the level of quality, cost and patient satisfaction that exists in the VA. Until that time, however, the Medicare model will suffice for non-veterans. The New Medicare should eliminate Parts C and D, and modify Part B in lieu of a service model that expands primary care and prevention, supports quality improvement, and spreads all costs across the entire system. The New Medicare should pay hospital costs on a per diem rather than a DRG basis; and should encourage the use of high technology only when clear outcome improvements to health are demonstrable. The differences in care and cost that exist between regions are unconscionable. The New Medicare should also include mental health and dental services, rehabilitation, and community care.

Expanding Medicare to include everyone can be accomplished in three years. The age for eligibility for adults could be lowered annually by 15 year increments; for children, providing coverage for those 0-1 in year one, then up to 10 in year two, and to 20 in year three would achieve universal coverage with minimal strain to the current system. Patients now covered by insurance would maintain their current patterns of care; those without coverage or a medical home, would be given the opportunity to choose one. Adding 16 percent to every primary care practice in the country might be a short term burden to the system; but if primary providers were

given a large increase in their fee schedule, they could be willing to add one hour to their day to meet the demand. Over three to five years, the increased primary care fees might draw physicians into primary care specialty training, helping to equilibrate what is now a disproportionate number of specialists in the American system.

A significant outcome of this change, apart from the fact that everyone will be covered, is that all providers will know the fee schedule for a particular service. Today, insurance carriers all have different fees, Medicare and Medicaid differ, and fees paid to some providers of care differ from those paid to others for the same service. This promotes inefficiency and efforts to beat the system; it encourages dishonesty. Adjustment in the fee schedules will take time, hard work; and must include representatives from all segments of the system to be equitable and acceptable.

Payment for the new program will require transferring premium dollars now paid by employers for private insurance into the Medicare Trust Fund, as each eligible age group moves from private insurance into the New Medicare program. The coverage for pregnant women and children would be paid in part by transferring the family coverage premiums into the Trust Fund, and the rest from the Federal monies now used by Medicaid for deliveries and other pediatric programs like SCHIP. The New Medicare should allow states to retain their portion of Medicaid dollars, a benefit of nearly \$200 billion, funds sorely needed by the states.

Under this scenario, the insurance industry will remain active for three years, diminishing in size each year. Corporate costs for health benefits will remain approximately the same, since the monies now purchasing private insurance for each age group will be transferred to the Trust Fund as that age group becomes eligible. Family coverage will be transferred to the Trust Fund. As premiums shift to the Trust Fund, corporate staff now used to choose insurance programs, examine utilization, determine benefits, and respond to personnel complaints, can be reassigned. Other insurance costs that cover worker health benefits will decline over time: Workers' Compensation, vehicle insurance, pension health benefits, etc.

Corporate premiums will not cover all health costs, however, since current costs also include patients' out-of-pocket costs. These point-of-service fees will be eliminated for patients, but will have to be covered by a small increase in personal income taxes.

No new finances will be required to pay for the New Medicare, sufficient funds already exist in the system to meet the \$2.3 trillion cost. Corporate premiums generate about \$900 billion. Out-of-pocket costs today approximate \$1,500 per individual, or \$450 billion. The payroll tax going into the Medicare Trust Fund to cover the elderly, approximately \$500 billion, will continue; and may decline in time as the system becomes more efficient in preventing the morbidity of those entering the 65 year old window. The Federal portion of the \$350 billion now spent by State and Federal general revenues for Medicaid will be added to the Trust Fund, and the state portion retained by each state. Most of the categorical funding now coming from HHS, such as Ryan White, Maternal and Child Health funds, special disability monies, etc. will all be rolled into the Trust Fund. These monies will allow the New Medicare to operate without a means test, without exclusions for pre-conditions, without the need for annual state legislative action, without the need for any definition of eligibility based on the Federal Poverty Line, and without the 30 percent overhead and profits now drained from the system. The only new "tax" is the income tax on individuals to offset the out-of-pocket costs now paid at the point of service. The New Medicare program will function as did the old, with minimal administrative overhead, saving clinicians and hospitals hundreds of billions of dollars in billing costs now required to keep up with the current paperwork.

In three years everyone in the U.S. will be covered. Preventable deaths in the uninsured, failure to use preventive services, individual bankruptcies for catastrophic illness, and the failure to provide adequate health care to prisoners, will all be eliminated. Initially, everyone will be covered under the same rules now governing Medicare; but these rules will have to change, so that by year 5, the entire system will have common service guidelines. Some service exclusions will exist, including cosmetic surgery, experimental treatments and those without scientific justification; but, the approved set of services will include all the care needed to promote health, to cure and care for disease. Profits will no longer drive the process, rather the care giving concept outlined by Hippocrates 2500 years ago will prevail. The pharmaceutical industry, the medical equipment industry, private transport services, etc., will provide services to the program under competitive bids. Fees and reimbursements will be based upon the cost to provide care and a relative value scale. Incentives may be used to encourage providers to work in underserved areas. And the system should cover public health costs up to 3 percent of the gross health expendi-

tures; allowing PH to meet its legislative mandates and be prepared for mass events.

HB 676 submitted by Congressman Conyers, and over 100 cosigners, would achieve these objectives. Everyone would be included, the states would be relieved of their Medicaid burden, companies providing health benefits would experience a decline in their costs.

Medicare Trust Fund problems would be resolved as large additional revenues from individuals and corporations are added, increasing the risk pool with large numbers who use limited medical services. With an entire nation covered by one common payer, the actual cost of care per individual will decline as many exploit prevention services, utilize early diagnosis and treatment, and reduce inappropriate use of hospital emergency services.

Statement of Karen Hawes

Speaking one's mind is what we should all be doing, in healthy debates and not heated arguments. When 47 million Americans is quoted as the number of people adversely affected by our present-day, health-scare system, the numbers game can be flipped and dissected to support any argument, even using the same numbers. However, knowing/seeing much of the impact firsthand, alongside comparisons with what is provided in other countries, the U.S. is not the leader when it comes to caring for its own. We may have many technological advances, but they are limited to the select few—this does not translate to being great as a nation; other nations, with perhaps fewer or less-fantastic advances, but who provide necessary care to their people, provides a greater national advancement than any bleeding-edge technology. The rhetoric does not reflect the reality, when it comes to our health care system.

Some mention that there are millions in America who choose to go without health care coverage. For those who are choosing to go without healthcare coverage, it's most likely because of cost, not because of choice. We all want quality care, not all of us can afford it; especially when you have families who have to choose between paying the rent or paying for ever-inflating insurance—for coverage that may not pay for your medical needs (due to multiple loopholes and contractual fine print). So, people gamble with their lives, in order to keep afloat and provide what they know is needed: food, shelter, etc. I think that every American should volunteer at one of these health clinics, at least once a year, to see it first-hand and at the front-line who "these people" are and how it is that things got this way "for them". It's a lot different than what's covered in the sound-bytes of our news sources. There are more people than we're being shown, who are frightened to death, no pun intended, about getting sick. This also reflects the factoid that well over half of Americans who file for bankruptcy have done so as a result of a major medical illness. When in America, it often is "your money or our life."

Statement of March of Dimes Foundation

The March of Dimes is pleased to submit testimony on the importance of health insurance coverage for women of childbearing age, infants and children on behalf of its over 3 million volunteers and 1500 staff. As you may know, the March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to conquer polio. Today, the Foundation works to improve the health of mothers, infants and children by preventing birth defects, prematurity and infant mortality through research, community services, education, and advocacy. The Foundation is a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 51 chapters in every state, the District of Columbia and Puerto Rico.

The March of Dimes thanks Chairman Stark and Members of the Subcommittee for holding a hearing on the topic of the instability of health coverage in America. According to the Institute of Medicine, health coverage is the single most important factor in determining whether a child receives medically-needed care. The IOM has also found that health coverage plays an important role in access to maternity care, and pregnant women without health insurance receive fewer health services and report greater difficulty in obtaining needed care than women with insurance.

Given the Foundation's history with the polio epidemics and our current focus on preterm birth, the March of Dimes is equally committed to ensuring that all women

of childbearing age, infants and children have coverage for preventive services as recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) and that high risk pregnant women and medically compromised children, such as those born preterm or with birth defects, have comprehensive coverage for special health care they require.

The March of Dimes has worked with Members of Congress, other Federal officials, and numerous states on efforts to improve, expand and protect both private and public coverage. Specifically in regard to private coverage, in 2006, the March of Dimes commissioned a report from the Georgetown University Health Policy Institute entitled, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change." This report found that numerous states have enacted laws to ensure that individuals covered by state regulated insurance plans received access to certain important benefits. For example, 19 states have requirements regarding maternity coverage, 27 states have requirements regarding the screening for and treatment of phenylketonuria (PKU), and 13 states have requirements that address coverage for the treatment of cleft lip/palate malformations. These measures provide access to critical care. As the Subcommittee considers healthcare reform proposals, the March of Dimes urges Members to recognize the importance of these mandates to pregnant women, children with birth defects, and their families.

The need for continued efforts to expand access to health coverage is clear. According to Census Bureau data prepared for the March of Dimes, in 2006, 9.4 million—12 percent—of the nation's 78 million children under age 19 lacked health insurance coverage. Some 61 percent of these children lived in families with incomes below 200 percent of poverty and may have been eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). In fact, public programs like Medicaid, SCHIP and Medicare are a critical source of access to care for many low income women of childbearing age, infants and children. Medicare finances approximately 10,000 births annually, and Medicaid financed 41 percent of hospital births in 2002. Medicaid also covered nearly 30 million children in 2004, and SCHIP covered approximately 6 million. The March of Dimes is dedicated to continuing to work with Members of the Subcommittee to ensure a swift reauthorization of SCHIP that will provide states with the tools and resources necessary to make significant gains in enrolling eligible pregnant women, infants and children. The Foundation is also eager to work with Members to ensure that the specific healthcare needs of women of childbearing age, infants and children are addressed in any healthcare reform efforts.

The March of Dimes supports access to comprehensive insurance coverage for all women of childbearing age, especially those who are pregnant, that covers the full scope of maternity care benefits recommended by the American College of Obstetricians and Gynecologists (ACOG) and the AAP. Women who receive maternity care are more likely to have access to screening and diagnostic tests that can help identify problems early; services to manage developing and existing problems; and education, counseling and referral to reduce risky behaviors like substance use and poor nutrition. Such care may thus help improve the health of both mothers and infants. In addition, postpartum care helps women appropriately space pregnancies, thus reducing the risk of preterm birth.

While maternity care is crucial, research increasingly shows that women who have regular access to health care before becoming pregnant have healthier pregnancies and better birth outcomes than women who begin care after they become pregnant. In fact, ACOG now recommends that women receive preconception care, defined as, "the identification of those conditions that could affect a future pregnancy or fetus and that may be amenable to intervention." Such care includes tobacco cessation counseling and pharmaceuticals, nutrition and folic acid counseling, and controlling pre-existing medical conditions that could impact a pregnancy (such as diabetes or hypertension). For these reasons, the March of Dimes believes that all women of childbearing age should have access to comprehensive health coverage to improve their chances of receiving these services.

Once again, the March of Dimes thanks Chairman Stark and Members of the Subcommittee for holding this important hearing and for providing us with this opportunity to submit testimony. The Foundation looks forward to working closely with Subcommittee Members to improve access to comprehensive health coverage for women of childbearing age, infants and children.

Submitted by Marina L. Weiss, Senior Vice President, Public Policy and Government Affairs

Contact: Amanda Jezek, Deputy Director, Federal Affairs

Statement of National Congress of American Indians

On behalf of the National Congress of American Indians (NCAI), we are pleased to present testimony to the House Committee on Ways and Means, Subcommittee on Health for the hearing on the Instability of Health Coverage in America.

NCAI is the oldest and largest American Indian organization in the United States. NCAI was founded in 1944 in response to termination and assimilation policies that the United States forced upon the tribal governments in contradiction of their treaty rights and status as sovereign governments. Today NCAI remains dedicated to protecting the rights of tribal governments to achieve self-determination and self-sufficiency.

American Indian and Alaska Natives Face Massive Disparities¹

Throughout America, health care is a top priority. It is widely accepted that high-quality health care is a necessity, not a luxury. In Indian Country, even the most basic health care *is* a luxury and high-quality health care is usually not even an option. Most tribal communities cannot easily access health care services and, even when services are available, they are often subject to decades-old, outdated practices and services.

Across every indicator, American Indian and Alaska Natives face massive disparities in health:

Life Expectancy

- Life expectancy of American Indian and Alaska Natives is nearly six years less than any other race or ethnic group in America—72.4 versus 77.8 for the general population.²
- The life expectancy for males on the Pine Ridge Reservation is 56 years old. The life expectancy for males from Iraq, Haiti, and Ghana is higher at 58, 59, and 60, respectively.³

Diabetes

- American Indians and Alaska Natives have the highest prevalence of Type 2 diabetes in the world and the incidence of type 2 diabetes is rising at 2.6 times the national average among American Indian and Alaska Native children and young adults.⁴
- The American Indian and Alaska Native diabetes death rate of 36.3⁵ per 100,000⁶ places Indian Country 17th out of 191 World Health Organization Member States.

Heart Disease

- The leading cause of death among American Indian and Alaska Natives are heart diseases—at 133.5⁷ per 100,000⁸—a higher rate than found in the general population.

Suicide

- Native people ages 15–34 make up 40 percent of all suicides within AI/AN populations.
- As a recent example, in the past 12 months there have been 213 suicide attempts on the Rosebud Sioux reservation. At least one suicide attempt every other day.

¹ Results from the 2006 National Survey on Drug Use and Health: National Findings

² National Vital Statistics Reports, U.S. States Life Tables, 2003. Available from http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf. (accessed April 2008).

³ United Nations, Department of Economic and Social Affairs, Population Division (2007), *World Population Prospects: The 2006 Revision, CD-ROM Edition—Comprehensive Dataset* (United Nations publications, forthcoming); supplemented by official national statistics published in United Nations *Demographic Yearbook 2003* and *Demographic Yearbook 2004*, available from the United Nations Statistics Division website, <http://unstats.un.org/unsd/demographic/products/dyb/default.htm> (accessed Dec 2007); and data compiled by the Secretariat of the Pacific Community (SPC) Demography Programme, available from the SPC website, <http://www.spc.int/prism/social/health.html> (accessed Dec 2007). <http://unstats.un.org/unsd/demographic/products/indwm/tab3a.htm>

⁴ National Center for Health Statistics, Health, United States, 2007, With Chartbook on Trends in the Health of Americans.

⁵ Adjusted to compensate for miscoding of Indian race on death certificates.

⁶ Trends in Indian Health 1998–1999. Indian Health Service. <http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp>.

⁷ Adjusted to compensate for miscoding of Indian race on death certificates.

⁸ Trends in Indian Health 1998–1999. Indian Health Service. <http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp>.

- Fetal Alcohol Syndrome (FAS) 1.5 to 2.5 Native children per 1,000 live births are afflicted with FAS.
- By Comparison, the general U.S. population is 0.2 to 1.0 per 1,000 live births.

Substance Use

- 19 percent of the Native population aged 12 years and over are substance abuse dependent.
- By Comparison, the general U.S. population is 9 percent of those aged 12 years and over are substance abuse dependent.
- 2 percent of the Native population currently abuses methamphetamine.
- By Comparison, the general U.S. population is 0.07 percent currently abuses methamphetamine.

Mental Health

- 30 percent of Native adults have had a serious psychological distress.
- By Comparison, the general U.S. population is 11 percent.

Health Insurance Coverage in Indian Country

American Indians and Alaska Natives have limited health care options. Because of higher rates of poverty and economic insecurity, American Indian and Alaska Natives are less likely to have continuous health insurance, and as a result, less access to healthcare resources. In 2003, 45 percent of American Indians and Alaska Natives have private health insurance coverage, 21.3 percent relied on Medicaid, and 30 percent had no health insurance—this compares to the 8.8 percent of uninsured in the majority population.⁹

Indian Health Service (IHS), the agency tasked to uphold the Federal Government's obligation to provide health care to American Indians and Alaska Natives, largely provides primary, onsite treatment. Coverage varies widely among Indian health programs and should not be assumed to be equivalent to the defined benefits packages of private insurance.¹⁰ In fact, according to the U.S. Census Bureau's Current Population Survey, individuals who solely report IHS health coverage are classified as uninsured.

Uninsured American Indian and Alaska Natives, which includes those receiving health care through IHS, are less likely to see a physician than those with insurance coverage. Uninsured Americans are also less likely to get screened for cancer, more likely to be diagnosed with an advanced stage of the disease, and less likely to survive that diagnosis than their privately insured counterparts.¹¹ Strong evidence suggests that having a usual source of care produces better health outcomes, reduced disparities, and reduced costs.¹² Considering the staggering health disparities faced by American Indians and Alaska Natives, it is clear that action must be taken to improve the health and well-being of our tribal communities.

Indian Health Care Improvement Act

The United States has a longstanding trust responsibility to provide health care services to American Indians and Alaska Natives. This responsibility is carried out by the Secretary of the United States Department of Health and Human Services through the Indian Health Service. Since its passage in 1976 the Indian Health Care Improvement Act (IHCIA) has provided the programmatic and legal framework for carrying out the Federal Government's trust responsibility for Indian health.

The need for this reauthorization is clear. The American Indian and Alaska Native population is the most negatively impacted by health disparities and suffers from chronic diseases and other illnesses at a rate disproportionate to that of the mainstream population.

The statistics provided accurately illustrate the deplorable health conditions of the American Indian and Alaska Native population at large. Many of these diseases and illnesses could be treated and/or prevented with adequate funding and proper care. While the health services delivered to American Indians and Alaska Natives have improved over time, the current service level is not adequately addressing the chronic need in the American Indian and Alaska Native population.

Reauthorizing the IHCIA would allocate funding to address the current needs in Indian health and provide Indian people with the same modernized and techno-

⁹Henry J. Kaiser Family Foundation Issue Brief, February 2004 & Income, Poverty, and Health Insurance Coverage in the United States: 2005.

¹⁰Zuckerman et al., American Journal of Public Health, Volume 94, Number 1, January 2004.

¹¹American Cancer Society report February 2008 issue of *CA: A Cancer Journal for Clinicians*.

¹²De Maeseneer JM, De Prins L, Gosset C, Heyerick J. Provider continuity in family medicine. *Ann Fam Med* 2003;1:144–8.

logically advanced health care delivery systems and services that are already afforded to mainstream America.

Nationally, health care has progressed to provide in-home care and to focus on disease prevention and health promotion. The IHCIA addresses these progressive approaches to health care delivery and will help move Indian health care into the 21st Century.

The reauthorization of the IHCIA is critical to ensuring healthy Indian communities nationwide. It is necessary to modernize the outdated health care delivery system and services that are currently found throughout Indian Country. Indian people must be given the opportunity to access health care that is up-to-date and directly addresses their needs. Indian people deserve to live in a world where their health care is as cutting edge as their fellow Americans.

Tax Treatment of Health Care Coverage

In light of these shattering disparities, tribal governments have been trying to be creative in addressing the health care challenges in their communities. Some tribes have met this challenge by providing an affordable healthcare plan for all their citizens regardless of need. This type of universal health coverage is similar to Medicare. However, some IRS agents—in examining specific tribal governments for their compliance dating back to 2002 or 2003—are asserting that this type of coverage, when provided by a tribal government, should be treated as a taxable benefit unlike Medicare which is another government benefit health plan that is not viewed as taxable to those eligible for coverage.

By virtue of this IRS action, Tribes are being penalized for providing creative solutions to their healthcare challenges. The penalty asserted is substantial: Withholding tax equal to 30 percent of the entire expenditure for tribal health care, IRS reporting penalties, possible negligence penalties, and interest—amounts totaling several millions of dollars each year. In the interim, no IRS guidance has been issued. The justification given by these IRS agents is that (1) government provided health plans do not have the benefit of a statutory exclusion (unlike employer-provided health care), (2) exclusion under the general welfare doctrine is not available where the coverage provided is universal (*i.e.*, not restricted to low-income members), and (3) healthcare benefits, when funded with gaming revenues, are considered to be deemed per capita distributions by a Tribe. This justification fails to recognize the basic function of a government which is to provide for fundamental citizen needs.

NCAI encourages the committee to begin oversight of this important issue in Indian Country. Guidance is needed at the highest level to ensure that Tribes who are diligently working to address the health needs in their communities are not subject to tax disincentives. If necessary, NCAI would support legislative action consistent with the sovereign power of governments to provide health care for their citizens.

Conclusion

The Federal Government's constitutional and treaty responsibility to address the serious health needs facing Indian Country must be met. We at NCAI urge you to make a strong commitment to meeting the Federal trust obligation in passing the Indian Health Care Improvement Act, investigating the tax treatment of health care coverage in tribal communities, and fully funding Indian Health Service. Such a commitment, coupled with continued efforts to strengthen tribal governments and to clarify the government-to-government relationship, truly will make a difference in helping us to create healthy communities in Indian Country.