WAYS TO REDUCE THE COST OF HEALTH INSURANCE FOR EMPLOYERS, EMPLOYEES AND THEIR FAMILIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON EDUCATION AND LABOR

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C O N T E N T S

WAYS TO REDUCE THE COST OF HEALTH INSURANCE FOR EMPLOYERS, EMPLOYEES AND THEIR FAMILIES

Thursday, April 23, 2009
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The Subcommittee met, pursuant to call, at 10:32 a.m., in Room 2175, Rayburn House Office Building, Hon. Robert Andrews [Chairman of the Subcommittee] presiding.

Present: Representatives Andrews, Wu, Hare, Tierney, Kucinich, Fudge, Kildee, Loebsack, Clarke, Courtney, Kline, Guthrie, Hunter, and Roe.

Also present: Representative Cassidy.

Staff present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Calemine, Labor Policy Deputy Director; Carlos Fenwick, Policy Advisor, Subcommittee on Health, Employment, Labor and Pensions; David Hartzler, Systems Administrator; Jessica Kahanek, Press Assistant; Therese Leung, Labor Policy Advisor; Sharon Lewis, Senior Disability Policy Advisor; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Counsel; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Robert Borden, General Counsel; Cameron Coursen, Assistant Communications Director; Ed Gilroy, Director of Workforce Policy; Rob Gregg, Senior Legislative Assistant; Alexa Marrero, Communications Director; Jim Paretti, Workforce Policy Counsel; Ken Serafin, Professional Staff Member; and Linda Stevens, Chief Clerk/Assistant to the General Counsel.

Chairman ANDREWS [presiding]. Good morning, ladies and gentlemen, thank you for your attendance this morning, and welcome to the Subcommittee.

On March 5th, the President gathered people of all walks of life and all points of view at the White House and launched what I think is the most significant effort in many years to try to address the very severe problem of the health care system in our country.

Let me start, from the outset, with a personal bias of mine. We have a health care financing and legal problem as opposed to a health care problem. We have a terrific health care system where doctors and nurses and therapists and researches and institutions do a great job. And we are blessed to live in a country with the talents of those men and women.

Because of the legal and economic structure that supports that system, we have a problem where far too few—far too few people get access to that system, where a lot of providers feel they are being driven out of the system because their very good judgments are being second guessed by people who do not share their expertise, and where many of us feel that money is wasted in the system not to provide and promote good health and to deal with illness, but for other purposes.

So I start from the premise that we want to preserve the very high quality and very great talents of so many people who have given so much of that system. But we want to extend its benefits to everyone. And we want to allocate its resources in a way that smart and fair and rational.

It was a remarkable experience on March 5th at the White House. We had people from very different points of view who agreed that the goals this time should be held in common.

And one of the goals that was, I think, universally shared was that we spend too much in the health care system relative to our national income. That we spend far more per capita than really anyone else in the developed world on health care, and do not get the results we should get from it.

So first and foremost in the health care debate that this Subcommittee, this Congress and this country is going to have over the next couple of weeks and months is the question of how to allocate costs in a more relational and sensible way in that system.

Closely related to that question obviously is how to cover everyone.

The two questions are clearly integrated and one depends on the other in every respect.

We are going to explore a number of different points of view this morning that deal with that question of cost and coverage in the health care system.

We have assembled what I think is an outstanding panel of people with a broad array of experiences, rich diversity of opinions. And we want to encourage a dynamic interchange between the members of the Committee and them members of the panel.

So the way that we are going to proceed this morning is, after the opening statements are done, we are going to hear from the witnesses.

And I would just finish my opening statement by saying this. The core problem, as I see it, is that for Americans, American families, out-of-pocket health care costs have gone up at three times the rate that they are pay check has. So insured people have taken a pay cut because of the explosion in out-of-pocket health care costs. The number of uninsured people has metastasized as a result of this cost explosion.

So I think the two issues go hand-in-glove. That until we have a more rational allocation of costs in our system and get costs under control, we will not get everyone covered. And until we get everyone covered, we will not have a rational cost allocation and get the costs under control. I think they are very much integrated questions and suggest integrated answers.

At this time, I am going to ask my friend from Minnesota, the senior Republican on the Subcommittee, Mr. Kline, for his comments.

Mr. KLINE. Thank you, Mr. Chairman.

I want to thank the witness. It does indeed look like we have another terrific panel here today.

I agree with the chairman's opening comments that we have got a problem here on how to pay for health care, who is going to pay for it, who is going to be covered, how are we going to do it and how are we going to make it work efficiently and effectively.

But we have wonderful health care, wonderful medical care in this country.

I am from Minnesota. The Mayo Clinic in Rochester is a destination point in the world. World leaders fly in to the United States to get their medical treatment there.

We need to be careful as we go forward that we do not destroy that wonderful health care, that wonderful medical care, the wonderful incentives that we have here and the opportunity that we have in this country to get medical care.

Being from Minnesota, our neighbor, Canada—I happen to know that many Canadians chose to or are forced to come to Minnesota for their medical care. They simply cannot get an MRI. Or they cannot get the care that they need.

So as we go forward, I would caution all of us to be careful to not destroy the good that we have here.

One of my concerns here is that some 160 million Americans get their health insurance under ERISA from their employers. We may be changing the paradigm. That is part of the debate that we are having here. But we need to be very careful, it seems to me, not to do harm and not to pull a thread on the sweater that is ERISA and start unraveling it and end up with millions of Americans not getting the coverage that they need.

So I am going to submit my statement for the record, without objection, if that is all right, Mr. Chairman?

I am very eager to get to the testimony of our witnesses.

And I yield back.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Senior Republican Member, Subcommittee on Health, Employment, Labor, and Pensions

Good morning, and welcome to our distinguished panel of witnesses. We look forward to hearing your perspectives and gaining the benefit of your expertise on issues of great national importance.

This morning's hearing is the second hearing on health care reform this year, and will try to address a very broad range of issues confronting our nation's health care system. While I am hopeful that meaningful changes can be made to improve health care cost, access and delivery, I am concerned that some of the proposals being considered and talked about may have the exact opposite effect.

We have learned from prior hearings that the employer-based health care system, though imperfect, has achieved a number of successes. Over 160 million Americans obtain insurance coverage from their employers, satisfaction levels are relatively high, and the number of people covered under this system has remained more or less constant through good and bad economic times. The main reason for this success is the federal ERISA law, which lets American businesses provide uniform, high quality benefits to all their employees across state lines, free from costly state benefit mandates.

Employers, employees, and their families are, justifiably, very concerned about rising health care costs. I continue to believe that as we try to address weaknesses

in the current system, we must be careful not to undermine ERISA by pulling one string at a time.

As we discuss ways to reduce the cost of health insurance for employers, we must be mindful of the fact that ERISA is the basis of our voluntary employer-based system, and we must build on what works within that structure. Policies to permit greater pooling of resources to purchase insurance and the development of innovative, cost-efficient benefit designs would expand access by encouraging more employers to provide coverage and reduce costs.

Some of the ideas to reform insurance systems being discussed could have the effect of driving people out of the voluntary, private employer-based health care system, make them more reliant on government programs and subsidies, and could ultimately lead to the nationalization of health care in America. I believe this could increase costs, stifle medical innovation, and reduce health care quality.

Mr. Chairman, we must be mindful that proposals which undermine ERISA should not be adopted. These include employer mandates, which would require employers to provide coverage or pay a tax. Similarly, adding benefit mandates increases the costs of coverage, and makes it more difficult to provide health insurance. Also, creating a "government plan", modeled on Medicare or some other government structure, to "compete" with private coverage could result in unfair competition and eliminate a private health insurance market.

Finally, Mr. Chairman, the cost of health reform and expanding access to health insurance coverage must be carefully considered before we vote to enact health care reform legislation. Merely passing legislation that expands access to benefits, without meaningful steps to control underlying health care costs, would not be wise, and will only lead to more unsustainable spending.

That said, I remain hopeful we can continue to work together to reach consensus on legislation to provide more affordable and efficient ways of delivering health care benefits.

With that, I'd like to welcome our seven distinguished witnesses today, and we should hear from them directly. I yield back my time.

Chairman ANDREWS. Thank you very much, Mr. Kline.

Without objection, the opening statements of any member of the Subcommittee or Full Committee who wishes to submit a statement in the record will be accepted.

Well, good morning, to the panel. We appreciate very much your written statements. They were terrific.

And without objection, they will be entered into the record of the hearing so the members will have the benefit of them.

The way we operate is we ask you to synopsize your written testimony in a 5-minute oral summary. That is difficult to do, but keep in mind the members have your written testimony. I am sure they have all read every word of the written testimony. Now, they certainly have it in front of them. And it is available to them.

The 5-minute summary gives us ample time for exchange between the members of the Committee and the members of the panel, which is our objective. We find that we learn more that way, so we appreciate that.

There is a system of lights that are in front of you. When the green light it on, it means your time to speak. When the yellow light goes on, it means you have 1 minute remaining in your 5 minutes. And when the red light goes on, it means we would ask you to quickly summarize your comments, that we can move on to the next person and keep things moving along.

I want to introduce the witnesses, read a brief biography of each, and then we will turn to your statements.

Mr. Ron Pollack has been working on this issue long before it became first-page news. He is the founding executive director of Families USA, a national organization for health care consumers whose mission is to achieve high-quality, affordable health coverage for

everyone in the United States. In that capacity, Mr. Pollack helped prepare the Patient's Bill of Rights that has been enacted by many state legislatures. He received his J.D. from New York University where he was an Arthur Garfield Hayes Civil Liberties fellow.

Mr. Pollack, thank you for your years of work on this issue. We are glad to have you with us today.

Mr. Michael Langan is a principle at the Towers Perrin law practice and has over 30 years experience in health and insurance law, employee welfare benefits and related public policy issues.

Before joining Towers Perrin, Mr. Langan was assistant counsel in the Corporate Law Department of the Prudential Insurance Company of America headquartered in Newark, New Jersey—very wisely on their part—and worked in his HMO subsidiary PRUCARE. He received his B.A. from King's College and a J.D. from the Seaton Hall University School of Law in South Orange, New Jersey.

Nice to have you with us, Mr. Langan.

Mr. William Vaughan is a senior health policy analyst for the Consumer's Union. Starting in 1965, he worked for various members of the House of Representative's Ways and Means Committee and retired in 2001 as a Health Subcommittee staff director for the minority. He graduated with a B.A. from the American University.

And, Mr. Vaughan, we all understand that the real yeomen and yeowomen around here are the staff members. And I remember your work at Ways and Means and appreciate it. And we are happy you are with us here this morning.

Ms. Janet Trautwein——

Did I pronounce your name correctly?

Chairman ANDREWS. Is a returning witness to the committee, I believe. I think she has been here before.

Is the executive vice president and CEO of the National Association of Health Underwriters in Arlington, Virginia. She also worked 4 years as legislative director and lobbyist for the Texas State Association of Health Underwriters. Ms. Trautwein received her B.A. in English literature from Elmhurst College.

And one of your members—last Friday I was sitting in a coffee shop across from a theater. I have a young child who performs in theater. And your member came in and saw me there and talked for a half an hour about all your talking points. So I heard already what you had to say. [Laughter.]

He was very persuasive.

Mr. William Oemichen——

Did I pronounce your name correctly?

Is the president and CEO of the Wisconsin Confederation of Cooperatives and the Minnesota Association of Cooperatives. He previously served as Wisconsin's top Consumer Protection and Trade Practices official from August of 1996 to September of 2001. And prior to that, as an accountant, malpractice, antitrust and cooperative attorney at a major Midwestern law firm.

Mr. Vaughan also worked for two Minnesota members of Congress in Washington, D.C. And has a B.A. in economics from Carlton College and a J.D. from the University of Wisconsin at Madison.

Welcome, we are happy to have you with us.

Dr. David U. Himmelstein—did I pronounce your name correctly, Doctor?

Is an associate professor of medicine at Harvard Medical School and practices primary care internal medicine. He currently serves as chief of the Social and Community Medicine Division at Cambridge Hospital. Dr. Himmelstein graduated from Columbia University's College of Physicians and Surgeons, completed a medical residency at Highland Hospital in Oakland, California, and a fellowship in general internal medicine at Harvard.

It is an honor to have you with us this morning, Doctor, thank you. Glad you are here.

And Ms. Karen Davenport is director of health policy at the Center for American Progress where she leads the Center's efforts, along with Mr. Podesta, to reinvigorate the national debate on health coverage for all Americans. She earned a B.A. in political science from Whitman College and an MPA from the Maxwell School of Citizenship and Public Affairs at Syracuse University.

We are very honored, fortunate to have you all with us.

And, Mr. Pollack, you are up.

STATEMENT OF RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK. Thank you, Mr. Chairman, and thanks for inviting me to this panel.

Your staff asked that we focus on some improvements that can be made on employer-based health coverage. And predominately, that is what my testimony will focus on.

I will be happy during the question and answer period to take up the challenge that you raised in the beginning about what are the different ingredients that can get us to universal coverage.

We believe that employer-based coverage can work together with public program coverage to recreate a uniquely American hybrid private and public approach to achieving the goal of quality, affordable coverage for all. This hybrid approach would strengthen employer-based health coverage by improving regulation of the market, subsidize private coverage for many workers with moderate incomes and expand public safety net programs, like Medicaid, to fill in gaps for low-income people whose needs are often not met by the employer-based system.

Employer-based coverage does provide critically important protections to consumers. It is guaranteed. That is people will not be denied coverage based on their health. Under current law, insurers are limited in their ability to exclude coverage of pre-existing conditions. And employees within a group cannot be charged higher premiums based on their age, health status or gender. Further, large employers are generally able to negotiate for good, comprehensive coverage for their employees.

However, there is room to improve our employer-based system from a consumer perspective.

First, under current law, insurers can exclude coverage for preexisting conditions for up to 1 year for employees who previously had less than 12 months of continuous coverage. These exclusions cause employees to postpone or forego treatment for serious illness such as cancer.

This law should be amended so that people have protections against pre-existing conditions when they first become employed and buy coverage.

Therefore, we at Families USA support the Pre-Existing Condition Patient Protection Act of 2009, introduced by Congressman Courtney, which would amend the risks to entirely prohibit pre-existing conditions exclusions in employer-based plans.

Second, under current law in 40 states, insurers can charge small employers high premiums if the employees, as a group, are in poorer health and/or because they have a higher proportion of women employees. This means that small businesses with higher numbers of people with health care needs or with higher numbers of women face unfair higher health insurance costs.

Therefore, Families USA recommends that Congress improve employer-based coverage for all workers by banning health status and gender rating nationally. Insurers should charge all businesses buying the same plan the same price.

Third, more must be done to address affordability. This requires that both low and moderate-income individuals receive premium subsidies that put their share of the cost of coverage within the family's financial reach. These subsidies should be larger for those with lower incomes or the least able to afford coverage. Further, these premium subsidies should be accompanied by appropriate out-of-pocket cost protections, deductibles, co-payments, limits on total coverage and uncovered benefits.

One key way to protect consumers from unaffordable high out-of-pocket costs is to make sure they can buy a comprehensive benefits package that covers the full range of health care services that people need.

I should note that a comprehensive benefits package must have reasonable annual and lifetime caps on the total dollar amount of health care services that will be covered.

In 2007, 22 percent of workers had caps from $1 million to $2 million. And some workers had caps as outrageously low as $250,000, a cap that would preclude coverage from typical cancer treatments.

Therefore, Families USA recommends passage of legislation, such as the Health Insurance Coverage Protection Act, H.R. 1085, co-sponsored by Congressman Kildee, that will increase the life time cap to $10 million in employer-based coverage for employers with 20 or more employees.

I notice my time is up, so I will stop there.

And happy to respond to questions.

[The statement of Mr. Pollack follows:]

Prepared Statement of Ron Pollack, Executive Director, Families USA

Mr. Chairman, Members of the Committee: Thank you for inviting Families USA to testify today at this very important hearing about health care reform. We are excited that Congress is moving forward with health care reform this year, and happy to help you think through the implications for employer-based health insurance.

We have two core goals for health care reform: that everyone who currently has satisfactory health care coverage can keep that coverage, and that those who do not currently have health care coverage can get it. We believe that the most effective and efficient way to achieve both of those goals is to build upon the existing health care system. The employer-based health insurance sector is of great importance, cov-

ering well over half of all non-elderly insured Americans. In health reform, we must do the following:

- strengthen employer-based health coverage by improving regulation of the market,
- subsidize coverage for those workers with low and moderate incomes to enable them to obtain and keep health coverage, and
- expand the Medicaid program to fill in the gaps for low-income people whose needs are not met by the employer-based system.

Strengthen Employer-Based Coverage

Employer-based coverage provides important protections: It is guaranteed—that is, people will not be denied coverage based on their health; insurers are limited in their ability to exclude coverage of pre-existing conditions; and employees within a group cannot be charged higher premiums based on their age, health status, or gender. Further, large employers are generally able to negotiate for good, comprehensive coverage for their employees. These protections are not provided in the individual insurance market in many states, much to the detriment of consumers, and they are essential protections to build upon in health care reform.

However, there are also weaknesses in the protections described above. Even limited pre-existing condition exclusions create inequities and contribute to the phenomenon of "underinsurance." And although employees performing similar jobs in a company cannot be charged different health insurance premiums, the business as a whole may pay higher premiums based on its employees' health or other characteristics. The variability of insurance offered by employers means that some employees get good coverage at work while others get coverage that leaves them exposed to high out-of-pocket costs or provides limited benefits, or they get no coverage at all. And finally, in the current health care system, even if people have very minimal incomes, many are not eligible for public coverage or any help paying their premiums.

I'd like to spend a few minutes talking about each of these problems and then talk more specifically about protections people with low incomes will need in a reformed market.

Improvements Needed in Employer-Based Coverage

Prohibit pre-existing condition exclusions

Under the Health Insurance Portability and Accountability Act (HIPAA), people have some protections against pre-existing condition exclusions when they receive coverage through their employers:

- They cannot be subject to a pre-existing condition exclusion if they have had 12 months of continuous coverage;
- Only conditions which have been treated or diagnosed by a medical professional in the last 6 months count as pre-existing conditions; and
- Insurers cannot decline to offer group coverage due to the health of an employee.

(In Medicaid and CHIP, people are not subjected to pre-existing condition exclusions at all.)

However, HIPAA does allow insurers to exclude coverage for a pre-existing condition for up to one year for employees who previously had less than 12 months of continuous coverage. (The exclusionary period is reduced by the amount of time that they had previous continuous coverage.) These exclusions cause employees to postpone or forgo treatment for serious illnesses such as cancer.[1]

Pre-existing condition limitations are intended to serve a policy goal of encouraging people to keep insurance, but this does not make much sense in the group market. Mostly, the people who go without coverage are those who do not have help paying premiums from their employer and who cannot afford to maintain coverage on their own. People who try to purchase coverage on their own in the individual market often face extremely high premiums, especially if they are older or in less than perfect health, and many are denied coverage altogether. And many adults, no matter how poor, do not qualify for Medicaid.

In passing the American Recovery and Reinvestment Act (ARRA),[2] Congress recognized the unfairness of counting a time that someone cannot afford coverage as a "break" that subjects people to pre-existing condition exclusions. Congress directed that any gaps in coverage between the time a person was laid off and when the new COBRA subsidy became available cannot be counted as a break in coverage and therefore the person cannot be subjected to new pre-existing condition exclusions. At the very least, this principle of not counting unavoidable gaps in coverage should be extended to a reformed market. Families USA recommends that ERISA be

amended to entirely prohibit pre-existing condition exclusions in employer-based plans. The Pre-existing Condition Patient Protection Act of 2009 would do this.

Prohibit premium variation based on health status and gender

In 40 states and the District of Columbia, small group insurers can charge employers higher premiums if the employees as a group seem to be in poorer health than average. In most of those states, insurers can also raise premiums in future years based on a business's medical claims.[3] This means that though employers are not supposed to discriminate in their hiring practices, they will pay more if they hire people who already have health conditions or who develop health problems. Similarly, gender rating in many states puts businesses with higher concentrations of female employees at a disadvantage.

Some states have addressed these problems through laws requiring community rating or adjusted community rating: Insurers must charge all small employers equally, no matter the health status (and in some states, the gender) of their employees. This effectively spreads the risk of the highest cost enrollees equally among all employers buying a particular health insurance policy. Families USA recommends that Congress further improve employer-based coverage by banning health status and gender rating nationally.

Spread costs and responsibility for health care equitably across employers

States confront several problems when they try to reform the employer-based health care system to better spread risk and ensure coverage. First, if they try to redistribute the cost of high claims across the population through risk pools or reinsurance systems, they can only readily assess insurers that they regulate to pay those claims—they cannot easily assess large, self-insured employers. High-cost claims should be spread to larger employers as well, and across policies offering different benefit designs. Second, if states try to subsidize coverage for people who do not have access to employer-sponsored care, they can easily create disincentives for employers who do provide coverage, yet state attempts to hold employers responsible for health care payments quickly confront ERISA challenges.

An employer-based system can only work if all employers either provide health benefits for their workers themselves or pay into a public system that provides care. Without this provision, employers and employees face great inequities: Through their premiums, those paying for coverage are also paying for the uncompensated care of workers in another business that did not provide coverage. Of course, employers could be exempted from a pay or play responsibility based on their size, revenues, and expenses if they did not have the funds to contribute. Massachusetts and Vermont currently require very small employer assessments to help pay for their health care systems. San Francisco requires a more significant contribution to the city's program for the uninsured by employers who do not elect to provide coverage themselves. San Francisco's system has withstood legal challenges thus far, but Congress could help to clarify a framework within which other states and localities can act.

Families USA recommends that Congress develop large national pools, including both large and small employers, to share the risk of high-cost claims. Further, Families USA recommends that Congress either establish an equitable system for employer contributions to health care nationally, or clarify that ERISA allows states to assess employers for public health care and to give tax credits to those that already cover their own workers. Some small employers will need federal subsidies in order to provide coverage for their workers.

Require adequate benefits

Some employers and some subsidized coverage programs have sought to control costs by purchasing minimal coverage. This is penny wise and pound foolish. Unable to afford the care that is not covered, consumers delay seeking care until they are much sicker. When they do finally seek care, they pay what they can—and go into debt doing so. The share they cannot pay—the uncompensated care—is shifted to other payers; we all pay a portion of these costs in our health insurance premiums.[4]

Limit cost-sharing and the sale of high deductible plans

When employers offer high-deductible health plans, the policies require families to spend an average of nearly $4,000 out of pocket before coverage begins. Half of working families with HSA-qualified high deductible plans are offered no other insurance options by their employers, and nearly half of employers offering these plans leave families on their own to pay the high deductibles out of pocket.[5] An analysis of Census data showed that only one in 10 families with incomes up to about $52,800 annually (about 300 percent of poverty for a family of three in 2008) could afford to pay the average deductible with their savings,[6] so if they have seri-

ous illnesses, these families will be left with medical debt. Employers should offer their employees a reasonably priced, low-deductible coverage option. When high-deductible plans are offered, there is a danger that healthier employees will gravitate to them and less-healthy employees will choose low-deductible plans; this "adverse selection" will drive up the premiums of low-deductible plans, which will encourage more people to opt for high-deductible plans, and so on. If health reform includes an exchange with a variety of cost-sharing options, the option with the lowest cost-sharing should not be priced higher due to the risks of those who select it. Instead, Families USA recommends development of a price structure for all product lines within an exchange that treats everyone in the exchange as being part of the same risk pool. The coverage option with the lowest cost-sharing should be priced as low as possible, and low-income people should receive meaningful subsidies to pay its premiums.

Retain important benefit mandates and raise benefit caps

Over the years, states have mandated that the plans they regulate provide certain benefits. Generally, these mandates were to fill holes that insurers typically left in coverage. For example, states have mandated that plans cover well-child care, colorectal screening, and diabetes supplies when some plans previously failed to cover these important services. Mandates do not now regulate the amount of hospital, doctor, and drug coverage the plans must provide. Some people have advocated for exemptions from benefit mandates as a way to save money. However, this leaves people without needed health care and creates hidden costs that still exist in the health care system. States that have analyzed the cost of various benefit mandates have found that most mandates enacted in their states raised premiums by less than 1 percent.[7] Further, when looking at the total cost of state mandates, one state found that the net cost impact of all 26 of its mandates was only 3-4 percent.[8] These findings suggest that the elimination of mandates from insurance plans would reap little in the way of premium reductions. Federal law currently sets few benefit mandates: It requires employer-based health plans to cover newborn care, certain care for women with cancer, and to provide mental health parity. If federal and state relationships change with respect to health insurance regulation, Congress or an independent body should look carefully at benefits mandates enacted by states to set a floor on coverage.

Further, annual and lifetime caps create barriers to care. In 2007, 22 percent of workers had caps from $1 million to $2 million,[9] and some workers had caps as outrageously low as $250,000[10]—a cap that would preclude coverage for typical cancer treatment. Few people ever hit their lifetime caps but for those who do, the consequences are disastrous.[11] Caps mean, for example, that cancer patients stop getting treatment. Premature infants on ventilators and toddlers receiving heart transplants are among those who may exhaust a $1 million cap, and the infusions that allow hemophiliacs to live normal lives can easily eat through a $2 million cap. While these treatments are too expensive for any one person to afford, since so few people need them, the cost is miniscule when spread across a population. Families USA recommends passage of legislation such as the Health Insurance Coverage Protection Act (S. 442/H.R. 1085) to increase the lifetime caps to $10 million in employer-based coverage for employers with 20 or more employees.

Provide for oversight of the health insurance market

Some states have done a better job than others of overseeing health insurance company behavior by requiring prior approval of health insurance rates and by setting standards about how much health insurers must spend on medical expenses (as opposed to administration and profit). In addition, they have looked at factors such as excessive compensation and whether a nonprofit insurer was investing in services that benefit the larger community when determining whether the insurer met its obligations in the marketplace. Standards such as minimum medical loss ratios and strong oversight are essential to controlling costs. New York, New Jersey, and Maine are examples of states that provided premium refunds to employers and individuals when plans failed to spend at least 75 percent of premium dollars on medical care. Colorado, Maryland, and Pennsylvania are examples of states where nonprofit insurers are now using surpluses that they had built over the years to make substantial contributions to community health needs. Families USA recommends setting federal and state responsibilities and standards for oversight of the health insurance marketplace.

Provide Adequate Subsidies for Moderate-Income Individuals

A regulated private health insurance market is an absolutely essential part of health care reform, but these reforms are not enough to help those with moderate incomes afford coverage. Moderate income individuals whose employers do not offer

health coverage, or whose employer-based coverage is too expensive, need more than just a better-regulated insurance market; they also need subsidies that put private coverage within financial reach. These subsidies should be larger for those with the lowest incomes, who are the least able to afford coverage. Further, these subsidies should be accompanied by appropriate limits on out-of-pocket costs for low-income individuals. Research points out the serious barriers that unaffordable out-of-pocket costs erect between moderate income individuals and needed health care.[12] If subsidies are insufficient for these individuals, they will continue to be left out of the nation's health care system.

Subsidies must be built on a regulated market as described above: Premiums should not vary based on health or gender; coverage must be available regardless of pre-existing conditions; benefits must be adequate and cost-sharing limited; and the federal government, together with states, should oversee the system to be sure that public dollars actually go to health care and that companies do not make unreasonable profits.

Expand and Improve Medicaid for Low-Income Individuals

Moderate-income individuals will benefit greatly from subsidized coverage available in a reformed private insurance market. But for the lowest-income Americans, the most appropriate coverage vehicle is undoubtedly the Medicaid program. Health reform must also address expanding and improving Medicaid to ensure that all Americans can have affordable, quality health coverage. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not. With respect to coverage for low-income Americans, Families USA recommends: (1) that a national Medicaid eligibility floor be established, and (2) that the enrollment process in Medicaid be streamlined to facilitate easier enrollment for all eligible individuals.

Why Medicaid?

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What's more, it is specially designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[13]

As in any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees without compromising access to care. However, Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A little-known fact is that Medicaid is actually more efficient at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs more than 20 percent less to cover low-income people in Medicaid than it does to cover them in private health insurance.[14] In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Cost-sharing protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits to how high other forms of cost-sharing can be. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments on individual services are limited to so-called "nominal" amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much on out-of-pocket costs as do low-income adults with Medicaid.[15] Research abounds demonstrating the serious burden these out-of-pocket health care costs can pose for low-income people.[16] When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on.[17] Because Medicaid incorporates such strong cost-sharing protections, peo-

ple enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive benefits

Medicaid's comprehensive benefit package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and as a result, people enrolled in Medicaid are less likely than both the uninsured and those with private coverage to lack a usual source of health care or to have an unmet health care need.[18]

Medicaid appeal rights and protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing ongoing treatment. They can also appeal enrollment or eligibility decisions, and have the right to a fair hearing. Also, unlike the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past, and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

Create a National Medicaid Eligibility Floor

To be eligible for Medicaid under federal law, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children, pregnant women, parents with dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. Only 16 states and the District of Columbia cover working parents at least up to the poverty level ($18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty ($12,268 for a family of three).[19] The picture is even grimmer for low-income adults who do not have dependent children: in 43 states, these individuals are ineligible for Medicaid no matter how low their income. An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.[20]

Health reform offers an opportunity to address these gaping holes in the health care safety net, and to ensure that, in addition to improving coverage for those with moderate incomes, the very lowest-income Americans are covered as well. Families USA recommends that Congress establish a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental, or health status. More than one in three uninsured Americans has an income below the poverty level.[21] Establishing a federal floor for Medicaid would significantly reduce the rate and number of uninsured Americans.

Streamline Medicaid Enrollment

In order to ensure that the new Medicaid expansion attracts the highest possible enrollment among those who are eligible, Families USA recommends that Congress

establish a new, simplified enrollment process for both current and newly eligible people. Experience with the Children's Health Insurance Program (CHIP) has shown the importance of establishing simple, streamlined enrollment policies and procedures to help eligible people get and keep coverage.[22] Examples of these simplifications include allowing 12 months of continuous eligibility to individuals once they are enrolled in Medicaid, minimizing the amount of documentation people need to provide when they apply and renew their coverage, eliminating asset tests, allowing application by mail and online, and simplifying the application itself so that it is short and easy to understand.

It will also be crucial that there be coordination in the application process for Medicaid and the subsidy for purchasing private health insurance coverage. Experience tells us that low-income people have fluctuating incomes, and those with incomes "at the margins" may not know in advance for which program they are eligible. It is imperative that the process for screening applications include provisions that facilitate enrollment, such as a "screen and enroll" requirement similar to that in CHIP, be included in any Medicaid expansion and any new program to subsidize private health coverage for low- to moderate-income individuals. Such a requirement would ensure that individuals who apply for the subsidy, but are actually eligible for Medicaid are enrolled in Medicaid and vice versa. The enrollment process should make sure that the right people get into the right program, and should not make people jump through unnecessary hoops to get there.

Conclusion

Strengthening the employer-based health coverage sector and expanding Medicaid are key components of health care reform. By addressing the problems described above, Congress will make great strides towards the goal of ensuring access to high quality, comprehensive, affordable health coverage for all Americans, while reducing the long-term costs of health care coverage.

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Chairman ANDREWS. Thank you, Mr. Pollack. And as I say, you are written statement has been entered into the record in its entirety, which we appreciate.

Mr. Langan, welcome to the Committee.

STATEMENT OF MICHAEL LANGAN, PRINCIPAL, TOWERS PERRIN

Mr. LANGAN. Thank you.

Mr. Chairman, Ranking Member Kline and members of the subcommittee, good morning. Thank you for the opportunity to join you today at this important hearing.

My name is Michael Langan. I am a principle at Towers Perrin, an employer benefit consulting firm, where I lead a group of benefit attorneys who analyze legislative and regulatory developments that affect our clients' employee benefits and compensation programs.

I am here today on behalf of the American Benefits Council, which is a trade association representing principally Fortune 500 companies who either sponsor or provide services to retirement and health plans that cover more than 100 million Americans.

The American Benefit Council's recommendations on health reform are contained in its January 2009 Condition Critical Report.

I would like to ask permission to submit the entire list of those recommendations for the hearing record.

Chairman ANDREWS. Without objection, they will be entered into the record.

Mr. LANGAN. Thank you.

Description number one in our report calls for building on what works. We believe that the best health reform options are those that preserve and strengthen the voluntary role that employers currently play as the source of health coverage for more than 160 million Americans.

Health reform that continues to engage employers as sponsors of employee health coverage will enable employers to apply their considerable health benefit expertise and innovation in a reformed system.

According to a 2008 Kaiser Family Foundation survey, 99 percent of employers with 200 or more employees offered health benefits to their workers. Moreover, that percentage has never been lower than 98 percent at any time in the last 10 years.

By comparison, the same survey shows that 62 percent of firms with fewer than 200 employees offered health coverage.

We believe the strategies that focus on making health coverage more affordable for employers of all sizes is the best way to ensure both the continuation of the high-levels of participation by large employers and to increase the levels of participation by smaller employers.

Indeed, one reason that we believe that a pay or play approach would be an inappropriate coverage solution is that it could easily lead to a net reduction in employer-sponsored coverage. Our concern is that this approach could drive some companies simply to pay rather than play. This would lower the level of employer engagement as an innovator and a demanding purchaser of health care services.

We believe that an essential component for maintaining a strong employer-based system starts with protecting the comprehensive federal regulatory framework established by ERISA. Employers that operate across state borders consider ERISA's framework essential to their ability to offer and administer employee benefits consistently and efficiently. This regulatory approach also translates into better benefits and lower costs for employees.

Our vision of health reform also calls for improvements both in private health insurance products, especially in the individual market, and in existing public programs. Both have important roles to play in a reformed and robust health care system. However, we also think that both of these sources of health coverage have worked best by serving distinctly different roles in populations.

The Council's health reform recommendations also include numerous recommendations directed at improving the quality and affordability of health care services.

For 20 years now, my firm has conducted an annual survey of large employers regarding their health care strategies and their plan costs. In the most recent Towers Perrin survey of health care costs, employers reported that the average per-employee costs for health coverage in 2009 is $9,660, almost $10,000 per employee. And this represents an average increase of 6 percent over last year. Employers also told us that the average cost of family health coverage will exceed $14,000 this year.

While these numbers alone are sobering, the impact of relentless health care increases is most starkly evident when compared with average wage increases over the last eight to 10 years. This gap between wage increases and the annual increase in health costs results in what we call the affordability gap. Over time, this widening gap erodes total compensation and employee purchasing power.

On page 5 of my statement, there is a chart that illustrates this gap.

Clearly, we believe that urgent action is needed to make the health care system less costly and more efficient while achieving more consistent delivery of high-quality care.

Our recommendations call for accelerating the development and implementation of consensus-based quality and performance measures, introducing these measures into our payment system starting with Medicare.

We feel that we need to reward health care providers on the basis of proven performance rather than simply the volume of services they deliver.

We also call for other measures to help bring health care costs under control, including building on the initial investments and health information technology, as well as independent research on therapies and procedures that consumers and providers can freely access.

Mr. Chairman, I will conclude with the observation that the most important prescription for health reform may well be the willingness of all major stakeholder groups to work collaboratively to achieve our shared goal of a stronger, more sustainable health care system. The members of the American Benefits Council and those of us at Towers Perrin are committed to working towards those goals to achieve heath care reform that it both urgently needs and can only succeed if it is developed through an open, consensus-based approach.

Thank you again for the opportunity to share our views, and I look forward to addressing any questions you may have.

[The statement of Mr. Langan follows:]

Statement from

Michael J. Langan

Principal, Towers Perrin

On behalf of the American Benefits Council

Before the

U.S. House of Representatives
Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

Hearing on

"Ways to Reduce the Cost of Health Insurance for Employers, Employees and Their Families"

April 23, 2009

Mr. Chairman, Ranking Member Kline and members of the subcommittee, thank you for the opportunity to join you today at this important hearing on "Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families." My name is Michael J. Langan and I am a Principal at Towers Perrin where I manage a group of employee benefits attorneys who analyze legislative and regulatory issues affecting employer benefit and compensation programs, including retirement, health and welfare, executive compensation and other human resource issues.

Towers Perrin is a global professional services firm that helps organizations improve performance through effective people, risk and financial management. The firm provides innovative solutions in the area of human capital strategy, program design and management, and in the areas of risk and capital management, insurance and reinsurance intermediary services and actuarial consulting. We have offices and alliance partners throughout the United States and in Canada, Europe, Asia, Latin America, South Africa, the Middle East, Australia and New Zealand.

I am here today on behalf of the American Benefits Council, a trade association representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans covering more than 100 million Americans.

In addition to my own background providing consulting advice to our clients to help them meet the benefits needs of their employees, my statement today is drawn from the diverse experience of the Council's membership, particularly its Board of Directors, which has shaped a set of 10 practical prescriptions to improve our health care system. The Council's recommendations on health reform are contained in its January 2009 report, *Condition Critical*, which is aimed at achieving a stronger, more sustainable health care system. I was privileged to serve as a member of the Council's Health Care Reform Task Force that worked throughout much of last year analyzing the many strengths and needs of our health care system and developing a set of specific policy proposals that we believe would build on its strengths while improving health quality, lowering health costs and extending coverage to all Americans.

The Importance of Employer-Sponsored Health Coverage

Mr. Chairman and Representative Kline, we are particularly grateful for your understanding and support for the employer-based health care system and your recognition of the vital role it plays in providing health coverage to more than 160 million Americans. As you, and all the members of this subcommittee, prepare to consider health reform legislation, we firmly believe that the employer-based health care system provides a solid foundation upon which to build toward the shared goal of achieving universal coverage.

In the Council's *Condition Critical* report, Prescription #1 calls for building on what works. For us, the best reform options are those that preserve and strengthen the voluntary role employers play as the largest source of health coverage for most Americans. By keeping employers engaged as sponsors of health coverage, we also keep the innovation and expertise employers bring to the table in the collective effort to achieve broad-based, practical health system reform.

One of the many strengths of our voluntary employer-based system is that group purchasing lowers health care costs because employers, especially larger employers, are able to effectively pool the risks of employees. In addition, employers are demanding purchasers of health care services. They are increasingly focused on leveraging their health care dollars with those who can demonstrate proven value and improved health care status for their employees and their families. Because employers have a strong interest in the health and productivity of their workforce, they work hard to identify solutions that improve productivity, reduce chronic illness, and lower disability costs. These investments in the health of their workforce not only provide broad access to primary care and specialty services, they increasingly have engaged employees in innovative health coaching and healthy lifestyle programs, cost and quality transparency initiatives, pharmaceutical management programs, and value-based health plan designs.

Typically, employers do not consider pre-existing health conditions when offering health coverage to their employees and do not adjust premiums, or limit coverage based on individual health status. Further, with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals cannot be denied health coverage due to their health status as they move from job to job. Employees typically report high levels of satisfaction with the health coverage they obtain through their employer and increasingly understand its value as the high cost of health coverage would make it much more difficult to obtain on their own.

Finally, it is important to keep in mind that nearly all employers with 200 or more employees provide health care coverage today. In fact, data from a 2008 Kaiser Family Foundation survey shows that 99 percent of employers with 200 or more employees offered health benefits to their workers, and that this percentage has never been lower than 98 percent at any time over the last ten years. By comparison, the same survey shows that 62 percent of firms with fewer than 200 employees offered health coverage.

As the subcommittee considers coverage solutions as part of health reform, we believe that strategies that focus on making health coverage more affordable for employers of all sizes is the best way to ensure both the continuation of the extremely high levels of participation by larger employers and increase the level of participation by smaller employers. Indeed, one reason we believe that a "pay or play" approach would be an inappropriate coverage solution is that the myriad requirements that would inevitably be imposed on those who might prefer to sponsor health coverage would ultimately, if

unintentionally, result in a net reduction in employer-sponsored coverage by leading some companies to simply "pay" rather than "play". This would lower the level of active employer engagement and their important role as innovative and demanding purchasers of health care services.

Maintaining the ERISA Framework

We believe that a vitally important component of maintaining a strong employer-based health system starts with protecting the federal regulatory framework established by the Employee Retirement Income Security Act (ERISA) that allows employers to offer valuable benefits to their employees under a single set of rules, rather than being subjected to conflicting and costly state or local regulations. Employers that operate across state boarders consider ERISA's framework essential to their ability to offer and administer employee benefits consistently and efficiently. This regulatory approach also translates into better benefits and lower costs for employees. In addition, holding employer-sponsored benefits accountable under a single set of rules, interpreted at the federal level, as ERISA now does, is fundamentally fair to all employees covered under the same plan regardless of where they may live.

State benefit mandates alone can add as much as 12 percent of total premium according to a 2006 report by the Massachusetts Division of Health Care Finance and Policy, a cost that must be borne by both employers and employees who share the full cost of coverage. Importantly, most large employers who operate on a multi-state or national basis consistently report that without the ERISA framework they would face the untenable choice of attempting to maintain health coverage for their employees at even higher costs because of the need to meet each state's separate set of benefits and regulatory requirements, or dropping health coverage entirely.

Improving the Individual Insurance Market and Public Programs

Health care reform will also require measures to ensure that those outside of employment-based health coverage are able to obtain meaningful, affordable coverage through the individual health insurance market. Our proposals include recommendations that would ensure that any person without health coverage through an employer and who is not otherwise eligible for coverage under a state or federal health insurance program could obtain in any state at least one individual market insurance plan that meets minimum federal requirements. These insurance products should be exempt from additional state benefit mandates, but for all other purposes – such as consumer protections, solvency requirements, rating rules and other requirements – state standards would continue to apply.

We also believe that reformed state-based high risk pools that meet minimum federal standards for coverage and rating can play a significant role in helping to keep the individual insurance market more affordable and competitive. In order to keep

coverage affordable for those enrolled in high-risk pools, we propose that premiums paid by enrollees in these state-based programs be limited and claims expenses that exceed the funding from enrollee premiums be shared by state and federal governments.

In addition to employer-based health coverage and improving the individual health insurance market, we believe that public health insurance programs such as Medicaid, Medicare and the Children's Health Insurance Program (CHIP) all must be improved, particularly by moving toward payment systems that reward health care providers who consistently meet evidence-based performance standards and away from payments based simply on the quantity of services delivered. Our recommendations for health care reform also call for the establishment of a federal eligibility floor for coverage for adults under Medicaid and more effective outreach and incentives for states to reach the more than 10 million individuals who are estimated to be eligible for health coverage under state-based health programs, but are not yet enrolled.

We also believe that the appropriate role for public health insurance programs is to complement, rather than compete with, private health plan options. Our vision of health reform calls for improvements in both private health insurance products, especially in the individual insurance market, and in public programs. Both have important roles to play in a reformed and robust health care system. However, we also think that both sources of health coverage have worked best by serving distinctly different roles and populations.

Improving the Quality and Efficiency of Health Care

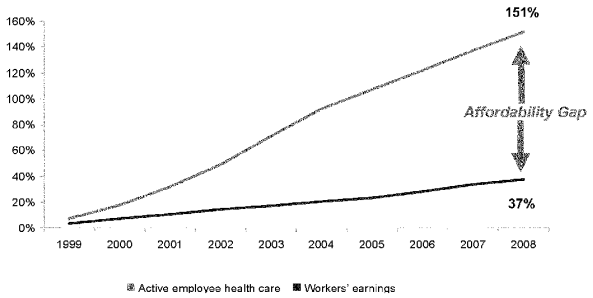
Health care spending already accounts for more than $2 trillion annually, more than 17 percent of our gross domestic product and, according to a 2008 study published in *Health Affairs*, our national spending on health care is expected to nearly double by 2016, reaching a staggering $4.3 trillion.

According to the most recent Towers Perrin survey of health care costs, employers reported that the average per employee cost for health coverage in 2009 is $9,660 and that this represents an average increase of 6 percent over last year. As in previous years, our survey also indicates that employers will shoulder the lion's share of these costs, subsidizing, on average, 78 percent of the premium and asking employees to cover the remaining 22 percent, plus applicable cost sharing for co-pays, deductibles and coinsurance for covered services.

Average employee health care costs vary significantly depending on whether the coverage is for an employee-only, where average 2009 costs are $4,860, while the average cost of family coverage is expected to be $14,244 this year. While these numbers are remarkable in themselves, the impact of annual health care cost increases is most starkly evident when compared with average wage increases over the last 8 or

10 years. This gap between average increases in health costs and average wage increases forms what we refer to as the "affordability gap". Over time, this results in an erosion in total compensation and employee purchasing power.

The growing affordability gap
Cumulative active employee health care costs vs. wage increases



Source: Towers Perrin *Health Care Cost Survey 2009* (active employee data) and Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey Sept-Sept, 1999-2008.

Clearly, urgent action is needed to make our health care system more efficient while also ensuring more consistent delivery of high quality care. That is why the American Benefits Council joined with over 190 employers and other organizations who recently sent a letter to President Obama (attached) stating that a strategy to control health costs must be integral to any effort to improve the health care system and that "controlling spiraling health care costs benefits every American seeking access to quality, affordable care and makes it possible for employers to continue their role as voluntary sponsors of health plans for their employees."

The Council's *Condition Critical* report includes numerous recommendations directed at achieving higher quality, more affordable health care. For example, we call for a nationwide interoperable health information network to be adopted to permit the exchange of vital health records and patient information much more efficiently and to provide a backbone for a wide range of emerging quality improvement initiatives. The funding for health IT that was included in the recent economic stimulus bill that the President signed in February 2009 will make a major contribution toward a seamless, electronic health care system, and we will support additional steps to build on these initial investments as part of health reform legislation.

A transformed health care system is also one that makes price and performance information easily accessible so consumers can quickly determine where to find those providers who have a proven record of delivering high quality care. To reach that goal, we need to accelerate the development and implementation of consensus-based quality measures and begin to introduce these measures into our payment systems, starting with Medicare, to reward health care providers on the basis of proven performance rather than simply the volume of services they deliver. This fundamental transformation in our payment for health care services will also give health care providers the tools they need to compare their performance with other professionals in their field in order to support and encourage continuous quality improvement.

We also believe that we should establish a national entity for significantly increasing the capacity for independent, rigorous comparative effectiveness research on medical technology and services. This research should provide unbiased information on both clinical and cost effectiveness of services and technologies to help ensure that more patients receive the most effective care for their condition. Again, we support the steps taken to begin this important work in the February 2009 economic stimulus legislation and believe health reform legislation should build further on this initial investment in comparative effectiveness research.

In addition, many employers have moved to stop payments for serious preventable errors (so-called "never events"), just as Medicare has begun to do, so patients are protected from egregious errors that can occur in the clinical setting and all purchasers of health care services can send a consistent message about the importance of effective internal controls to avoid preventable errors.

Beyond these steps, other measures are needed in health reform legislation to help bring health care costs under control. For example, we need to reach agreement on effective medical liability reform to help limit frivolous litigation and reduce the costs of defensive medicine, stronger incentives for individuals to take personal responsibility for their own wellness and disease prevention, greater participation in proven chronic care and disease management programs, and a clear regulatory pathway to permit the approval of "bio-similar" or "bio-generic" drugs with appropriate protections of intellectual property rights for innovators.

The important message is that no one of these steps on their own will be sufficient to significantly bend the cost curve in health care. The effort will require a series of steps to be taken as part of health reform, but collectively these steps can make a significant difference, even if the net result is lowering the projected rates of growth by only 1 or 2 percent annually over the next 10 years. Most of all, from the perspective of most employers who already offer health coverage to their employees and are looking for better solutions to help meet that commitment in the future, the key test of whether health reform is meaningful will be the degree to which it squarely and fairly helps bring health care costs under control.

Conclusion

These are times of extraordinary economic turmoil and challenges. Some have even suggested that health reform may need to wait until we address other more urgent economic recovery priorities. We take the opposite view. Addressing the nation's health policy challenges is an integral element of — rather than an obstacle to — economic recovery and personal financial security. We agree with the growing consensus among our political leaders, economists, and business leaders that the current rate of spending for health care is not sustainable for individuals, employers, state or federal government or the American economy. Health reform is an urgent national priority and requires our best, collective efforts to see that it is achieved as swiftly as possible.

The American Benefits Council's prescriptions for health reform also recognize that the most important prescription for health reform may well be the willingness of all major stakeholder groups to engage in a collaborative effort to develop health reform solutions. As an organization whose members either directly sponsor or administer employee benefits covering more than 100 million Americans, we are committed to working with all those who believe, as we do, that health reform is both urgently needed and can only succeed if it is developed through an open, consensus-based process. If we take this path and are guided by a set of pragmatic prescriptions, we can succeed in achieving fundamental health care reform.

We look forward to working with this subcommittee, the Obama Administration, and other major stakeholders in our health care system in developing sensible solutions to deliver on the promise of making quality, affordable health care a reality for all Americans. Thank you again for the opportunity to share our views with you today and I look forward to addressing any questions you may have.

Attachment: Employer group letter to President Obama, April 1, 2009

April 1, 2009

The President
The White House
Washington, D. C. 20500

Dear Mr. President:

The undersigned companies and associations applaud your commitment to comprehensive, bipartisan health care reform, and share your belief that all Americans should have access to affordable health care coverage. As voluntary providers of health care to more than 170 million Americans, employers are leading the way in helping to improve our health care system. While firmly committed to helping workers and their families meet their health care needs, employers are also struggling with health care costs.

We have a direct and real stake in the outcome of health reform efforts. For decades, employers have provided health benefits for solid business reasons. Since 1999, however, employment-based health insurance premiums have increased 120 percent, compared to cumulative inflation of 44 percent and cumulative wage growth of 29 percent during the same period. If we fail to improve our health care system, rising health care costs will threaten the viability of U.S. businesses of all sizes and put job security, pay increases and other vital employee benefits at risk for millions of American workers.

A strategy to control costs must be the foundation of any effort to improve the health care system. Controlling spiraling health care costs benefits every American seeking access to quality, affordable care and makes it possible for employers to continue their role as voluntary sponsors of health plans for their employees. Faced with a severe and continuing economic crisis, employers simply cannot absorb new burdens, such as specific coverage levels or payment requirements, no matter how well intentioned.

Fortunately, many of the proposals to control costs can also improve quality and value. Health IT is one example, but there are many others. Employers have led the way in driving for a higher quality, evidence-based health care system and have an urgent interest in finding solutions that foster continuous quality improvement.

Any successful reform effort must build on the strengths of America's voluntary employer-based system while ensuring there is a greater variety of affordable private health plan options in the marketplace for all. By making it easier, not harder, for employers to provide quality health coverage for workers and their families we can not only strengthen health security, we can strengthen our nation's economic security.

We are eager to work with you to find solutions for this urgent national priority.

Sincerely,

Acry Fab, Inc.
Alcoa Inc.
Allegiance Benefit Plan Management, Inc.
American Administration Services Co.
American Airlines
American Bakers Association
American Benefits Council
American Boiler Manufacturers Association
American Farm Bureau Federation
American Hotel & Lodging Association
American Rental Association
American Society of Home Inspectors
American Staffing Association
American Veterinary Medical Association
AmeriGas Propane, Inc.
Aon Corp.
Arizona Chamber of Commerce
Associated Builders and Contractors, Inc.
Associated Industries of Massachusetts
Association of Equipment Manufacturers
Association of Ship Brokers & Agents
Assurant, Inc.
AT&T
Auntie Anne's, Inc.
Automotive Aftermarket Industry Association
Avaya Inc.
Ball Corporation
Battery Council International
Best Buy Co., Inc.
Birmingham (AL) Regional Chamber of Commerce
Bison Gear & Engineering
Boeing
BTE Technologies, Inc.
Buck Consultants, LLC.
Buffalo Wild Wings, Inc.
Business Roundtable
Case New Holland
Caterpillar Inc.
Chevron Corporation
Chicopee Chamber of Commerce (MA)
Chrysler LLC
CIGNA
Clark & Associates of Nevada, Inc.
Computing Technology Industry Association (CompTIA)
Corporate Healthcare Coalition
Darden Restaurants Inc.
Deere & Company
Delta Airlines
Deseret Mutual
Dollar General Corporation
DTE Energy
Eastman Kodak Company
EBS Advisors, Inc.
El Paso Corporation
Employers Council on Flexible Compensation
Exelon Corporation
Express Employment Professionals
F.C. Brengman & Associates
FMC Corporation
Food Marketing Institute
Ford
Fox Entertainment Group
Gap Inc.
Gateway Regional Chamber of Commerce (NJ)
General Mills
General Motors Corporation
Goodrich Corporation
Great Plains Energy Incorporated
Greater New Haven Chamber of Commerce
Harris Corp.
HealthCare 21 Business Coalition
Healthways
Hewitt Associates LLC

Honeywell
HR Policy Association
Independent Electrical Contractors
Independent Office Products & Furniture Dealers Association
Ingram Industries Inc.
Institute of Electrical and Electronics Engineers - United States of America
International Foodservice Distributors Association
International Franchise Association
International Housewares Association
JELD-WEN, Inc.
Jostens, Inc.
Koller Enterprises Inc.
Kraft Foods Inc.
Lamiglas, Inc.
Los Angeles (CA) Chamber of Commerce
Louisiana Business Group on Health
Lowe's Companies, Inc.
Manhattan Chamber of Commerce
Maryland Chamber of Commerce
MassMutual Financial Groups
Medco
Meridian Health
MetLife
Miles Fiberglass & Composites, Inc.
Mobile (AL) Area Chamber of Commerce
Monsanto Company
Montana Chamber of Commerce
Motor & Equipment Manufacturers Association
Motorola, Inc.
Mutual of Omaha
National Association of Computer Consultant Businesses
National Association of Convenience Stores
National Association of Health Underwriters
National Association of Home Builders
National Association of Manufacturers
National Association of Theatre Owners
National Association of Wholesaler-Distributors
National Burglar and Fire Alarm Association
National Business Group on Health
National Coalition on Benefits
National Federation of Independent Business
National Funeral Directors Association
National Lumber and Building Material Dealers Association
National Restaurant Association
National Retail Federation
National Roofing Contractors Association
National Rural Electric Cooperative Association
National Tooling and Machining Association
New Jersey Chamber of Commerce
Northeastern Retail Lumber Association
Northwestern Mutual
Palm Desert (CA) Chamber of Commerce
Paul, Hastings, Janofsky & Walker LLP
Pharmaceutical Care Management Association
Phoenix Electric Mfg. Co.
Pietzsch, Bonnett & Womack, PA
PPG Industries
Precision Metalforming Association
Principal Financial Group
Printing Industries of America
Professional Golfers' Association of America
Quality Float Works, Inc.
Raytheon Company
Red Bud Industries, Inc.
Reno Sparks (NV) Chamber of Commerce
Retail Industry Leaders Association
Rochester Business Alliance (NY)
Ryder System, Inc.

Santa Clara (CA) Chamber of Commerce
Scottsdale (AZ) Chamber of Commerce
Sears Holdings Corporation
Sebago Lakes Region Chamber of Commerce (ME)
Self-Insurance Institute of America
Small Business & Entrepreneurship Council
Snyder's of Hanover
Society for Human Resource Management
Society of American Florists
Society of the Plastics Industry
South Carolina Business Coalition on Health
Specialty Equipment Market Association
Spring Consulting Group LLC
Stuart/Martin County (FL) Chamber of Commerce
SUPERVALU INC.
TechAmerica
Tempe (AZ) Chamber of Commerce
Textile Rental Services Association of America
The Adhesive and Sealant Council, Inc.
The Association for Suppliers of Printing, Publishing and Converting Technologies
The Black & Decker Corporation
The Council of Insurance Agents & Brokers
The Dow Chemical Company
The ERISA Industry Committee
The Financial Services Roundtable
The New Jersey Business and Industry Association
The Savitz Organization, Inc.
Timesavers, Inc.
Tire Industry Association
Tyco Electronics
U.S. Chamber of Commerce
U.S. Foodservice, Inc.
Union Pacific Corporation
United States Steel Corporation
Unum
UPS
Verizon Communications
Visant Corporation
Volvo Group North America
Waste Management
Wedding and Event Videographers Association International
WellPoint, Inc.
Western Growers
WillisHRH
Xerox Corporation
Yazaki North America Inc.

cc: Members of the U.S. House of Representatives
Members of the United States Senate

Chairman ANDREWS. Thank you, Mr. Langan.
Mr. Vaughan, welcome.

STATEMENT OF WILLIAM VAUGHAN, SENIOR HEALTH POLICY ANALYST, CONSUMERS UNION

Mr. VAUGHAN. Mr. Chairman, members of the Committee, thank you for the invitation to testify on how to save money in health insurance. That is a little bit like being invited to shoot fish in a barrel. And we appreciate the opportunity.

Consumers Union is the nonprofit, independent publisher of Consumer Reports. And we do not just test toasters. We try to help people with health issues.

We are really using comparative effectiveness research to save folks millions and millions of dollars on the safest most effective brand and prescription drugs.

We support reform of the health system. Our readership tells us it is a top priority. My testimony documents why. And we have stories from many of your congressional districts, particularly moving ones from Mr. Courtney's and Mr. Loebsack's districts, in the back of my statement.

So how to save money. One thing to do would be to set up a federal office to work with the states, not take over, but work with the states in collecting and sharing information about consumer complaints and emerging fraud issues. State enforcement of insurance laws, antifraud issues, is very uneven, and we need to do better.

And the basis of that recommendation comes out of a court case in the Newark area, sir, and a settlement by New York A.G. Cuomo this spring in the United case that is so seemingly obvious. And how did this go on for so long? You feel it is almost Homer Simpson like.

The issue involved—and I will show you some math on this. This issue involved, is most of us, 70 percent of us, have a point of service, or PPO, kind of health policy where, if we need a specialist, we can go out——

Chairman ANDREWS. Maybe the young lady can stand so all the members can see the chart.

Mr. VAUGHAN. Okay, sorry.

If we go out of network for specialty care or if you want to go up Hopkins for a specialty operation, you can go. But you have to pay, of course. And let's say the doctor charged you $200. And the usual customary and reasonable fees in the area were $200. So in and 80-20 policy, you would owe $40. Well, another procedure, the doc charges $200. Usual customary and reasonable is $150; you, the insured, pay $120, you owe $80. You still owe the doctor the $200 he charged. UCR, where does that come from? Believe it or not, it is from subsidiaries owned by the insurance companies. And Cuomo and the court cases basically found that over a period of a decade, those numbers were getting low-balled.

Thank you very much.

Those numbers were getting low balled. And consumers were paying hundreds of millions of dollars over a decade more than should have.

Senator Rockefeller says they were paying a billion bucks or more.

That was such an obvious conflict of interest. Why did it take so long? If we had a federal office where—the first complaints were coming in around 2000 from AMA. We need somebody to help say, hey, guys, something is happening out there. Let's get together and protect consumers.

As a consumer rep, I hate to say it, but most of us are pretty terrible shoppers for health insurance.

Sorry, Neil.

But, "Honey, let's go shopping for health insurance this Saturday morning," would put and fear and dread in most of our hearts. [Laughter.]

And we leave a lot of money on the table. We do not get a great deal. And the documentation for this is in—Part D and in C plans. We are not getting the best deal.

In this reform bill, if you want to use consumers to drive towards value and to drive towards savings, we need some help big time. We need an office that will maybe grant the states for one-on-one counseling. We need a site that would compare quality and effectiveness and price of insurance plans.

Very important, we need some standardization of definitions. Our current issue has a couple, thought they had hospitalization insurance. Fine print, it started on the second day, after the lab tests, after the surgery room charges. They ended with a huge bill. Darn it, hospitalization means hospitalization, drug coverage means drug coverage, means chemotherapy, means the antiemetic that lets you take the chemotherapy. We need some definitions like that so that people know what they are buying.

But most, most, most important is there needs to be a market place or a forum where people can make meaningful choices among a manageable number of plans. In C, in Part D, in Part C—We are looking at 40, 60, 80 plans. Consumers just shut down. Most of these are meaningless, picky little differences. Give us some major choices in a format where we can shop. And before you sign up for that policy, you see the price and the quality ratings of the comparable plans in that category.

Thank you very much, and I hope that this can become a great historic Congress which will finally solve a century-old effort to get dependable, affordable, quality health care to all Americans.

[The statement of Mr. Vaughan follows:]

Executive Summary: Statement of Consumers Union, April 23, 2009

A national health reform law is a huge opportunity to reduce the cost of health insurance for employers, employees and their families. Savings can be achieved by

Establishing a permanent insurance anti-fraud watchdog unit to work with States to prevent and detect the kind of abuses seen in the HealthNet and UnitedHealth-Ingenix case, where consumers have lost hundreds of millions of dollars over the past decade because of insurers underpaying for out-of-network costs;

Empowering consumers in the marketplace:

- Create an honest database where consumers can see beforehand what their out-of-network costs are likely to be, thus enabling some increased shopping;
- A new Office of Consumer Health Insurance Education and Information that will:
- Provide general and comparative information about insurance quality, prices, and policies using consumer-friendly formats
- Require standardization of insurance definitions and forms so consumers can easily compare policies on an "apples-to-apples' basis
- Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under typical treatment scenarios
- Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site
- Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support to community-based non-profit organizations providing one-on-one insurance counseling to consumers
- An insurance "exchange" or "connector," offering a choice of plans, that will:
- Include an optimal number of plan choices—not too few and not too many—and limit excessive variations in benefit design so that plans compete more on price and quality
- Ensure that before selecting a plan, the consumer sees the price and quality ratings of comparatble plans
- Require plans to provide year-long benefit, price, and provider network stability

• Protect against marketing abuses and punish insurers that mislead consumers
• Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, and balance-billing and co-pay problems, and to appeal coverage denials

Investigate the growing concentration (mergers) in the insurance and provider sectors and determine why, despite their purchasing power, insurers are unable to adequately slow health inflation.

Prepared Statement of William Vaughan, Health Policy Analyst, Consumers Union

Mr. Chairman, Members of the Committee: Thank you for inviting Consumers Union to testify on Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families.

Consumers Union is the independent, non-profit publisher of Consumer Reports.[1]

We not only evaluate consumer products like cars and toasters, we rate various health care providers and insurance products, and we apply comparative effectiveness research to save consumers millions and millions of dollars in purchasing the safest, most effective brand and generic drugs.[2] Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you in big trouble.

We believe (1) a structured marketplace where consumers can shop intelligently for insurance and (2) increased oversight, to prevent the type of abuses revealed in the UnitedHealth-Ingenix case, can create enormous, multi-billion dollar savings in insurance for taxpayers, employers, employees and their families

The Crisis in Health Insurance: The Uninsured and the Underinsured

Our readers and our polling tell us that the high cost of health care and the insecurity in the current system are the #1 long-term consumer problem facing American families.

As the Committee is painfully aware, the cost of health insurance has increased dramatically in recent years. Consumers are both paying more in premiums, and shouldering a higher burden for out-of-pocket expenses, including deductibles, co-payments and other expenses not covered by their health insurance.

According to the Kaiser Family Foundation, the cumulative growth in health insurance premiums between 1999 and 2008 was 119%, compared with cumulative inflation of 29% and cumulative wage growth of 34%. The rapid growth in overall premium levels means that both employers and workers are paying much higher amounts than they did a few years ago. The average employee contribution to company-provided health insurance has increased more than 120 percent since 2000. Too many under age 65 Americans are just another premium increase, a pink slip, an accident or an illness away from losing insurance or facing bankrupting medical costs.

The uninsured and the insured alike are facing serious financial problems because of the extraordinary high cost of American health care, which is forcing millions of Americans into the condition of being 'underinsured.' While the definition of the "underinsured" varies, quantitative definitions used by the government tend to focus on the percent of adults between 19 and 64 whose out-of-pocket health care expenses (excluding premiums) are 10 percent or more of family income.[3] The ranks of the underinsured have grown. The Commonwealth Fund estimates that 42 percent of U.S. adults were uninsured or underinsured in 2007.[4] You can be sure that with the recent loss of millions of jobs, these numbers will rise dramatically in 2008 and 2009.

Research by the Consumer Reports National Research Center used a series of questions to determine the percent who were underinsured based on answers to questions such as whether they considered their deductible too high, and whether they felt adequately covered for costs of surgery, doctors visits, and catastrophic medical conditions. We found that 41 percent of the adult population sampled lacked adequate health coverage. Nine percent of the underinsured (by our survey) took extraordinary measures to pay medical bills, including dipping into IRAs, 401(k)s or pension funds, selling cars, trucks or boats, or taking on home equity or second mortgage loans.

Underinsurance is a problem for two key reasons: Inadequate coverage results in the financial burden of uncovered health care. In our survey, for example, 30% of the underinsured had out-of-pocket costs of $3,000 or more for the previous 12 months.[5] Underinsurance can lead to medical debt and even bankruptcy. The second

problem posed by underinsurance is delayed or denied health care and poorer health outcomes, caused by the financial barrier to care.

The key breakdowns of the health coverage marketplace that have fueled the growth in the underinsured included the increase in high deductible coverage, annual caps in coverage, lifetime benefit limits, limited benefits, pre-existing condition exclusions, higher co-pays, out-of-network charges, barebones policies, and a flawed individual health insurance market.

Real Examples of People with Insurance Market Problems

Last summer, Consumers Union traveled around the country and collected over 5,000 'stories' documenting why our nation needs fundamental health care reform. Appendix 1 is a tiny sample of those stories from some of your constituents, focusing on the particular problems of high cost, inadequate benefits, pre-existing condition exclusions, and administrative hassles in the individual insurance market.

Solutions

We hope that this year Congress will enact reform legislation to ensure that a comprehensive package of benefits is always available and affordable for every American. That legislation will mean a number of big changes, including insurance reform: no pre-existing conditions and no waiting periods.

Assuming you enact that kind of reform, it will probably include some form of annual open enrollment period in some type of 'marketplace' or 'connector' where private and—we hope—a public plan could compete for consumers.

It is in that marketplace of enrollment that we ask you to provide critical consumer reforms which will lower costs and save money for America's employers, employees, their families, and taxpayers.

Why Consumers Need Help Shopping for Insurance

The honest, sad truth is that most of us are terrible shoppers when it comes to insurance.

The proof is all around you.

– In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[6]

– In the somewhat structured Medigap market where there is a choice of plans A-L, some people spend up to 16 times the cost of an identical policy.[7]

– In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available.[8]

– In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[9]

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[10] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc., ad nauseum.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide a structure to that marketplace.

We recommend the following in any legislation you enact:

Empower Consumers in a New Health Insurance Marketplace

• A new Office of Consumer Health Insurance Education and Information that will:

– Provide general and comparative information about insurance issues and policies using consumer-friendly formats.

We need a Medicare Compare-type website (with some improvements) applied to all health insurance sectors where policies can be compared on price and quality. Extending this comparison site to all insurance would help stop the waste in the Medigap market where seniors are talked into buying a standard policy that may be up to 1600 percent of the cost of the low-cost plan in their state.

– Require standardization of insurance definitions and forms so consumers can easily compare policies on an "apples-to-apples' basis.

This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. In our May magazine article, we describe a policy in which the fine-print excluded the first day of hospitalization—usually or often the most expensive day when lab and surgical suite costs are incurred.

NAIC could be charged with developing these definitions, backed up by the Secretary if they fail to act.

−Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under typical treatment scenarios.

See Appendix II for how much policies can vary—to the surprise and shock of consumers.

The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[11]

−Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site.

The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

−Institute and operate quality rating programs of insurance products and services.

This would be similar to the Medicare Part D website, with its '5 star' system.

−Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers.

These programs need to be greatly expanded if you want the marketplace/connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public. Instead of roughly a $1 per Medicare beneficiary for the SHIPs, the new program should be funded at roughly the level that employers provide for insurance counseling. We understand that can range from $5 to $10 or more per employee.

• An insurance "exchange" or "connector," offering a choice of plans, that will:

−Like Medigap, include an optimal number of plan choices—not too few and not too many.

− Limit excessive variations in benefit design so that plans compete more on price and quality.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[12] Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[13] The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

It is shocking that CMS allowed roughly 1400 Part C plans with less than 10 members to continue to clutter the marketplace. What a waste of time and money for all concerned. Reform legislation should set some guidance on preventing the proliferation of many plans with tiny differences that just serve to confuse a consumer's ability to shop on price and quality.

We hope you will enact a core benefit package which all Americans will always have. If people want to buy additional coverage, there would be identical packages of extra coverage (as in the Medigap program) that many different companies could offer for sale.

Consumers would have to be shown the pricing and quality ratings of those different packages before purchase. (Chairman Stark's AmeriCare bill includes much of this concept.[14])

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition.[15]

−Require information on price and quality to be presented in user-friendly formats

Medicare law requires a pharmacist to tell consumers if there is a lower-priced generic available in their plan. A similar concept in the insurance market might be scored by CBO as driving savings. That is, before you enroll in a plan, you must be told if there is an insurer with equal or better quality ratings offering the same standard structured package.

−Require plans to provide year-long benefit, price, and provider network stability

In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to

sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

–Protect against marketing abuses and punish insurers that mislead consumers

We urge stronger penalties against sales abuses. We assume that any reform bill will include the best possible risk adjustment so as to reduce insurers constant efforts to avoid the least healthy individuals (e.g., rewarding sales forces for signing up healthy individuals). This would have the added benefit of encouraging development of best practices for efficient treatment of these complex cases—which is a key part of controlling costs over time.

–Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials

We urge you to require the standardization and simplification of grievance and appeals processes, so that it is easier for consumers to get what they are paying for.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service. The key to this is ensuring that the nation's insurers have honest, usable appeals processes in place. This legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER.

Do More to Fight Fraud in Insurance

American consumers need a better system to prevent, detect, and correct insurance fraud and abuse.

We are surprised that there has not been more outrage over the recent court findings and discoveries of the New York Attorney General that for at least a decade American consumers have been ripped off by a combination of health insurers and subsidiary data collection firm practices.

In the midst of this escalating crisis of out-of-pocket costs, consumers have also been forced to contend with a gravely-flawed out-of-network reimbursement system. According to a recent investigation by New York Attorney General Andrew Cuomo, and recent settlements with some the nation's largest insurance carriers, it now appears that consumers may have been underpaid for their out-of-network reimbursements by hundreds of millions of dollars. Senate Commerce Committee Chairman has said "billions of dollars."[16] The databases used to calculate out-of-network reimbursements are riddled with serious data quality problems and massive financial conflicts of interest.

Over the last several years, Consumers Union has become increasingly concerned about consumer problems in obtaining fair, appropriate and timely reimbursement for out-of-network health services. These problems came to our attention as a result of consumer complaints, concerns expressed by physicians and employers, reports in the news media, and litigation. In particular, in New York state, we were aware that the American Medical Association, the Medical Society of the State of New York, other state medical societies, New York State United Teachers, Civil Service Employees Association (CSEA), other public employee unions and other consumer plaintiffs had sued UnitedHealth Group in 2000, alleging that they were being systematically shortchanged regarding out-of-network payments.

We were therefore very pleased when Attorney General Andrew Cuomo initiated a national investigation of problems relating to out-of-network charges in February, 2008. The methods used by insurance companies to calculate "usual, customary and reasonable" rates (also known as UCR rates) have long been obscure and mysterious to consumers. It was not easy for consumers to verify the basis of the alleged UCR rates, or to contest perceived underpayments. Companies are supposed to disclose the details of how they calculate these charges upon request. But in practice many consumers found it difficult to find out how the charges are calculated, and what they are based on.

Over 110 million Americans—roughly one in three consumers—are covered by health insurance plans which provide an out-of-network option, such as Preferred Provider Organizations (PPOs) and Point of Service (POS) plans This includes approximately 70% of consumers who have employer-sponsored health coverage.

Consumers and employers often pay higher premiums to participate in an out-of-network insurance plan, because it gives patients greater flexibility in seeking care from doctors, specialists and providers who are not in a closed health plan network. In most out-of-network plans, the insurer agrees to pay a fixed percentage of the "usual, customary and reasonable" rate for the service (typically 80% of the rate),

which is supposed to be a fair reflection of the market rate for that service in a geographic area. Because the health plan does not have a contract with the out-of-network doctor or provider, the consumer is financially responsible for paying the balance of the bill—whatever the insurance company doesn't pay. By law, the provider may pursue the consumer for the entire amount of the payment, regardless of how little or how much the insurer reimburses the consumer.

Even if UCR charges were calculated accurately, consumers could still experience "sticker shock" when they get the medical bills for out-of-network care. Why? They may not understand that the insurance company didn't agree to pay 80% of the doctor's bill—they only agreed to pay 80% of the "usual and customary" rate, which is a kind of average of charges in a geographic area.

For example, suppose a patient went to visit the doctor for a physical, and was charged $200. Eighty percent of $200 is $160. But if an impartial and accurate calculation of "usual and customary rate" shows that what other comparable doctors charge for physicals is an average of $160, the insurance company would only pay $128, or 80% of $160. The consumer would be responsible for paying the balance of $72.

The key problem with the out-of-network reimbursement system is that the UCR rates were not calculated in a fair and impartial way. For the last ten years or so, the primary databases that are used by insurers to determine "usual, customary and reasonable" rates have been owned by Ingenix, a wholly-owned subsidiary of UnitedHealth Group. Ingenix operates a very large repository of commercial medical billing data, and prepares billing schedules that are used to calculate the market price of provider health services. In 1998, Ingenix purchased the Prevailing Healthcare Charges System (PHCS), a database that was first developed by the Health Insurance Association of America, an insurance industry trade association started in 1974. Also in 1997, Ingenix purchased Medical Data Research and a customized Fee Analyzer from Medicode, a Utah-based health care company.

Thanks to the Attorney General's investigation, however, we now know that there were serious problems with the Ingenix database that appear to have consistently led to patients paying more, and insurers paying less. In January, 2009, Attorney General Cuomo announced key findings from his office's investigation regarding the out-of-network reimbursement system:

• According to an independent analysis of over 1 million billing records in New York state, the Ingenix databases understate the market rate for physician visits by rates ranging from 10 to 28 percent across New York state. Consumers got much less than the promised UCR rate, so that instead of getting reimbursed for 80% of the UCR charge, they effectively got 70%, 60% or less. Given the very large number of consumers in out-of-network plans—110 million nationally—this translates into hundreds of millions of dollars in losses (perhaps more) over the last ten years for consumers around the country.

• UnitedHealth has a serious financial conflict of interest in owning and operating the Ingenix databases in connection with determining reimbursement rates. Ingenix is not an independent database—it is wholly-owned by UnitedHealth Group, Inc. It receives billing data from many insurers and in turn furnishes data back to them, including to its own parent company, UnitedHealth. UnitedHealth had a financial incentive to understate the UCR rates it provided to its own affiliates, and other health insurers also had an incentive to manipulate the data they submit to Ingenix so as to depress reimbursement rates.

• In general, there is no easy way for consumers to find out what the UCR rates are before visiting a medical provider. The Attorney General characterized Ingenix as a "black box" for consumers, who could not easily find out what level of reimbursement they would receive when selecting a provider. When they received a bill for out-of-network services, consumers weren't sure if the insurance company was underpaying them, or whether the physician was overcharging them.

• As an example of the lack of transparency, when UnitedHealth members complained their medical costs were unfairly high, the United hid its connection to Ingenix by claiming the UCR rate was the product of "independent research."

• The Ingenix database had a range of serious data problems, including faulty data collection, outdated information, improper pooling of dissimilar charges, and failure to conduct regular audits of the billing data submitted by insurers.

As a result of the Attorney General's investigation, on January 13, UnitedHealth agreed to close the two databases operated by Ingenix, and pay $50 million to a qualified nonprofit organization that will establish a new, independent database to help determine fair out-of-network reimbursement rates for consumers throughout the U.S.

As a central result of his investigation, Attorney General Cuomo concluded that:

"* * * the structure of the out-of-network reimbursement system is broken. The system that is meant to reimburse consumers fairly as a reflection of the market is instead wholly owned and operated by the [insurance] industry. The determination of out-of-network rates is an industry-wide problem and accordingly needs an industry-wide solution.

Consumers require an independent database to reflect true market-rate information, rather than a database owned and operated by an insurance company. A viable alternative that provides rates fairly reflecting the market based on reliable data should be set up to solve this problem * * * Consumers should be able to find out the rate of reimbursement before they decide to go out of network, and they should be able to find out the purchase price before they shop for insurance policies or for out-of-network care."

While UnitedHealth did not acknowledge any wrongdoing in the settlement, its agreement with the New York Attorney General ended the role of Ingenix in calculating UCR charges, and created a new national framework for a fair solution. In fact, in a press release announcing the settlement, Thomas L. Strickland, Executive Vice President and Chief Legal Officer of UnitedHealth Group, expressed strong support for a nonprofit database to maintain a national repository of medical billing information:

"We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy. We are pleased that a not-for-profit entity will play this important role for the marketplace."

Shortly after settling with the Attorney General's office, UnitedHealth also settled the lawsuit brought by the AMA and Medical Society of the State of New York, other physician groups, unions and consumer plaintiffs for $350 million, the largest insurance cash settlement in US history. As sought by MSSNY and the other physician groups, United also agreed to reform the way that out-of-network charges were calculated.

Since January, nine other insurers with operations in New York State, including huge national insurers such as Wellpoint, Aetna and Cigna, have also agreed to stop using data furnished by Ingenix, and to contribute funds in support of the new nonprofit database. The leaders of other insurance companies have also expressed support for a new nonprofit database to increase transparency and reduce conflicts of interest, and pledged to use the database when it becomes available. Two insurance companies agreed to also reprocess claims from consumers who believe they were underpaid for their out-of-network charges.

All told, the Attorney General has now collected over $94 million to support the new independent database, which will be based at a university in New York.

Implications of the New York State Investigation

From a consumer point of view, Attorney General Cuomo's intervention has been extremely helpful for consumers in New York and across the U.S. This investigation squarely exposed the problems resulting in underpayment of consumers and physicians, and created a sweeping new framework for a national solution. The plan set out in the agreements reached by Attorney General Cuomo will help bring comprehensive, sweeping reform to the out-of-network reimbursement system.

The investigation has exposed a swamp of financial shenanigans, and now reached a critical juncture. Consumers Union is calling for coordinated action by state and federal policymakers and regulators to help to consolidate the investigation's gains, and ensure that the new database for calculating out-of-network charges will be broadly used across the entire marketplace.

First, regulators need to hold insurance companies accountable to their contractual promises, on an ongoing basis. Consumers clearly have the right to expect that their health insurance policies will pay the bills that they are legally obligated to pay. We rely on the promises our insurance companies make in their contracts, and we expect the provisions of those contracts to be enforced by regulators and the courts. If your policy says it will pay you 80% of the "usual and customary" charge for a medical service, it should pay that amount.

To enforce this principle in New York state, Attorney General Cuomo used his authority under New York's General Business Law §349 and §350, which prohibits deceptive acts and practices against consumers, to bring the insurance industry into compliance in New York state, as well as sections of the insurance law and the common law. Other states have similar laws, and they should be appropriately used when needed to prevent egregious consumer rip-offs.

Everyone can easily agree that insurance companies should not engage in deceptive or unfair practices against consumers. But the reality is that it takes sustained effort and political will to achieve the vigorous, comprehensive enforcement of state

and federal insurance and consumer protection laws and regulations. In this case, the technical nature of the subject matter, and the obscure, veiled nature of the Ingenix database, resulted in a persisting rip-off that unfortunately took far too many years to rein in.

This case raises very troubling questions about why financial rip-offs persist in the marketplace for many years without effective intervention at the state or federal level. Why didn't the alarms go off earlier about unfair practices that created very large financial losses for consumers? Since this rip-off was occurring all across the Nation, why didn't a Federal agency or official step in to stop it and help consumers?

As part of health care reform, we hope you will create a national office charged with working with and assisting State regulators, to monitor and investigate health insurance issues such as this. In addition, perhaps a way can be found to extend the qui tam or Lincoln law whistleblower provisions to abuses such as this. In addition, the insurance "hotline" idea we proposed earlier in this testimony could serve as a locus for citizen complaints that could help ensure timely investigations.

Second, in any reform bill, consumers should be able to obtain up-to-date information on usual and customary charges through a national, free web site, and have a good fix on what their potential reimbursements will be when they visit physicians and other health care providers.

Third, by arranging for some of the largest health insurers in the country to support the new database, Attorney General Cuomo has paved the way for a comprehensive national resolution of these issues. We would note, however, that there are many other health insurance companies who used data from the Ingenix databases, including state-based and regional health plans in the South, Midwest and Western states, who do not have operations in New York state. These companies were not reached by the investigation or the agreements, so they have not necessarily halted their use of the Ingenix database, or notified consumers of its shortcomings. We therefore encourage Congress to investigate the nature and extent of the use of the Ingenix databases by other health insurance companies throughout the U.S., and solutions for halting this practice and securing restitution for consumers.

Is There Too Much Market Concentration Among Insurers, and If So, Why Are They Failing to Control Costs So Badly?

For decades, the health delivery marketplace has been inflating roughly twice as fast as the rest of the economy, creating special burdens for American businesses and taxpayers, and raising rates of un-insurance, under-insurance, personal bankruptcy and increased morbidity and even mortality for uninsured consumers.

Recently, there have been rumors of possible further mergers among some of the nation's largest health insurers.

We believe it would be useful for Congress—perhaps with several Committees working together—to investigate the level of market concentration in the health insurance versus health provider sectors to determine if there are steps that should be taken in health reform to bring us a system which is better at reducing the Cost of Health Insurance for Employers, Employees and their Families.

A Congressional investigation could address the following kinds of questions:

It is often thought that a large buyer can demand discounts and be able to control costs better than many small purchasers. At the same time, it is usually feared that a monopolist will collect excessive profits from their market dominance. There are reports that in a sixth of our large metropolitan areas, a single insurer/purchaser has enrolled 70 percent or more of the local consumer-patient population. It would seem that in such a situation, the insurer could both control costs and reap windfall or oligopolistic profits. Obviously the insurers are not doing a good job controlling costs, but are they collecting higher than expected profits? That is, do we have the worst of both worlds: higher profits being added to failure to control costs?

But at the same time that insurers have been consolidating, there are reports that in many markets, hospital and physician practices have been merging and have formed a dominant countervailing force. Has the consolidation of providers been a contributing factor in the crippling rate of health inflation? Yet while oligopolistic or even monopolistic behavior among providers is a source of concern, so is quality of care. And there is strong data that smaller hospitals, which do limited numbers of procedures, often have a difficult time delivering quality outcomes. In general, consumers needing complex treatments are well-advised to seek out hospitals and practices which do large volumes of such treatments (centers of excellence) and which coordinate care. From a quality, medical education, and research point of view, a larger health care provider can often be a good thing.

The March 2009 Medicare Payment Advisory Commission report to Congress provides a remarkable chart showing that an eighth of the nation's larger hospitals which deliver the highest quality care have, on average, positive Medicare margins and are below average cost hospitals. The other seven-eighths of the hospitals have poorer quality and higher costs. It is MedPAC's thesis that while Medicare is paying approximately 100% of the costs of an efficient provider, the private insurers (who have become relatively consolidated and may be planning further consolidation) are paying about 132 percent of cost at most hospitals. Basically, MedPAC is saying that the private insurers, despite their growing consolidation, have become toothless buyers, and are often turning a blind eye to the unacceptable rate of medical inflation.

This raises a fundamental question: if large private buyers who feel a need to maintain a broad network of health care providers cannot control costs, what is the alternative? As we consider health care reform, doesn't this argue for a public plan option (like Medicare) that can set rates at the approximate level of cost that an efficient provider can deliver quality care?

If the current situation does not argue for a public plan option, then why are these large insurers not doing a better job in controlling health care inflation, and what hope is there that they will do a better job in the future? What kinds of amendments would Congress need to make to ensure that the private payers can hold inflation down to at least Medicare's past rates of growth?

Conclusion

We thank you again for this opportunity to testify. The American health care system can be fixed, but consumers need tools to help drive the system toward quality and cost savings. And we need strong regulators who prevent future gross abuses like those revealed in the UnitedHealth-Ingenix case. The reforms we have suggested are keys to this goal.

APPENDIX I

Examples of why America needs comprehensive health care reform, collected in 2008 during Consumer Union's tour of the United States

This is a small sample of the 5000-plus stories we collected. The sample concentrates on cost, pre-existing condition exclusion, and poor coverage problems in the individual market, along with examples of what it means to be uninsured because one cannot afford a policy. All of these individuals are willing to be contacted upon request for further discussion.

Kristin from Beaverton, OR—1 Wu

I am a single mom who has been out of work for almost a year. I started working 2 months ago and was diagnosed with Interstitial Cystitis last week. I went to fill my prescription of "Elmiron" and to my horror found out that AFTER my insurance discount, I will still have to pay $283/mo. for my medication. I also take buproprion and effexor xr. This means that I will be paying $420/mo for medication alone. I already pay almost $400 for my insurance. I live on $1000/mo after paying my mortgage (which I currently can't do anything about due to the market) payment. Now I will live on $200???? Yet, because I took a contract position until the end of the year, I make too much money for any assistance programs. I am very frustrated with the system and I'm tired of being taken advantage of for insurance and medication that I need. Maybe I would be better off not working and getting assistance. This is a serious problem with our society! Sometimes not working and depending on assistance is the ONLY way to get our medications * * * what else can I do?

Melinda from Lakewood, OH—10 Kucinich

I'm a 46 year old self-employed woman. I have not had health insurance since 2002 or 2003. As a company of one/an individual, I am denied more favorable underwriting/rates/cost savings and benefits afforded to companies of 2 or more. I have pre-existing conditions. From 2003 through 2007, I estimate I paid (out of pocket) an average of $7,000 per year in medical expenses. Most of these payments have been made using funds saved for retirement. The last "best" proposal I received for individual health insurance included a $10,000 deductible and an annual premium of over $5,000. Most of my $7,000 in annual medical expenses would be considered uncovered and would not count towards meeting my deductible. From my perspective, I would need to receive benefits in excess of $22,000 before I would "break even". If I work, I can make very good money, often grossing in excess of $75,000 per year. As far as I know, this income would exclude me from participation in any existing or proposed program supporting guaranteed access to health care. I have never benefited from government supported programs. No scholarships or loans,

worker's comp, unemployment or Social Security. I have always planned on providing for myself—including paying for my health care during both my working and retirement years. I do not expect a "free ride". I want guaranteed access to competitively priced health care/insurance and I am willing to pay for it. I just need help leveling the playing field. No denial of coverage. No exorbitant premiums. No limited benefits—just because I am an individual with pre-existing conditions.

Keith from Lakewood, OH—10 Kucinich

"My wife and I are retired, more by reason of lost employment than anything else. We are not yet eligible for Medicare. When our coverage under COBRA was soon to end, I searched high and low for affordable health insurance. I called agents. I searched over the internet. I called insurance companies directly. What I found is that, because I have high blood pressure (which has been under control for years) and she has Type 2 diabetes (also under control), we are unable to buy a private policy for anything less than $3000 a month, for each of us! And even at that price, I couldn't get a firm commitment without paying three months premiums in advance. That's $18,000! As a result, my wife was forced to find another job (she's an RN, and therefore much more employable than I am) just for the health insurance. So instead of traveling the US in our RV, as we had hoped, she's working the night shift at a local hospital, and I'm picking up odd jobs as I can while we wait for Medicare."

Neil from Pepper Pike, OH—11 Fudge

"Due to pre-existing conditions, I have been relegated to few choices for insurance coverage, and all at extremely high costs. Premiums for my wife and myself, with $1000 deductibles, have been exceeding $24,000 per year for many years! I have not been able to find insurers willing to cover us at a reasonable cost. Regulated, universal coverage is the only answer to provide health coverage for all persons without bankrupting so many."

Jamie from Clio, MI—5 Kildee

"With the faltering economy my small cell phone business of 12 years is slowly sinking. I had Blue Cross Blue Shield of Michigan. In 1999 it cost $450.00 a month to cover myself, my husband and our three daughters. When I could no longer afford the coverage it was up to $1600.00 per month for my husband and I and only two of our college age daughters. Same coverage, an 80/20 split, so there were some 'out of pocket' expenses too. I have also been unable to maintain my term life insurance policy of 10 years I still can't believe after 12 years in business that I wouldn't be able to pay my bills. It is very heart wrenching. Especially when we had to cut our daughters off while they were still in college."

Carolyn from Media, PA—7 Sestak

"After my COBRA coverage ended, I applied for health insurance as an individual. I decided to work for myself and I am 53 years old. A couple of companies rejected me but finally I received coverage but with exclusions for depression, migraines, and high cholesterol and a high deductible. All of these conditions are treated with medication. Originally, the rate was about $350, which I thought was reasonable. Unfortunately, after just 4 years my rate is now over $512. My agent tells me the plan has closed which means that my premiums will continue to skyrocket since no new members will be added to the pool. I applied for insurance again and was rejected for the same reasons. I see these conditions as somewhat common and assume that only someone in perfect health can receive an individual health plan. On the other hand, someone with cancer can obtain insurance as long as they are employed (typically). Since I have many years before I am eligible for Medicare, this situation is a big concern. I do not understand why individuals cannot have guaranteed access like employed people since the insurance company's overall risk is still spread. But, I suppose the rate they would charge would be astronomical. I wish there was some organization that individuals could join and gain coverage as part of a large pool. One other issue is the treatment of these costs at tax time. My total costs run about $10,000 which is a large percentage of income. If costs do skyrocket, I might have to lower my standard of living. The overall health care situation in this country is astonishing given our supposed wealth as a nation. We claim to have the best health care but this is not borne out by surveys and studies. Certain politicians scare the populace with terms such as "socialized medicine" and drown out other voices of reason. Shame on us."

Keith from Hilton Head, SC—2 Wilson

I am a currently partially retired but still practicing physician. I am still under 65 and have a high deductible ($5200) Blue Cross Policy (SC). The premiun went

up $250 per month this year. This represented an almost 50% increase. We had made no claims on the policy during the last 3-4 years we have had it. I contacted BC and was told that the rate increase was approved by the State of SC Insurance Commission. I contacted them and have received no acceptable answer. This is just one of the outrageous examples of the appalling state of the US Health Care System. I am currently working as a Physician in New Zealand where good care is delivered at a third of the cost of the US and actually medical professionals are reimbursed as well or even better than in the US. It is not difficult to figure where the wastes are!!

June from Spokane, WA—5 McMorris-Rodgers

I just retired early at 60, I have RA and have struggled for years to support myself on what I earn. My pension income covers all my expenses but I am unable to get an insurance company to take me because of my 'pre-existing' condition. I am exploring all possibilities for health care but make just enough monthly to disqualify me for state programs. Medication is soooo expensive with no co-pay. I have five more years before I qualify for medicare.

Jean from Marietta, GA—6 Price

I own a small business and cannot find affordable health care coverage. I pay way too much money for a high deductible policy and every year on my birthday I get hit with another huge increase in premium. Because I am the only empolyee of my business I don't have enough people to make up a group policy so I pay what I think is about the highest rates that are out there. I am in excellent health and had hoped the current administration would have created a health care plan to allow small business owners like myself to pool together to get a better rate. I find it unfair that I have to pay such high rates simply because I am not part of a larger group. I am in excellent health so the insurance company is making 100% profit on me.

Eileen from Roswell, GA—6 Price

A few years ago, when we had group coverage, I had my first colonoscopy. A BENIGN polyp was removed during that procedure. We subsequently had to sign up for individual insurance. We applied to Golden Rule (who required our payment information before even accepting our application). Once the acceptance letter arrived, I found that they had disallowed any further colonoscopy procedures * * * and any disease that has to do with my colon, and various other organs, as a preexisting condition! I called the Georgia insurance commissioner's office to see if that was even legal. They told me that a preexisting condition is anything you have now or have ever had * * * so it is perfectly legal for them to deny me coverage.

Nancy from Atlanta, GA—6 Price

"I work for a small employer and pay about $90 every two weeks totaling $2,136 a year. Then add what my employer pays for me and it is probably $4,000 a year. Our current plan has a $2,000 deductible, meaning any tests we get we pay for until we hit $2,000. And so, most of us skip needed tests because we cannot afford it. So, we are paying lots into the plan and getting nothing back. What is wrong with this picture, everything. Americans deserve affordable healthcare and preventative tests so we do not become seriously ill. I spend most of my disposable income on healthcare costs, energy and food with little left for anything else, including a well needed vacation. We need a united movement to demand Washington wake up and start to take care of us and they get taken care of with our tax money. This has impacted our national economy and our Government has become Wall Street vs Main street. No one seems to care about our lack of adequate care and the costs to individuals and business. The healthcare industry has bought our government and sold the citizens of the USA as the cost. Help us start the fight to come up with a system we can all be proud of and afford."

Rick from Canton, GA—6 Price

I am unemployed and just lost my insurance on Jan 1, 2009. I am 59 and have a few health and mental health issues. First of all, I had prostate cancer that was diagnosed in the end of 2006 and treated in early 2007. All went exceptionally well, I am glad to say. However, I need Prostate-Specific Antigen (PSA) tests every quarter to make sure that it doesn't come back; then, I will need the tests twice a year and eventually once a year as time goes on. I do not know how I am going to pay for an urologist or the blood work until I begin working and receive a salary and insurance. Oh, wait—it is a preexisting condition! Unless I get hired by a large enough company, and it doesn't exclude pre-existing conditions, I'll have to wait a year to have my post-cancer visits covered or anything else tied in with the treatment.

Bruce from Cloverport, KY—2 Guthrie

I am a 57 year old man in bad health. My wife is 6 years younger than I am. Health insurance is so expensive that I will have to work until I am 71, so my wife can be covered under Medicare.

Michael from Iowa City, IA—2 Loebsack

"I wanted to switch to a healthcare policy with the highest deductible in order to lower my premiums. My individual policy was with Wellmark of Iowa and I also got my current policy with Wellmark. In order to get virtually the same policy, except with a higher deductible, they called me and said that I would have to agree to waive coverage for mental health, anything to do with my eyes, and anything to do with my G.I. tract. Their request for the waivers surprised me because I had had very little problems with those things. I agree to sign the waivers in order to save money because of the lower premiums that come with the high deductible policy."

Joel from Brooklyn, NY—11 Clarke

"I am among the uninsured. I cannot afford health insurance. I am a published, prizewinning novelist and I have been, among other things, in chronic pain for about seven years, in both knees. I also have other health problems I cannot see to, even though I know that this is dangerous, especially at the age of 61. I make enough money not to qualify for Medicaid, or even New York State's budget/help-out plan, but I am far from being able to afford health insurance at anything approaching the current rate. I'm in trouble and do not know if there is anything I can do about it. How's that for a story?"

Jan from Lebanon, CT—2 Courtney

"My husband and I were squeezed out of our jobs as we approached the age of 60. We moved to a less expensive area, and are now self employed. At age 62 we spend as much on our monthly health care premiums as we used to spend on our mortgage. Together we pay over $1300/mo. for premiums and the copays we are responsible for are higher. Having health insurance tied to employment does not make sense in the present atmosphere of job insecurity. We feel caught in a financial bind until we reach Medicare age."

Grace from Danielson, CT—2 Courtney

"I work for a healthcare services company. In short I do provide necessary services to disabled and elderly clients who would not otherwise be able to remain in their homes. They all have Social Security or Disability income that provides for doctor visits and medications and emergency surgeries when necessary. I have no health insurance from the company for whom I work. In 2006 I had to have an incisional hernia surgery. I waited until it had started to strangle itself. I received help through a federal program to pay my hospital bill. But there was no program to pay for my anesthesia bill or my doctor bill. The total bill was somewhere between $10,000 and $12,000 with about $7600 being paid on the hospital bill. The doctor has been real good to me and not pushed the issue. The anesthesia bill went to collection and is now registered with the credit reporting agencies. There is nothing I can do about this. This is a non-profit company. My weekly hours are less than 40 and I live in Connecticut which is the 2nd or 3rd most expensive state to live in. Every penny I make is tied up in survival. My rent has gone up $50 since the operation. My gas for the car (I pay all but a $50 stipend) has tripled, my electric bill has nearly doubled and my grocery bill has tripled. I am 58 years old and am having a hard time finding a good paying job. I got a $.25 raise in February and already the groceries and a recent raise in the electric bill have eaten that raise and next year's as well. I could very easily be homeless by this time next year. If it were not for help with heating oil I would already be there. Not because I don't work for a living but because what I make is less than an existence at this point. I suspect my electric will be shut off in May due to my inability to pay. If I become seriously ill I have nothing to help me with expenses or medical bills. I make nearly $20,000 per year. Unless something is done to change this I am going under. I need help for a lot of things but I have no where to turn. According to the State of Connecticut I make too much money. Once upon a time I could have done well on this but not now."

APPENDIX II

* * * and out-of-pocket expenses can vary widely	Massachusetts plan	California plan
With its lower premium and deductible, the California plan at right would seem the better deal. But because California, unlike Massachusetts, allows the sale of plans with large coverage gaps, a patient there will pay far more than a Massachusetts patient for the same breast cancer treatments, as the breakdown below shows.	Monthly premium for any 55-year-old: $399 Annual deductible: $2,200 Co-pays: $25 office visit, $250 outpatient surgery after deductible, $10 for generic drugs, $25 for nonpreferred generic and brand name, $45 for nonpreferred brand name Co-insurance: 20% for some services Out-of-pocket maximum: $5,000, includes deductible, co-insurance, and all co-payments Exclusions and limits: Cap of 24 mental-health visits,$3,000 cap on equipment Lifetime benefits: Unlimited	Monthly premium for a healthy 55-year-old: $246 Annual deductible: $1,000 Co-pays: $25 preventive care office visits Co-insurance: 20% for most covered services Out-of-pocket maximum: $2,500, includes hospital and surgical co-insurance only Exclusions and limits: Prescription drugs, most mental-health care, and wigs for chemotherapy patients not covered. Outpatient care not covered until out-of-pocket maximum satisfied from hospital/surgical co-insurance Lifetime benefits: $5 million

Service and total cost	**Patient pays**	**Patient pays**
Hospital	$0	$705
Surgery	981	1,136
Office visits and procedures	1,833	2,010
Prescription drugs	1,108	5,985
Laboratory and imaging tests	808	3,772
Chemotherapy and radiation therapy	1,987	21,113
Mental-health care	950	2,700
Prosthesis	0	350
TOTAL $104,535	**$7,668**	**$37,767**

Source: Karen Pollitz, Georgetown University Health Policy Institute, using real policies and claims data from state high-risk pool. Copyright (c) 2002-2007 Consumers Union of U.S., Inc. May, 2009 issue

ENDNOTES

[1] Consumers Union, the nonprofit publisher of Consumer Reports, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

[3] Jessica Banthin, AHRQ, "Out of Pocket Burdens for Health Care, Insured, Uninsured, and Underinsured," September 23, 2008.

[4] Cathy Schoen, et.al., How Many are Underinsured? Trends Among U.S. Adults, 2003 And 2007, Health Tracking, Health Affairs—Web Exclusive, June 10, 2008. See also: Jessica S. Banthin and Didem Bernard, Changes in Financial Burdens for Health Care—National Estimates for the Population Younger than 65 Years, 1996 to 2003, JAMA, December 13, 2006.

[5] Health Care Experiences of the American Public: May 2007 Survey, Consumer Reports National Research Center Survey Research Report

[6] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.

[7] See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.

[8] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.

[9] SeniorJournal.com, March 29, 2009.

[10] HHS Office of Disease Prevention and Health Promotion

[11] Op. cit., p. 68.

[12] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

[13] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

[14] HR 193, Sec. 2266(c)(2) SIMPLIFICATION OF BENEFITS-'(A) IN GENERAL-Each AmeriCare supplemental policy shall only offer benefits consistent with the standards, promulgated by the Secretary, that provide——

'(i) limitations on the groups or packages of benefits, including a core group of basic benefits and not to exceed 9 other different benefit packages, that may be offered under an AmeriCare supplemental policy;

'(ii) that a person may not issue an AmeriCare supplemental policy without offering such a policy with only the core-group of basic benefits and without providing an outline of coverage in a standard form approved by the Secretary;

'(iii) uniform language and definitions to be used with respect to such benefits; and

'(iv) uniform format to be used in the policy with respect to such benefits.

'(B) INNOVATION—The Secretary may approve the offering of new or innovative and cost-effective benefit packages in addition to those provided under subparagraph (A).

[15] Center for Budget and Policy Priorities, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," by Sarah Lueck, March 31, 2009.

[16] Senate Commerce Committee, Opening Statement at hearing of March 31, 2009.

Chairman ANDREWS. Thank you, Mr. Vaughan. Although, I would find it a bit odd that a great and historic achievement would be based upon citing Homer Simpson. [Laughter.]

So hopefully that—we will have better luck than Mr. Simpson does. But thank you very much.

Ms. Trautwein, welcome. We are glad to have you back.

STATEMENT OF JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Ms. TRAUTWEIN. Thank you.

I am here today representing over 20,000 employee benefits specialists nationally. Because of our experience with employer-sponsored coverage, we believe that any reform proposal, like many of our other panelists, should begin and center on employer-sponsored coverage.

And I just want to reiterate the reasons for that.

First of all, there are many different reasons why employer-sponsored coverage is an advantage. But one of the most important that I want to make sure, as we move forward with reform, that we do not leave out the significant financial contributions that employers make towards the cost of coverage for employees and their dependents. Without the funding provided through employers, many people who have coverage today would be uninsured.

Now, a number of stakeholders in the health reform debate have articulated the belief that a public-slant option is necessary in the marketplace and should be offered as an alternative to traditional private market, employer-sponsored and individual health insurance coverage.

All right, I have to share. And it is probably—you are probably not surprised that we have a lot of concern about such a program. Chief among them is a potential for an unlevel playing field and the difficulty that a public program would have competing on a level playing field with the private plan. We believe this would

complicate and make the pooling process much more difficult for private insurance carriers and employer-sponsored plans.

Now, another key issue is the cost impact a public plan option would have on all Americans due to cost shifting or the hidden tax imposed when providers of medical care are forced to adjust their prices they charge to private companies and employers in order to offset losses from government programs.

A recent Milliman Report estimated that over $1700 of the annual premium for an average family of four is due to cost shifting alone. And if another public program is added, we are concerned that this amount would go higher.

Finally, we question the need for such a system in light of the insurance reforms that have been proposed by the insurance industry.

We guarantee issue, no pre-existing conditions and no rating for health status. We fail to see the economic or social benefit in spending vast sums of money on a new government system that could be better utilized on the subsidies to help real people get the coverage they need.

And I want to stress, our intent is not to discourage health reform itself. We firmly believe that the current system is unsustainable. There is no doubt that changes are needed. But we believe that we have to address those changes by addressing the true underlying problem with our existing programs.

And you mentioned that in your opening remarks, and that is the cost of care.

We have identified some key health care cost containment mechanisms that should be included in a national comprehensive reform effort. And we have outlined these in the written statement. But, in summary, I would just say that they include an emphasis on wellness and prevention, better use of evidence-based medicine, pay for performance, and ensuring interoperability of electronic medical records. And we believe that government and employer plans can lead in these efforts.

As a part of overall health reform, we all realize that tax and other subsidies will be needed to make coverage available. And some immediate changes need to be made in our system simply to provide equity for individual market consumers with our counterparts and our employer-sponsored plans.

And I have detailed what those specific changes should be. And they would help self-employed people, which I know are a concern of this group as well.

I would like to stress though that this should not be done at the expense of those participating in employer-sponsored plans. We urge Congress not to tamper with the current tax exclusion and employer deduction.

Additional subsidies will also be needed for low-income individuals and very importantly for risk adjustment in plans. These are essential components of reform. And they will be critical to its success.

Reform discussions have also included increasing the role of employers in providing coverage. And although most larger and many small employers provide health insurance coverage, we believe a mandate to force employers to provide coverage to their employees,

while well-intentioned, would have a negative impact on wages and jobs creation. And it would principally impact low-skilled employees because employers would be forced to cut jobs to control their skyrocketing labor costs. We just do not think that is what is needed in today's economy. And we believe that there are other roles that employers can play that may actually be more valuable than the role of being mandated to provide coverage.

I would like to close by briefly mentioning Connector. There is nothing inherently wrong with the pooling of groups of insurance purchasers. Insurers and employer plans do this all the time. But we have to remember that pooling alone does not impact costs enough to make the significant difference that all of us are looking for, because it does not impact the cost of care which drives the cost of insurance. And if we expected different results, we just can look to history where these purchasing arrangements have been tried before.

And over a period of time, the pools actually end up being a more expensive option in the environment. And we are concerned that if a national connector exchange does not allow for competitive market outside of the connector, a situation could develop where there would be nothing left for people to go to if the pool imploded.

And I see that my time is us, so I will close for now. And I look forward to questions later.

[The statement of Ms. Trautwein follows:]

Prepared Statement of Janet Stokes Trautwein, Executive Vice President and CEO, National Association of Health Underwriters

Good morning. My name is Janet Trautwein, and I am the CEO of the National Association of Health Underwriters (NAHU). NAHU is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 20,000 employee benefit specialists nationally. Our members oversee the health insurance plans of millions of Americans and work on a daily basis to help employers purchase, design and implement health plans for their employees. We appreciate the opportunity to be here today to share our thoughts on ways to make health insurance coverage more affordable for both employers and their employees.

We believe all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and should improve rather than drain our country's economy.

NAHU believes that any reform proposal should build on the strengths of our current system, which centers on employer-sponsored coverage. Our support for the employer-based system is well-founded, as this system efficiently combines key elements that make health care accessible to individuals and families all over America by providing the financing to pay for health care services.

Benefits of Employer-Sponsored Coverage

The federal government supports employer-sponsored coverage through the Tax Code by recognizing health insurance premiums paid by employers on behalf of their workers as a business cost, which are generally deductible by the employer for tax purposes. These same premium payments by employers are currently not taxable to employees as a part of their compensation. NAHU believes the preservation of this current federal employer deduction and employee exclusion is critical to the success of any health reform effort.

For working individuals, there are a multitude of advantages to employer-sponsored coverage, not the least of which is the significant contribution most employers make toward the cost of coverage for employees and their dependents. The average employee receives an 84 percent subsidy from his employer toward the cost of coverage, regardless of income. This subsidy—on average—has remained constant over time even though health care costs have increased substantially. This high level of subsidy results in a very high "take up" of coverage by employees. Without the fund-

ing provided through employers, many people who have coverage today would be uninsured.

Employers provide coverage to their employees for an important business reason: to attract and retain the best employees. Even the smallest of employers that struggle with the cost of coverage want to be able to distinguish themselves from their competitors by being known as a great place to work with comprehensive benefits. When designing health care solutions, we need to make sure we preserve the employer's connection to their plan and the funding that goes along with it for their employees.

For larger employers, group purchasing power helps them obtain preferential pricing and enables them to provide benefits that are generally more extensive than what is available to consumers spending a similar amount in the individual market. Administrative costs are also lower than in the individual market because coverage is provided to many individuals through a single transaction with one employer.

With any size of employer plan, controlled entry into the plan at the time of hire ensures that those entering employer sponsored plans are doing so as a result of their employment rather than as a result of their believing they need to seek health insurance coverage. For this reason, risk is spread more efficiently and effectively with less adverse selection than in the individual market. The ease of group purchasing and enrollment, combined with the reliable payment of group coverage, results in many more insured persons than if they were required to obtain coverage on their own.

Employer-based health insurance is also more flexible than government-run public insurance programs such as Medicare, as it allows benefits to be customized to the specific employer groups. Even a small employer has many choices in plan design. Driven by their bottom line and utilizing a relatively streamlined management system, employers strive to obtain the best coverage at the lowest cost to meet their goal of hiring and retaining the best possible workers. Employer flexibility allows their plans to be modified over time to take advantage of current cost and quality considerations and to meet the specific needs of their group of workers. Employers also have the capability to pick and choose among new benefit, payment and organization innovations, and can implement new programs and halt unsuccessful ones relatively quickly. In contrast, public programs are less likely to be able to meet the precise needs and wants of their entire constituency, and response to innovations and changes in the insured population's needs is likely to be slower because of the political and regulatory process.

Regarding a government-run public plan option, there are many stakeholders in the health care reform debate that have articulated the belief that such a plan is necessary in the marketplace and should be offered as an alternative to traditional private-market, employer-sponsored and individual health insurance coverage. NAHU feels that, when crafting comprehensive health reform legislation, Congress needs to avoid creating a public health plan option to be offered as an alternative to, or in competition with, private-market health plan offerings.

NAHU has many concerns about a public health coverage program buy-in option that competes with the private insurance market. Chief among them is the potential for an unlevel playing field between the two coverage options. Even if extreme care was taken to ensure that factors such as subsidies, rating and issuance requirements were the same relative to the public and private plan options, the two options could never truly be equal.

It will cause significant problems if the rules that apply to public plan coverage differ from those that apply to private insurance markets. Bad products will drive out good ones. If a level playing field between public and private cannot be established and sustained, it could deprive patients and providers of access and appropriate incentives and payment mechanisms to achieve the best value for health care dollars.

The creation of a government-run public plan insurance program also would likely complicate and make more difficult the most efficient pooling of risk among private insurance carriers, especially in employer-based coverage. Current natural groups relating to geography or age would likely become fragmented and discrete, thereby diminishing the advantages and efficiencies of group purchasing.

As but one possible scenario, to the degree that younger and healthier people enroll in a government-run public plan, the "remaining" employer-based market could become a less healthy mix of insurable risk, as sicker, older workers stay with their employer-based coverage while more of the healthier workers move to a public plan. And the exodus of younger and healthier populations from an employer's pool would likely drive up the costs of the employer plan, for both the employer and beneficiary alike. The likely destabilization of group risk pools that could well result raises the

question of whether employers would continue to offer health insurance to their workforce.

Another key issue is the cost impact a public plan option will have on all Americans, particularly in this economic climate. If Congress creates a public health plan option for the under-65 population, privately insured people will be forced to bear significant indirect costs due to its existence because of cost-shifting, or the "hidden tax" imposed when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and they have a significant impact on private health insurance premiums. A recent Milliman report estimated that annual health care spending for an average family of four is $1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates, with total provider reimbursement unchanged.

The ideal solution for this would require that providers be reimbursed at the same level they are commercially for all public plans. Given the changing nature of commercial provider contracts, this may not be possible for public programs, but efforts to equalize payments would go a long way toward resolving the payment disparity and would provide significantly greater payment and premium stability for providers and employers and their employees.

NAHU's final concern regarding a new government-run public plan option is such a plan's long-term fiscal and actuarial sustainability, which is already a significant issue with the federal Medicare program. From the 2008 Trustees' Report, Medicare's liabilities are expected to exceed revenue dedicated to paying for the program by $36 trillion over the next 75 years, and the trust fund that pays for hospital services is expected to go bankrupt in 2019. Total Medicare spending is projected to more than triple as a share of the national economy, rising from 3.2 percent of GDP in 2007 to 6.3 percent in 2030, 8.4 percent in 2050, and 10.7 percent in 2080. Federal individual income tax collections amount to only about 8.5 percent of GDP. Covering just the increase in Medicare spending expected by 2030 would require a 36-percent, across-theboard individual income tax hike.

By contrast, there are very few industries in the United States that are as heavily regulated as private health insurance markets. Private health insurance markets are subject to stringent actuarial and solvency standards, standards that a government-run public plan option is unlikely to be held against, if the experiences of Medicare and Medicaid are any lesson. This is not to say that health insurance markets cannot be improved upon through government reforms to enhance access, affordability and consumer rights but, whether through the federal government or state governments, there are myriad laws and regulations that address a range of standards and requirements that currently oversee health plans and health insurance.

Cost Containment

NAHU applauds government leaders and others who have put forward comprehensive reform proposals, even when we disagree with their proposed solutions. There is no doubt that changes are needed, but changes must begin by addressing the true underlying problem with our existing system: the cost of medical care. The reality is that consumers pay for all health care costs in one of three ways: through taxes, health insurance premiums or out-of-pocket expenditures. If the cost of health care becomes too great, the method of payment no longer matters—the country and its people will be bankrupt and/or unable to access care.

Constraining skyrocketing medical costs is the most critical—and vexing—aspect of health care reform. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans. There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions by individual citizens and elected officials.

However, NAHU has identified some key health care cost containment mechanisms that should be included in any national comprehensive reform effort. First among them is wellness promotion. Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. Research shows that behavior is the most significant determinant of health status,[1] with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. Furthermore, the Centers for Disease Control and Prevention estimates that 75 cents of each U.S. health care dollar is spent on treatments for patients with

[1] Mercer Management Journal 18; Centers for Disease Control and Prevention.

one or more chronic condition (such as heart disease, asthma, cancer or diabetes). These diseases are often preventable, and frequently manageable through early detection, improved diet, exercise and treatment therapy.

We believe that the first step by government should be by example, and that all federal and state governments should be required to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage programs such as Medicaid, Medicare, CHIP and the Veterans Health System. Standards for the most effective programs have been developed by URAC, and would provide benchmarks for best practices in this area. We also believe that private employers should be provided with legal protection, tax incentives and premium incentives for implementing smoking, drug, alcohol and other wellness programs to encourage their employees and their families to adopt healthier lifestyles.

A second effort toward cost containment would be to identify ways to avoid duplication of procedures and overuse of high-end procedures in situations where they add little value. Both patients and the provider community should focus on identifying less expensive but equally efficacious alternatives. In addition, preventable mistakes by providers of medical care not only drive up health care costs, but also cost lives.

We believe incentives should be provided for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine. And although we are greatly encouraged by the funds included in the stimulus bill for creation of electronic medical records, they will be of little use unless standards for interoperability are created to unify the health care system, reduce errors and duplicative procedures, and improve patient satisfaction.

Access for All

Although we are strong supporters of employer-sponsored coverage, it is important to include solutions to help those accessing health insurance through the individual health insurance market too. Controlling cost in this market is more difficult than in an employer-sponsored plan, not because of an inability to pool like policies together—all insurers pool their individual market business—but rather because individuals may voluntarily enter the system whenever they want to, and because they pay for coverage on their own, with after-tax dollars and with no employer contribution. For this reason, the market is prone to a phenomenon known as "adverse selection." Adverse selection occurs when a person delays buying an insurance product until he or she anticipates an immediate need for the benefit. Since individuals always know more about their own health status than anyone else does, and because all of the cost of buying individual health coverage is borne by the insured, the amount of adverse selection occurring in the individual market is very high. This has a direct impact on the pricing of individual-market policies and is the reason why most states today use medical underwriting for individual health insurance coverage.

From a pure access perspective, it would seem that one of the simplest ways to get individual-market buyers covered would be to require that all individual health insurance policies be issued on a guaranteed-issue basis without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. As you are aware, America's Health Insurance Plans and the Blue Cross Blue Shield Association have recently announced that they would be able to guarantee-issue coverage in the individual health insurance market and rate without regard to pre-existing conditions IF everyone is required to carry coverage. It is important to note that this is distinctly different from our voluntary system today. If such a purchase mandate is passed, enforcement will take time to become effective. Without near-universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. It is very important that some type of financial backstop or risk adjuster be used to ensure that the result of market reform is not the exorbitant premiums we currently see in states that already require guaranteed issue of individual policies but do not require universal coverage or have a financial backstop in place.

As we look at premium stability and the demonstrated importance of an adequate risk-adjustment mechanism, one good model to look at for both the individual and small-employer market is New York with its Healthy New York program. Small employers, sole proprietors and uninsured working individuals, regardless of health status, who meet set eligibility criteria and participation rules can purchase a limited range of comprehensive coverage options offered through private carriers and

backstopped with a state-level reinsurance pool for extraordinary claims. Although New York is a guaranteed-issue state for all markets, it still uses this mechanism to spread the risk of higher-risk participants. If we compare the rates for similar coverage in neighboring New Jersey, which is also a guaranteed-issue state but with no financial backstop, it becomes clear that, although premiums are higher in New York than in non-guaranteed-issue states due to community rating laws, the financial backstop provided by the reinsurance mechanism has improved affordability there.

Portability of Coverage—Pre-existing Condition Clauses

Many people interchange the terms "health status or medical underwriting" with "preexisting condition clauses." These are two distinct insurance terms and need to be discussed separately.

Underwriting based on health status or medical history has to do with how initial health insurance premium rates are determined. In most states, insurers are able to consider a person's health status, along with other important factors, when determining initial rates in the individual and small-group markets. In the individual market, the personal health history of the individual or family applying for coverage is one of the factors used; in the case of small-employer groups, the overall health of the group is considered. In larger groups, where risk is spread more broadly, actual claims experience is used as the primary rate determinant. After the initial premium rate is determined in the individual and small-group markets, then the individuals or small groups are pooled internally by their health insurance carrier, and subsequent rate increases are based on the overall claims experience of the internal pool.

A pre-existing conditions clause applies to coverage already in force and limits the amount of time a particular condition may be excluded from coverage. Pre-existing condition clauses are used to prevent the adverse selection caused by people from failing to obtain coverage until they know they need the benefit.

Pre-existing condition clauses are rarely a problem for those with employer-sponsored coverage because the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established uniform rules in this area for the group market. Carriers can look back at a new group member's medical history for no more than the six months prior to when the individual joined the group and may exclude coverage for certain conditions for up to 12 months. However, the law rewards those who have consistently maintained health insurance coverage. As long as a new group member has no more than a 63-day break in coverage, the group health plan must give the individual credit for their prior coverage. This credit for prior coverage, as well as the controlled entry and exit into group plans, means that preexisting condition clauses rarely need to be exercised in the group market. They only come into play to prevent true adverse selection, and their timeframe is limited and relatively consistent across the states.

In the individual market, though, there are no consistent rules. Right now, state exclusionary and look-back periods for pre-existing conditions in the individual market range from none at all to five years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a federal maximum look-back window of six months and a 12-month exclusionary period was established for the states. Having a pre-existing conditions rule that is consistent in both the individual and group model would also be much simpler for consumers to understand.

Additionally, there is no protection for individuals who want to change carriers or health insurance products within the individual market. A simple way to change this would be to allow consumers credit against any pre-existing conditions limits for prior individual coverage when changing insurance plans, if there is no greater than a 63-day break in coverage, just as is required in the group market by HIPAA. In the absence of a fully implemented and enforceable individual purchase mandate, plans and high-risk options must be able to look back at a new applicant's medical history and impose reasonable waiting periods in order to mitigate adverse selection. Until implementation is complete, greater standardization of limitations is necessary and warranted.

Another inconsistency among both individual and small-group state individual health insurance markets is the way that premium rates are determined at the time of application. Most states allow for the use of medical history or health status as an underwriting factor, as I just discussed. In a few states, the laws require that rates be the same for everyone regardless of gender, age, health status or geographic location (community rating). In a number of others, rating factors are determined by the state but are limited in nature (i.e., age, gender, industry, wellness, etc.), which is known as modified community rating. However, even in states with

modified community rating, the rating factors and how they may be applied vary significantly by state. It is NAHU's view that state individual health insurance markets would benefit from greater standardization as to how premium rates are determined.

The federal government could require that all states meet a minimum standard of rate stabilization by requiring modified community rating instead of health status rating. However, this would need to be undertaken slowly in order to protect against extreme rate shock to some populations, especially younger individuals. Additionally, it is extremely important that wide adjustments be allowed for non-health measures. At a minimum, variations need to be allowed for applicant age of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should be allowed for other factors such as wellness plan participation, smoking status, industry, family composition and geography.

Finally, the federal government should also make improvements to existing law to make health insurance coverage more portable for people who leave their jobs and employer-based coverage and need to buy coverage in the individual market. Examples of such individuals include early retirees or people who are starting a small business or freelancing, perhaps because they are having trouble finding other work with employer-based coverage. HIPAA attempts to provide individuals who are leaving group health insurance coverage with portability protections to make it easier for them to purchase coverage in the individual market. Unfortunately, the protections are confusing and many consumers unintentionally invalidate their HIPAA guaranteed-issue rights without realizing it, and then risk being denied coverage when they apply for individual coverage.

Under current law, individuals who are leaving group coverage must exhaust either COBRA continuation coverage or any state-mandated continuation-of-coverage option if COBRA is not applicable, before they have any group-to-individual portability rights under HIPAA. Once the consumer exhausts these options, if available, then he or she can purchase certain types of individual coverage on a guaranteed-issue basis, provided that there is no more than a 63-day break in coverage.

Most people who leave group coverage are unaware of all of the stipulations required to receive federal portability-of-coverage protections. Faced with high COBRA or state-continuation premiums, many individuals decline such coverage initially or after a few months. Then, depending on their health status or a family member's, they may experience extreme difficulty obtaining individual-market coverage. To solve this problem, the HIPAA requirement to exhaust state continuation coverage or COBRA before federal guarantees are available should be rescinded, and individuals leaving group coverage should be able to exercise their federal group-to-individual portability rights immediately, provided that there is no more than a 63-day break in coverage.

Subsidies

Some changes need to be made in our tax system simply to provide equity for individual market consumers with their counterparts in employer-sponsored plans. For example, removing the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form and allowing the deduction of individual insurance premiums as a medical expense in itemized deductions would help many people who are part-time workers or who work for employers that don't offer health insurance coverage. And to put self-employed individuals who are sole proprietors or who have Sub-S corporations on a level playing field with businesses organized as "C" corporations, their current deduction from gross income should be changed to a full deductible business expense on Schedule C.

NAHU also supports targeted premium-assistance programs for low-income individuals purchasing private coverage, and we feel that the federal government should help finance such programs. A subsidy program could be national in scope, or each state could be required to create one that suits the unique needs of its citizens in partnership with the federal government. Several states have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform. I have included a link to a chart that itemizes some of the state subsidy programs that provide us with some good models and creative ways to help both employers and their employees with the cost of health insurance coverage. Two states in particular should be looked to as models:

Oregon

The Oregon Family Health Insurance Assistance Program (FHIAP)[2] is one state program that could serve as a model. FHIAP is an innovative state coverage initiative that subsidizes both employer-sponsored coverage and individual insurance coverage. Eligible families making over 150% of the Federal Poverty Level who do not receive cash assistance must participate if employer coverage is available, and others can participate on a voluntary basis. Licensed health insurance professionals help employers and individuals with enrollment and participation. The program subsidizes coverage on a sliding scale according to income. Subsidies range from 50% to 95% of the premium. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer. FHIAP members pay part of the premium. They also pay other costs of private health insurance, such as co-payments and deductibles. Once approved for FHIAP, members are eligible to remain in the program for 12 months. Three to four months before the member's eligibility ends, FHIAP sends a new application and members may re-apply. FHIAP provides direct premium assistance through the insurer for people who use its benefits to purchase individual coverage. For those with employer coverage, FHIAP reimburses employees for the cost of their premium within four days of receipt of a valid pay stub denoting the employee contribution. This program has been around for a number of years and struggles each year with funding, but many have benefited from it and it is a streamlined approach with little administrative cost.

Oklahoma

Oklahoma's Employer/Employee Partnership for Insurance Coverage (OEPIC or Insure Oklahoma)[3] is another very successful state subsidy program that works with both employer-sponsored and individual health insurance coverage for self-employed people, certain unemployed individuals and working individuals who do not have access to small-group health coverage. In 2008, 9,923 employees and dependents were directly subsidized by Insure Oklahoma, which is a 234% increase from the previous year.[4] Licensed insurance agents and brokers help identify applicable participants and enroll people and employers in the plan. Through the program, the employer pays only 25% of the premium of the low-wage worker, the employee pays up to 15% of the premium, and the state pays the remainder. The program's passage was supported by insurers, small employers, agents and brokers, and providers. It is funded by a state tobacco tax and federal funds based on a Medicaid Health Insurance Flexibility and Accountability waiver. Twenty insurers participate, offering dozens of qualified products that meet simple specified coverage standards.

Connectors and Exchanges

In 2006, Massachusetts policymakers enacted a far-reaching health reform plan, creating what is known as the Massachusetts health insurance "connector," along with other reforms all designed to improve health insurance coverage affordability and accessibility. Now many policymakers, both in Congress and in other states, are exploring whether the connector concept, which is also sometimes referred to as an exchange or portal or one-stop-shop among other terms, is an effective means of reducing the number of uninsured Americans.

NAHU has thoroughly evaluated the policy ideas behind health insurance connector proposals. We recognize that some believe the connector concept has promise. But NAHU believes Congress needs to carefully weigh the pros and cons of any connector or exchange proposal concerning access to health insurance.

An important point to remember is that the Massachusetts connector is a form of purchasing pool. While purchasing pools may provide more health plan options for individuals to choose from, history shows that they do not reduce health insurance costs. The most successful state purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable. NAHU is concerned that if a national connector or Exchange is established in such a way that does not allow for a competitive market outside of the connector, a situation could develop that could endanger the ability of individuals and employers to find health care financing in the future.

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[2] *http://www.oregon.gov/OPHP/FHIAP/*

[3] *http://www.oepic.ok.gov/*

[4] Blue Cross Blue Shield Association. "Insure Oklahoma: Overview and Impact." *http://www.bcbs.com/issues/uninsured/background/insure-oklahoma-overview.html*

In many ways, a connector operates like the Federal Employees Health Benefit Plan, in which many private insurance plans compete to provide coverage for federal workers. But, unlike the FEHBP, a connector does not achieve the marketing and other advantages of a homogenous group. All health insurance products sold through a connector are individual policies, even if they are purchased by an employer in lieu of traditional group insurance coverage. Employers purchasing coverage through a connector may be required to establish premium-only Section 125 "cafeteria" policies through which the connector policies would be purchased. In Massachusetts, the connector replaces the individual insurance market and is a means for qualified individuals to enroll in a state-subsidized health insurance option known as Commonwealth Care. Due to legal obstacles, the Massachusetts connector was only recently able to begin marketing policies to small-employer groups, three years after the Connector was created.

Since the creation of the Massachusetts connector, connector or exchange bills have been introduced in more than 30 state legislatures and the U.S. Congress, as well as many think tanks and foundations, some of whom are represented today at this hearing. Some proponents of a connector believe that our nation's health coverage system should evolve from a primarily employer-based insurance system to an individually based one. A connector would partly achieve this goal and could potentially expand individual employee health insurance options, but it could also cause employees who have traditional group coverage now to lose important benefits.

Proponents say that connectors are government-managed markets that sell individual private and portable health insurance while preserving market forces and fostering competition. Furthermore, it has been argued that pooling a group of individual policies within the connector can mitigate some risk and stabilize premiums. NAHU is not convinced these arguments are true.

There are several reasons why past large-scale health insurance purchasing cooperatives have failed, including adverse selection and an inability to reduce administrative costs. Risk adjustment has been a particular problem. The fact is that when an individual in an employer group can select the coverage that will benefit his or her specific situation the most, they will do exactly that. This usually results in the sickest employees choosing the most flexible coverage that will allow them the greatest degree of provider selection and treatment options. After a while, this pool coverage option is selected so often by sick people that it can not sustain the financial losses and is forced to leave the pool to offer coverage outside the pool environment in a situation where it's more likely to get a variety of risks.

Purchasing cooperatives also have failed to yield significantly lower administrative costs for employers, employees and insurers, and the same will likely hold true for connectors. It is often argued that many individuals and small businesses purchasing coverage together will be able to translate their bulk purchasing power into discounts normally achieved by large businesses. However, many diverse individuals buying insurance together do not have the same rating and risk profile as one large and generally more homogenous employer group, even if one were to merge individual and small-group markets.

In addition, the cost savings associated with large-employer coverage primarily comes from the fact that the enrollees work for the same employer and have a standardized point of contact. A connector would have to individually address the needs of many subscribers separately. Finally, a connector with 5,000 participating individuals isn't really a pool of 5,000. If there are 10 plan choices with 500 people selecting each choice, what you really have are 10 500-person groups insured by different carriers, not one group of 5,000. As a William M. Mercer study on health insurance purchasing cooperatives commissioned by the Commonwealth of Virginia concluded:

"The historical success of HIPCs has been disappointing in general. The enrollments have never reached the expected levels required to enable the HIPCs to be significant negotiators in the market and the hoped-for cost savings have not materialized." [5]

Potential Conflicts with ERISA, HIPAA and COBRA

NAHU has serious legal concerns about connectors, particularly with regard to situations in which employers would be purchasing or sponsoring individual coverage for employees. Depending on a connector's structure, we see potential conflicts with a number of federal laws, including ERISA, COBRA and HIPAA. These laws serve essential functions to protect consumers, and NAHU does not want to see these protections diminished.

[5] Mercer, William M. Review of Health Insurance Purchasing Cooperatives (HIPCs). Private study Commissioned by the Commonwealth of Virginia. September 15, 1999.

Many connector proposals would require participating employers to create Section 125 cafeteria plans and mandate coverage of certain benefits and employer contributions. This could trigger potential ERISA challenges. These administrative burdens would add to health insurance administrative costs with little, if any, value to consumers or employers. Potential conflicts with HIPAA and COBRA are also of great concern to NAHU. In Massachusetts, all policies sold through the connector are individual policies even if they are offered through an employer. This raises important COBRA and HIPAA questions for employees of companies that previously offered traditional group health insurance coverage but are now offering such coverage through a connector. For example:

- Do employees forfeit their COBRA rights?
- If not, when is COBRA eligibility triggered—upon termination of employment or at the time of the employer group enrollment in the connector individual policy?
- When would group-to-individual portability guaranteed-issue rights under HIPAA be triggered?

These eligibility concerns will likely need to be addressed by Congress if a national connector is created, or it may become a matter for the federal courts. And the potential for such courts limiting existing rights of group health insurance consumers is significant and worrisome.

HIPAA group health provisions also appear to be problematic for connector proposals. HIPAA requires that health plans that involve an employer must comply with all of the group health insurance protections the law mandates. Connector plans sold through employer groups would seem to clearly fall under the category of employer involvement, particularly if employer contributions or the creation of a Section 125 plan were involved. Therefore, Congress would need to clarify that individual health insurance policies purchased by employees with no premium financed by the employer are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA or ERISA.

Finally, and most important, NAHU feels that connector proposals would do nothing to address the rapidly rising costs of providing medical care in this country, which is the true source of high health insurance premiums. Health insurance market reform measures, no matter how they are structured, do little to reduce costs. In fact, overall state health program costs in Massachusetts have increased by 42 percent since the enactment of the 2006 reforms. The cost of medical care is the key driver in rising health insurance premiums. It is what's putting the cost of health care coverage beyond the reach of many Americans.

Structuring of a Connector or Exchange

Despite all of our concerns about a traditional health insurance exchange, NAHU does recognize the need for greater opportunities to enroll individuals in health insurance coverage. In particular, the issue of individuals who are eligible for programs like Medicaid and CHIP but are not actually enrolling in the coverage needs to be addressed. There is also the perception that uninsured individuals need a centralized place to access coverage option, connect with qualified professionals and make choices based on their individual needs and budgets. Finally, the employer-sponsored health insurance system provides tax advantages but it's not always an available option for everyone.

If Congress does decide to create a national connector or exchange, it is critical that such an entity be structured in such a way that it does not damage or eliminate the traditional private insurance marketplace. If pools totally replace other private-market options, there may be no other vehicle for coverage if the pool fails. One of the most key structural decisions that will need to be made is if a national connector will be a "portal" or a bricks-and-mortar institution and regulatory body that also sells private coverage or offers a public program option. The flea-market approach may be the best way to provide consumers with easier access to coverage options without disrupting the existing private insurance market.

The Internet-based travel company Travelocity is an example of a flea-market approach to access to a service: Private companies compete and sell their products in one place. Travelocity does not regulate the routes airlines fly, nor does it regulate the prices that vendors charge consumers.

Another structural issue Congress will need to address is how a national connector or exchange will mesh with existing and varying state coverage rules and consumer protections. Plan rating rules and other requirements should mirror state laws outside the connector, otherwise adverse selection will be rampant. National experience with purchasing pools of all kinds shows that pools that operate at the state level that also fairly compete with plans outside the pool are the least disruptive to the market. Under no circumstances should rating laws be less restrictive inside the connector, and rating laws more restrictive than the outside market will

cause selection against the connector. Also, in terms of rating requirements, Congress should keep in mind that current state rating law differences reveal that more restrictive age bands result in higher costs and lower participation over time.

Greater stability will also be realized by not mixing market types (i.e., not combining individuals purchasing coverage independently with small businesses or other group coverage). State laws differ significantly between the group and individual markets and, actuarially, these segments are quite different. Combining them would cause adverse selection to the pool. And although including the self-employed in a connector is an attractive idea, it should be done cautiously as it can cause the same problems as combining individual and small-employer markets. If both small groups and the self-employed are eligible for participation, extra restrictions should be made on the self-employed to control entry into the pool and to ensure the existence of a business.

One function of the Massachusetts connector is to administer the state's subsidized coverage program, Commonwealth Care. If a national connector is utilized as a means of subsidy administration, such subsidies should be broad-based and available to eligible individuals and businesses both inside and outside the connector. If subsidies are available only inside the connector, crowd-out from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the pool can also result in higher-than-expected costs for those in the pool and an apparent larger number of uninsured than actually exist.

Employer Mandates

Although we are strong proponents of employer-sponsored coverage, a mandate to force employers to provide health insurance to their employees, while well-intentioned, could actually hurt American workers and health insurance coverage by decreasing jobs and economic growth, as well as do little to reach the current uninsured population. It would have a negative impact on wages and job creation, and would principally impact low-skilled employees because employers would be forced to cut jobs to control skyrocketing labor costs.

Measures that would force an employer to spend certain dollar amounts or percentages of their payroll on a health plan that may bear little resemblance to what is needed by a particular employee population merely provide a disincentive for responsible spending and health insurance rate containment.

Additionally, such proposals often come with an opportunity for employers to "opt out" of providing coverage themselves and instead pay into a government-sponsored plan or fund that would provide coverage in lieu of the employer's plan. Such programs would compete unfairly with the private market and cause employers that continue to provide coverage to experience higher costs due to cost-shifting. In a similar vein, proposals that allow employees to opt out of their employer-sponsored plans in favor of some type of pooled purchasing arrangement would jeopardize the ability of employers to continue to offer their plans by decreasing pooling efficiencies, increasing employer administrative cost for tracking plan selection, and jeopardizing the employer's ability to meet plan-participation requirements.

Conclusion

The United States health care system works for the vast majority of its citizens, yet we can do better. Improvement will require strong leadership, a thorough debate of all proposals and, ultimately, difficult compromises and decisions. All stakeholders will feel some pain in order to achieve a universal gain. NAHU agrees with those who recognize that the status quo can no longer be everyone's second choice, and we pledge full participation in the coming debate.

Ultimately, we believe the time is right for a solution that controls medical care spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished without limiting people's ability to choose the health plan that best fits their needs and without creating an expensive, unneeded new government bureaucracy. We look forward to working with all interested parties in achieving our common goal: a world-class and affordable health care system for all Americans.

I would be happy to respond to any questions or comments.

Chairman ANDREWS. Ms. Trautwein, thank you very much. We appreciate your testimony.

Mr. Oemichen, welcome. We are happy to have you with us.

STATEMENT OF WILLIAM OEMICHEN, PRESIDENT AND CEO, COOPERATIVE NETWORK

Mr. OEMICHEN. Good morning, Chairman Andrews, Ranking Member Kline and members of the Subcommittee. Thank you for the opportunity to testify in support of federal reforms that would allow small employers, their employees and their families to gain greater access to affordable, quality health insurance coverage.

I am Bill Oemichen. I am president and CEO of Cooperative Networks, a Minnesota and Wisconsin association of more than 600 cooperative businesses owned by more than 6.3 million residents of both states.

I am testifying today on behalf of the Alliance for Employee Benefits Cooperative, a broad-based coalition of cooperative organizations committed to advancing health care and benefits coverage for American workers and families through the creation of employee benefit cooperatives. Our alliance members operate in all 50 states, represent over 13,000 member owners and approximately 40,000 local businesses and more than 700,000 employees.

We all know that a critical piece of the health care puzzle is the need to expand coverage among small businesses and their employees. Small businesses lack economies of both scale and expertise in providing health and other employee benefits to their workers. Small employers that attempt to provide health insurance for their employees face far greater challenges than larger employers, including stricter underwriting, higher prices, fewer choices, lower quality benefits and little or no data upon which to make informed decisions. For these reasons, millions of small business employees do not receive health care and benefits coverage.

To address this problem, an aggregation method for small businesses that allow them to achieve the economies of scale and expertise they need is essential.

Employee benefit cooperatives would provide such a method and would do so in such a way that ensures small businesses, small business employees receive quality coverage.

This leads to a logical question, "What is an employee benefit cooperative?" An employee benefit cooperative would be a cooperative organized under Internal Revenue Code subchapter T, with at least 21 shareholders, all in the same line of business. Under this approach, small employers would join with employee benefit cooperatives as shareholder-members. And the employee benefit cooperative would be the aggregating vehicle utilized to purchase and deliver health insurance and other employee benefits to their employees or to the employees and their shareholder-members. Employee benefit cooperatives would be required to cover all the employees of its shareholder-members.

We believe that cooperatives are ideally suited to serve as a small business aggregator vehicle for employee benefit purposes.

Cooperatives have a long and deep history in our nation and have been utilized by Americans for centuries to achieve economies of scale and expertise. In many instances, they are built to band together to achieve group purchasing power and provide value-added expertise and organization is the driving force behind the creation of a cooperative.

To date, our nation's employee benefit laws generally have not recognized the ability to utilize the cooperative form for benefits delivery. This problem can be fixed relatively simply by clarifying that an employee benefit cooperative is recognized as a single employer under federal employee benefits law.

I want to take a minute to distinguish employer benefit cooperatives from other proposals in recent years that have sought some form of business aggregation for health care delivery purposes, most notably Association Health Plans, or AHPs. The employee benefit cooperative model is different in several important respects.

First and foremost, employee benefit cooperatives are not attempting to avoid state benefit standards, such as community rating and guaranteed issue. In addition, self insurance is not a necessary competent of the proposal. Employee benefit cooperatives can partner with the existing private insurance system so long as the employee benefit cooperatives have the right of negotiation as a single employer. Finally, the structural characteristics of Internal Revenue Code, subchapter T, cooperatives generally, and of the employee benefit cooperative in particular, provide additional protection.

I know first hand from experience in Minnesota and Wisconsin and, hopefully shortly in Michigan, that the cooperative model works.

My organization, the Cooperative Network, is working to provide health insurance to small businesses and farmers throughout the state of Wisconsin. And as I said, I also hope to do the same shortly in Minnesota and Michigan.

For example, with the Farmers health Cooperative of Wisconsin, we have successfully used the power of group purchasing to negotiate a lower renewal rate increase, provide first-dollar coverage of preventative coverage up to the first $500, and ensure that farm-related accidents are covered by health insurance. We were able to accomplish all this without denying insurance to anyone that meets our membership criteria.

We have also helped create small business school districts and even physician cooperatives that are providing expanded benefits to the member-owners.

In closing, let me reemphasize how necessary it is that there be an aggregation vehicle for small businesses to achieve the economies or scale and expertise to maintain health and other employee benefits programs for their employees.

Thank you very much for the opportunity to testify, and I also am very willing to answer questions for you.

[The statement of Mr. Oemichen follows:]

Testimony of William (Bill) L. Oemichen

on behalf of

the Alliance for Employee Benefit Cooperatives

before the Committee on Education and Labor

Health, Employment, Labor, and Pensions Subcommittee

United States House of Representatives

April 23, 2009

Good morning, Chairman Andrews, Ranking Member Kline, and Members of the Subcommittee. Thank you for the opportunity to testify in support of federal reforms that would allow small employers, their employees, and their families to gain greater access to affordable, quality health insurance coverage.

My name is Bill Oemichen, and I am the President and CEO of the Cooperative Network, a Minnesota and Wisconsin association of more than 600 cooperative businesses owned by more than 6.3 million residents of both states. I am testifying today on behalf of the Alliance for Employee Benefit Cooperatives, a broad-based coalition of cooperative organizations committed to advancing health care and benefits coverage for American workers and families through the creation of "Employee Benefit Cooperatives". Alliance members operate in all 50 States, representing over 13,000 member-owners, approximately 40,000 local businesses, and more than 700,000 employees. A current roster of the members of the Alliance is attached as Appendix A.

The Challenge – Addressing the Health Care Crisis for Small Business Employees

We all know that a critical piece of the health care puzzle is the need to expand coverage among small businesses and their employees. Generally speaking, small businesses lack economies of both scale and expertise vis-à-vis larger employers in providing health, retirement, and other employee benefits to their workers. In particular, small employers that attempt to provide health insurance for their employees face far greater challenges

than larger employers: stricter underwriting, higher prices, fewer choices, lower quality benefits and little or no data upon which to base informed decisions. For this reason, millions of small business employees do not receive health care and benefits coverage, and small business employers that do provide benefits often struggle to maintain these programs.

To expand health care coverage among these small businesses, some means of providing for organized and representative aggregation is essential.

Employee Benefit Cooperatives, a private sector solution designed to meet this essential component of health care reform, would do so in way that will level the playing field for small businesses, while facilitating the objectives of broadening access and improving health care quality through plan design, education, and communication.

The Employee Benefit Cooperative Approach

This leads to the logical question: what is an Employee Benefit Cooperative?

An Employee Benefit Cooperative would be a cooperative organized under Internal Revenue Code subchapter T section 1381 for the purpose of providing health care and other employee benefits to the employees of its shareholder-members. Under this approach, small employers would join an Employee Benefit Cooperative as one of no

fewer than 21 shareholder-members, and the cooperative would then be the aggregating vehicle utilized to purchase and deliver health insurance benefits to the employees of its shareholder-members.

Pursuant to a written agreement, these cooperatives would require substantially all of the employees of any shareholder to participate in its benefit plans, and for the shareholders to be in similar lines of business. These and other preconditions reinforce a commonality of purpose that hinges on more than just the procurement of health benefits coverage, thus removing the risks of adverse underwriting selection.

One of the unique characteristics of the Employee Benefit Cooperative model is that it intends to deliver health care benefits as part of a total integrated package of health, retirement and other employee benefits. Employee Benefit Cooperatives are envisioned as private connectors that provide small employers and their employees with access to competitive health benefits, and that also wrap other available federal benefit programs around that health care core. For example, there are tax favored benefit programs that, when used in conjunction with an insured program of health benefits, can help lower and manage costs, but the use of which is largely out of the reach for most small business because of a lack of administrative capacity and expertise. This includes Cafeteria Plans for pre-tax premium contributions, dependent care and flexible spending accounts; and direct reimbursement programs that can be used in health plan design. Employee Benefit

Cooperatives can also foster the expansion of small business retirement planning, since the expertise and capacity to deliver the one will function to deliver the other.

The complexity of the operating mechanics of the employer function is vastly underestimated, and yet expertise in this area is crucial to effective benefits management, communication and negotiation. Accordingly, some form of aggregation that brings benefit management expertise to the small employer market is essential. In this capacity, Employee Benefit Cooperatives can deliver better overall value, broadening and deepening the larger objectives of health care reform.

Cooperatives have a long and deep history in our nation, having been utilized by Americans for centuries to help themselves and their neighbors improve their lives, principally by providing economies of scale and expertise for their shareholder-members. The defining structural characteristics of cooperatives are these: equity and ownership are limited to its member/owners, they are democratically controlled, and the Internal Revenue Code requires the allocation of earnings to its shareholders in the form of dividends.

Cooperatives span our economy, with deep roots in farming and agriculture, wholesale and retail grocery, credit services (including the farm credit system, banking and credit unions), retailing of all kinds, insurance, electric and telephone utilities, hospitals, housing, and

virtually any form of commerce imaginable. Nearly 30,000 U.S. cooperatives operate at 73,000 places of business, accounting for $3 trillion in assets, $654 billion in revenue, more than 2 million jobs, $75 billion in wages and a total of $133 billion in value-added income.[1]

In many instances, the ability to band together to achieve group purchasing power and provide value-added expertise and organization is the driving force behind the creation of a cooperative. However, because our nation's employee benefits laws have been constructed in a way that generally does not recognize the ability to utilize the cooperative form for benefits delivery, this powerful tool has not been available to expand and enhance health care and other employee benefits.

Achieving this capacity requires the recognition of the proposed Employee Benefit Cooperatives as single employers for the purposes of federal employee benefits law. If some form of aggregation is essential to assisting small businesses and our rural communities as part of health care reform, cooperatives – Employee Benefit Cooperatives – are a nearly ideal vehicle.

[1] University of Wisconsin, *Research on the Economic Impact of Cooperatives*, March 2009, Center for Cooperatives.

Distinguishing from Other Small Business Aggregation Models

This, of course, is not the first time that a proposal has been offered to allow small business aggregation for health plan purposes. Association Health Plans (AHPs) and Small Business Health Plans (SBHPs) are two small business aggregation proposals that have been hotly debated in recent years. The Employee Benefit Cooperative model is different from these prior models in the following important respects:

- First and foremost, Employee Benefit Cooperatives are not attempting to avoid state benefit standards such as community rating and guaranteed issue. That being said, the authority for multi-state aggregation on a common benefit platform is important.

- Self-insurance is not a necessary component of the proposal: Employee Benefit Cooperatives can partner with the existing private insurance system provided Employee Benefit Cooperatives have the right of negotiation as a single employer across state lines. By eliminating the myriad number of third party providers inherent in the self-insurance model, the incentives to misuse the cooperative model are eliminated.

- The structural characteristics of IRC Code § 1381 Subchapter T cooperatives generally, and of the employee benefit cooperative in particular, provide additional protections. As economic "pass through" entities, a direct correlation exists between a cooperative's economic operations and a shareholder's welfare, with excess revenue required by law to be allocated to the shareholder's interest. This intrinsic economic self interest is

supported by the democratic obligations of cooperative operation that require the subordination of capital to the voting rights of shareholders: one shareholder, one vote. In short, they are ideal for the intended purpose of watching after the health and welfare interests of an employer and its employees.

Success in the Field: The Cooperative Network Experience

My own experience in Minnesota and Wisconsin leading the Cooperative Network proves that the cooperative model can work for benefits delivery. Our cooperative model is currently providing health insurance coverage to farmers and agribusinesses via the Farmers' Health Cooperative of Wisconsin which contracted with Aetna to begin providing coverage in April of 2007. The cooperative has successfully used the power of group purchasing to negotiate low renewal rate increases of less than 10 percent each year, provide first dollar coverage of preventative care up to the first $500 and ensure that farm-related accidents are covered by health insurance. This latter benefit was typically excluded from farm health insurance plans, and placed the farmer's livelihood at risk. We were able to accomplish all this without denying insurance to any farmers or agribusiness that meets our membership criteria.

Our Wisconsin success was dependent upon passage of a 2003 State law, Wisconsin Statutes section 185.99, that made clear individuals, small employers, and others could join together as one large group for the purpose of purchasing health insurance. This law passed the Wisconsin Senate and Assembly unanimously.

The *Co-op Care* model is not just for farmers. It is also working for small employers in Brown County Wisconsin, where local employers took the initiative to start a co-op (Healthy Lifestyles Cooperative) for businesses in that area of Wisconsin. This cooperative includes more than 120 small employers and 3,600 individual lives. This cooperative has been able to offer prevention, health, and wellness benefits that were not otherwise made available to the individual employers members prior to participating in the cooperative. Several other regional, small business groups, school districts, and even the Medical Society of Wisconsin (Physician's Health Cooperative), is following suit to develop health care purchasing cooperatives for their members. These cooperatives are focused on improving the health of their member-owners and, as non-profit businesses, exist only to serve their member-owners' healthcare needs. These are only a few of a number of examples.

Before concluding this brief discussion of our Wisconsin healthcare cooperative development efforts, I must recognize the substantial credibility that the $4.45 million in FY05 and FY06 Congressional appropriations (for start-up administrative costs and initial stop loss) gave our Co-op Care project with insurers. The appropriations effort, led by Senator Herb Kohl and Representative David Obey and supported by other members of the Wisconsin and Minnesota Congressional delegations, demonstrated the uniqueness of our Co-op Care project. This funding is targeted to support development of healthcare cooperatives for farmers because they usually are viewed as "high risk", and as a result, have difficulty purchasing insurance in the small group or individual market.

In Minnesota, we are taking a similar approach to help farmers leverage their large group purchasing power to create a *Co-op Care* demonstration project that would give farm families access to a guaranteed issue product with no exclusions for pre-existing health conditions. However, our Minnesota efforts have not yet achieved similar positive results due to a very different Minnesota insurance market and a different State regulatory review process. Cooperative Network members such as Land O' Lakes, CHS member cooperatives, Dairy Farmers of America, and Farm Credit are frustrated we cannot offer similar plans in both States even though they are able to do business in both States.

At the end of the day, however, without the single employer status proposed in the Employee Benefit Cooperative initiative, the ability to fully leverage the good, self interested values of a cooperative's members, its inherent economies of scale, and the management structure that provides for the expertise necessary to navigate employee benefits – with or without health reform – will be limited to the states where we currently operate. Current federal law prohibits us from providing a uniform product, price, education, communication and management strategy, even in these two bordering states, without enabling cooperatives to do what they do so well.

The unique and defining characteristic of the Employee Benefit Cooperative initiative is its intention to provide a total benefits solution. Health insurance, while the primary focus of these discussions, is just one part of the entire health, welfare and pension benefits function that is dependent on employer expertise, and that ought to be discussed and facilitated,

where possible, as a whole. The Employee Benefit Cooperative model provides for that possibility.

Conclusion

For health care reform (and benefits reform more broadly) to succeed, a field-level means of providing for small business aggregation will be crucial to effecting and maximizing enrollment and participation. We believe strongly that Employee Benefit Cooperatives would provide an ideal means for achieving this purpose. We look forward to working with the Committee on these important issues.

ALLIANCE FOR EMPLOYEE BENEFIT COOPERATIVES MEMBERS

Blue Hawk Distribution Cooperative, Inc.— www.bluehawk.coop
Blue Hawk is a purchasing cooperative of heating, ventilation, air conditioning and refrigeration products distributors to the residential and construction trades with 205 members in 908 locations.

CCA Global Partners—www.ccaglobal.com
CCA Global Partners is an organization of 15 franchise purchasing cooperatives concentrated in retail flooring and lighting (Carpet One and Lighting One) with 3,600 United States locations and $10.2 billion in aggregate sales.

Compliant Pharmacy Alliance Cooperative
Compliant Pharmacy Alliance Cooperative is a purchasing cooperative of 564 independent pharmacies across the United States.

Cooperative Network—www.cooperativenetwork.com
Cooperative Network is the association representing more than 600 member cooperatives in Wisconsin and Minnesota, owned by more than 6.3 million residents, providing government relations, education, marketing and technical services.

Federation of Southern Cooperatives—www.federationsoutherncoop.com
The Federation is a cooperative of 12,000 African-American family farms in the southeast working through 35 agricultural cooperatives to purchase supplies, provide technical assistance and market their crops.

National Cooperative Business Association—www.ncba.coop
NCBA is the lead national membership association representing cooperatives of all types and in all industries.

National Cooperative Grocers Association (NCGA)—www.ncga.coop
NCGA is a business services cooperative for 130 natural food co-ops located in 32 states.

Nationwide—www.nationwide.com
Nationwide is one of the largest insurance and financial services companies in the world, with more than $160 billion in statutory assets. Nationwide offers a full range of insurance products and financial services for home, car, family and financial security.

NCB (National Cooperative Bank)—www.ncb.coop
NCB is a cooperative bank, serving consumer, worker and housing cooperatives with more than 2,600 customer-owners and $6.19 million in assets under management.

Thanexus, Inc.—www.thanexus.coop
Thanexus, Inc. is a funeral practice management cooperative created by the New Jersey State Funeral Directors Association (NJSFDA) that represents 109 funeral homes in New Jersey.

U.S. Central Credit Union—www.uscentral.org
U.S. Central is the wholesale financial credit union serving 8,400 credit unions across the country.

Unified Grocers—www.unifiedgrocers.com
Unified Grocers is a retailer-owned wholesale grocery cooperative that provides grocery products and services to independent retailers throughout the Western United States.

Wakefern Food Corporation—www.wakefern.com
The cooperative supplier to the 217 Shop Rite Supermarkets that serve the greater New Jersey region.

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Chairman ANDREWS. Thank you. We are happy to have you here. We very much appreciate your testimony.

Doctor, welcome to the Committee. We are pleased that you are with us.

STATEMENT OF DAVID HIMMELSTEIN, ASSOCIATE PROFESSOR OF MEDICINE, HARVARD UNIVERSITY

Dr. HIMMELSTEIN. Mr. Chairman, thank you so much for having me.

I am a primary care doctor, and I am flying back after this hearing to make rounds at Massachusetts General Hospital and thank

my internists and residents for being willing to stay until 8 o'clock tonight to do rounds with me.

I also serve as a national spokesperson and was co-founder of Physicians for a National Health Program. Our 16,000 physician members support single-payer, nonprofit national health insurance because of the overwhelming evidence that lesser reforms will fail us. And we support H.R. 676 that Mr. Conyers has introduced.

Health reform must address the cost price of not only for the uninsured but for the insured as well.

My research group found that illness and medical bills contributed to about half of all medical bankruptcies in the U.S. in 2001, and even more than that in 2007, I might say, in a study we have coming out shortly.

Strikingly, three-quarters of these medically bankrupt American families—and remember 1 million Americans are bankrupted by medical problems each year. Three quarters of them had insurance when they first got sick. But that coverage was too skimpy to protect them from financial collapse.

The employer-based system is not working, even for those who have employer-based coverage.

A single-payer reform would make care affordable through vast savings on bureaucracy and profits. As my colleagues and I have shown in research published in the New England Journal of Medicine, administration now consumes $0.31 of every health dollar in the U.S., nearly double what costs are in Canada.

In other words, if we cut our bureaucratic costs to Canadian levels, we would save nearly $400 billion annually, more than enough to cover the uninsured and to eliminate co-payments and deductibles for all Americans. By simplifying the payment system, Canada has cut insurance overhead to 1 percent, one-twentieth of Aetna's level. They do not pay their CEO $225,000 each day, as Aetna's CEO receives.

And they have eliminated mounds of expensive paperwork for doctors and hospitals. In fact, while cutting insurance overhead could save us $131 billion each year, our insurers waste much more than that because of the useless paperwork they inflict on hospitals and on doctors.

A Canadian doctor gets paid like a fire department does in the U.S. It negotiates a global budget with a single insurance plan in its province and gets one check each month that covers virtually all costs. They do not have to bill for every Band-Aid and aspirin tablet.

At my hospital, we know our budget January 1, but we collect it piecemeal in fights with hundreds of insurers over thousands of bills each day. The result is that hundreds of people work for Mass General's billing department, while Toronto General employs a handful, mostly to send bills to Americans who wonder across the border.

All together, U.S. hospitals could save $120 billion annually on bureaucracy under a single-payer system. And doctors in the U.S. waste about $95 billion each year fighting with insurance companies and the useless paperwork they inflict on us.

Significantly, these massive potential savings can only be achieved through a single-payer reform. A health reform plan with

a public plan option might realize some savings on insurance overhead, but as long as multiple private plans co-exist with the public plan, hospitals and doctors would have to maintain our costly billing and internal cost tracking operations.

Indeed, my colleagues and I estimate that if half of all privately insured Americans switch to a public plan with overhead at Medicare's levels, you would get administrative savings about 9 percent of what could be achieved under a single payer.

While administrative savings from reform that includes a Medicare-like public option are modest, at least they are real.

In contrast, other widely touted cost-control measures are completely illusionary. A raft of studies shows that prevention saves lives. But it usually actually costs money. I spend my day as a primary care doctor, doing it because it saves lives. But we have no illusions that we are saving money.

The recently-completed Medicare demonstration project found no cost savings come from chronic disease management. And the claims that computers will save money are based on pure conjecture.

We have a study about to be published, of 3000 hospitals, showing that hospitals with higher computerization levels actually have higher costs.

My home state of Massachusetts' recent experience with health reform illustrates the dangers of believing overly optimistic cost-control claims. Before its passage, the reform's backers promised many of the things being promised for lesser reforms here in D.C. Instead, costs have skyrocketed, rising 23 percent in just 2 years. And insurance exchanges added 4 percent for its own administrative costs to the already high cost of care. One in five Massachusetts residents still say they cannot afford care.

In sum, a single-payer reform would make universal comprehensive coverage affordable by diverting hundreds of billions of dollars from bureaucracy to patient care. Lesser reforms, even those that include a public plan, cannot realize such savings.

While reforms that maintain a major role for private insurers may seem politically expedient, they are economically and medically nonsensical.

Thank you.

[The statement of Dr. Himmelstein follows:]

Prepared Statement of David U. Himmelstein, M.D.

Mr. Chairman, members of the Committee. My name is David Himmelstein. I am a primary care doctor in Cambridge, Massachusetts and Associate Professor of Medicine at Harvard. I also serve as National Spokesperson for Physicians for a National Health Program. Our 15,000 physician members support non-profit, single payer national health insurance because of overwhelming evidence that lesser reforms will fail.

Health reform must address the cost crisis for insured as well as uninsured Americans. My research group found that illness and medical bills caused about half of all personal bankruptcies in 2001, and even more than that in 2007. Strikingly, three quarters of the medically bankrupt were insured. But their coverage was too skimpy to protect them from financial collapse.

A single payer reform would make care affordable through vast savings on bureaucracy and profits. As my colleagues and I have shown in research published in the New England Journal of Medicine, administration consumes 31% of health spending in the U.S., nearly double what Canada spends. In other words, if we cut our bureaucratic costs to Canadian levels, we'd save nearly $400 billion annually—

more than enough to cover the uninsured and to eliminate copayments and deductibles for all Americans.

By simplifying its payment system Canada has cut insurance overhead to 1% of premiums—one twentieth of Aetna's overhead—and eliminated mounds of expensive paperwork for doctors and hospitals. In fact, while cutting insurance overhead could save us $131 billion annually, our insurers waste much more than that because of the useless paperwork they inflict on doctors and hospitals.

A Canadian hospital gets paid like a fire department does in the U.S. It negotiates a global budget with the single insurance plan in its province, and gets one check each month that covers virtually all costs. They don't have to bill for each bandaid and aspirin tablet. At my hospital, we know our budget on January 1, but we collect it piecemeal in fights with hundreds of insurers over thousands of bills each day. The result is that hundreds of people work for Mass General's billing department, while Toronto General employs only a handful—mostly to send bills to Americans who wander across the border. Altogether, U.S. hospitals could save about $120 billion annually on bureaucracy under a single payer system.

And doctors in the U.S. waste about $95 billion each year fighting with insurance companies and filling out useless paperwork.

Unfortunately, these massive potential savings on bureaucracy can only be achieved through a single payer reform. A health reform plan that includes a public plan option might realize some savings on insurance overhead. However, as long as multiple private plans coexist with the public plan, hospitals and doctors would have to maintain their costly billing and internal cost tracking apparatus. Indeed, my colleagues and I estimate that even if half of all privately insured Americans switched to a public plan with overhead at Medicare's level, the administrative savings would amount to only 9% of the savings under single payer.

While administrative savings from a reform that includes a Medicare-like public plan option are modest, at least they're real. In contrast, other widely touted cost control measures are completely illusory. A raft of studies shows that prevention saves lives, but usually costs money. The recently-completed Medicare demonstration project found no cost savings from chronic disease management programs. And the claim that computers will save money is based on pure conjecture. Indeed, in a study of 3000 U.S. hospitals that my colleagues and I have recently completed, the most computerized hospitals had, if anything, slightly higher costs.

My home state of Massachusetts recent experience with health reform illustrates the dangers of believing overly optimistic cost control claims. Before its passage, the reform's backers made many of the same claims for savings that we're hearing today in Washington. Prevention, disease management, computers, and a health insurance exchange were supposed to make reform affordable. Instead, costs have skyrocketed, rising 23% between 2005 and 2007, and the insurance exchange adds 4% for its own administrative costs on top of the already high overhead charged by private insurers. As a result, one in five Massachusetts residents went without care last year because they couldn't afford it. Hundreds of thousands remain uninsured, and the state has drained money from safety net hospitals and clinics to kept the reform afloat.

In sum, a single payer reform would make universal, comprehensive coverage affordable by diverting hundreds of billions of dollars from bureaucracy to patient care. Lesser reforms—even those that include a public plan option—cannot realize such savings. While reforms that maintain a major role for private insurers may be politically attractive, they are economically and medically nonsensical.

Chairman ANDREWS. Doctor, thank you very much. And we appreciate the long day that you are putting in to be with us today. We appreciate it very much.

Dr. HIMMELSTEIN. My residents are putting in a longer day.

Chairman ANDREWS. Well, you will be there at 8 o'clock with them though, so thank you.

Ms. Davenport, welcome.

STATEMENT OF KAREN DAVENPORT, DIRECTOR OF HEALTH POLICY, CENTER FOR AMERICAN PROGRESS

Ms. DAVENPORT. Thank you very much, Mr. Chairman and members of the Subcommittee. I am honored to be here today to testify

on improving health coverage for American employers and American families.

My focus today is on ensuring access to affordable, meaningful coverage for all workers who obtain health coverage through their employer, which in some circumstances may be outside the national insurance exchange, which is a prominent feature of the current health care debate.

Headline stories usually focus on problems in the so-called nongroups market where individuals struggle on their own to obtain meaningful health insurance coverage at a reasonable cost, and mostly fail to find it.

But the employer market where 160 million Americans obtain their health insurance poses plenty of problems too. Most importantly, nearly 9 million workers employed by larger employers were uninsured in 2007. In some cases, employees are not eligible for insurance. In others, they cannot afford to enroll in the coverage that their employer offers. Finally, even if workers are eligible for and can afford this coverage, they cannot be confident that it will be good enough to pay for their health care needs.

We know that while adults with employer-sponsored health insurance are less likely to be underinsured than those who purchase coverage through the individual markets, even employees in large companies experience underinsurance.

Of course, employers, and large employers in particular, have also pioneered innovative approaches to health coverage and cost control, including quality improvement initiatives, wellness programs and employee education efforts. These types of initiatives have reduced their health care spending and blazed the trail for delivery system improvements in the broader health care systems.

With these market conditions in mind, Congress may wish to consider exactly how health reform addresses gaps in the employer market.

While all employers and workers may benefit from obtaining coverage through the healthy competitive market an exchange will create, Congress may decide that opening the exchange to all employers outweighs the benefits to workers, particularly the possibility that employers with older or sicker workforces may enter the exchange in larger numbers, thus destabilizing rates during the start-up phase of an exchange.

Instead, Congress may wish to consider improvements to the health insurance market outside the exchange, improvements that can guarantee coverage and consumer protections for all workers with employer-sponsored health insurance.

In that case, there are several steps to consider.

First, Congress can make sure that American families can access health care whether they obtain their coverage inside or outside the exchange.

Regardless of where Americans obtain their health insurance, they need to know that their health benefits will be accessible and protected. Basic consumer protections include complaints and appeals processes, enrollment mechanisms, plan information requirements and the plan's responsibility to make data available for monitoring and oversight activities, as well as the vigorous oversight activities themselves.

These protections should apply to all health insurance, whether the policy originates from within the insurance exchange, and employer-purchased policy or a self-insured employer plan.

Second, health coverage should be adequate and affordable inside and outside the exchange. For example, to ensure affordability for families, Congress may choose to require companies that offer coverage outside the exchange to pay a minimum proportion of premiums.

Similarly, to ensure that health benefits are adequate, Congress may choose to apply the same benefit standards to policies sold inside an outside the exchange.

Of course, if the final reform package includes an individual requirement to carry health insurance, then this requirement will also interact with the standards for employer-sponsored benefit packages.

An individual coverage requirement would necessarily include a minimum-benefit standard and an expectation that workers could meet this requirement through the coverage offered by their employer.

If Congress chooses to explicitly share responsibility for health coverage across individuals and employers, then it may be best to apply the same coverage standard to both parties, a standard that would apply to coverage inside and outside the exchange.

Any steps Congress make take to guarantee good coverage outside the exchange will probably represent little or no change for many large employers, since any new requirements are likely to reflect what these employers do today. But affordability and coverage standards will increase costs for the employers who offer substandard benefits and for employers who cover only a modest proportion of health insurance premiums themselves.

Therefore, Congress will want to consider the tradeoffs involved for these employers and their workers. Some employers may, if they can, drop coverage all together. Others may pass costs onto their employees, which will particularly affect lower-skilled and lower-wage workers. So Congress may choose to provide additional options for these vulnerable workers.

While all workers should have access to affordable coverage, low-income workers should have additional avenues for enrolling in coverage that works best for them. By enabling these workers to obtain coverage through the exchange, even though they work for large employers who do not participate in the exchange, Congress can improve these workers' overall financial health and wellbeing.

To conclude, Congress faces choices about how to guarantee adequate, affordable coverage for Americans who work for large employers. However, the benefits of making these decisions are irrefutable. Reforming our nation's health care system is a challenging task, but the results will be worth it—lower costs and better coverage.

Thank you for your commitment to providing affordable, high-quality health coverage for all Americans.

[The statement of Ms. Davenport follows:]

Prepared Statement of Karen Davenport, Director of Health Policy, Center for American Progress Action Fund

Chairman Andrews, Congressman Kline, and Members of the Subcommittee, I am honored to be here today to testify on improving health coverage for American employers and American families. As you well know, health care reform is critical to restoring the financial health and well-being of our nation's families. Reform means reducing the crushing burden of rising health care costs on America's families, businesses, and governments at all levels. It also means ensuring that everyone has reliable, meaningful, affordable health coverage. Reform efforts that achieve one but not both of these goals will be incomplete. That's why policymakers and health care experts are considering the idea of a national health insurance exchange—an improved health care market that would offer individuals and employers a new avenue for acquiring private or publicly sponsored health insurance. My focus today, however, is on assuring access to affordable, meaningful coverage for all workers who obtain health coverage through their employer, which in some circumstances may be outside of the national insurance exchange.

Market issues

Problems in the nation's health insurance markets are one of the driving forces behind health care reform. Headline stories usually focus on problems in the so-called nongroup market, where individuals struggle on their own to obtain meaningful health insurance coverage at a reasonable cost and mostly fail to find it. But the employer market—where 160 million Americans obtain their health insurance—boasts plenty of problems as well. Most striking, of course, is the rapid escalation of premiums for employer-sponsored insurance, which have increased 119 percent since 1998.[1] In addition, nearly 9 million workers employed by larger employers (companies with 100 or more workers) were uninsured in 2007.[2]

The business characteristics of companies influence whether an employer offers coverage. Companies that employ a high proportion of low-wage workers, a high proportion of part-time workers, or a high proportion of younger workers are the least likely to offer health benefits.[3] Workers employed by large companies are most likely to be offered benefits, with 99 percent of companies with 200 or more workers offering health benefits. Yet even the employees of these larger companies cannot be certain they will be eligible for this coverage or that health coverage will be within their financial reach.

Even among these larger firms, for example, 21 percent of workers are not eligible for coverage. And regardless of company size, only 71 percent of employees who work for companies with many low-wage workers are eligible for coverage, compared to 81 percent of employees at companies with a low proportion of low-wage workers.

Large companies are less likely than small ones to require employees to pay a substantial portion of their health insurance premiums. But even among larger employers, 6 percent of them require employees to pay more than half the cost of a family premium.[4] And even if workers are eligible for and can afford the coverage their employer offers, they cannot be confident that this coverage will be good enough to pay for their health care needs. The Commonwealth Fund 2007 Biennial Health Insurance Survey, which examined the prevalence of underinsurance[a] among adults with health insurance, found that while adults with employer-sponsored health insurance are less likely to be underinsured than those who purchase coverage through the individual market, even employees in large companies experience underinsurance.[5]

Of course, employers—and large employers in particular—have also pioneered innovative approaches to health coverage and cost control. In a set of case studies examining employers' experiences offering health benefits, the Center for American Progress profiled two multinational employers' care coordination strategies and employee education efforts. One company worked with local providers to improve care for common conditions within their workforce and created employee education initiatives such as "welcome to health insurance" phone calls to educate employees about their benefits, appropriate use of the emergency room, and the importance of establishing a primary care provider.

The other company created a decision-support program for employees, which provided information on best practices, treatment options, and provider quality ratings for employees with particular diagnoses.[6] These initiatives—and similar efforts by other major employers—have reduced their health care spending and blazed the trail for delivery system improvements in the broader health care system.

Nevertheless, the escalating costs and coverage gaps in the employer market suggest that as we seek to provide all Americans with guaranteed, affordable health

insurance, we must find solutions for those with employer-sponsored coverage as well as the uninsured.

Principles for improving the employer market

With these market conditions in mind, Congress may wish to consider exactly how health reform addresses the gaps in the employer market so evident today. Guaranteeing adequate, affordable coverage for all Americans regardless of where they obtain their health insurance is a key component of health reform. Health care reforms that establish fundamental inequities between a national health insurance exchange and the employer-based health insurance market (the source of most Americans' health insurance today) will ultimately compromise our efforts to fix our broken health care system. Therefore, as Congress moves forward with reform legislation, I urge you to keep in mind three basic principles for improving the employer market:

First, make sure that American families can access health care whether they obtain their coverage inside or outside the exchange. Basic consumer protections should apply to all health insurance, whether the policy originates from the insurance exchange, an employer-purchased policy, or a self-insured employer plan.

Second, health coverage should be adequate and affordable inside and outside the exchange. Many employers who offer health coverage will be able to meet the benefit and affordability standards that apply within the exchange.

Third, consider additional options for vulnerable workers. All workers should have access to affordable coverage, but low-income workers should have additional avenues for enrolling in coverage that works best for them. By enabling these workers to obtain coverage through the exchange—even though they work for large employers who do not participate in the exchange—Congress can improve these workers' overall financial health and well-being.

Steps forward for the employer market

As Congress considers reforms to our nation's health insurance markets, it must consider changes that will help workers in large businesses acquire and maintain adequate, affordable health coverage. One option would be to enable all employers to purchase coverage through the exchange, including large employers. The principles behind the exchange—a healthy, competitive market that provides individuals with a range of easily comparable insurance options available without regard to health status or insurance history—would provide coverage guarantees that all workers should enjoy. Similarly, all workers can benefit from the opportunity to choose between private coverage and a public health insurance plan within the exchange, particularly because vigorous competition on price and quality across private and public plans should drive down costs.

Members of Congress, however, may decide that the risks of opening the exchange to all employers outweigh the benefits to workers—particularly the possibility that employers with older or sicker workforces may enter the exchange in large numbers, thus destabilizing rates during the start-up phase of the exchange. Instead, Congress may wish to consider improvements to the health insurance market outside of the exchange—improvements that can guarantee coverage and consumer protections for all workers with employer-sponsored health insurance.

There are many issues to consider here, but I will examine some improvements that should provide additional coverage guarantees for workers outside of a health insurance exchange, and then discuss other choices the committee may consider with respect to low-income workers.

First, to make sure that workers who obtain coverage outside of the exchange enjoy equivalent access to coverage and to health care, Congress may wish to consider coverage rules and insurance standards for all employers. Other witnesses will discuss problems with pre-existing condition exclusions and lifetime limits on health insurance coverage. Additional issues include other types of access protections, such as complaints and appeals processes, enrollment mechanisms, plan information requirements, other enrollee rights, and plans' responsibility to make data available for monitoring and oversight activities as well as research. By imposing equivalent requirements on plans that sell coverage within and outside of the exchange, as well as employers who self-insure, Congress can ensure that regardless of where Americans obtain their health insurance they can know their health benefits will be accessible and protected.

A second set of concerns relates to other issues at the heart of health care reform—whether coverage is adequate and affordable. It is likely that within the health insurance exchange, plans will offer policies designed around a standard benefit package. One of Congress's balancing acts will be to weigh the competing claims of adequate benefits and costs. Another challenge will be to ensure that health cov-

erage and health services are affordable for low- and middle-income families. Congress will need to determine income eligibility for government help with premiums and cost-sharing, and the size of these subsidies. For families who obtain coverage through the exchange, the questions facing Congress are straightforward even if the answers require a balance between ensuring access and controlling public costs. But the balancing act between good benefits, family affordability, and total costs is equally important in the employer market that remains outside of the exchange.

Any steps Congress may take to guarantee good coverage in this market will probably represent little or no change for many large employers, since these new requirements are likely to reflect many employers' current practices. For example, to ensure affordability, Congress may choose to require companies that offer coverage outside of the exchange to pay a minimum proportion of plan premiums. Similarly, to ensure that health benefits are adequate, Congress may choose to apply the same benefit standards to policies sold inside and outside of the exchange. Of course, if the final health reform package includes an individual requirement to carry health insurance, then this requirement will also interact with standards for employer-sponsored benefit packages. An individual coverage requirement would necessarily include a minimum benefit standard—and an expectation that workers could meet this requirement through the coverage offered by their employer. If Congress chooses to explicitly share responsibility for health coverage across individuals and employers, then it may be best to apply the same coverage standard to both parties—a standard that would also apply to coverage inside and outside the exchange.

Many large employers will be able to meet new affordability and coverage thresholds. But these steps will increase costs for the employers who offer substandard benefit packages today, and for employers who cover only a modest proportion of health insurance premiums themselves. A pay-or-play requirement raises similar concerns. Congress will therefore want to consider the tradeoffs involved and likely outcomes for these types of employers and their workers.

Employers who will experience new costs to reach coverage and affordability standards may drop coverage altogether unless they are required to maintain it. If they are mandated to maintain coverage, then they may cut wages or jobs to cover the cost, or they may directly pass increased benefit costs to workers while maintaining their current contribution levels. These possible employer reactions—wage and job losses or increased benefit costs for workers—would particularly hurt low-income or low-skilled workers. Of course, the availability of lower-cost coverage through the exchange—particularly with the additional competitive pressure of a public health insurance plan—should also slow the growth of health care costs for the entire system, thus reducing pressure on wages. But in the short term, more highly skilled workers may simply find new employment if their employer drops coverage or passes increased costs to their work force. Lower-skilled workers, on the other hand, would have less ability to evade these consequences and to obtain affordable coverage.

Congress may therefore want to establish good benefits and affordability standards for coverage outside the exchange while providing a safety net or escape valve to protect low-income workers. One option would be to enable workers to individually choose to enroll in exchange-based coverage. Employers could be required to pay into the exchange what they would have otherwise paid to cover the worker, and the worker would pay premiums to the exchange that would be reduced by the appropriate premium subsidy for their income level. Congress could limit this approach to those employees who would be better off with exchange-based coverage, largely because they would receive a premium subsidy through the exchange and therefore pay less for coverage in that market.

Conclusion

While problems in the nongroup market have garnered the lion's share of attention in the policy debate, Congress must also make choices to guarantee adequate, affordable coverage to Americans who work for large employers. However, the benefits of making these decisions are irrefutable. Reforming our nation's health care system is a challenging task but the results will be worth the effort—lower costs and better coverage.

Thank you for your commitment to providing affordable, high-quality health coverage for all Americans. I look forward to working with you to achieve this goal.

ENDNOTES

[a] This study classified individuals as "underinsured" if they experienced either out-of-pocket medical expenses that equaled or exceeded 10 percent of income, deductibles that equaled or exceeded 5 percent of income, or, if the respondent had income below 200 percent of the federal poverty level, out-of-pocket medical expenses that amounted to at least 5 percent of income.

[1] Kaiser Family Foundation, "Trends in Health Care Costs and Spending" (March 2009), available at *http://www.kff.org/insurance/upload/7692—02.pdf.*
[2] P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," EBRI Issue Brief No. 321, September 2008, available at *http://www.ebri.org/pdf/briefspdf/EBRI—IB—09a-2008.pdf.*
[3] Kaiser Family Foundation/Health Research Education Trust, "Employer Health Benefits 2008 Annual Survey," available at *http://ehbs.kff.org/pdf/7790.pdf.*
[4] Ibid.
[5] C. Schoen, S. Collins, J. Kriss and M. Doty, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Health Affairs 27 (4) (2008): w298-2309.
[6] M. Seshamani, "Opportunity Costs and Opportunities Lost: Businesses Speak Out About the US Health Care System" (Washington: Center for American Progress, April 2007), available at *http://www.americanprogress.org/issues/2007/04/pdf/health—business—case—study.pdf.*

Chairman ANDREWS. Thank you, Ms. Davenport.

And thank you, ladies and gentlemen. I appreciate very much your efforts.

I think what is most proper and impressive is that everyone here said what they are for. They advocated for a specific solution. And that is a big step forward in and of itself.

We have had 40 years of dialogue in American politics about what is wrong. I think it is very refreshing that people are taking the responsibility to say what they are for. And it is our job to try to reconcile those very divergent points of view.

We started the discussion with asking, how might costs be controlled so that coverage could be expanded. And we have heard a lot of different ideas. We have heard about increasing competitive options and competition. We have heard about employer cooperatives. We have heard about trying to root our fraud and conflict of interest from the system. We have heard about better education, lifestyle choices, chronic disease management. We have heard about excessive profits of the insurance industry and the paperwork burden on practitioners. We have heard about changes in the insurance laws that deal with pre-existing conditions and life-time policy caps, benefit caps and what not.

Some combination of those, I am certain, will reduce costs and therefore insure more people and therefore reduce costs.

But I am equally certain that the gap that exists between the income of most uninsured people and the price of an insurance policy will not get them covered even with each of those options having their most optimal impact.

And as some of us discussed at the White House meeting, this is where the rubber really meets the road, is paying for insurance for uninsured people.

And I wanted to walk through that with a number of witnesses.

And I would start with Ms. Trautwein.

Your group has played a very constructive role in this discussion. We appreciate that. And your testimony this morning had a lot of constructive ideas.

But I wanted to talk to you about the cost of insuring uninsured people. And I think you would agree that the vast majority of those uninsured people have very low incomes, correct? That they are people who are 200 percent of the poverty or below. They do not make much money.

Which, you know, is $40,000 for a family of four and under.

You have indicated this morning that you oppose a pay-or-play system and employer mandate. And you have stated your reasons.

You oppose the idea of limiting the tax exclusion or deductibility for the so-called higher-cost plans. And I understand your reasons.

What do you favor in raising the money to pay for the subsidies that you make reference to for uninsured people? You testified correctly that substantial subsidies are necessary to cover these men, women and children. How should be pay for it?

Ms. TRAUTWEIN. Well, that is a tough question because I think——

Chairman ANDREWS. Yes, it is.

Ms. TRAUTWEIN. That is why I was first. I think that—you know, we have been advocating for refundable tax credits and other subsidies for this very category of people for at least 12 years——

Chairman ANDREWS. Okay. I know that it is a good idea. How would you finance the tax credits?

Ms. TRAUTWEIN. I hope that we will be able to finance some of it through savings in the system. I think we are also going to have to look at other creative ways. One of them——

Chairman ANDREWS. I will tell you, Congressional Budget Office—and I think this is wise because it is conservative—gives us no credit for any projected future savings. So if we want to pass a law this year that covers the person who works in a convenience store or a gas station, and her children, the CBO will not give us a dollar's worth of credit for some savings we might get 10 years from now. So what are the other creative ways?

Ms. TRAUTWEIN. Well, we have talked and we have a proposal called Healthy Access. It is a proposal for health reform. And we have talked about the fact that it is difficult and that it is pretty fiscally irresponsible to advocate all these things without any way to pay for it.

Chairman ANDREWS. Right.

Ms. TRAUTWEIN. Acknowledging the difficulty, we have looked at things that—the sin-tax type of thing, such as, you know, a cigarette tax, a Twinkie tax. That kind of thing.

Chairman ANDREWS. I will grant that, of course, we raised the cigarette tax to pay for SCHIP expansion, and it was controversial. We did it. But I think we have kind of maxed that out for a while. What else?

Ms. TRAUTWEIN. So I am not sure that I have any more constructive—I wanted to talk about——

Chairman ANDREWS. The President—if I can? The President has two specific ideas. One is that the tax deductions for the top 5 percent would be repealed that are due to expire. He let them expire. Do you favor that?

Ms. TRAUTWEIN. Gee, I do not want to be one of these people who says we do not have a position on it, but, you know, I think we are going to have to look at creative things. That may be one of them.

Chairman ANDREWS. Okay.

Ms. TRAUTWEIN. You know, that may be one of them——

Chairman ANDREWS. Fair enough. Fair enough. So you——

Ms. TRAUTWEIN. I think we are also——

Chairman ANDREWS. Well, the other thing he has proposed is phasing out the subsidies to the insurance industries under the Medicare Advantage Program. Do you favor that?

Ms. TRAUTWEIN. Did you say to phase out the Medicare Advantage Program?

Chairman ANDREWS. Yes. The subsidies to the insurance industries in the Medicare Advantage, under Part D. Do you favor that?

Ms. TRAUTWEIN. Well, the feedback that I get from my members is that specifically certain types of Medicare Advantage Programs really help people who are low to middle-low-income. So I would be concerned if they all went away.

Chairman ANDREWS. Okay. Well, you know, and I say this in good spirit. One can be concerned about anything. But the main concern that we have is to cover 47 million uninsured people takes a lot of money. It probably takes between $150 and $200 billion a year.

The President has made two very specific proposals that would raise about 40 percent of that money. We either support them or you oppose them. I support his ideas. But those who do not support his ideas, I think, have the responsibility to either offer an alternative, as the Doctor has, or, you know—or understand that we are not going to get near universal coverage without that.

And, Mr. Langan, you have talked about the effects of employer mandates actually depopulating the number of people who are insured. Has that happened in Massachusetts under their employer mandate?

Mr. LANGAN. Mr. Chairman, not yet. But my reaction would be to stay tuned. I think there are stresses showing in the Massachusetts——

Chairman ANDREWS. Well, why would it have not happened yet?

Mr. LANGAN. Well, because it has been in place for a relatively short period of time. And also, I give credit to the authors of the program in Massachusetts, the multi-stakeholder effort that produced what is a—you know, an ingenious expansion of coverage. And I think employers recognize that.

As someone who works with employers now, day in and day out, who are complying or seeking to comply with the Massachusetts mandate, it has been an epiphany. I think the spirit of that reform was that the requirements on employers would be set so low that most large employers would be unaffected. And that has——

Chairman ANDREWS. Yes. And I do understand that it is a plan in flux.

I see my time has expired. I want to give our colleagues plenty of time.

Mr. Kline is recognized.

Mr. LANGAN. Thank you.

Mr. KLINE. Thanks, Mr. Chairman.

And thanks again to the witnesses. It is a fascinating and diverse group.

For Dr. Himmelstein, I was a little bit surprised at the report that people from Massachusetts were moving up to Canada for the medical care. In Minnesota, we see the trickle working the other way.

We are trying to explore ways to reduce the cost of health insurance for employers, employees and their families according to the title of this hearing. And it has been fascinating to hear your suggestions.

Let me turn to you, Ms. Trautwein. I understand the chairman's interest in finding out where you would source the money. But we are really not a sort of tax or budget committee. And we looked at the president's budget. He is paying for a lot of stuff with several trillions of dollars in debt. Maybe that is just the answer. I certainly hope not. But we seem to have lost our aversion to trillions of dollars of debt in sort of a striking way.

Ms. Trautwein, you noted that some states work voluntarily with employers to provide premium assistance subsidies for low-income persons purchasing private coverage. Can you just take some of the time to explain how those work? And would not that argue against the concept of an employer mandate?

Ms. TRAUTWEIN. Yes, there is actually—I will point out two of them. But there are a dozen—about a dozen of them that are really good.

One of them is in Oregon. It is the Family Health Insurance Assistance Program. It has been around for many years. It is not a real overly bureaucratic system. It is simple subsidies to both employer-sponsored coverage for people who are low income, who cannot pay their share of the premiums there, as well as people that are individual plans. And it has been quite successful—helps people getting coverage many times over the years. And it is run by just a couple of people in the Oregon government. So it is not heavily bureaucratic. It is very simply run.

The other one that is newer is very, very interesting, in Oklahoma. And it has actually increased its enrollment 200 percent in 2008. And it is what you call one of the three-share programs, so the employee puts in part of the money. The employer puts in part. And then there is a fund in the state that funds the rest. And it is working very well. There is a good shared partnership, shared responsibility there. I think it is a great idea, and I think it could be replicated in other states if we had some encouragement for them to do so.

Again, these programs just do not always have enough funding. But they have been able to figure out how to do some waivers and other things to keep that funding going.

Mr. KLINE. Thank you.

Mr. Langan, I started this hearing talking about my concerns with unraveling ERISA. We may be looking at an entirely different paradigm. Dr. Himmelstein has a single-payer national health plan, for example. We are going to look at some paradigms.

But I want to get to the issue of unraveling or weakening ERISA. And employer mandates—and we heard Mr. Pollack talking about some of those—it seems to me are part of that issue when you start to go and take away little pieces.

These employer mandates, regardless of how they are structured, would that help or hurt employers' ability to provide the very insurance that we are talking about?

Mr. LANGAN. I think that has a great deal to do with the structure of those requirements. I think one of the tremendous strengths of the current voluntary employer-based system is that it has enabled employers to offer uniform coverage across state lines and enjoy the efficiencies of doing so. If we move in the direction of multiple regional or now even municipal employer mandates for

health coverage—you have not seen administrative costs until employers have to start to comply with the 50 or maybe 100 different regulators in terms of the requirements applicable to their health plans. So I think the structure of requirements are critical.

ERISA's ability to establish a standard and give employers the ability to maintain a single, consistent plan across state lines is one of its essential strengths.

Mandates, in and of themselves, add expense. There is no denying that. The health care reformers in Massachusetts have indicated that mandates add about 12 percent to the costs of an employer plan on average. So it has an added expense. But it would be exacerbated by multiple mandates which are characteristic of some reform programs.

Mr. KLINE. I see my time is expired.

I yield back, Mr. Chairman.

Chairman ANDREWS. Thank you, Mr. Kline.

The gentleman from Illinois, Mr. Hare is recognized.

Mr. HARE. Thank you, Mr. Chairman.

Mr. Pollack, one of my biggest concerns is improving, you know, portability for people who lose their jobs. And let me put a human face on this and then ask you a question.

I had a couple whose—the father worked at Butler Manufacturing in Galesburg, Illinois, had enough time. The son also worked there. The father, after Butler shut down, went over seas, had to spend two-thirds of his pension to continue his health care. The son did not have any because he did not have enough time in. So he went to work part time, had some heart problems, did not go because he did not have any insurance. They found him in the shower, dead of a heart attack.

I can remember to this day when the press was asking his—the parents of this young man, they said, you know, "Are you upset with God that He took your son?" And he said, "God did not take my son. The government did because they did not have the courage to make health insurance portable for people like my son."

By the way, this man's wife went to the hospital to see her son when they brought him in. And she had a heart attack upon viewing her son. And now he is working for eight bucks an hour at repairing lawn mower engines at a hardware store.

We could do a lot better than this. I think this is shameful.

You know, I thoroughly support what Dr. Himmelstein is proposing here.

But what I am trying to figure out is what do you think we can do to allow portability for people, who lose their jobs through no fault of their own, to be able to have health care that can follow them to a job that they are going to?

Mr. POLLACK. Well, thank you for your question. I think there are a couple of different responses. Obviously, the situation that exists today, when people lose their job, often the first thing they look to is can they secure COBRA coverage. And, of course, COBRA coverage is not an adequate means to this.

We released a report not too long ago that looked at what the average COBRA premiums are compared to the average unemployment insurance benefits. And if you look at the average COBRA premiums compared to average unemployment insurance benefits,

it consumes about 85 percent of those unemployment insurance benefits.

Now, I think the Congress did a good thing with the president in providing subsidies for people. But it is only a temporary solution, obviously.

I think having a system like a connector, like an exchange, where people can select coverage, and that coverage they can stay with, irrespective with what job they are in, could work. But obviously, what needs to go with that is for low-income people—we have heard several people on this panel talk about it. There have to be adequate subsidies for people so that those people who cannot afford coverage get some help with that.

The average premiums today for employer-sponsored insurance for family coverage is about $13,000 a year. And that is simply unaffordable, particularly for a worker whose family is in moderate income.

So I think coupling a system like an exchange or connector, including significant sliding-scale subsidies, would be very helpful.

Mr. HARE. Mr. Oemichen, I have a lot of rural area in my district, a lot of farmers, a lot of small business. How can the employee benefit cooperative, a concept that you talked about in your testimony, you know, help the—like self-employed farmer in—that give them the opportunity? Because they are spending thousands of dollars on equipment, thousands of dollars on fertilizer and they are—they do not have the money?

Mr. OEMICHEN. Mr. Chairman, Congressman Hare, let me just tell a quick story. In Wisconsin, we were seeing an exit of three dairy farmers a day from the dairy industry. We asked them why they were leaving the dairy industry, and they said because it was principally the failure to be able to get access to affordable, quality health insurance. It was not dairy prices. It was health insurance.

We asked 4,000 Minnesota farmers exactly the same question, and they told us exactly the same answer.

So we decided, well, it—from the cooperative model, we have always banded people together when there has been a need. So we asked the farmers, "Do you want to own a health insurance cooperative?" And fortunately, the response was very, very overwhelming. They said, "You work to help us find an insurance company that will provide us insurance." In this case it is Aetna. And we were able to contract with Aetna for a cooperative that is totally owned, totally led by the farmers in the state of Wisconsin. And we can do the same thing in the state of Illinois.

We would appreciate some thought to federal legislation much along the lines of what we are talking about to give us the ability to go across state borders. Because the primary difficulty we have had is trying to take a model that we developed in Wisconsin and bring it back to my home state of Minnesota, because there are different insurance regulations, different mandates.

And then to the state of Illinois, I will tell you that we have almost one-third of the state's dairy industry now in the cooperative model. I have received many calls from farmers saying, "Now my spouse can work back on the farm and contribute to the farm because we can have insurance."

And almost 80 percent of their benefits have gone up under our farm plan. And up to 50 percent have said their actual costs have gone down. And so we think that we have really contributed hopefully to the future success of the Wisconsin dairy industry, and hopefully agriculture, across the United States.

We have also applied this in the small-business context. And I will be really short here. We never had dreamed and, excuse me, Doctor, that physicians had their own problems in accessing health care. [Laughter.]

We have now formed two health care cooperatives for physicians in the state of Wisconsin.

Mr. HARE. Well, my time is up. But if you would not mind getting maybe hold of me or my office, I would love to talk you about this for Illinois and my district.

Mr. POLLACK. I would be happy to do that.

Mr. HARE. Thank you.

Chairman ANDREWS. We just wish you were a little more enthusiastic about your program there. [Laughter.]

Mr. POLLACK. Sorry, Mr. Chairman.

Chairman ANDREWS. Thank you very much.

Thank you, Phil.

The gentleman who is a member of the full committee, who is absolutely welcome here in the Subcommittee, the gentleman from Louisiana, Dr. Cassidy is recognized for 5 minutes.

Dr. CASSIDY. Thank you, Chairman Andrews. I enjoyed being here. You said earlier that it is wise because it is conservative. I think we are kindred spirits.

Ms. Davenport, Ivan Seidenberg, the chair and CEO of Verizon, but also the chair of the Business Roundtable and Health and Retirement Task Force—he gave a great presentation to us. And he said that he did not want a single-payer plan even though the Business Roundtable really wants something done, because he has never seen government hold individuals accountable for their own health, whereas, at least in the business-sponsored programs, they can do wellness.

And you mentioned yourself how they have put in innovative programs that have lowered their costs. I would just like your thoughts on that.

Ms. DAVENPORT. Well, the Center for American Progress, a couple of years ago, did a series of case studies around businesses and their experiences offering health insurance. One of the things that we profiled were some of the wellness initiatives and other efforts that a couple of the large multi-national companies in United States have offered. And they included working with local providers to improve care for some conditions that are common among their employees, offering sort of a welcome-to-health-insurance phone call to help people to understand the importance of finding a primary care provider, and things like that.

What was interesting was—is, first, the kind of innovations that they used and the results that they had. But, second, that while they were able to find savings and to improve health care through those innovations, that, to a large extent, they were still price takers in terms of health insurance. That was more true in our case studies——

Dr. CASSIDY. Price takers means what? I am sorry.

Ms. DAVENPORT. Means that they had relatively limited ability to negotiate with health insurance plans. So two companies chose to self insure. What we saw with other companies in the case studies that they did was that they really had to take whatever price was offered to them by the health insurance companies. They had to——

Dr. CASSIDY. So you do find that there is a benefit to these companies—they do have this innovation. They do put in successful programs but they are limited by other factors.

Ms. DAVENPORT. That is right.

Dr. CASSIDY. Yes, Dr. Himmelstein, I am actually not nearly as nihilistic as you regarding prevention. I will say this because obesity is killing our nation. And unless we—I saw a Health Affairs article which said that the amount of obesity in our nation is driving the tech boom, that is driving up the cost and, according to this article, could almost completely account for the difference in health care costs between the United States and Europe, if you normalize for obesity.

Now, if we take what Ms. Davenport just said, that the private sector has been more innovative in terms of wellness programs, I actually am a little nihilistic—I am nihilistic that the public plan would have that same sort of accountability built into it that would help address, for example, obesity.

Dr. HIMMELSTEIN. So there is that faulty study that you quote from Health Affairs. There is a much more carefully done study that actually shows that obesity saves us money in the health care system over the long term because it kills people early and we do not have to pay for their costs over the long term.

Dr. CASSIDY. Well, actually, I would be interested in seeing that article. I am a little surprised by that.

Dr. HIMMELSTEIN. I would be happy to provide it for you.

Dr. CASSIDY. May I finish? Because I have limited time. Because if nothing else, dialysis, if look at Cooper's analysis of Dartmouth Atlas—and I truly think that in his analysis, that if you look at dialysis costs, diabetes, hypertension, coronary artery disease, et cetera, which is directly deliberate—in fact, Homer Simpson sprinkles are driving up the health care costs for the rest of us because he has obesity, has that little tire around his waste. [Laughter.]

So the problem with obesity-related health conditions is they are chronic, unlike cigarette smoking, which kills you like that.

Dr. HIMMELSTEIN. I mean, these are very attractive notions, but if you actually look at the medical literature—and this was summarized in The New England Journal last year—the overwhelming majority of preventive measures increase costs. They do not decrease. There were a few——

Dr. CASSIDY. But I am speaking specifically of obesity, because actually I think obesity may be related to things such as fructose, the lack of a walking environment in cities, et cetera, et cetera.

Dr. HIMMELSTEIN. And those are clearly things we ought to be doing. And the pay off may be 50 years from now. But if we are talking about the next 5 years——

Dr. CASSIDY. But actually, if you look at the G.M. data, the G.M. data shows that for every decrease in BMI, that their cost per em-

ployee significantly decreases. And even if you put a cofactor, such as hypertension, if you lower their weight, their cost decreases, from G.M.

Dr. HIMMELSTEIN. But if you look at Frank Sacks' recent article, in The New England Journal, comparing a variety of approaches to obesity, none of them have shown durable——

Dr. CASSIDY. Oh, now, I am not speaking about the treatment of obesity. That is a whole different piece of legislation. I am talking about the potential cost savings related to that.

I think I have lost my time. I am sorry.

Dr. HIMMELSTEIN. The question is can you actually do it? And just to answer the second part of your question, holding individuals accountable, yes, I think we have the ultimate accountability. And that is we have the death sentence for these people. Smoking, obesity, all of those things carry the death sentence. And when you——

Dr. CASSIDY. But besides, particularly the single-payer plan——

Dr. HIMMELSTEIN [continuing]. Applying for that——

Dr. CASSIDY [continuing]. Pre-mortum care.

Dr. HIMMELSTEIN [continuing]. Is a way to make people actually decrease costs. I——

Dr. CASSIDY. Thank you.

Chairman ANDREWS. Thank you. The gentleman's time has expired.

We have made history today that I have to note now, this is the first congressional hearing that ever cited Fredrick Nietzsche, the great nihilist. [Laughter.]

And Homer Simpson. I think the two of them being lumped together is truly an historic occasion. [Laughter.]

I am happy to call upon some of the more main stream cultural view, the gentleman from Connecticut——

[Laughter.]

Mr. COURTNEY.

Mr. COURTNEY. From boring old Connecticut.

Thank you, Mr. Chairman, and thank you for this hearing. This is, I think, an historic moment really sort of kicking off the dialogue and effort that this country is about to embark on to really rise to a generational challenge and fix our health care system.

And all the testimony and witnesses have been just terrific this morning.

I want to focus on the issue of pre-existing condition exclusion, which Mr. Pollack referenced in his testimony. We have a bill before us, 1588, which basically would abolish pre-existing conditions across the board.

And our research for this legislation which determined that 45 percent of Americans have a chronic condition of one form or another. Twenty-six million Americans are enrolled in the individual market where there is basically no protection to speak of in terms of the really just harsh discrimination that is applied towards individuals. Obviously, this is an important issue for our committee because it goes right to the heart of our ERISA cognizance.

And one of things that has happened since this bill has been filed has been really a gusher of outpouring from particularly provider groups, who have to deal with this issue on a day-in and day-out

basis. The American Heart Association submitted a letter this morning.

But that the one that really took my breath away was the National Association of Obstetricians and Gynecologists who talked about the fact that in many instances, a women, who has had a past caesarian delivery, is treated as someone with a pre-existing condition, although the likelihood of that resulting in any chronic costs is almost zero, as my wife would attest.

And domestic violence victims are also sometimes subject to pre-existing condition exclusions. It is barbaric. I mean, there is really no other way to describe the way that this operates.

And, Mr. Pollack, just, again, to walk through the state of the law right now, because HIPAA, in 1996, made a partial effort to address this issue. Some people feel that the group market is basically sort of, you know, solved the problem. But in fact, there really were gaps left in the group market as far as individuals being still subjected to it. And again, particularly with life-threatening chronic conditions, it sometimes can be just devastating.

Again, I just wonder if you could reiterate again the fact that we do need to address that end of the market.

Mr. POLLACK. Well, there is no question that HIPAA left a lot of gaps. And, you know, it did provide guaranteed issue for those people with continuous coverage. Of course, it did not do anything about regulating premiums. And so you can be given the benefit of guaranteed issue, but if, then, you are charged an arm and a leg because you have got a pre-existing condition, that is not going to make coverage really truly available for you.

I mean, we can actually go over the litany, by the way, of what constitutes a pre-existing condition. We came across a pre-existing condition exclusion because somebody was too short. I mean, we really can give you a number of examples that take this to the point of ludicrousness.

So I think in terms of HIPAA, obviously, we have got to do something to make sure that when somebody is guaranteed that it can be issued to them, it is issued at an affordable price and there needs to be some regulation of underwriting.

In addition to that, as I mentioned, and that it is very important with your legislation, is that you can provide essentially underwriting for an entire company, if that company has got a significant number of people, or even perhaps if it is a small company, even one individual who has got a major health condition. And even though employers are not supposed to check with their prospective employees what kind of health conditions they have, obviously it is going to make them very conscious of this. So this is something that clearly needs to be corrected.

Mr. COURTNEY. Right. And when HIPAA passed—I mean, when the—obviously, the huge question was there before, what about the self employed and the individuals who really have virtually have no protection.

You know, the answer back then was, well, we will have high-risk pools that will be out there at the state level to sort of pick up people who, again, have these conditions.

Mr. Vaughan, I do not know if your organization has had much experience, but I suspect you might have in terms of what the—how those have operated.

Mr. VAUGHAN. We have not done a comprehensive study, but they do not work. The rates get very high, very fast. And they cover very, very few people. And we need a national solution. It just is not working.

Mr. POLLACK. You know, high risk pools really have not worked. They are just—as Bill just indicated, there is a very, very tiny portion of the population are in the high-risk pools. They are often tremendously underfunded. A lot of people, who might think qualify for a high-risk pool, never get in. They are on a waiting list. And these high-risk pools do not do much in terms of dealing with getting the premiums down. And so those two are underwritten in such a way that the costs are, for too many people, unaffordable.

Mr. COURTNEY. Thank you, Mr. Chairman.

Chairman ANDREWS. The gentleman's time has expired.

We very much appreciate the gentleman's leadership work on pre-existing condition issues since the day he first got here to the Congress.

We are pleased to recognize the gentleman from California, Mr. Hunter.

Mr. HUNTER. Thank you, Mr. Chairman.

Thank you, panel, for being here.

And since I am not overly burdened by knowledge on this subject, neither Nietzsche, nor Homer Simpson, I am going to yield to one of the doctors here, my good colleague, Mr. Roe.

We are surrounded by doctors, so we figure we will give them a chance to talk here. So I yield my time to Mr. Roe, Mr. Chairman.

Chairman ANDREWS. The gentleman is recognized.

Dr. ROE. Thank you, Mr. Chairman.

And Mr. Chairman, thank you for having this hearing.

You made a statement a moment ago that—about how to pay for this. It is not going to be less expensive to insure and pay for 47 million more people. I think there are some savings out there. But it is going to cost more money, I think.

And let me just share with you, and I would like to make part of the record, a statement, if I could, later.

Chairman ANDREWS. Without objection.

[The information follows:]

Prepared Statement of Hon. David P. Roe, a Representative in Congress From the State of Tennessee

As a physician from Tennessee who has delivered babies for over 30 years, I have seen our health care system change dramatically. Some people said I must have gone off off my meds when I decided to run for Congress, but having extensive experience as a physician enables me to lend my experience to the debate over health reform in Washington.

I was part of a medical group with 70 physicians and 350 staff, and we've lived through many attempts at reform at the national and at the state level. Some may recall that in the early 1990s, managed care was pitched to physicians and the public as the cure for an ailing health care system, but all it managed to do was move revenue from providers and patients to insurance companies and third party payers and not decrease costs as advertised. It serves as a cautionary tale for anyone who would believe that there's a silver bullet out there for what ails our system today.

In medicine, there's no such thing as a Republican disease or a Democratic disease—there's just disease; likewise, good ideas on health care reform shouldn't be

defined by a party, but by meeting a series of principles for reform. Since arriving in Washington, I've listened to people from all sides of the political spectrum and have developed a few principles that I believe health care reform must encompass:

1. Above All, Do No Harm

A doctor's Hippocratic Oath should be applied to any reform considered. While many have focused on what's wrong with the current system, there's still a lot that is right. 85 percent of Americans today have health insurance and for the vast majority of them, the system works. They go in and see their doctor, who in turn diagnoses them and sends them home with a prescription or remedy that addresses the problem. When Washington tries to "fix" our health care system for one person, I want to make sure the result isn't a downgrade of care for three others.

2. Doctors and patients should make medical decisions

I prefer a system with private health insurers who ultimately do a better job of putting decision-making authority in doctors' and patients' hands. The problem with publicly-operated health insurance (the new way of saying government-run health care) is that care must be rationed to meet the budget. Consider that here in America, the five-year survival rate for breast cancer has increased from 50 percent to 98 percent, largely because of education, early diagnosis and sophisticated medical treatment. But in England, which has a national health system, they're no longer covering mammograms because too many false positives resulted in more costly biopsies being performed. While it's less costly to wait for a lump to develop, no American in their right mind would think this is a reasonable approach to providing care. But these are the choices that have to be made in a public health plan funded with taxpayer dollars.

3. Every American should have access to health insurance

We should be able to agree that every American should have access to a basic benefits package that makes sure they are covered when they go to the doctors' office or hospital. This isn't Rolls Royce coverage that includes cosmetic surgery, hair transplants or fertility treatments, but basic benefits.

4. Health care costs shouldn't bankrupt you

Basic catastrophic coverage will prevent many individuals from being wiped out when they get cancer or a life-threatening illness. We had a good start when we coupled health savings accounts with high-deductible health plans. I'd like to see more done to move plans in this direction. I recently was helping a woman who worked in a local nursing home who was without health insurance and discovered she had lymphoma. What little money she had been able to save would soon be gone and then some to pay for her treatment—a low-cost catastrophic policy would prevent this from happening

5. Health coverage should be portable

Individuals who get sick often feel trapped in their current job because if they chose to leave their job, their health insurance would be terminated, along with their protection against pre-existing conditions. We need some changes to how individuals purchase their insurance so that if your job ends—by choice or by layoff—you won't find yourself without the ability to afford treatment.

6. To lower costs, everyone should have "skin in the game"

Study after study proves that when care is free, it is overutilized. In Tennessee under TennCARE (our state's Medicaid plan), we saw first-hand that when patients got a cold, instead of simply going to the local drugstore and buying some cold medicine, they went to the doctor for a prescription so the cold medicine was free. Some argue that this is illogical or an anomaly, but the fact is, it's a logical, rational decision—they saved money by going to the doctor and getting a prescription.

Everyone has a lot at stake in this debate, and there are many good ideas that deserve debate and a thoughtful vetting. I am hopeful if we come together to agree on a framework like what I've described, reform is possible. Then it will be incumbent on all of us to commit to getting it done—not fast, but right. Too much is at stake to fail.

Dr. ROE. Thank you.

I think there are some basic principles in health care that we would like to agree on. One is that we would like to see that every American have access to affordable health care. I think there is no

question every body on this panel, even though you may see it in a different way, want that outcome. I certainly do.

Number two, you should not be bankrupted by an illness. And I see this many times. If you develop a very expensive cancer or whatever, you do not want to be bankrupted.

And I think it should be portable. We have mentioned that. You should not have to be Bill Gates to pay for the COBRA coverage, as Mr. Pollack pointed out.

And everyone should have an—some investment in the—in their health care, be it a health savings account or some amount of money you have to pay.

And I live in Tennessee—is where I am from. And we tried an experiment called TennCare—it is still going on—about 15 or 16 years ago. And I went to the local hospital administrators before I came here and I said, "What costs, what percent of costs did TennCare pay of your costs?" And it is about 60 percent. Medicare pays about 90 percent.

And then you have the uninsured. And then you have the privately insured, as I have. And I personally used the health savings account because I do believe that prevention works and saves money.

Bottom line is, as those cost shifts are done, employers in Tennessee made a perfectly logical decision. They dropped their private health insurance. 45 percent of the people that went on TennCare when it first came into being had private health insurance when they started. But it cost less money, so they have dropped that business cost, driving the cost of private insurance, just one more cost-driver, higher.

And what I predict what will happen here in the federal system, depending on how it is structured, is that very thing will happen again. You will have a situation where you have this cooperative or health plan and business will, again, make perfectly logical choices. They will drop that and drop—and I would think General Motors and Chrysler, it is the first thing they did, would be to use this publicly subsidized plan. From where the money is coming from, I do not know.

What happens and what ultimately happens for the—for me, the patient, or the doctor, you have to understand, if you budget a certain amount of money, invariably waits are going to happen. It is going—it is invariable. It is going to happen.

An example is this. In England, they used to do screening mammograms for all women. When I started my medical practice, the 5-year survival rate of breast cancer was 50 percent. Today, for a woman, it is 98 percent. That is a tremendous success that we have had in this country.

In England, during the time that they were doing screening mammograms, it was 78 percent. And what has happened over there is the biopsies actually cost more money than the screening mammograms did. So they dropped doing screening mammography.

And as Dr. Himmelstein knows, it takes about two centimeters, three-quarters of an inch to feel a mass, at which time a certain percentage of those have already metastasized. So that is going to cost life.

We are not going to do that in this country. I cannot, for 1 second, believe that we are going to do that.

I am not sure who said it. We have a plan in Tennessee now. It is called Cover Tennessee. It is not—you cannot buy but so much care for $1,800 a year, but a similar situation to what Oklahoma has. We have had ours about 3 or 4 years, where the employee puts $50 in a month, the employer puts $50 and the state puts $50 a month to buy health basic coverage.

Another comment I want to make is about the cooperatives. I think is a tremendous idea, where you bring various interests together, pool those interests, and then they are able to purchase health insurance.

There are going to be unintended consequences of any proposal that we do. And what I do not want to do is to push in a system where the government—I say this laughingly, but it is also seriously—if you like the way the government has managed AIG, you are going to love the way they manage your health care.

And I would like to just comment about the cooperatives and how you see that helping the uninsured right now.

Chairman ANDREWS. We would just ask if you would briefly respond because the gentleman's time has expired, if you would answer the question.

Mr. OEMICHEN. I will. I will not be quite so enthusiastic this time. [Laughter.]

We have started——

Chairman ANDREWS. Please do. Please do.

Mr. OEMICHEN. We have 15 cooperatives underway in the state of Wisconsin, and they run across the whole range of small employer groups, whether it is agriculture or all the way up to physicians.

And we think it is a very good model because it brings people together. They have bigger—better bargaining power to then contract with insurance companies. And we have gone to full insured modeling in the state of Wisconsin.

Dr. ROE. Thank you.

Chairman ANDREWS. Thank you, Doctor.

The gentleman from Oregon has been interested working very quietly, but effectively on the issue of making health care more productive through technology for many years. And I am sure it must be satisfying for him to see that debate coming front and center.

It is my pleasure to recognize the gentleman from Oregon, Mr. Wu.

Mr. WU. Thank you very much, Mr. Chairman. And I would very much like to get to those technologic issues, if I get another bite at the apple.

I think the Chairman has very appropriately raised some issues of reality that we must face, fiscal reality. There are fiscal realities. There are policy and health care realities. And then there are sort of those special realities of perception that we deal with in this chamber and in this—and in this town, and one of those is my impression about health care as provided by employer-based plans.

To the extent that you all know—and I will not restrict you to a yes or no, but if you could, try to stay as close as possible to yes or no, I do not know, or a couple-of-sentence explanation of the

data on which you base your answer. For 150 to 180 million people, who receive their health care through employer-based insurance plans, do these folks, by and large, like the health care or the health care insurance that they have?

And I will just go across the board from Mr. Pollack across.

Mr. POLLACK. I would say most do.

Mr. LANGAN. I would say a resounding, overwhelming yes. And we can provide the data that corresponds with that.

Mr. VAUGHAN. I am in between the two. Most do.

Ms. TRAUTWEIN. Yes, I do.

Mr. OEMICHEN. Most do, and anecdotally, yes.

Dr. HIMMELSTEIN. Surveys show they are much less satisfied than Medicare patients. But also they are happy generally until they get sick. And then they discover their insurance actually does not work. So Mr. Pollack says it is guaranteed coverage. It is guaranteed until you are too sick to work. And then you lose your coverage from your employer. That is what we found when we studied the medically bankrupt.

Mr. WU. Thank you.

Ms. DAVENPORT. I think most do.

Mr. WU. Okay.

And I am just drawing the conclusion from that, that it would be relatively difficult to reform health care in a way which would be perceived as taking those health plans away.

And Ms. Davenport, I would like to get to one part of your testimony—I believe it is on page 6—about Congress may wish to consider coverage rules and insurance standards for all employers. And elsewhere in your written testimony, you addressed standards for exchange programs.

And in reading that over and thinking about it, would that preclude, say, a young person's approach of either that person or a company, an employer, taking a catastrophic insurance-only approach, making a cost-benefit analysis that I am healthy, and I am just going to get minimal coverage. Would rules preclude that?

Ms. DAVENPORT. Well, I think it depends on what kind of rules end up being implemented. If the goal is to make sure that everybody has comprehensive coverage, then I think that, by definition, would preclude catastrophic-only coverage, which we have—somebody with a severe health condition or unexpected health condition paying large out-of-pocket costs. But I think it will depend on what ends up being the standard for coverage.

Mr. WU. Okay.

And, Mr. Langan, I know that you probably have some views on uniform national rules. And I would like to ask you to respond to that in writing, because I want to take my last minute to express a concern of mine.

I think that it is a worthwhile goal to have broadly defined benefits. But I do remember a time, not very long ago, when I was sitting in this committee's room, when we were in the minority, and there was a president of the other party in office. And Oregon had a broader set of state requirements about benefits. And I paid a great price for fighting association health plans substantially because they overrode Oregon law about benefits. And I am at least

a little bit concerned that we may override state law or other rules now.

And it is inevitable—I hope it is not in my lifetime—that the other party will come back into control, and I am just concerned that the shoe may be on the other foot at that time, and we would be less able to resist rollback benefits for individuals on a state-by-state basis.

And with that, I yield back.

And thank you, Mr. Chairman.

Chairman ANDREWS. I think the gentleman.

The chair is pleased to recognize Dr. Roe.

Dr. ROE. Thank you.

Chairman ANDREWS. The gentleman from Tennessee.

Dr. ROE. I do hope the gentleman is still young when the other party takes back control, too, like he his now. [Laughter.]

Chairman ANDREWS. I hope he lives to be 125, Doctor. [Laughter.]

Dr. ROE. One of the nice advantages of being an obstetrician is that you get to deliver a lot of your voters. So I have an advantage on a lot of people who run. [Laughter.]

This is an extremely complicated issue. And I would love to spend the rest of the day discussing the various options because you all bring a lot to the table, every single one of you do. And this is not going to be easy to figure out.

One of the things I think that you have to do is that you have to have ownership in your health care plan. And let me just explain to you that I saw people in my own practice who were on the state plan, who had come to me for maybe a bad cold. And again, this is a perfectly logical decision, because if you go to the local pharmacy or CVS or whatever, it is going to cost you $10 or $15 to buy those cold medicines if you have just a bad cold. Whereas, if you have a private insurance plan that has a fairly good $20, $40, $50 deductible, you will not do that. You will make the decision it is cheaper to go to the pharmacy. And this is a perfectly logical decision.

We saw over utilization of those services in Tennessee. That is one of the problems that we have.

And I just want to here, maybe, whoever can comment about this. Also, in the private health insurance, we have the same thing. The busiest month I had of the year was always December. And the reason is because you have met your deductible.

And what we have got—and I liken this to if I had car-buying insurance, and I have a $25,000 deductible, I am driving a Ferrari. I am not going to be driving a Honda or a Ford or a G.M.

So how do you align those incentives? I think a single system only puts you in—gives one option, whereas the private insurers with the various options—I can choose to have a health savings account because I live a—hopefully a healthy lifestyle and so forth, and I can save my own money because I have got skin in the game.

Comments?

Mr. LANGAN. Doctor, I think a private employer, particularly large employer-sponsored plans, provide ample evidence of what really happens there that demonstrates the innovation and the cre-

ativity, the role that employers bring to the health care system currently.

These 99 percent of employers, who are providing coverage to their employees, over 200 lives, do not provide a static plan that goes unchanged year to year. The plans evolve. The employer's strategy evolves. The employer is weighing the needs of employees, who the employer has to face everyday, and who need to be healthy and productive people and happy workers, with the resources that are available.

And the programs that employers innovate, such as increase in personal responsibility, account-based health plans, the transparency that our employers are trying to bring to the health care market so that the $200 charge that Mr. Vaughan illustrated earlier that an employer might have for a service, is often unknown to the patient before the service is rendered. And so, large employers, at least, and many employers are trying to move towards systems that will bring that transparency into play. But that requires data. It requires electronic enhancement of the system.

But I think employers are on the cutting edge of those innovations, some of which migrate, we hope, to the public programs Medicare and Medicaid.

Dr. ROE. Well, just a quick comment on Medicare. Years ago, we did a particular test at our office. It cost—we negotiated the price with the pathologist for Medicare patients for $10. And we could not do that because Medicare paid $15 and we could not bring a lower cost. And so it cost our patients, just in one practice, an extra $50,000 a year because of the lack of this.

I would like to have a comment in my brief time left on pay-or-play. I wanted to learn more about that and what your comments on. Whoever in the panel can pick that up?

Mr. LANGAN. I think pay-or-play is often perceived as a somewhat benign health care reform proposition. I think the concern that the employers, at least those I work with every day, have about it is that it will begin a process. The ranking member mentioned the pulling the thread out of the garment earlier. It will begin a process in which the public option, the pay option that employers might have, will eventually eat up the rest of the system.

It will not necessarily happen tomorrow. But it will begin a process that will begin to erode this record of success in covering 170-plus million people through the dynamic private-employer system. And it would happen through the need for a the public program that was—needs—perhaps a company pay-or-play to set rates that will exacerbate the cost shifting that goes on between private plans and public options.

Employers on the margins would eventually fall into the pay column, it is feared, and the dynamic environment in which large employers provide this coverage to 99 percent of employees above 200 lives would start to come apart.

Dr. ROE. Yes, Mr. Pollack?

Mr. POLLACK. Yes, you know, every time we have this conversation, this issue turns out, you know, what is the new burden we are going to be creating for those businesses that do not provide coverage.

Let's think for a moment about the burden of businesses that do provide coverage and the inequity that is established.

You know, we are going to be releasing next month updates of numbers that we published in 2005 that looked at what are the added premiums that are borne by those who pay for health coverage, whether it is employers or individuals, to pay for the uncompensated health care costs of the uninsured. In 2005, for family coverage, it was $922. It is higher today.

And so, what happens is, for those employers that are providing coverage, they are not just providing coverage for their workers, they are actually paying for the costs of their competitors, who are not providing coverage.

And so, I think we have to think about this in a more equitable manner. And how that gets structured, you know, can be debated. And whether it is pay-or-play or whether it is some kind of a mandate, whether there is some contribution to pay for the costs that are going to be needed to subsidize benefits. You need to have something like that if you want to create equity in the system.

And one last point. A lot was made about this public program option creating an unlevel playing field, which was actually kind of strange criticism because the unlevel playing field in Medicare today is actually tilted towards the private companies in Medicare Advantage than it is in terms of public coverage.

But you can separate the role of a competitor and rule makers. And I think you can create a level playing field that would enable a true competition to take place that would hopefully generate savings.

Chairman ANDREWS. The gentleman's time has expired.

Dr. ROE. Thank you, Mr. Chairman.

Chairman ANDREWS. We appreciate his knowledge.

The gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you very much.

You know, look, I heard one of my colleagues indicate that he thought it would be difficult to address taking away health plans that people currently have. And I think that is probably an inappropriate way to discuss this. We are not talking about taking away people's health care. It ought to be phrased, well, us making sure that they have health care that continues to be available to them.

And I think today's current economy is showing us that having an employer that gives you a health plan does not ensure that you are going to have health coverage once you lose your job. And in large numbers, that shifts the burden, who is paying for health care significantly.

So as long as we are going to keep trying to talk about it with those words of taking away somebody's health plan, then I think we are going to have a result that is preconceived and not necessarily the good one.

You know, we are not selling widgets here. I think everybody on the panel understands that. You know, there is a whole difference between health care and widgets. You know, not everybody needs a widget. And not everybody needs to be able to afford it or have access to a widget. But health care is different. And I think the

1,800-pound gorilla in this room has been unspoken. It is insurance companies.

You know, if we really want to do something, we can talk about coverage, we can talk about quality, and most of the reforms that I have seen proposed do not really save us much in terms of money.

The 2008 CBO report says we will save less than a one-tenth of a percent for a comparative effectiveness research if that is put into place. Prevention may cost you more money if it means more visits and things of that nature. Pay-for-performance, there is no real evidence either way on that. So we are really talking about what are we going to do to control costs while we do those other things that may, in fact, cost us more.

So, Doctor Himmelstein, maybe you can tell me what is the value added to your patients of insurance companies? What do they bring to the table?

Dr. HIMMELSTEIN. Far from adding value, they detract value. They take my patient's time and effort often in a time in their life when they ill afford to have those efforts, and they are upset.

Mr. TIERNEY. What I am hearing is there is—everybody is trying to find a reason to keep the insurance companies in business instead of cutting right to the quick of it here, which is, you know, what do we—what value to your patients—their marketing costs? What value to your patients, those—their excessive profits have? What value to patients and the CEO is making a quarter of a million every month bring to it on that? And what does their underwriting do except exclude people from the process?

So why do not we try and find a process that just eliminates that or worse——

You know, if we cannot eliminate them—let me ask you this, Mr. Pollack. Cannot we at least—if we feel it is an 1,800-pound gorilla and we just cannot win the fight of getting rid of insurance companies and going into a much better administrative system that the good doctor tells us would lower our administrative costs from 31 percent to 3 percent—cannot we at least find the gumption to come down and say, "All right, look, if you are going to administer this program as an insurance company, then you must spend" and name the percentage we think is appropriate, on patient health care, not on marketing, not on salaries, not on underwriting or whatever.

Now they are incentivized to get themselves paid the way they are handsomely paid, is going to be to improve on all those areas. But at least we are ensuring that the money the employers or employees are paying is going to health care.

Dr. HIMMELSTEIN. Mr. Tierney, I think there are a lot of things we can do to improve the market that exists today. And I do not think we are going to eliminate insurance companies. That may a desirable outcome for some on the panel. But I do not think that is likely to happen.

Mr. TIERNEY. Well, can you——

Dr. HIMMELSTEIN. No, I would——

Mr. TIERNEY. Tell me what you think the insurance companies had to value for a patient.

Dr. HIMMELSTEIN. Well, I am—I do not represent insurance companies. So I am not——

Mr. TIERNEY. I know you do not. That is why I am asking for your opinion on what they bring to the value.

Dr. HIMMELSTEIN. I am not going to try to make that case.

Let me do say however, there are a number of things we can do within what I think are going to be the parameters of this debate that address some of the questions that you are raising.

Number one, as you suggested, we can establish medical-loss ratios so that we say that a very substantial percentage of the premium dollar actually gets used to health care as opposed to other administrative-related expenses.

Number two, we should be regulating the insurance industry so that the practices that prevent people with pre-existing conditions from getting health coverage—we certainly should be changing that.

As Bill Vaughan suggested earlier, I think we can do something better in terms of trying to standardize benefits. It is enormously confusing for there to be—for people to be comparing apples with oranges with elephants or kangaroos. It is very hard for people to understand. We saw that so clearly when Medicare Part D was established.

So I would say that, just like we did with Medigap, I think we can create some standardization that is going to make it easier for people to make choices.

And the last thing is—and this is going to be very tough—and that is we need to create a platform in terms of how physicians and hospitals and other providers have to code their payments. You go to any physician office, you go to any hospital, such a huge portion of expenses are paid on administrative-related costs. If——

Mr. TIERNEY. Well, that is essentially the value added by insurance companies. They add the confusion and they add the codes.

Dr. HIMMELSTEIN. But unfortunately—cannot address those.

Mr. POLLACK. But we can create a platform that is going to enable us to make it easier for providers so that they do not have to deal with 30 different codes for 30 different insurance carriers.

Dr. HIMMELSTEIN. But that is not our problem. The problem is actually the private insurance company wants not to pay. It is not the codes that are the problems.

You do not understand, Ron.

It is the multiple insurers not wanting to pay that is the problem. It is allowing the private insurance industry in the middle that is the problem. We already have a uniform bill for our hospitals, one bill. But the insurers abuse it. And there is no regulation you could not put in place.

We have been talking about this for 70 years in this country. You have been trying to get the private insurance through the B.A. for 70 years. You have not been able to do it. You are not going to be able to do it.

He was worried about can the federal government make AIG behave. What about AIG as an example of the private insurance agency behavior? Much bigger problem than the private—than the federal government's behavior in this case.

Chairman ANDREWS. Thank you, Doctor.

Thank the gentleman.

Mr. TIERNEY. Mr. Chairman, I just hope that in future hearings you might have a hearing that really hits the 1,800-pound gorilla on the head, is insurance, as opposed to having to hear about how can we all help insurance companies survive on that. I hope we——

Chairman ANDREWS. Very much so.

Mr. TIERNEY. Thank you.

Chairman ANDREWS. And I welcome that opportunity.

I am pleased to recognize the gentleman from Ohio, Mr. Kucinich, who has been a passionate advocate for health care reform through his career.

Mr. KUCINICH. Thank you, Mr. Chairman, for holding this hearing.

And I want to associate myself with the remarks of Mr. Tierney.

Our efforts in Congress should be about health care, not insurance care. And what we know and what Dr. Himmelstein was talking about is that the insurance companies make money not providing health care. There is a perverse disincentive set up in the system so they do not provide health care.

How is it that we have 50 million Americans that do not have any health insurance? How do we have 50 million—another 50 million, who are underinsured?

And one of the things I am sure about, Mr. Chairman, is, in this whole health care debate, they are so concerned about protecting—and I am not thinking about the chair because he is a co-sponsor of my bill. But, you know, I heard what Mr. Tierney said, and I feel the same way. You know, there is such a concern about protecting the insurance companies and their profits.

Now I, of course, and the co-sponsor, co-author of the bill, H.R. 676, with Mr. Conyers, a bill that provides for a single-payer plan. And this is a town which loves polls. Well, single-payer has the support of 59 percent of all physicians, 60 percent of the American public, over 75 members of Congress.

And I want to say, including the Chairman and several members of this Committee have signed on to the bill.

And yet, everything I am reading about the health care debate is making me deeply concerned that this Congress is going to miss a rare opportunity to adopt a single-payer bill. And I am convinced we need a back-up plan.

Now, Dr. Himmelstein, as you know, several state legislatures have shown interest in a single-payer health care. California has twice-passed a single-payer bill in the last 3 years. But it has been vetoed by the governor. Illinois, Minnesota, Pennsylvania, Washington, New York and other states have strong single-payer efforts under way. In my own state, in Ohio, there is a strong civic action movement for single-payer.

They all face barriers in the ERISA preemption and they needs to get a waiver to redirect their federal health care money.

Now, Dr. Himmelstein, if a public-private plan, like the one being proposed, is adopted, would it be important to allow the states to allow the states to adopt their own single-payer plans?

Dr. HIMMELSTEIN. I think if the federal government is going to head the nation down a dead-end street, a public-private plan, which we know will not work—it has been tried in three separate states during the 1980s and 1990s, and failed in all of those. At

least give an option for the states to innovate and to help us get out of this mess.

So there ought to be at least that exit strategy for moving us forward.

I might say to you also, the state of Maine legislature passed, I understand, just two weeks ago, an endorsement of your bill, Congressman.

Mr. KUCINICH. Well, how did the single—thank you. How did the single-payer health care system take hold and grow in Canada where it is so popular?

Dr. HIMMELSTEIN. Well, it started in the province of Saskatchewan where one bull politician, since voted by Canadians the most beloved of Canadian political leader of all times, innovated that program in that small province. It became such a popular program that conservative government in Ottawa actually adopted it nationwide.

Mr. KUCINICH. A number of people think that a hybrid public-private health care plan will lead to a single payer because the inefficient private plans will not be able to compete with the public plan. Do you agree?

Dr. HIMMELSTEIN. I think unfortunately we have evidence from the Medicare program that that is not the case, that the private insurances can effectively lobby the rules to make sure that they get a subsidy from it. And one would have to believe that the Republicans of the 1960s were fooled, because they proposed, as a method to block the passage of Medicare, a public-private plan very much like the public-plan option that is being proposed today as an effort to block Medicare's passage back in 1961 and 1962.

Mr. KUCINICH. Well, let's talk about the overhead. Private insurance has a higher overhead than public plans. Why is that?

Dr. HIMMELSTEIN. Well, first of all, they have to do the underwriting. We heard about 20,000 people, who work as underwriters for private employee benefit firms. That is an expensive proposition, which a public plans need not have. Advertising, collecting money through premiums and keeping track of that, the oversight of paying each bill, which in a Canadian-style program, does not exist.

And, of course, the CEO salaries. And the one thing I missed—I disagree with Mr. Tierney about is at Aetna, the CEO made not a quarter of a million dollars a month, but a quarter of a million dollars a day, including weekends and holidays.

Mr. KUCINICH. All right. Okay. Final question, can you talk about single-payer reform offering mechanisms to moderate health care cost inflation.

Dr. HIMMELSTEIN. Well, I have talked about the administrative savings, which CBO and GAO, in the past, have said would actually pay for all of the additional coverage needed in this country.

But in addition to that, you have got mechanisms for rationalizing the investments in facilities in this country. We have now got a proliferation of machinery, which often actually worsens the quality of care. So when you have got five heart transplant programs in one city, none of those programs doing enough surgery to actually be good at it, you have worsened the quality of care and driven up the costs. And some reasonable health planning mecha-

nisms would go a long way—and the Dartmouth Group has shown this—to moderating costs and simultaneously improving quality of care.

Mr. KUCINICH. Thank you very much, Doctor.

Again, Chairman Andrews, I want to thank you for holding this hearing. It really gives us a chance to get into this. Thank you.

Chairman ANDREWS. You are very welcome. And it is great to have you here.

Now, Mr. Hare has expressed a desire to have a second round of questions. And because this is an issue of such gravity, we are going to accede to that.

I am going to—here is what I propose that we do. I obviously will give the minority the first opportunity. It is their turn.

Are there other members on the majority side that wish to ask a second question?

John?

Or Dennis?

Mr. HARE. I would, yes.

Chairman ANDREWS. Okay, well, then, we will have—Mr. Kline will have his time, and then Mr. Hare and then Mr. Kucinich. And then I will close the hearing, if that is acceptable to everyone.

Mr. KLINE. Yes, thank you, Mr. Chairman.

I will not take all my time in the interest in time, both ours and the panels and all the people in the room.

There is obviously a great deal of disagreement and diversity here. We have it on the panel.

I am sure that my good friend, Mr. Kucinich, is not surprised that I am not a co-sponsor of his bill, and not likely to be.

And we have seen differences here between physicians, with extraordinary physicians, some of my colleagues and Mr. Himmelstein. There are going to be differences. We have got a long way to go here.

I will just reiterate that, as we go forward, we need to be mindful of the 160 million people who are getting their insurance now through employers, and that we not pull that string unless and until we are ready to replace the paradigm.

And with that, I will yield back, Mr. Chairman.

Chairman ANDREWS. I thank my friend.

And I am pleased to recognize the gentleman from Illinois, Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. And I appreciate you giving me the opportunity for a second round here.

You know, Doctor, let me ask you this. The single-payer that you support, we hear a lot of the criticisms—long lines, cannot get tests. You know, we are going to have problems. First of all, I would like to find out if, in fact, you subscribe to that notion.

Dr. HIMMELSTEIN. There are waits for a few high-technology services in Canada. But, in fact, Canadians visit the doctor more often than we do, have more hospital care per capita than we do in terms of days in the hospital, and even for many kinds of procedures, get as much or more than Americans do. So there are a limited number of things that there are shortages of and waits for in Canada.

And one should say that they spend half as much per person on health care as we do in Canada. And if they were to double their budget, there would be no waits at all for any kind of care. And they will have much better access, not only than they do, but than we do.

Mr. HARE. Does anybody on the panel—and I do not mean to be facetious about this. But does anybody on the panel know if there has been any movement at all in Canada to jettison their health care and adopt the American health care system?

Dr. HIMMELSTEIN. There was a survey of Canadians, and 3 percent of Canadians are prepared to go back to a U.S.-style system of care, which one of my Canadian colleagues tells me is their illiteracy rate. [Laughter.]

Mr. HARE. Well——

[Laughter.]

Doctor, that is a hard one to follow.

I just have to say I do support my friend Dennis' bill. And let me tell you, I—sometimes—I know the government is not always the answer for everything. But I have to tell you, I used to serve on the House Veterans Affairs Committee. And I think the VA health care—if you talk to veterans, we do a pretty darn good job of helping our veterans. So we can do more, and we need to.

But, you know, I do not—I have a lot of veterans in my district that will tell me, "I do not want to go to the hospital. I go to the VA because I get really good care there." That is a government program.

I have people that are on Medicare and Medicaid. And they are grateful and thankful to God that they have that type of coverage.

So, you know, at times, you would swear that the federal government cannot do anything right. And I will admit we have made some mistakes up here.

But it would just seem to me that if we are really going to get serious about covering 50 million people and the 50 million that are under insured, and the people that Mr. Courtney talked about, with pre-existing conditions, for heaven's sake, with a caesarian birth, and those kinds of things that make absolutely no sense, and if we really subscribe to the notion that health care in this country ought to be a right and not a privilege, then I think we are going to have to do something. And I think we are going to have to do something bold, because it is not getting it the way we are doing it now.

The administrative costs alone, as you said, doctor, was, what, 31 percent or—trying to think. Imagine the number of people we could insure if we eliminated the administrative costs of it.

So, you know, I go back to saying this. I think all of us up here, all members of the House and Senate, we have got very good health care plans. We all pay for them obviously. They are not totally free. But I want to see the day when every person in this country—and as I said, for that young man who lost his job and, as that man said, he did not—he said, "God, made a place for my son." He said, "I do not blame God for this. I blame the government because they would not do anything about this." And this is a man, by the way, that had to borrow $8,000 to bury his son.

Now, this is the United States of America. And, you know, I am not—you know, I do not—we can argue back and forth and all of this. But if we are really dead serious about making sure everybody has access to quality health care with the doctor they want to go to, the hospital they want to go to and do preventative care, then we have to invest in this. Because if we do not—it has not been working for the past—I do not know how many years. And it is not working now.

And so I appreciate you all being here. But I have to tell you, I think whatever we do, we better be bold and we better get it right. And if we do not insure those that are uninsured, and we do not stop this hemorrhaging of people that are kicked off because of bogus pre-existing conditions, we are never going to get this right.

So thank you, Mr. Chairman.

Chairman ANDREWS. Thank you, Mr. Hare.

The chair is pleased to recognize the gentleman from Ohio, Mr. Kucinich.

Mr. KUCINICH. Thank you very much.

Picking up on what Mr. Hare said, the overhead is at least 31 percent. Some say it is a size 33.

Now, if you consider that, in the United States, about $2.6 trillion a year is spent on health care, that is about 16 percent or 17 percent of our gross domestic product. What that means is that about $800 billion a year goes for the activities of the for-profit system for corporate profits, stock options, executive salaries, advertising, marketing, the cost of paperwork. $800 billion a year.

Now, if you took $800 billion a year and you put that into care for people, you would have enough to cover the 50 million who are uninsured and to provide full coverage for people who are under insured.

So we are talking about a lot of money here, which is why there is such a ferocious battle going on in the capital over trying to maintain the position of private insurers, because of the—strictly because of the amount of money that is involved here. And, of course, then, has become an engine to accelerate the wealth of the nation upwards from the American people into the pockets of the insurance companies.

Now, I want to go back to the questions that I was asking Doctor Himmelstein.

Do other authorities—can you state any authorities that agree that a single-payer system would generate large administrative savings?

Dr. HIMMELSTEIN. Back some years ago, the Congressional Budget Office looked at this question. They concluded that a single-payer system could cover everybody with completely comprehensive coverage without any increase in health care costs at all.

The General Accountability Office, back at the request of Mr. Conyers in the late 1980s, concluded the same thing.

I might say that Lou and Associates, which is actually owned by an insurance firm, owned by United Health Care, has done a number of studies commissioned by states around the country and has concluded the same thing. To their credit, they are honest enough to say that if you wipe our bosses out of the equation, you could cover everybody without any increase in health care costs. They

made that estimate at the—on a contract for the Massachusetts Medical Society on a contract for the health reform debate in California, and for a number of other states around the country.

So it is not just my conclusions. That conclusion has been reached by others in their studies.

Mr. KUCINICH. Now, you mentioned Massachusetts. Massachusetts gets a lot of discussion based on the plan that they have had. People have claimed that the reform is working well. And what—could you give us an assessment of the Massachusetts plan and its relevancy or lack thereof to the moment.

Dr. HIMMELSTEIN. Well, I work in the plan. And what we know so far is the costs have been driven up substantially, as we had predicted. Government——

Mr. KUCINICH. Why?

Dr. HIMMELSTEIN. Because essentially, the private insurance company has been kept in the middle. And the way we are increasing coverage is by buying additional coverage from them on top of the already high costs. And we have added the administrative costs of the insurance exchange, which adds 4 percent to every policy they sell, the connecter, on top of the already high administrative costs. And we have had no means of cost containment.

The survey actually shows that, of those directly affected by the reform, more say they have been hurt by it than helped by is because——

Mr. KUCINICH. Why?

Dr. HIMMELSTEIN. The cost of coverage that you are required to buy is extraordinarily high. We had quite——

Mr. KUCINICH. So people are required to buy their coverage. And how much are they required to pay for the coverage?

Dr. HIMMELSTEIN. For someone my age, the required coverage would be a $4,800 dollar per person, per year, and that carries a $2,000 deductible. So you lay out $6,800 out-of-pocket before you get a penny of coverage.

Mr. KUCINICH. So you are required. What happens if you do not buy it?

Dr. HIMMELSTEIN. A $1000 fine. So the——

Mr. KUCINICH. Are they fining people? Have they fined people?

Dr. HIMMELSTEIN. They are. They fined some people last year. And we have many more coming up with tax season this year.

Mr. KUCINICH. What if you cannot afford health insurance?

Dr. HIMMELSTEIN. There is a standard that says if you are above that standard, it is deemed affordable, you must buy it. You pay the cover—you pay the fine. If you go to a hospital, you pay the fine and you pay a part of the required coverage. So that is why people——

Mr. KUCINICH. Is this plan going to fail, in your estimation?

Dr. HIMMELSTEIN. I am sorry?

Mr. KUCINICH. Is the Massachusetts plan viable then? Is it——

Dr. HIMMELSTEIN. I think it is economically not viable. And I think, for my patients, that it is not viable.

Mr. KUCINICH. Do you think it will fail?

Dr. HIMMELSTEIN. Pardon?

Mr. KUCINICH. Do you think it will fail as a plan?

Dr. HIMMELSTEIN. I think it will fail. And if I may say, I work at the public hospital system, which just has seen massive budget cuts in order to keep the system afloat. We are closing half of our in-patient psychiatric beds. And we have more psychiatric beds than all of the other teaching hospitals in Boston combined. So we are creating a massive shortage in the care of the chronically mentally ill.

Mr. KUCINICH. Thank you, Doctor Himmelstein.

And I want to thank the chair for indulging this second round of questions.

Thank you.

Chairman ANDREWS. Absolutely. Glad to be able to hear the answers on the questions.

The gentleman from Oregon, Mr. Wu?

Mr. WU. Thank you, Mr. Chairman.

And I do intend now to take up Chairman Andrew's invitation to ask a question or two about health information technology.

And I understand that you all are here to talk about general issues, but I would like to invite you all to talk a little bit about health information technology, a field that I have been laboring in for several years. And that is a high priority for this administration in its efforts to make health care more effective and more efficient, whether you call it by electronic medical records or personal records or any other name.

I would just like—whoever wants to take a moment to address what benefits to patients and providers do you see coming from implementation of health information technology as a part of health care reform?

Mr. Langan?

Mr. LANGAN. I think employers who sponsor health plans now for their employees, many of them have been anxious and some have moved out front to try to tap the promise of electronic health records and health I.T. generally. I think our system is a very pluralistic system in terms of providers and provider settings and industries and so forth. And everyone knows, I believe, that the health insurance industry has come relatively late to the process of adopting standardization, which blew through many industries at an earlier time. And so it has been, for various reasons, resistant to the kind of standardization that can bring about efficiency and frankly better quality care.

And so employers have been pushing this envelope within the limitations that currently exist.

And it illustrates one of the things that I think employers bring to the systems currently that could be lost in the event we move to, say, in the direction of a single-payer system.

Employers tend to seek to integrate the health care coverage that they provide to employees to other programs, absenteeism, disability. And the advent of electronic health records will help them to integrate those efforts. And that is why we have supported and applauded the initial funding that was in the economic recovery bill.

Chairman ANDREWS. Thank you, Mr. Langan.

They are calling a vote so I am going to—if folks could move along.

Mr. WU. Dr. Himmelstein?

Dr. HIMMELSTEIN. I am an enthusiast for electronic medical records. I have spent 20 years a director of clinical computing. And it can clearly improve quality. But too often, commercial pressures actually distort the computer programs we are using. We are adopting inadequate records and we know they do not work. And there is no evidence at all that it saves money. I think it can upgrade quality. But at this point, it actually increases costs.

Just to give you one example, at Partner's Health Care, the parent corporation of Massachusetts General and Brigham Women's Hospital, 1,000 people work in our health I.T. department. And there is no way we are going to get savings equivalent to that expenditure to keep that health I.T. program afloat.

So, yes, it can improve quality. It takes more provider time. And someone who uses an electronic medical record, it is frustrating because you have to enter all that data. And it is worth doing, but let's not fantasize that it will save costs.

Mr. WU. I understand, Doctor Himmelstein. I think that that experience has been shared in some other places. That is why I always open by saying increasing patient safety, improving quality and perhaps reducing the rate of increase of medical costs, but we will see. We will hope for the best.

And because we are getting to this cost issue, I would like to jump within my 5 minutes to how do you pay for health care I.T., whether it is in an employer-based plan, an insurance company or a single-payer plan.

What do you see as the bump to practitioners, to a doctor in a solo office or any other care health care provider? What do you think the bump should be from whether it is from Medicare, a single payer or an employer-based health plan? What do you need to bump the compensation so that you have more uptake of technology of where it is abysmal right now, from small providers, because of cost concerns?

Mr. VAUGHAN. We are a little surprised that this is one of the few industries in America you have to pay to get people to use a computer. I mean, local hardware stores have done it and everybody else has. And there is——

Mr. WU. Well, Mr. Vaughan, the reason why you have to pay to get someone to use a computer is because, as Doctor Himmelstein has pointed out, it costs you time to train up. It costs you time to deal with the system. And the provider pays for it. But it is the insurer who derives most of the economic benefit. And it is that—this juncture that really causes that phenomenon.

Mr. VAUGHAN. Point well taken. There is good data from CMS that going to e-prescribing is saving lives, reducing duplicate prescriptions and avoiding counteractions. And I would urge as part of the reform bill, speeding the carrots and sticks to get to e-prescribing.

And what you did in the stimulus package, that ought to be a heck of a lot of enough to get this ball rolling and——

Mr. WU. Could you address the issue of how much of a bump—I know you do not like the bump.

Chairman ANDREWS. The gentleman's time has expired.

We will get this answer. And then we have a floor vote too.

So, Mr. Vaughan?

Mr. VAUGHAN. I think the bump——

Chairman ANDREWS. So, no Simpson references. Please answer the question. [Laughter.]

Mr. VAUGHAN. I sure will. Sorry.

But I would just—well, I will conclude that just the point that the hearing has gone on a little over 2 hours, some time during this period, if the IOM is right, four fellow citizens have died because they were uninsured. So whatever you do, single payer, whatever, please do something.

Chairman ANDREWS. That is a very sobering and appropriate note to end our discussion for today. But today's discussion is the beginning.

It is interesting—I want to thank the panelists for two points. First is for your indulgence of time, the depths of your knowledge and the enthusiasm of your contributions. Thank you all very, very much.

The other thing you have done though is given us a microcosmic example of the macro problem here. I think everyone here wants a really high-quality health care system, and they want every person to be able to access and use it. I think there is universal agreement on that. But it is very hard to accomplish that. And you have heard a microcosmic example this morning of the many issues that pop up when you are trying to get that done.

This Committee, the House, the Congress, the country are going to be struggling through these questions over the course of the next couple of months.

You have given us excellent material to work from.

We are going to be back in touch with each one of you for further reviews as we go forward.

And I, again, appreciate your effort.

As previously ordered, members will have 14 days to submit additional materials for the hearing record. Any member who wishes to submit follow-up questions in writing to the witnesses should coordinate with the majority staff within 14 days.

Without objection, the hearing is adjourned.

Thank you.

[The statement of Mr. Solmonese, submitted by Mr. Andrews, follows:]

Prepared Statement of Joe Solmonese, President, Human Rights Campaign

On behalf of the Human Rights Campaign and our over 700,000 members and supporters nationwide, I thank Representative Andrews for convening this hearing on ways to reduce the cost of health coverage. As the nation's largest civil rights organization advocating for the lesbian, gay, bisexual, and transgender ("LGBT") community, the Human Rights Campaign strongly supports measures that will make coverage more affordable for all Americans.

The high—and increasing—cost of health insurance is of particular importance to LGBT people. Nearly one in four lesbian and gay adults lack health insurance and these adults are more than twice as likely as their heterosexual counterparts to be uninsured.[1] For some of these people, unfair taxation of employer-provided health benefits is partly to blame.

Families rely heavily on employer-provided health insurance, a benefit that is increasingly offered to same-sex couples. As of this hearing, over 57% of Fortune 500 companies now offer equal health benefits to their employees' same-sex domestic

[1] *http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=1307*

partners—up from only one in 1992. Unfortunately, our tax system does not reflect this advance toward true meritocracy in the workplace. Under current federal law, employer-provided health benefits for domestic partners are subject to income tax and payroll tax. As a result, a lesbian or gay employee who takes advantage of this benefit takes home less pay than the colleague at the next cubicle. Some families have to forego the benefits altogether because this unfair tax renders the coverage too expensive—adding them needlessly to the millions of uninsured Americans in this country.

The following example illustrates how this tax inequity functions, and its result upon an average worker: In 2006 Steve earned $32,000 per year and owed $3,155 in federal income and payroll taxes. Steve's employer also paid the monthly premium of $907 for the insurance coverage for Steve and his wife. Of this amount, $572 was the amount in excess of the premium for self-only coverage. None of this coverage was taxable under current law, because employer contributions for the worker and a spouse or dependent child are excluded from taxable income. Steve's co-worker, Jim, earned the same salary and had the same coverage for himself and his same-sex partner. However, the value of the coverage provided to the partner is subject to federal income and payroll taxes. As a result, $6,864 of income is imputed to Jim and his federal income and payroll tax liability increased from $3,155 to $4,710. This represents nearly a 50% increase over Steve and his wife's tax liability.

For many families, especially those with modest incomes, the tax hit is more than they can bear. In the example above, a family earning $32,000 would most likely find that the additional $1,555 in tax liability puts coverage beyond their means.

Taxing these benefits also raises costs for employers. The benefits are not only considered imputed income, but also wages for payroll tax purposes. As a result, the employer must pay additional payroll taxes on these benefits that they do not pay for spouse and dependent child coverage.

It is imperative that the federal government not pile unfair taxes onto some families who are coping with the spiraling cost of health care. The Tax Equity for Health Plan Beneficiaries Act, which was H.R. 1820 in the 110th Congress, would eliminate the tax inequity and render health insurance more affordable for many American families.[2] Regardless of which approach Congress takes to health care reform, federal policies for families must treat all families equally. As this Subcommittee considers the important question of reducing the cost of health insurance, we strongly recommend that it support eliminating the tax on employer-provided health benefits.

[Whereupon, at 12:42 p.m., the Subcommittee was adjourned.]

[2] A similar bill was introduced in the Senate in the 110th Congress—the Tax Equity for Domestic Partner and Health Plan Beneficiaries Act (S. 1556).