

THE TRI-COMMITTEE DRAFT PROPOSAL FOR HEALTH CARE REFORM

HEARING

BEFORE THE

COMMITTEE ON

EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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C O N T E N T S

	Page
Hearing held on June 23, 2009	1
Statement of Members:	
Andrews, Hon. Robert E., a Representative in Congress from the State of New Jersey	8
Submission for the record: Statement of Hewitt Associates LLC	209
Kline, Hon. John, Senior Republican Member, Committee on Education and Labor	5
Prepared statement of	7
Miller, Hon. George, Chairman, Committee on Education and Labor	1
Prepared statement of	4
Questions for the record submitted to Dr. Hacker	194
Questions for the record submitted to Dr. Romer	29
Submissions for the record:	
Statement of the HR Policy Association, Internet address to	195
Price, Hon. Tom, a Representative in Congress from the State of Georgia .	10
Prepared statement of	12
Articles submitted:	
From the Hill, June 10, 2009, "A Back-Door Path to a Govern- ment Takeover"	218
From Politico, May 3, 2009, "To Reform, Create a Real Market- place"	220
From the Washington Times, April 1, 2009, "Getting Health Care Reform Right"	221
Sablan, Hon. Gregorio Kilili Camacho, a Delegate in Congress from the Northern Mariana Islands, prepared statement of	13
Scott, Hon. Robert C. "Bobby," a Representative in Congress from the State of Virginia, submissions for the record:	
Policy brief by the George Washington University Department of Health Policy	195
EPSDT amendment	207
300 percent amendment	208
Medicaid and CHIP amendment	208
Statement of Witnesses:	
Arensmeyer, John, founder & CEO, Small Business Majority	80
Prepared statement of	82
Hacker, Jacob S., Ph.D., University of California, Berkeley, professor of political science; faculty co-director, Center on Health Economic & Family Security, Berkeley School of Law	68
Prepared statement of	70
Responses to questions for the record	194
Klein, James A., president, American Benefits Council	138
Prepared statement of	141
Moffit Robert E., Ph.D., director, Center for Health Policy Studies, the Heritage Foundation	156
Prepared statement of	157
Harvard Health Policy Review article, Internet address to	156
Mullan, Fitzhugh, M.D., Murdock head professor of medicine and health policy, George Washington University	167
Prepared statement of	169
Pollack, Ron, executive director, Families USA	46
Prepared statement of	48
Pollitz, Karen, research professor, Georgetown University Health Policy Institute	127

IV

	Page
Statement of Witnesses—Continued	
Pollitz, Karen, research professor, Georgetown University Health Policy Institute—Continued	
Prepared statement of	129
Romer, Christina D., Chair, Council of Economic Advisers	14
Prepared statement of	18
Additional submission, “The Economic Case for Health Care Reform,” Internet address to	24
Responses to questions for the record	30
Shea, Gerald M., assistant to the president, American Federation of Labor and Congress of Industrial Organizations (AFL–CIO)	52
Prepared statement of	54
Speranza, Paul S., Jr., vice chairman, general counsel and secretary, Wegmans Food Markets, Inc.	63
Prepared statement of	64
Stapley, Michael, on behalf of the ERISA Industry Committee	75
Prepared statement of	77
Vaughan, William, senior health policy analyst, Consumers Union	149
Prepared statement of	151
Visco, Fran, J.D., president, National Breast Cancer Coalition	86
Prepared statement of	87
Wcislo, Celia, assistant division director, SEIU United Healthcare Work- ers East	134
Prepared statement of	136
Young, ReShonda, Alpha Express, Inc.	164
Prepared statement of	165

THE TRI-COMMITTEE DRAFT PROPOSAL FOR HEALTH CARE REFORM

**Tuesday, June 23, 2009
U.S. House of Representatives
Committee on Education and Labor
Washington, DC**

The committee met, pursuant to call, at 12:05 p.m., in room 2175, Rayburn House Office Building, Hon. George Miller [chairman of the committee] presiding.

Present: Representatives Miller, Kildee, Payne, Andrews, Scott, Woolsey, Hinojosa, McCarthy, Tierney, Kucinich, Davis, Loeb sack, Hirono, Hare, Clarke, Courtney, Fudge, Polis, Tonko, Sablan, Titus, Kline, Petri, Castle, McMorris Rodgers, Price, Guthrie, Cassidy, Hunter, Roe, and Thompson,

Staff Present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Jody Cal emine, General Counsel; Carlos Fenwick, Policy Advisor, Subcommittee on Health, Employment, Labor and Pensions; David Hartzler, Systems Administrator Jessica Kahanek, Press Assistant; Ricardo Martinez, Policy Advisor, Subcommittee on Higher Education, Lifelong Learning and Competitiveness; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Counsel; Rachel Racusen, Communications Director; Meredith Regine, Junior Legislative Associate, Labor; James Schroll, Junior Legislative Associate, Labor; Michele Varnhagen, Labor Policy Director; Mark Zuckerman, Staff Director; Robert Borden, Minority General Counsel; Cameron Coursen, Minority Assistant Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Alexa Marrero, Minority Communications Director; Jim Paret ti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Professional Staff Member; Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel; and Sally Stroup, Minority Staff Director.

Chairman MILLER. Good afternoon. The Committee on Education and Labor will come to order for purposes of conducting the hearing on the Tri-Committee Discussion Draft for health care reform in our country.

But before we begin this hearing, I would like to welcome Congressman Kline to his first hearing as our new incoming Ranking Member from the Republican Party, the senior Republican on our committee, and welcome him to the committee in that position and

say congratulations to him and that I look forward to working with him to continue our efforts to rebuild our country and improve the lives of American families.

Welcome, Mr. Kline. Congratulations to you.

Mr. KLINE. Thank you, Mr. Chairman.

Chairman MILLER. Today, as I said, we will examine the House tri-committee discussion draft for health care reform. This hearing marks the next step in our critical and historical effort to guarantee all Americans access to quality affordable health care.

No one can argue that our Nation's current health care path is sustainable. Premiums and health care costs have skyrocketed for families and businesses alike. In today's system, insurance company bureaucrats hold all of the power. They get to decide whether to cover a care that a doctor recommends for their patient. They can deny coverage or delay treatment based upon preexisting conditions, sending millions of people into devastating debt and prolonging anxiety or suffering from unattended care.

Americans with health care are deeply concerned that their employer may scale back or even cancel their coverage, and if they lose their job they will lose their health insurance, too.

The cost of 47 million uninsured people in our country is also unsustainable. The lack of coverage jeopardizes not only their personal health but our Nation's economic condition. The uninsured costs the rest of us about \$1,100 per family in higher premiums. The numerous and serious weaknesses in our health care system have combined to deliver a crushing blow to America's families, businesses and to our country's fiscal future.

Last Friday the three committees of jurisdiction in the House of Representatives unveiled our discussion draft for health care reform. It reflects months of hard work, of extensive meetings with Democrats and Republicans, with the Senators, with the Congressional Budget Office, with the administration officials and stakeholders in an opening collaborative process.

Consistent with President Obama's goals, our draft builds on what works and fixes what is broken in our current system. It lays the foundation for an American solution that will reduce costs, guarantee choice of doctors and plans and ensure access to affordable quality health care for all.

For Americans just beginning to pay attention to this health care debate, here are some critical ways that the reform will directly help you and your family. Our proposed reform will cover about 95 percent of all Americans. If you like your doctor or your health care plan, you can keep them. You won't have to worry about coverage if your employer drops it or you lose your job. Copays for preventive care won't exist. Premiums or coverage will not be based upon preexisting conditions, gender or occupation. You will have a choice of a high-quality, affordable public health insurance plan, and your doctors and nurses will have access to the best information organized in the best way to offer you individualized care.

Our draft will help drive down health care costs in several ways.

First, it ensures competition in the marketplace by establishing a new health insurance exchange that includes a strong public health insurance option that will compete on a level playing field

to keep the insurance companies honest. This will help lower costs for everyone.

Second, it trims costs by simplifying paperwork and preventing waste, fraud and abuse.

Third and most importantly, it controls costs by reducing spending.

These health care reforms will be fully paid for. President Obama has outlined a menu of cost reductions that we will consider and have to make some very tough decisions about. But this weekend's pledge by the pharmaceutical companies demonstrates that the President is successful in building a diverse coalition committed to reducing spending while improving affordability.

Our draft outlines where other significant portions of this funding will come from, promotes efficiencies in Medicare and Medicaid, and ending overpayments to private plans. This does not mean that we will be cutting services; instead we will improve them and strengthen the long-term sustainability so we can continue to provide the quality and dependable health care service for years to come.

Next, our reform will guarantee people a real choice of doctors, nurses and insurance plans through the exchange. Under our draft, as we said, if you like it you can keep it. People who aren't covered will be able to choose a menu of affordable plans, both public and private. This coverage will be portable and guaranteed no matter if an employer drops coverage or people lose their jobs.

Finally, our draft ensures that all Americans can afford quality health care based upon a sliding scale. Every plan offered through the exchange will include essential benefits, including no copays for preventative service, coverage for dental and vision coverage for children, caps on annual out-of-pocket expenses that will protect against medical bankruptcy. It ensures that care will be as it should be, and that is patient-centered, driven by patients' needs and the expertise of doctors. It will simply not invest in utilization, but more so in outcomes. It invests in prevention and wellness. It ends the insurance companies' discriminatory practices. It also requires shared responsibilities by individuals, employers, and the government to ensure that all Americans have access to these benefits.

In the coming weeks we will continue to seek input from stakeholders and lawmakers, but many are also clamoring for inaction. Let me be clear on this one point. On behalf of every parent seeking care for their sick child, for every American hoping that health care costs are not their last stop before bankruptcy, I assure you that the one thing that is in fact off the table in this effort is saying no to health care reform.

To succeed we will need the cooperation of all of our colleagues and of our President. There will be a tremendous pressure to think only about one narrow interest or another, but instead we must think about the future of our country and every American who expects that this year, this will be the year that we will make a health care system part of America's shiny future and not a cause of further financial chaos.

[The statement of Mr. Miller follows:]

**Prepared Statement of Hon. George Miller, Chairman, Committee on
Education and Labor**

Good afternoon.

First, I'd like to welcome Congressman Kline to his first hearing as our committee's incoming Senior Republican.

I look forward to working together to rebuild our country and improve the lives of America's families.

Today, we will examine the House Tri-Committee discussion draft for health care reform.

This hearing marks the next step in our critical and historic effort to guarantee all Americans access to quality, affordable health care.

Unsustainable costs to families

No one can argue that our nation's current health care path is sustainable. Premiums and health care costs have skyrocketed for families and businesses alike.

In today's system, insurance company bureaucrats hold all the power. They get to decide whether to cover the care a doctor recommends for their patient.

They can deny coverage or delay treatment based on a pre-existing condition—sending millions of people into devastating debt and prolonging anxiety or suffering from unattended care.

Portability

Americans with health care are deeply concerned that their employer may scale back or cancel their coverage, and that if they lose their job they will lose their health insurance too.

The cost of the 47 million uninsured people in our country is also unsustainable. Lack of coverage jeopardizes not only their personal health but our nation's economic condition.

The uninsured cost the rest of us about \$1,100 extra per year per family in higher premiums.

These numerous and serious weaknesses in our health care system have combined to deliver a crushing blow to America's families, businesses and our country's fiscal future.

Tri-committee draft proposal

Last Friday, the three committees of jurisdiction unveiled our discussion draft for health care reform.

It reflects months of hard work and extensive meetings with Democrats and Republicans, Senators, the Congressional Budget Office, Administration officials, and stakeholders, engaged in an open and collaborative process.

Consistent with President Obama's goals, our draft builds on what works and fixes what's broken in our current system.

It lays the foundation for an American solution that will reduce costs, guarantee choice of doctors and plans, and ensure access to affordable, quality health care for all.

For Americans just beginning to pay attention to the health care debate, here are critical ways that our reforms will directly help you and your family:

- Our proposed reforms will cover at least 95 percent of Americans;
- If you like your doctor or health plan, you can keep them;
- You won't have to worry about coverage if your employer drops it or you lose your job;
- Co-pays for preventive care won't exist;
- Premiums or coverage will not be based on pre-existing conditions, gender, or occupation;
- You will have the choice of a high-quality, affordable public health insurance plan; and
- Your doctors and nurses will have access to the best information to offer you individualized care.

Reduce costs

Our draft will drive down health care costs in several ways.

Second, it trims costs by simplifying paperwork and preventing waste, fraud and abuse.

Third—and most importantly—it controls costs by reducing spending. Health reform will be fully paid for.

President Obama has outlined a menu of cost reductions that we will consider and have to make very tough decisions about.

But this weekend's pledge by pharmaceutical companies demonstrates that the President is successfully building a diverse coalition committed to reducing spending while improving affordability.

Our draft outlines where another significant portion of this funding will come from: promoting efficiencies in Medicare and Medicaid and ending overpayments to private plans.

This does not mean cutting services. Instead, we will improve them and strengthen their long-term sustainability, so they can continue to provide quality, dependable health care for years to come.

Guarantee choice

Next, our reforms will guarantee people a real choice of doctors, nurses, and insurance plans through the exchange.

Under our draft, if you like what you have, you keep it.

People who aren't covered will be able to choose from a menu of affordable plans, including quality public and private health insurance plans.

This coverage will be portable and guaranteed—no matter if an employer drops coverage or people lose their jobs.

Quality and affordable care

Finally, our draft ensures that all Americans can afford quality health care, based on a sliding scale.

Every plan offered through the exchange will include essential benefits, including no copays for preventative care, dental and vision coverage for children, and caps on annual out-of-pocket expenses that will protect against medical bankruptcy.

It invests in prevention and wellness and it ends insurance companies' discriminatory practices.

It also requires shared responsibility by individuals, employers and the government to ensure that all Americans have access to these benefits.

'No' is off the table

In the coming weeks, we will continue to seek input from stakeholders and lawmakers. But many are also clamoring for inaction. Let me be very clear on this one point. On behalf of every parent seeking care for their sick child, and every American hoping that health care costs are not their last stop before bankruptcy, I can assure you: The one thing that is 'off the table' in this effort is saying 'No' to health care reform. To succeed, we will need the cooperation of all of our colleagues and our President.

There will be tremendous pressure to think only about one narrow interest or another. Instead, we must think of the future of our country and every American who expects that this year will be the year that we make our health care system part of America's shining future and not the cause of further financial chaos.

Chairman MILLER. With that, I would like to recognize Mr. Kline for the purposes of an opening statement.

Mr. KLINE. Thank you, Mr. Chairman, and thank you for your kind welcome. That may be the only time I ever get a round of applause from you, Mr. Chairman, so I am going to savor it as long as I can.

I want to thank our witnesses for being here. I know you are going to introduce some very distinguished panels. There are a lot of interested parties sitting out here in front of us today, as well they should be, because health care spending today accounts for approximately one-sixth of our economy, more than any other industry.

Millions of Americans have limited coverage or no coverage at all. Some of them, particularly young adults, voluntarily choose not to secure coverage, whether from a youthful sense of invincibility or an understandable skepticism that the cost is not worth the benefit. Still others are eligible for coverage through the job, but choose for a variety of reasons not to enroll. Many of the uninsured work for small businesses which cannot achieve the efficiencies or economies of scale of larger employers. As a result their costs are

much higher, often too high for both the small business owner and the worker.

I could go on, but the point is simple: The root causes of the high rate of uninsured Americans are many and varied, as are the reasons for the sustained increase in cost for those who are covered. The solution, however, is far from simple. A one-size-fits-all approach will not eliminate the problem or its root causes. Yet here we are this afternoon looking at the very definition of a one-size-fits-all approach, a health care system increasingly controlled and administered by the Federal Government. This draft legislation, as far as I can tell, fails to address many of the structural flaws at the root of our current crisis.

The President has pledged, and I quote: If you like your doctor, you will be able to keep your doctor, period; if you like your health care plan, you will be able to keep your health care plan, period, no one will take it away, no matter what, closed quote.

But the Congressional Budget Office projects that 23 million Americans will lose their current coverage under a plan being debated in the U.S. Senate. Ideas in the bill before us, such as the National Health Exchange, would shift millions of Americans out of their current coverage and into a government-run plan. It might be the 23 million in the Senate plan, it might be more, we just don't know. What we do know about the Democrats' plan, it is the Democrats' plan. We haven't seen it until we got a glimpse of the 852-page monster on Friday. The Democrats' plan is it increases the role of the Federal Government through a new government-run plan and an expansion of Medicaid. With government spending on health care already exploding and the Federal Medicare and Medicaid programs already on the road to insolvency, I can't imagine the reasoning behind intensifying the stress placed on these programs.

Employers are struggling to maintain coverage for their workers at a time when costs continue to rise and the economy continues to flail. But rather than offer relief, the Democrats' plan saddles employers with a pay-or-play scheme that threatens harsh financial sanctions and puts jobs at risk.

This may be my first hearing as the Education and Labor senior Republican, but today we are all first-timers. In fact, this is the very first hearing on health care reform held by the full committee in the 111th Congress. And unfortunately, it may be the only hearing before the Democrats' plan is marked up.

The Speaker has announced earlier this year that a health care overhaul will be voted on in the House before the August district work period. That doesn't give us much time for a serious debate. And that is too bad, Mr. Chairman, because this is a very serious issue. It deserves a real debate. The American people deserve an opportunity to weigh in. You haven't allowed that to happen. The so-called tri-committee draft is 852 pages. It was released on Friday afternoon. Perhaps most troubling, today's hearing has taken place when many Members of Congress are still in their congressional districts or on their way back to Washington. And I have to say, Mr. Chairman, I am very pleased at the turnout here today. I was skeptical that we would get this many to come in this early.

It doesn't have to be this way. Last week the Republican Health Care Solutions Group released a plan that we believe could serve as a basis of a bipartisan reform package. It contains commonsense solutions such as allowing children to remain covered by their parents' plans until they reach age 25, and making it easier for Americans to get health coverage when they lose or change jobs. It makes these changes while maintaining and improving upon the parts of the system that function well.

Of particular interest to this committee, the Republican plan keeps much of the ERISA-based system in place, which would enable Americans who like their current coverage, many of whom receive it through their employer, to keep what they have.

But as much as I support these principles of the Republican plan I wish we didn't need to frame this debate in partisan terms. Health care reform is far too important for partisan gamesmanship. It is also far too important to rush. Today may be our first hearing, but I hope it won't be our last. The proposal we are debating today is clearly partisan, but I continue to believe that Republicans and Democrats can and should come together to develop an American plan that will make health care more affordable, reduce the number of uninsured Americans and increase quality at a price that our country can afford.

Thank you, Mr. Chairman. I yield back.

Chairman MILLER. Thank you.

[The statement of Mr. Kline follows:]

**Prepared Statement of Hon. John Kline, Senior Republican Member,
Committee on Education and Labor**

Thank you Chairman Miller, and good afternoon.

America is facing a crisis in our health care system. Costs are spiraling out of control, leaving families, employers, and taxpayers to shoulder the burden.

Health care spending today accounts for approximately one-sixth of our economy—more than any other industry. That's up from 13.8 percent of GDP in 2000 and 5.2 percent in 1960.

Millions of Americans have limited coverage or no coverage at all. Some of them, particularly young adults, voluntarily choose not to secure coverage—whether from a youthful sense of invincibility or an understandable skepticism that the cost is not worth the benefit. Still others are eligible for coverage through their job, but choose—for a variety of reasons—not to enroll. Many of the uninsured work for small businesses, which cannot achieve the efficiencies or economies of scale of larger employers. As a result, their costs are much higher—often too high for both the small business owner and the worker.

I could go on, but the point is simple: the root causes of the high rate of uninsured Americans are many and varied—as are the reasons for the sustained increase in costs for those who are covered.

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What we do know about the Democrats' plan is that it increases the role of the federal government through a new, government-run plan and an expansion of Med-

icaid. With government spending on health care already exploding, and the federal Medicare and Medicaid programs already on the road to insolvency, I can't imagine the reasoning behind intensifying the stress placed on these programs.

Employers are struggling to maintain coverage for their workers at a time when costs continue to rise and the economy continues to flail. But rather than offer relief, the Democrats' plan saddles employers with a "pay or play" scheme that threatens harsh financial sanctions and puts jobs at risk.

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Thank you, I yield back.

Chairman MILLER. I would now recognize the Chairman of the subcommittee of jurisdiction, the Subcommittee on Health, Employment, Labor and Pensions, Mr. Andrews, for an opening statement.

Mr. ANDREWS. I thank the Chairman. I also would like to welcome Mr. Kline to his new position and wish him the best. And we will get to Dr. Romer as well. Thank you.

I did want to take a minute and respond to some of the things that Mr. Kline said in his remarks, that there is an estimate that 23 million would lose their coverage under the Senate bill. The Congressional Budget Office has not yet reviewed the House draft that was released on Friday. I am confident that when they do, they will find that employer-based coverage will be very strong for a very long time. As the President has promised, if you like the plan that you are in, you get to keep it. That is one of the cornerstones of the legislation that we have here.

And the substance that backs up that promise is this: About 80 percent of American employers are already doing what this bill calls for. That is, to provide a very healthy benefits package for people. And when they do, that employer gets exposed to what we call the Hippocratic principle: We do no harm. We say to about 80

percent of American employers, thank you for what you are doing, we are leaving you alone, we are not making any significant change to your ERISA preemption, we are not forcing you to join any exchange or any other marketplace, we are leaving you alone.

What we are trying to do for American businesses and families and labor unions and other institutions is to make health care more affordable. And the way that we are doing that is to require something that has really never been required before under Federal law but that has always been required under our system of organizing our economy, which is competition.

In too many instances, Americans live in circumstances where insurance companies are not compelled to compete for their business. In 36 States, in 36 States, the top two companies in the marketplace have at least 65 percent of the business. Let me say that again. In 36 States today, the top two providers have about two-thirds of the covered lives in two-thirds of the business.

There is insufficient competition. Americans benefit from competition. At our grocery stores, in the housing market, financial services, in so many other areas of American life, when someone has to compete for your business, you as a consumer do better, you have higher quality, more choice and lower cost. That is not the reality of the health care insurance market in our country today, and this plan makes it the reality. One of the ways we make it the reality is to assure that every American who is in the exchange, who is uninsured and looking for health care, and eventually every buyer of health care in this country, will have the choice of a robust, nonprofit, public competitor to the private insurance plans.

Let me be very clear about this. Rhetoric has been thrown about about nationalizing health care and forcing everyone to live under a government health care system. I would, first of all, say we should ask some of our moms and dads how they feel about a government health care system called Medicare. They are rather happy with it for the most part. But putting that aside for the moment, what this plan does is to say that uninsured people will have a choice, a choice of which health insurer is better for them. If they choose a private employer, that is where they will go and they will make a significant contribution from their own income to get there, and they will receive a subsidy to help them get the insurance they don't presently have. If they prefer the public option, they will have that.

But for the first time, we will have a marketplace in health insurance policies that really does require competition among the insurance companies who offer this coverage.

The final thing that I would say is that there was a reference to my friend from Minnesota about the pay-or-play structure and the confiscatory problems for employers. Let me be very clear about this. This plan divides the employer world into three categories: the vast majority of American employers who do provide very generous benefits voluntarily; this plan leaves them alone. For small businesses, for the person who is running a small business and struggling to stay ahead, this plan recognizes that an exemption from the employer mandate is necessary. The draft does not specifically speak to the scope of that exemption.

Part of the purpose of the debate that begins today is to fill in that blank. It is for the Members on both sides of the aisle to come up with their best analysis of what that exemption ought to be. But I assure you this: There will be a small business exemption that takes into account the hardworking, struggling, entrepreneur who simply can't afford health insurance because his or her business would go under. And there is a third category of employer; that is, an employer that has the wherewithal to insure his or her employees but chooses not to. That will change. That employer will have the obligation to cover employees at a decent level, because when he or she chooses not to do that everyone else pays for that now—the employer who does insure, the family who does insure, the taxpayer who pays taxes. So we look forward to this beginning of a process to deliberate, look at these issues, and come to a solution.

I just close with this one thought, Mr. Chairman. There is some concern about this being rushed. I think it is about 50 years too late, and I think it is long past time we got to this business. I look forward to it and yield back.

Chairman MILLER. The gentleman's time has expired.

Dr. Price is recognized.

Dr. PRICE. Thank you. Thank you, Mr. Chairman. I want to thank you and Ranking Member Kline for holding this hearing today. I want to thank our distinguished panels of witnesses today, many with great experience. I appreciate the time that they have taken out of their busy schedules to be with us.

As a physician, there is one certainty that I hear from my former colleagues, and that is that the status quo in health care is unacceptable. So no one—let me be clear—no one is clamoring for inaction.

Today we are at a crossroads. Our broken medical delivery structure is in dire need of meaningful reform, and today's hearing represents the beginning of an historic debate on how we achieve full access to affordable, quality health care while preserving the patient-doctor relationship without undue governmental interference.

When Congress established Medicare, a national health insurance program for seniors, over 40 years ago, it wrote into the law, quote: Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.

And that remains the law of the land. However, as any physician on the front lines of health care can tell you, these words ring hollow, as does its promise. As time has passed, and as I can attest to firsthand after nearly a quarter of a century as a practicing surgeon, there may have been no greater negative impact on the, quote, manner in which medical services are provided, unquote, than the intrusion of the Federal Government into health care.

Under the current Medicare program, patients are told which doctors they may see and how frequently. Doctors in turn are often told which procedures or tests they may or may not order or provide.

This is really the ability of patients and doctors to make independent health care decisions, some of the most personal that we make. And the doctor-patient relationship, once sacrosanct, is being

trampled by coverage rules, inflexible regulations and one-size-fits-all policies. To exacerbate the matter, most medical practices, including some of the largest and most respected institutions in our Nation, find it necessary to limit, yes limit, the number of Medicare patients they see. The delivery system devised and controlled by Washington is clearly not the model for reform.

As this committee begins to critically analyze this tri-committee draft proposal, I raise these specific points because I fear that we are not only repeating the same mistakes, but taking them a step further by permanently institutionalizing them into our health care delivery system for all.

Take, for instance, the newly created Health Benefits Advisory Committee that is being established to make recommendations on minimum health benefit standards and cost-sharing levels. It will be comprised mainly of Federal bureaucrats and Presidential appointees, and, just like the Comparative Effective Research Council enacted earlier this year, will not necessarily have a single actively practicing physician among its members. Not one.

This is the very type of Federal health board envisioned by some proponents of a government takeover which will dictate personal medical treatments allowed solely on the basis of cost. Having the government defining what quality medical care is, this is not what Americans view as the right direction or the change they desire. They know what you know; and that is that quality is best evaluated by patients and their families making decisions with a knowledgeable, concerned, and compassionate physician.

Ask the veteran waiting endlessly for needed surgery, because the surgical unit has met its quotas. Ask the senior, the new Medicare patient, who can't find a doctor able to see any more Medicare patients. Ask those who utilize the Indian Health Service if they receive the choices necessary to respond appropriately to their needs. And ask the Medicaid mom if the system facilitates her treatment. Ask them. Ask them if their health care delivery system best responds to their needs.

These are the four health systems Washington currently controls and none of them meet the principles of health care we all hold dear: accessibility, affordability, quality, responsiveness, innovation, choices.

Now, there are positive solutions, ones that would improve each of these systems and ease coverage opportunities for those currently uninsured or underinsured. And that is what we should be doing; not forcing every single American into a system that, of necessity, will betray those principles dear to all.

In the final analysis the question becomes: Will we allow Americans the opportunity to opt out? Will we allow free people the right to decide that this isn't the system that they want for themselves or for their family? And I would hope that the panelists would address that question. This is hardly a step in preserving the patient-doctor relationship.

When you pore through the pages of this bill, as you will note, Mr. Chairman, and others on the panel, isn't on our desk this morning, we see that it is based on a government-as-solution philosophy. This means more Federal supervision and more Federal administration. And it will ultimately come to rely on mandates,

rationing, bureaucracy and third-party decision making, all of which interfere with personal-private medical decisions.

This is hardly a step that preserves the patient-doctor relationship, the one thing that arguably has allowed America to have some of the greatest health care in the world. This bill offers an approach that is incapable of providing quality care which is accessible, innovative, and responsive. Achieving this positive type of change will only be possible by embracing a fundamental rethinking of our health care delivery system which champions personal ownership of coverage.

There are positive solutions to the challenge we face, and I am hopeful that the committees in the House will allow for an open, vibrant, robust debate and deliberative process, one that respects America's doctors, but most of all, one that respects America's patients, and I yield back.

Chairman MILLER. I thank the gentleman.

[The statement of Dr. Price follows:]

Prepared Statement of Hon. Tom Price, a Representative in Congress From the State of Georgia

Good morning and thank you, Chairman Miller and Ranking Member Kline. I would like to begin by thanking our distinguished panels of witnesses for appearing today. We appreciate that they have taken time out of their busy schedules to share their expertise and experiences with us.

As a physician, there is one certainty I hear from my former colleagues—the status quo in health care is unacceptable. So today, we are at a crossroads. Our broken medical delivery structure is in dire need of meaningful reform. And today's hearing represents the beginning of an historic debate on how we achieve full access to affordable, quality health care, while preserving the patient-doctor relationship, without undue governmental interference.

When Congress established Medicare, a national health insurance program for seniors more than 40 years ago, it wrote into law, "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided * * *". This remains the law of the land. However, as any physician on the front lines of health care can tell you, those words and that promise ring hollow.

As time has passed, and as I can attest to firsthand after nearly a quarter century as a practicing surgeon, there may have been no greater negative impact on the "manner in which medical services are provided" than the intrusion of the federal government into health care.

Under the current Medicare program, patients are often told which doctors they may see and how frequently. Doctors, in turn, are often told which procedures or tests they may and may not order or provide. This has eroded the ability of patients and their doctors to make independent health care decisions—some of the most personal we make. And the doctor-patient relationship, once sacrosanct, is being trampled by coverage rules, inflexible regulations, and one-size-fits-all policies.

To exasperate the matter, most medical practices, including some of the largest and most respected institutions in the nation, find it necessary to limit the number of Medicare patients they see. The delivery system devised and controlled by Washington is clearly not the model for reform.

As this Committee begins to critically analyze the Tri-Committee Draft Proposal for Health Care Reform, I raise these specific points because I fear we are not only repeating the same mistakes but taking them a step further by permanently institutionalizing them into our health care delivery system.

Take for instance the newly created Health Benefits Advisory Committee. It is being established to make recommendations on minimum health benefit standards and cost-sharing levels. It will be comprised mainly of federal bureaucrats and presidential appointees. It, just like the Comparative Effectiveness Research Council enacted earlier this year, will not necessarily have a single actively practicing physician among its members. Not one! And this is the very type of federal health board, envisioned by some proponents of a government takeover, which could dictate personal medical treatments allowed—solely on the basis of cost.

Having the government defining what “quality” medical care is, this is not what Americans view as the right direction. They know what you know, and that is that quality is best evaluated by patients and their families, making decisions with a knowledgeable, concerned, compassionate physician.

Ask the veteran waiting endlessly for needed surgery because the surgical unit has met its ‘quota’. Ask the senior, the new Medicare patient, who cannot find a doctor able to see anymore Medicare patients. Ask those who utilize the Indian Health Service if they receive the choices necessary to respond appropriately to their needs. And ask the Medicaid mom, if the system facilitates her treatment. Ask them.

Ask them if their health care delivery system best responds to their needs. Those are the four health systems Washington currently controls. None of them meet the principles of health care we should hold dear—accessibility, affordability, quality, responsiveness, innovation, and choices.

There are positive solutions—ones that would improve each of these systems—and ease coverage opportunities for those currently uninsured or underinsured. That is what we should be doing, not forcing every single American into a system that, of necessity, will betray those principles dear to all.

In the final analysis, the question becomes, will we allow Americans the opportunity to opt out? Will we allow free people the right to decide? This is not the system I want for my family, and I’d like the panelists to address that question.

When you pour through the pages of this bill, you will see that the Tri-Committee Draft Proposal for Health Care Reform is based on a “government-as-solution” philosophy. This means more federal supervision and administration. It will ultimately come to rely on mandates, rationing, bureaucracy, and third-party decision-making, all of which interfere with personal, private medical decisions. This is hardly a step that preserves the doctor-patient relationship—the one thing that, arguably, has allowed America to have some of the greatest health care in the world.

This bill offers an approach that is incapable of providing quality care which is accessible, innovative and responsive. Achieving this positive type of change will only be possible by embracing a fundamental rethinking of our health care delivery system which champions personal ownership of coverage.

There are positive solutions to the challenges we face. I’m hopeful the House will allow for an open, vibrant, robust debate and deliberative process—one that respects America’s doctors—but most of all—America’s patients.

Thank you, and I look forward to hearing from the witnesses.

Chairman MILLER. Pursuant to committee rule 7(c) all members may submit opening statements in writing which will be made part of the permanent record.

[The statement of Mr. Sablan follows:]

Prepared Statement of Hon. Gregorio Kilili Camacho Sablan, a Delegate in Congress From the Northern Mariana Islands

I want to thank Chairman Miller, Mr. Andrews, the other Members of the Committee, and the staff for all the time and effort put forth towards the drafting of this plan to reform health care for all Americans. Thanks also to the witnesses for taking the time to discuss these issues. And thank you to my staff for their hard work examining and briefing me on this bill. Obviously this proposed legislation represents an enormous shift in American health care policy, and it is important that we take all available information into account before making decisions with such huge consequences.

That having been said, I would also like to express my concern that Americans living in the territories, including my constituents in the Northern Mariana Islands, will not benefit from our work here if the current draft becomes law. These citizens, who face some of the greatest health disparities and the greatest challenges in finding and accessing affordable health care, must be included before we can consider the transformation of American health care complete.

I agree with my colleagues that individual and employer health insurance mandates, along with the other reforms that this Congress will introduce into our health care system, will help fulfill the promise made by our President and my colleagues in Congress that all Americans should have access to affordable, quality health care. I hope my colleagues in the Committee will work with me towards the inclusion of all Americans in these programs, including the four and a half million Americans living in the territories.

Chairman MILLER. Our first panel this morning will be made up of Dr. Romer. Dr. Christina Romer is the Chair of the Council of Economic Advisors in President Obama's administration. She is also the former Vice President of the American Economic Association and the Garth B. Wilson Professor of Economics at the University of California, Berkeley. Dr. Romer holds a B.A. from the College of William and Mary and her Ph.D. from Massachusetts Institute of Technology.

Dr. Romer, welcome to the committee. I know there were a lot of scheduling changes over the weekend to get you here, and I appreciate your cooperation and the administration's cooperation to make you available to the committee.

I also know that we have a very short leash on your time, and Dr. Romer will be leaving pretty close to 1:30 if everybody holds to their schedule. That means not everybody is going to get to ask her a question, but we will go as rapidly and as quickly as we are allowed under the rules.

Chairman MILLER. Welcome to the committee, and your entire statement will be placed in the record, and you can proceed in the manner in which you are most comfortable. Thank you.

STATEMENT OF DR. CHRISTINA ROMER, CHAIR, COUNCIL OF ECONOMIC ADVISERS

Ms. ROMER. Thank you very much.

Chairman MILLER. You will have ten minutes. Then at nine minutes an orange light will go on, I believe. And then you can start summarizing and we will allow for questions. Thank you.

Ms. ROMER. Wonderful. Chairman Miller, Ranking Member Kline, and members of the committee it is indeed an honor to be with you today to discuss the economics of health care reform. The President, as you know, has identified comprehensive meaningful health care reform as a top priority, and the administration is grateful to the Congress for working so quickly and tirelessly on this important issue.

In my remarks today, I will discuss the economic comparative of reform that satisfies the President's dual goals of slowing the growth rate of health care costs significantly and providing quality, affordable, health insurance coverage for all Americans. The figures in the analysis that underlie my testimony today are contained in the Council of Economic Advisors report, "The Economic Case For Health Care Reform." With your permission I would like to include a copy of that report in my testimony so that the sources and methodology are fully documented for the committee.

Well, many of the crucial trends in American health care are well known, but the Council of Economic Advisors worked with others in the administration to develop projections of what will happen in the absence of reform. Spelling out these facts and trends makes a compelling case that the status quo is simply not an option.

Now, one key fact is that health care expenditures in the United States are about 18 percent of GDP, thereby the highest of any country.

And if we can go to the first figure. This figure shows our projections of the likely path of national health care expenditures. These expenditures are projected to rise sharply. By 2040, health expendi-

tures could be roughly one-third of total output in the U.S. economy.

How about for households? Well, for households rising health care expenditures will likely show up in rising insurance premiums. Even if employers continue to pay the lion's share of premiums, both economic theory and empirical evidence suggest that this trend will show up in stagnating take-home wages.

This next figure shows our projections of total compensation and compensation less insurance costs, both in inflation-adjusted dollars. The wedge-shaped area between the two lines shows our predicted levels of insurance premiums. What you see is that without reform, the noninsurance part of compensation will grow very slowly and will likely fall eventually as premiums rise rapidly.

Rising health care costs also mean that government spending on Medicare and Medicaid will rise sharply over time.

If we go to the next figure, in this picture the dash line shows the projected path of combined Federal and State spending on Medicare and Medicaid. Our projections show that these expenditures, which are currently 6 percent of GDP, will rise to 15 percent of GDP by 2040. In the absence of tremendous increases in taxes or reductions in other types of government spending, this trend implies a devastating and frankly unsustainable rise in the Federal budget deficit.

Another trend that is too crucial to be ignored is the rise in the number of Americans without health insurance. Currently 46 million people in the United States are uninsured.

In the absence of reform, if we look at the next picture, this number is projected to rise to about 72 million in 2040, an increase of 26 million people over the next 30 years. The President has emphasized that providing quality, affordable, health insurance for all Americans is a key goal of reform.

For the many Americans who currently have health insurance, as has been noted here this morning, the President has promised that if you like your doctor and your existing plan you can keep them. The President and Congress are also proposing methods to make the existing system work better for all families, such as simplification of insurance forms and electronic health records that reduce duplication of tests and prevent medical errors.

For the millions of Americans without insurance, the President is committed to working with Congress to design a sensible cost-effective method of coverage expansion. Expanding coverage will likely involve the creation of a health insurance exchange that gives individuals and small groups the same benefits of risk pooling and elimination of adverse selection that employees of large firms enjoy.

One feature of health reform that the President has emphasized is that no one should be denied health coverage due to preexisting conditions. Americans with health problems need the security of knowing that if they change jobs or lose their jobs, they will still be able to get health insurance coverage.

Now, there are important benefits to the economy and to society of coverage expansion. The most important of these involves the health and economic well-being of the uninsured. In our report we use the best available estimates to try to quantify the costs and

benefits of expanding coverage to all Americans. Among the benefits that we attempt to put a dollar value on are the increase in life expectancy, the improvement in health, and the decreased risk of financial ruin from high medical bills.

We find the benefits of expanding coverage to the uninsured are very large, and substantially greater than the costs. Our estimates show that the net benefits, the benefits minus the costs, are roughly \$100 billion per year or about two-thirds of a percent of GDP.

Another effect of expanding coverage is increased labor supply. With expanded coverage, some people who would not be able to work because of disability would be able to get health care that prevents or effectively treats the disability. They would therefore be able to stay in the labor force.

Similarly, some workers currently in the labor force would be more productive if they had health care. We believe that the net impact on effective labor supply will be positive and will increase GDP.

Expanding coverage will also improve the efficiency of the labor market. Creating an insurance exchange and eliminating restrictions on preexisting conditions would end the phenomenon of job lock, where worries about health insurance cause workers to stay in jobs even when better ones are available. Our estimate is that this benefit could be about two-tenths of a percent of GDP each year.

Similarly, we examine the fact that small businesses are disadvantaged in the labor market because current employer-sponsored insurance is so expensive for them. Moving to a system that removes that disadvantage could be beneficial to the competitiveness of the important small business sector of the economy.

Now, while the benefits of expanding coverage are substantial, slowing the growth rate of health care costs is essential to moving the economy off its unsustainable path and securing a better economic future for the American people.

And in discussing cost containment, I want to focus on the slowing of the growth rate of cost. This is the so-called curve-bending that can last for decades. Slowing cost growth is quite separate from the actions we might take immediately to cut the level of government medical spending. These immediate reductions are crucial for paying for the expansion of coverage and other health care reforms in the short run. But thinking about the changes that will save us from the unsustainable long-run trends slowing cost growth year after year is essential.

Now, many meaningful reforms are necessary to slow the growth rate of cost over time. The CEA report focused on the conceptual importance of reforms rather than the mechanics. But the report does describe in broad terms the kind of changes that might be implemented. We discuss, for example, changes in payment systems such as bundling of payments for hospital and post-hospital care and change in the organization of care delivery, such as the formation of accountable care organizations and medical homes as ways to reduce fragmentation and promote more effective and more efficient care. We emphasize the crucial role of investments in health information technology and research on what works and what doesn't could play in reining in cost growth.

The President in his speech last week to the American Medical Association made some specific suggestions for reforms along the lines that I have described. He also said that he was open to changes that would give the recommendations of the Medicare Payment Advisory Commission greater chance of adoption and implementation.

The Congressional Budget Office has also outlined a large number of game-changing reforms that experts believe could slow cost growth. In our report we speak of the benefits of slowing the growth rate of health care costs, but each of our figures implicitly shows the impact of not slowing cost growth.

To help emphasize the importance of doing reform well, I will describe them from that perspective this morning. Fundamentally, what slowing cost growth does is to free up resources. If we restrain costs by eliminating waste and inefficiency, we could have the same real amount of health care with resources left over to produce the other things that we value. This causes standards of living to be higher.

In our analysis we consider varying degrees of cost containment. In particular, we look at the effect of slowing the annual growth rate of health care costs by 1½, 1, and just half a percentage point. We analyze the effects of freeing up resources in a standard growth accounting framework. Our framework includes the effect of slowing cost growth on the deficit and capital formation or investment.

If we go to the next figure, this figure shows the crucial importance of slowing cost growth for standards of living. To make these numbers more concrete, we translate them into the effects on the income for a typical family of four, again in constant inflation-adjusted dollars. The bottom line shows the projected path of real family income without reform. The higher path show family income under different degrees of cost containment. Our numbers suggest that failing to slow cost growth results in substantially lower standards of living for American families. Without reform, our analysis predicts that the typical family income in 2020 will be roughly \$2,600 lower than it would be if we managed to slow the growth rate of costs by 1½ percentage points. By 2030 it will be nearly \$10,000 lower than if we managed to slow cost growth.

Failing to control the growth of health care costs will condemn American families to much lower standards of living than they would experience with successful reform. Slowing the growth of health care costs will also have enormous effects on the budget deficit.

This last figure shows the reduction in the Federal budget deficit due to different degrees of cost containment. Consider the numbers in the middle for 2030. They show that slowing the growth rate of health care costs by 1½ percentage points will reduce the deficit by 3 percent of GDP. Put another way, failing to slow cost growth by 1½ points per year will result in a deficit that is higher by 3 percent of GDP. By not slowing costs we will leave our children a budget deficit in 2040 that is 6 percent of GDP higher than it would have been with successful reform.

The numbers illustrate the crucial truth that serious health care cost growth containment is central to our long-run fiscal stability. Taken together, the analysis by the Council of Economic Advisors

shows that doing nothing on health care reform is simply not an option. Expanding coverage will unquestionably have benefits for economic well-being, the efficiency of the labor market, and the competitiveness of small businesses. But only by undertaking meaningful reforms of slowing the growth of health care costs can we assure American families of rising standards of living and falling, rather than ever-increasing, budget deficits.

The President has spoken frequently of the need to provide the American economy with a new foundation. His goal is that we not only come through the current economic crisis, but emerge a stronger, more durable economy. Health care reform that provides quality affordable coverage for all Americans and genuinely slows the growth rate of cost significantly is a crucial part of that new foundation. Successful reform is fundamental to the long-run health of the American economy. Thank you.

[The statement of Ms. Romer follows:]

**Prepared Statement of Dr. Christina D. Romer, Chair,
Council of Economic Advisers**

Chairman Miller, Ranking Member McKeon, members of the Committee, it is an honor to be with you today to discuss the economics of health care reform. The President has identified comprehensive health care reform as a top priority. The Administration is grateful to the Congress for working so quickly and tirelessly on this important issue. In my remarks today I will discuss the economic imperative of health care reform that satisfies the President's dual goals of slowing the growth rate of health care costs significantly and providing quality, affordable health insurance coverage for all Americans.

I will first discuss the obvious, but sometimes forgotten point that the status quo is not an option. The projections for health care spending and what it means for households and the government budget show that we are on an unsustainable path. Without reform that slows the growth rate of costs, take-home pay for working families will stagnate and the budget deficit will mushroom. The projections for insurance coverage show that small employers are likely to reduce health insurance coverage substantially, leading to a swelling of the number of people without insurance in the United States over the coming decades.

I will then discuss the economic impact of coverage expansion and the importance of cost containment. A study released by the Council of Economic Advisers (CEA) on June 2, 2009 estimated the benefits to society and the economy of expanding coverage.¹ Our study found that coverage expansion has crucial positive effects on overall economic well-being, the efficiency of the labor market, and the competitiveness of the crucial small businesses sector. The CEA study also showed that successful cost growth containment was essential to the long-run health of our economy. I cannot emphasize enough the need to make meaningful changes that will genuinely slow the growth rate of health care costs. Only by doing so will we be able to avoid the dire long-term projections of stagnating living standards and crushing budget deficits.

The figures and analysis that underlie my testimony today are contained in the CEA report *The Economic Case for Health Care Reform*. With your permission, I would like to include a copy of that report with my testimony, so that the sources and methodology are fully documented for the Committee.

I. Trends in the absence of reform

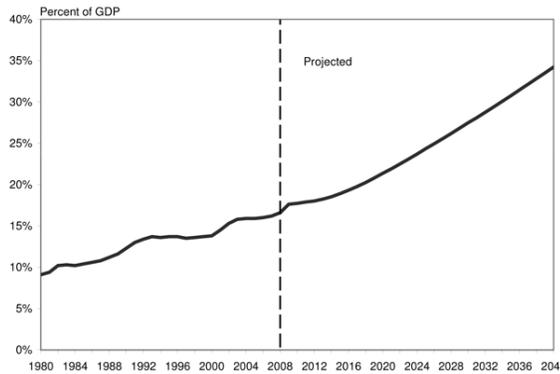
Let me start with a discussion of where we are and where we are headed. Many of the crucial economic trends in American health care are well known. But, the Council of Economic Advisers worked with others in the Administration to develop projections of what will happen in the absence of reform. Spelling out these facts and trends makes a compelling case that doing nothing is simply not an option.

Rising Health Expenditures. One key fact is that health care expenditures in the United States are currently about 18 percent of GDP, by far the highest of any country. These expenditures are projected to rise sharply. This figure shows our pro-

¹ Council of Economic Advisers, *The Economic Case for Health Care Reform*, June 2, 2009, <http://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/>

jection of the likely path of national health care expenditures. By 2040, health expenditures could be roughly one-third of total output in the U.S. economy.

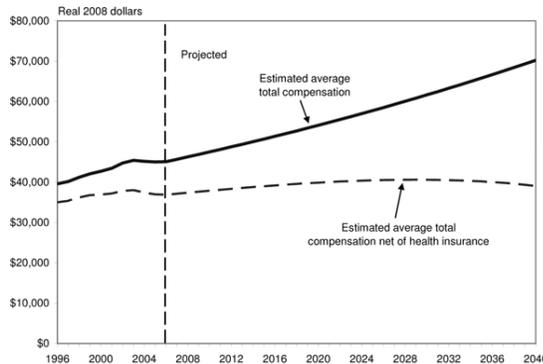
National Health Expenditures as a Share of GDP, 1980-2040



Source: CEA calculations.

Effect on Households. For households, rising health care expenditures will likely show up in rising insurance premiums. Even if employers continue to pay the lion's share of premiums, both economic theory and empirical evidence suggest that this trend will show up in stagnating take-home wages for American working families. This figure shows our projection of total compensation and compensation less insurance costs, both in inflation-adjusted dollars. The wedge-shaped area between the two lines shows our predicted level of insurance premiums, again in constant dollars. We project that without reform, the non-insurance part of compensation will grow very slowly, and likely fall eventually, as premiums rise sharply over time.

Projected Annual Total Compensation and Health Insurance Premiums

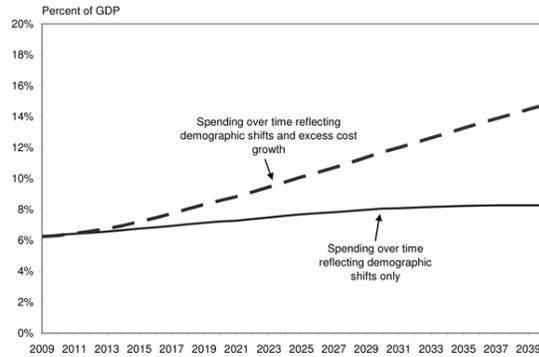


Source: CEA calculations.

Effect on Government. Rapidly rising health care costs also mean that government spending on Medicare and Medicaid will rise sharply over time. The dashed line in this figure shows the projected path of combined Federal and state spending on Medicare and Medicaid. Our projections show that these expenditures, which are currently about 6 percent of GDP, will rise to 15 percent of GDP by 2040. The solid line shows the projected rise in Medicare and Medicaid expenditures due only to demographic factors, such as the aging of the baby-boom generation. A crucial fact is that only about one-quarter of the total rise in government health expenditures is

due to demographic changes. The other three-quarters is due to the fact that health care spending per enrollee is rising much more rapidly than GDP. In the absence of tremendous increases in taxes or reductions in other types of government spending, this trend implies a devastating, and frankly unsustainable, rise in the Federal budget deficit.

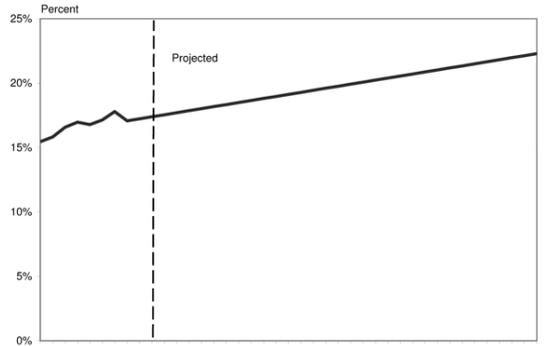
Projections of Total Spending on Medicare and Medicaid as a Share of GDP, 2009-2040



Source: CEA calculations.
Note: Total spending includes both Federal and state expenditures.

Trends in Lack of Insurance. Another trend that is well known, but too crucial to be ignored, is the rise in the number of Americans without health insurance. Currently 46 million people in the United States are uninsured. In the absence of reform, this number is projected to rise to about 72 million by 2040, an increase of 26 million people over the next thirty years.

Projected Percentage of the U.S. Population Under Age 65 without Health Insurance, 2000-2040



Source: CEA projections using U.S. Census Bureau's Annual Social and Economic (ASEC) Supplement.

II. The economic impact of coverage expansion

The President has emphasized that providing quality, affordable health insurance coverage for all Americans is a key goal of reform. For the many Americans who currently have health insurance, the President has emphasized that if you like your doctor and your existing plan, you can keep them. He is committed to maintaining and building upon the employer-based health care system. The President and Congress are also proposing methods to make the existing system work better for all

families, such as administrative simplification of insurance forms and electronic health records that reduce duplication of tests and prevent medical errors.

Needed Reforms. For the millions of Americans without insurance, the President is committed to working with Congress to design a sensible, cost-effective method of coverage expansion. A crucial challenge of coverage expansion is designing mechanisms that overcome market failures. For example, the fact that individuals know more about their likely health expenditures than potential insurers leads insurers to charge rates for individual and small group coverage that are above the average cost of providing coverage for these segments in the population. Expanding coverage will likely involve the creation of a health insurance exchange that gives individuals and small groups the same benefits of risk-pooling and elimination of adverse selection that employees of large firms enjoy.

One feature of health reform that the President has emphasized is that no one should be denied health coverage due to pre-existing conditions. Americans with health problems need the security of knowing that if they change jobs or lose their job, they will still be able to get health insurance coverage.

Effects on Economic Well-Being. There are important benefits to the economy and society of coverage expansion. The most important of these involves the health and economic well-being of the uninsured. In our report, we use the best available estimates to try to quantify the costs and benefits of expanding coverage to all Americans. Among the benefits we attempt to put a dollar value on are the increase in life expectancy and the improvement in health. Evidence from the health economics literature suggests that if all of the uninsured had health insurance, there would be many fewer deaths among adults with chronic conditions, such as cancer and hypertension, and with acute conditions, such as heart attacks and injuries resulting from automobile accidents. Indeed, a 2002 study by the Institute of Medicine estimated that there are approximately 18,000 more deaths among uninsured adults each year than would occur if they had health insurance.² We also consider the benefit of health insurance as a way to reduce individuals' chance of financial ruin from high medical bills.

The costs to society of covering the uninsured represent a mix of public and private costs and come from existing studies, not estimates of plans currently being contemplated by Congress. We find the benefits of coverage to the uninsured are very large and substantially greater than the costs. Our estimates show that the net benefits—the benefits minus the costs—are roughly \$100 billion per year, or about $\frac{2}{3}$ of a percent of GDP.

Effects on Labor Supply. Another effect of expanding coverage that we consider is increased labor supply. With full health insurance coverage, some people who would not be able to work because of disability would be able to get health care that prevents or effectively treats the disability. They would therefore be able to stay in the labor force longer. A related effect is that some workers currently in the labor force would be more productive with better health care. How large these effects might be are hard to predict. And, there could be offsetting effects: for example, with a better insurance market some workers who are working just to get health insurance might retire earlier. But, we believe that the net impact on effective labor supply will be positive and will further increase GDP.

Effects on the Efficiency of the Labor Market. The final impact that we identify is the effect of expanding coverage on the efficiency of the labor market. Expanding coverage and eliminating restrictions on pre-existing conditions would end the phenomenon of “job lock,” where worries about health insurance cause workers to stay in their jobs even when ones that pay more or are a better match are available. Our estimates, based on a range of economic studies, are that this benefit could be about $\frac{2}{10}$ of a percent of GDP each year. Similarly, we examine the fact that small businesses are currently disadvantaged in the labor market because current employer-sponsored insurance is so expensive for them (due in large part to the fact that they do not have a large workforce over which to pool risk). Moving to an insurance system that removes this disadvantage should be beneficial to the competitiveness of the important small business sector of the economy.

III. The crucial impact of slowing the growth rate of health care costs

While the benefits of coverage expansion are substantial, slowing the growth rate of health care costs is also essential to achieving some of the fundamental benefits of health care reform. As discussed previously, the U.S. health care system is on an unsustainable path. Successful cost growth containment is central to changing that path and securing a better economic future for the American people.

²Institute of Medicine. “Care Without Coverage: Too Little, Too Late.” May 2002. <http://www.iom.edu/CMS/3809/4660/4333.aspx>.

Needed Reforms. In discussing cost containment, I want to focus on slowing the growth rate of costs. This is the so-called “curve-bending” that can last for decades. Slowing the growth rate of costs is quite separate from actions that we might take immediately to cut the level of government medical spending, such as the more than \$300 billion of Medicare and Medicaid savings proposed in our budget and the roughly \$313 billion of additional savings the Administration proposed two weeks ago.³ These immediate reductions are unquestionably important for paying for the expansion of coverage and other health care reforms in the short run. Indeed, the President has frequently emphasized that health care reform must not add to the deficit in the next decade. But, for thinking about the changes that will save us from the unsustainable long-run trends I discussed earlier, slowing cost growth year after year is essential, and what we focus on in our study.

Of course, coverage expansion is likely to make some types of cost growth containment possible. For example, with coverage, individuals have improved access to primary care and may be more likely to receive education about disease prevention and management of chronic conditions. Smoking cessation and weight management are two preventative measures that could reduce cost growth over time, while improving health and quality of life.

Many other meaningful reforms are necessary to slow the growth rate of costs over time. The CEA report focused on the conceptual importance of reforms, rather than the mechanics. But the report does describe in broad terms the kind of changes that might be implemented. For example, we discuss changes in payments systems, such as bundling of payments for hospital and post-hospital care. We also discuss changes in the organization of care delivery, such as the formation of accountable care organizations and medical homes, as ways to reduce fragmentation and promote more effective and more efficient care delivery. We emphasize the crucial role that investments in health information technology and research on what works and what doesn’t could play in reining in cost growth over time. The President, in his speech last week to the American Medical Association, made some specific suggestions for reform along these lines.⁴ He also said that he was open to changes that would give the recommendations of the Medicare Payment Advisory Commission greater chance of adoption and implementation. The Congressional Budget Office has also outlined a large number of “game changing” reforms that experts believe would slow cost growth.⁵

Evidence that Slowing Cost Growth is Possible. The CEA report also surveys the evidence, much of it from international comparisons and comparisons across different parts of the United States, that there is substantial inefficiency in the current system. The finding of this survey is that up to 30 percent of health expenditures in the United States (which is equivalent to about 5 percent of GDP) could be cut without affecting health care quality or outcomes. This is important in making the case that slowing the growth rate of costs by improving efficiency is possible. For example, our estimates suggest that we could slow cost growth by 1.5 percentage points per year for almost a quarter of a century before we have exhausted the existing inefficiency.

In our report, we speak of the benefits of slowing the growth rate of health care costs. But, each of our figures implicitly shows the impact of not slowing the growth rate of costs. To help emphasize the importance of doing reform well, I will describe them from that perspective this morning.

Effect on Living Standards. Fundamentally, what slowing cost growth does is free up resources. If we restrain costs by eliminating waste and inefficiency, we can have the same real amount of health care with resources left over to produce other things that we value. This causes standards of living to be higher with a slower growth rate of health care costs. In our analysis, we consider varying degrees of cost containment. In particular, we look at the effects of slowing the annual growth rate of health care costs by 1.5, 1.0, and 0.5 percentage points. To be conservative, we assume that it takes a few years for genuine curve-bending to kick in.

³Office of Management and Budget, Fiscal 2010 Budget Fact Sheet, Transforming and Modernizing America’s Health Care System, <http://www.whitehouse.gov/omb/fy2010-key-healthcare/>; and The White House, “Paying for Health Care Reform,” June 13, 2009, <http://www.whitehouse.gov/MedicareFactSheetFinal/>.

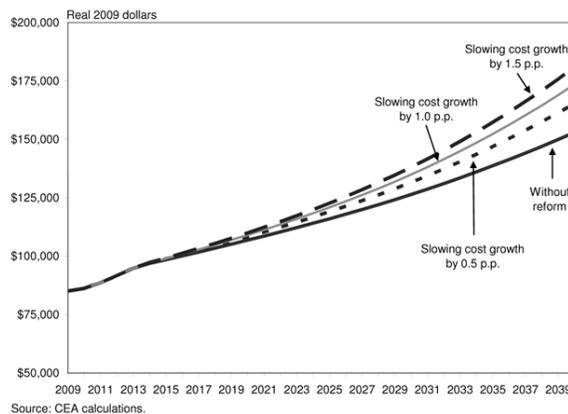
⁴The White House, “Remarks by the President at the Annual Conference of the American Medical Association, June 15, 2009, <http://www.whitehouse.gov/the-press-office/Remarks-by-the-President-to-the-Annual-Conference-of-the-American-Medical-Association/>

⁵Congressional Budget Office, “Health Care Reform and the Federal Budget,” Letter to the Honorable Kent Conrad and the Honorable Judd Gregg, June 16, 2009, <http://www.cbo.gov/ftpdocs/103xx/doc10311/06-16-HealthReformAndFederalBudget.pdf>; and Budget Options, Volume 1: Health Care, December 2008, <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

We analyze the effects of this freeing up of resources in a standard growth accounting framework. Our framework includes the effect of slowing cost growth on the deficit and capital formation (or investment). Because the government is a major provider of health care, slowing the growth rate of health care costs would lower the deficit and thus raise public saving. And, efficiency gains that raise income would lead to some additional private saving. All of this increased saving would tend to lower interest rates and encourage investment. This extra investment increases output even more.

This figure shows the crucial importance of slowing cost growth for standards of living. To make these numbers more concrete, we translate them into the effects on the income of a typical family of four (in constant dollars). The bottom line shows the projected path of real family income without reform. The higher paths show family income under different degrees of cost containment.

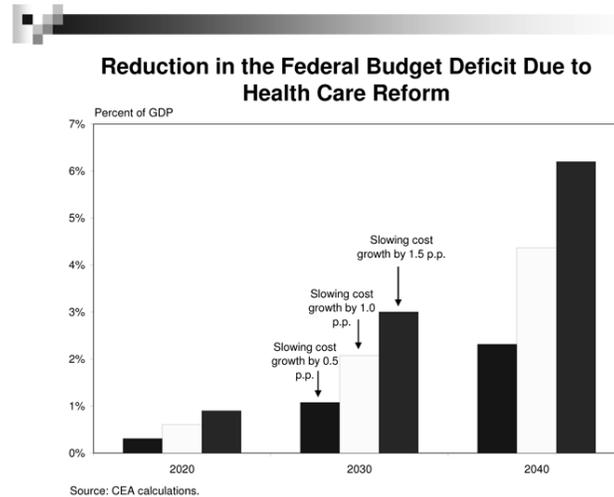
Estimated Family Income with and without Health Care Reform



Our numbers suggest that failing to slow cost growth results in substantially lower standards of living for American families. Without reform, our analysis predicts that typical family income in 2020 will be roughly \$2,600 lower than it would be if we managed to slow the growth rate of costs by 1.5 percentage points. By 2030, it will be nearly \$10,000 lower than if we managed to slow cost growth. Failing to control the growth rate of costs will condemn American families to much lower standards of living than they would experience with successful reform.

Effect on the Budget Deficit. I also want to discuss what our analysis implies about the effect of health care cost containment on the Federal budget deficit. I need to be very clear that our estimates are not official budget projections, which would be based on detailed projections of spending and revenues. Ours are more a back-of-the-envelope calculation. And, they do not include the costs of coverage expansion, because the President has suggested spending cuts and revenue increases that are expected to cover the additional costs in the next decade. Our numbers show the effect of slowing cost growth over the long term.

We find that the implications of not slowing cost growth for the deficit are very large. This figure shows the reduction in the Federal budget deficit due to different degrees of cost containment. Consider the numbers for 2030. They show that slowing the growth rate of health care costs by 1.5 percentage points will reduce the deficit by 3 percent of GDP relative to the case of no reform. Put another way, failing to slow the growth rate of health care costs by 1.5 percentage points per year will result in a deficit that is higher by 3 percent of GDP. By not slowing costs, we will leave our children a budget deficit in 2040 that is 6 percent of GDP higher than it would have been with successful reform. The numbers illustrate the crucial truth that serious health care cost growth containment is central to long-run fiscal stability.



Effect on Short-Run Macroeconomic Performance. Finally, by not slowing the growth rate of costs, we will also likely forego a period of better-than-average economic performance. When health care costs are growing more slowly, wages can grow without firms' costs rising, so firms do not raise prices as much. This allows monetary policy to lower the unemployment rate while keeping inflation steady. Our estimates suggest that slowing cost growth by 1.5 percentage points per year would lower normal unemployment by around $\frac{1}{4}$ of a percentage point. This translates into an increase in employment of about 500,000 jobs. While this is almost surely not a permanent effect, it could last for a number of years.

Taken together, the analysis by the Council of Economic Advisers shows that doing nothing on health care is not an option. The country is on an unsustainable path. Expanding coverage will unquestionably have benefits for economic well-being, the efficiency of the labor market, and the competitiveness of small businesses. But, undertaking meaningful reforms to slow the growth rate of health care costs is absolutely essential. Only by doing so can we avoid a stagnation of living standards and skyrocketing budget deficits.

The President has spoken frequently of the need to provide the American economy with "a new foundation." His goal is that we not only come through the current economic crisis, but emerge a stronger, more durable economy. Health care reform that provides quality, affordable coverage for all Americans and genuinely slows the growth rate of costs significantly is a crucial part of that new foundation. Meaningful reform is absolutely essential to the long-run health of the American economy.

[An additional submission by Dr. Romer, "The Economic Case for Health Care Reform," may be accessed at the following Internet address:]

<http://www.whitehouse.gov/assets/documents/CEA-Health-Care-Report.pdf>

Chairman MILLER. Thank you for the study that the Council did, and also, again, for your testimony and being with us.

I would like to return to—and speaking of concept level, the idea that the President has put on the table now, I think twice or more times, and that is that there are internal savings and cost-cutting that need to be made within how we deliver medicine today, how we deliver health care today.

You, I believe, said it is 18 percent of the gross domestic product. Mr. Kline, or one of you, said that in your statements. And I think

that is much higher than almost every other nation in terms of what we are spending.

And yet we are saddled with the other side of that argument, which is our health status is not much better, and in many important indicators is worse than nations that spend less. And the President has suggested, I think, almost \$600 billion in cost-cuttings, changes, and savings that need to take place. Some of those I suspect will not be adopted by the Congress, but they all reflect the understanding that in the current system we are sort of just paying for utilization; the more you use, the more you are getting reimbursed, wherever you are, whatever plan you are in, whether you are in Medicaid, Medicare, and the private health insurance plans.

And it also suggests that providers of health care, because of consolidation and changes, are becoming more and more powerful in how that is done. So we back up and these costs really become fundamental to—you talk about bending the curve, but if in fact we are going to get out of this box we are in now, most middle-class working people, any wage increase that they might get is taken over by increased share of their premiums or exclusions or co-payments that have been added, and that has been the trend over the last ten years. They are offloading that onto workers. So as you point out, they essentially eat up any possible wage increase that you might have. Any discretionary income that you might get from that increase is essentially gone in those payments.

I would just like you to expand a little bit on that idea, that to change from a utilization-based system to a system that is based upon outcomes and procedures and efficiencies, that there are an awful lot of studies suggesting that it would make a dramatic difference in the total cost to this Nation, whether it be a government program or with businesses and families who are paying for their coverage.

Ms. ROMER. I couldn't agree with you more that we absolutely—at the rate we are going, the numbers that we have show very much that most of that rising in total compensation that comes to workers because of productivity changes and all of that will be taken up by bigger health insurance premiums, so that they see their take-home wages basically being flat or even going down towards the end of the period.

I think a crucial point that you make is that when we talk about curve-bending, slowing the growth rate of cost, we are talking about doing it through improving efficiency. And the crucial part is that as good as the American health care system is—we know it is a technological leader for example—we do feel there is a lot of inefficiency.

And you mentioned the international evidence. People also talk about the huge differences in expenditure on medical care across the country, or even in the same counties within a State, that people say that—researchers say we just can't explain by differences in health needs or differences in the demographics of the population. So that the experts tell us there is up to about 30 percent of health care expenditure that is just being wasted.

What that means is we have got a lot of fat that we can cut out of the system without having any diminution of care. And indeed

what the President is committed to is maintaining and improving the quality of care.

And I would just give you one other number, which is we have talked a lot about can we slow the growth rate of cost by say 1½ points a year. Well, the crucial thing is with the kind of inefficiency that is there, we can do that for 25 years before we actually use up the existing amount of inefficiency. So the kind of changes that we have mentioned, that the President has talked about, absolutely can do that. And they are just absolutely crucial to do.

Chairman MILLER. They are not without controversy, I might add. They are crucial. But I know that the President met with a number of the providers, with pharmaceutical groups, insurance groups, hospitals and others and they talked about taking out, I guess, about 1½ percent, about \$2 trillion over the next ten years. Obviously, laying pencil to paper became more controversial than the discussions.

But I think we as policymakers should recognize what they are telling us. We may have to screw up the courage to make the decisions, but that kind of money is lying on the table with that kind of rather small annual changes and outlays. And, again, if it is accompanied with a policy directed toward efficiencies and better outcomes and a better health care status for American citizens, it seems to me that a big chunk of this bill should take us in that direction. Thank you very much.

Go ahead.

Ms. ROMER. I was going to say you are absolutely right, the 1½ points may sound small, but it is enormous in terms of its effect on the economy. And you are absolutely right that it is going to step on some toes to get any of these.

One example that I give, the bundling of care, one of the things we often talk about is a bundling post, you know, your hospitalization and the 30 days after. That is just such a win for patients and for cost effectiveness because we think that it gives hospitals and providers the right incentives to make sure you don't get sent home too early and that you don't end up back in the hospital. And that is just one that is going to be just a win-win and should absolutely not be as controversial as some of the others.

Chairman MILLER. Thank you. Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman. Thank you, Dr. Romer, for your testimony.

I think that there is absolute agreement on both sides of the aisle here, as Dr. Price mentioned, that we all recognize that we need health care reform. And certainly if you could be reducing costs, that needs to be part of it.

I must say I always cringe a little bit when I think about the government being the one stepping on toes, as you say, to make that happen. And I am also going to say that I am a little skeptical. Getting the government to cut out the fat would seem to defy its history, but I guess hope does spring eternal.

We don't know, of course, right now what the cost of this draft is. We have looked at the CBO estimates already on the version in the Senate. We don't know what this is. It almost certainly is going to be over \$1 trillion. So it is a little bit hard, I would think, for an economist—and you are here as an economist—to really assess

the impact. But I know that or I suspect that you have looked at the issue of employer mandate and what it might—the employer mandate to provide health insurance coverage, what it might do to job losses.

Do you know, is there any professional literature or some estimate of what the job losses might be with an employer mandate? And by the way, I might note that this draft has not only an employer mandate, but an individual mandate, thereby solving the debate that has been going on for several months about which way it should be. And I will have to give you credit, you did solve the debate, Mr. Chairman. Not in the way I expected, but there it is.

So back to you, Dr. Romer. Have you seen estimates as to what job losses might be with an employer mandate such as is held in this draft?

Ms. ROMER. I think in answering that question the first thing we have to make clear is that the vast majority of employers currently do provide health insurance for their employees, and so an employer mandate will just be telling them to keep on doing what they have been doing. So it would have no effect at all on them. And then what effects it could have on other employers depends very much on how it is structured.

And as has been mentioned, one of the things that people are being very cognizant of is how do we treat small employers and those kind of things. I think there is literature, but it certainly has a whole range of estimates, depending on how the system is structured. I do think it is important to realize the reason people talk about having shared responsibilities with employers, and that is that we do think that the employer-based system that we have is something that people are familiar with, and the President has committed to keeping that as a system going forward.

Mr. KLINE. So you don't have any estimates what the job losses might be? I have seen numbers as high as 4 million or 5 million job losses with an employer mandate.

Ms. ROMER. I certainly have not seen numbers like that. That would be, I would think, exceptionally large.

Mr. KLINE. But again, we simply—we just don't know. And there are certainly some concerns with this draft bill that there would be reverse incentives or incentives for employers to drop their coverage. And that is something we are going to be analyzing as we go forward here with the debate on this and the other versions that are out there.

And, of course, we are anxiously awaiting a score from the CBO so we know what we are talking about in terms of dollars here.

I have several of my colleagues here who want to ask questions, including—I think we have three physicians with us here today. So in the interest of time and being ever the optimist that we can keep moving, Mr. Chairman, I am going to waive my time back.

Chairman MILLER. I thank the gentleman for that. Mr. Kildee is recognized.

Mr. KILDEE. Thank you, Mr. Chairman. Following through somewhat on Mr. Kline's question, Ms. Romer, CBO scores the Senate bill at \$1.6 trillion, largely because it does not provide an employer mandate or a payroll tax. The House bill will cost about \$1 trillion,

largely due to the mandate to provide insurance or pay the 8 percent payroll tax except for small employers.

How important is it that the employers continue to provide insurance or pay the 8 percent payroll tax along with other nonproviding employees? Is 8 percent adequate or realistic? Does the Senate bill meet the President's standards?

Ms. ROMER. I think you are all getting at certainly a key issue, which is how one structures the employer shared responsibility that is important to maintaining the system that we have, the insurance being employer-based, and for controlling costs, so that is certainly important. I think the details are something that we will be analyzing more and I am sure the Congressional Budget Office and your staffs will be analyzing more.

One issue I do want to bring up that, as Mr. Kline was talking about, employment effects from the mandate. I have to tell you that slowing the growth rate of cost, in our report one of the things that we say is that that has a beneficial effect on employment; that by having a period when costs are not rising as much, that helps to give us a period of unusually good economic performance.

And so I think we certainly want to look at the totality of the plan because we think it can certainly have some positive employment benefits.

Mr. KILDEE. But the omission in the Senate bill of the employer mandate is not a small issue. It is a rather fundamental part of the President's plan, is it not?

Ms. ROMER. The President has certainly expressed the view that he does very much want to stay within the current largely employer-sponsored health insurance, and some sort of shared responsibility is very important.

Mr. KILDEE. And the cost to the government of \$1.6 trillion must concern the President, too, rather have part of that cost retained or taken up by the employer.

Ms. ROMER. Absolutely. The President has from the beginning said that we need to certainly make sure that anything we do does not increase the deficit in the 10-year budget window. And it needs to have the fundamental kind of reforms that I was talking about that will actually lower the budget deficit outside that window. So that is a top priority for the President.

Mr. KILDEE. Thank you, Ms. Romer.

Chairman MILLER. Dr. Price.

Dr. PRICE. Thank you, Mr. Chairman.

I want to thank you for your testimony, Dr. Romer. You mentioned at the beginning of your testimony that you are an economist, and we are going to talk about the economics of it, but you delved into the health care, so my questions will bounce back and forth, if that is all right. You started out talking about the fact that we spend 18 percent of our GDP on health care in this Nation. As an economist, how much should we spend?

Ms. ROMER. I think there is no single number. You are getting at a point, a good point, that is there is not some fixed amount. What I do feel we know is that we shouldn't be wasting; and so the estimates that maybe as much as 5 percent of GDP that we are spending is just wasted.

Dr. PRICE. But it is not your testimony that the government ought to set a specific amount that we ought to be spending on health care; is that correct?

Ms. ROMER. No, of course not.

Dr. PRICE. And in your testimony you also say that 46 million folks are uninsured. Is that uninsured today?

Ms. ROMER. That is actually a crucial point. It is at a point in time. Because experts will certainly tell you over, say, a 2-year period, probably twice that many people go through some period of lack of insurance.

Dr. PRICE. Isn't the 46 million number, though, those that are episodically uninsured at some point during the course of the last 12 months?

Ms. ROMER. No. That is at a point in time. And the number is like 82 million for over some 2-year period.

Dr. PRICE. If you could provide the data on that, I would appreciate it.

Ms. ROMER. I believe the citations are in our report, but I will absolutely make sure you have it.

Dr. PRICE. Thanks. And a breakdown of those 46 million is helpful to decide how we in fact get them insured, right? So it would be helpful to know exactly who those folks are and why they are not insured.

[The information follows:]

Questions for the Record Submitted to Dr. Romer

Thank you for testifying at the Tuesday, June 23, 2009, Committee on Education and Labor hearing on "The Tri-Committee Draft Proposal for Health Care Reform." One of the Committee members had additional questions for which she would like written responses from you for the hearing record.

Congresswoman Carolyn McCarthy (D-NY) asks the following questions:

1. In many cases payments to providers from private insurance companies, as well as Medicaid and Medicare, do not reimburse providers for the full cost of the care provided. What, if anything, is being done to address this issue?

2. There has been a great deal of discussion regarding the practice of payment bundling. Could you explain what this bundling is and how it would work?

3. How can we address waste and fraud in a way that does not penalize providers who are providing appropriate services?

4. Regarding efforts to close or reduce the donut hole—how will we pay for these efforts?

5. The United States spends much more than other nations on healthcare. Part of this has been attributed to high administrative costs. Where do these high administrative costs come from? How will this reform bill reduce these administrative costs?

6. The United States Currently Spends 18% of GDP on healthcare. Estimates suggest that if nothing is done to reduce those costs, the percentage could increase to 33% of GDP by 2040. How will this reform bill help to address this issue? What size reduction in growth in healthcare spending as a percentage of GDP is expected?

7. Millions of people face financial hardships, including bankruptcy, as a result of healthcare costs. I've recently been working with the bleeding disorders community on a resolution calling for improvements in the diagnosis of care for bleeding disorders. These disorders, however, are costly and continue throughout the life of the individual. As a result, many individuals reach their lifetime insurance cap. Can you talk about the number of people that insurance caps affect and the expected benefits of removing the insurance cap?

8. As you know, the United States is currently experiencing a severe nursing shortage and we are unable to meet our current and future healthcare needs. I have proposed a number of bills to be included in healthcare reform, including the Nurse Training and Retention Act, which I am pleased has been included in the released draft, and the Student-to-School Nurse Ratio Improvement Act. In addition, I had a number of provisions included in the Higher Education Act to increase the number

of nurse faculty and nursing students. Do you have any proposals for how we can address the nursing shortage and how healthcare reform will affect nurses?

Please send your written response to the Committee on Education and Labor staff by COB on Tuesday, July 24, 2009—the date on which the hearing record will close. If you have any questions, please contact the Committee. Once again, we greatly appreciate your testimony at this hearing.

Sincerely,

GEORGE MILLER, *Chairman.*

Responses to Questions for the Record From Dr. Romer

1. In many cases payments to providers from private insurance companies, as well as Medicaid and Medicare, do not reimburse providers for the full cost of the care provided. What, if anything, is being done to address this issue?

Based on analysis of the 2006 American Hospital Association Annual Survey data (the most recent year available), among community hospitals, the aggregate hospital payment to cost ratio was 91.3% for Medicare, 85.8% for Medicaid (includes DSH payments), and 130.3% for private payers. It is important to be mindful that these aggregate statistics do not suggest that all hospitals lose money on Medicare and Medicaid patients. Hospitals that are more efficient in their provision of care often make money.

Since the final legislative language has not yet been released from the three committees, we are unable to comment on any specific proposals that are being considered with respect to Medicare and Medicaid payment rates.

2. There has been a great deal of discussion regarding the practice of payment bundling. Could you explain what this bundling is and how it would work?

Bundled payments represent one strategy to lower the number of unnecessary services and improve the quality of care in hospital-based, post-discharge, and outpatient care settings. Under a bundled payment system, an appropriately set payment is allocated for all treatment surrounding a well-defined episode of care (e.g., knee replacement, 6 month period of care for a person with congestive heart failure), rather than independent charges for each prescribed service (e.g., office visit, lab tests, MRI).

Bundled payments would function much like the prospective payment for hospitalizations that currently exist in Medicare today, but would extend across provider types and/or within the outpatient setting. There are exciting new innovations coming from the private sector with respect to developing the clinical coding algorithms and implementation designs to integrate bundled payments into current systems used by insurers.

Bundled payments give providers a strong incentive to use resources wisely and get the treatment right the first time because if the costs of care exceed the bundled payment, providers bear financial liability. Bundled payment systems increase the efficiency of resource use by promoting care coordination among the multiple providers who supply care during an episode. Lack of care coordination has often been cited as a major contributing factor to preventable re-admissions among Medicare beneficiaries. The idea is not to reduce the amount of care, but to eliminate low value or redundant care, thereby reducing costs without compromising quality. Indeed, bundled payments can increase quality by giving a single provider crucial oversight responsibility, and by encouraging infection control, patient education, and other health investment measures that improve outcomes.

3. How can we address waste and fraud in a way that does not penalize providers who are providing appropriate services?

Private insurers, Medicare and Medicaid are making important investments to identify waste and fraud in the health care system. Examples of fraud include billing for services or items that were not provided, billing for work already reimbursed by another insurer, or altering claim forms; examples of waste may include claims for services that are not medically necessary.

Insurers use a variety of tools when analyzing their data in order to detect fraud and waste. These techniques include edits, alerts, and pattern detection. Both private insurers and government purchasers continue to develop refinements to predictive models that will accurately detect fraud and waste and not inadvertently target providers who are prescribing appropriate services.

Perhaps one of the most important things that private insurers, Medicare, and Medicaid can do is to have regular communications with providers about the importance of identifying fraud and waste so that everyone can be made better off (pro-

viders, government, and taxpayers) when the few “bad apples” are identified, denied payment, and in some cases prosecuted.

4. Regarding efforts to close or reduce the donut hole—how will we pay for these efforts?

In general, Medicare Part D is financed by beneficiary premiums and general revenues.

In June, the pharmaceutical industry pledged to reduce by at least 50% the cost of brand-name prescription drugs for Medicare beneficiaries who fall into the donut hole (the gap in coverage between annual total spending of \$2700 and \$6154 in 2009). We are currently awaiting details about how such a pledge will be formally implemented, including the mechanism by which plans and pharmaceutical companies will be able to distinguish when a beneficiary hits the donut hole.

5. The United States spends much more than other nations on healthcare. Part of this has been attributed to high administrative costs. Where do these high administrative costs come from? How will this reform bill reduce these administrative costs?

The United States spends significantly more on health care administrative costs than other countries. A McKinsey Institute report indicated that as of December 2008, administrative costs accounted for 7% of overall health care costs (\$145 billion) in the U.S., or \$486 per person compared to an average of \$103 for other OECD countries. For a typical medical group (including clinicians’ time), the cost of administration ranges from 10% to 27% of revenues.

High administrative costs are partially due to fragmentation in our health care system. Our system of multiple payers, independent providers, and the lack of coordination between them leads to greater administrative costs for hospitals and physicians. For instance, forms, billing, and other administrative details are not standardized across payers and providers, thereby increasing costs and potential mistakes. The individual and small group markets, where the high initial administrative cost burdens cannot be spread across a large pool of beneficiaries as in the large employer market are another source of high administrative costs.

An insurance exchange may reduce administrative costs, especially those associated with the individual and small-group market, by standardizing application forms and streamlining insurance purchases for larger groups of employees. Other proposed strategies for administrative simplification and cost reduction include creating a standardized electronic billing system that could be used by all providers, suppliers and payers and increased adoption of health information technology in general to reduce mistakes and increase coordination.

6. The United States Currently Spends 18% of GDP on healthcare. Estimates suggest that if nothing is done to reduce those costs, the percentage could increase to 33% of GDP by 2040. How will this reform bill help to address this issue? What size reduction in growth in healthcare spending as a percentage of GDP is expected?

Any reform legislation needs to provide ways to not only pay for the new expenditures associated with the expansion of coverage and health care investments, but also to slow the growth rate of health care costs. Proposals to slow the growth rather of costs, often referred to as “game changers,” need to be targeted to address some of the key drivers of inefficiency in the health care system. In particular, “game changer” proposals should align provider incentives to promote efficiency and provision of high quality care. They should increase the flexibility of administered pricing systems to incorporate new information about the effectiveness of treatment and improvements in the productivity of inputs to medical care. They should reduce fragmentation in the system through standardization of billing and other administrative processes. And, they should include investments to strengthen the system, including implementation of information technology and electronic medical records, comparative effectiveness research, creation and dissemination of price and quality information for consumers, and generation of timely performance feedback for providers.

Estimates by the Council of Economic Advisers suggest that slowing the growth rate of health care costs by 1.5 percentage points per year would result in health care expenditures in 2040 equal to 23% of GDP. This is dramatically less than the 34% of GDP that we project will occur in the absence of successful health care reform.

7. Millions of people face financial hardships, including bankruptcy, as a result of healthcare costs. I’ve recently been working with the bleeding disorders community on a resolution calling for improvements in the diagnosis of care for bleeding disorders. These disorders, however, are costly and continue throughout the life of the individual. As a result, many individuals reach their lifetime insurance cap. Can you

talk about the number of people that insurance caps affect and the expected benefits of removing the insurance cap?

According to the AHIP December 2007 survey of individual health insurance plans, the average lifetime maximum benefit is \$4.2 million for single coverage in a PPO or POS plan, \$3.0 million for HMOs and \$4.3 million for HSAs.

Unfortunately, there are no public sources of data to tell us how many individuals with private insurance have reached annual and/or lifetime insurance maximum benefit limits on their policies.

8. As you know, the United States is currently experiencing a severe nursing shortage and we are unable to meet our current and future healthcare needs. I have proposed a number of bills to be included in healthcare reform, including the Nurse Training and Retention Act, which I am pleased has been included in the released draft, and the Student-to-School Nurse Ratio Improvement Act. In addition, I had a number of provisions included in the Higher Education Act to increase the number of nurse faculty and nursing students. Do you have any proposals for how we can address the nursing shortage and how healthcare reform will affect nurses?

The research literature suggests that there will likely be some workforce shortages in coming decades, particularly for nurses, non-physician clinicians, and primary care physicians. Assuming health care reform expands coverage to a significant proportion of the 46 million Americans who are uninsured, there could be a noticeable increase in the demand for medical care. In turn, this will increase the demand for nursing labor as well as other types of medical personnel. While CEA does not have any specific workforce proposals that it endorses, we are working with the Department of Health and Human Services in the development of ideas to address this issue.

Dr. PRICE. You also mentioned, as other folks have, that the President's goal—and it is reiterated over and over and over—that if you like your current plan or if you like your current doctor, you can keep them. Do you know where that is in the bill?

Ms. ROMER. Absolutely. And things like the employer mandate is part of making sure that large employers, that today the vast majority of them do provide health insurance.

Dr. PRICE. I am asking about if an individual likes their current plan, and maybe they don't get it through their employer and maybe in fact their plan doesn't comply with every parameter of the current draft bill, how are they going to be able to keep that?

Ms. ROMER. The President is fundamentally talking about maintaining what is good about the system that we have.

Dr. PRICE. That is not my question.

Ms. ROMER. One of the things that he has been saying is, for example, you may like your plan. And one of the things we may do is slow the growth rate of cost of your plan. So that is something that is not only—

Dr. PRICE. The question is whether or not patients are going to be able to keep their plan if they like it. What if, for example, there is an employer out there—and you have said that if the employers that already provide health insurance, health coverage, for their employees that they will be just fine, right?

Ms. ROMER. Uh-huh.

Dr. PRICE. What if the policy that those employees and that employer like and provide for their employers doesn't comply with the specifics of the bill; will they be able to keep that one?

Ms. ROMER. Certainly my understanding—and I won't pretend to be an expert in the bill—but certainly I think what is being planned is, for example, for plans in the exchange to have a minimum level of benefits.

Dr. PRICE. So if I were to tell you that in the bill it says that if a plan doesn't comply with the specifics that are outlined in the bill, that that employer is going to have to move to a different plan within 5 years, would that be unusual or would that seem outrageous to you?

Ms. ROMER. I think the crucial thing is what kind of changes are we talking about? The President was saying he wanted the American people to know that fundamentally if you like what you have, it will still be there.

Dr. PRICE. What if you like what you have, Dr. Romer, though, and it doesn't fit with the definition in the bill? My reading of the bill is that you can't keep that.

Ms. ROMER. I think the crucial thing, the bill is talking about setting a minimum standard of what can count as a plan.

Dr. PRICE. So it is possible that you may like what you have, but you may not be able to keep it, right?

Ms. ROMER. I would have to look at the specifics.

Dr. PRICE. Good. You talk about portability and the importance of portability. And it is extremely important. You got to be able to take your insurance with you. Isn't there a different way to do that, or aren't there other ways to do that besides what is being outlined in the bill? For example, if you owned your health insurance policy regardless of who would pay for it, wouldn't that be a way to accomplish portability?

Ms. ROMER. We certainly have seen, for example, a lot of trouble. People have trouble with portability. Certainly given that the vast majority of Americans have employer-provided, they don't have something that is—

Dr. PRICE. Dr. Romer, if an individual owned their policy, regardless of who paid for it, couldn't they take it with them regardless of their job situation?

Ms. ROMER. Yes, that would seem to me that—

Dr. PRICE. I notice in your testimony you didn't mention either liability reform or regulatory reform. Would you be able to tell the committee how much that contributes to the cost of health care in the Nation, liability cost and regulatory cost?

Ms. ROMER. We have actually been looking at that. One of the things in our report is to point out that there are a large number of things that are behind how much health care costs are today and how much they have been rising. My read of the professional literature is that the estimates are all over the map. It is certainly a part of why costs are high and a part of why they are rising. I think my read of the evidence is it is not the primary reason.

Dr. PRICE. As an economist, though, you could put a number on that and you could get that for the committee.

Ms. ROMER. I will certainly do the research.

Dr. PRICE. Thank you so much. Thank you, Mr. Chairman.

Chairman MILLER. Mr. Payne.

Mr. PAYNE. Thank you very much. With expanded coverage, I assume that there should be more wellness prevention. When you are poor—you know when I was young, you know people think you are crazy when you go to a doctor if you weren't sick, because well people couldn't afford to go to the doctor even when we were sick, more or less when you weren't.

However, how much do you think as this moves on the wellness, the prevention, if that can be an educational part of the coverage? Is there any quantifiable number that you think would show a slowing in the increase, or have you kicked in any leveling off by virtue of the preventive part?

Ms. ROMER. That is an excellent question because it does—you know in our report, we often talk about the benefits of coverage expansion and the benefits of slowing the growth rate of costs. And, of course, those two things do intersect exactly where you talk about—with wellness and prevention—because when someone has health insurance coverage, they tend to have a relationship with a primary care physician who does do the education and the focus on wellness that we do think can slow the growth rate of cost.

Especially, again, my understanding of the literature, things like smoking cessation programs, weight management, are absolutely things that can slow the growth rate of cost over time. I think the important thing is it is not the only thing we need to do, and that there are other things like how we reward value over volume and changing the delivery system that are also very important to slowing cost, but certainly wellness is one component.

Mr. PAYNE. Thank you. Also I have had concerns. As we do know, there are certainly underserved communities in rural areas where it is difficult, and of course in urban areas, the type of part of the district that I represent—and of course, my concern continually is access to a physician or to quality care.

And I am wondering, you know, kind of getting ahead of things, but how are we going to ensure in towns in the district that I represent that there will be the opportunity for wellness and the opportunity for preventive services, because we do know that there is certainly a lack of quality—or lack of any physicians in general in many of the underserved districts?

Ms. ROMER. I think, again, one the very strong features of the tri-committee bill is that it does address these workforce issues that we know. Especially if we are going to move to a system where there is more coverage, more access to primary care, we need more primary care physicians. So I think these workforce issues are going to be important. I know it is something that my staff and others in the White House are absolutely thinking about because that is going to be an issue.

And your point about the geographical, it is not just the numbers but the geographical distribution is going to be very important.

Mr. PAYNE. I will just yield back the balance of my time.

Chairman MILLER. Dr. Cassidy.

Dr. CASSIDY. Thank you, Dr. Romer.

I enjoyed your Council of Economic Advisors report on the problem, but there are no prescriptions, as you say, and this effectively is a prescription. And in your testimony, you allude to some stuff; some of it seems as if you are telling me down is up and up is down. For example, Medicaid and Medicare, quite impressively, is driving cost. And yet we are going to increase Medicaid to 133 percent of Federal poverty level.

I have an article here from Health Affairs, out of the Lewin Group, that points out when you have increased Medicare and Medicaid as a proportion of your payer mix, for the private insur-

ance company it drives their cost up, the hydraulic effect. You push down here because you use your monopsony power to drive up rates and it pushes up there, gaming the system for the public thing.

So one question I have is, how are we going to control Medicaid when we are increasing the reimbursement levels and we are increasing eligibility? Again, that is just cost purposes.

Secondly, you know, next Tuesday morning, I am going to be treating lots of Medicaid patients in a public hospital in Louisiana, as I have for 20 years. I don't think a single one of them would say it is patient-centered. As I looked through 800 pages this last weekend, I didn't see much that said "patient-centered." We are using that rhetoric, but as a guy that has been spending 20 years trying to address that, I don't see it.

And the accountable care organization is an unproven concept. And even the advocates admit that there are lots of obstacles for it to be instituted. Bundling is unproven, frankly. I keep on wondering how we are going to save money and lessons by using the States' monopsony power to drive down the provider reimbursement. Which brings me back to this, which says that you are going to drive up the cost for the private insurance companies, effectively gaming the system so that people migrate towards the public.

I have asked several questions, and I apologize. If you can address those, please.

Ms. ROMER. So the crucial thing that you are mentioning—and something the President is well aware of—is what we are talking about in terms of extending coverage in some of the reforms we are doing now, like health information technology and the payment reforms. Those are absolutely going to cost money and that is why he has put \$948

billion of suggested savings and other revenue sources to pay for those kinds of expansions now in the budget window, and then to make the kind of fundamental changes that will slow the growth rate of costs over time.

One of the things you did mention, like the accountable care organizations, one of the strengths, again, of the bill, the pilot programs that surely are going to be a part of how we move forward on this, is figuring out what does slow the growth rate of costs.

Dr. CASSIDY. We do know a couple of things that slow the growth rate. ACOs have not been proven to do so. But one thing that slows the growth rate is HSAs, Health Savings Accounts. I have a Kaiser Family Foundation thing that shows for similar benefits, similar demographics among beneficiaries, an HSA has 30 percent lower costs than a fee-for-service. There is nothing in here and—that is a very patient-centered concept—there is nothing in here about an HSA.

Secondly, I would say that there is nothing in here about what the Safeway program has, which has variable premiums for people who enroll in preventive medicine. Indeed, as best as I could tell, this would not allow that in the public option, and yet the one preventative measure that has worked is actually making the patient a little fiscally responsible for lifestyle choices.

Ms. ROMER. The main thing I would say is I would highly recommend the Big Fix CBO volume that I actually keep on my

bedside table on budget options. There are 108 things that they proposed as things that could help to slow the growth rate of cost.

What you are pointing out, there are a range of things; the tri-committee bill has some of them in it. The important thing is we have absolutely got to take these measures and and they are absolutely ones that the vast majority—

Dr. CASSIDY. I am almost out of time.

Except for using monopsony power to negotiate lower rates, is there one thing in here that is proven to lower cost?

Ms. ROMER. Absolutely. I believe things like bundling, that the evidence is that that has worked in other places where we are bundling. So we are thinking of expanding that.

Dr. CASSIDY. If you had to bet your house on that, would you bet your house on that evidence? Because it is slender and it goes both ways.

Ms. ROMER. It is cited in our report, and I will make sure we track it down for you.

Dr. CASSIDY. Thank you very much.

Chairman MILLER. Mr. Andrews.

Mr. ANDREWS. A lot of Americans are betting the house. That is the problem. They lose their house, they lose everything they had. So we are betting on fixing the problem.

I want to come back to Dr. Price's questions to you about the President's commitment that if you like your plan, you get to keep it.

Dr. Price posed an example where if a plan that an employer provides falls short of the credible minimum coverage that is in the House draft, the question is what would happen? The answer is the employer would have to come up with that, that is true. But I want to examine with you whether someone is likely to like that plan.

The President said if you like that plan, you get to keep it.

Ms. ROMER. I think most people like something that is better.

Mr. ANDREWS. It is my understanding in the House draft that the minimum coverage is based upon 70 percent of the actuarial value of the Federal Employees Health Benefit Plan. That is a pretty modest number. And do you think it would be likely that a plan below that number might not have access to primary care like OB-GYN care, annual checkups?

Ms. ROMER. There are certainly going to be limitations.

Mr. ANDREWS. Do you think it is likely that a plan that would fall below that would probably have an immense copay in the middle, or deductible in the middle, where you get some primary care coverage but then have an enormous donut hole, something the majority is very familiar with and we are going to fill. Do you think it is very likely that they have that huge donut hole in the middle?

Ms. ROMER. I think it is likely.

Mr. ANDREWS. How likely do you think that somebody would have catastrophic care coverage if their plan fell below that 70 percent threshold?

Ms. ROMER. Exactly. They are likely to have high out-of-pocket expenses.

Mr. ANDREWS. So I guess it is metaphysically possible that somebody would like that kind of plan, and we think that the reality is that people would not like something like that.

Let me come back to employee mandates that Mr. Kline asked about. Your projections of economic growth are based upon the President's conceptual plan; is that right?

Ms. ROMER. They are based—I mean, the crucial thing, the principles that the President laid down—

Mr. ANDREWS. One of those was that all employers would have some fair share of responsibility, right?

Ms. ROMER. The main thing we were focusing on was slowing the growth of costs.

Mr. ANDREWS. Your projections take into account the dynamics of a requirement of employer responsibilities; is that correct?

Ms. ROMER. Our projections are on a much broader level, so they don't have those kind of details in them, so they are based on—

Mr. ANDREWS. But that is one of the ways we would get that cost growth curve to bend, I assume.

What happens—you are an economist and I am sure you can tell us this—but let us say that you run a retail store and I run a retail store, and you voluntarily insure your employees and you are in excess of this minimum standard so this bill leaves you alone, lets you keep doing whatever you want to keep doing. And I don't, I don't provide health care to my employees. And one of my employees gets into a motorcycle accident, who pays the bill?

Ms. ROMER. Depends on whether they had private—

Mr. ANDREWS. Let's assume that she is one of the uninsured.

Ms. ROMER. So it would be uncompensated care.

Mr. ANDREWS. Who pays for uncompensated care?

Ms. ROMER. Well, all of us as taxpayers and all of us who have private insurance.

Mr. ANDREWS. So you, as the retail owner who does insure your employees, is picking up part of the cost for me, who doesn't. Is that right?

Ms. ROMER. Absolutely, as do the rest of us.

Mr. ANDREWS. So this plan would also take into account that economic issue where we are leveling that playing field a bit, and there are taxes imposed, aren't there, also at the State and local level to cover uncompensated care?

Ms. ROMER. Absolutely.

Mr. ANDREWS. What would happen to those State and local taxes if this draft were enacted and people got health insurance under this plan?

Ms. ROMER. We absolutely expect that uncompensated care would go down.

Mr. ANDREWS. Let me ask you one other question about your economic assumptions here.

How many jobs do you think it would cost us to do nothing? And I know the other side says no one is in favor of doing nothing. That is rather odd; since everyone is in favor of doing something, nothing has been done for 50 years. What would it cost to do nothing in terms of lost jobs for the economy?

Ms. ROMER. Certainly. What we have numbers on are it what is going to cost in terms of, you know, our total standard of living; and there we have enormous numbers about how we are absolutely going to have lower standards of living. We certainly have the short-run impact on jobs.

So our numbers were that, by not having successful reform, we get numbers like we are costing ourselves maybe 50,000 jobs that we could be having if we had successful reform, at least for a while, in terms of better economic performance.

Mr. ANDREWS. I thank you and yield back.

Mr. CASTLE. Dr. Romer, I have been trying to figure out exactly what context you are here for. Is the administration supporting the tri-committee bill? Or there are other bills out there. There are Senate bills, there are Republican propositions. I am not exactly sure where the administration is. Is this now your bill?

Ms. ROMER. The crucial thing is I am here representing the administration, to tell you that health care reform is the President's number one priority, and I think what I was describing is what the President sees as kind of the key principles. We do know there are lots of bills, and each one of them has certain strength. And so we are here to help move that conversation along.

Mr. CASTLE. So you are not supporting this bill, per se, but you are supporting the principles?

Ms. ROMER. We are absolutely supporting successful health care reform, which is the number one thing on the President's agenda.

Mr. CASTLE. My numbers may not be exactly correct, and you can correct me. I have seen a chart on the 46 million people who are uninsured, and something like 9- or 10 million of those are people who are not legally in the United States of America.

My question to you is, what would this plan or what does the administration propose with respect to those individuals; that they would have to be insured and would the government be in a position, if they are low-income, to have to pay for that insurance? I mean, you are dealing with a situation where it is what do we do with somebody who perhaps should not be here to begin with.

Ms. ROMER. So there are several things to point out. One is we talk—we mentioned with Dr. Price about the 46 million. That actually is more like 82 million when you think of people who are uninsured at a point in time. A crucial fact of that is probably 80 per-

cent of those are workers, most of them are middle-class families that go kind of in and out of insurance.

On the issue of undocumented workers, the President has said that he does not support government-provided health insurance for undocumented workers, but he has certainly also talked about the importance of comprehensive immigration reform that he thinks is important.

Mr. CASTLE. So we should take that number away from the 46 million in terms of those who we are concerned about protecting at this point?

Ms. ROMER. Yes.

Mr. CASTLE. I am from Delaware. In my State—this is probably true of a lot of States—there is a lot of free or subsidized medical help. The Federal community health centers are a perfect example of that, but prescription drug programs that exist throughout the country, volunteer position programs. I just read about a cancer program we have in Delaware for people who are low-income. We have employer-based clinics, hospital clinics, et cetera.

If we go to a universal system, what is going to happen to those programs? And my concern is that all of a sudden, people are going to say everybody is insured now and we don't have to do these. And we are going to lose a lot—from an economic point of view—a lot of relatively free medical help which is being provided in this country. Has that been factored economically into what is being done at the White House, or in this legislation or anywhere else that you know about?

Ms. ROMER. We certainly do know that there is a lot of uncompensated care in the country, and a lot of it ends up being paid for by the government. So I would think as we moved, certainly, from government-run programs that are providing uncompensated care, we would just be changing how they are paid for by making these now—workers that are currently uninsured would now have insurance. But so many of these wonderful programs, I would assume they would continue but in a different guise.

Mr. CASTLE. I wish somebody would look at that. I don't think a lot of these are necessarily with cost-shifting over to the government, with the exception of public community health centers, the things I need are mostly volunteer activities by either corporations or different entities who are willing to help. I am concerned about that loss.

Another insurance area that concerns me is the whole area of prevention and wellness, which I think is in this legislation. I haven't read it carefully at this point. And certainly, I think we all agree it is a key for improving health care for all of us in America. But has anyone looked at what cost savings can realistically be obtained by imposing prevention and wellness programs, preventing diabetes, that kind of thing? That may be a little bit too difficult to do, but do you have a grasp on that?

Ms. ROMER. It is something I know—it is something that is heavily studied. Actually, I will tell you about I was doing an interview on television and someone said, aren't you just going to make people live longer? And I said yes, guilty as charged.

But that is sort of one of the key issues here is that we do know wellness often is cost-effective over a range, but then people live longer. So figuring out what it saves in general, you're absolutely right, there are some estimates. The things I cited like smoking cessation, weight management, those do seem to help. But if we make people live longer, I don't apologize for that.

Chairman MILLER. At this point, I am going to call on Mr. Scott and then Dr. Roe and then Ms. Woolsey and then Mr. Hunter. And then Ms. Romer is going to be allowed to leave the committee under our arrangement of getting her here today. Then we will hear from our second panel.

So, Mr. Scott.

Mr. SCOTT. I need to follow up on the comments from Mr. Andrews on the cost shifting.

I have heard that it is about a hundred dollars per family that goes to paying for the costs of indigent care. Is that about right?

Ms. ROMER. I would have to check the numbers, but it is certainly substantial.

Mr. SCOTT. Can you say a word about the importance of covering prenatal care and early child comprehensive care?

Ms. ROMER. I think that goes to Mr. Castle's point that in terms of preventative care that has a good payoff, I feel very strongly that the evidence suggests that prenatal and child care—child well care is crucial.

Mr. SCOTT. Now, the Medicaid program has a program called EPSDT. It is a comprehensive set of benefits. Is it essential that same comprehensive set of benefits, which includes preventative and screening tests, be available on all policies?

Ms. ROMER. So I think the specifics—I mean, that is part of this bill certainly talks about setting up a professional advisory board to decide what benefits. I think that certainly is a crucial issue and something that requires very careful thought.

Mr. SCOTT. And in terms of competition, what portion of the public plans, Medicare and Medicaid, actually go to health care, and how much is spent in administration compared to the private plans? How much is spent on administration and how much actually goes to health care?

Ms. ROMER. I think you are making an important point, which is that we do know the public plans, Medicare and Medicaid, do have lower administrative costs. And that is one of the reasons, when we think about setting up a public option, one of the ways that it will be able to put competitive pressure on private firms, because it is likely to have lower administrative costs.

Mr. SCOTT. Is there much difference between the two?

Ms. ROMER. Yes. I believe it is substantial.

Mr. SCOTT. Does 25 to 40 percent administration in these private plans, is that an order of magnitude that you understand, and about 3 percent in the public plans?

Ms. ROMER. I would definitely have to check the numbers to make sure I was answering correctly, but I am happy to get back to you on that.

Mr. SCOTT. One of the things that we are trying to do is transform health care at the same time we are trying to get coverage and change the health delivery system at the same time we are doing financial access. Should we do them one at a time or all at the same time?

Ms. ROMER. I think the President has very smartly said that we can certainly do many things at once, and I have complete confidence in the Congress as well—and these are all crucial issues. These are all part of what the President has called the new foundation, and they are all aimed at the same thing, which is making this a healthier, stronger economy.

Mr. SCOTT. One of the things that we have been asked is, how we are going to pay for it? We are going to be making some decisions on taxes in the next few months—the estate tax, what I call the bare minimum fair share tax, that is the alternative minimum tax. Where would these be in the list of priorities compared to universal health care?

Ms. ROMER. So what the President has said is absolutely that he thinks comprehensive health care reform is crucial, and he has given a list of ways to pay for it. About two-thirds are suggested savings for Medicare and Medicaid and about one-third coming from new tax revenues. And he had a suggestion which is limiting

the itemized deductions on high-income earners. You listed some others.

Mr. SCOTT. Should we enact health care and then figure out how much in terms of tax cuts we can afford? Or should we pass all of the tax cuts first and see if we can get around to health care?

Ms. ROMER. I think we should do a sensible health care reform that does what we need to do for health care and make sure that it doesn't increase the deficit in the crucial 10-year budget window.

Chairman MILLER. Dr. Roe.

Dr. ROE. I would like to agree with all of your economic arguments if they didn't go exactly the opposite of what happened to us in Tennessee.

We got a Medicaid waiver, as you know, 16 years ago in this State to form a managed-care health care plan called TennCare to hopefully cover most of the people in Tennessee. What happened was, it was a very rich plan and offered a lot of benefits, like I believe this government-run option is going to be. And what happened was small businesses first, but others made a perfectly logical decision to drop their private health insurance and go into the government-run TennCare plan. And 45 percent of the people who are in the TennCare plan, or were in the TennCare plan, had private health care insurance but dropped it for this government option.

The problem with the government plans is this: When you talk to the providers, the hospitals, and the other providers, TennCare paid 60 percent of the costs of providing the care—very rich in the promises but only 60 percent of the costs. Medicare pays about 90 percent of the costs. So you've got two of the government plans that don't pay the costs of the care. And the uninsured pay somewhere in between, shifting more and more and more costs onto the private insurers.

And to answer Mr. Scott's question, it is about \$100-\$150 a month is what the answer is, the cost that is shifted. That is the data that I have seen.

What I fear in a government option, a government-run bureaucratic plan, is this very thing will happen again on a national scale. You are going to have a very rich plan that has offered all of these benefits, and here you are in private health insurance out here, and you are going to have your cost shifted to you even more and more. And businesses will make a perfectly logical decision, which is to drop the the government option.

So over time—it won't happen immediately, it will happen over time.

In Tennessee what our Democratic Governor did, along with the legislature, was he cut the rolls because it was bankrupting the State. And your assumption it is going to save money goes in the face of what our experience has been in Tennessee. Could you respond to that?

Ms. ROMER. I think the crucial thing is what it shows is how important it is to get the details correct. And that absolutely how one sets up the public plan and all of that is going to be important. But one of the things that the tri-committee bill does—and that the President certainly emphasized—is it needs to be on a level playing

field and that, for example, being paid for by premiums that are paid into the public plans. I think that is important.

Dr. ROE. If what you have just said happens, you don't need a public plan. You can have another insurance plan. It will be a subsidized plan. The premiums, I will guarantee you, will not pay for the cost of that care.

Let me answer a question Dr. Price had just a moment ago. I went back to my own group. I am in a medical group at home that had about 350 employees. And this astonished me. We had offered last year a high-deductible insurance plan, a health savings account. First we offered it to the physicians and then we offered it to every one in our group, which is over 300 people.

What percent do you think took that plan? 10 percent? 15? 84. And the reason was because they could look at a \$5,000 deductible—this is a plan that will be gone with this current plan. I can tell you those will be gone because there is no health savings account in this current legislation or any that I have seen.

And what these employees found out, along with me—that is what plan I had—was if you do believe in the wellness and prevention, this economically incentivizes you to do that. You get to keep the money at the end of the day. So all of the health savings accounts in the country—and I was amazed that 84 percent of the 294 that we have health insurance, 248 got a high-deductible plan in our group and didn't take traditional insurance.

Could you comment on that?

Ms. ROMER. Certainly I would like to do more research to know whether that is a common occurrence. We do know that health savings accounts do tend to be most popular with the healthy and the affluent.

But I want to come back to your TennCare example because one of things, if you are worried about the employers dropping their coverage, again that goes to much of our discussion as to how important the shared employer responsibility can be to ensure that that system remains.

Dr. ROE. They didn't drop the coverage. They just allowed them to get the government plan which, again, didn't pay the providers but two-thirds of the cost of providing the care, which shifted costs back to private insurers.

So I would certainly like to know how many people would lose, because all of the HSAs lose there. The 250 right there I know will.

What I would like to know also when you provide all of this extra—when all of this other care comes in, who is going to provide it? Right now, we don't have enough doctors in America. We have more doctors dying and retiring in the next 10 years than we are producing in this country.

Chairman MILLER. Ms. Woolsey.

Ms. WOOLSEY. Dr. Romer, you give me great confidence that we are on our way to doing something very reasonable and we have got good leadership, and thank you for yours.

I have a short question, and then I have a little bit larger discussion.

Choice. We are assuming that employer coverage is something that every single employee likes. If you like your coverage, you get to keep it. How many people are going to feel trapped because they

have to keep it? Have you looked at that at all? And how do you see the phasing in when everybody will have a choice?

Ms. ROMER. I certainly think that is an issue we do need to look at more. What the President has emphasized is the importance of choice. That is one reason he wanted the public plan to exist in the exchange, to make sure that even in areas where there might only be one or two providers, that you do have a choice. So that is certainly a principle that he thinks is important.

Ms. WOOLSEY. Well, I will move on to kind of a broad question that a lot of us ask ourselves up here.

What exactly is the economic value for having private insurance carriers in the system in the first place?

Ms. ROMER. We certainly think that in general—what I tell my introductory students is that competition is a good thing and that it is something that does tend to lead to innovation, it does tend to lead to cost containment. And so I think that would be certainly one of the benefits that one could see from having a private system.

Ms. WOOLSEY. But real competition, if we don't offer a robust public plan as one of our choices, will there actually be competition in the system when we rewrite it?

Ms. ROMER. We certainly think—again, depending on how narrow the insurance exchange is, we do know there are many markets where there isn't robust competition now, where there are just one or two providers. So that is a role that the public plan can play.

Ms. WOOLSEY. Do you have any hesitation in the Federal Government providing that good plan with the—are you worried that insurance companies can't compete? They seem to be quite worried.

Ms. ROMER. I think the important thing is how it is designed. I think the tri-committee proposal certainly is trying to address that and make sure that the public plan is on a level playing field, and I think that is important.

Ms. WOOLSEY. Is our role, our primary role, to offer the public a choice of a good public plan—if they want it—or is our role to be very worried about what happens to the insurance companies?

Ms. ROMER. I think in general your role is to come up with a comprehensive reform of health care and—I do want to say that the tri-committee bill, I think, is an important step in coming up with a bill that does encompass so many of the principles that the President has said were important. And that dual thing of expanding coverage and making the kinds of meaningful reforms that will slow the growth rates of cost, those are absolutely crucial.

Chairman MILLER. Mr. Hunter.

Mr. HUNTER. Thank you, Mr. Chairman. And thank you, Dr. Romer, for being here.

Quick question. Under the draft bill, individuals face an actual tax penalty of 2 percent of adjusted gross income, up to the amount of the national average premium through the new exchange if they failed to obtain acceptable coverage.

Have you, your office, or anybody in the administration done any projection as to the level of a tax on an individual that will make it effective as a penalty? So basically, how much of a punishment tax is it going to take to make people sign on to this to get an ac-

ceptable coverage that meets 100 percent of all of the mandates? How much do we have to punish them?

Ms. ROMER. I think certainly there are a range of estimates out there. One of the things that the administration has been very cognizant of is just how important things like auto-enrollment can be for getting people to sign up for things that we think we can actually get a very long way by just making the information available or making it easy.

And then I would have to do more research to know how much more shared responsibility it would take.

Mr. HUNTER. What I am asking is—it is in this bill that you basically punish, through different taxes, people until they sign on to acceptable coverage. So you haven't done any projections to what equals an acceptable punishment tax for people to sign on to this?

Ms. ROMER. I think one of the things the Congressional Budget Office will do is figure out if what has been proposed is large enough to get a large number of—

Mr. HUNTER. There will have to be some punishment tax, some acceptable level of some kind of inclination for people to sign on to this, those that don't want to.

Ms. ROMER. Certainly that is one of the issues. My understanding is there are lots of different views in the different bills coming through Congress. One of the things I believe is true in the tri-committee bill—and I know is a focus of many bills—is to have a hardship waiver for a family that says they can't do it for a particular reason. And I think most of the bills do have a clause like that.

Mr. HUNTER. I am going to yield the balance of my time to Mr. Guthrie.

Mr. GUTHRIE. Thank you. Just a quick question.

I was in Human Resources for a manufacturing company that offered a plan better than the Federal plan. My question for this, if we are going to tax employer-based benefits—which is certainly on the table and I think the President has not ruled that out—and you say you can keep what you currently have, and I think most people that are satisfied with their health insurance are probably getting it from an employer because it is subsidized by the employer. If we tax that benefit, it will go up 38½ percent, what the corporate income tax rate is. So economics would say the business would probably lower what they offer in order to meet that benefit.

So if we are going to increase the cost of employer-based benefit 38 percent, then it will probably drop down to the credible minimal coverage. So people will actually lose the value of their benefit.

The second thing is, I am from Kentucky, and we did health care reform in the mid-1990s and people were allowed to keep their plan if they were happy with it, but it disrupted the marketplace, and that was impossible because people quit offering insurance.

So basically I want to focus in the remaining time on taxing the benefit and the behavior that will cause people who provide employer-based benefits.

Ms. ROMER. One of the things that you are getting at, the President has not supported getting rid of the exclusion on—for employer-provided health insurance—for some of the reasons that you talked about—and for the second one, the issue of disruption.

He does—I mean, part of saying that if you like what you have, you can keep it, is he doesn't want to make changes that will cause major changes in who is providing health insurance.

Mr. GUTHRIE. So he is not supporting a bill that will include taxing employer-based benefits? Because it will cause disruptions. So he is not supporting that?

Ms. ROMER. The President has put forward a suggestion. He thinks a better way to pay for this is limiting the itemized deductions with these \$600-plus billion of savings from the Medicare and Medicaid programs, and that is what he supports.

Chairman MILLER. Dr. Romer, thank you very much for taking your time to appear before the committee and to answer questions. I apologize to other members of the committee that did not get the chance to speak to Dr. Romer and ask her a question. I think there are some who would like to submit questions to you. If you could respond to those in a timely fashion we would appreciate. Thank you so very much.

Our second panel will be made up of Ron Pollack, Gerald Shea, Paul Speranza, Jacob Hacker, Michael Stapley, John Arensmeyer and Fran Visco.

Ron Pollack is the founding executive director of Families USA, a national organization for health care consumers whose mission is to achieve high-quality affordable health care for all Americans. Mr. Pollack received his degree from New York University.

Mr. Gerald Shea is the Assistant to the President of the Governmental Affairs, the AFL-CIO. Mr. Shea is a member of the Prospective Payment Advisement Committee, a congressionally appointed advisory board on Medicare, and also a founding member of the Foundation on Accountability and National Coalition of Organizations that helps consumers make health care choices based upon quality. Mr. Shea earned his B.A. from Boston College.

Mr. Paul Speranza is the Senior Vice President, General Counsel, and Secretary of Wegmans Food Markets, a family-owned supermarket chain. He is the senior counsel of the board of directors of the U.S. Chamber of Commerce and the past chairman of Lifetime Health. Mr. Speranza holds a B.S. Degree from Syracuse University and a J.D. and a LL.M from New York University.

Dr. Jacob Hacker is a political science professor and the Co-director of the Berkeley Center on Health, Economic and Family Security at U.C. Berkeley. He is also the author of Health Care for America: A Proposal for Guaranteed Affordable Health Care for All Americans. Dr. Hacker has a B.A. from Harvard University and a Ph.D. from Yale University.

Mr. Michael Stapley is the CEO of Deseret Mutual Insurance Company and Deseret Mutual Benefit Administration. He is the founder and member of the board of Utah Health Information Network and Electronic Health Care Company. Mr. Stapley earned his B.A. and his MPA from Brigham Young University.

Mr. John Arensmeyer is the founder and CEO of Small Business Majority, a leading small business advocate for comprehensive health care reforms. Mr. Arensmeyer earned his B.A. from the University of Pennsylvania and his J.D. from Rutgers University.

Ms. Fran Visco is the first president of the National Breast Cancer Coalition and Fund, and is serving as a member of the board

of directors of the Executive Committee. In 1993, Ms. Visco was appointed to the President's Cancer Panel and was reappointed in 1996 and 1999. Ms. Visco is a graduate of St. Joseph's University and earned her J.D. from Villanova Law School.

Welcome to the committee. We look forward to your testimony. We thank you for taking your time to share your expertise and experience with the committee.

As you know, those who have testified before, when you begin to testify, a green light will go on and you will have 5 minutes. At the 4-minute mark, an orange light will go on and you can think about wrapping up your testimony. But we want you to feel free to finish in a way that you get to present a coherent case.

Ron Pollack, we are going to begin with you.

**STATEMENT OF RON POLLACK, FOUNDING EXECUTIVE
DIRECTOR, FAMILIES USA**

Mr. POLLACK. Thank you, Mr. Chairman, and thank you, members of the committee.

Chairman MILLER. Can we ask you to pull the microphone a little bit closer?

Mr. POLLACK. Mr. Chairman, I want to thank you—particularly you and Congressman Rangel and Congressman Waxman for coming up with a unified bill. For those of us who have been around in other iterations of health care reform, it is rather unusual to have a unified bill, and we thank you very much for doing that.

We at Families USA strongly endorse the House bill that has been introduced, because we think it significantly deals with the key values that consumers are really looking for as part of health care reform. It provides choice; it makes coverage affordable; it ensures that coverage will be stable; and it ends discrimination among insurance companies.

Now, with respect to choice, we have heard said numerous times that this plan, as well as the President's principles, you can keep the coverage that you have if you like it. I remember Mr. Kline indicated early on in the hearing that he raised questions about 23 million losing coverage as a result of the CBO score of the Senate Health Committee. If you look at the CBO score, you will see that they have said it is an incomplete analysis of an incomplete bill. And I don't think we are going to see anything like that with respect to the House bill.

This provides new opportunities to get coverage if you are in a small business. It creates a health insurance exchange which does something which the American public wants; namely, they want to have the same kind of options that Members of Congress have, and the health exchange is going to provide that opportunity. And in so doing, it will provide accurate and helpful information about benefits and rights.

It creates reasonable rules about how insurance companies should operate, so that if you have insurance you actually know what you are getting, as opposed to finding out that you didn't have something at a point when you need care. And it provides a public option that we think is very helpful because it not only provides more choice, but it provides a real opportunity for getting costs down, and it provides a stable, portable option.

Now, another value that consumers care deeply about is making coverage affordable. And one of the key ways that this plan makes coverage affordable is through the new subsidies that are provided on a sliding scale up to 400 percent of the Federal poverty level. We think that is absolutely critical. It also places a cap on out-of-pocket costs. It is not simply the premiums that people pay in order to get coverage. They also pay deductibles, copays, and there may be a cap in how much an insurance company pays out.

Now, when people have coverage they won't be bankrupted, they won't be surprised, and the care will be affordable to them. And it provides an important safety net, through the Medicaid program, by establishing a floor on eligibility of 133 percent of the Federal poverty level.

Mr. Andrews and Mr. Scott were talking earlier about the kind of cost shifts that take place when people don't have coverage, and we released a study that the President cited last week that showed in 2008, the cost shift—the hidden health tax, if you will—for those who have coverage to pay for the uncompensated health care costs for the uninsured in 2008 was \$1,017. And I would suggest that this year it is considerably higher, because more people lost their jobs, and in the process lost their health care. It is probably closer to \$1,100.

This plan also ends insurance company discrimination. You no longer can be denied coverage due to a preexisting condition. When you get coverage, you are not going to have a loophole so that everything is covered other than your preexisting condition. It means that insurance companies are not going to drop you or raise your rates due to the filing of a claim. It is going to mean that post-claims underwriting, that happens all too frequently, that you get coverage and then when you need care, the insurance company says to you, you actually didn't disclose certain kinds of things, and they drop you from your coverage. And it makes sure that insurance premiums are not going to vary based on health conditions.

Lastly, this plan provides coverage we can count on. It provides coverage for preventative services that are very important. It will provide coverage based on the best science. Yes, there will be a Health Benefits Council that will work with the Secretary, but that Health Benefits Council will be charged with coming up with the best science, so that health plans are developed that really make sense and therefore we won't have enormous waste in our system, which we have today. And it will provide a range of insurance options.

In short, I don't remember, one of you talked about health insurance coverage like a house. Well, this plan doesn't make you get out of the house. It doesn't make you sell the house. But what it does do is it gives you tools. So if you have got a leak in your roof, it can be fixed. If you need an addition to your house, it can be fixed. It means if you need some remodeling, it can be fixed.

So I say to you, Mr. Chairman, we are delighted to be able to say we strongly support the bill that has been introduced, and we will work tirelessly to see that it is enacted this year.

[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 participate in today's hearing on health care reform. Families USA is a non-profit organization that advocates on behalf of consumers in health care policy debates. Our analysis of the House bill, grounded in our consumer perspective, finds that the House bill will provide significant help to both uninsured and insured Americans. We applaud the three House Committees that worked cooperatively to draft this pro-consumer proposal. It will end discrimination and unfair practices by insurance companies, make quality health insurance coverage truly affordable for hard-working families, give Americans the choice to keep the coverage they have now or choose from new options, and make sure that everyone of us has health insurance coverage we can count on to protect our families.

The Urgent Need for Coverage Stability

For consumers who can't buy coverage now, the House bill is significant help on the way. For consumers who struggle to pay more and more for premiums and get less and less coverage each year, the House bill shows that significant help is on the way.

And none too soon. For the American people, fundamentally reforming our nation's health care system is of utmost urgency. One out of three Americans under the age of 65, 86.7 million people, went without health insurance for some period of time during 2007 and 2008. Of these uninsured, four out of five were from working families. The crisis of the uninsured is not about a small segment of our population; it is about our friends, our neighbors and our family members.

There are millions of people like Christine and her husband from North Carolina. Christine works two part-time jobs—a total of 60 hours per week. Her husband is a carpenter. While he used to make good money, he hasn't been getting any business because of the economic downturn. That's why Christine had to take a second job, and why they had to cancel their medically underwritten, non-group private insurance coverage. The premiums rose to \$600 a month for the two of them, and they just couldn't afford to pay. And Christine says it wasn't even good coverage. She describes it as a discount plan for the self-employed. "Do we pay the light bill this month, or do we keep our insurance?" asks Christine. These were the kinds of choices Christine's family had to make. And, of course, neither of her part-time jobs offers health insurance. "Everything is scary when you're uninsured," she says. "I had a breast cancer scare about a year ago." Breast cancer runs in her family, so of course they paid out of pocket to get her a mammogram. Fortunately, it turned out she didn't have cancer. They also pay out of pocket to manage her husband's diabetes. Christine reports that even those costs can really add up and squeeze their family budget. Just recently Christine told us that she paid \$220 to get treatment for bronchitis and strep throat. She let it go for a week, trying to get over-the-counter remedies, hoping that is was just allergies.

When you factor in the effects of the recession—job losses and the accompanying loss of job-based coverage, the tightening of family budgets, and pressure on the bottom lines of American businesses—you can expect the number of uninsured Americans to rise to record levels if nothing is done. We can't afford to do nothing. If left as is, the rising costs of health care will be unsustainable for individuals, businesses, and our overall economy. Take, for example, John in South Carolina who lost his IT job last November. He couldn't afford to pay the full premiums to keep the insurance he had through his job. The family tried to keep coverage through the medically underwritten, non-group private market, but it didn't cover any of his children's allergies, psoriasis, or other pre-existing conditions. As John put it, maintaining even this private market coverage "completely cleaned them out."

American families want peace of mind—knowing that if they lose their job or move to a new job they will still have health insurance coverage. Mr. Chairman, the House bill will provide that peace of mind to American families—providing affordable, quality health coverage through the good times and the tough times.

Even before the recession, many small businesses were already struggling to be able to help their workers pay for insurance coverage. A couple examples from Maryland are small business owners Eileen and Mark. Eileen has owned a small communications and design firm for 30 years. She recently had to reduce the amount she contributes to premiums for her employees again—this time from 65 percent to 60 percent. She'd like to provide more help to her workers but her premiums in the small group market keep going up higher and higher as her employees grow older and some have health problems. Mark owns a moving and storage company that his father started in 1956. He wants to keep providing family coverage for his workers but says he is giving into the pressure of rising premiums and

may only offer individual coverage soon. He doesn't know how long he will be able to afford to offer any coverage for his workers.

Small business owners across our nation need help so that they can afford to provide health insurance to their workers. Businessmen understand that if their workers are covered by insurance and have access to health care, they will be more productive on the job and less turn-over from illness can be prevented. Thank you, Mr. Chairman, for including in the Housel bill concrete help to small businesses by stabilizing premium increases and providing small business owners subsidies to help with the cost of coverage.

The Urgent Need for Cost Stability

At the same time that the number of Americans going without insurance is rising, people who have insurance are struggling to be able to keep what they have and pay for their share of rising premiums. We have a crisis of affordability. Premiums for both job-based and individually purchased health insurance have risen rapidly over the last few decades: From 2000 to 2008, the average worker's share of average annual family premiums rose from \$1,656 to \$3,354, an increase of nearly 103 percent. Although families are paying more and more for coverage, they are getting less and less: On average, deductibles and copayments are increasing, there are more limits on covered services, and other limits are being placed on benefits in an effort to hold down the cost of coverage. Insured families across our nation are at clear risk of going into debt and bankruptcy because of costly medical bills.

The House bill will deliver very concrete relief to people with insurance in a number of ways. First, individuals, families, and businesses will have a new and transparent place to go to compare plans and premiums in a standard format—the Exchange. The Exchange will offer four standard levels of insurance benefits packages; all levels will cover core benefits and include cost-sharing protections. Consumers and businesses will understand what they are buying. The coverage won't leave people with more holes than coverage or a denial slip and an unpaid medical bill when they get sick and file a claim. Second, the insurance companies offering plans in the Exchange will be required to abide by reasonable regulations that help hold down premium growth. For example, the Exchange will restrict how high an insurance company can set premiums for a given plan, and if premiums are too high in relation to the cost of health care services paid for by an insurer, refunds will be provided to consumers. Third, the Exchange will offer a public plan option that will compete with private insurers to make sure the purchasers of insurance (individuals and businesses) are able to secure the most value for their premium dollars.

Coverage Stability = Cost Stability

The House bill—by providing access to quality, affordable health coverage to millions of Americans—will save countless lives. And the American people understand the moral imperative of the issue. Less obvious, however, is the fact that covering the uninsured will help contain rising health care costs for people with health coverage today and improve the quality and efficiency of our health care system—both primary goals for national health reform. These two problems—uninsurance and high premiums—are interrelated. In fact, the presence of uninsured people in our nation's health care system adds to the cost of the health insurance premiums that American consumers and businesses must pay for coverage. If we reduce the number of uninsured, we reduce the cost of health insurance. This is true for several reasons.

First, the cost of care for people who don't have insurance doesn't just disappear. We all pay—in the form of higher medical bills and higher insurance premiums—for the care provided to the uninsured. When people who don't have insurance get sick, many delay or forgo care. And when they can no longer ignore serious symptoms, they see doctors and go to hospitals. They struggle to pay as much as they can of their medical bills (nationally, more than one-third of the cost of care for the uninsured is paid by the uninsured themselves, out of their own pockets). Much of the remaining cost is financed by doctors and hospitals charging higher rates for services provided to people with insurance. Insurance companies pass these increased costs on to purchasers of insurance through higher premiums. In 2008, on average, \$1017 of the cost of family health insurance coverage was attributed to the cost of caring for the uninsured—an amount that can be characterized as a “hidden health tax” that all of us with insurance now pay.

Second, if everyone is in the health care system, we can slow down the growth of health care spending. If everyone has quality, affordable health care—including preventive services, as well as early diagnosis and treatment of conditions—we can manage chronic disease rather than manage the crises that result from delayed care. When everyone has coverage, health conditions can be treated early, before

they become expensive problems that drive up total health care spending. If we can slow the growth of health care spending as a share of our GDP, we'll be better able to invest in education, our national infrastructure, and other national priorities.

Third, when everyone has quality, affordable coverage, cost-saving public health goals are achievable. Doctors play a key role in motivating patients to reduce obesity, control high blood pressure, lower cholesterol, and reduce other risk factors. Efforts to improve our nation's overall health through public health initiatives cannot be successful if millions of people are left behind because they don't have insurance.

Fourth, public health threats and epidemics cannot be monitored and addressed when so many people in our nation are uninsured. In order to address health threats such as flu viruses, Lyme disease, West Nile virus, and tuberculosis, we need to be able to develop a complete picture of disease prevalence and patterns of transmission. When we leave millions of people outside the health care system, we hinder our efforts to identify patterns and deal with these threats early and effectively.

Mr. Chairman, the House bill—by providing affordable, quality health insurance to all—is a win-win for every American in this country. Health care reform is not “just” about the one out of three Americans who went without health insurance coverage during the last two years, it is also about making our health insurance more affordable and our health care system work better for every one of us who has insurance today.

Health Care Reform that Builds on the Foundation of Our Current, Uniquely American System

Now some fear mongers are telling consumers that they will lose the choice to keep the coverage they have now through their job. This is odd to me. For anyone who has been following the debate and reads the draft of the House bill must know they are misleading American consumers. No one will be forced to leave the coverage they have now or change doctors. Yes, they might choose to leave it—because there will be new options that may work better and be more affordable for some families. That's how a robust marketplace works—it offers a range of choices and provides good information about those choices to consumers.

Families USA applauds the approach of the House bill. It builds on the system we have today. I think of it this way. We are doing some “re-modeling”—making improvements and additions. The House bill takes the current system and keeps what works and fixes some of the leaks and problems—so that insurance is more affordable, covers what you need when you need it, and doesn't take away choices but actually provides more choices.

Health Care Reform: Real Help to Consumers

From the American consumer's perspective, there are numerous important features in the House bill that will improve the current health insurance system for consumers. The following are some of the important attributes of the legislation.

1. The House bill will stop insurance company discrimination

- The House Bill will stop insurance companies from denying coverage to people because they have a pre-existing condition or are in less-than-perfect health.
- The House bill will stop insurance companies from excluding from coverage pre-existing conditions. Insurance companies will have to cover what you need—not write loopholes into policies that leave consumers with unpaid medical bills.
- The House Bill will stop insurance companies from dropping your coverage or raising your rates because you filed a claim for payment of a medical bill.
- The House Bill will stop insurance companies from putting confusing clauses and fine print into policies so not even a health policy professor can tell what is covered and what is not.
- The House bill will stop insurance companies from denying payment of medical bills because you didn't dot an “i” or cross a “t” on your insurance application form or because you didn't know—even though your doctor didn't either—that you had a health care problem.

2. The House bill will make health insurance coverage more affordable for all Americans

- The House bill provides robust premium subsidies to help individuals and families for the purchase of insurance coverage. Subsidies will be available to hard-working American families with incomes up to \$88,200 for a family of four. Subsidies will be provided on a sliding scale so people needing the most help get it.
- The House bill caps how much consumers have to spend out-of-pocket on deductibles, copayments and other costs so that people with insurance are protected

from high medical expenses and bankruptcy when they or their family members get sick.

- The House bill provides health care safety net coverage through the Medicaid program to people with disabilities and people at the very lowest income levels—people who often have special health care needs and no current coverage options available. Virtually all major health care stakeholders—including the American Medical Association, the American College of Physicians, the Federation of American Hospitals, the U.S. Chamber of Commerce, the National Federation of Independent Businesses, the Business Roundtable, the AARP, the Pharmaceutical Researchers and Manufacturers of America, and America’s Health Insurance Plans, to name only a few—are on record expressing support for serving the lowest income populations through Medicaid. These diverse groups recognize that the Medicaid program provides unique services and protections for our most vulnerable Americans.

3. The House bill gives consumers more choices of health insurance plans and options

- The House bill creates an insurance exchange—a new marketplace of insurance plans that will be easy for consumers to use and will provide accurate, understandable information about benefits and consumer rights.

- The House bill’s new exchange or marketplace will have reasonable rules about how insurance companies operate—how they must treat their customers and when they must promptly pay medical bills. There will be help available to consumers when they have a problem with their insurance company—they won’t have to fight the company on their own and all alone.

- The House bill’s new exchange will give consumers the choice to purchase a public health insurance plan. This plan won’t have special rules or money to give it an advantage over private insurance; it will provide new competition to private insurance plans on value for the dollar and service. We believe that such a public plan option will drive value through reduced administrative costs, and will provide a stable, portable option for consumers.

- Not a single consumer across the nation will be forced out of their current employer-based coverage. In fact, the House bill makes sure that more employers offer coverage to their workers. Many uninsured today work for small businesses that want to provide coverage but can’t afford to do so. The House Bill provides a new small business tax credit for some small businesses with 23 or fewer employees to help with the cost of coverage.

4. The House bill provides for health insurance coverage consumer can count on

- The House bill will stop insurance companies from offering benefit packages that are more holes than coverage. Plans will cover essential medical services without odd limits on how much is covered or for how long a time. Plans will cover preventive services like check-ups, screenings, and lab tests without any copayments. And insurance companies won’t be able to design plans that work for the young and healthy and leave the rest of us behind.

- The House bill will provide a range of insurance options that can be easily compared. Consumers will know what a plan covers, what they may have to pay out of their own pockets, and won’t have any surprise bills. Sick consumers will be able to focus on their getting better rather than dealing with a possible medical bankruptcy.

There is clearly a long list of “pluses” for consumers in health care reform. What will be expected from consumers in return? The House Bill asks that each and every American be responsible for having health insurance—but only after the new fair insurance rules and marketplaces are in place and premium subsidies are available. Even then, the responsibility to purchase insurance will be waived for individuals and families who would face a special financial hardship to do so. No legislation can see into the future to understand the kinds of special family situations that might arise, so there is room to protect families with special financial struggles.

In conclusion, for American consumers who believe the current health insurance system works well for them—the House bill protects you. For American consumers who believe that the current health insurance system is like that house in the real estate ads coined a “handy-man’s special”—that is, it needs some leaks fixed, perhaps an addition, a little re-modeling, but it holds great promise—the U.S. House of Representatives provides a toolbox to get the improvements done.

Chairman MILLER. Mr. Shea, welcome to the committee.

**STATEMENT OF GERALD SHEA, ASSISTANT TO THE
PRESIDENT, AFL-CIO**

Mr. SHEA. Thank you, Mr. Chairman, and good afternoon to all of the committee members.

I want to start by congratulating you for putting forward a bill that we think really addresses the issues that the American people are concerned about, and we look forward to working with you on this bill.

Our druthers might be to be talking today about a single-payer plan. But we think the bill that you put forward, based on the current system anchored in employer-based coverage, does provide a way to get the reform we need.

What I want to talk to you about briefly today is what we think it takes to stabilize the employment-based system, which is the backbone of both the coverage and the financing of health care in the United States, as you know. It has proved remarkably resilient despite enormous cost pressure. It has shown that employers want to continue to offer coverage and that employees highly value the coverage they get at work. But we have lost 5 percentage points in coverage of people between the ages of 18 and 64 in an employment-based coverage from 2000 to 2007. And frankly, this is a pretty fragile system at the moment.

We think that it takes three things to stabilize this system, and we think that your draft version of the bill is a very good start on providing those three things.

One, we need to control costs. That is the core problem that we are facing in here. If we don't do that and we don't take strong steps to do it, nothing else we want to do will be possible.

Secondly, we have to put everybody into coverage. That means everybody has coverage, everybody participates in financing coverage, everybody takes responsibility for their own personal health coverage.

And then lastly, we really do need to reform the way care is delivered. We have started on that in the last few years. There was a consensus, I think, in the health field that we can do that. We really need to move that forward, and this bill is a great opportunity to do it.

I wanted to start just by commenting on your provisions that all employers would be required to pay, along with all employees. This pay-or-play kind of proposal is essential, in our view, if you are going to base your reform on employer-sponsored insurance because, one, it takes some cost pressure off the Federal Government for providing the subsidies. Everybody we get covered in this is someone who doesn't need to have a Federal subsidy out of tax dollars.

Two, it helps stabilize those employers who are providing coverage, because they are no longer picking up the extra costs. They are covering the costs of care for those people whose employers are not covering. And an overwhelming majority of businesses do now provide coverages, as has been cited here, and want to continue providing it.

The only firms that would really see an increase in costs are those firms that are not now currently offering benefits, mostly small, low-wage firms. And your bill addresses their concerns in

terms of subsidies and tax credits to provide benefits, but also offers the option that they could pay into a fund that would allow employees to get coverage not based in the workplace.

In terms of controlling costs, there are two core issues here. One is—or strategies. One is the public insurance plan option. This is an important element in terms of assuring coverage and guaranteeing benefits; but it is essential, from our point of view, in terms of introducing competition into the insurance market. We now don't have any in our experience bargaining health benefits for 50 million people per year. We do not have any effective competition in the insurance market, but we believe that a public insurance plan would spur that kind of competition.

I know there are a lot of issues, and those similar issues have been said here about the design of a public plan. I think these are design issues that can be addressed and they can be solved, and we can do this in a way that protects all of the interests in health care. No one has an interest in turning the situation topsy-turvy.

The second strategy that is really key in terms of controlling costs is delivery system reform. And your bill makes a very strong start in that direction. You put an emphasis on primary care, and that is important.

We would urge you also to look at the quality improvement sections of the legislation to make sure that all health care workers are involved in this quality enterprise. We have to not only address the supply of physicians and nurses, we have to assess the quality of the job they do. And in the last 15 years, we have turned—certainly for nurses and other frontline health care workers—this caring profession into some lousy jobs in many cases. We can correct that, but it takes addressing the work situation, not just the supply situation, of health care workers. You have vehicles to do that, and we are talking about that with staff about the best way to approach that.

There has been a strong collaboration between payers and consumers and people in the medical professions and hospitals over the past 10 years in terms of doing this delivery system reform and changing to a system that is based on quality and rewards value. It starts with measuring quality performance on standardized measures, reporting that, those results, and then linking payments to the performance in terms of quality.

This is really the opportunity to take what has been developed in the wake of, and is based on, President Clinton's quality commission some years ago, and put it into practice.

And then lastly, Mr. Chairman, I want to comment on the financing aspects. As I said, we think that everybody needs to participate in this. And we believe that there is enough money in the system to pay for health reform and to cover everybody.

But those people who want to say we have to pay for reform solely out of money in this system, we think are just chasing fool's gold. It is not possible to do this without additional money. We believe we have to look outside the health care system to do it, even though over time the reform will reap substantial advantage.

And additionally and finally, this really is a way to undermine the political and the public support for reasons that have been discussed earlier.

[The statement of Mr. Shea follows:]

Prepared Statement of Gerald M. Shea, Assistant to the President, American Federation of Labor and Congress of Industrial Organizations (AFL-CIO)

The AFL-CIO represents 11 million members, including 2.5 million members in Working America, our community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Together, unions negotiate benefits for some 50 million people in America.

Our members have a significant stake in health care reform because unions represent the largest block of organized consumers in the nation. In addition, unions also sponsor health plans through funds that are jointly-trusted with management. Many union members work in health care, as well, so they have a dual interest in health reform.

Even as unions continue to negotiate benefits for our members, American labor has long advocated for health care for everyone, not just those in unions or with stable jobs. For over 100 years, America's unions have called for universal coverage built on a social insurance model, an approach that has proven effective and efficient across the globe and one we have employed successfully for decades to provide income and health security for the elderly.

The AFL-CIO led the lobbying effort to enact Medicare in 1965, and we have backed many legislative efforts since then to expand coverage. We continue to believe that a social insurance model is the simplest and most cost effective way to provide benefits for all.

However, the condition of health care in America is too dire for those of us lucky enough to have good coverage to debate endlessly over what the best approach would be. It is time—indeed, it is past time—to enact comprehensive health care reform. Today our members are ready to stand with President Obama and Congress and help pass the President's plan for comprehensive health care reform.

AFL-CIO's views on comprehensive health care reform

Today I would like to explain the AFL-CIO's views on what comprehensive health care reform should look like, and specifically our views on the historic tri-committee discussion draft unveiled in the House of Representatives last week.

We start from the premise that we can fix our broken health care system by building on what works. For most Americans, that means employer-sponsored health insurance (ESI), which is the backbone of health care financing and coverage in America.

The AFL-CIO has advocated a three-point program to guarantee quality affordable health care for all—a program that consists of: (1) lowering costs; (2) improving quality; and (3) covering everyone by ensuring full participation of all public and private sector employers and making affordable health coverage available to everyone. All three of these objectives must be achieved together; none can be achieved in isolation. And we believe the tri-committee discussion draft will in fact help achieve all three of these objectives simultaneously.

We caution, however, that one financing option under consideration in the Senate Finance Committee—the taxation of employer-sponsored health benefits—would go in the exact opposite direction by destabilizing the employer-based health insurance system.

Our present course is unsustainable

Whatever one may think about the way health care should be reformed, we can all agree that our present course is not sustainable—for workers, for businesses, for the federal budget, or for the economy as a whole. If we continue down the current path, health care costs will crush families, business and government at all levels.

Our members are among the most fortunate workers. Thanks to collective bargaining, they generally have good benefits provided by their employers. Yet even well-insured workers are struggling with health care cost increases that are outpacing wage increases. And far too many working families find themselves joining the ranks of the uninsured or under-insured as businesses shut down or lay off employees.

In April and May 2009, the AFL-CIO conducted our 2009 Health Care for America Survey, which showed that people need urgent relief from the pressure of rising health care costs that are bankrupting families and endangering their health.

More than half of respondents said they cannot get the care they need at a price they can afford. Three quarters were dissatisfied with their household's health care costs.

Ann from Georgia (self-employed with two children) wrote: “We have that HSA plan with supposedly low premiums. However, those ‘low’ premiums only start low. Every year they get higher and higher. One year they increased 129 percent in just one year. Our health care costs have exceeded 35 percent of our income for two years. We are on the verge of canceling health care insurance. We would have already done this if we didn’t have two children.”

A third of those with insurance—and three quarters of those without—reported that they forgo basic medical care because of high costs.

Karen from Florida wrote: “My insurance deductible equals four to five months of take home pay each year. My insurance bill is split with my employer but equals two days of pay each month. How am I supposed to go to a doctor?”

Iris from Florida writes: “I am unemployed because I had to quit my job to care for my elderly mother. My children decided to pay [for medical insurance] for me. So what is the problem? The deductibles are so high that I cannot go to the doctor. And we keep paying \$300 monthly just in case I have to go to the hospital. In the meantime, I cannot afford to go to the doctor.”

As economic conditions have gotten worse, workers who lose their jobs have been losing their health care. Nearly a quarter of respondents said someone in their household lost coverage in the past year due to losing or changing jobs.

Renee from Ohio wrote: “It is pretty scary that millions of hard working retirees as well as those working may lose their insurance, and yes I am talking about the auto industry. My husband could lose his benefits, which he thinks he will. I don’t know how my kids will be able to get their annual checkups. How can anyone get ahead in this country? I don’t understand how it came to this. I just don’t want to think about the future anymore.”

Once workers lose their health care coverage, it is hard for them to get it back. One quarter of those without health insurance said they were denied coverage in the past year due to “pre-existing conditions.”

Kerry from New Mexico wrote: “I am desperate for our country to finally do something for my family so a health crisis does not kill one of us or leave us completely financially devastated.”

The data bear out the stories these workers are telling us. Between 1999 and 2008, premiums for family coverage increased 119 percent, three and a half times faster than cumulative wage increases over the same time period.¹

Workers’ out-of-pocket costs are going up as well, leading to more under-insured workers who can no longer count on their health benefits to keep health care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were under-insured jumped from 15.6 million to 25.2 million.²

Skyrocketing costs are pushing more workers out of insurance altogether. The current number of uninsured almost certainly exceeds 50 million. The Council of Economic Advisers estimates that number will rise to 72 million by 2040 in the absence of reform.³

Health costs are burdening American businesses, as well as workers. U.S. firms that provide adequate health benefits are put at a significant disadvantage when they compete in the global marketplace with foreign firms that do not carry health care costs on their balance sheets. The same is true for U.S. businesses in domestic competition against employers that provide little or no coverage.

The present course is unsustainable for the economy as a whole, as well. Health care expenditures currently amount to about 18 percent of our GDP. The Council of Economic Advisers estimates that this percentage will rise to 34 percent by 2040 in the absence of reform.⁴ The Congressional Budget Office (CBO) projects that health care expenditures will rise to 49 percent of GDP by 2082.

The present course is likewise unsustainable for the federal budget. If we fail to “bend the cost curve,” health care spending will balloon our federal budget deficit and squeeze out funding for essential non-health care priorities. Almost half of current health care spending is covered by federal, state, and local governments. If health care costs continue to grow at historical rates, the Council of Economic Advisers estimates that Medicare and Medicaid spending will rise to nearly 15 percent of GDP by 2040.⁵ As then CBO director and now OMB director Peter Orszag has noted, health care cost trends are the “single most important factor determining the nation’s long term fiscal condition.”

To fix our long-term structural budget deficits, we have to fix Medicare and Medicaid, and to fix Medicare and Medicaid, we have to control health care costs in the private sector. There is no practical way to control public health care costs without addressing private health care costs as well. Private and public health care are delivered largely by the same providers, using the same drugs, the same treatments, and the same procedures.

In short, the health of our family budgets, our federal budget, and our economy depends on the success of health care reform this year.

Building on what works

The AFL-CIO believes comprehensive reform can build on what works in our current health care system while creating new options for obtaining coverage and lowering costs for families, business, and government at all levels.

For the majority of Americans, what works in our current health care system is employer-based coverage—the backbone of health care coverage and financing in America. Over 160 million people under age 65 have health benefits tied to the workplace.

Employer-sponsored coverage has proven remarkably stable in the face of exorbitant health care cost inflation. Its survival is testimony to the strong interest workers have in keeping coverage tied to the workplace—even at the expense of wage gains for the past 30 years—and the interest of employers to recruit and retain talented workers through job-based benefits.

In fact, it is hard to imagine successful health reform that does not include a substantial role for employer-based coverage. Building on the core foundation of employer-provided health coverage will allow working families to keep what they now have * * * or choose from a new set of options to maintain coverage. We think building on this foundation will also help minimize the disruption that results from the difficult changes that are a necessary part of any reform, and thereby maximize public support for reform.

In order to build on this foundation, we must stabilize the employment-based system, which risks being destabilized by unsustainable cost inflation. We must reverse the steady erosion of employer-provided coverage in recent years. The percentage of 18 to 64-year-olds with ESI dropped five percentage points from 2000-2007, and without prompt dramatic action the rate of decline is expected to increase sharply.⁶

We believe the tri-committee discussion draft will stabilize the employer-based health care system through the following specific policy proposals: (1) a requirement that employers assume responsibility for contributing to the cost of health care for their employees through a “pay or play” system; (2) special assistance for firms that maintain coverage for pre-Medicare retirees, which will prevent further deterioration of the employer-based system; (3) a public health insurance option, which will inject competition into the health care system and lower costs throughout the system for employers and workers alike; (4) health care delivery reforms to get better value from our health care system and contain long-term costs; and (5) insurance market reforms, individual subsidies, Medicaid expansion, and improvements to Medicare, which will help make affordable coverage available to everyone.

Pay or Play

A key reform needed to stabilize the employer-based coverage system is the requirement that public sector and private sector employers assume responsibility for contributing toward the cost of health care for their employees. Employers should be required either to offer health benefits to their workers directly, or to pay into a public fund to finance coverage for uninsured workers—a proposal known as “pay or play.”

The tri-committee discussion draft outlines a reasonable and effective employer responsibility requirement that we believe would help shore up employer-based coverage. The proposal would ensure that workers could get affordable coverage either through their employer-sponsored plan or through a national exchange with a contribution from their employer. And it would extend, on a pro-rated basis, an employer’s responsibility for part time workers, to eliminate any incentives for employers to move workers to part-time status to avoid the new requirement.

We believe such a “pay or play” system has many virtues. It would bring in needed revenue from firms that opt to “pay,” which would hold down federal costs associated with providing subsidized coverage for low-income workers in those firms.

“Pay or play” would likewise hold down federal costs by keeping employers from dumping their low-wage employees into new subsidized plans. In the absence of an employer responsibility requirement, publicly subsidized coverage for low-wage workers would prompt many employers of low-wage workers to discontinue current coverage to take advantage of available subsidies. The resulting increase in federal costs could well doom health care reform.

“Pay or play” would help stabilize the employer-based health care system in several ways. It would level the playing field so that free rider businesses could no longer shift their costs to businesses offering good benefits. A recent study found more than \$1,000 of every family plan premium goes to cover the cost of care for the uninsured, most of whom are employed.⁷ “Pay or play” would encourage employ-

ers to offer their own coverage and penalize employers that do not. And it would minimize disruption for workers who already have health care coverage and wish to keep it.

“Pay or play” would thus go a long way towards extending coverage to the uninsured, since most of the uninsured have at least one full-time worker in their family. And it would be critical in making coverage affordable for workers who do not qualify for income-based credits or subsidies, especially if health care reform includes a new requirement that all individuals obtain coverage.

Arguments against Pay or Play

Opponents of an employer responsibility requirement raise the objection that “pay or play” would increase payroll costs for businesses. We believe this objection is misplaced.

First of all, it should be emphasized that the overwhelming majority of businesses already provide health benefits that would likely meet the new requirements, so they would not see any new costs. In fact, they would see their costs go down as health care coverage is expanded—thanks to the elimination of cost shifting—and as other health care reforms take hold that drive down costs throughout the health care system.

The only firms that might see an increase in costs are firms that do not currently offer health care benefits, or firms that offer benefits that are inadequate to meet a reasonable standard. The vast majority of firms that currently do not offer health care benefits are small firms, and they are mostly low-wage employers. Comprehensive health care reform generally would give small firms more affordable options for providing health benefits for their workers, probably in combination with additional subsidies for employers of low-wage employees.

Opponents of an employer responsibility requirement warn that employers that have to pay more for health insurance would be less likely to raise wages in the short term. The widely endorsed economic view, however, is that such employers would still raise wages over the long term.

Opponents of “pay or play” next argue that employers required to pay more for health insurance might eliminate jobs or hire more slowly as a result. But the same dire predictions have been made routinely about proposals to increase the minimum wage, with comparable increases in employer costs, and those predictions have not been borne out. Recent studies of minimum wage increases have found no measurable impact on employment.⁸ Economists have observed that employers faced with higher payroll costs from a minimum wage increase can offset some of those costs through savings associated with higher productivity, decreased turnover and absenteeism, and improved worker morale.⁹

The same would be true of an employer responsibility requirement. Any increase in employer costs would be offset by productivity gains and by a healthier workforce. The Council of Economic Advisers notes that the economy as a whole would benefit from more rational job mobility and a better match of workers’ skills to jobs when health benefits are no longer influencing employment decisions.¹⁰ Finally, it should be noted that the majority of firms that currently do not offer health benefits compete in markets where their rivals likewise do not provide benefits, so they would not be put at a competitive disadvantage.

Pay or Play and firm size

Health care reform must make coverage affordable for small businesses that have difficulty obtaining coverage in the current market. However, the AFL-CIO believes the “pay or play” requirement should apply to firms regardless of their size.

Smaller businesses will be allowed to meet the “play” requirement by buying coverage that meets fair rating rules through the new exchange, which would include the option of a public health insurance plan that makes coverage more affordable. We do support the inclusion of a small business tax credit, targeted at the smallest firms with low-wage workers, precisely because we believe an employer requirement should not exempt businesses based solely on size.

If small businesses are exempted from “pay or play,” the number of employees is a particularly poor measure for the exemption because it is a poor predictor of a firm’s ability to pay. A doctor’s office or small law firm may have more capacity to pay than a larger restaurant or store. A carve-out for small firms with fewer than a specified number of employees also creates a potentially costly hurdle for firms nearing the threshold to hire additional employees. A better approach would be to apply the requirement based on payroll or gross receipts. Finally, we believe special treatment for such businesses should be phased out over time to eliminate disparities based on firm size.

Also, any “pay or play” requirement should take into account how workers in certain segments of our economy, such as airlines and railroads, schedule their hours and the classification of workers as full-time or part-time should ensure that these workers are not inadvertently excluded from coverage.

Special assistance for companies that maintain benefits for pre-Medicare retirees

We look forward to working with the committees to develop greater specificity on the proposal for a federally-funded catastrophic reinsurance program for employers that provide health benefits to retirees age 55 to 64. Such a reinsurance program would help prevent further deterioration of the employer-provided health care system, and is an essential component of any health care reform legislation.

A reinsurance program is critically necessary to help offset costs for employers that contribute to health benefits for pre-Medicare retirees. The pre-Medicare population generally has higher health care costs, and employers offering them coverage retirees incur enormous expense. But without that coverage, individuals in this age bracket have tremendous difficulty purchasing health insurance in the individual market, or they are able to do so only at a very high cost.

We believe such a reinsurance program must have dedicated funding. In addition, in the longer term, we believe firms should be able to purchase coverage for their retirees through the exchange. This would help make coverage more affordable for firms that provide retiree health benefits.

Public health insurance plan option

The AFL-CIO supports the creation of a strong public health insurance option to compete with private health insurance plans. The tri-committee discussion draft includes a strong public plan that would compete on a level playing field with reformed private health plan options in a new national exchange.

We believe a public health insurance plan is the key to making health care coverage more affordable for working families, businesses, and governments, all of which are increasingly burdened by escalating health care costs. A public plan would have lower administrative costs than private plans and would not have to earn a profit. These features, combined with its ability to establish payment rates, would result in lower premiums for the public plan.

A public health insurance plan would also promote competition and keep private plans honest. Consolidation in the private insurance industry has narrowed price and quality competition. In fact, in 2005, private insurance markets in 96 percent of metropolitan areas were considered highly concentrated and anti-competitive, which left consumers with little choice.¹¹ A public health insurance option, coupled with a more regulated private insurance market, would break the stranglehold that a handful of companies have on the insurance market and would give consumers enough choices to vote with their feet and change plans.

We also believe a public health insurance plan would be critical for driving quality improvements and more rational provider payments throughout the health care system. A public health insurance plan can introduce quality advancements and innovation that private insurance companies or private purchasers have proven themselves unable to implement. For example, until Medicare took the lead in reforms linking payment to performance on standardized quality measures, private insurers and payers were not making appreciable headway towards a value-based health system. Just as Medicare is driving quality improvements that private plans are now adopting, a public health insurance plan could lead the way in developing innovative quality improvement methodologies, stronger value-based payment mechanisms, more substantial quality incentives, and more widespread evidence-based protocols.

Because increased competition and quality reforms would help contain costs throughout the health care system, employers that continue to provide benefits directly would benefit from these savings, as would employers that purchase coverage for their workers through the exchange. And because premiums would be lower, spending on federal subsidies for individuals who qualify for subsidies would also be lower.

A public health insurance plan would also guarantee that there will be a stable and high quality source of continuous coverage available to everyone throughout the country. By contrast, private insurance plans can change their benefits, alter cost-sharing, contract with different providers, move in and out of markets, and change benefit or provider networks. A public health insurance plan would be a reliable and necessary backstop to a changing private insurance market, and a safe harbor for working families that lose their workplace coverage.

A public health insurance plan available to everyone would also provide rural areas with the security of health benefits that are there when rural residents need them, just as Medicare has been a constant source of coverage as private Medicare Advantage and Part D plans churn in and out of rural areas every year.

Clearly, the public supports a public health insurance plan option. A recent New York Times poll shows that the public health insurance plan is supported by 72 percent of voters.¹²

Delivery system reform

Variation in Medicare spending across states suggests that up to 30 percent of health care costs could be saved without compromising health care outcomes. Differences in health care expenditures across countries suggest that health care expenditures could be lowered by 5 percent of GDP without compromising outcomes by reducing inefficiencies in the current system.

Experts estimate we waste one third of our health care spending, or \$800 billion, every year on health care that is no real value to patients. According to the Council of Economic Advisers, the sources of inefficiency in the U.S. health care system include payment systems that reward medical inputs rather than outcomes, high administrative costs, and inadequate focus on disease prevention.¹³

We must restructure our health care system to achieve better quality and better value, and we must transform our delivery system into one that rewards better care, not just more care. We can start by doing the following:

- Measure and report on the quality of care, the comparative effectiveness of drugs and procedures, and what medical science shows to be best practices and use that information to create quality improvement tools that allow doctors to individualize high-quality care for each of their patients;
- Put technology in place to automate health care data; and
- Reform the way we pay for care so doctors have the financial incentives to continuously improve care for their patients.

The February 2009 economic recovery package, with its substantial investment in health information technology (HIT) and research on the comparative effectiveness of drugs and medical devices, marks an historic first step in the right direction.

The tri-committee discussion draft builds on the investments of the economic recovery package by encouraging greater emphasis on primary care and prevention, and greater emphasis on innovative delivery and payment models, such as accountable care organizations and bundled payments for acute and post-acute care. The draft also makes needed investments in our health care workforce—with emphasis on primary care—to ensure access to needed care and better reward primary care providers.

The tri-committee discussion draft emphasizes and invests in quality measurement and improvement methodologies. But we believe more can be done to foster innovation in health care delivery by building on the significant quality measurement and improvement underway within health care in recent years. The AFL-CIO has invested considerable resources and time working on system reform, as part of the broad collaboration of consumers, purchasers, physician organizations, hospitals, and government agencies at both the state and federal levels.

This strong collaboration between payers and providers has created breakthrough improvements in health care delivery. The process improvement techniques pioneered in other U.S. industries—for example, six sigma quality standards and rapid-cycle problem analysis, solution development and testing, and wide-spread diffusion in a short time period—have been shown to work and hold enormous promise, but federal leadership in delivery system reform is indispensable.

We must also put into place a system of broad consultation with consumers, purchasers, physicians, insurers and health care organizations in setting national priorities for health care quality improvement and in implementing standardized measures of quality throughout health care. With quality measurement as a foundation, reform can empower those who deliver care, pay for care, and oversee care to work with those who receive care to innovate and modernize health service delivery.

Affordable coverage for everyone

Today we have a fragmented health care system characterized by cost shifting and price distortions because as many as 50 million people have no coverage.

According to Families USA, the uninsured received \$116 billion worth of care from hospitals, doctors, and other providers in 2008, about \$42.7 billion of which was uncompensated care.¹⁴ The costs for uncompensated care are shifted to insurers and then passed on to families and businesses in the form of higher premiums. For family health coverage, the additional annual premium due to uncompensated care was \$1,017 in 2008.

While our members generally have employer-based health coverage, stabilizing the employer-based health system will require covering the uninsured to make health care more efficient and prevent cost-shifting. We cannot cover everyone without bringing down costs overall, and we cannot control costs without getting everyone in the system.

The good news is that, according to the Council of Economic Advisers, expanding health insurance coverage to the uninsured will increase net U.S. economic well-being by roughly \$100 billion per year, which is substantially more than the cost of insuring the uninsured.¹⁵

The most important policy proposal for extending health care coverage to the uninsured is “pay or play,” which I discussed earlier in my testimony. But the tri-committee discussion draft includes several other proposals that would also expand health care coverage, including insurance market reforms, the establishment of an insurance market exchange, individual subsidies, the expansion of Medicaid, and improvements to Medicare.

Insurance market reforms

Ensuring access to health care coverage will require significant changes to the current private insurance market, in which people are now denied coverage or charged more because of their health status. Market reforms for everyone who buys coverage in the individual and group market will make coverage more fair, transparent, affordable, and secure.

The AFL-CIO fully supports the prohibition on rating based on health status, gender, and class of business; the prohibition on the imposition of pre-existing condition exclusions; guaranteed issue and renewal; and greater transparency and limits on plans’ non-claims costs. While we would prefer a flat prohibition on rating based on age, we believe the proposal to limit age rating to 2 to 1 is a strong alternative. Any variation allowed above that limit threatens to make coverage unaffordable for older individuals.

Insurance market exchange

The AFL-CIO also strongly supports the proposal to create a national health insurance exchange to provide individuals and businesses with a place to enroll in plans that meet certain criteria on benefits, affordability, quality, and transparency. We believe this will be a mechanism for simplifying enrollment and applying uniform standards.

The tri-committee discussion draft establishes a mechanism that offers consumers a way to compare plans based on quality and cost. While the exchange will initially be open to individuals and small employers, we believe there should be a commitment to allowing public and private sector employers beyond the small group definition to purchase coverage through the exchange after the first two years that the exchange is operational.

Subsidies for low- and moderate-income workers

Subsidies will be essential for making coverage affordable for low- and moderate-income individuals and families. We support the proposal to make subsidies relative to income, with more substantial subsidies applied to more comprehensive coverage for the lowest income enrollees. We also support ensuring that coverage is affordable by applying the subsidies to premiums as well as out of pocket costs.

Medicaid expansion

We strongly support extension of Medicaid coverage to all under 133 percent of poverty, with sufficient resources to states to offset the new costs.

Medicare improvements

In addition to eliminating subsidies that give private Medicare Advantage plans a competitive advantage over traditional Medicare and deplete the Trust Fund, the tri-committee discussion draft makes needed improvements in benefits for Medicare beneficiaries. The draft closes the gap in prescription drug coverage over time, eliminates cost sharing for preventive services, and improves the low-income subsidy program.

Financing health care reform

There are at least three key elements of health care reform that will also affect savings and revenues available for reform: a public health insurance option, delivery system reform, and an employer responsibility requirement. Though these policy proposals are absolutely necessary to improve the value we get for our health care spending, in the short run they will not be sufficient to fund reform.

The Senate Finance Committee has said that all savings and revenue for health reform must come from within the health care budget. However, because health care reform is an urgent national priority that will produce benefits across our economy and improve our national budget outlook, we agree with the President that we should look beyond health care spending to obtain additional revenues. We support the major elements of the President's budget proposal for the Health Reform Reserve Fund, including savings in Medicare and Medicaid, limiting the itemized deductions for households in the top two tax brackets, and other modifications to reduce the tax gap, as well as making the tax system fairer and more progressive.

One financing option under consideration in the Senate Finance Committee is a cap on the current tax exclusion for employer-provided health care benefits so that some portion of current health care benefits would be subject to taxes. We believe this is an extraordinarily bad idea.

Taxing benefits would disrupt the employer-based system

Capping the tax exclusion would undermine efforts to stabilize the employer-provided health care system. Employers would likely respond by increasing employee cost-sharing to a level at which benefits would become unaffordable for low-wage workers, or by eliminating benefits altogether. Capping the exclusion would also encourage workers to seek coverage outside their ESI group when this is economically advantageous, thereby complicating the role of employers enormously and giving them another incentive to discontinue coverage.

Congress and the President have assured Americans that they will be able to keep the health care coverage they have if they like it. This approach makes enormous sense and generates broad public support. A cap on the tax exclusion would violate this basic understanding and threaten to disrupt the primary source of health care coverage and financing for most Americans.

Until health care reform has been proven successful in lowering costs and making coverage available to uninsured workers through new private and public plan options, we should not make any changes that threaten the source of health care coverage for 160 million Americans.

Taxing benefits would be unfair to high cost workers

The Senate Finance Committee is considering capping the tax exclusion for relatively high cost plans. This would be an unfair tax on workers whose benefits cost more for reasons beyond their control.

The exact same plan could cost well under \$15,000 in one company and more than \$20,000 in another depending on factors that have nothing to do with the generosity of coverage. According to one study, premiums for the same health benefits can more than double when an individual crosses state lines.¹⁶

The cost of coverage can be the reflection of many factors: the size of the firm; the demographics of the workforce; the health status of the covered workers and families; whether the industry is considered by insurers to be "high risk;" geographic differences in cost; and whether there are pre-Medicare retirees covered through the same plan.

Studies show that placing a cap on tax-free benefits would have the greatest impact on workers in small firms; firms with older workers and retirees, and workers with family plans that cover children. This is because insurance companies regularly charge higher rates for coverage for these workers.

Under one proposal, over 41 percent of workers at a firm with older workers would be taxed on their health care benefits, but only 16 percent of workers at a firm with younger workers would be taxed. Almost 30 percent of workers at a smaller firm would be taxed, but only 17 percent of workers at a larger firm. Over 41 percent of workers with family coverage would be taxed, but less than 20 percent of workers with individual coverage.¹⁷

If workers have to pay more taxes because some of their co-workers have costly medical conditions, health coverage would be transformed from a workplace benefit that everyone supports to one that splits workforces between the healthy and the sick.

Some argue that the existing tax exclusion is regressive, because higher income workers get a bigger tax advantage. But this is only one part of the story.

A recent report points out that while households in higher tax brackets get a greater benefit from the tax exclusion in absolute dollar amounts, low and moderate income workers would be impacted more from capping the exclusion because their taxes would increase by a larger share than those of higher income workers. The report found that workers with employer-provided health benefits who make between \$40,000 and \$50,000 would see their tax liability increase on average 28 percent, while those who make between \$50,000 and \$75,000 would see their tax liabil-

ity increase on average 20 percent. By contrast, workers who make more than \$200,000 would see an average increase in their tax liability of only one tenth of one percent. In short, capping the tax exclusion would not make it more progressive.¹⁸

Taxing health care benefits would not bring down health care costs, either. It would just shift more of those costs onto workers. Economists say the tax exclusion leads workers to get too much coverage, but capping the tax exclusion would not do anything to address a key cost driver: the fact that 20 percent of the population consumes 80 percent of our health care spending. Taxing health benefits would not change that fact.

Conclusion

The AFL-CIO applauds the work of the committees in outlining a strong, effective, comprehensive plan for guaranteeing quality affordable health care for all. We believe the tri-committee discussion draft would stabilize the employer-based health insurance system by simultaneously achieving the goals of lowering costs, covering everyone, and improving quality. We stand ready to work with all three committees to enact reform that achieves these goals. America's working families can wait no longer.

ENDNOTES

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Chairman MILLER. Mr. Speranza.

STATEMENT OF PAUL SPERANZA, JR., SENIOR VICE PRESIDENT, GENERAL COUNSEL AND SECRETARY, WEGMANS FOOD MARKETS ON BEHALF OF THE CHAMBER OF COMMERCE

Mr. SPERANZA. I want to thank you for being here this afternoon.

I am Vice Chairman and General Counsel of Wegmans Food Markets, and I am here representing the United States Chamber of Commerce, where I am former past chairman of the board. I am also representing the Rochester Business Alliance which is the Rochester, New York, Chamber of Commerce. It is a handy opportunity to travel around the country on behalf of the U.S. Chamber of Commerce.

My number one issue was the quality and affordability and accessibility of health care. As I would talk to audiences large and small, this is what was on people's minds: the quality and affordability in health care. And they also want to have programs that they can understand and programs that are transparent, which we think is of critical importance.

The two words that I would like to share with you today are finding common ground and collaboration. The United States Chamber of Commerce, the Rochester Chamber of Commerce, we agree to at least 90 percent of what is in this bill, and I think it needs to be stressed that is indeed the case.

I would like to share with you an example. Rochester, New York, back in the early 1990s—according to President Bill Clinton when he did a nationally televised speech on health care last time around—he said Rochester, New York was a community that got it right, was the only one that got it right.

What has transpired since is 4 years ago, the U.S. Chamber that I represented, the American Medical Association, the American Hospital Association, large insurers, large health care companies, came together in Washington—about 15 people—and their task was to find programs and policies that can be rolled back to local communities. Didn't cost a lot of money to be done relatively quickly, that didn't require change in nonregulation. We in Rochester took that seriously. We put together a consortium of seven large businesses—Wegmans is one of them—and we have had very good results.

For example, we have put into place a regional health information organization. We took efficiency experts from our manufacturing companies and put them into the hospital systems to make them more efficient. We developed a wellness program called "Eat Well, Live Well" that my company developed. We encouraged employees to walk 10,000 steps a day, eat five cups of fruits and vegetables a day. We turned it over to this group and last year, we had over 200 organizations in Rochester participate, more than 44,000 employees. It is the largest community-wide wellness program in the world.

More recently, we have entered into a partnership, this consortium of businesses, with a health systems organization, the only one of its kind in the State that is given statutory authority by New York. They represent all of the health care stakeholders in our community. They also represent labor unions. They represent the religious organizations, minority communities, et cetera. We

have figured out how to collaborate in Rochester. Common ground is the key to that.

What we would like to be able to do is invite members of this committee, President Obama, to come to Rochester to see how we have done it. We think we owe it to the American people to get collaboration right.

With respect to the bill before us today, a couple of points. We need to have enough time to digest the bill. Each Member of Congress needs to do that. We do as well. I had 24 hours' notice to be here today, 2 hours to write my testimony. My sense is we don't want to take so long that this idea gets killed, but we need to take enough time where people will really understand. And there are best practices in the country that you can look at. Rochester isn't the only community. Many others do as well.

Second, cost. We have heard costs anywhere from \$1 trillion to \$1.6 trillion. Either there are not enough rich people in this country to pay for that cost, so directly or indirectly many more Americans will pay for the cost of the programs. And also with programs like this and other ones that have been put in place over the last months and the last number of years, there will be more inflation; and inflation is a tax on everyone in America, including the poorest of the poor.

In terms of a couple of other points, with respect to the health care government option for insurance, I disagree with that approach. Mr. Andrews had talked about food companies a little bit earlier. I wouldn't want to have a government-run grocery store across the street from me, a manufacturer wouldn't want to have a government run manufacturing plant across the street from them. Yes, there should be competition, but it seems to me that Congress could figure out a way to change State and Federal regulation and law to enhance that competition. We think that is important and the way to be able to do that.

With respect to pay-or-play, we disagree with that approach.

With respect to ERISA—I know my time is running short—we think ERISA works and works well. There are so many complexities as relates to this bill, we think that ought to be left alone.

So in conclusion, we need to find the common ground—believe me, there is a lot of common ground—for the good of the American people. The American people do want change. We want change. And we want meaningful change, transparent change. We should be able to buy health care the same way we buy automobiles and other goods and services in this country. Health care should be no different. If you give people the information and transparency and quality, they will do the right thing. Competition is the American way. Thank you.

Chairman MILLER. Thank you.

[The statement of Mr. Speranza follows:]

Prepared Statement of Paul S. Speranza, Jr., Vice Chairman, General Counsel and Secretary, Wegmans Food Markets, Inc.

Chairman Miller, Congressman Kline, members of the Education and Labor Committee, thank you for the invitation to testify at this hearing. I am Paul Speranza, Vice Chairman, General Counsel and Secretary of Wegmans Food Markets. Wegmans is a regional food chain with 39,000 employees. I am pleased to be here today to testify on behalf of the U.S. Chamber of Commerce, the world's largest

business federation, representing more than three million businesses of every size, sector and region. I am past Chairman of the Board of the Chamber and previously chaired the Chamber's Employee Benefits Committee, which develops Chamber policy governing health issues, for seven years. I am also representing the Rochester Business Alliance, where I lead its health care initiatives.

The key concepts I want to share with you today are collaboration and common ground, just as we have done in Rochester, New York. In a nationally televised speech in the early 1990's President William Clinton singled out Rochester as the one community in America that got health care right. For the last four years a collaboration of seven large employers, including Wegmans, has worked hard to regain its national health care status. We have worked on several initiatives including establishing a regional health information organization and employing lean six sigma concepts to assist the local hospital systems to be more efficient. The collaboration also instituted a wellness program called "eat well, live well" which encourages its employees to eat 5 cups of fruits and vegetables per day and walk 10,000 steps per day. Last year over 44,000 employees from over 200 organizations participated, making this (to our knowledge) the largest community-wide wellness program in the world. The last United States Secretary of Health and Human Services, Michael Leavitt gave Rochester an award for its overall health care efforts, and another award for its wellness program.

Recently our RBA employer consortium entered into a partnership with the Finger Lakes Health Systems Agency, the only organization of its kind in New York State which is granted its authority by New York State. It represents all relevant stakeholders in the community including minority groups, religious groups, labor unions and all health care stake holders. We are about to embark on a massive community-wide hypertension initiative. Hypertension impacts members of minority communities much more than other groups. Our community has come together and worked together to improve the quality, affordability and access to health care. Our goal is to be the healthiest community in America.

We invite each committee member and President Obama to come to Rochester to learn about what we have done. If we can do it in Rochester, we can do it anywhere. Other American communities also have experiences to share, showing that many of our health care problems can be improved by dedicated people in local communities. Around America we all need enough time to share our best practices. Congress can help us with information technology, wellness, end-of-life matters, incentives to change behavior of our citizens and appropriate incentives for our physicians and other health care providers to manage systems efficiently. All of these items will save substantial money.

As you know, more than half of all Americans receive health insurance benefits voluntarily provided by their employers, and the Chamber is committed to reforming the health system to lower costs, improve quality, and expand coverage. The employer-based system voluntarily provides health benefits to over 130 million Americans, who are overwhelmingly satisfied with their benefits and want their employers to continue providing them. Employers have been great innovators in health care, and many reforms we have led the way on have kept the unsustainable rising costs of health insurance from reaching the breaking point.

Process

The Chamber applauds Congress for making health reform a priority. However, we have grave concerns about process being used to advance this legislation. This Committee, in cooperation with the two other committees of primary jurisdiction, crafted legislation behind closed doors. This more than 850-page bill was released just four days ago, and although it still contains significant gaps (including missing cost estimates and expected offsets), already we are engaged in hearings, markups possibly scheduled soon, and the bill will be rushed to the floor without proper time for consideration and revision. The Chamber hopes that the sponsors of this legislation will conduct a process that truly engages stakeholders and discards this rush to legislate, and that they build a piece of legislation that solves the problems we face without creating massive new problems or significantly disrupting the current system. We need a reasonable amount of time to understand the implications of what has been proposed and the opportunity to suggest alternatives that will work.

The business community has been supportive of reform for some time now, as health care costs have continued to rise much faster than the rate of inflation. Even as health insurance premium costs have more than doubled in the past decade, employers continue to pay \$500 billion a year into the system voluntarily to cover em-

ployees.¹ It should be easy to draft a bill that employers can support—we are desperate in the face of these unsustainable cost increases. Unfortunately, rather than focusing on common sense, pragmatic reforms (as we have done in Rochester) that both sides of the aisle could support, this legislation embodies a range of bad ideas that threaten to bring down many good initiatives that deserve your support.

Employer Mandate (“Pay-or-Play”)

The Chamber does not believe that a mandate on employers to sponsor health insurance will make serious headway to cover the uninsured, but rather could lead to a loss of jobs. Employers who can afford to sponsor health insurance typically provide generous benefits—and most large employers do. Employers who cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so—small employers, seasonal employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits. The Massachusetts employer mandate failed to have a meaningful effect on the uninsured, and actually exempted most of the businesses that didn’t offer insurance—but it was disruptive to existing plans. In fact, reliance on that employer mandate in part contributed to serious funding problems in the Massachusetts plan.²

A better, smarter approach would be to focus on bringing down the costs of health insurance, and encouraging individuals to obtain coverage. This would bring market forces to bear on employers, as their employees would ask anew for benefits that satisfied their individual requirements, without hurting the economy—while also helping more people to obtain insurance and making health care more affordable for all.

Minimum Coverage (“Essential Benefits”)

Even businesses that already offer generous benefits are determined not to be burdened by government-mandated levels of benefits. Because most government employees enjoy the extremely expensive FEHBP (Federal Employees Health Benefit Plan), there is a belief in Congress that it makes sense to force all businesses offering benefits to approach the offerings of FEHBP. However, this would be completely unaffordable and impractical. The design of benefits is a decision that needs to be left between employers and employees. Government-dictated one-size-fits-all plan designs will be disastrous for business—to suppose that a computer programming company and a coal-mining company can afford the same kinds and levels of benefits reveals a lack of understanding of the realities faced by businesses and working Americans.

We are especially concerned about proposals to anoint a new committee of unelected bureaucrats, the majority of which will have had no experience in designing benefits plans, who will basically make laws regarding required levels of benefits. Although Congress may feel an urge to punt this controversial issue to an outside “public-private” group, it is too important, and represents too great a threat to the economic wellbeing of America’s job creators, to be allowed to be handed off.

Government-Run Insurance Plan (“Public Option”)

This legislation contains an especially egregious proposal to create a new government-run health insurance plan to “compete” with the private sector. Recent studies continue to find that government cannot and would not compete on a level playing field with private competitors in the insurance market. Government programs tend to hide administrative costs by outsourcing to various other departments and agencies, forcing individuals, enrollees, and participating businesses to pick up the slack. Government costs are artificially low due to cost-shifting to private payers—the consulting firm Milliman recently found that private insurance costs 20-30 percent more because of underpayment by government payers.³ Proponents of government plans usually cite to MedPAC reports that say government plans pay fairly and private plans overpay—however, numerous providers, hospitals and businesses have reported to the Chamber that private payers tend to support public plan enrollees, and reductions in payment from private plans (or increased enrollment in public

¹Employee Benefit Research Institute: “EBRI Databook on Employee Benefits, Chapter 2: Finances of the Employee Benefit System.” Updated September 2008. <http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf>

²See Congressional Budget Office: “Key Issues in Analyzing Major Health Insurance Proposals—December 2008”. Available at: <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf>.

³Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers. Milliman, December 2008. <http://www.ahip.org/content/default.aspx?docid=25216>

plans) would be likely to put many out of business, or at least to severely curtail access to care. The fact that this proposal would directly use Medicare rates is extremely dangerous.

This would be compounded by the problem of a massive shift from the private sector to the public sector. The Lewin Group actuarial firm recently found that tens of millions would be drawn to a public plan by artificially low premiums—a situation that would only worsen the already debilitating cost-shift private payers experience.⁴ A loss of 119 million Americans from the private sector to the public sector would devastate the remaining private sector, and likely could lead to the eventuality of a government-run insurance “option” being the only option available.

The business community joins most Americans in opposing a “public option” that would likely be an unfair competitor or lead us toward government-run health care for all. A recent poll by the Kaiser Family Foundation found that while Americans are initially open to a “public option”, when they learn that it might have an unfair advantage over the private sector or that it might lead to single-payer, they strongly opposed it.⁵

Even an editorial in the Washington Post has cited the “public option” as a backdoor way to bring the nation to single-payer, socialized medicine. The President’s promise that Americans will be able to keep the health insurance they have cannot be kept if we move to such a system.

We can find no meaningful justification for creation of a new government-run insurance plan other than to gut the private market and bring a large portion of America into government-run health care. Whether or not this proposal is a Trojan horse for single-payer health care, it is apparent that its cause is ideological, not pragmatic or driven by a desire for market competition or good health policy.

ERISA Changes

The reason so many employers are able to offer quality, affordable health insurance to their tens of millions of employees is because the Employee Retirement Income Security Act of 1974 (ERISA) allows them to administer uniform benefits across state lines, with maximum flexibility to allow employers to design plans that meet their employees’ needs.⁶ This proposal would threaten the success of ERISA plans by apparently allowing a new host of lawsuits under state law, revisiting many issues raised by the Patients’ Bill of Rights of past Congresses. Obviously, if this is true, we would be very troubled by these provisions.

Congress should be focused on lowering the costs of health care and expanding access to those currently without coverage. Why is there an effort to interfere with the parts of the system that are working well? The Chamber views such initiatives as counterproductive at best, and at worst, efforts to force more Americans out of private, voluntary employer-provided coverage, and into a government-controlled exchange that will inevitably lure individuals into a government-run insurance plan. These solutions in search of a problem will cause unnecessary disruption in current plan offerings—contrasting with the President and many leaders in Congress’ constant claim that “if you like the plan you have, you can keep it.”

Financing of Health Reform

This Congress made the bold and fiscally responsible decision to offset new spending and operate under a pay-as-you-go structure to avoid increasing the deficit. This proposal may end up appearing deficit neutral on its face, but only because there are numerous proposals to pair it with massive new taxes. These taxes would be devastating to the economy, to businesses, and to the workers they employ. Among these wrong-headed proposals is a movement to create a European-style Value-Added Tax (VAT). A VAT would have negative implications throughout the entire economy, particularly hurting those with the lowest incomes, who would see the same increases in the costs of affected goods that those with higher incomes would see. This would hurt the already lowered consumption levels we are currently experiencing, lengthening the economic downturn. There are not enough “rich” people in America to pay for this. Taxes of many others will rise. With this and other major

⁴The Cost and Coverage Impacts of a Public Plan: Alternative Design Options. Lewin Group staff working paper #4, April 2009. <http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPublicPlan-Alternative%20DesignOptions.pdf>

⁵Kaiser Family Foundation Health Tracking Poll, April 2009. <http://www.kff.org/kaiserpolls/upload/7891.pdf>.

⁶Over a hundred million Americans have health, retirement and other valuable benefits voluntarily provided by their employer under a nationally uniform framework established by the Employee Retirement Income Security Act. See National Coalition on Benefits: About the Coalition. Available at: <http://www.coalitiononbenefits.org/About/>

government expenditures of the recent past, the inflation that will flow from all of this will be a tax on everybody.

Proposals to tax sugary drinks and alcohol would be similarly regressive. The revenues gained under such a proposal would come directly from those with the lowest incomes who have the fewest options to purchase and the least time and ability to change their dietary habits. These would also be the people most likely to further forego needed care if health expenditures through tax-free vehicles like Flexible Spending Arrangements and Health Savings Accounts were threatened.

Proposals to tax employee health benefits would also have extremely negative reverberations in the economy. These taxes would fall directly on workers, who would see their taxable income increased—although employers would also see FICA and payroll taxes increase, and would have to pass some or all of those costs on to the workers.

Reforms Widely Supported

Congress has rightly recognized that now is the time to reform the insurance markets. This will necessitate some hard decisions about how to enact and enforce guaranteed issue of insurance to all comers, guaranteed renewals, rate control, increased access to competing options, and more. And Congress has rightly recognized that these reforms will not be feasible unless everyone is in the system and has skin in the game—no gaming the system and waiting to buy insurance until you are sick.

If we can build connectors that work, and reform the insurance market, much of the work is done. We need to focus on controlling costs and making coverage affordable, and the initial task will be complete. This will be extremely challenging, necessitating a variety of delivery system reforms, payment and reimbursement reform, implementation of comprehensive strategies to boost health information technology, wellness, prevention, disease management, coordination of care, initiatives to support primary care and much more. This will require sacrifice on the part of many groups—insurers, hospitals, pharmaceutical companies, providers, workers, and yes, employers.

Further, this large bill has left out many of the key solutions we believe could lower health care costs and improve quality. Medical liability reform was not explored, not even test projects through creation of specialized health courts. The massive Medicare claims database, which could be used to jump start quality and transparency efforts, is left out. Employers are not given any safe harbors or encouragement to create wellness programs for employees. Enrollees in public programs are not given the option to instead take their government premiums and enroll in competing private options. And individuals and the self-employed are not given options to use pre-tax dollars to purchase health insurance, and thus still will not have tax parity.

The business community stands ready to work with Congress to pass such reforms. The Chamber will be on the front line fighting for the success of legislation that truly addresses these problems and proposes these solutions. But the Tri-Committee bill is a far cry from such a targeted piece of legislation. All of us, as Americans, can find common ground and collaborate just as we have done in Rochester, New York.

Chairman MILLER. Dr. Hacker, welcome.

STATEMENT OF DR. JACOB HACKER, PROFESSOR AND CO-DIRECTOR OF THE BERKELEY CENTER ON HEALTH, ECONOMIC, AND FAMILY SECURITY, UNIVERSITY OF CALIFORNIA BERKELEY

Mr. HACKER. Thank you, Chairman Miller, and members of the committee. It is an honor to speak with you today. Health care is at the epicenter of economic insecurity in the United States, a reflection of our Nation's uniquely fragmented and costly framework of health insurance. Now, this framework is distinctively American, and any effort to improve it must be distinctively American as well, building on the best elements of the present system: large group health plans in the public and private sectors.

But an American solution must also fix what is not working. By allowing Americans without access to secure workplace coverage, to

choose among group insurance plans, will provide strong guarantees of quality, affordable coverage over time.

To succeed, these reforms must be based on three strong pillars: shared risk, shared responsibility, and personal responsibility. Shared risk means we need a new national insurance exchange that allows workers without secure coverage to access good group health plans with premium assistance to ensure affordability. To promote competition and accountability this exchange must also include as a choice a public health insurance plan competing with private insurers.

Now, this public health insurance plan is a linchpin of a distinctively American strategy. It will provide a backup for those without workplace insurance in all parts of the Nation. Indeed in most of the country, especially rural areas, insurance markets are highly consolidated, and private plans are passing on costs to enroll these employers rather than bargaining with increasingly consolidated provider groups or improving their own efficiency.

A public plan must also provide a benchmark for private plans, pressing them to focus on value and innovation rather than shifting costs or screening out high-risk patients.

And, finally, a public plan will provide a cost-controlled backstop. Public insurance has lowered administrative expenses in private plans. It obtains larger volume discounts. It does not have to earn a profit, and experience suggests it has a superior ability to control spending while maintaining broad access over time.

Now, I would encourage the committee to ensure that the public plan has an extensive network of hospitals and doctors immediately. And the simplest and most efficient way to build the network is to assume that all doctors and hospitals that accept Medicare payments are in the network but give them a choice to opt out.

The plan should also have the authority to use modified Medicare rates and to employ information technology and new payment approaches and care coordination strategies to improve efficiency and quality. If we are to truly bend the curve of health spending, the public and private sectors will have to work together competing on a level playing field. This task cannot fall on private insurers or the Medicare program alone.

Make no mistake, Americans want to have the choice of enrolling in a public insurance plan. In a recent poll, 72 percent supported this option, including a majority of Republicans. Another recent poll found 83 percent support.

The other two pillars of an American solution are shared and personal responsibility. This means that employers and individuals should be expected to contribute to the cost of their coverage once affordable options are available.

Employer responsibility, sometimes known as play-or-pay, is vital in ways that are not always properly understood. Yes, it provides an important source of funding, reducing the direct cost of reform to the Federal Government. But it also ensures that reform will not undermine employment-based health insurance. In the absence of a play-or-pay requirement, firms with large numbers of low-wage workers who qualify for new subsidies for insurance within the exchange will have less incentive to insure their workers di-

rectly. Moreover, employer responsibility requirements serve to level the playing field between firms that do and do not provide coverage.

In play-or-pay proposals, employer contributions are not penalties, they are payments for the coverage of workers whose enrollment in the exchange flows from the employer's decision to contribute. This ensures that the roughly 95 percent of non-elderly Americans who work or live in the family of a worker have access to good insurance through the workplace connection. And while there are valid concerns about small employers, a survey by Small Business Majority found support for more than half of small business owners in California for reform along these lines. They were willing to accept the requirement to contribute to health care in return for the ability to access an affordable plan for their workers.

Concerns about small businesses, where most uninsured workers are employed, will be best addressed through a sliding-scale requirement on firms rather than by excluding small firms from the requirement altogether.

Shared risk, shared responsibility, personal responsibility, these are the pillars of a uniquely American solution. Together they will create accountability in American health insurance, expand coverage while making it more affordable for workers and their families, and adequately fund our health care priorities while putting in place the preconditions for long-term savings to the Federal Government.

Chairman MILLER. Thank you.

[The statement of Mr. Hacker follows:]

Prepared Statement of Jacob S. Hacker, Ph.D., University of California, Berkeley, Professor of Political Science; Faculty Co-Director, Center on Health Economic & Family Security, Berkeley School of Law

Public Plan Choice and Play-or-Pay: Critical Elements to Ensure Accountability and Affordability and Control Costs

I thank the committee for the honor of speaking today about the pressing need for national health reform based on the principles of shared risk, shared responsibility, and personal responsibility. For national reform to succeed, it must create accountability in American health insurance, expand coverage while making it more affordable for workers and their families, and adequately fund our health care priorities while putting in place the preconditions for long-term savings to the federal budget. The draft legislation prepared by this special tri-committee promises enormous progress in meeting all three of these goals.

My remarks are divided into two parts. In the first, I explain why the "public-private hybrid" approach embodied in the tri-committee draft legislation is vital to ensuring accountability in American health insurance. I focus in particular on the need for a public health insurance plan that Americans without secure workplace coverage can choose as a coverage option that will compete with private plans. In the second part, I emphasize the need for shared responsibility to expand affordable coverage, emphasizing the constructive role that employers can play in providing or helping to finance coverage so that affordable insurance is available to all Americans through the workplace connection. Both accountability within the insurance market and shared responsibility are necessary to slow the growth in health care costs not just for workers and their families but also for employers, states, and the federal government.

I. THE NEED FOR ACCOUNTABILITY IN AMERICAN HEALTH INSURANCE¹

In recent years, the need for comprehensive health reform has become glaringly apparent. Health insurance premiums have skyrocketed, more than doubling from 1999 to 2008,² while the scope and generosity of private coverage have plummeted. Not only have the ranks of the uninsured continued to expand, but, in addition, the number of Americans who have insurance yet lack adequate protection against medical costs has increased dramatically.³ More than half of bankruptcy filings are related to medical care, with the vast majority of medical bankruptcies involving households that have insurance coverage.⁴ Employers, workers, states and localities, and the federal government—all have seen their budgets under siege because of runaway health care costs and all require long-term relief.

Amid the crisis, there has emerged a growing recognition not just of the need for action but also of the virtues of a public-private “hybrid” approach to health reform. The approach to reform embodied in the tri-committee draft legislation is such a model—a model that builds on the best elements of the present system: large group plans in the public and private sectors. By lowering the cost of care and requiring that all firms eventually contribute to the cost of coverage, the legislation would encourage employers to continue to provide health insurance. At the same time, it would put in place a new means—the so-called health insurance exchange—of allowing Americans without access to secure workplace coverage to choose among insurance plans that provide strong guarantees of quality affordable coverage over time.

The Case for Public Plan Choice

An essential feature of this new framework for obtaining group coverage is “public plan choice,” the creation of a new public plan modeled after Medicare that would be available to Americans younger than 65 who lack good employment-based coverage. Public plan choice is not by any stretch of the imagination “Medicare for all.” Rather, it simply creates a public health insurance plan with incentives to focus on value and innovation that competes on a level playing field with private insurers within the new insurance exchange. Private employment-based coverage would continue, and workers without such coverage would be able to choose from a menu of options that includes a range of private insurance plans as well as the new public health insurance plan.

Moreover, this new public health insurance plan should be—and is, in the draft legislation—self-supporting after initial setup costs are financed (that is, it should be financed by the same sources as any other plan within the exchange, notably, individual premiums, employer contributions, and income-related subsidies). It should also be—and is—subject to the same rules as the private plans and be separate from the national exchange, so the referee (the exchange) does not have a player (the plan) in the game.

This idea is overwhelmingly popular. In a recent poll conducted by the New York Times and CBS News, 72 percent of those questioned supported a government-administered insurance plan that would compete with private insurance. The support for a public plan came from Republicans and Democrats alike. Half of those who identified as Republicans said they would support a public plan, along with three-quarters of independents and nine out of ten Democrats.

Choice, Accountability, and “Healthy Competition”

The aim of public plan choice is healthy competition—that is, competition to make Americans better cared for and more secure. Such competition requires not an endless array of choices, but rather a reasonable number of meaningfully different choices. In much of the country today, health insurance competition is remarkably limited. Most metropolitan areas have no more than a few dominant insurers in control of the market. And these companies are often unable or unwilling to rein in health care costs. It is often in their interest to pay higher rates to key doctors and

¹This section is based on Jacob S. Hacker, “The Case for Public Plan Choice,” and “Healthy Competition,” both available at <http://www.law.berkeley.edu/chefs.htm>. Additional citations are available in these briefs.

²The Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits, 2008 Summary of Findings*, 1.

³Cathy Schoen, et al., “How Many are Underinsured? Trends Among US Adults, 2003 and 2007.” The Commonwealth Fund. June 2008. Accessed November 25, <http://www.commonwealthfund.org/publications/publications—show.htm?doc—id=688615>.

⁴David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, *The American Journal of Medicine*, June 2009, David Himmelstein, et al., “Illness and Injury As Contributors To Bankruptcy.” *Health Affairs*, 2005. Accessed November 25, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1>.

hospitals because they can pass on these costs to individuals and employers. In the process, they make it difficult for weaker insurers to build competitive provider networks and bring costs down. Even the largest insurers are hard-pressed to enter established markets.

Because the hospital market has grown increasingly concentrated, moreover, providers wield considerable power of their own to drive up the rates they receive from insurers and restrict competition. In areas where hospital market concentration has grown the most, hospital prices and profitability are very high, yet service and quality of care is no better than in other areas, the evidence suggests.⁵ As John Holahan and Linda Blumberg of the Urban Institute explain, “Dominant insurers do not seem to use their market power to drive hard bargains with providers * * *. Competition in insurance markets is often about getting the lowest risk enrollees as opposed to competing on price and the efficient delivery of care.”⁶

A public health insurance plan would provide greater competition for insurers and providers and greater choice for Americans. Indeed, a key reason for public plan choice is that public health insurance offers a set of valued features that private plans are generally unable or unwilling to provide. Stability, wide pooling of risks, transparency, affordability of premiums, broad provider access, the capacity to collect and use patient information on a large scale to improve care—these are all hallmarks of public health insurance that private plans have inherent difficulties providing. On the other hand, private plans are generally more flexible and more capable of building integrated provider networks, and they have at times moved into new areas of care management in advance of the public sector.

In short, public and private plans have unique strengths, and both should have an important role in a reformed system. Public plan choice simply means that all Americans without good workplace coverage, not just the elderly or the poor, should have access to the distinctive strengths of a public health insurance plan, as well as the strengths of private plans. Such healthy competition has long been the stated rationale for encouraging Medicare to include private plans alongside the public program. The argument for a competitive partnership between public insurance and private plans applies at least as strongly to nonelderly Americans as it does to those in Medicare.

Healthy competition is about accountability. If public and private plans are competing on fair and equal terms, the choice of enrollees between the two will place a crucial check on each. If the public plan becomes too rigid, more Americans will opt for private plans. If private plans engage in practices that obstruct access to needed care and undermine health security, then the public plan will offer a release valve. New rules for private insurance could go some way toward encouraging private plans to focus on providing value. But without a public plan as a benchmark, backup, and check on private plans, key problems in the insurance market will remain.

Public Plan Choice is Essential to Cost Control

Perhaps the most pressing of these problems is skyrocketing costs. Public health insurance has much lower administrative expenses than private plans, it obtains larger volume discounts because of its broad reach, and it does not have to earn profits as many private plans do. Furthermore, experience suggests that these lower costs are accompanied by a superior ability to control spending over time. Medicare has a better track record than private health plans in controlling costs while maintaining broad access to care, especially over the last fifteen years. By way of illustration, between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance.⁷

Over the last generation, public insurance has pioneered new payment and quality-improvement methods that have frequently set the standard for private plans. More important, it has the potential to carry out these vital tasks much more effectively in the future, using information technology, large databases of practices and outcomes, and new payment approaches and care-coordination strategies. Indeed, a new public plan could spearhead improvement of existing public programs as well as private plans.

⁵ John Holahan and Linda Blumberg, “Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?” Urban Institute Health Policy Center, 2008, <http://www.urban.org/UploadedPDF/411762—public—insurance.pdf>, 3.

⁶ *Ibid.*, 3.

⁷ Hacker, “The Case for Public Plan Choice,” available at <http://www.law.berkeley.edu/chefs.htm>.

To be sure, there are reasonable concerns about how a new public plan will use its bargaining power—concerns reflected in current proposals for state-based public plans, consumer cooperatives established by the states, or even private insurers under public contract. Yet a watered-down public plan or a private alternative to a public plan would not serve the three vital functions of a competing public health insurance plan—to be a “benchmark” for private plans, a “backup” to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control “backstop.” Consumer cooperatives, for example, will be extremely difficult to create and are unlikely to serve as a backup in most of the nation. They will also lack the ability to be a cost-control backstop, much less a benchmark for private plans, because they will not have the reach or authority to implement innovative delivery and payment reforms.

In sum, public plan choice is essential to set a standard against which private plans must compete. Without a public plan competing with private plans, we will continue to lack strong mechanisms to rein in costs and drive value down the road.

II. THE NEED FOR SHARED RESPONSIBILITY⁸

The other aspect of the draft legislation I wish to comment on is the requirement that employers either provide health insurance to their workers or help fund coverage for those workers through the new national insurance exchange. In my view, the exchange should eventually be open to all employees of firms that choose to pay regardless of worker income or firm size, with reasonable premiums for higher-income workers.

A play-or-pay requirement is essential to any hybrid health reform proposal that builds on the current system of job-based coverage while providing new options to broaden coverage to the uninsured. Financing any health coverage expansion will be challenging. An employer requirement makes it easier by providing an important source of funding and reducing the direct cost to the federal government. At the same time, such a requirement is essential if reform is to avoid greatly reducing the provision of employment-based insurance.

Why Have a Play-or-Pay Requirement?

Job-based coverage is still the major means that non-elderly Americans receive health benefits. Nationally, about 62 percent of Americans under age 65 get their health coverage through their employer or the employer of a family member. Replacing employer financing would require substituting highly visible taxes or mandates on individuals for the relatively hidden contributions now made (nominally at least) by employers.

In the absence of a binding employer requirement, moreover, the direct costs to the federal government would substantially increase. Firms with large numbers of low-wage workers who would qualify for new subsidies for insurance would have less incentive to cover their workers directly, allowing their workers to obtain insurance outside the workplace with the new subsidies. How extensive such crowd-out would be is a matter of debate. Employee benefits tend to be “sticky,” at least in the short run. Benefits are highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage. But over time employers should be expected to move toward benefit strategies that minimize their costs, including allowing their workers to be covered by public programs or subsidized individual insurance.

Finally, employer responsibility requirements serve to level the playing field between firms that do and do not provide coverage. The vast majority of medium and large firms offer health care on the job, at least to their full-time workers. Many small firms, particularly higher-wage firms, also provide coverage. Yet a substantial share of firms do not, with rates of non-provision highest among small employers. In firms that do offer coverage, eligibility and benefits vary substantially. Nationally, 77 percent of the uninsured work or have a family member who works, and are not self-employed. A quarter of the working uninsured are in firms with less than ten workers; another third are in firms with 10 to 99 employees. The final 41 percent work for employers with more than 100 workers. Nearly one-third of those who are covered through a job are covered by a business with fewer than 100 workers.

When firms do not provide coverage, or only provide coverage to a limited fraction of their workforce, it raises the costs of employment-based coverage and puts pressure on firms that do offer benefits to cut back their offerings. One path by which

⁸This section is based on Ken Jacobs and Jacob S. Hacker, “How to Structure a ‘Play-or-Pay’ Requirement on Employers,” available online at <http://www.law.berkeley.edu/chefs.htm>. Additional citations are available in the brief.

this occurs is the shifting of the costs of caring for the uninsured: As uninsured workers and their dependents are forced to rely on emergency rooms for care, costs are shifted not only onto the public but also into the health premiums of firms that do offer coverage. It is estimated that the cost of uncompensated care raises health premiums by between 5 and 10 percent. Another path is spousal and dependent coverage: A firm offering family benefits picks up the cost of spouses working in firms without health care and the costs of dependents that might have been insured by another firm.

How the Play-or-Pay Requirement Should be Structured

Play-or-pay should apply to as broad a range of firms as possible. While there are valid concerns about the effect of such a requirement on small employers, it is important to keep in mind small employers would benefit from a health-care expansion that would provide coverage to their employees. A survey by Small Business Majority found support from more than half of small business owners in California for a health reform proposal along these lines. They were willing to accept the requirement that they contribute to health care in return for the ability to access an affordable plan for their workers. Concerns about economic impacts on small businesses would be best addressed through a sliding scale requirement on firms, rather than by excluding small firms from the requirement altogether.

Moreover, the play-or-pay requirement should apply to all of a firm's employees as well as their employees' spouses and non-working children. While 97 percent of large firms offer health coverage, they only cover an average of 70 percent of their employees. In fact, three out of four workers who do not have coverage through their employer work at firms where fellow workers have coverage. The plurality of these uncovered workers are not eligible for coverage (45 percent); the next largest share have not taken-up coverage (30 percent), often because the costs are viewed as prohibitive. If part-time workers are excluded, it creates a strong incentive for employers to offer part-time employment as a way of reducing costs. There is evidence of significant labor market sorting along these lines in Hawaii as a result of its health-care mandate. A requirement on part-time workers can be structured so that it is not economically burdensome on employers.

The Economic Benefits of Shared Responsibility

The main argument against employer requirements is that they place a tax on employment, leading to fewer jobs. Recent economics research as well as the experience of California strongly suggests, however, that these concerns are overstated when it comes to the play-or-pay proposals currently under consideration, with their relatively modest employer requirements.

Firms may absorb the costs of an employer requirement in a variety of ways. Over time, we would expect a large share of the cost to be passed on to workers through forgone wage increases. Pass-throughs to consumers are also well documented. After the passage of the health-care ordinance in San Francisco, many restaurants added small health-care surcharges to their checks to cover the costs of the program.

The main concern is for workers at or near the minimum wage. As long as all employers face the same rules, however, firms with workers at or near the minimum wage may pass on part of the cost to consumers without impacting their ability to compete. The vast majority of firms that currently do not offer health benefits are in markets where their competitors also do not provide benefits, and thus would see increases similar to those of their competitors. Moreover, the incremental costs even for these firms would be small.

It is also important to keep in mind that health reforms with employer requirements promise new benefits for firms and workers as well as new costs. Many firms that provide coverage for working dependents of their employees would no longer have to. Some firms that provide coverage would also benefit from the option of enrolling their workers in the new exchange, which would effectively cap their direct obligations. All firms would benefit from the reduction in unpaid medical bills incurred by the uninsured. Firms would further benefit from any savings due to a reduced rate of health-care cost growth.

Expanded access to health care can also be expected to raise productivity through improved worker health and labor force participation, and better matches of jobs to workers skills. Workers without health coverage are more likely to miss necessary care, less likely to receive treatment for chronic conditions, and more likely to suffer from debilitating conditions that will keep them out of the workforce. Broader coverage is likely to result in decreased absenteeism and exits from the labor force due to disability. There is strong evidence that health insurance plays an important role in worker mobility decisions. Universal coverage would decrease "job-lock" and improve matches between workers skills and positions.

In sum, the net impact of a broad health-care reform that included shared responsibility for employers would be positive for business and the economy as a whole.

CONCLUSION

Health reform is essential for improving the economic security of American workers and their families. By far the largest effect of broadening and upgrading coverage and lowering and subsidizing premiums is to immediately help struggling Americans who are currently facing the worst economic downturn in at least a generation. These vital reforms will also provide a rescue package for state and local governments facing rising Medicaid and CHIP costs, for doctors and hospitals that treat the uninsured and inadequately insured, for community institutions that help people in distress—in short, for all the rapidly fraying threads of our health care safety net. No less important, creating a public plan to compete with private plans while bringing as many Americans as possible into a reformed insurance framework is essential for bringing down the rate of increase of costs over time and to reducing the long-term financial threat of health care to workers and their families and to employers, states, and the federal government.

Chairman MILLER. Mr. Stapley, welcome.

STATEMENT OF MICHAEL J. STAPLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, DESERET MUTUAL INSURANCE COMPANY AND DESERET MUTUAL BENEFIT ADMINISTRATORS

Mr. STAPLEY. Thank you, Chairman Miller and Congressman Kline, for the opportunity to testify today on behalf of the ERISA Industry Committee whose members provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC has long supported reforms to the Nation's health care system that change the way we pay for health care, increase its efficiency, reduce cost, extend health coverage to those who are uninsured or underinsured, and improve quality.

To that end, we released in 2007 a new benefits platform for life security that lays out an innovative national framework for health and retirement security. As we contemplate the issues that are before us, there are three basic principles that we think are important:

First, do no harm. There has been a stated commitment to the employer-based system by the President and others. Health care reform should build on the success of this system that serves 170 million Americans and their employers, not hurt it.

Second, control costs. Spiraling health care costs threaten our global competitiveness as well as our national solvency. Reform must focus on reducing these costs and ensure that what we pay for has value. Without cost containment, effective cost containment, we will not change the system.

Thirdly, expand access. Access to the 47 million or 82 million, however we choose to count it, Americans who do not have it must be expanded while recognizing that a chief cause of inadequate access is the high cost of care.

Now, we recognize as an organization that there is a lot in our current system that is not working well. To this end, we created the new benefits platform that we released a couple of years ago.

With these principles in mind that we just articulated, and this new benefits platform we articulated, the following things that we support that are a part of health care reform and in large measure a part of the many proposals that are being considered by the President and Congress.

First, we support a competitive pluralistic health care system in which employers and individuals have choices among health plans that compete on the basis of quality, cost and effectiveness.

Second, we support an insurance exchange or gateway, provided that it follows uniform national standards.

Thirdly, broad flexibility for employers to choose how they provide health benefits to their employees and their families while protecting employers from systematic adverse selection.

Fourth, incentives in the current financing system that promote responsible cost management rather than risk avoidance and aggressive claims administration.

Fifth, improvements in the transparency and accountability of both providers and health plans.

Sixth, payment reforms that secure financial incentives that drive desired changes.

And, lastly, an individual mandate with subsidies to assist financially disadvantaged individuals.

Now, there are also some issues, some concerns with the current proposals, that we feel like need more discussion. First, the tax cap is difficult to define so it can be administered in a fair and equitable way. Second, it may mean that some employers would redesign their plan so that the benefits they provide would fall below the level that was taxed. In fact, we might create an incentive to do that with the result that their employees would be provided with less generous health coverage. Other employers would choose to keep their existing plans which could result in adverse selection as young and healthy employees leave the employer plan to seek cheaper coverage elsewhere that would not be taxed. This could compromise many large viable risk pools and could also greatly diminish an employer's ability to offer efficient and innovative health care coverage to its employees.

As the cost of providing benefits increases, more employers would exit the system.

The public plan. If a public plan could fairly be fashioned, it must be structured in a way that the employer plans end up bearing the burden of additional—do not end of bearing the burden of additional cost shifts. There is currently—and there is no question about it—there is currently unfair cost shifting from Medicare to employer plans in the current system. Expansion of cost shifting would cause employers to rethink whether they can afford to provide high-quality health care to their employees, and it also compromises the notion with respect to whether or not you really got a plan that is competing on a fair and equitable basis.

There are also concerns about the adverse selection that would be experienced if individuals in employer-sponsored plans were permitted to opt out of the employer plan and into a public plan, especially if the employer were compelled to pay for the individual's participation in the public plan and/or finance any subsidy given low-income individuals who opted out.

Employer mandates. Including minimum benefit packages by definition restricts our ability to devise and operate health care plans that best meet the need of our employers. Mandates increase cost and limit flexibility. They are also difficult to define so they can be simply and uniformly applied. Coupled with punitive regu-

latory regimes, employer mandates will discourage employers from continuing to provide quality affordable health care to their employees.

Finally, talking about preemption. Without national uniformity made possible by ERISA's preemptive doctrine, large multi-State employers simply could not offer quality health care coverage to their employees. Any future legislation must continue to accord preemption and national uniformity of regulation in a similar priority.

There are many employers that offer benefits in all 50 States. We can testify to the fact that in most States where we have some responsibility to comply with State mandates, the administration is costly and complex and difficult to comply with.

In conclusion, ERIC is committed to the goal of responsibly reforming the Nation's health care system to cover the uninsured, control costs, and improve quality and do all three in a manner that does not undermine the system that currently offers quality health care to 170 million satisfied Americans. ERIC members have a major stake in America's health care system and we intend to continue to play a constructive role in this debate.

Thank you for your time.

Chairman MILLER. Thank you very much.

[The statement of Mr. Stapley follows:]

**Prepared Statement of Michael Stapley, on Behalf of the
ERISA Industry Committee**

Chairman Miller, Ranking Member Kline, and other Members of the Committee: thank you for the opportunity to testify on the important subject of healthcare reform. I am speaking today on behalf of the ERISA Industry Committee, an association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC has a strong interest in proposals that affect its members' ability to continue to deliver high-quality, cost-effective benefits.

We must change the way we pay for and deliver health care in the United States. Reining in health care costs is absolutely essential to this country's future economic success. ERIC strongly supports reforms to the nation's healthcare system that will increase its efficiency, reduce costs, and extend health care coverage to those who are uninsured or underinsured.

ERIC has thought deeply about this subject. In 2007, we released A New Benefits Platform for Life Security that lays out our vision of a conceptual framework for overhauling our national approach to providing health and retirement security. Many of the positions we staked out in this Platform have been incorporated into proposals currently under consideration in Congress. Although we believe our Platform could make further significant contributions to the present debate, we will concentrate our remarks today on the legislative concepts that are currently under discussion.

Three basic principles are of fundamental importance to change and must be considered as we move forward.

1. Do no harm. The current voluntary employment-based system provides health coverage to 170 million people, about 61% of the non-Medicare population. This system has served both employers and employees well. Employers have the flexibility they need to tailor their plans to the needs of their workforce while also aggressively pursuing the innovative changes that have led to substantial advancements in so many arenas, including the fields of wellness and prevention. Employees strongly support their employer provided benefits and benefit significantly from this system. They enjoy access to high-quality care with guaranteed issue, limited preexisting condition exclusions, a uniform premium structure, and the other advantages afforded participants in the large risk pools of group plans. Any health care reforms should build on the strengths of this system.

2. Control costs. The relentless increases in the cost of health care threaten the viability of U.S. corporations in a global economy, while the upward spiral in the costs of Medicare and Medicaid threatens our national solvency. In addition, a substantial portion of the health care we now consume, perhaps as much as 20% to 40%, has no value. The centerpiece of healthcare reform must focus on reducing these costs. Reform that fails to focus on cost control will not only ultimately prove ineffective but will undermine health care coverage.

3. Expand access. 47 million Americans do not have adequate access to health care. Of those, approximately half are unable to afford coverage. History will not judge kindly an affluent society that ignores this problem. We must remember, however, that inadequate access is aggravated, if not caused, by the high level of cost. Our effectiveness in solving the access problem depends on restraining the growth of health care costs.

With these foundation principles in mind, I would like to focus on what we can support in a responsible healthcare reform initiative.

1. ERIC strongly supports a competitive, pluralistic health care system in which employers and individuals have choices among several health plans that compete on the basis of quality, cost, and effectiveness. There is an urgent need to eliminate the significant waste in the current health care delivery system, establish a foundation for responsible cost management in the future, and systematically ensure quality health care for all Americans. Too many reforms pursued in the past have made changes at the edges of health care delivery when fundamental structural changes are needed. ERIC believes that a properly designed, responsibly regulated pluralistic system will be able to correct the deficiencies in the current system and produce significant improvements in costs, quality, and access.

2. ERIC's Benefits Platform supports the establishment of an insurance exchange or gateway that provides a fair and equitable method for the distribution of insurance products. If exchanges are established, they should follow uniform national standards.

3. Employers should be given broad flexibility regarding how they choose to provide health benefits to their employees and their families but should be protected from systematic adverse selection by the plans in the exchange. Employers should be given the option of choosing to continue in the current system and arrange for and sponsor their own health plan alternatives. At the same time, employers should have the flexibility to provide financial resources to their employees to purchase health plans through the insurance exchange from among competing health plans. The employer should not be required under any circumstance to provide financial resources to employees to purchase insurance through an insurance exchange when the employer has chosen to continue in the current system. To allow this would create systematic adverse selection problems that could ultimately result in the demise of the employer-based system. This is inconsistent with the stated objectives of the President to support the continuation of the current system.

4. Incentives in the current financing system must be changed from risk avoidance to responsible cost management. The foundation principle of a fair and equitable financing system for health care must be that the cost of disease and injury must be distributed across all plans offered through the exchange. In the end it is the expectation that health plans offered through the exchange should be strongly incentivized to differentiate their products and premiums based on efficiencies generated by better administrative practices derived from improved payment systems, disease management, utilization management, case management, lifestyle management and other innovative initiatives designed to lower cost, increase quality and improve accountability. Large employer plans have pursued these goals with notable success.

5. Transparency and accountability of both providers and health plans must be improved.

- There has been much discussion on the need for better provider transparency in terms of both cost and quality. We are fully supportive of these initiatives.

- There has been less discussion about the need for better health plan transparency and accountability. It is widely recognized that the practices of some private health plans create an enormous frustration to both consumers and providers of health care. Medicare does provide a good example of more consistent administration of health plans. In a restructured system, it will be important to establish mechanisms where there can be standardization and full transparency of administrative practices of health plans that are offered through the exchange. This might include disclosure of health expense loadings, the number and cost of denied claims, the efficiency of claims administration and other administrative practices, and consumer assessments of each health plan.

6. ERIC strongly supports payment reform. There is strong evidence that financial incentives must drive the changes that are desired. President Obama's budget director, Peter Orszag, recently stated that, for example, "nearly 30% of Medicare's cost could be saved without negatively affecting health outcomes if spending in high and medium cost areas could be reduced to the level in low cost areas". In both the private and public sectors, we must stop rewarding providers for doing more and instead incentivize them to provide high quality health care that delivers true value to the American consumer. It is irresponsible to perpetuate a system in which between 20% and 40% of the health care delivered has no value. Payment reform is essential to this objective.

7. Every citizen should be required to obtain health care coverage, with standards established at the federal level. Because a significant portion of the population is unable to afford adequate coverage, ERIC would support subsidies to assist financially disadvantaged individuals.

I would like to devote my remaining remarks to the areas in current legislative proposals where the "Do no harm" principle is most at risk.

Taxation of benefits: Several proposals have been made to curtail the favorable tax treatment for employees of employer-provided health benefits. One proposal would eliminate the exclusion entirely. Others would impose a cap based on the value of health insurance, an individual's income, or a combination of the two.

ERIC has serious concerns with limiting the ability of an employee to exclude from income the value of employer-provided health insurance. If this exclusion were curtailed, many large employers would follow one of two approaches. Some would redesign their plans to meet the new cost standard in the legislation, below which taxation would not be imposed. This would necessarily mean that their employees would be provided with less generous health coverage.

Other employers would choose to keep their existing plans; if the value of the plan exceeded the standard in the legislation, employees would face taxation on the "excess" value. If this were to occur, employment-based insurance would suffer. Young, healthy employees would either seek to exit their employers' plans in search of cheaper coverage rather than pay taxes on a more expensive plan or pressure their employers to reduce coverage. If younger workers sought cheaper coverage elsewhere, an employer plan that once had a favorable and balanced risk pool would now be left with an older, sicker, more costly population whose premiums would eventually become unsustainable. Loss of a large, viable risk pool would greatly diminish an employer's ability to offer efficient and innovative health care coverage to its employees. As the cost of providing benefits increased, more employers would exit the system.

There are also equity and administrative issues associated with a tax cap that need to be carefully assessed. We are concerned that if a cap is to be imposed, it not discriminate against individuals by virtue of higher premium costs due to geography, the demographic composition of the group, or because they happen to work for a small firm.

A public plan: ERIC has several serious concerns with the creation of a public plan that would compete with the current private marketplace. Although at present we do not know how this new plan would be structured, we have profound reservations with the prospect of a public plan modeled after Medicare. Medicare does provide an example of an efficient, consistent, and fair claims administrator; there are also examples of consistent, fair claims administrators among private health plans. Medicare is not, however, a sterling example of what a restructured financing system should look like. In fact, Medicare has perpetuated some of the cost problems that we have in our current health care system by rewarding those who provide more care, regardless of value.

Our most fundamental concern with a public plan based on Medicare, however, is the potential for even greater cost-shifting than exists today. Right now ERIC members subsidize the cost of Medicare. This includes both administrative and claim costs. One example of the administrative subsidy relates to the fact that Medicare does not pay anything for transaction fees associated with the electronic movement of claims from providers to Medicare intermediaries. These transaction costs are not free. They must be absorbed by other paying customers, including employer plans.

Moreover, according to most providers, Medicare's reimbursement rates do not cover their costs. Contrary to what many people say, these rates are not negotiated, they are mandated. Providers argue that in most cases they accept these rates because they want to continue treating patients that have been treated all of their lives. Hospitals argue that they have no choice. They believe that they survive only because they are able to charge higher rates to private plans and other customers.

In short, the provider shortfall from Medicare is shifted to the private sector, a practice that is unacceptable in a reformed system.

At the end of the day, ERIC's position is that if a public plan could be fairly fashioned, it must not be structured in such a way that employer plans end up bearing the burden of additional cost shifts. Health care costs are already rising at an unsustainable rate. Increased cost-shifting would trigger the warning light that causes employers to rethink whether they can afford to provide high quality health care to their employees. An exodus of employment-based plans from the nation's healthcare system would diminish the development of practices to improve the quality of health care and the pursuit of innovative strategies to bring healthcare costs under control that are core strengths of the employment-based system.

Employee opt-outs: We are also concerned about the adverse selection that would be experienced if individual participants in employer-sponsored plans were permitted to opt out of the employer plan and into a public plan, especially if the employer were compelled to pay for the individual's participation in the public plan and/or finance any subsidy given low-income individuals who opted out. If permitted, an opt-out would undermine the demographic fairness of a large risk pool that is a feature of employer plans. Over time, young, healthy employees would seek cheaper coverage outside of the employer's plan, and older, sicker employees would remain in the plan. Eventually, employer plans would become havens for employees with the worst risk profiles, and this would be reflected in ever-higher premium costs. At some point, employers would no longer be able to provide affordable coverage to their workers.

Employer mandates: Employer mandates, especially their manifestation in the "pay-or-play" penalties currently under discussion, have the potential to seriously harm employer-sponsored plans. ERIC members generally provide high quality benefits with generous employer contributions; thus, it would appear that a "pay or play" requirement would have little or no relevance for us. As we have learned from the experience in Massachusetts, however, this is not always the case, and—as is so often true in life—the devil is in the details. For instance, if the employer mandate only required that employers offer a set minimum package of benefits to employees that met a specified, modest actuarial value, then many—but not all—major employers would meet that bar. But if the mandate were to require that all full-time employees were to be covered, and full-time were defined as working 25 hours per week, many other employers would drop below the bar. If the mandate were to further include no cost-sharing for prevention or wellness and full coverage of mental health benefits, others would drop out.

Employer mandates by definition restrict our ability to devise and operate health care plans that best meet the needs of our employees. Mandates increase costs and limit flexibility. Coupled with punitive regulatory regimes, employer mandates will discourage employers from continuing to provide quality, affordable health care to their employees. This is not an idle threat; one need look no farther than the nation's moribund defined benefit plan system to see the effects of overly complex rules and regulations.

Preemption: I would be remiss if I did not take this opportunity to underscore the absolute inviolability of ERISA preemption. Without the national uniformity made possible by ERISA's preemption doctrine, large multistate employers simply could not offer quality healthcare coverage to their employees. Its importance was recognized by the original sponsors of ERISA as critical to ensuring that employers provided sound and secure benefits. Any future legislation must continue to accord preemption and national uniformity of regulation a similar priority.

Conclusion: ERIC is committed to the goal of reforming the nation's healthcare system in a responsible manner that will extend health care to those without it and that will reverse the current fatal escalation in the costs of health care. Equally important, I believe, is that this reform be accomplished without undermining the system that currently offers quality health care to 170 million satisfied Americans.

ERIC intends to continue to play a constructive role in this debate.

Thank you, and I would be happy to respond to any questions.

Chairman MILLER. Mr. Arensmeyer.

**STATEMENT OF JOHN ARENSMEYER, FOUNDER AND CEO,
SMALL BUSINESS MAJORITY**

Mr. ARENSMEYER. Thank you, Chairman Miller, Ranking Member Kline, and members of the committee. The Small Business Ma-

majority appreciates this opportunity to present the small business perspective on the House tri-committee draft health care reform plan. We support the effort to move this legislation through the Congress expeditiously, and thank you for bringing this forward in a timely manner.

Small Business Majority is a nonprofit, nonpartisan organization founded and run by small business owners and focused on solving our biggest problem that we face today, the skyrocketing cost of health care. We represent the 27 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific research to understand and represent the interests of all small businesses.

I have been an entrepreneur for more than 20 years, including 12 years owning and managing an Internet communications company. Together with the other senior managers in our organization, we have a total of 70 years running successful small businesses ranging from high-tech to food production to retail. We hear stories every day from small business owners who can't get affordable coverage.

Louise Hardaway, a would-be entrepreneur in Nashville, Tennessee had to abandon her business stream after just a few months, because she couldn't get decent coverage. One company quoted her a \$13,000 monthly premium.

Others, such as Larry Pierson, owner of a mail order bakery in Santa Cruz, California, struggled to do the right thing and provide health care coverage. Larry notes that, "The tremendous downside to being uninsured can be instant poverty and bankruptcy. That is not something my employees deserve."

Our polling confirms that controlling health costs to small business owners is number one concern. Indeed, on average, we pay more than 18 percent more for health care coverage than big businesses. An economic study that we released earlier this month, based upon research by noted MIT economist Jonathan Gruber, found that without reform, health care will cost small businesses \$2.4 trillion over the next ten years. As such, we are pleased to see that the House bill addresses key cost containment measures such as expanded use of health IT, transparency, prevention, primary care and chronic disease management.

Our polling shows that 80 percent of small business owners believe that the key to controlling costs is a marketplace where there is healthy competition. To this end, there must be an insurance exchange that is well-designed and robust.

We are very pleased that the committee's bill proposes a national insurance marketplace with the option for State or regional exchanges that adhere to national rules. Moreover, we are encouraged by the committee's proposal that there be standardized benefit packages along with guaranteed coverage without regard to preexisting conditions or health status, a cap on premiums and out-of-pocket costs, and marketplace transparency.

We understand that a balanced set of reforms will require everyone to participate; 66 percent of small business owners in our recent polls, in 16 States for which we are releasing preliminary data today, support the idea that the responsibility for financing a

health care system should be shared among individuals, employers, providers and government.

It should be noted that respondents to our surveys included an average of 17 percent more Republicans than Democrats, 40 percent to 23 percent, while 28 identified as Independent.

According to the results of the economic modeling done for us by Professor Gruber, comprehensive reform that includes even modest cost containment measures and a well-designed structure of employer responsibility will offer a vast improvement over the status quo. A system with appropriate levels of tax credits, sliding scales and exclusions will give small businesses the relief they need, potentially saving us as much as \$855 billion over the next ten years, reducing lost wages by up to \$339 billion—and, in response to the question that the Ranking Member asked Dr. Romer—minimizing job losses up to 72 percent.

We are very pleased that the committees have addressed some of the affordability concerns of the smallest businesses. Professor Gruber has modeled specific scenarios, described in detail in our report, and we look forward to working with you to ensure the best balance between the need to finance the system and our ability to pay.

Finally, another issue of great concern to us is the unfair tax treatment of the 21 million self-employed Americans. Under the current Tax Code, self-employed individuals are unable to deduct premiums as a business expense and are required to pay an additional 15.3 percent self-employment tax on their health care costs. We encourage that this inequity be rectified in the final bill passed by the House.

Chairman Miller, when you announced this historic bill you noted that health care premiums had spiraled out of control, quote, placing our fiscal future in peril. As small business owners, we agree wholeheartedly, health care reform is not an ideological issue, it is an economic and practical one. We are encouraged by the overall approach of this bill and look forward to working with you to make it a reality this year. Thank you.

Chairman MILLER. Thank you.

[The statement of Mr. Arensmeyer follows:]

**Prepared Statement of John Arensmeyer, Founder & CEO,
Small Business Majority**

Good afternoon Chairman Miller, Ranking Member Kline and members of the committee. Small Business Majority appreciates the opportunity to present the small business perspective on the draft healthcare reform plan being considered by the House Education and Labor Committee. We support the effort to move this legislation through Congress expeditiously, and thank you, along with the leadership of both the Ways and Means and Energy and Commerce committees, for bringing a proposal forward for discussion in such a timely manner.

Small Business Majority is a nonprofit, nonpartisan organization founded and run by small business owners and focused on solving the biggest problem facing small businesses today: the skyrocketing cost of healthcare. We represent the 27 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific research to understand and represent the interests of all small businesses.

I have been an entrepreneur for more than 20 years, including 12 years owning and managing an Internet communications company specializing in financial services. Together with two other senior managers in our organization, we have a total of 70 years running successful small businesses ranging from high-tech to food production to retail.

We are pleased to be here today to support comprehensive healthcare reform that will reduce the costs of insurance and medical care, while making coverage affordable, fair and accessible. Our research shows that comprehensive health insurance reform is small business owners' number one need, and controlling costs is essential to ensuring our ability to obtain high-quality, affordable healthcare for ourselves, our families and our employees.

My testimony will highlight the issues of most interest to small businesses. I'll discuss what we have learned from our scientific research about both the opinions of small business owners and the projected economic impact of various reform options—and the impact of failing to act. The points I'll be making include:

- Our research shows that small business owners want and need reform now. The high cost of healthcare is killing us.
- Small businesses are willing to be part of the solution.
- A properly designed shared responsibility reform model will significantly help small businesses, according to an economic study we commissioned from M.I.T. economist Jonathan Gruber
- The committees' discussion draft addresses many of the necessary elements in comprehensive reform, particularly controlling costs, creating a robust exchange, instituting insurance market reforms and establishing a workable system of shared responsibility that takes into account the needs of the smallest businesses.
- We look forward to working with the committees to ensure that their recommendations on small business obligations, exemptions and tax credits are most helpful to small businesses and are consistent with our ability to pay.
- The tax rules for purchase of health insurance by the self-employed must be brought in line with those of all other businesses.

Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is our biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.¹

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.² Small businesses, including the growing legions of the self-employed, need a level playing field to succeed and continue as the job generator for the U.S. economy.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a \$13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says that "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of us feel we have a responsibility to do so. With staffs of 5, 10 or even 20 people, we run tight-knit organizations, know our employees well and depend on each employee for our businesses' success. We don't want to see our valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

Many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, among firms with 3 to 9 workers, the percentage that offers insurance dropped from 57% in 2000 to 49% in 2008.³

¹"Study shows small business owners support health reform," Robert Wood Johnson Foundation, 2008.

²J Gabel et al, Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down, Health Affairs, May/June 2006.

³Kaiser Family Foundation/HRET Employer Health Benefits Annual Survey, 2008

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small business owners, employees or their dependents, according to Employee Benefit Research Institute estimates.⁴

Our scientific research reinforces what we hear anecdotally every day: High healthcare costs are putting enormous pressure on small business owners. We have just completed a series of telephone surveys of a scientific sample of small business owners in 16 states. The staggering cost of health coverage is reflected in some of the key findings:

- An average of 72% say they are struggling to afford health insurance;
- An average of 69% overall say reform is necessary to save the economy;
- and when asked about the most important goals for healthcare reform, the top choice is most often “control costs.”

Finally, if we don’t get control of the healthcare crisis facing small businesses, we will impede our overall economic growth. Small businesses under 100 employees employ 42% of American workers.⁵ Traditionally, small businesses lead the way out of recessions. Addressing this crisis is essential to our vitality as a nation.

Cost Containment Comes First

We have sponsored research that actually models what would happen to small business without comprehensive reform, contrasted with three different levels of support to small business. The research underlying this report, made public earlier this month, was conducted for Small Business Majority by Jonathan Gruber, noted economist at the Massachusetts Institute of Technology. Dr. Gruber’s research found that without reform, the continued rising cost of healthcare coverage will cost small businesses \$2.4 trillion over the next ten years.⁶

We need to slow the growth of overall healthcare costs to make coverage affordable and to improve the competitiveness of small businesses. The key to cost containment is to create a marketplace where there is healthy competition among insurers, which would create incentives to lower costs by increasing price competition. Specific actions that are likely to have the most impact include expanded use of health IT, research about what works in medicine, transparency and public reporting of costs and quality, incentives for expanded use of preventive services, primary care and effective management of chronic conditions, malpractice reform, and reduction in waste, fraud and abuse. We are pleased to see that the House discussion draft addresses many of these approaches.

A Robust Exchange Coupled with Insurance Market Reforms is Essential

We believe that it is essential to have an insurance exchange that is well-designed and robust. A broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed. Indeed, our recent opinion research shows that 80% of small business owners in those states surveyed support a health insurance pool to create a marketplace where small businesses and individuals choose their coverage.

The current insurance marketplace is broken, particularly for small businesses, which cannot access plans with favorable rates because of their small size. Kaiser Family Foundation research shows that insurers’ administrative costs are 18% higher for individual and small business health plans than for large groups. Those costs are passed along in higher premiums.

We are very pleased that the committees’ discussion draft would establish a national insurance marketplace for individuals and businesses to comparison shop for coverage. It is good policy for states to establish state or regional exchanges that adhere to the national rules to ensure maximum flexibility and incorporation of particular local needs.

Moreover, we are encouraged by the committees’ proposal that there be standardized benefit packages to make it easier to make informed choices on cost and quality, along with guaranteed availability of coverage, no exclusions for preexisting health conditions, health insurance rating rules that prohibit adjustments for health status, a cap on premiums and out-of-pocket spending, marketplace transparency, and affordability credits to ensure that small business employees and others can actually participate without financial hardship.

⁴ Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population

⁵ U.S. Bureau of Census, 2006 County Business Patterns

⁶ The Economic Impact of Healthcare Reform on Small Business, Small Business Majority; available at www.smallbusinessmajority.org

To be financially successful, the exchange must ensure that it avoids adverse selection. Requirements that individuals and businesses purchase insurance, accompanied by guarantees of affordability, will help provide a wide, diverse base for the exchange. It is vital that the ultimate design of the exchange include as broad a group as possible and potentially include incentives for people to buy into it. To create stability it is important that the exchange can grow in strength as quickly as possible, taking into account the need to ensure a smooth transition.

For small businesses, this kind of exchange will go far in reducing the chaos and decreasing the administrative burden involved in choosing and maintaining health insurance both for business owners and for their employees if they offer coverage.

Healthcare Reform Based on Shared Responsibility Benefits Small Business

Small business owners understand that a balanced set of comprehensive reforms will require everyone to participate. 66% of small business owners responding to our recent state surveys support the idea that the responsibility for financing a more affordable healthcare system should be shared among individuals, employers, insurance companies, providers and government. It should be noted that respondents to our surveys included an average of 20% more Republicans (40%) than Democrats (22%), while 28% identified as independent.

According to the results of our economic modeling, comprehensive reform that includes even modest cost containment measures and a well-designed structure for employer responsibility will offer a vast improvement over the status quo and spiraling future costs for small businesses. A system requiring an employer contribution, with appropriate levels of tax credits, sliding scales and exclusions, will give small businesses the relief they need, potentially saving as much as \$855 billion over the next 10 years, reducing lost wages by up to \$339 billion and minimizing job losses by 72%.

The committees' discussion draft proposes an employer requirement to provide health insurance to workers. As shown by our research, this framework is workable, and, if properly designed, can produce substantial benefits for small businesses. Our modeling of the most successful reform scenarios presumes an exemption for the smallest businesses, a sliding scale of obligations based upon the size of payroll or the number of employees up to 6.5% of payroll and tax credits of 50% of health costs for employees earning under \$100,000 at businesses with fewer than 50 employees. We are very pleased that the committees have addressed many of the affordability concerns of the smallest businesses, and we look forward to working with you to ensure the best balance between benefit to small businesses and our ability to pay.

Tax Equity for the Self-Employed

Finally, another issue of great concern to us is the unfair tax treatment of the 21 million self-employed people in this country. Under the current tax code, self-employed individuals are unable to deduct premiums as a business expense and are required to pay an additional 15.3% self-employment tax on their healthcare costs. These business owners are at a significant tax disadvantage to larger businesses, which do not pay payroll taxes on the health insurance they provide employees. It is one of many barriers these Americans face in trying to access affordable health insurance for themselves and their families.

The self-employed should be allowed to fully deduct their health insurance premiums for the purposes of their income tax and self-employment tax. We encourage the addition of this provision in the final bill passed by the committees.

Conclusion

When Chairman Miller announced this historic bill, six months in the making, he noted that healthcare premiums had spiraled out of control, "placing our fiscal future in peril."

We agree. Healthcare reform is not an ideological issue—it's an economic one. Small business owners know this, which is why they overwhelmingly support a comprehensive solution to reforming the way we pay for healthcare. We are encouraged by the overall approach of this bill and look forward to working with you to make it a reality this year.

Chairman MILLER. Ms. Visco.

**STATEMENT OF FRAN VISCO, J.D., PRESIDENT, NATIONAL
BREAST CANCER COALITION**

Ms. VISCO. Chairman Miller, Ranking Member Kline, members of the committee, I am a 22-year breast cancer survivor, and I represent the National Breast Cancer Coalition, a coalition of hundreds of organizations and tens of thousands of individuals dedicated to ending breast cancer. We recognize that we will not achieve that mission unless everyone has access to the quality care they need.

NBCC is grateful for the opportunity to present our positions to this committee, and we are excited about the possibility, which we want to make a certainty, that this country will enact guaranteed access to quality health care for all now.

We have a grassroots board of directors. It is 25 of our member organizations, and they spent several years working on this issue. We invested resources in educating them, our field network, and the public about the various approaches and issues surrounding health care reform, and we developed a framework for a health care system guaranteeing access, which was submitted for the record with my written testimony.

We need a system of patient-centered care; yes, a term that gets thrown around quite freely. But you know the problems. There were some stories identified in my written testimony and there are so many more. Women sharing prescription drugs, delaying treatments, losing their jobs and losing insurance facing a diagnosis of breast cancer.

Our focus as a Nation should be on solving those issues, always centered on the patient, on the individual. How do we reform the system so that everyone has access to the quality care they need, when they need it; that guarantees everyone a comprehensive set of basic benefits that are based on evidence or are contributing to the evidence base?

We know you have many pressures from many different fronts, but we need to always keep focused on the patient, on the individual, centered on that goal. We should not begin by figuring out how to maintain drug prices or physician reimbursement or maintain the existing insurance industry. Those issues should only be addressed within the context of, first and foremost, the patients, the health of the individuals in this country.

The history of health care reform is the story of all constituencies that don't want to give anything up. We all have to give something up to achieve our goal; money, certainly, and the National Breast Cancer Coalition understands that.

And our framework makes clear we believe in shared responsibility. We should all share the financial cost of reforming the system. Perhaps we have to accept the longer wait for a test that would adversely impact our expectations, but not our health. But what we don't want to give up is our health, our lives.

We have all been working on these issues for many years. We know what to do, we just need the courage to do it. We applaud the approach outlined by this committee. It meets many of the principles of our framework for access to care. Our efforts in this area were led by Carolina Hinestrosa, the Executive Vice President of NBCC. She died on Sunday as a result of side effects from her

breast cancer treatment. She spent her last days working on this, and we will work our hearts out passionately, committed for Carolina, but also because we know it is the right thing to do and it is necessary to reach our goal of ending breast cancer.

We need make certain that this system supports the right care. We need comparative effectiveness research to reach that goal.

Now, we have spent some time understanding the issue beyond the sound bites and recognize without question the need for this approach in health care. Comparative effectiveness research is research in the real-life settings all doctors and patients face.

This is an extraordinary time. We are ready to change for the better the system of health care in this country. The infrastructure we build to get there needs consumers and patients at all tables. Their perspective is necessary to ensure that decisions regarding health care will have a meaningful positive impact for those on the receiving end of care: the patients and their families. And they are the ones who will have to navigate the complex web of rules and requirements in any health insurance system.

It is important that it is not just any patient or consumer. They must be accountable. They must represent to and report back to organizations that represent those affected by their issue, by their medical condition, and must be knowledgeable about the health care system and well-trained.

I didn't understand why in the 1990s when the health care reform effort failed, the American public did not storm Washington and demand that Congress and the White House make access to care a reality. This time we are ready and we are passionately committed to achieve that reality.

On behalf of the National Breast Cancer Coalition, we pledge to work with you to achieve the goal of guaranteed access to quality health care for all. Thank you.

Chairman MILLER. Thank you very much.
[The statement of Ms. Visco follows:]

**Prepared Statement of Fran Visco, J.D., President,
National Breast Cancer Coalition**

Thank you, Chairman Miller and members of the House Education and Labor Committee for the opportunity to testify at your hearing on the Tri-Committee Draft Proposal for Health Reform. I am honored to have this opportunity to appear before you today.

I am Fran Visco, a 21-year breast cancer survivor, a wife and mother, a lawyer, and President of the National Breast Cancer Coalition (NBCC). This organization and the testimony I present today represent the hundreds of member organizations and thousands of individual members from across the country.

NBCC's mission is to eradicate breast cancer. NBCC's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made.

The National Breast Cancer Coalition Framework for Health Care Reform

Since its inception in 1991, NBCC has known that the only way to achieve our mission to end breast cancer is to ensure guaranteed access to comprehensive, quality health care for all. After several years of research and analysis, in 2007, NBCC articulated its vision for accomplishing this goal when our grassroots Board of Directors approved a Framework for a Health Care System Guaranteeing Access to Quality Health Care for All which builds on Principles it adopted in 2003. Throughout the process of developing the Framework, NBCC applied its longstanding commitment to advancing evidence-based medicine and training consumers to strive to-

wards systems change. NBCC believes strongly in guaranteed access to coverage for all, educated patient participation at all levels of health system decision making, shared responsibility and benefits that are based on medical evidence and cost effectiveness so that patients can be assured of consistent, high quality health care. I am submitting a copy of the NBCC Framework for the record.

There are three million women living with breast cancer in this country today. This year, more than 40,000 will die of the disease and more than 240,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it truly early or how to cure it. It is an incredibly complex disease, and too few women have access to the care they need. We simply can no longer afford to accept the status quo when it comes to our health care system.

Our long standing commitment to health care reform is driven by the experiences and stories of the millions of women who have not only received the devastating diagnosis of breast cancer but have also had to suffer the injustices of our current health insurance system. We hear and live these stories, from women who share their breast cancer drugs with others who are un- or underinsured, to those who delay treatment or who ignore symptoms because they do not know how to pay for care. There are far too many stories.

Carolyn, from Los Angeles, had insurance and access to tamoxifen. So did one other woman in her breast cancer support group. But others lacked insurance and the funds to pay for treatment. So Carolyn and her friend shared their tamoxifen with these women. No one received the right amount of the drug.

Patricia from New Hampshire is 61, her husband 64. When he was laid off after 27 years, they lost their health insurance. Then she was diagnosed with breast cancer. She found insurance, for herself, at \$929 per month. Their joint income was \$40,000.

Sonia from Florida was also uninsured at the time of her breast cancer diagnosis. She managed to find fragmented care, and was refused further treatment at other institutions. She could not find insurance—even if she could afford it—because of her pre-existing condition.

Mary, from Waterloo, Iowa worked for a large corporation that changed health plans in the middle of her breast cancer treatment. Her doctors and hospital were no longer covered and she was forced to leave her doctors in the midst of a complex treatment regimen.

These are just some of the representative stories of what women face today in our existing health care system.

The House Tri-Committee Health Reform Discussion Draft

Mr. Chairman, on behalf of NBCC, I commend you as well as the Chairmen of the House Energy and Commerce and the House Ways and Means Committees for your leadership and hard work in putting together a health care reform proposal to provide quality affordable health care for all Americans and control health care costs. We are also pleased to see that your draft legislation includes many of the key elements that are reflected in NBCC's Framework for a Health Care System Guaranteeing Access to Quality Health Care for All (Framework).

NBCC's Framework calls for a health care system in which coverage is guaranteed to all individuals, does not discriminate or deny coverage for any reason, including pre-existing conditions. We are pleased that the draft legislation establishes options and expands Medicaid eligibility. All of these elements are critical to ensuring that those with insurance they like can keep it while also giving those for whom insurance has been out of reach the opportunity to finally afford coverage for themselves and their family.

While the public plan option was not included in our original Framework, the NBCC Board of Directors recently endorsed this approach because it believes a public plan is important to providing patients' choice and injecting more competition into the insurance market, with the goal of keeping costs down.

We are pleased that the House Tri-Committee discussion draft bill guarantees coverage and ends many of the discriminatory insurance practices that have put meaningful coverage out of reach for many Americans with millions more in fear of losing their coverage should they experience a catastrophic illness such as breast cancer. Specifically, your bill prohibits pre-existing condition exclusions and also bars plans from rating based on gender or health status. The bill also includes several provisions to keep health care affordable, including no annual or lifetime limits on benefits as well as an annual cap on out of pocket spending and sliding scale credits based on income to help people afford to purchase insurance.

NBCC's Framework calls for an independent public/private Federal-level board to determine the benefits package. The basic benefits package should be equivalent to the most comprehensive plan available to members of Congress through the Federal

Employees Health Benefit Plan (FEHBP) and should guarantee coverage for care that is based on scientific evidence and is continuously reviewed and updated based on evidence.

We are pleased that your legislation proposes a new 18-member public/private independent Federal-level Health Benefits Advisory Committee (Committee) that will recommend a new essential benefit package that will establish a core set of comprehensive benefits, make periodic updates to the benefits, and caps the amount of money a person or family spends on covered services in a year. We urge the Committee to ensure that the basic benefit package is as comprehensive and guarantees coverage for care that is based on the best available scientific evidence and is cost effective. It is imperative that the core set of benefits be available to everyone, regardless of ability to pay. Moreover, the benefits should be limited to those interventions determined to be efficacious, safe, cost-effective and based on sound evidence, or as part of a clinical trial or otherwise appropriately contributing to the evidence base.

NBCC strongly supports comparative effectiveness research and believes that it is necessary to help ensure quality, affordable health care for all. We need a high level of evidence for doctors and patients to choose which care is appropriate, for whom, and under what circumstances and who should pay for it. This is critical to patient-centered care. There are two necessary components to this evidence: the first is high quality clinical research of new interventions and the second, and equally necessary component, is research of interventions in the real life settings all doctors and patients face. Comparative effectiveness research is a term to describe this second component. It provides an opportunity to conduct research to find these answers, in settings that reflect the situations of the average person, adding value beyond what we obtain from the highly controlled setting of traditional clinical trials.

Women—all individuals—should have access to care that helps them, care that improves their lives. Today there is increasing use of technology in health care, certainly in breast cancer, with increased cost and little known benefit to patients. Comparative effectiveness will help guide us through this maze. For example, it could tell us which of the many gene based tests on the market actually are accurate and clinically useful. Also, as we strive to detect breast cancer earlier and earlier, we tend to find many abnormalities that will never become life threatening, yet we do not know how to deal with this information. Ductal carcinoma in situ (DCIS) is one such condition. DCIS is treated like it is cancer, so we over treat many women with significant harmful side effects. Comparative effectiveness research can tell us which of the various interventions for DCIS are the most helpful and least harmful.

There is a breast cancer drug that has been hailed as a breakthrough. It is a targeted therapy that costs tens of thousands of dollars a year. There are at least two tests to determine which women will benefit from this drug and we have known for over a decade that one provides much more accurate information. Yet we still pay for both tests and for the drug in women who will not benefit. And many women who would benefit do not get the drug. There are many similar questions that we have known for years that women face every day. We do not have the answers, but we could.

This rational approach to health care can significantly improve care. However, for comparative effectiveness research to do so, it depends on the following:

- **Quality**—Comparative effectiveness research must be held to the highest standards of quality. This research must employ rigorous methods that can provide reliable answers to our specific questions. These may include experimental designs, observational studies like registries, systematic reviews and other methods. Incorporating new technologies to better understand the utility of biomarkers and the interplay of co-morbidities will help achieve the promises of biomedical research progress on an individual level. Great care needs to be taken to ensure that there are clear standards of quality so the investment in comparative effectiveness research delivers value to the public.

- **Transparency**—Doctors, patients and policy makers must be able to trust the results of comparative effectiveness research. While quality is vital to that goal, transparency and accountability are also key. The processes for setting priorities, defining criteria and reporting results must be transparent and easily accessible to all. Methods and data must be shared so they can be publicly critiqued and widely used in a practical manner. Moreover, trained lay consumer advocates must be meaningfully involved in all aspects of decision-making that affects comparative effectiveness research.

- **Independence**—Comparative effectiveness research infrastructure must be sheltered from political pressure. The usefulness and value of comparative effectiveness research lie in its independent assessment of different interventions, the results of

which can be used by all the different stakeholders in decision-making. The process for selection of topics to be studied must be objective, and the results must be credible. The entire research process must be insulated from political pressures and conflicts of interest generated by both government and private-sector stakeholders.

- **Integrity**—Comparative effectiveness research must be conducted with integrity. High quality methods, accurate and detailed record keeping, and honest publication of the results, regardless of the outcome, must be emphasized. All contributors to comparative effectiveness research must publicly disclose all relevant relationships and conflicts of interest. Institutional guidelines and procedures must be in place to define and address conflicts.

Comparative effectiveness research must deliver value to the individual and society by strengthening the evidence base, enabling better decision-making, improving health outcomes, more fairly allocating healthcare resources, and containing the currently unsustainable health care costs.

We are pleased that your draft legislation builds upon the foundation that was set forth in the American Recovery and Reinvestment Act of 2009 (ARRA) to provide for a robust and rigorous comparative effectiveness research program. Specifically, your legislation creates a Comparative Effectiveness Commission that has been tasked with advising, overseeing and evaluating the research and findings of the Center for Comparative Effectiveness Research at the Agency for Healthcare Research and Quality. Your legislation seeks to ensure transparency, credibility, and access to research by requiring the disclosure of any conflicts; providing stakeholders input into the process; requiring the dissemination of the findings; and creating a Comparative Effectiveness Research Trust Fund (CERTF) to ensure that this critical research receives adequate funding and is not subject to an annual appropriations process. Such efforts are essential to ensuring that the public and providers are informed, and therefore patients receive, the most effective and appropriate treatment for their particular condition. Such research will greatly enhance the delivery of efficient, effective and high quality care that provides true benefit to patients in need. We simply cannot and should not continue to tolerate the massive amounts of wasteful, inefficient and in some cases, harmful care being administered in today's broken health care system.

NBCC's Framework calls for a significant number (25%) of educated patient/consumer members on all committees, commissions and boards involved in health care including those established to review and assess the best evidenced-based treatment options, their cost effectiveness, decide the level of benefits and determine effective methods for communicating health care information to consumers, providers and plans. Patient advocates—members of the lay public who are educated and trained—can play an integral role in ensuring that the health care system is responsive to the needs of the medical and scientific communities as well as health care consumers. Their perspective is necessary to ensure that decisions regarding benefit packages, insurance reforms, research and other aspects of the health care system are meaningful and will have a positive impact for those on the receiving end of health care—the patients and their families. The perspective of patients and families is also important as they are the ones who must navigate the complex web of rules and requirements in any health insurance system.

The leadership and membership of the various committees and commissions contemplated by your bill will determine its success. These individuals, no matter which constituency they represent, must be chosen based on their proven ability to participate in these types of decisions. We are pleased that your draft bill demonstrates your commitment to ensuring that patients, consumers and their families have a strong voice and role to play in a reformed health care system. In particular, we are heartened to see that the independent private-public Health Benefits Advisory Committee assigned to provide recommendations on a benefit package would include consumer representatives. We also appreciate that your bill provides patient advocates a role to play on the Comparative Effectiveness Commission. We would however encourage you to specify that 25 % of these committees are comprised of consumers or patient advocates to ensure that they can contribute to this process in a meaningful way. We also would ask that you consider integrating the following language everywhere such entities are described in your bill:

“The term ‘educated consumer or patient advocate’ means an individual who is accountable to, represents and reports back to organizations that represent those affected by a specific disease or medical condition and is knowledgeable about the health care system and has received training to make informed decisions regarding health, medical and scientific matters.”

NBCC's Framework calls for the implementation of strategies to significantly reduce the administrative cost of the health care system, to simplify the current sys-

tem, reduce duplication, inaccuracies, and inefficient record keeping and provide for system-wide electronic record keeping.

We are pleased that your discussion draft makes a priority of appropriately controlling the rising cost of health care. Your proposal will reduce the growth in health care spending in numerous ways including health care delivery system reform and improvements in payment accuracy. Your legislation will realign payment incentives to reduce overuse, slow the growth of health care costs, and improve Americans' health. Your bill will also ensure physician and patient access to the latest and most scientifically complete information on available medical treatments and will invest in development of robust quality measures on health outcomes.

NBCC's Framework calls for shared responsibility. The system should be financed in part through cost savings and shared responsibility. Everyone—individuals, employers, and government—share responsibility to support the health care system. Individuals should be required to financially contribute to the system based on their ability to pay. All employers should be required to contribute to the system. Subsidies or a sliding scale should be implemented to ensure that small businesses are not disproportionately affected by these payments. And no individual can be denied coverage for inability to pay.

We are pleased that your plan provides sliding scale affordability credits to low and moderate income families and assistance to small employers.

We are pleased that your draft legislation recognizes that for health care reform to be successful and sustainable over the long-term, it will require the shared responsibility and commitment of all participants in the system—individuals, employers and the government.

Commitment of the National Breast Cancer Coalition

NBCC is strongly committed to achieving meaningful health care reform this year, as we truly believe it is essential for all women with or at risk for breast cancer and for everyone to have access to high quality, affordable and reliable health insurance coverage. Without it, advances in medical research will remain out of reach for many individuals and patients in need and we cannot guarantee those who have been diagnosed with breast cancer will receive the necessary treatment or medical care that is critical to their successful recovery. NBCC and its members are dedicated to working with you to achieve affordable quality health care for all.

Thank you again for the opportunity to testify today and for giving hope to all women and their families, and especially to the 3 million women in the United States living with breast cancer. I look forward to working with you to ensure that health care reform is enacted into law this year.

APRIL 2008

NBCC's Framework for a Health Care System

Guaranteeing Access to Quality Health Care for All

The National Breast Cancer Coalition (NBCC) has advocated for guaranteed access to quality health care for all since its inception in 1991. In 2003 NBCC adopted its Principles for Achieving Guaranteed Access to Quality Health Care for All. NBCC analyzed various approaches to achieving its goal in order to develop public policy that moves beyond incremental changes to the existing health care system toward true comprehensive reform. NBCC's extensive research and analysis gave rise to its Framework for a Health Care System Guaranteeing Access to Quality Health Care for All. This Framework is intended primarily to address the issue of health care coverage. NBCC continues to work on approaches to quality and access beyond coverage.

NBCC presented the Framework at its Annual Advocacy Training Conference in April 2008 and NBCC advocates presented it to their Members of Congress during Lobby Day on April 29th. NBCC looks forward to working with Members of Congress and other stakeholders to advance the goals articulated in the Framework.

Key Points of NBCC's Framework

- The Framework is premised on the fundamental belief that health care is a right and that all people present in the United States should have access to quality health care regardless of their immigration, residency status, or ability to pay.
- The Framework is an outline for legislation that will support a system of evidence-based health care coverage for everyone.
- The Framework provides that the basic benefits covered are comprehensive and evidence-based.
- The system resulting from the Framework will include mechanisms to:
 - Support development of new evidence through clinical research

- Continually refine benefits through comparative effectiveness and cost effectiveness analyses
- Reduce over and under use of care
- Include educated consumers in all decision making
- The system will be financed in part through cost savings and shared responsibility:
 - Everyone—individuals, employers, and government—share responsibility to support the system.
 - Individuals will be required to financially contribute to the system based on their ability to pay.
 - All employers will be required to contribute to the system. The Framework would phase out employer-sponsored health insurance. Subsidies or a sliding scale should be implemented to ensure that small businesses are not disproportionately affected by these payments.

The National Breast Cancer Coalition's number one public policy priority is guaranteed access to quality health care for all. This document outlines a Framework developed by NBCC's Board of Directors that is based on the organization's Principles for Guaranteed Access to Quality Health Care for All adopted in 2003. This Framework addresses a legislative approach to coverage issues. NBCC recognizes that access to quality health care goes beyond coverage.

A health care system that is built on this Framework will:

- provide a basic benefits package that is comprehensive and based on sound scientific evidence;
- maintain continuity of coverage;
- be efficient and cost-effective;
- be fully-funded through shared financial responsibility;
- be sustainable and affordable.

The health care system must be accountable to the users and the public. A system must be established to:

- evaluate and support development of medical evidence for health interventions upon which coverage will be based;
- support ongoing and continuous comparison of interventions to ensure access to appropriate and cost-effective health care;
- modify and expand current benefits as appropriate based on evidence.

I. Benefits Package

1. All eligible individuals will be provided with coverage for a benefits package equivalent to the most comprehensive plan available to Members of Congress through the Federal Employees Health Benefit Plan.

2. The benefits package guarantees coverage for care that is based on the best available scientific evidence and is cost effective (as determined by the Federal board described below). Care that does not meet these criteria will not be covered, unless it is being provided as part of a quality clinical trial or otherwise appropriately contributing to the further development of the evidence base.

II. Eligibility

1. Coverage is guaranteed to all eligible individuals.

a. An eligible individual is one who is present in the United States. (Note: the extent of coverage will vary based upon reason for presence and duration of stay).

2. All eligible individuals will be automatically enrolled and covered at the point of attaining eligibility.

III. Determination of, Modifications to and Expansion of Benefits

1. A Federal-level board shall have the authority to implement a system of coverage determination based on evidence. The board shall be appointed and include members representing the lay public (at least 25%). The members shall have staggered terms longer than 4 years.

a. Cost-effectiveness shall be a factor considered by the Board in making benefit coverage decisions.

2. A separate and independent body, including at least 25% membership from the lay public, shall be appointed to develop a system for assessing comparative effectiveness of interventions, the results of which must be utilized by the board determining coverage benefits.

3. The comprehensive benefits package and any modifications thereto shall be limited to those interventions that the boards deem to be: efficacious, safe, cost-effective, based on sound evidence; or either as part of a quality clinical trial or otherwise appropriately contributing to the evidence base.

4. Elective Benefits

a. Commercially available private health plans may provide coverage of benefits not included in the benefit package.

IV. Efficiency

1. The government shall implement strategies to significantly reduce the current administrative costs of the health care system and all such savings shall go toward providing coverage.

2. The government shall also develop and implement strategies to simplify the current system, reduce duplication, inaccuracies, and inefficient record keeping and provide for system-wide, interoperable electronic record keeping.

V. Information and Education

1. Accurate, timely, and readily accessible information about health care coverage, access and the scientific evidence base shall be available to everyone. All health care providers must offer clear information to consumers on the benefits and harms of all options, and the quality of the evidence for each option.

2. A national panel shall be established to work with the public to review evidence and help design effective methods for communicating health care information to consumers, providers and plans.

VI. Financing

1. All individuals are required to financially contribute to the system according to their ability to pay.

2. All employers are also required to financially contribute to the system.

Under this Framework employer-sponsored health insurance will be phased out, however, all employers are required to financially contribute to the system.

3. The federal government shall establish a method for determining the financial contributions for individuals and employers.

4. No individual can be denied coverage because of inability to pay.

5. In addition to individual and employer contributions, the system will be financed by the public and private savings from efficiencies (referred to in the section on efficiency) as well as other government funding sources.

Chairman MILLER. Thank you all for your testimony, and again for taking your time to be with us and sharing your expertise and your experience with us. We will pick up where we left off with the members on our side.

Mr. Hinojosa is recognized.

Mr. HINOJOSA. Mr. Chairman, I apologize that I was at another commitment, and I am going to yield back my time and listen to my colleagues ask their questions.

Chairman MILLER. Why don't you yield your time to Mrs. McCarthy?

Mr. HINOJOSA. I yield my time to the gentlewoman from New York, Mrs. McCarthy.

Mrs. MCCARTHY. I thank you, and I thank the gentleman for his time. Listening to the testimony from the first panel and this panel, one of the things that I am going to be focusing on—I spent 32 years as a nurse, and the nursing shortage in this country is severe. Not only the nursing shortage, but almost all health care workers, plus primary care doctors. I don't see how this plan could actually work unless we have the workforce that can go behind it.

I am pleased that we have some initiatives in this bill that will work on towards primary care doctors and nurses, but also the public health centers, if that is where we are going to go, especially for those that have the insurance.

I grew up with a public health center. That is where I went for all my medical care, my shots, my polio shots, all of that, because my mother and father didn't have health care insurance. There is nothing wrong with that as long as we teach the patient or give

the patient the dignity that they should deserve wherever they go to get an examination.

And to be very honest with you, on some of our hospitals, which are overworked, have no money to improve their facilities, and to see those that don't have health care insurance—and that is a lot of people that have just gotten out of work—you are treated like cattle, and the dignity is taken away from the person and the patient. And that is totally wrong.

They say that a country is as great only as the health of their people. And I consider this a great country, but I do not believe that our health care is the best out there. So with that being said, we have a lot of work to do. And I hope that both sides actually come together because this is the time that we need to have this done. It is the time to have it done.

From the first witness, Dr. Romer, she talked about bundling; but a lot of people don't understand or know how the bundling is actually going to work between the hospital and the patient. The waste and fraud, where is that going to—you know, how are we going weed that out to save money but not punish the doctors that are out there?

Payment to the doctors and the hospital. I have to tell you, if anyone gets the health care that I have, I see what they pay to the doctors and to the hospital, and I will tell you it is outrageous; they don't get paid enough. And you wonder why a lot of them are not accepting any patients. That has to be taken care of.

So I am hoping as we go forward that we can work on this. I am glad to see that the donut hole has been closed, I think that is terrific. Certainly that is the biggest complaint of most of my—

Chairman MILLER. It is not closed yet.

Mrs. MCCARTHY. Sorry?

Chairman MILLER. We have a contribution toward closing it. It is not closed yet. It is a fairly large donut hole. It is very helpful, what has taken place this weekend.

Mrs. MCCARTHY. Well, if we are going to make that sacrifice, I mean this is the time, this is our time to do the right thing. That is my opinion. And the donut hole for all my seniors is something that should be concerned about, because, let's face it, the majority of our seniors, unfortunately, start getting the most care, health care, when they are over 65 to 70, to 75. That is when our bodies start breaking down.

So with that, I am hoping—and, again, with all the witnesses, they had—I know this is kind of more of a speech, and everybody here knows I don't give many speeches, but this is something I feel passionate about.

You know, when you talk about your cancer patients and not being able to get the care that they need because they can't afford it, to talk about the cancer patients that the families will spend all of their money to take care of someone that they love, I mean if we as a Nation can't share those costs to be helpful to the family and to the people, I believe our country, I believe our Americans actually do believe in taking care of each other.

With that, I yield back the balance of my time.

Chairman MILLER. The gentlewoman yields back. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman and Ranking Member, for having this hearing today. Health care has been—up until January, I spent 28 years in health care. I thought maybe I would retire from there, actually. It wasn't to be. And I find myself here today.

And I come to Congress, actually, with many of my freshman colleagues with health care backgrounds. And so you know my commitment. I got involved in public policy because of health care and working to ensure access, affordability, quality and choice of health care; a frustration of costs that I saw that were being driven up, frankly, by government intervention, as a result of regulations that were piled on like layers on an onion. The regulations probably made sense at one time, but we have to go back to the 1960s to find the roots of many of them. And one thing we don't do is peel things away in government, we just add layers on, and the frustration that I had on behalf of my patients of how that was increasing costs and decreasing access.

And I appreciate this opportunity today. This is really one of the first opportunities to engage in this discussion, which has been pretty frustrating for someone who came to Washington, after almost 30 years in health care, with ideas that we could do things a little better. And so I appreciate the opportunity today.

Frankly, the change that we need needs to be the proper change, and a result of full debate and full discussions. And we have not had that opportunity. That has been a real frustration of mine and, I think, a number of my colleagues.

There are some serious concerns. A few of these I just mention briefly with the proposal on the table. It is creating a taxpayer Federal Government provider that will not really compete, but ultimately will consume the private health providers. We will wind up with a monopoly and it will be a government provider.

Most of my frustration has been a result of dealing with Medicaid and Medicare in terms of the access and the quality of services for the consumers I have served for three decades. Frankly, I find the flawed funding mechanisms in terms of competition being named, yet we are going to ultimately, I believe, decrease competition because of this new government entity that is taxpayer-funded.

The savings from HIT I have concerns with. I think there are immediate gains for HIT, obviously for health information record, but in the long run is it sustainable? That is the type of thing that you have to be able to reinvest in every time a new generation of technology comes along.

And I raised that question in a previous forum and there were no thoughts about what happens a number of years from now when the technology changes and our health care providers find themselves without the resources to do that.

So frankly, marching ahead, my first question, Mr. Speranza, you noted that an employer mandate will lead to loss of jobs. Some studies have found economic analysis prepared by our previous witness, Dr. Romer, that an employer mandate costing \$300 billion over ten years will result in a loss of 3.7 million jobs. Can you elaborate on how an employer mandate would work in your company?

Mr. SPERANZA. Wegmans Food Markets provides full health insurance and has for decades. As a matter of fact, one of the things we take pride in is Fortune Magazine has listed us as one of the top 100 companies to work for. In the last 5 years we have either been number 1 through 5 on the list, and we are the only company in America to have that designation. Our corporate philosophy is our employees always come first, and we mean it. If we take care of our employees, our customers take care of themselves. And if our customers are taken care of, our bottom line takes care of itself.

Our view as it relates to our own business, and quite frankly our industry, is we make our own decisions as to what benefits we should provide. If competition doesn't do that, we attract, we think, better employees as is shown how we have done this in the past.

I will share one other thing with you. I talked about collaboration before. Over the years—we have 39,000 employees, about 2,000 are in unions, Teamsters union and the bakers union. And for years it would be the company against the union, and we changed that and we worked very hard. Right now we have provision in our labor contracts where if there are enhancements in our employee benefits in health care without negotiation, the union people get them as well. If, unfortunately, there has to be a reduction in health care benefits without negotiation, that happens as well. We built a team and we built a team that works.

That is what I think America is all about. You make those choices at the lowest possible level, which is company by company. If there are companies, Mr. Thompson, that choose not to do that under the present system, I think they will pay the price by not being able to retain employees, which is very costly, or not to get the quality of employees. That is one approach.

The only other thing I would say, going back to the testimony, is that there hasn't been much said about the fact that we don't have enough physicians, we don't have enough nurses, we don't have enough health care workers. Why shouldn't there be incentives?

I am a lawyer. Do you know that there are three times more law schools in this country than there are medical schools?

Creating incentives for health care workers. I would love to come back on another day when you are talking about education. Quite frankly, one of the things—and if you want to come to Rochester, I invited you with respect to health care. Perhaps you would come back as it relates to education. We have a number of programs to help economically disadvantaged children. We encourage them to go into the health care industry, whether that is physicians, whether to anything else in health care. So my sense is let the market prevail as much as we can. That is the American way.

Mr. THOMPSON. And I appreciate your comments on the supply side of providing accessible and affordable health care. I think that has been pretty much ignored. And with that, my time is expired, Mr. Chairman.

Chairman MILLER. Mr. Kucinich.

Mr. KUCINICH. Thank you, Mr. Chairman.

To Mr. Speranza, I want to call your attention to a documented letter that was in the New England Journal of Medicine in the June 4, 2009 edition, where it says that the insurance industry has

over \$4.4 billion in investments in tobacco companies. Do you have any comment on that?

Mr. SPERANZA. Well, I guess my first comment would be we were the first major chain in the United States to stop selling cigarettes, so I think that is where we stand.

Mr. KUCINICH. I am asking about the industry, though.

Mr. SPERANZA. I guess I would say with respect to that, I haven't given that a lot of thought. I do know that the insurance companies most likely have a fiduciary responsibility to do the best they can with their investments.

Mr. KUCINICH. Right.

Mr. SPERANZA. I am not an economist.

Mr. KUCINICH. Thank you. You know, Melton Friedman said this—I am not often someone who quotes him, but it is worth quoting in light of what you just said. He said, "Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their stockholders as possible: That is a quote that is included in this article in the New England Journal.

Now, I would just like to say, Mr. Chairman, the fact that insurance companies can invest in tobacco companies—seemingly contradictory assumptions if you are talking about public health—ought to be of note to this committee when we start marking up the legislation.

Now, Professor Hacker, I believe health care is a human right. I think everyone deserves it. That means no financial barriers to care. It means all medically necessary services are covered. The draft bill under consideration today is many badly needed reforms and has a very strong public plan option. But even with this, it is clear that millions will still remain uninsured and underinsured.

What are the models for health care finance that would be consistent with the principle that health care is a human right?

Mr. HACKER. Thank you, Congressman. I think that it is first worth noting that the broadening of coverage, that I would think is going to be foreseen when we look seriously at the effects of this piece of legislation, is going to be very substantial. The proposal that I developed some years ago, Health Care for America, which is very similar to this draft legislation, would cover almost all Americans. And when I say "almost all," my proposal would cover all but a tiny, tiny share, roughly.

Mr. KUCINICH. Are you saying that this bill that we have heard widely discussed at this committee—we will soon be marking up the bill that has been fairly well described—meets the test of health care as a human right?

Mr. HACKER. I think that it meets the test of providing affordable quality coverage.

Mr. KUCINICH. Does it meet the test of health care as a human right?

Mr. HACKER. I think that it does. That is a very high standard. I teach in my university the idea of democracy is an ideal. No system actually lives up to that standard.

Mr. KUCINICH. So you are saying some people have the rights and other people don't, even in a democracy; is that what you are saying?

Mr. HACKER. No. I am actually saying that I believe that the standard of health care is a human right, that this proposal will move us dramatically closer to that ideal in our present system.

Mr. KUCINICH. I am concerned about medical bankruptcies. There is an update of a landmark Harvard study published on June 4, 2009 that found that two out of every three bankruptcies are related to medical bills. In 2001 that number is about 51 percent; 78 percent of those medical bankruptcies happen to people who actually had insurance before they got sick. It is a stark illustration of the consequence of giving health insurance companies the ability to sell plans that don't provide an adequate level of coverage.

How many medical bankruptcies would the bill under consideration today allow?

Mr. HACKER. I cannot give you an exact estimate, but I can say it would dramatically reduce the number of medical bankruptcies.

Mr. KUCINICH. Would there be no medical bankruptcies?

Mr. HACKER. Well, I don't know if there would be no medical bankruptcies. However, it is worth noting that some of those medical bankruptcies are due to lost income due to sickness in the Himmelstein-Warren study. So it is not clear to me that those would be prevented, even if we had the most stringent requirements of affordability.

Mr. KUCINICH. This study says two out of every three bankruptcies are related to medical bills. This is the landmark Harvard study. It didn't say it is related to people losing their income.

Mr. HACKER. Some portion of that total is due to people—lost income due to sickness rather than to medical cost.

Mr. KUCINICH. Did you read this study?

Mr. HACKER. I have indeed.

Mr. KUCINICH. And you are saying that it has to do with that the two out of every three bankruptcies—which the Harvard study says relates to medical bills—you are saying that a more correct characterization would be that it is also related to people losing their income.

Mr. HACKER. I don't know the exact division within the study. I am saying that some portion of medical bankruptcies in that study are due to lost income due to sickness.

But I want to reiterate that the two ways in which this legislation would dramatically reduce medical bankruptcies are, one, it would make a dramatic move towards ensuring that coverage is affordable through the exchange as well as through employer coverage plans that now have to meet minimum requirements.

Two, it would create a true public insurance plan competing with private plans that would have set benefits in law that would offer people guaranteed security.

Mr. KUCINICH. Mr. Chairman, I just want to point out that just saying that insurance is affordable doesn't mean the hospital bills are. Thank you.

Mr. HACKER. But there are limits on cost sharing within the bill of \$5,000.

Chairman MILLER. The gentleman's time has expired. Mrs. McMorris.

Mrs. MCMORRIS RODGERS. Thank you, Mr. Chairman. And I too want to say thank you to everyone for their testimony.

I think this is an important issue that we are facing. I am a big supporter of health IT. I think it has huge potential to save costs and also improve health care delivery. I am excited about wellness. I think we as a country have become way too lax in our own personal responsibility for taking care of our health.

I do have very very deep concerns about this government option, though, and I wanted to direct a question to Mr. Stapley. Because when you look at who is insured today, 50 percent are in some kind of a government plan—Medicare, Medicaid, TRICARE—50 percent are in private, and then we have the uninsured that we need to address. And I continue to hear that the reason that we need this government plan is to control cost.

And yet what happens today is that we know Medicare, Medicaid, TRICARE, doesn't pay the cost, and that it is the private sector that has to subsidize the cost of government not paying the cost of these plans.

So I wanted to ask Mr. Stapley if he would just comment on what you believe the impact of the government option would be on private health insurance, and will it create competition or is it simply going to centralize control with the Federal Government?

Mr. STAPLEY. Those are outstanding questions. I don't know that I could quantify what I think the impact is. I think from the perspective of employers it is more of a fear of the unknown in terms of what might happen. I would say, first of all, that in terms of an insurance exchange, aside from the issue of the public plan, that it is very important that the plans that are offered through the insurance exchange be accountable. And I think it is a fair criticism of the current system. I don't think the financing system in the United States today is accountable. I think they do all kinds of things that are abusive, and so forth and so forth, that we have to correct.

Now, when you move to the public plan, the concern is that if they pay at Medicare—or make Medicaid-like rates, or they continue to do some of the sorts of things they do on the administrative side, it could create problems.

Now, let me give you two examples that I think are very appropriate. I was involved in the creation of the Utah Health Information Network. I am the current chairman of their board. I think it is one of the most successful health information exchanges in the United States. We transact an enormously high percentage of our administrative transactions in Utah electronically. We do Medicare transactions as well. We do all of their transactions. We send them from providers in the State of Utah to the intermediary in South Dakota. They pay us not one red cent for those transactions. We transact them free.

UHIN, Utah Health Information Network, is made up of a consortium of payers, physicians, hospitals and so forth. Those transactions are not free; they cost money. Every transaction costs something. So the fact that Medicare pays nothing means that the rest of us have to pay more to accommodate that. That is true, as I un-

derstand it, with every health information exchange in the United States.

Now, if you move to the care side, I think it is a little more complicated question. But I can tell you that we sit down every year and negotiate with a very respected health care system in the State of Utah that all of you probably heard about in the last couple of weeks, because they have been part of the debate. And we sit down and we say, okay, let's talk about what we are going to pay you next year. And they say, well, I will tell you what is going to happen here. Our charge masters, or our cost of doing business, has gone up by, say, 3 percent or 4 percent. Medicare comes along and says, guess what? We are going to give you 1 percent. Now, this is a theoretical example. Therefore, they tell us, you are going to pay 5 percent because we have got to make up what Medicare is not going to pay to us.

Now, how that translates out into the system in its entirety in terms of higher health care cost, I don't know. I personally think that one of the questions you have to ask is, if 100 percent of the reimbursement in our health care system today were based on Medicare rates, what kind of an impact would that have on the health care system?

And I am not in a position to answer that question, but it would have an impact.

Mrs. MCMORRIS RODGERS. Thank you. I appreciate your answer.

I am going to quickly run out of time, and I had a question I wanted to direct to Ms. Visco. Just talking about cancer in this country and survivability, because you know we actually lead the world in survivability rates. When you compare America with breast cancer, 84 percent survival versus 69 percent in the U.K.; prostate, 92 percent survival rates in America, 51 percent in the U.K., are you concerned—or what would you attribute that to compared to what is happening around the world?

Ms. VISCO. Well, I think it is a very—the answer to that question is incredibly complex, the extent to which you look at survivability and see what percentage is due to earlier detection; in some situations, what is due to better treatment. Of course, the incidence of cancer is incredibly high in this country compared to many other countries. And certainly the incidence of breast cancer is incredibly high compared to many other countries. But it is an incredibly complicated analysis to sort of tease out what results in a mortality benefit or a survivor benefit.

Mrs. MCMORRIS RODGERS. Thank you.

Chairman MILLER. Mrs. Davis of California.

Mrs. DAVIS. Thank you very much, Mr. Chairman. I wanted to just quickly—and I know this probably would have been a better question for Ms. Romer—but I wanted to just focus on the Medicaid and Medicare issue and the concern that we would be trying to pick up some cost savings through that.

As you know, in California and New York, people start getting a little nervous about this because we look to those costs. Could any of you comment on that, and whether or not—she had mentioned limiting the itemized reductions for Medicare and Medicaid, that that would be one place of picking up some savings. Do you all have experience with that enough to know what are we talking

about there realistically? And does that bring us to a question of whether the large States and the small States, if the competition is going to be such that both are paying essentially the same thing for that care, which we know today is not true? Do you want to comment on that, Mr. Shea?

Mr. SHEA. Congresswoman, if I understand your question correctly, let me answer it this way. There has been under way, ever since the first Institute of Medicine report, an effort, a cooperative effort across the board in health care to understand how it is that we can address the systemic quality problems that we have; because it is clear that we have problems, and there are costs, enormous costs linked to that. The Institute's own estimate well publicizes that 30 percent of the money that we spend every year is for care that really doesn't help people. So we need to have—and the field knows this, and they recognize it and people are working on doing this.

So that we are on track now to change the way care is done and the way care is paid for, to make it based on quality in a way it has never done before.

I would like to quote something my business colleagues say to us across the bargaining table. They say, "We pay for health care like nothing else we do in business." We pay the same, regardless of whether it is world-class care, okay care, or downright dangerous care. And we don't even know which is which, because we don't get that information back. We just got to change the way we approach this.

And the current system has done some things very well, but it has caused a train wreck of costs.

Mrs. DAVIS. Is there a way that we can talk, though, about the cost of health care as being equitable across all States? Is that a realistic even assumption that that can be done?

Mr. SHEA. I think it is really part of this whole approach. People were shocked when the numbers first came out that showed in controlled studies how the cost in Florida was much higher than the cost in Minnesota, one of the famous ones. People know that these are practice patterns. They don't have to do with the science of care, they don't have to do with what is best medicine. These are solvable problems as are many of the other things in health care. We know how to go about it.

We need the structure that your bill would give us, or at least begins to give us, to get at that so that we can take a coordinated national strategy in dealing with this. I could go on for several hours about this if you would like, but there are elements in your bill that really put us on this road to an entirely different kind of health care delivery system.

Mrs. DAVIS. Mr. Pollack, and then I wanted to go to a cost-sharing question. I know that Mr. Kucinich raised that in terms of copays, and again whether or not we can include equitable cost-sharing provisions in the health care reforms themselves. Mr. Pollack.

Mr. POLLACK. In terms of cost-sharing, obviously cost-sharing affects people at different income levels very differently. And one of the things that I think is a real benefit in this legislation is you provide certain kinds of cost-sharing protections that are predi-

cated on income. And I think that is very important. Now, with respect to your—

Mrs. DAVIS. Is that not limiting copayments?

Mr. POLLACK. I am sorry?

Mrs. DAVIS. Limiting copayments by income, is that specifically what you mean?

Mr. POLLACK. There should be some out-of-pocket cap, which this legislation includes, which would preclude the kind of things that Congressman Kucinich was worried about in terms of medical bankruptcies. I think this legislation goes a long distance in providing protection on that.

Now, with respect to differences in care, I just say two quick things. One of the most remarkable pieces of work that I have seen in a long time was in a recent article in the New Yorker by Dr. Atule Gawande who actually examined not just the differences, say, between Miami and Minneapolis—which is often what people look at—but he actually compared McAllen, Texas with El Paso, Texas. And he found that in McAllen, Texas the costs were about double what they are in El Paso.

I think there are a number of things that we can do. I think there are some things that this bill would do that would help change those disparities. I think the promotion of comparative effectiveness research is very important in getting that proliferated as substantially as possible. Not precluding a doctor from making a clinical decision, but at least providing guidance to the physician and to the patient, I think that is very important.

So I think there are some things that can be done which I think will reduce this wasteful spending that occurs in too many places. One last thing, and that is—

Chairman MILLER. That will be your last thing.

Mr. POLLACK. Sorry?

Mrs. DAVIS. The Chairman is ready to gavel us down here. I wanted to follow up with Mr. Speranza.

Chairman MILLER. I don't know whether Mr. Speranza wanted to jump in on your question. It looked like at one point he wanted to jump in in response. Go ahead.

Mr. SPERANZA. Just very briefly. With respect to the cost of care, I think we really need to focus in on that. There are so many things that communities can do: unwarranted variation in hospitals, infection rates in hospitals, those sorts of things. And if there were medical guidelines evidence-based throughout the country, that would go a long way toward this.

So if you gave incentives to physicians—right now they are on piece work like a manufacturing line—if you paid physicians based on outcomes and encouraged them to get into wellness and those sorts of things.

And that is the last thing I would say, whether it be Wegmans or Safeway and others, we want to have the opportunity as employers to work with our employees to change behavior. It helps the employee. Nobody wants to get a heart attack, nobody wants to get sick. And so this bill, it looks like, stops you from doing that. We really ought to be looking at it the other way. We need to change behavior in a positive way.

Chairman MILLER. Mr. Loeb sack.

Mr. LOEBSACK. Thank you, Mr. Chairman. And thanks to our witnesses. Great questions all around.

I think the idea of personal responsibility, Mr. Speranza, is really important, and I agree with my colleague Congresswoman McMorris Rodgers, on that. I think we can all agree on that.

Obviously I think we have to do all we can to promote personal responsibility. And when it comes to wellness, I think that is absolutely critical. There is no doubt about it.

There is a lot to like, I think, about this bill. Certainly I think wellness is a part of it, important part of it. Health IT is an important part of it as well, as was mentioned. I think a public plan option is the way to go. And I am going to ask Dr. Hacker about that in a second.

Dealing with catastrophic costs, clearly that is something we have to deal with. There is no doubt about it. And I could go on and on.

I do want to pick up a little bit on the regional and geographic disparities questions. I am from Iowa so that may not surprise you why I want to pick up on that. Iowa, as maybe everyone on the panel—maybe not—knows, is consistently ranked at or near the top in terms of outcomes and efficiency, quality of service, all the rest. We are among the best, if not the best.

Yet Iowa—and not just Iowa, but there are a number of States that rank high in terms of outcomes but rank low in terms of reimbursement rates.

I just want to ask any of you here to offer any remarks that you might with respect to the current bill and whether it really gets at that issue or not, and what we might be able to do to really remedy some of those geographic disparities that we see.

In particular, I think Mr. Pollack and Mr. Shea might be willing to speak to that.

Mr. SHEA. I appreciate the question, Mr. Congressman, and I think you are right on track.

I think one of the ideas that has been widely discussed is that notion that as we link payments to quality we need to do rapid-cycle testing of the way to do that so that we are not in the system where Medicare once a year sets rates and so forth. We need a more flexible and nimble approach that really matches the quality improvement efforts that are being done around the country and that rewards those and incentivizes those.

I know that in the Senate health bill I was admiring some of the things that they did that were just beginning steps to do this but that were just sensible kinds of things like, well, we are going to pay a physician's office extra money if they do follow-up on hospital discharges. This is a huge problem. It costs us an enormous amount of money. It is very simple to solve, but the current system we have has nobody responsible for that. Well, why not pay a little bit extra money to save some money? So I think this is one big point.

The other thing I would just say is I really think that, with the advent of a public plan, we are going to see a much more responsive public system to payment rates because it is not going to be just the elderly or just the poor. If we mainstream public insur-

ance, I think we are going to get a much more responsive public insurance system all the way around.

Mr. LOEBSACK. Okay. Thank you.

Did you want to say anything, Mr. Pollack?

Mr. POLLACK. I would just add, too, that I think that the more we move health care into a more group planned system I think we are going to create a lot of efficiencies, and we are going to provide greater coordination of care. Particularly for people who have got chronic conditions, many of them have multiple chronic conditions, and if they go to one specialist and then they go to another specialist, this specialist may be terrific but may not know how that treatment affects another problem. So we do need greater coordination of care. We need medical homes. I think if we do that we are going to not just improve quality but I think we are going to create cost efficiencies in the process.

Mr. LOEBSACK. Thank you.

Dr. Hacker, I am a former political scientist, by the way, so it is nice to see you here. Thank you.

I do want to ask you about the public plan choice and how it will create competition and, in particular, if you could rebut the argument that private insurances are simply going to be pushed out of business by the creation of a public plan. Can you sort of help us resolve that issue?

Mr. HACKER. Well, first of all, I am glad to be speaking to a fellow political scientist. You can see why I am glad. We do not get a lot of representation. No pun intended. That was why I immediately reached for the Ideal of Democracy in talking to Congressman Kucinich.

This argument that is often made that a public plan would undermine or would destroy private insurance I think is absolutely backwards. It will change the business of private insurance, but it will not put private insurance out of business, and I think there are two reasons to emphasize why that is the case.

First of all, remember that the core of this legislation and this approach is to build on employment-based coverage and is to encourage employers to continue to provide insurance, which is why I emphasize requiring that employers either provide health insurance or help fund coverage for their workers, which will prevent the kind of erosion of employment-based coverage that is often a source of concern.

Second of all, the public plan would be an option within the exchange alongside private plans, and that is why I think it is so crucial. Because, as I said, it would be a benchmark for the private plans, creating accountability where it often does not exist. In your own home State, I believe the largest insurer has 80 percent of the market, so having this benchmark and this competitive pressure is going to improve private insurers.

Second of all, it will be a crucial backstop for cost control, and it will be a backup for people who want to have an alternative to these dominant insurers.

Just as was said, with regard to public insurance, it needs to innovate and improve its practices and that that kind of innovation needs to take place in the private insurance market. Having that competition will encourage innovation.

Within the Medicare program, for example, plans like Kaiser, for example, do very well precisely because they have an innovative business model. Private plans have more flexibility to adapt provider networks. They have what might be called a “grand advantage” in many cases.

As we know, for many Americans, the idea of a public plan is still something that still does need to be mainstreamed. I think we should understand this, therefore, as not a threat to private insurance but as a threat of the old way of doing private insurance. It is healthy competition that will improve both the public plan and the private insurers.

Mr. LOEBSACK. Thank you.

Thank you, Mr. Chair.

Chairman MILLER. Thank you.

In calling on the members, the Chair has made a mistake. We are going to keep doing what we are doing on our side, which is working down the members who have not had a question. I should have come back, since this is the second panel, and recognized the Republican members for a second round. So we have finished with Mr. Loeb sack, and we will go to Mr. Kline. Then we will go back on our side and work through our members.

Mr. KLINE. Thank you, Mr. Chairman, for sorting that out. I must admit it got a little bit confusing. There are a lot of members, a lot of panels.

It is my first day. That is my excuse.

Chairman MILLER. Mine, too.

Mr. KLINE. Mr. Arensmeyer, I wanted to talk a little bit about small businesses. There are some unanswered questions in the draft legislation, but there are some things that are in there. So the first thing I want to sort of grapple here with for a minute is what you are defining as a “small business.” Is that 10 employees, 25, 50, 100? Do you have a working definition that you are working with?

Mr. ARENSMEYER. Well, we represent the interests of those of 100 employees or fewer, but it may be that the legislation ends up setting different standards at different amounts that are less than that.

Mr. KLINE. Okay. It does. I was just trying to put it in context what the bulk of your comments addressed concerning businesses up to 100 employees.

In the legislation, it seems to me it says that it provides a health insurance tax credit for small businesses equal to 50 percent of the cost of coverage for firms where the average employee compensation is less than \$20,000, which I suppose is an incentive to keep your wages low. Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers. So that certainly clearly would not address a large portion of the small businesses that you represent if they stop at 25.

Mr. ARENSMEYER. In the modeling that Professor Gruber did for us, we did generally look at tax credits that are a little bit more robust than that. That is absolutely true. There are a series of dials and levers as you look at sliding scales and tax credits and exemptions. You cannot look at these in the absolute. But we definitely have some models, and clearly those models that are more “gen-

erous" in the sense of tax credits for larger amounts, sliding scales that are not as high, greater exemptions, there is obviously going to be a greater benefit financially to small businesses. So you have to look at this all together.

Mr. KLINE. Well, this sliding scale apparently stops at 25, and we are not sure about the exemptions yet. That will be an interesting question.

I notice in the modeling, Jonathan Gruber's model, the scenario that was most advantageous for small employers was the scenario that exempted small businesses. I think that was a 1 to 10 employer. Was that what he was looking at there?

Mr. ARENSMEYER. Correct.

Mr. KLINE. So we still have not answered the question of 11 to 100.

Mr. ARENSMEYER. But there were substantial benefits. Even with that model, there were huge benefits for small business with the reform and with the shared responsibility.

Mr. KLINE. But it depends upon where that small business exemption comes in; is that not true?

Mr. ARENSMEYER. Well, pretty much every model of the Professor Gruber model produced a better result than the status quo. Because the status quo is such an absolute disaster for small business. Fewer than 50 percent of the smallest businesses are even offering it anymore.

So clearly we would love to work with the committee to figure out the right balance of tax credits, sliding scales, and exemptions, but virtually any system where some recognition is given to the special needs of small business that has reform in it and that deals with the cost containment is going to be far better for small businesses than the status quo.

Mr. KLINE. I certainly agree that small businesses need some help in a lot of areas.

Let me move to Mr. Speranza, if I could. I appreciate your comments about Rochester. Of course, in Minnesota, we have Rochester, Minnesota, which has been referred to a couple of times here. We are pretty proud of the Mayo Clinic and of the work that it has done there. There has been some real collaborative work in changing things.

Do you have any more comments about reforms that were left out of the bill that you would like to have seen, from your perspective, such as strong medical liability provisions or things that would help control costs?

Mr. SPERANZA. Yes. I think the few things that I think would make the most sense are, as I mentioned earlier, liability reform is very important. We know that medicine is practiced in a defensive way, which is very costly. That would be number one.

Health information technology. I know there is already \$19 billion allocated to that. Having nationwide standards, being able to actually implement that and to get the savings would be very important.

Wellness. With respect to the kinds of programs we have talked about, we would like to have more incentives to change behavior, not less. Those are very important.

The last point I would make, with respect to what was in the bill is the insurance option. This has everything to do with capitalism. It really does. There are other ways for us smart people, in a collaborative way, to solve that problem.

In a different forum, I would like to challenge Dr. Hacker to a debate on capitalism, and we will do that at a different time and at a different place or we can agree to collaborate and to find a way and come back to you. Because, quite frankly, I think he has got it backwards. I firmly believe in the American way and in capitalism, and that is a slippery slope you are talking about going down.

Mr. KLINE. Thank you. I yield back.

Chairman MILLER. Ms. Hirono.

Ms. HIRONO. Thank you, Mr. Chairman.

I have a very quick question for Mr. Stapley, and then I want to move on to some questions for some other members of the panel.

Mr. Stapley, since you are representing the ERISA industry committee, I am wondering whether you are familiar with Hawaii's exemption from ERISA.

Mr. STAPLEY. Yes, I am.

Ms. HIRONO. If so, do you think that—

Mr. STAPLEY. We have a large employer in Hawaii, as a matter of fact.

Ms. HIRONO. Do you think that Hawaii's exemption or waiver from ERISA should continue in any health care reform bill just to make sure that they can continue doing what they are doing?

Mr. STAPLEY. Well, you have put me, really, on the spot.

Ms. HIRONO. If you can answer the question—

Mr. STAPLEY. In Hawaii, we have a couple of large employers—the Polynesian Cultural Center, for example, and Brigham University Hawaii. They are our players in the State of Hawaii.

I would say this. I guess I would say no, very simply; and my concern is that in a restructured system, which I do think needs to be significantly restructured, you have to have national uniformity. To the extent that you do not have national uniformity, it does create interesting challenges.

Now, we comply with the Hawaii Prepaid Health Act, and we appear before the Hawaii Prepaid Health Council all of the time. I would say that we spend enormously more effort in one State than we spend in combinations of other States by virtue of the fact that we have to comply with unique requirements. At the same time, I know that it does provide some benefits to the citizens of the State of Hawaii.

The other thing that it does is—we actually have an employer in the State of Hawaii and their employees who have requested a plan that we offer in all 49 States except for Hawaii, and we do not offer it simply because we cannot comply with the Hawaii Prepaid Health Act. From their perspective, that is wrong. We would like that choice, but because of prepaid health we cannot provide it.

Ms. HIRONO. Thank you for that perspective. Obviously, I will have to think about it a little bit more.

For some of the other panelists, I think, from what I know about the private health care insurance system, there is really a lack of transparency. For example, I do not know of any State that re-

quires the health insurance carriers to file their rates and to justify their rates. We do that in workers' compensation; and for those States that have no-fault auto insurance, it is prior approval. So there is really a lack of transparency. I do think that the public option will bring more transparency into the whole system.

Some of you also mentioned that we should have nationwide standards. Mr. Shea and Dr. Hacker, it is astounding to me that such a high percentage—Dr. Romer mentioned that maybe 30 percent of the money that we spend on health care is really wasted. So I wanted to ask you gentleman in particular whether there are enough specific requirements or language in this bill that addresses the waste that is in the system currently.

Mr. SHEA. If I may, Congresswoman, thank you.

I think that the bill, as drafted, has a number of the elements of what we need to have a national effective strategy for addressing quality problems and for improving delivery system. I do not think it is as well integrated or as robust as it could be, and we had discussions even over the weekend with some of the staff about this. I think it needs some work.

One of the things that I think is really important is that currently we have a consensus development process for quality standards. It is not mandated by HHS. It is developed in a public-private organization called the National Quality Forum. This has full representation of all of the people who are going to be asked to move up to this—the physician organizations, the hospital organizations. So, if we are going to get the kind of change, the really big change we want, the people who deliver the care have to be brought into this, and they have to have their 2 cents. So that is sort of a process that we think needs a strong place in the bill. In the draft, it does not appear at this moment.

Ms. HIRONO. Do you agree, Dr. Hacker?

Mr. HACKER. I do agree. I also would say that you are absolutely right to emphasize the benefits of transparency in this broad process. It is the case that we know about this 30 percent precisely because Medicare has collected this information and has made it public so that researchers can use it. The Dartmouth Atlas studies that have been so influential are based on Medicare data. I think, just as a starting point, the commitment has to be toward much greater availability of the kind of information we need to make these judgments.

I would say that we often understand the public plan, quite rightly, as a central way of providing people with secure coverage, but it also really needs to be on the forefront of improving the delivery and the quality of care in conjunction with and in coordination with private insurance plans and with these kinds of public-private partnerships that Mr. Shea mentioned.

I would say, on that front, one thing that has not been mentioned is that President Obama has rightly said that the Medicare Payment Advisory Commission should play an improved role in trying to make sure that Medicare is paying for services more efficiently. I believe strongly that both Medicare and the new public plan should be doing a much better job of encouraging the right care and quality care, rather than just more care.

Ms. HIRONO. I do not have time, but with the Chair's indulgence I just want to say, as we move toward a national standard, I think it is really important that these standards acknowledge evidence-based differences based on race, for example, American Indians and native Hawaiians. Would you agree?

Mr. HACKER. [Nods head.]

Ms. HIRONO. Thank you.

Chairman MILLER. Dr. Price.

Dr. PRICE. Thank you, Mr. Chairman.

Mr. Chairman, the final comment in my opening statement was that there are positive solutions to the challenges that we face; and I am hopeful that the House will allow for an open, vibrant, robust debate and a deliberative process, one that respects America's doctors but, most of all, one that respects America's patients. We have heard less talk about the patients specifically in this discussion than I had hoped. I think there is a lot of common ground, however, the common ground being in health IT, the common ground being in the area of wellness, and the common ground being in the area of prevention.

I want to have folks address, if you would, one of the comments that I made in my opening statement, which is, if this grandiose plan comes to pass and if there are some Americans out there who believe that it is not addressing their health care needs and if, for example, they want to go visit a physician of their choosing and if they decide that they want that physician to treat him or her for a specific illness or malady or problem, should they have the right to do that outside of the current structure, Mr. Pollack?

Mr. POLLACK. I think they should have that right. They may be required to pay some additional amount of money outside of the network.

Dr. PRICE. So if they wanted to use their own resources, they ought to have that right?

Mr. POLLACK. I do believe that, yes.

Dr. PRICE. Are you aware that that is not included in the present bill? Would that give you pause?

Mr. POLLACK. Well, most health plans, even things like PPOs—I am in a PPO. We can go outside of the network. I am presuming that that will be retained.

Dr. PRICE. Thanks.

Mr. Shea, you would agree with that?

Mr. SHEA. Yes, sir, I would.

Dr. PRICE. Does anybody disagree that Americans ought to be able to opt out if they so desire?

Mr. Pollack and Mr. Shea, I am interested in following up on the issue of who decides what "quality" is and who decides what specific care patients receive. As a physician, I was always frustrated when somebody stepped between me and my patients and said, "you cannot do that," even though I felt it was in the best interest of the patient and the patient clearly trusted that decision.

On the comparative effect of this research council and on this new health choices panel that is in the bill, there does not appear to be any language that provides for specialty societies to be the final determinant of what is quality and what care ought to be provided patients. Is that something that you believe to be important?

Mr. POLLACK. As I read the bill, what happened is the Health Benefits Council would provide some recommendations concerning what would be in the standard benefit. That would then go to the Secretary. Now, that does not mean that somebody cannot get care that might not be included as part of a plan. That happens today.

Dr. PRICE. But that language itself is not in the current bill as it relates to the government option.

Mr. POLLACK. I am not sure I follow.

Dr. PRICE. That the final determinant of who decides what care to be provided is—

Mr. POLLACK. No, there is nothing in the bill that says that somebody is going to make a decision, a clinical decision, about what care you receive.

Dr. PRICE. Reclaiming my time, I would respectfully disagree; and I would hope that what we could agree upon is that that language itself needs to be in the bill, that clinical decisions ought not be provided by the Comparative Effective Research Council, by the health benefits—

Mr. POLLACK. I do not think anyone disagrees with that. You know, today, an insurance company decides what is in a plan.

Dr. PRICE. Exactly. Exactly. That is wrong.

Mr. POLLACK. That, some might say, might come between a clinical decision—

Dr. PRICE. Without a doubt.

Mr. POLLACK. I guess what I am saying is you will know what your coverage is, but nobody is going to tell you you cannot get this procedure or that procedure. There is nothing in the bill.

Dr. PRICE. I hope that that is all included in the bill, and I look forward to your support for that kind of language.

Mr. POLLACK. It is already there.

Dr. PRICE. Then please show me where it is, not this second but as we move forward. I look forward to talking with you about it.

Mr. HACKER, you talked about there being no real worry about crowd-out if there is a government option. You are familiar with Medicare Part B, the physicians' component of Medicare?

Mr. HACKER. Am I familiar with Medicare, Part B?

Dr. PRICE. Yes.

Mr. HACKER. Yes.

Dr. PRICE. It is a public option. It is a voluntary program. It is a voluntary program. What percentage of the market share does it hold?

Mr. HACKER. The market share of Medicare, Part B is about—I think, essentially, 99 percent of elderly Americans are enrolled in it.

Dr. PRICE. Do you not believe that that has resulted in the crowd-out of other private entities that would have provided health coverage for seniors if they had been given an opportunity to without the subsidies that are placed in Medicare?

Mr. HACKER. Well, Medicare, Part B is essentially a faux voluntary program in the sense that it is 75 percent financed by general revenues. At the time it was created, there were very few private options that were of any quality for elderly Americans. What we are talking about here with the public plan choices is an option available only to people within the exchange where there would be

no subsidies from general revenues. So I think that they are not analogous examples at all.

Dr. PRICE. I would agree with that at the very beginning of the bill. But over a period of 5 years everybody comes into the plan that is defined by the government through this bill as it is currently constructed, and that is the concern that many of us have.

Mr. HACKER. I understand that is a concern. I really do not believe that it is a valid concern, and I have tried to explain why.

I think that it is important to understand that, first of all, many people will want to be in a private plan.

Second of all, many private plans are offering an innovative alternative to what the public plan would be providing.

Third, most people would still get private coverage through their places of employment under this legislation.

Fourth, I have argued—and the bill embodies this argument—that this should be on a level playing field with no special treatment for the public plan vis-a-vis the private plans.

Dr. PRICE. I would suggest, Mr. Chairman, that that is not what is incorporated in the bill. I would hope that that is what the final product will be, but, at the current moment, that is not what is incorporated in the bill.

Chairman MILLER. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

I am not a physician. I am not an attorney. I am a former clothing worker who cut the lining for men's suits in a factory for 13 years. I am trying to look at this from a commonsense perspective.

Dr. Hacker, if I have it correct, you said that 72 percent of Americans support a public option.

Mr. HACKER. That was in the recent New York Times/CBS poll.

Mr. HARE. So almost three-fourths of the people in this country support a public option?

Mr. HACKER. Yes. In fact, 83 percent supported it in the Employee Benefit Research Institute poll just before this one.

Mr. HARE. Well, I do, too, so count me in as one of those 72 percent of the people; and I think it will grow larger when they find out about it.

What I find interesting about all of this—and I am not here to defend the trial attorneys, but I was just at my doctor's the other day. He has been an internist now for 20 years. He has never had a med-mal suit ever filed against him. His insurance rates have quadrupled in the last 3 years. He has never had a claim.

I spoke to another doctor who had one claim filed against her in 18 years. She said it was frivolous. Her insurance company that was supposed to be representing her told her to plead it out because it was easier and because it would take too much time to go to court.

So I think if we are going to beat up on one end of it, I think we ought to take a look at the other end of it. I mean, usually, under an automobile policy, if you are driving safely, don't you get a discount for safe driving?

My doctor got his rates quadrupled for never having anything filed against him, and one doctor was told by her insurance company to plead out. I said, doctor, why did you do it? I said, that would be like the equivalent of my going into a store, walking out,

and being accused of shoplifting when I did not do it; and my attorney is saying, I would just plead out because you do not want to have to take time off from work. The fact of the matter is your reputation is at stake here.

So I think we need to take a look at that aspect of it, too.

The other thing and the reason I support this public option—and I want to ask Mr. Shea about this and Mr. Pollack. We have heard today about the wonders of medical savings accounts. I do not know how in heaven's name people can save money when they are barely holding on to their homes, when their hours are cut, and then we hear about what a great thing it is.

Quite frankly, isn't it true that the vast majority of people in health savings accounts are wealthy people and that they are not middle-income people or lower-income people really? Are they or am I missing this?

Mr. POLLACK. I would say that the assumption that a medical savings account is going to save this country money on health care is a mistake. The overwhelming majority of costs in our health care system are for major interventions. It is not at the front end with deductibility.

So if you create higher deductibles it is not going to save significant money for America's health care system. What it might do is prevent people from getting preventative care, from getting tests, from getting initial examinations. I think that is a mistake.

I also think it is a mistake to provide tax incentives that are clearly regressive. Because the higher the tax bracket you are in the higher the tax benefit you get from a medical savings account. It turns out that those people who tend to opt into a medical savings account are somewhat wealthier and are somewhat healthier. Those who are wealthier are not so worried about a high deductible. It is not going to faze them at all. For those people who are less wealthy, it is going to faze them. That wealthier person who is in a higher tax bracket is going to get a higher tax benefit.

So I think it is a mistake to go in that direction. It is not going to save money. It is regressive, and I think it is a disincentive for getting the preventative care we should be encouraging.

Mr. HARE. Mr. Shea, I wanted to ask you about the portability thing here because my time is running out.

I met a couple whose son worked in a factory in Galesburg, Illinois. The factory closed. He had 9 years in. When they shut down, he lost his insurance. He went to work part time doing some jobs until he could find a job. He died at 31 years of age because he had a heart attack and he had no insurance.

I asked one of his parents, are you mad at God for taking your son? He said, God did not take my son. He made a special place. This government did because they did not have an insurance plan that would cover him when he lost his job and went to another.

Under this bill, that man could have gone into the public system. If we do not have a public plan, how in heaven's name are people who lose their jobs going to afford a health care plan? I mean, are these benevolent insurance companies just going to hand it to them and charge them basically nothing?

Mr. SHEA. Congressman, we just released a survey this morning. We did an online survey, which we have done for a couple of years.

Twenty-three thousand people responded to the survey. It is not scientific, but 23,000 people is a pretty good number. Six thousand people wrote us their individual stories. One of the phrases that kept on coming up is, you know, "I lost my insurance" or "I ran into the cap on my insurance and I never knew about it." People say, "well, you know, I am now on the faith-based plan. I pray I do not get sick."

There is no way without—just going back to Ron's point, I think what we need to focus on is basic health security. Let's get the trains running right, which they are not now, and then if we want to talk about bells and whistles and special things, that is a different story, but we do not have the basics right.

Chairman MILLER. Mr. Castle.

Mr. CASTLE. Well, thank you, Mr. Chairman.

Mr. Chairman, I have been listening to this panel, which I think has been excellent, and obviously, I have been reading and studying all this as well as all the rest of us have. I have got to tell you that my concerns are almost increasing rather than diminishing at this point.

When you look at the costs in the health care system and when you look at the cost of prescription drugs—and you can argue whatever the reasons for that may be or you want to do something like take the prescription Part D plan and close the donut hole, for example, or medical inventions, both hard inventions and procedures which are going on now, which are becoming more and more extensive and complicated out there. There are the costs of education for medical personnel. Somebody mentioned that there are three times as many law schools as medical schools. That is going to go up probably to about six to one. Law schools make money for universities, in case nobody has realized that. Medical schools are generally losers for universities. It is just a high-cost item.

There are medical malpractice costs, which we are not doing a lot about in this particular legislation. There are the insurance rates, the salaries of medical personnel, be it those running hospitals or whatever it may be. There is the whole idea of adding portability and preexisting conditions to existing health care plans in this country.

I look at Medicaid and Medicare and how they are driving the budgetary situations in this country into a corner in terms of where we are going. I even worry about the cost of things like health information technology, which I think ultimately is something we need to do and that might even be helpful in terms of saving money, but the initial cost of it is so great. I even worry about the cost of the public option. Even though it is theoretically paid for, my hunch is there would be a lot of backroom costs to that that we have not seen completely yet.

I happen to believe in a lot of concepts I am hearing about today. I would love to see everybody insured in some way or another, at least provided with health care in some way or another, but I am worried that we are biting off a lot here. I have seen the estimates for the Senate plans. I am not sure what the estimate costs for these plans are going to be. Can we afford it or are we just going to make the political decision that we are going to afford it and that we are going to pay for it?

I would just hope, as a committee and as we listen to expert witnesses and as we put this together, that we are being thoughtful and careful about what we are doing. Maybe we have to do something less. I do not mean lesser. I mean just perhaps less than the grand approach in this particular situation so there will be a manageable circumstance. We have to continually look at every single cost-saving component we can in terms of how we are dealing with any of these issues.

So I have no questions of the panel. I will be happy to yield back my time, but as just one member sitting on this committee I do express concerns about where this is going to all end up, and I think we need to always know the details of the costs and how we are paying for it.

Chairman MILLER. Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

I just generally want to ask a little bit here. It seems to me that everybody has sort of walked away from the single-payer thing without much of a fight, which is sort of surprising to me, for a number of people on the panel here. So we are looking at how we are going to try to keep costs down.

When I talk to people, they are usually more in line when they find out the size of the salaries that private insurance companies are getting, when they find out the amount of money that is being spent on overhead and on marketing, when they see the size of the profit that is out there. We are going to have to do some kind of regulation in order to try and make people who are paying health insurance premiums already think they are getting something for their buck if they are going to be paying more money in some way to help other people get insured. So it would seem to me that the idea of the medical loss ratio is something that we ought to at least consider and try to make that a reasonable number.

Mr. HACKER, what do you think about that?

Mr. HACKER. I think that one reason to have the public plan is precisely to address those concerns.

I think that it is also worth noting that, while there is no intention in this public plan to have a Medicare for all systems, that some of the virtues of having that system are achieved by having a competitor in the market, in this exchange, that embodies those values of putting patients before profits by making sure that people have broad coverage, by making sure that the focus is on improving care and on innovating over time.

Mr. TIERNEY. That sense of competition may eventually bring some sense back to the premiums usage of the private companies.

Why don't we just initially require, if they want to get into the exchange—or whatever you are going to call it—that they have to meet some sort of a particular level as a consumer right here and that they have to spend at least a certain number of premium dollars on direct medical care?

Mr. HACKER. I believe there actually is a medical loss ratio standard in the legislation.

Mr. TIERNEY. Well, I know. I know who put it there. The point is, do you agree that it ought to be there? What is the purpose for it? I think it is at a rather low number at 85 percent. It ought to be more.

Mr. HACKER. Actually, it may sound very low, but, unfortunately, as you well know, many insurance companies today spend well less than 85 percent of their income on care. Even within Medicare Advantage plans, there are many cases where only 82 or 83 percent of their spending is on the actual delivery of care to patients.

Mr. TIERNEY. Of course, in Mr. Pollack's USA families today, there was a study done where it shows people are doing far less than that. Some do as low as 60 percent; am I right?

Mr. POLLACK. Some of them go as low as 60 percent.

Mr. TIERNEY. I guess the only point I am trying to make—and I do not mean to be too sarcastic about it—is it is ridiculous that we are worried. I hear people say, well, we are worried about a public option plan. It might put these private companies out of business or they will not make enough profit.

What should be our primary concern is making sure we get the best deal for the consumer. They get health care, and they get the premium dollar spent on health care. I do not care whether you are from the United States Chamber of Commerce or from the labor unions or if you are anybody else. All of your members want to get a decent deal on this; and all of them, when I talked to them, were outraged at the high salaries the executives make, at the amount of money that is spent on marketing, at the amount of money that goes into not just profit but into outrageous profit. And I do not understand the sensitivities of all of us around here about being so concerned about their existence and about their ability to keep on doing that to the consumer.

So I think that is the point to be made. If we are going to waltz away from single payer, which sort of disturbs me considerably, at least we ought to fight to make sure they are going to participate in the exchange, which is going to be a benefit to them. They ought to at least have to give something back to the consumer and not be allowed to continue to do that.

Mr. Shea, if you want to respond to that, it is fine with me.

Mr. SHEA. I was just sitting back and saying, well said. I think that is right.

The other thing I would say, though, Congressman, is that we have to realize that these costs are not just at the highest level. They are not just in the advertising or in the marketing or in the obscene executive salaries, as I would consider them, as I have read the numbers. They have to do with the basic relationship between insurance companies and the people who are providing the care.

There was a great example given by the Boston Globe recently of the relationship. Usually these things are not revealed. It revealed the BlueCross relationship with Partners Health Care, the biggest system in Boston.

We need public service organizations. They may be private companies, but they claim to do a public service. We need them to be watchdogs, not lapdogs, in terms of this issue. So I think you are exactly right.

Mr. TIERNEY. I will not ask it again, but Mr. Pollack was on the last panel. I asked him—and I do not think anybody was satisfactory in answering it. I have yet to hear a description of what value-added insurance companies really bring to direct patient care. Just

what is it they bring to the table? Mr. Hacker, do you want to tell me what it is that insurance companies do to move a patient's care forward?

Mr. HACKER. I think the best insurance companies have been able to innovate and to provide high-quality care and good customer service to their patients. I believe that insurance companies in the current environment have incentives to engage in the kinds of practices that Mr. Shea just spoke about, which is passing costs on to consumers and employers rather than bargaining for better prices with providers or trying to weed out unhealthy people rather than providing care to those who need it.

If we change the incentives and say, as a condition of entering the exchange, you have to abide by these strict rules and you are going to have to compete with a public-service-oriented plan, a public health plan on fair and equal terms, I think that public—the insurance plans, I hope that they can rise to this moment and can provide the kind of innovation, customer service, and delivery system benefits that we have seen among the best plans.

Chairman MILLER. It certainly would be a statement of hope over experience.

Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman. Just a couple of things.

Mr. Pollack, you are wrong about who would have that plan. In our own practice, out of the 294 people who have a health savings account, I would dare say that the people who work in doctors' offices consider themselves wealthy, and those are the folks that have those plans.

Just a comment. Having practiced medicine for 31 years, let me explain to you how, until you get malpractice straightened out, you are going to have a difficult time controlling costs.

You came to me in the emergency room 30 years ago. You had right-sided pain, right low-quadrant pain. I would examine you and say, you know, let's get a blood count that costs \$25, a temperature, and a physical exam. That is what we did. Come back if you are not feeling better.

Today when you come in, you are going to get a CT scan, because that is now the standard of care to diagnose appendicitis. What happens is that is a \$1,000 test, as opposed to a \$50 emergency room visit; and if you do not do that, just get the pencil out and write commas and zeros, because that is what you are going to pay.

Access to this technology and then to the legal climate has created this. Unless you get meaningful malpractice reform, doctors are going to behave in their own self-interest, which is not to get sued. If they are sued, what they are going to do is they are going to have all of the documentation they can possibly get their hands on to prove they did not do malpractice.

So I am just pointing that out as a given.

One of the things that I think Ms. Visco said that was very, very important and one of the reasons that I am concerned about this government plan is that you are absolutely right. Patients and doctors should be making decisions, not health insurance companies and not public plans. Let me give you an example.

When I began my practice, about 50 percent of women died of breast cancer when I started practice. That was why the big argu-

ment came: Do you do a radical surgery or a simple surgery? It did not matter. The results were the same.

What has occurred now over time is that we have almost above a 95 percent 5-year survival rate; and that is a wonderful thing, when a patient comes in, to be able to tell her you are going to live through this awful disease. Our practice averaged seeing one new breast cancer patient a week. That is how often we saw that disease.

In England, they have quit doing screening mammography, and the reason they quit doing it was that, with the wire-guided biopsy, the false positive rate of the test tells you you have something when you do not. The wire-guided biopsy, using a radiologist, costs more than the screening mammography. So nice their comparative effectiveness made a decision not to continue to do routine mammographies. I would argue, as you just did so eloquently, that screening mammography with the new digital mammograms, with patient education, and with new medicines raise this level of survival.

In the single-payer system, what happens and the way they all work at the bottom of the day, at the end of the day, is they ration care. That is how they work. You have so many dollars spent on health care, and then after you have spent those dollars, waits occur.

In Canada, a great place, it takes 117 days to get a bypass operation. This is not Phil Roe talking. This is the president of the Canadian Medical Association. In the past, he has stated you can get your dog's hip replaced in a week, but it takes you 2 to 3 years to get your own hip replaced in that system.

So that is my concern, is that a government bureaucrat will be making that decision based on a budgetary number, not on the patient and the doctor.

Let me tell you what. I am not here to defend private health insurance companies. I can promise you, when I was a young doctor, I thought they would provide health care, and I think Mr. Pollack pointed out that they are there to make money.

Comment.

Ms. VISCO. Well, what I would like to say is that what we want, what patients want, is care based on evidence. That is what we want.

I did not mean to say the decision should be made solely by patients and doctors. I did not mean to say that decisions should be made by insurance companies.

What we want is a system that supports decisions based on a high level of evidence or on interventions that are helping us get evidence, and that is the way it should work. It does not work that way now, and a significant percentage of care is not based on a high level of evidence. Those are decisions that, unfortunately, are often made by physicians. But if we had a system that supported evidence-based interventions and supported care—

Dr. ROE. Excuse me. You would not support a system that would not do screening mammography, would you?

Ms. VISCO. I would support a system that only used screening mammography in appropriate age groups and in appropriate situations.

Dr. ROE. Oh, absolutely. I agree. But not at all. This is not at all at any age.

Ms. VISCO. I am unaware of that, and I will go back to my office and look up that the U.K. has stopped screening mammography. I was unaware that that happened.

Dr. ROE. One other question, Mr. Stapley. Medical loss ratio, would you comment on that?

Mr. STAPLEY. You know, I think that there are a lot of plans that have been abusive, that have very, very terrible loss ratios, but there are a lot of private plans that have very good loss ratios, in the neighborhood of 94, 95, 96 percent, and so we have a tendency to focus on the extreme. I would simply say that there are private plans out there that have a community focus, that are interested in the people they serve, and that want to make sure they get cost-effective, high-quality health care and that they do it at a very low cost.

I would also point out—I mean, I am not opposed to Medicare. I think Medicare, in terms of consistent, fair administration, I think they are probably one of the best plans in the marketplace. They are a very good plan. But I do not think that Medicare is a sterling example of what we want our financing system to look like. Because Medicare has issues, too, with respect to the fact that they incentivize a lot of unnecessary care. In fact, a lot of the things that you saw in McAllen, Texas, that have been referred to in contrast with El Paso are based on a reimbursement system that has been perpetuated by Medicare.

I do not say that the private system is any better. It is not. They have followed suit. They have done the same thing. They are incentivizing more care, not high-quality care, not cost-effective care. But there are examples of private plans that do a pretty good job.

Chairman MILLER. Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman.

I would like to focus the panel for a moment on the self-employed, which Mr. Arensmeyer talked about a little bit in his testimony. He told the story about Louise Hardaway, who could not find insurance or was quoted \$13,000 a month.

You know, I just want to ask you just to confirm what I think is true and, actually, know is true. Her situation is not created by government, by government option programs or by mandates. I mean, in fact, the self-employed right now are completely exposed to the marketplace with absolutely no protection under prior HIPAA laws and, in most States, with virtually no regulatory protection. I mean, that group needs help, isn't that correct, Mr. Arensmeyer?

Mr. ARENSMEYER. Absolutely. It is a growing part of our economy, 21 million now and growing. It is a critical part of our 21st century, high-tech economy. You are absolutely right. I mean, the system could not work any worse than it is working for them. It is directly impeding our economic growth.

Mr. COURTNEY. I am trying, Mr. Speranza, to sort of decipher where the Chamber is on this issue. I mean you sort, of at the end of your statement talked about the Chamber thinks it is time to reform insurance markets, but you sort of danced around the ques-

tion about making the folks in that end of the market participate or not. I guess the question I want to ask you is, does the Chamber support or does it not support an individual mandate?

Mr. SPERANZA. I would say that we would certainly consider that. Again, I am not an accountant.

Mr. COURTNEY. Wait a minute. You are here, representing the Chamber, as someone speaking on health insurance.

Mr. SPERANZA. Yes.

Mr. COURTNEY. I come from Connecticut, and we are surrounded by insurance companies. When you talk about reforming the market, their response always is, fine, but you have to have an individual mandate. Because, otherwise, you are basically creating a system of adverse selection, and rates are just going to go through the roof, and the Chamber is smart enough and experienced enough to understand that dilemma.

Really, I think this committee and the people of this country and, frankly, your members, of which I was one of them up till about 2 years ago, deserve an answer in terms of where the Chamber stands on this issue.

Mr. SPERANZA. I cannot make policy for the Chamber.

Mr. COURTNEY. Well, I would ask that the Chamber come back to—

Mr. SPERANZA. From my discussion with the health care experts, it is something that, as I understand, they would seriously consider. Personally, I would as well.

Mr. COURTNEY. Frankly, I think the issue has been out there for years, and the Chamber has enough staff and experience in this issue and, frankly, it has enough members who are directly impacted by it that they deserve an answer, and we need to understand that as we go forward over the next 6 weeks or so.

Mr. SPERANZA. What I would promise is getting an answer back from staff on that point.

Mr. COURTNEY. Mr. Hacker, in your testimony, I noticed you were very clear about supporting an employer mandate. It was sort of an absence of comment in terms of the individual mandate. I was just wondering if you wanted to chime in.

Mr. HACKER. No. In my original proposal, Health Care for America, there is, indeed, an individual mandate. All I would say is that I think it is essential that you have both an employer and an individual requirement and that there be a real emphasis on the affordability of coverage if you do have an individual requirement.

My main concern is always how do you ensure that people get enrolled. An individual requirement without strong measures to ensure enrollment will not work, and I think this is particularly true with populations like the self-employed, who I think would benefit the most of any employment group in many ways from having the choice of plans within an exchange.

So what I would say—and this is not in the legislation—is, if there is a tax penalty associated with failure to provide insurance, that at the same time that that penalty is assessed or before it is assessed that people should be given the menu of options within the exchange and should be given the option to enroll for coverage within the exchange. I think that is exactly the kind of constructive step that is being proposed in a lot of other areas. Try to give peo-

ple these choices and to make sure that, when possible, people are opting out rather than opting in, automatic enrollment. I think if we did that we would move towards a system of seamless coverage that would get us very close to covering all Americans and achieving Congressman Kucinich's goal of health care as a human right.

Mr. COURTNEY. Mr. Arensmeyer, again, your members go through the experience of applying for insurance as a self-employed. Again, they are the risk takers, the capitalists, who want to go out and pursue their dreams, but if they have old sports' injuries or cesareans or chronic illnesses, they get shut out either with outrageous premiums or with the denial of coverage completely.

For them, I mean, we have got to fix this. If we really care about the market and a capitalist system, these are the people for whom we have got to create a path to health insurance coverage; isn't that correct, Mr. Arensmeyer?

Mr. ARENSMEYER. Exactly. There is tax inequality, too, the 15.3 percent self-employment tax that a self-employed person cannot deduct the way a business owner can deduct.

I mean, if you think about this country prides itself on entrepreneurship. The health care system does nothing but put impediments in the way of going out on your own, striking out, taking risks.

Also, if you look at traditionally pulling out of recessions in the past, it is the small business sector that leads the way out of the recession. Usually, at some point in time, the small business sector is creating 100 percent of the net new jobs when moving out of recession.

So it is completely crazy. We have heard a lot of talk today about the private sector and competition, but we do not have a system that has got the kind of competition we need. We do not have a system that encourages competition among businesses. It is precisely this type of approach that the committee has put forward that is going to enhance the ability for everyone in the system to compete and ultimately to allow the businesses out there to compete, those that are building products and that are providing services.

Mr. COURTNEY. Thank you, Mr. Chairman.

Chairman MILLER. Mr. Thompson.

Mr. THOMPSON. Mr. Stapley, you noted in your testimony that private employers already subsidize costs of Medicare. Can you provide an example of that?

Mr. STAPLEY. I provided two examples earlier. There is a situation, for example, on the electronic transmittal of claims where Medicare does not pay for that, so the private participants in the system have to subsidize that.

On the other hand, I just gave the example of just a classic negotiation when you are working out rates so that you are going to pay providers. Where they say Medicare is giving me a 2 percent increase and my charge max is going up by 4 percent, that means yours is going up by 6 percent.

Now, you know, from my perspective, the issue really is if the public plan truly does compete on a level playing field. In other words, I am not having to pay them money to compete against me, so they can compete on a level playing field. I mean, if you can re-

solve that issue, then I think that you will find that large employers will probably feel a little better about it. I do not know if they would feel totally good about it, but if you can guarantee that the public plan, in terms of a reimbursement perspective, is playing on a level playing field, that makes it easier to deal with. Yet we do not want to subsidize them and then turn around and they have lower rates so they create an incentive, actually, for our employees to leave the system and go to the public plan.

Mr. THOMPSON. Some of the recurring themes we have heard this afternoon were innovation, competition, decreasing costs. They are all important things when it comes to improving our health care system.

Other than rolling out, taking out of the equation a taxpayer-funded government competitor, are there other methods—and this is for the whole panel—that you would recommend or that would do that among private health insurance providers where they would encourage competition, decrease costs, and motivate innovation?

I will open that up to the entire panel.

Mr. STAPLEY. I would be happy to speak to that to a degree.

I think the establishment of an insurance exchange is a huge step forward in a positive direction if you do this so that you level the playing field for the system. I think it is very true that the current small group and individual market is totally dysfunctional. It is an embarrassment to this country. This has to be reformed.

In the process of putting together the ground rules in terms of how the insurance exchange works, you have to make sure that every individual American, whether they come from an employer plan, a small employer plan, or they are individuals, they access the exchange and the plans in the exchange on the same basis. That means that the private plans have a set of rules they have to play by. There is community rating. There is, perhaps, risk adjustment. You might do modified community rating.

All of those things are essential insurance reforms that must absolutely, unequivocally, uniformly, equitably apply to every plan that is offered through the exchange. In and of itself, that is a huge step forward in creating a better basis for competition than we have in the present system.

Beyond that, I would say, in my opinion, the centerpiece for reform still has to be cost management. We talked about competition. You have to have payment reform, and you have to create an incentive for the payers and for the health care systems that are engaged with the system to do something differently than incentivize the provider system to do more even if it has no value. So you have got to look at episodic reimbursement—at different kinds of reimbursement systems that reward providers that provide high-quality, low-cost care that is focused on medical guidelines and so forth and that disincentivizes the provision of care that has no value.

So I think there are challenges in terms of the number of plans that are available in some marketplaces. You would hope that the availability of exchange and the establishment of a uniform, level playing field would make it so that you have more entrants in the system. I think we all hope that that would be the case and that that, in and of itself, would promote competition.

Mr. ARENSMEYER. Congressman, I think we need to look at the exchange of the ultimate free marketplace. It needs to be as robust as possible. There need to be rules of the road.

Beyond that, insurance companies, whoever is providing insurance, whether it is a public plan or a private plan, is going to be judged. Their success is going to be based on their level of service, the quality of what they are providing, and it is something that is going to be transparent. It is going to be there for everyone to see—for individuals, for small employers, for whatever size can participate in the exchange. It has got to be as robust as possible in order to really get the level of competition that is needed.

Mr. STAPLEY. Can I make one more statement?

One of the unique provisions of the proposal that was set forth by ERIC a couple of years ago is the section that deals with health plan transparency. I guess I would honestly have to say that the regulatory structure in the United States has not done a very good job of regulating insurance companies. You have to have transparency to the extent that a lot of things that are not public now with respect to how insurance companies do business become public.

Denial rates, for example, have a huge impact on what your ultimate benefit is. You might have a plan that says, I pay 90 percent of your benefit after a deductible. But, at the end of the day, their administrative practices in terms of how they adjudicate claims can actually result in a lesser benefit.

We have experienced that. We offer benefits in all 50 States. We have seen insurance plans that we offer in some States that, because of their aggressive administrative practices, end up delivering lower benefits.

So health plan transparency, which is the cornerstone of the initiative put forth by ERIC, is critical to the proper functioning of the exchange as part of leveling the playing field, as part of making sure that the public knows exactly what they are buying when they purchase it.

Chairman MILLER. Ms. Fudge.

Ms. FUDGE. No questions, Mr. Chairman.

Chairman MILLER. Mr. Kildee.

Mr. KILDEE. I have no more questions.

Chairman MILLER. Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

We have heard a lot about the difference in the reimbursement rate of the Medicaid/Medicare programs as opposed to the private plans. I was not aware that there was that much difference. Do any of the insurance plans pay less than Medicare or Medicaid? Does anybody know?

Dr. Hacker.

Mr. HACKER. I should just say Medicaid rates are substantially lower than private insurance rates so that it is highly unlikely. There are probably some plans that do not pay on the same basis as Medicare, that is, on a more or less fee-for-service basis, that are paying something equivalent or close to equivalent to what Medicare pays. The evidence is that most private insurance plans that pay on a fee-for-service basis pay something higher than what Medicare rates are.

Mr. SCOTT. Well, should we require all insurance companies in the exchange, including the public option, to pay the same reimbursement rate, including HMOs?

Mr. HACKER. Well, I do not think that we should require HMOs to pay the same reimbursement rate precisely for the reason I just mentioned, which is that they pay in a different way. If you are paying your doctors on a per-person basis or on a salary or if you are using bundled payments, then it is not comparable to the way in which Medicare pays.

As we have argued and as Mr. Shea and I have argued, we think strongly that Medicare should move towards innovative ways of paying for care. There are proposals that have been discussed in the past for having private plans that pay on a more or less fee-for-service basis that are competing with a public plan or separately from a public plan. They pay at the rates that a public plan would. In many countries, they have something like this. It is called "all-payer rate setting." It is not actually being discussed today. The Medicare Advantage fee-for-service plans are allowed to pay Medicare rates, the private fee-for-service plans.

I think one thing that should be said—and this is very important—is that Medicare has passed innovations in the way it pays for care, such as the DRG system for hospitals. They have frequently set the standard for the way in which private plans pay for care.

So this is one of the reasons why I think we need a public plan that is focused on the non-elderly, who have very different needs than the elderly, which is coming up with new and innovative payment methods that I believe strongly, through transparency, not only will be made available but also will disseminate into the private sector.

Mr. SCOTT. Well, one of the ways you can make money is to underwrite and make sure you only get healthy people in the plan, and this is technically prohibited in the plan.

How do you avoid informal underwriting where you market the benefits, if you have very poor benefits for diabetes, HIV/AIDS, things like that, so that those with those problems will not choose your product? How do you avoid informal underwriting?

Mr. STAPLEY. I think there are a lot of things that have to be part of the exchange to prevent that sort of thing from happening. My opinion is there are lots of ways to avoid risks. In fact, the name of the game in the current private system is risk avoidance. The reason that that is the case is that the incentives in our system create that. You can make a lot more money if you are a for-profit plan, for example, by avoiding risk than you can by being an efficient administrator. So what you have to do is you have to structure the design of the exchange in such a way that you take away those incentives.

Now, you have the classic things like underwriting. You have this small group and individual market and so forth, but, beyond that, you can have benefit design that is intended to make it so that sicker people would not take the plan. So you would have to have some, in my opinion, standardization of benefits to make it so that it is harder to do that.

You can have, for example, geographic risk selection. We have employers in Illinois. It is really fascinating to me the kind of coverage that we can get in Chicago that we cannot get in Nauvoo, which is in the central part of Illinois. That is simply because those plans have made the decision: I cannot make as much money in Central Illinois as I can make in Chicago. Therefore, I am not going to offer my coverage there.

So the plans ought to be required to cover the entire service area and so forth. That has to be kind of a regulatory scheme to eliminate the externalities that make it so that plans compete on an unfair basis.

Mr. SCOTT. I am trying to get another question in before my time runs out.

Mr. Shea, there is a pay-or-play in Massachusetts where your employees don't get any insurance. Is it important that if you choose the "pay" option that the employees actually get coverage.

Mr. SHEA. Absolutely. And it is also important that there is a meaningful payment option, not like Massachusetts, that they are \$300 a year per employee, or whatever it is, and you are proposing something that is substantial. I think that is a way to design it.

Chairman MILLER. Dr. Cassidy.

Dr. CASSIDY. Ms. Visco, my wife is a breast cancer surgeon, and when you speak I just think, oh, my gosh, isn't that just music to my ears and my wife's ears? We share your concern.

Dr. Hacker, a couple of things. Your proposal—and, by the way, congratulations. I think this is your brainchild, and obviously it has really become something. The public option is really innovative in that it nationalizes an insurance company or creates a government-run health insurance company. But as you are speaking about the payment methods, Medicaid and Medicare have lagged far behind ERISA companies, for example, in coming up with innovative payment schemes. Way behind.

So as I look at this—and I try to think the patient is central in this proposal which we have—I don't really ever see that the patient is really central to cost savings or the patient is central to improving outcomes. What I do see is that there is a great emphasis on using bargaining power to decrease costs, even though in your paper you mention that probably for physicians that bargaining power has been used to excess and you can demonstrably show in some cases that physicians—that access has decreased because of it. Indeed, the CBO scoring of this, or maybe the Senate document, the CBO scoring said there would be limited access to some specialists because of rates paid by the public option.

So I don't see that much innovative. So let me bounce it back to you. If we are really going to come up with a patient-centered plan, I think the only way that history has shown us that we can save money is by doing so. The only way we can improve outcomes is by doing so. Why not HSAs? HSAs, according to Kaiser—I keep on saying this but it is just—I feel like a tree farm in the forest—for a similar demographic, a similar set of benefits, HSAs cost 30 percent less than do a fee-for-service plan. The patient is now in control.

Yesterday, I was speaking to someone. They have an HSA. They said that their doctor prescribed them a \$150 proton pump inhib-

itor. They went to him and said, listen, we are paying for this out of our HSA, and they asked for a substitute, and they got a \$20 generic substitute. That is because the patient initiated it. By the way, her health care was not compromised.

I don't see much innovative beyond using monopsony power to drive down costs and presumably shifting whatever degree you shift. We can argue over that.

Two, how do we effectively make the patients central, as opposed to the payment mechanisms or the government bureaucracy which must administer this program?

Mr. HACKER. Thanks for the compliment. At this particular moment, I don't want to be considered the author of this proposal.

Dr. CASSIDY. I wouldn't, either, but that is okay.

Mr. HACKER. So I want to address each of your questions in turn.

With regard to the question of whether or not this is an innovative approach, I think it is very important to emphasize, as I have, and this is emphasized in the legislation, that the idea would not be to replicate the Medicare program but to create a new program that had a broader set of benefits, a different risk—

Dr. CASSIDY. You are very explicit that you are using the same way to control costs as Medicare, which is through monopsony power and using your bargaining power to lower rates.

Mr. HACKER. I believe I said that it should be one tool that the plan should have.

Dr. CASSIDY. The other tools that you suggest have not been proven to work. For example, accountable care organizations are theoretical, but even the proponents will admit that it is basically a pilot project.

Now, health IT—and in your paper—and thank you for your intellectual honesty—you point out the preventions, benefits, and controlling costs are limited.

Mr. HACKER. That is interesting. I don't remember saying prevention was limited. I do say that there has been great skepticism on the part of the Congressional Budget Office with regard to the cost-control effects of some of these measures, and it should be noted that, whether or not prevention reduces cost, it is a good thing to do.

But I was going to just say quickly that one tool that the plan should have is to use its bargaining power, but it should be allowed to innovate. I was very pleased to see in this legislation that after a period of time that the plan would actually be developing new payment modalities. And I said—and care coordination strategies.

I said repeatedly that I believe that is what needs to happen and that it will be easier to do with a public plan that is focused on the non-elderly than it is in the current Medicare program.

I also think it is important to think about how to separate this plan from some of the political forces that have made it hard for Medicare to do the more value-oriented purchasing that we would like it to do.

I agree completely that patients should be central. It is worth noting, for all of its flaws within the Medicare programs, there are very high levels of patient satisfaction.

Dr. CASSIDY. Yes, but that is because they are relatively screened from the costs, and that is one of the reasons it is going bankrupt

in 2017. And in your proposal there is no requirement for market capitalization or for business capitalization. Rather, it is the full faith and credit of the Federal Government.

Mr. HACKER. I believe there are many reasons why patients are satisfied with Medicare, but my read of the surveys are that they are favorable for it because of the ease that they have in finding physicians and having access to specialists and the sense that they don't have to wait for doctors. And those are things that I think that the public plan can provide.

Chairman MILLER. Thank you very much for the patience with the committee and for all of your testimony that you have given us today.

I hope that we can continue to engage you as we move forward in this process. There are a number of very good and relevant suggestions that have been made by this panel, and we hope that you would agree to let us continue to pick your brains on this one. Thank you very much.

I will introduce the next panel.

Ms. Karen Pollitz is the Research Professor and Project Director at the Georgetown University where she directs research on health insurance reform. From 1993 to 1997, she served as Deputy Assistant Secretary of Health Legislation at the U.S. Department of Health and Human Services. Ms. Pollitz has a BA from Overland College and an MPP from the University of California, Berkeley.

Ms. Celia Wcislo is an executive board member of the Service Employees International Union as well as Assistant Division Director of 1199 SCIU United Health Care Workers East, a union of more than 300,000 health care workers. She also serves as a board member of the Commonwealth Connector Authority. And Ms. Wcislo holds a BS from the University of Massachusetts, Boston, as a graduate of the Harvard Trade Union Program.

Mr. James Klein is the President of the American Benefits Council, the trade association representing Fortune 500 companies that sponsor and administer health and retirement benefits. Mr. Klein is a graduate of Tufts University and a graduate of the National Law Center at George Washington University.

Mr. William Vaughan is Senior Health Policy Analyst for Consumers Union. Starting in 1965, he worked for various Members of the House of Representatives, the Ways and Means Committee, and retired in 2001 as the Health Subcommittee Minority Staff Director. Mr. Vaughan has graduated with a BA from American University.

Dr. Robert Moffit is the Director of Health Policy Studies at the Heritage Foundation, specializing in health policy issues. He is a former senior official at the U.S. Department of Health and Human Research Services and was involved in Massachusetts health insurance reform initiatives in 2005. Mr. Moffit holds his BA from La-Salle University and his Ph.D from the University of Arizona.

Ms. ReShonda Young is the operations manager of Alpha Express, a small business in Waterloo, Iowa, where she serves as the company's operations manager. Ms. Young is also a leader in the Iowa Main Street Alliance, a coalition of small businesses across Iowa. Ms. Young has a BA from Wartburg College.

Dr. Fitzhugh Mullan is a Murdock Head Professor of Medicine and Health Policy at George Washington University. He earned his rank of Assistant Surgeon General when he directed the Bureau of Health Professions. Dr. Mullan holds a BA from Harvard and an MD from the University of Chicago.

Welcome to all of you. Thank you for your patience today.

You have watched the drill here. You will be given 5 minutes to summarize your written statement. Also, if you think there is something you want to comment on during your presentation that you have heard from the previous panel, do so if you think it would be helpful.

Chairman MILLER. Professor Pollitz, welcome.

STATEMENT OF KAREN POLLITZ, RESEARCH PROFESSOR AND PROJECT DIRECTOR OF THE HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Ms. POLLITZ. Thank you, Mr. Chairman.

Congratulations on a very fine tri-committee draft proposal for health care reform. It is an impressive accomplishment worthy of the challenge we face to make health care available, affordable, and adequate for all Americans. Your hard work and wisdom and practicality and that of your excellent staff is evident in this proposal, and this time I know you will get the job done.

Your proposal defines a minimum health benefits standard. It requires all Americans to have at least that level of coverage, with shared responsibility for paying for that by employers. It creates tax credits for small businesses. It expands Medicaid and creates new premium and cost-sharing subsidies for private coverage to help other Americans of modest means.

The proposal also establishes strong new market reforms for private insurance with important consumer protections. It creates a new health insurance exchange, an organized marketplace that will give consumers, individuals, and small employers a great deal of assistance with enrollment, appeals, applications for subsidies, provide comparative information about plan choices; and, on their behalf, the exchange will negotiate with insurers over the premiums for health insurance in order to get the best possible bargains. And, importantly, consumers and employers who buy coverage in the exchange will also have the choice of a new public plan option.

You have heard about the recent national poll that indicates Americans strongly favor such an option. It can address the failures of competitive health insurance markets today.

First, it offers consumers an alternative to private health plans that for years have competed on the basis of discriminating against people when they are sick. Just last week, your colleagues on the Energy and Commerce Committee held a hearing on health insurance rescissions. One woman who was battling breast cancer testified that her coverage had been revoked for failure to disclose a visit to a dermatologist for acne. When consumers are required to buy coverage, having a public option that doesn't have a track record of behaving in this way will give many peace of mind.

And, second, a public plan option will promote cost containment. Research shows that insurance markets today do not compete to hold down costs. Rather, insurers and providers negotiate to pass

costs through to policyholders while maintaining and even growing profits.

For the first few years, the public plan option will be allowed to base its payments to doctors and hospitals on the fee schedules used by Medicare. Thereafter, it will develop innovative payment methodologies to hold down costs.

Mr. Chairman, clearly as this bill moves through the legislative process there will be opportunities to modify and improve it; and in my written statement, I offered several recommendations in that regard and would briefly just describe three of those for you now.

First, with respect to the essential benefit package, the bill does create a benefit standard, and it appears to be a solid one, but it doesn't create an out-of-pocket limit on cost sharing for care received outside of a plan network, and that is an important omission to correct. And your plan does not specifically reference as a benchmark the BlueCross/BlueShield standard option plan offered through the FEHBP today.

Many have talked about that plan which so many Members of Congress have as coverage today as being an appropriate benchmark of minimum coverage for all Americans. It is not clear whether your essential benefit package meets that standard, but it should; and if it doesn't, the standard should be improved. And if that raises the cost of the bill, it will be imperative to find additional resources.

Over the next decade, our economy will generate more than \$187 trillion in gross domestic product, and we will spend a projected \$33 trillion on medical care. Investment in health care reform that guarantees adequate protection for individuals and families is worthwhile.

Second, with regard to rules governing health insurance, new rules won't be meaningful unless there are resources for oversight and enforcement. After the enactment of HIPAA, a witness at a congressional hearing for the Department of Labor testified that the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.

For health reform bills, your final health reform bill must appropriate resources for the Department of Labor as well as for HHS and State insurance departments so that there is capacity to oversee and enforce the new standards. Your colleague on the Appropriations Committee, Congresswoman DeLauro, has introduced legislation to do this.

And, finally, with regard to subsidies, the bill creates a sliding-scale assistance so that middle-class Americans with income up to 400 percent of the poverty level will not have to pay more than 10 percent of their income toward premiums. As charts in my written statement illustrate, however, some consumers—including self-employed, who have been mentioned a lot today—who have incomes above that level may still face affordability problems. This is especially likely for people who have to buy family coverage and for baby boomers who could face much higher premiums under age rating that is allowed under this bill.

I hope the committee will consider setting a premium so that no American will have to spend more than 10 percent of their income on health insurance.

Chairman MILLER. Thank you.
[The statement of Ms. Pollitz follows:]

Prepared Statement of Karen Pollitz, Research Professor, Georgetown University Health Policy Institute

Good afternoon, Mr. Chairman and Members of the Committee.

I am Karen Pollitz, a Research Professor at the Georgetown University Health Policy Institute, where I study the regulation of private health insurance.

I commend the Members of the three House Committees, including this one, for the Tri-Committee Draft Proposal for Health Care Reform. Your hard work, wisdom, and practicality are evident in this proposal. It contains the key elements necessary for effective health care reform that will achieve universal coverage and introduce cost discipline into the health care system. I congratulate you on this effort, and as a citizen, I thank you for it. This time, you will get the job done.

In my remarks today, I will comment on some of the central health care reform provisions contained primarily in the first five titles of the draft legislation and offer several suggestions that I hope you will find helpful and constructive as you work toward enactment later this year.

For health care reform to provide all Americans with secure coverage, changes must be adopted and enforced to ensure that health insurance is always available, affordable, and adequate. Key elements of the Tri-Committee proposal will address these critical needs.

Individual responsibility The legislation requires all Americans to have health insurance coverage. More importantly, it makes other changes to our coverage system to enable people to comply with this requirement.

Essential benefit standard A most basic component of health care reform is to define what constitutes health insurance. Far too many policies that provide inadequate coverage are on the market today, and as a result, almost as many Americans are under-insured as uninsured. Recent studies find that 57 million Americans are burdened with medical debt, and 75 percent of them have health insurance.¹ Medical bills continue to be a leading contributor to personal bankruptcy and most medical bankruptcies also occur among people who are insured. This spring, Consumer Reports magazine reported on a host of health insurance products that nonetheless left policyholders on their own to pay tens of thousands of dollars (or more) in medical bills.² Studies show the under-insured, similar to the uninsured, have difficulty accessing timely and quality health care.³

A fundamental purpose of health care reform must be to put an end to medical debt and medical bankruptcy, and to ensure that health coverage is, indeed, a ticket to health care. The Tri-Committee draft proposal sets national standards for an essential health benefits package that includes hospital care, inpatient and outpatient medical care, prescription drugs, mental health and substance abuse treatment, rehab services, preventive care services, and maternity care. The essential benefits package includes additional, enhanced benefits for children. Cost sharing for covered services provided in-network cannot exceed \$5,000 per year for an individual, \$10,000 for a family. The annual limit on cost sharing is a comprehensive limit that applies to all forms of cost sharing, similar to that required for tax preferred HSA-eligible health plans today.

All qualified health benefit plans will be required to cover the essential benefits package. Three levels of plan options can be offered. The Basic Plan level must set cost sharing to achieve an actuarial value of 70 percent of the essential benefits package. Enhanced and Premium Plan options must have actuarial values of 85 and 95 percent, respectively, of the essential benefits package.

A Health Benefits Advisory Committee chaired by the Surgeon General will fill in other important details on plan features, such as the annual deductible(s) and update the benefit package over time.

Recommendation—The essential benefit package must include a maximum out-of-pocket limit whether people receive care in or out of network. Though the bill provides for the establishment of network adequacy standards, patients nonetheless need protection against unlimited cost sharing when they must seek care out of network. The sickest people are most likely to need care from sub-specialists who may not participate in their plan network. And any patient who is hospitalized may inadvertently receive costly care from non-network doctors whom they do not choose (for example, anesthesiologists, radiologists, pathologists, emergency physicians.)

In addition, an often mentioned benchmark standard for coverage adequacy is the Standard Option plan offered by Blue Cross Blue Shield under the Federal Employees Health Benefits Program (FEHBP)—coverage that most federal employees and many Members of Congress have today. The essential benefits package outlined in

the draft proposal appears to provide less coverage than this FEHBP standard. If that is the case, additional resources should be included to raise the minimum benefit standard. Over the next decade, our economy will generate more than \$187 trillion in gross domestic product and we will spend a projected \$33 trillion on medical care. The investment in health care reform that guarantees an adequate level of protection for individuals and families is worthwhile.

Whatever benefit standard is ultimately adopted, the Health Benefits Advisory Committee should be required to regularly report on medical bills that individuals and families incur. Updates to the essential benefits package over time should strengthen coverage adequacy.

Finally, the draft proposal continues to permit the sale of certain so-called “ex-cepted benefits” in traditional health insurance markets. These would include cancer policies and other dread disease and limited benefit policies. Consumers are vulnerable to abusive marketing practices when it comes to these policies and state regulators have long warned they are a poor value.⁴ At a minimum, such policies should contain warning labels that they do not constitute qualified health benefit plans and that coverage is duplicative of that provided under qualified health benefit plans.

Subsidies and Medicaid expansion Overwhelmingly, today, the uninsured have low incomes and lack coverage chiefly because they cannot afford it. The Tri-Committee proposal addresses affordability in two ways.

First, it expands Medicaid coverage to all Americans with family incomes up to 133⅓ percent of the federal poverty level (FPL). This is an important departure from the current Medicaid program, which only provides coverage for certain categories of individuals—children and their parents, and other adults only if they are elderly or disabled—and which applies varied income eligibility standards that often vary significantly by state. To make this expansion affordable for states, the draft legislation provides that the federal government will pay the full cost of covering new expansion populations—childless adults and other adults for whom income eligibility levels are below 133⅓ percent FPL. Further, to ensure individual choice, Medicaid-eligible individuals will have the choice between enrolling in Medicaid or seeking other subsidized private health insurance coverage.

Second, the discussion draft provides for sliding scale financial assistance for individuals and families to purchase private health insurance. Premium subsidies would be offered on a sliding scale for people with family income up to 400 percent of FPL. At last count, ten percent of the uninsured, or some 5 million Americans, had incomes equal to 400 percent FPL or more. This is due to the fact that our measure of poverty level income is very low, while the cost of good health coverage is relatively expensive. For a family of 3, an income of 400 percent of FPL is \$73,240. For that family to enroll in the FEHBP Blue Cross Blue Shield Standard Option plan, the annual premium would cost \$13,446, or 18 percent of gross family income.

Because people with incomes above the subsidy levels provided in this bill may find quality health insurance coverage costs more than they can afford, you should consider improvements to the premium subsidy schedule as you work through the legislative process this year.

Importantly, the discussion draft also provides subsidies for cost sharing under private health insurance. This is also critically important. Deductibles, co-pays, and coinsurance are additional payments required of insured individuals at the point when they seek health care. Decades of research shows that cost sharing deters the use of care, including medically necessary care, particularly by people with limited income. Further, research shows that when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5 percent of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills.⁵ Cost sharing subsidies are necessary to ensure that people can afford to access covered benefits.

Recommendation—Depending on what premiums are charged for qualified health benefit plans, subsidies capped at 400 percent of FPL may prove to be insufficient to ensure affordable health care for all Americans. The Committee might consider instead a rule that no individual or family will have to pay more than 10 percent of income on health insurance premiums (with lower limits set for low-income individuals, as the Tri-Committee draft does.) Cutting subsidies off entirely at an arbitrary income level can leave families vulnerable. The Massachusetts health care reform experience is instructive. In that state, subsidies are limited to residents with incomes to 300 percent of FPL, and as a result, the state waives the individual mandate on grounds of affordability for approximately 2 percent of residents.⁶

As shown in Figures 1 and 2, if the intent of the Committees is to assure that no families or individuals will have to pay more than 10 percent of income for health insurance premiums, and if the FEHBP Blue Cross plan is used as a bench-

mark premium, then people will need help beyond that provided for in the draft proposal. The cost of good coverage is will be sizeable compared to what many working families earn. (See Figure 3) A subsidy system that caps people's liability for premiums at no more than 10 percent of income would be more protective and subsidies would taper off gradually, avoiding a cliff. Some assistance would reach people at higher income levels, though help provided to higher earners would be modest.

Figure 1. Comparison of Single Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Affordability Protection (maximum share of income)	Individual Pays	Amount Help Needed	(%) Help Needed
100%	\$10,830	\$5,872	54%	0	0	\$5,872	100%
150%	\$16,245	\$5,872	36%	0	0	\$5,872	100%
200%	\$21,660	\$5,872	27%	2%	\$433	\$5,439	93%
250%	\$27,075	\$5,872	22%	4%	\$1,083	\$4,789	82%
300%	\$32,490	\$5,872	18%	6%	\$1,949	\$3,923	67%
400%	\$43,320	\$5,872	14%	8%	\$3,466	\$2,406	41%
500%	\$54,150	\$5,872	11%	10%	\$5,415	\$457	8%
600%	\$64,980	\$5,872	9%	10%	\$5,872	0	0
1,600%	\$174,000	\$5,872	3%	10%	\$5,872	0	0

Figure 2. Comparison of Family Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Affordability Protection (maximum share of income)	Family Pays	Amount Help Needed	(%) Help Needed
100%	\$18,310	\$13,446	73%	0	0	\$13,446	100%
150%	\$27,465	\$13,446	49%	0	0	\$13,446	100%
200%	\$36,620	\$13,446	37%	2%	\$732	\$12,714	95%
250%	\$45,775	\$13,446	29%	4%	\$1,831	\$11,615	86%
300%	\$54,930	\$13,446	24%	6%	\$3,296	\$10,150	75%
400%	\$73,240	\$13,446	18%	8%	\$5,860	\$7,586	56%
500%	\$91,550	\$13,446	15%	10%	\$9,155	\$4,291	32%
600%	\$109,860	\$13,446	12%	10%	\$10,986	\$2,460	18%
700%	\$128,170	\$13,446	11%	10%	\$12,817	\$629	5%
735%	\$134,460	\$13,446	10%	10%	\$13,446	0	0
950%	\$174,000	\$13,446	8%	10%	\$13,446	0	0

Figure 3. What do people earn?

Individual			Family of 3		
% FPL	Annual Income	Example occupations*	% FPL	Annual Income	Example occupations*
100%	\$10,830		100%	\$18,310	
150%	\$16,245	Fast food worker	150%	\$27,465	Dishwasher + part time laundry worker
200%	\$21,660	Home health aide	200%	\$36,620	Cafeteria attendant + shampooer
250%	\$27,075	School bus driver	250%	\$45,775	Restaurant cook + stock clerk
300%	\$32,490	Travel agent	300%	\$54,930	Receptionist + secretary
400%	\$43,320	Social worker	400%	\$73,240	Police officer + child care worker
500%	\$54,150	High school teacher	500%	\$91,550	Legal secretary + electrician
600%	\$64,980	Nurse (RN)	600%	\$109,860	Real estate agent + librarian
1,600%	\$174,000	U.S. Congressman	950%	\$174,000	Administrative law judge + aerospace engineer

* Source: Bureau of Labor Statistics

Private health insurance market reforms The Tri-Committee proposal prohibits the use of common insurance industry practices today that have the effect of discriminating against people based on health status. Under reform, health insurance would have to be offered on a guaranteed issue basis. No longer could individuals or employer groups be denied coverage based on health status or health history, although insurers would be allowed to surcharge premiums by as much as 100 percent based on age—a strong proxy for health status. The discussion draft also provides for guaranteed renewability of coverage—a requirement of current law—with clarification that the rescission of health insurance is also prohibited. In other words, insurers will be explicitly prohibited from a common practice today of taking back coverage from individuals and employer groups after claims are made. The

draft legislation also prohibits the imposition of pre-existing condition exclusion periods and prohibits insurers from varying premiums based on health status. These market rules will promote the spreading of risk, instead of today's industry practices of segregating risk. And they are essential in a world where people are required to have health insurance.

Other new market rules will ensure that coverage works well and efficiently for consumers. Standards for network adequacy and the timely payment of claims are provided for under the bill. In addition, insurers will be required to meet minimum loss ratios of 85 percent, so that no more than 15 percent of premium dollars can be spent on marketing, administrative costs, and profits.

Recommendation—Consideration should be given to tighter limits on age adjustments to premiums, or for elimination of such adjustments altogether. Particularly if premium subsidies are capped at 400 percent FPL, affordability problems may be substantial for members of the “Baby Boom” generation. Premiums for coverage sold today in Massachusetts, where age rating of 2:1 is also permitted, illustrate the affordability problem for people as we age. See Figure 4.

Figure 4. Monthly age-rated premiums (2:1), family of 3, Massachusetts

Plan-type	Age 24	Age 64
Bronze	\$626 - \$1,020	\$1,144 - \$1,759
Silver	\$834 - \$1,466	\$1,648 - \$2,483
Gold	\$1,091 - \$1,878	\$2,183 - \$3,172

Finally, for market reforms to be meaningful, Congress must authorize and appropriate resources for oversight and enforcement, both at the federal and state level. The Tri-Committee proposal wisely requires extensive data disclosure by health plans so that regulators may monitor compliance with market rules. But regulators will need expert staff to review and analyze data, as well as to conduct compliance audits and respond to consumer problems and complaints.

Resources at the federal level are particularly lacking and must be increased. At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the Agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.⁷

Additional resources will also be needed at the U.S. Department of Labor (DOL). After the enactment of HIPAA, a witness for DOL testified the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.⁸

At the state level, limited regulatory resources are also an issue. In addition to regulation of health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent. State regulators necessarily focus primarily on licensing and solvency.⁹ Dedicated staff to oversee health insurance and, in particular, health insurer compliance with HIPAA rules are limited. Enforcement of consumer protections is often triggered by complaints.

In order for new insurance market rules to deliver on promised consumer protections, strong oversight and enforcement will be essential. Your colleague, Congresswoman Rosa DeLauro, has wisely introduced legislation (HR 2427) to strengthen oversight and enforcement capacity at the federal and state level.

Establishment of a national health insurance Exchange The Tri-Committee proposal also provides for the establishment of a national health insurance Exchange. An Exchange is a more organized health insurance market than what individuals, employers, and insurers are used to today. For purchasers in the Exchange, there will be subsidies to make premiums affordable. There will also be considerable new sources and types of assistance—for example, the provision of comparative information about plan choices, as well as assistance with enrollment, determination of eligibility for subsidies and/or Medicaid, appeals, and so on. Many of these services will be provided by a new Health Insurance Ombudsman, created solely to help consumers navigate the coverage system and make choices that are best for them.

For sellers of health insurance, the Exchange will accept bids and negotiate with insurers over the premiums they charge. The Exchange will also exercise much clos-

er oversight over health insurance than generally occurs today. Insurers will be required to report data on their products and practices in order to make more transparent the black box that is private health insurance today. These data will be used in the establishment of risk adjustments to premiums, and to monitor compliance with market rules and consumer protections.

Initially, the Exchange will serve those consumers who are most in need of these added protections—individuals and the smallest employers (with fewer than 20 employees) who lack market clout and the resources to hire human resources experts of their own. Authority to permit other employers to participate in the Exchange is delegated to a Commissioner starting in the fourth year of implementation.

The Commissioner is also authorized to require that certain consumer protections—such as network adequacy protections, transparency standards, and external appeals—apply to all qualified health benefit plans, including those outside the Exchange. However, the Commissioner might not require parallel protections. Further, the legislation does not require that insurers offer the same plan options at the same prices both inside and outside the Exchange.

Recommendation—In order to protect against risk selection, it is important for requirements to be identical for all qualified health benefit plans, no matter where they are sold, in or outside of the Exchange. If insurers can vary the plan options and prices they offer in different markets, they will be more able to steer risk. The Tri-Committee plan includes sanctions for employers found to steer risk into the Exchange. Similar sanctions should be applied to insurers, in addition to parallel rules to minimize this possibility.

A public plan option Within the health insurance Exchange, consumers will have a choice of private health insurance plans and carriers, as well as a public plan option. This is a key provision in the draft reform bill that will promote both choice and cost containment. A recent national poll indicates Americans are strongly behind the establishment of a public plan option to compete with private health insurers.¹⁰ The public plan option must meet the requirements of other qualified health benefit plans offered by private insurers. By introducing this option into the marketplace, a public plan option can address failures of competitive health insurance markets today.

First, it offers consumers an alternative to private health plans that, for years, have competed on the basis of discriminating against people when they are sick. At a hearing of the House Energy and Commerce Committee just last week, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who is currently battling breast cancer testified that her coverage was revoked for failure to disclose a visit to a dermatologist for acne. At this hearing, when asked whether they would cease the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not. Experiences like these make some consumers distrust private insurers.¹¹ If consumers are required to buy health insurance, having a public coverage option that does not have to compete on the basis of profits will give many peace of mind.

Second, a public plan option will promote cost containment. Research shows that competitive health insurance markets today do not operate to hold down costs. Rather, insurers and providers negotiate to pass cost increases on to policyholders while maintaining and even growing corporate profits.¹² Under the Tri-Committee proposal, the public plan option will initially be allowed to base its payments to doctors, hospitals, and most other providers on the fee schedules used by Medicare, albeit at a higher level than Medicare pays today. The public plan will negotiate new payment rates for prescription drugs with pharmaceutical companies. And it will be able to offer bonus payments for providers that participate in both Medicare and the public plan. The public plan option is further tasked with development of innovative payment methodologies that hold down cost and promote quality. This will help move the market in the direction of competition based on the efficient delivery of health care services.

Shared responsibility Finally, the Tri-Committee draft proposal provides for a continued role by employers in the provision of health benefits. Most insured Americans today get health coverage at work and a stated goal of health care reform is to let people keep current coverage if they are satisfied with it. A requirement for employers to provide health benefits (“play”) or contribute toward the cost of other public subsidies for coverage (“pay”) is consistent with this goal and will help keep employer resources in the financing system.

Conclusion Mr. Chairman, the Tri-Committee draft proposal for health care reform is an impressive accomplishment, worthy of the challenges we face to make health coverage available, affordable, and adequate for all Americans. Your proposal defines a minimum health benefits standard, requires all Americans to have it, and

institutes reforms to ensure affordable coverage in reformed markets with added, important consumer protections. You also make available a new public plan option that will add to consumer choice and move insurance markets to compete on the basis of cost efficiency, not risk selection.

No doubt, others will recommend modifications as I have today. The legislative process was intended to consider all points of view and then to act in the best interests of the public you represent. I could not be more pleased to see this legislative process at work. I thank you for your courage and commitment to health care reform that secures good, affordable health coverage for all Americans, and will be happy to provide you any additional information or assistance that I can.

ENDNOTES

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²"Hazardous health plans: Coverage gaps can leave you in big trouble," Consumer Reports, May 2009.

³Cathy Schoen, et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," The Commonwealth Fund, June 10, 2008.

⁴See, for example, <http://www.ncdoi.com/consumer/consumer—publications/health%>

⁵Peter Cunningham, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change Tracking Research Brief No. 10, December 2008.

⁶Health Care Reform Facts and Figures, Commonwealth Connector, June 2009.

⁷Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

⁸Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.

⁹National Association of Insurance Commissioners, 2007 Insurance Department Resources Report, 2008.

¹⁰Kevin Sack and Marjorie Connelly, "In Poll, Wide Support for Government-Run Health" New York Times, June 21, 2009.

¹¹Gallup poll, June 17, 2009, available at <http://www.gallup.com/poll/120890/Healthcare-AmericansTrust-Physicians-Politicians.aspx>

¹²James Robinson, "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, November/December 2004.

Chairman MILLER. Ms. Wcislo.

**STATEMENT OF CELIA WCISLO, EXECUTIVE BOARD MEMBER,
SERVICE EMPLOYEES INTERNATIONAL UNION**

Ms. WCISLO. Thank you.

I am testifying today on behalf of the Service Employees International Union. Chairman Miller, members of the committee, I applaud you for your draft bill that was released last week. I am a local and national officer as well as a board member of the Connector, which is implementing health care reform in Massachusetts.

First, Americans are ready to fix health care. I have no doubt about it. Your draft bill includes many of the essential elements that will start that fix today.

SEIU supports a robust health insurance exchange. That is what I do on a regular basis as a Connector board member. We found three very good reasons for it.

One, it has allowed consumers to compare and find insurance plans all in one place so they have some choices and they understand their choices.

Secondly, we built on our Medicaid program so as people move off Medicaid into subsidized care or into the employer market they have a path through which they can go and they can call one place and find out what they are entitled to.

And, finally, we have set a minimum standard of what health insurance is, which is protect our markets and models what you were going to do in the advisory committee.

SEIU supports the public health insurance option in your bill as a way to keep costs down and foster price competition in the private market. While the Connector board has been very effective in providing subsidized care to the low-income folks, we do not have a model of how to intervene in the private market, and I believe this approach will do that. It could pool the costs alone—small employers and individual folks in the market in our State, when we did that, it saved 30 to 40 percent for individuals who were forced to buy it on their own.

One way of addressing some of the concerns about unfair competition that I heard today is to make sure that the public plan pays rates equivalent to Medicare or a little higher. In particular, I am concerned that Medicaid does not pay as well for primary care, and you would have to look at that, but that would level the playing field because it will provide a closer to a single—a sole—you know, a joint-payer system where people are each paying the same amount and will limit the amount of shifting onto the private insurance premiums.

SEIU supports the setting of minimum benefit standards that connect to such standards for health insurance, and we applaud the House for this proposal in this bill. Our standards have been critical to keeping the floor from dropping out of our insurance market and have protected consumers from predatory insurance companies.

We also support the 400 percent affordability scale. Our scale stops at 300 percent, and clearly 60,000 of the people who are waived out of our individual mandate were waived out because they could not afford it. Your bill fixes that.

And, finally, we support shared responsibility. Employers, individuals, and the government must alter the part to make it a sustainable and affordable system that covers everyone.

Massachusetts reform continues to be successful for many reasons, but I would say the major reason is the approach of shared responsibility that the House tri-committee bill adopts. We have an individual mandate, we have government support and an employer mandate, and it has worked. And, in fact, a recent study by Health Affairs showed that people more likely—the public more likely supports any kind of change in health care if all of us chip in, and they are left more resistant if it falls on only individuals.

Our individual mandate and our employer mandate have worked, and 70 percent of our residents still approve of the reform. SEIU applauds your proposal to make employers continue paying.

One of the representatives mentioned Tennessee. There was no pay-or-play system in Tennessee.

In closing, I would not like the choice to dump it onto the backs of government. I think we need to keep the moneys that employees put into the system in the system, and your pay-or-play idea would do that.

To date, those two combined purchases in Massachusetts, an individual and an employer mandate, appear to have worked. We have 440,000 people out of 650,000 insured in less than 3 years.

That is pretty amazing. That is 70 percent of our uninsured. Of those, 191,000 were paid by employers or individuals buying through the connector. That is, 44 percent was paid not with government subsidies at all but through business and individuals contributing. That is very important, and your plan will do that.

Additionally, since 2003, the number of our employers that provide insurance has gone up—68 percent to 72 percent. That is contrary to the entire national States' markets. We have proved that by having such a mandate we will bring in employers who weren't offering it before.

And your requirement that looks at the entire payroll, your entire payer payroll, is more fair because it does not hit low-income employers in a more difficult way based on the size and their ability to pay. It is critical that reform mandates—both business and individuals—contribute to the cost of everyone, along with government.

We must build a safety net for those individuals and small businesses that do not have access now and access to affordable insurance. We want a health plan to provide competition and continuity in the market. We believe your draft bill is a great step forward for that, and we support it.

Mr. ANDREWS [presiding]. Thank you.

[The statement of Ms. Wcislo follows:]

**Prepared Statement of Celia Wcislo, Assistant Division Director,
SEIU United Healthcare Workers East**

My name is Celia Wcislo, and I am testifying today on behalf of the Service Employees International Union. Chairman Miller and members of the committee, SEIU applauds you for the discussion draft bill released on June 19. I am a local and national officer of SEIU as well as a board member of the Commonwealth Connector Authority. This authority was set up to implement Massachusetts' healthcare reform legislation, and I have been a board member since the first meeting in 2006.

Americans are ready to fix healthcare. According to a poll conducted in April by the Kaiser Family Foundation, a solid majority of the respondents agree that the current economic crisis makes it more important that we reform healthcare now. Your discussion draft includes some essential elements that will promote coverage and access, cost containment, and improved quality and value:

A Robust Health Insurance Exchange: As a member of the Connector Board, we have found this form of exchange important for many reasons:

1. It has created a set of products, and a Web portal that, for the first time, allows consumers to compare insurance products in one place, helping them to find the information and comparisons they need to select the plan that best fits their needs.

2. The Connector has also built on top of the state's Medicaid virtual gateway, so individuals can quickly be enrolled in the appropriate subsidized plans.

3. We have established a "minimum wage" type standard for what minimum benefit coverage should look like, much as the proposed advisory committee chaired by the surgeon general would do in the discussion draft. I will speak to this more in a few minutes.

A Public Health Insurance Option: SEIU fully supports a public health insurance option as a way to keep costs down and foster price competition in the private market. While the Connector has been able to keep the cost of our subsidized plans low because of our exclusive market position and our role in defining benefits and co-pays, we have had little impact on the private market. That has meant that premiums continue to rise, and many small business owners are feeling the financial impact. In particular, in Massachusetts we have only just begun to offer plans to the small group market and it is still in the pilot stage.

One way of addressing some of the concerns of "unfair competition" that have been raised by private insurance plans is to make sure the public option pays adequate provider rates. In Massachusetts, the use of Medicaid Disproportionate Share funding to pay for coverage expansion has meant a dramatic cut in both Medicaid and DSH hospital rates that is devastating for the safety net delivery system. Cur-

rently, hospitals that are treating those on Medicaid are facing cuts that could destabilize these systems that treat low-income individuals. To avoid a cost-shift to private insurance plans, a public plan should pay above Medicare rates (and pay better for primary care services which are dramatically underpaid in Medicare).

Massachusetts has recently set up a Payment Reform Commission to solve this problem of different methods of payment. We are looking to move away from paying for volume and toward paying to promote prevention and health. Additionally, we are trying to solve the problems of cost-shifting between Medicaid, Medicare and private coverage. A public plan could help in demonstrating how all three areas of insurance can be better moved to one playing field.

Minimum Benefit Standards: The Connector sets minimum standards for health insurance, and we applaud the House proposal for setting minimum standards. While resisted by some insurance companies, the Connector has set a floor of what health insurance should be and has allowed the Division of Insurance and attorney general's office to better police the insurance market and protect consumers. Our minimum standards are meaningful and include most, if not all, of the benefits we mandate in state law.

This has been critical in keeping the floor from dropping out of our current market and giving consumers' confidence that what they are buying provides real health protection.

Affordability: We are pleased to see that the Tri-Committee bill proposes an affordability scale that goes to 400 percent FPL, or \$88,000 for a family of four. In Massachusetts one of the largest groups of residents which have received waivers from the individual mandate are those with incomes between 300 percent to 400 percent FPL, which fall outside of the Connector's authority. We still have a cliff at 300 percent, where individuals who have been buying subsidized coverage may not be able to afford even our lowest coverage level once they are no longer subsidized. In 2007 and 2008, at least 60,000 and then 51,000 individuals were ruled to be unable to afford the insurance available to them. By providing assistance for individuals and families with incomes at four times the poverty level, your legislation makes an individual requirement fairer and less burdensome for individuals and families.

Shared Responsibility: Employers, individuals, and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. The journal *Health Affairs* recently published a paper by Bob Blendon and colleagues showing stronger public support for a shared responsibility approach to reform compared to an approach that relies solely on individual responsibility. Massachusetts' reform continues to be successful for many reasons, but I would say the major reason and context of our work has been the approach of shared responsibility that the House Tri-Committee bill adopts.

We have both an individual mandate and an employer mandate to provide coverage. These have both been phased in gradually and have, in fact, received very little real opposition from residents. By making government, business and individuals share in responsibility and cost, healthcare reform still receives high public support (close to 70 percent).

Businesses that do not provide coverage face two types of penalties: a per-worker "play-or-pay" payment, as well as potential penalty assessed for the cost of care if their worker needs government help with healthcare costs. This was designed into the bill to avoid "crowd out," or the action of companies to drop coverage and pass the cost onto government programs. A play-or-pay mechanism based on the size of payroll, such as your bill proposes, is a better approach than a per-worker fee because it is more reflective of the employers' ability to pay and less regressive.

To date, these two combined approaches appear to have worked better in Massachusetts than most predicted. The Division of Healthcare Financing and Policy reports that 438,000 residents are newly insured since reform started, of which 150,000 have purchased insurance through employer-sponsored insurance, and 41,000 have bought through the individual market. So while there may have been some small number of employers who have dropped coverage, fully 44 percent of the newly insured have bought coverage in the private market with no subsidies.

Additionally, from 2003 until 2007, the number of employers which offer health insurance has risen from 68 percent to 72 percent, heading in a better direction than the national trend, which continues to see the erosion of ESI. However, Massachusetts is not representative of the nation in this regard. We had a higher rate of employer-sponsored coverage than the national average when we began our reforms.

Opponents of the play-or-pay proposal say that it will result in massive job losses and high costs to employers. This is not the case. Two recent studies, one by Philip Cryan at Berkeley and the other by Ken Jacobs and Jacob Hacker, using the pro-

posed play-or-pay requirement—with the “pay” being between 6 percent and 8 percent of payroll—found that the net effect of such a policy would result in minimal job losses—between one-tenth of 1 percent and .03 percent. Minimal job losses likely to be offset by other impacts of healthcare reform including improved efficiency and productivity of the labor market. Nearly 75 percent of the 45 million uninsured could gain coverage through an employer mandate. Under the play-or-pay proposal, the studies indicate that the increase in payroll costs from the employer requirement is likely to again be offset through declines in the cost of coverage and increased productivity.¹

Reform has fundamentally improved coverage for Massachusetts’ residents. But it has not solved all of our problems. Close to 3 percent remain uninsured, with many others underinsured. Large employers, while providing generous benefits for their full-time employees, still have many employees whose work status as part time, temporary, or not eligible for coverage means they are eligible to receive subsidized care. The House draft proposal would require employers to either contribute a pro rata share for part-time employees or pay into a fund, an important provision of the bill that Massachusetts could have benefited from.

If Congress were only to adopt a “fair share” approach for employers who do not provide affordable coverage, there could be some serious consequences:

- The proposal would have a much greater effect on employers not offering coverage who have employees with lower family incomes than employers not offering coverage who have higher income employees.

- Employers would have incentives to tilt hiring toward people who have health coverage through a family member, who have a spouse who has a good income, teenagers whose parents make a decent living, and people without children (since the income limits for Medicaid and subsidies rise with family size). Poor parents with children in one-earner families would be particularly disadvantaged.

- Employees (or prospective employees) who know their employer would be charged might be discouraged from applying for Medicaid or subsidies even though they are eligible, and might forgo healthcare that they need as a consequence. And this could discourage employers from hiring persons with disabilities since they are often enrolled in Medicaid programs.

I would also make several suggestions about how the employer mandate should be structured:

- Base the required payment on the size of an employer’s payroll rather than the number or type of employees. A per-employee requirement would disproportionately affect firms with larger numbers of low-wage workers, as compared with firms with smaller numbers of highly compensated individuals. The House proposal contains a flat 8% of payroll penalty, which is reasonable and fair, and will take into account firms with a significant numbers of low-wage workers. In Massachusetts, we considered taking similar steps, but was dropped because of concerns from our state leaders of an ERISA challenge.

- To protect small firms with low-wage workers, exempt a specified dollar amount from the amount of payroll subject to tax. The amount of payroll exempted from tax should be kept small, however, so that as many firms as possible are subject to the play-or-pay requirement.

It is critical that reform mandates both businesses and individuals to contribute to the cost of insuring everyone, along with the government. We must build a safety net for those individuals and small businesses that do not have adequate access to affordable insurance. We need a public plan to provide needed competition and continuity in the market. And we have to make sure we set a floor on what essential insurance is, so that we truly make available coverage that is as good as what you all receive as Members of Congress.

Mr. ANDREWS. Mr. Klein.

**STATEMENT OF JAMES KLEIN, PRESIDENT, AMERICAN
BENEFITS COUNCIL**

Mr. KLEIN. Thank you very much, Mr. Chairman, Mr. Kline, members of the committee.

¹ Philip Cryan, June 2009. “Will A Play-or-pay Policy for Healthcare Cause Job Losses? Goldman School, University of California, Berkeley For the Institute for America’s Future and the Economic Policy Institute, And Ken Jacobs and Jacob Hacker June 2009 “How to structure a play-or-pay requirement for employers: lessons from California for national healthcare reform.” Advancing National Healthcare Reform: Policy Brief.

The American Benefits Council represents companies that either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans, so we are very privileged and grateful for the opportunity to be here today.

President Obama and many congressional leaders and certainly many people who we have heard from today have all said that health care reform should ensure that if people are happy with their health care coverage, they should be allowed to keep it. That seems to be a basic understanding that everyone agrees upon.

Over 160 million Americans receive their coverage from an employer-sponsored plan at a cost to employers of over \$530 billion per year. According to recent surveys, over two-thirds of Americans rate their coverage as either excellent or very good. So that means that for many people letting them keep the coverage that is right for them and for their families requires maintaining the employer-sponsored health coverage system.

But, frankly, to give meaning to President Obama's pledge, it is essential that the ability to retain one's coverage is not just true as a technical, legal matter that the employer-sponsored system would continue but rather that as a practical matter that what emerges from health care reform legislation is a system that employers want to continue to participate in and a system that does not skew individuals' choices as to whether or not they should remain with their employer plan or seek their coverage elsewhere.

To respond to a question that Representative Woolsey asked earlier, we are not interested in trapping employees in their employer plans, but neither do we want the structure of the system to be such that they would be induced to leave their employer plan.

So with that by way of background, let me share some of the chief concerns that employers have as they examine the emerging health care debate.

First, the employer pay-or-play mandate. One employer concern is the slippery slope argument that even if employers can meet the financial obligations of the mandate today that, over time, it will grow and become unaffordable. But, frankly, that is really only one part of the concern. The equally if not more compelling concern for employers is that the regulatory structure that would necessarily accompany a mandate of this type would inevitably, if unintentionally, leave many employers to choose to pay rather than to play. Put another way, employers so strongly believe in the value added by employers' sponsorship and administration of health plans that they are concerned that the structure could erode rather than build upon the employer-based system.

Secondly, ERISA. It is well-known that ERISA's Federal framework is essential to design and maintain a consistent set of benefits for workers wherever they live or work, operating under a uniformed regulatory structure. But, again, that is only part of the story. The other dimension of employers' concerns around potential changes to ERISA is that Congress might make substantive changes to ERISA itself that will expose employers to substantial financial liability.

So let me put that another way. It is not enough to just have uniform Federal rules. The rules themselves have to be reasonable and administrable, protecting the interests and concerns of participants

and beneficiaries, at the same time not inducing employers to exit the system. Again, not causing them to pay rather than to play.

From our initial review of the tri-committee draft proposal, it appears that three different penalty regimes would result from this bill. For employers operating outside the insurance exchange, the current system of remedies would largely continue. For employers and individuals obtaining coverage within the new insurance exchanges, varied and limited State remedies would be permitted; and for the new public plan operating within the exchange, the uniform Federal rules that currently apply to Medicare would prevail.

This does not create the proverbial level playing field for employers selecting to obtain coverage for their workers through one of the exchange plans.

Third, the public plan. Many people assume that employers have some kind of visceral, philosophical opposition to any program run by the government. That is not so. It certainly is not the case for the American Benefits Council and our very comprehensive proposals on reforming the health care system. It certainly calls for an important role for the government to play.

There really are two important roles for the government to play. First, public plans are essential to help the lowest-income individuals and those whose connection with the workforce may be so intermittent that an employer-based plan may not be the best venue for them to obtain coverage; and, of course, a reformed individual insurance market also helps that group.

And, secondly, the government can facilitate and regulate the system whereby people select from a variety of different competing private plans, such as the role of government to operate these exchanges, for example, or a Medicare Part D part of a model where people select again among different private plans.

Employers' concerns about a public plan option emerges from decades of experience that we have heard a lot about, particularly on the prior panel, of massive cost shifts from public plans, notably Medicare. The government sets the reimbursement rates to providers very low, and then other purchasers end up paying more. There are no cost savings achieved. They are simply moved from one payer to another.

I see that my time is up here. So, on the other hand, I was just about to get to the part of the bill that I like. I am sure it won't take very long.

I guess the last point I would make about the public plan, though, is if they are going to operate by different rules, then obviously it won't fairly compete with the private plans. If they're going to operate by the same rules, what is the point?

But, on a positive note, employers want to be sure that health care reform gives full attention to improving quality outcomes. If health reform only results in expanding coverage for the uninsured, it will be a magnificent achievement but also a terrible missed opportunity.

We want to commend you for recognizing the need to address quality issues in the legislation. Perhaps rather than taking up more time during the prepared statements, I will just answer any questions.

Chairman MILLER [presiding]. Thank you.

[The statement of Mr. Klein follows:]

**Prepared Statement of James A. Klein, President,
American Benefits Council**

Mr. Chairman, Ranking Member Kline and members of the committee, thank you for the opportunity to join you today at this important hearing on the “Tri-Committee Draft Proposal for Health Care Reform.” My name is James A. Klein, and I am President of the American Benefits Council (the “Council”). The Council is a public policy organization representing major U.S. employers that operate nationwide, as well as other organizations that assist employers of all sizes in providing benefits to their workers and families. Collectively, the Council’s members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

We commend the Education and Labor, Ways and Means and Energy and Commerce committees, for the collective commitment to reform of the nation’s health care system and for providing the Council with this opportunity to share our perspectives on how best to achieve it.

Coverage, Cost and Quality

The Council’s recommendations on health reform are contained in the January 2009 report *Condition Critical*,¹ which is aimed at achieving a stronger, more sustainable health care system. The Council’s Health Care Reform Task Force worked throughout last year analyzing our health care system and developing a set of specific policy proposals that we believe would build on the system’s strengths while improving health quality, lowering health costs and extending coverage to all Americans.

As a country, we spent approximately \$2.4 trillion on health care in 2007, according to the most recent available data from the U.S. Department of Health and Human Services.² This amount is almost twice as much as we spent in 1996, and total national health care spending is projected to double yet again by 2017.³ That level of increase is not sustainable. We already spend far more per capita on health care than any other developed nation, yet we rank well below other countries on many vital indicators of health status. However, perhaps even more troubling is the well-documented evidence that patients receive appropriate care for their conditions only about 55 percent of the time,⁴ and medical errors may account for as many as 98,000 fatalities each year.

It all adds up to an annual rate of increase in health care spending that exceeds by three or more times projected increases in the gross domestic product or the future growth in employee wages and far outpaces the expected growth in federal or state revenues.⁵ Taken together, these projections make it abundantly clear that no matter who ultimately pays the bill, health care must be made more affordable, or it cannot be made more available. In addition, our health care system is marked by wide and unexplained variations in both the overuse and underuse of health services and all too frequently subjects patients to preventable medical errors. Moreover, despite widespread agreement on the importance of extending health coverage for all Americans, too many people are left without coverage entirely, including an estimated nine million children.

There is now a broad consensus that we need to take well-reasoned steps to reform the current health care system. However, while doing so undoubtedly will be costly, simply spending more money is not the solution to the system’s challenges. Indeed, among the most compelling reforms required are those that, if designed properly, will help reduce costs and obviate, to some extent, the need to raise revenue.

Building on the Employer-Sponsored Health Coverage System

The Council firmly believes that the employer-based health care system provides a solid foundation upon which to build toward the shared goal of achieving universal coverage. The current employer-based model for health care has been, and continues to be, very successful in delivering comprehensive health care to a majority of American families. In 2007, 61% of non-elderly Americans—or nearly 160 million Americans—were covered by employer-based health insurance.⁶

All available data indicates that, by and large, those 160 million Americans who receive health care coverage through the employment setting are exceedingly happy with the coverage. In a 2007 study by the National Business Group on Health, over 67% considered their employer-provided coverage to be either “excellent” or “very good”. Thus, for most Americans, the current employer-based system is not just

working, it is winning at delivering critical and comprehensive health care coverage to our nation's families.

The Value of Employer Engagement

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 very demanding purchasers of health care services. They are 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.

Concerns with Pay or Play Mandate

Like the tri-committee reform proposals, the Council believes that all individuals should have an obligation to obtain health coverage and, accordingly, financial assistance will be required to enable some low and moderate income people to obtain that coverage. However, it does not follow that an employer requirement to provide coverage is needed to achieve universal coverage. 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 survey⁷ 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.

One important reason we believe that a "pay or play" employer mandate 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.

Further, we are concerned about proposals under consideration that could require employers to pay their "normal" premium contribution to a health insurance exchange if an employee opts out of an employer plan. In particular, it would be inappropriate for such opt-out requirements to apply where employees are offered qualified coverage through an employer plan to satisfy their individual coverage obligation. Opt-out provisions would be particularly problematic for self-insured employers who could be required to contribute significantly more to the exchange than what some of these employees may have actually cost the employer if they had remained in their plan. This would occur whenever younger, healthier employees opt-out of the employer plan and obtain coverage through the insurance exchange. In effect, employers would be required to both "pay and play" for those employees who opt-out of their employer-sponsored plan and obtain coverage elsewhere.

Minimum Benefit Standard

We also believe that a federal minimum benefit standard is needed only for the purpose of determining whether individuals have enrolled in qualified health coverage and have met their individual coverage obligation. Once this standard is defined, employers will have strong incentives to ensure that their plans meet or exceed the minimum coverage standard applied to individuals. To not do so would leave their employees without adequate levels of coverage and subject to year-end penalties. Individuals who enroll in these employer plans will therefore satisfy their individual coverage obligation and those without employer coverage will be able to enroll in a wide range of health plan choices in the reformed insurance marketplace.

Further, we recommend that a safe harbor be available for qualified high deductible health care coverage. By doing so, individuals who enroll in a high deductible plan that meets existing federal standards would be assured of fulfilling their indi-

vidual coverage obligation. This also helps ensure that high deductible plans are not required to become more costly and retains this affordable health plan choice.

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 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. 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 to the total premium according to a 2008 report by the Massachusetts Division of Health Care Finance and Policy,⁸ 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.

However, ensuring the maintenance of a federal framework is not the only concern that employers have with regard to ERISA. Equally important is to ensure that new burdensome requirements are not imposed in ERISA itself. Such changes that might expose employers to greater liability would have a chilling effect on employers' willingness and ability to continue sponsoring plans.

Our initial review of the tri-committee draft proposal raises serious concerns with regard to ERISA, since it appears to establish two different penalty regimes within the insurance exchanges. For health plans there would be varied and unlimited penalties prescribed under state law. By contrast, in the federal public plan outlined in the draft, a uniform federal enforcement regime (i.e. as prescribed for Medicare) would apply. Yet a third regime would apply for health coverage provided outside the exchanges. Inasmuch as employers will be permitted to obtain coverage through the exchanges, this will subject employers to expansive new liabilities.

The potential for varied state remedies or onerous new federal remedies to erode private employer-sponsored health coverage cannot be overestimated. Employers would face the prospect of either maintaining health benefits for their employees or being subject to unlimited state law remedies or dropping coverage to avoid excessive financial risk. We believe that this provision alone could seriously destabilize employer-based coverage.

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. The Council's proposals enumerated in Condition Critical 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 rec-

ommendations 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 recognize that several public plan alternatives are still under consideration by Congress. These alternatives range from permitting a “Medicare-like” plan to compete with private health plan options in the reformed health insurance market, to having a third party administrator or public cooperative organize networks of health providers and negotiate payment rates for public plan options that would compete with private health plans, or possible fallback options similar to the approach Congress adopted as part of the Medicare Part D program.

The conditions needed to achieve a reformed and well regulated private market will be challenging enough without attempting to introduce public plan options that risk destabilizing the insurance market at the time when it will be undergoing significant change and meeting demanding new standards. Moreover, we are confident that responsible federal insurance reform standards will lead to wide availability of private health plan options in all parts of the country, as it did for plans providing the Medicare prescription drug benefit. In this regard, it is very encouraging that the private insurance industry has already expressed its clear support for the range of reforms (e.g. guaranteed issue and renewability, prohibitions on pre-existing condition exclusions, etc.) that are needed and that acceptable in a system in which everyone has the obligation to obtain coverage.

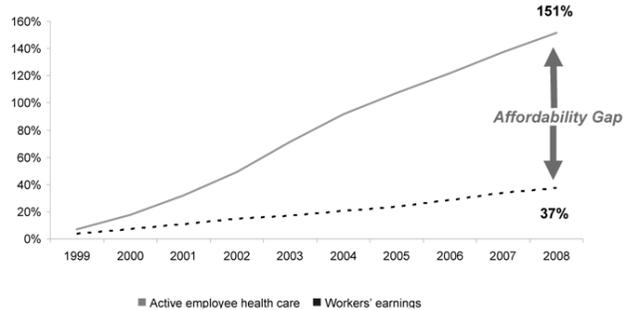
The appropriate role for public health insurance programs is to complement, rather than compete with, private health plan options. Our vision of health reform calls for improvements in both private health insurance products, especially in the individual insurance market, and in public programs. Both 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

According to the most recent Towers Perrin survey of health care costs,⁹ 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, the 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 eight 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 erosion of 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.

Reform Through System-Based Savings

The Council's Condition Critical report includes numerous recommendations directed at achieving higher quality, more affordable health care.

Reduced Costs Through Increased Quality of Care

Health care may be the one service or product in the United States, where many purchasers routinely and willingly pay as much, or more, for poor quality as for good quality. Notably, some of the largest contributing—and most controllable—factors fueling the rapid rise in health care costs are the uneven quality of care and a system that too often provides unnecessary, ineffective, or insufficient treatment.

The Council believes there are a host of reforms that can be undertaken to increase the quality of care, and that will also result in significant cost savings system-wide. They include the following:

- Implement nationwide interoperable health information technology. Providers and other stakeholders must be linked to ensure that patient records and other information are readily available. Overall, the health care system lags far behind other industries in the use of information technology to advance efficiency, consistency and safety.
- Provide safe harbor protections for health care providers and payers for decisions and practices that are evidence-based. Determinations that are consistent with consensus-based quality measures or comparative effectiveness research should be protected by liability safe harbors.
- Establish a national review process to rigorously examine existing and proposed state and federal benefit mandates. This review process should aim to sunset existing benefit mandates that are not evidence-based, consistent with best practices in benefits design and clinical care, or are contributing unnecessarily to increases in health care costs.
- Promote personal wellness and ownership for maintaining a healthy lifestyle. Incentives should be strengthened for the expansion of benefit plans, workplace wellness programs and educational programs that promote wellness and encourage greater personal responsibility for adopting a healthy and safe lifestyle.
- Increase participation in chronic disease management programs. The availability of, and participation in, focused care management initiatives to address chronic diseases and other health care priorities should be significantly expanded.
- Expand the understanding and availability of appropriate end-of-life care options. Best practices research should be expanded to assist patients, families, health care providers and other caregivers in considering therapeutically appropriate end-of-life care options.

Increased Savings Through Transparency in Pricing and Quality

Another area where system-based reforms can deliver significant cost savings is by making price and performance information more easily accessible, so consumers can identify providers with a proven record of delivering high quality care. A more transparent system also gives health care providers needed tools to evaluate their

performance and encourages continuous quality improvement. A transparent health care system provides incentives to move consumers and health care providers in the direction of evidence-based care by relying on clear, objective information on treatment options and costs. Transparency also protects patients from unsafe or unproven care. Finally, while consumers should certainly be armed with information to identify high performance health care providers, they should also be able to steer clear of those with high rates of medical errors or who fail to deliver evidence-based care.

Employers play a unique role in making the health care system more transparent by working with health care providers, insurers, consumer groups and government officials to help identify and disseminate the type and amount of information needed for better health care decision making. Many employers have developed effective incentives to encourage broad employee participation in a wide range of health improvement initiatives. This experience will be essential in creating a critical mass of users of cost and quality information in order to establish a consumer-centric health care system.

The following changes can help increase transparency, thus leading to better, more informed health care purchasing decisions and significant cost savings for the system as a whole:

- Design and implement consensus-based quality and cost measures. Public-private partnerships representing major health care system stakeholders have proven to be effective in developing initial sets of quality measures. Cost measures should also be developed based on episodes of care rather than unit prices for components of health care services.
- Transform the current payment structure from a procedure-based, fee-for-service system to a value-based system. Health care providers should be rewarded by a payment system that initially provides financial incentives for routine reporting of quality and cost information based on nationally adopted consensus measures. Ultimately, health providers should be rewarded for their demonstrated performance in the delivery of quality care, rather than simply the volume of services provided.
- Foster continuous improvement by health care providers. Health care providers should be equipped with comparative clinical performance information to support continuous improvement in patient care.
- Expand the use of consumer incentives in a broader range of health plan options. Health plans should provide incentives for plan participants to choose services from health care providers who deliver care consistent with consensus-based quality measures and demonstrate a commitment to quality improvement. Greater use of “consumer-directed” plans is one such strategy to achieve this objective.
- Expand the practice of nonpayment for serious preventable medical errors. All payers for health care services should adopt the practice, used by Medicare, where no payments are made for certain serious preventable medical errors, also known as “never events”. A consistent response by all public and private payers to end such payments will lead to more effective internal controls to improve patient care and safety. Health care providers also should be required to report all medical errors as a condition of payment by Medicare.
- Establish a national entity with a broad-based governance body to significantly increase the capacity for independent, valid comparative research on clinical and cost effectiveness of medical technology and services. Rigorous comparative effectiveness research is needed to examine clinical and cost evidence to support decisions on medical technology, treatment options and services to help ensure that more patients receive the right care for their condition.

All of the above-mentioned proposals are systemic improvements that should generate cost savings that can be used as part of a fiscally sound approach to overall health system reform. In addition, reform of medical liability rules that address unwarranted attorney’s fees and excessive damage awards is an important component of legal system reform that will have beneficial affects on the health system in terms of reducing the need for unneeded tests and procedures that are performed not because of any medical necessity but purely as a means of curtailing the risk of medical malpractice lawsuits.

Shared Responsibility

There is broad national consensus that we need health reform. The Council strongly shares that view. We do, however, believe that the costs associated with health reform should be shared equitably by all stakeholders within the system. Although the proposals to finance health reform do not lie directly within the purview of the Education and Labor Committee, we appreciate that all three committees of jurisdiction are working closely with one another and therefore we wish to share our thoughts on these matters for the formal hearing record.

Significantly, employers and employees already expend a significant amount of financial resources to ensure that employees and their families have health coverage. In 2007, employers as a group paid an astounding \$530+ billion for group health plan coverage for their workers and their families.¹⁰ On average, this amounted to \$9,325 per employee for family coverage in 2008.¹¹ Notably, employees have also been working hard to pay their share of our nation's health care burden. In 2008, in addition to the employer premium contributions noted above, employees paid on average \$3,354 towards the premium costs associated with their employment-based health coverage.¹² Accordingly, to the extent that additional revenue sources are needed, after taking into account those generated from system-based changes, Congress should acknowledge that employers and employees already are contributing a substantial sum.

On a related note, given that the costs associated with health reform will not be insignificant, Congress should ensure that any reforms are both desirable and effective. History has shown that where the American taxpayer is asked to "foot the bill," reforms enacted without deliberate consideration can result in taxpayer disapproval, unanticipated additional costs and even wholesale repeal of the reform. Perhaps the best example of this is the enactment and prompt repeal of the Medicare Catastrophic Coverage Act in the late 1980s.¹³ The reform was intended to help our aging population enhance Medicare coverage, and was to be paid for by Medicare-eligible individuals in the form of higher Medicare premiums. Once enacted, however, many of these individuals were soon confronted with higher premium costs for a benefit they were already receiving from other sources or did not desire. With widespread and growing dissatisfaction among seniors over the change, Congress eventually repealed the measure.¹⁴

Undoubtedly, Congress recalls the lessons learned by this experience. Even where reforms are based on lawmakers' best intentions, if the reform is not one valued or desired by the American public, especially where we are asking them to pay for the reforms in the form of higher taxes or reduced employer-based benefits, this can lead to an unsustainable system of changes.

Notably, in the Medicare catastrophic example, many of the benefit improvements were lost when the financing mechanism proved unsustainable and the law was repealed. With comprehensive health care reform, if we fail to move in a reasoned and fiscally sound manner, it is likely to be very difficult, if not impossible, to undo any unintended negative consequences. Accordingly, the Council urges Congress to carefully consider any and all legislative changes only if economically and politically sustainable sources of financing are available.

Capping the Exclusion on Employer-Provided Health Coverage

There has been considerable discussion as to whether the employee exclusion for employer-provided coverage should be modified. Some have suggested that the value of the current employee exclusion should be limited or otherwise "capped"—either by limiting the amount of the exclusion to some specific amount—thereby taxing employer-paid coverage in excess of such amount—or by allowing the availability of the employee exclusion only to persons with incomes below a certain threshold.

It would be a mistake to limit or otherwise undermine the exclusion. Accounting for less than 10% of our annual health expenditures, there can be little doubt that the employee exclusion makes possible essential coverage for a significant majority of American families. Limiting the exclusion based upon the cost of some level of coverage raises a number of issues:

- Geographical differences in cost. In order to ensure that all individuals are taxed fairly, any limit to the employee exclusion would need to take into account the very real variations in cost depending on where an individual resides. Unless this reality is taken into account, any limit on the current employee exclusion would operate as nothing more a tax on individuals who live in higher-cost areas. But even those in lower-cost areas might not be protected. For example, if an individual works for a large multi-state employer, with most of its employees in high cost areas, such individual might be subject to tax because the insurance cost for the group as a whole is generally higher.

- Differences in age among employees. Any limit on the employee exclusion could penalize workers based on age. Most notably, older workers likely would be subject to a higher tax than younger workers because their coverage generally costs more. Additionally, younger workers who are employed by a company with a comparatively older, more expensive workforce, likely would be taxed more than their counterpart sat another company with an overall younger workforce.

- Family and other coverage classes. Almost all employers provide a set number of classes of coverage. They can be as few as self-only coverage or self-only and family coverage. Alternatively, they can be more numerous, based on an individual's

specific number of dependents (such as employee +1 dependent, employee +2 dependents, employee +3 dependents, etc.), although most employers have some upper limit at which all persons with this number or more dependents are all placed within the same class for purposes of determining their premium cost. Unless any limit on the exclusion takes this fact into account, it is quite likely that the limit could treat people inequitably because, for example, all persons who are enrolled in family coverage with a given employer would likely pay the same tax even though persons with fewer dependents effectively have much less valuable coverage than those with more dependents.

- Treatment of multi-state plans. In order for any limit not to result in tax inequities, an extraordinarily complex set of rules would need to be devised to specify if, and how, multi-state employers can combine worksite employee groups for purposes of valuing and pricing health insurance. Without such rules, workers whose employers combine their workforces from high cost areas would be more likely to run afoul of any limit on the employee exclusion than workers whose employer combines workforces from high and low cost areas for purposes of valuing and pricing health coverage. Complexity and inequity would result.

- Indexing. Unless any limit on the current employee exclusion is indexed using an appropriate measure that reflects real cost increases, any such limit is unlikely to keep pace with increasing health costs. The end result would be that the tax benefits delivered vis-a-vis the employee exclusion in Year 1 would be less in each subsequent year. Notably, this is, in part, how the Bush Administration's health reform proposal was scored as revenue neutral over 10 years, by indexing the proposed standard above-the-line deduction based on the overall Consumer Price Index (CPI), not the health factor of the CPI, which is a much more reliable indicator of annual health cost increases.

Some have suggested that a "cap" on the amount of the exclusion and/or the absence of any meaningful indexing would help contain health costs. It is true that changes in the employee exclusion would likely make health care more expensive for employees and that generally when you make something more expensive people tend to use less of it. If only it were that simple when it comes to health coverage! It is hard to imagine that employers or employees need any additional incentives to try and reduce health care costs. It is unclear whether such cost containment would in fact be realized. We doubt that the nation would want to experience diminished health care coverage based on such an untested theory.

As the above discussion is intended to demonstrate, it would be very difficult, if not impossible, to design a limit to the current employee exclusion that did not result in tax inequities and/or require a burdensome and costly set of valuation rules for employers and workers. Notably, this was tried once before with the enactment of Internal Revenue Code Section 89 and it was famously unsuccessful. Despite best intentions, the statutory and regulatory regime established by Congress and the Treasury Department for purposes of valuing employer-provided health coverage proved completely unworkable. The regime was extremely expensive and burdensome for employers to administer and would have resulted in diminished coverage for American workers. Congress was left with no choice but to repeal section 89 just as the law was going into effect after employers had wasted countless millions of dollars in a futile effort to comply with a set of ill-advised requirements.

One reason the valuation rules were so complex under section 89 is because there is great diversity among employer plans. This diversity is driven in large part by employer innovations in plan design fashioned to provide the coverage that best meets a workforce's specific coverage needs. So quite apart from the cost and complexity that section 89 imposed on employers, had it gone into effect, it would have stifled innovation and inexorably led to coverage that was less responsive to workers' needs.

A limit on the exclusion based not upon the extent of coverage, but rather on the income of the family receiving such coverage has its own set of complexities and inequities. It is essentially nothing more than an effective tax increase on higher-income individuals, just a less straightforward and explicit one. This is because the value of any employer-paid coverage would be taxable to such individuals as additional W-2 wages. One can only begin to imagine the complexities and inequities that would result from imposing a tax on families who incomes are above the specified threshold, but whose members have differing levels of health coverage from multiple sources. Limits on the employee exclusion undoubtedly would have a destabilizing effect on the employer-sponsored health coverage system. An even more obvious and greater destabilization of the system would result if limits were imposed on employers' ability to deduct health care expenditures.

Conclusion

These are times of extraordinary economic turmoil and challenges. If approached with great care, addressing the nation's health policy challenges can be an integral element of—rather than an obstacle to—economic recovery and achieving personal financial security. The American Benefits Council stands ready to continue providing information and the perspectives of the companies and professionals who are designing, administering and paying for health plans providing comprehensive health coverage for workers and their families. We thank you for the opportunity to serve the Congress as you undertake the important task upon which you have embarked.

ENDNOTES

¹AMERICAN BENEFITS COUNCIL, CRITICAL CONDITION: TEN PRESCRIPTIONS FOR REFORMING HEALTH CARE QUALITY, COST AND COVERAGE (2009), available at <http://www.americanbenefitscouncil.com/documents/condition-critical2009.pdf>.

²NATIONAL COALITION ON HEALTH CARE, HEALTH INSURANCE COSTS (2008), available at <http://www.nhc.org/documents/Cost%20Fact%20Sheet-2009.pdf>.

³See *id.*

⁴Elizabeth McGlynn et al., The Quality of Health Care Delivered to Adults in the United States, 348:26 NEW ENG. J. MED. 2635 (June 26, 2003), available at <http://content.nejm.org/cgi/content/full/348/26/2635>.

⁵NATIONAL COALITION ON HEALTH CARE, HEALTH INSURANCE COSTS (2008), available at <http://www.nhc.org/documents/Cost%20Fact%20Sheet-2009.pdf>.

⁶KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE (2007).

⁷THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY (2008), available at <http://ehbs.kff.org/>.

⁸MASSACHUSETTS DIVISION OF HEALTH CARE FINANCE AND POLICY, COMPREHENSIVE REVIEW OF MANDATED BENEFITS IN MASSACHUSETTS REPORT TO THE LEGISLATURE (2008), available at <http://www.heartland.org/custom/semod-policybot/pdf/23617.pdf>.

⁹TOWERS PERRIN, HEALTH CARE COST SURVEY (2008), available at <http://www.towersperrin.com/tp/showdctmdoc.jsp?url=Master-Brand-2/USA/Press-Releases/2008/20080924/2008-09-24b.htm&country=global>.

¹⁰EMPLOYEE BENEFIT RESEARCH INST., EBRI DATABOOK ON EMPLOYEE BENEFITS tbl.2.2f (2009), <http://www.ebri.org/publications/books/index.cfm?fa=databook>.

¹¹THE KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY (2008), available at <http://ehbs.kff.org/>.

¹²*Id.* This amount reflects the portion of the premium paid by an employee for coverage for a family of four.

¹³Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360.

¹⁴Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234.

Chairman MILLER. Mr. Vaughan.

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

Mr. VAUGHAN. Thank you for inviting us to testify.

With Consumers Union, the independent, non-profit publisher of Consumer Reports, we don't just test tires and toys. We try to help people with good medical products, and we are enthusiastic users of comparative research to help consumers save money and get the cheapest but most effective and safest drugs. And, Dr. Cassidy, we would go with that \$20 generic over that purple pill because they are scientifically equivalent.

We for a long time advocated health care for everybody, and we have written to our subscribers saying that it has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is how soon.

That, unfortunately, is our 1939 auto issue. Seventy years. Chairman Andrews, you were saying 50 years. I would argue 70 years. And if we had only had reform—this was the old Dingell

dad's bill, Wagner-Dingell, we were endorsing. If we had passed that, I think some of the auto plants of northern Ohio and Michigan would still be making the great models that are in this issue.

We think that not only would it be good for the industries of those States but, more importantly, the Institute of Medicine has noted that each year about 18,000 people die prematurely and unnecessarily because of not having health insurance. And when you think about it, since this magazine issued, about twice as many people have died from not having health insurance as were killed in World War II and all of our conflicts since.

So it is so far past time to do something, and this will be one of the great Congresses of all time if you can pass a good bill. And we think the draft bill that you have before you is such a bill. We are pleased to endorse its principles and intent. We assume there will be some more savings or regressive financing to make it budget neutral and sustainable. But this is a bill that would bring health security, peace of mind, affordable and comprehensive care to American families.

There are too many good things in the bill to list in a 5-minute statement, but there are some that haven't got a lot of attention.

Mr. Scott had mentioned well baby care. That is a benefit spelled out on page 25. And Dr. Price and the other doctors who take on Medicaid patients, which is basically charity care now, you do the rates you are reimbursed for primary care, you will be paid a lot more, and I think that is important.

Major nursing home reforms for quality, exposing the flood of drug and device money to doctors in medical schools that we think can so often distort medical practice, and promoting primary care and the training of new doctors. So the bill is filled with these kinds of provisions.

Our testimony lays out our health care reform principles from our August magazine and how well the bill matches with those, and it is a great match. So we thank you.

A bill this size, you would be shocked if we didn't have a few subjects for small improvements, and we hope you will consider them.

One is help consumers drive towards quality more. We have been here for about 4½ half hours, and that means that about 51 to 52 fellow Americans have died of hospital-acquired, health-care-acquired infections. During the course of the day, it is an Air France plane crashing. We need to know more about how hospitals do in fighting these infections and help consumers with that kind of public information.

And the other thing is both the Chamber and ERIC spoke about consumers being better shoppers. We are lousy health insurance shoppers. We leave a lot of money on the table. We are confused by the whole process. If you give us exchanges where the insurance definitions are identical, where we can compare hospitalization means hospitalization, not starting on the second day or some fine print like that, and if you make the plans more like Medigap policies so that people can shop on identical plans, then we can drive price and we can move towards quality.

But thank you very much, and good luck in this wonderful project you have started.

Chairman MILLER. Thank you.

[The statement of Mr. Vaughan follows:]

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

Consumers Union is the independent, non-profit publisher of Consumer Reports. We strongly endorse the approach taken in the Tri-Committee Draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, “peace of mind” health insurance for every American.

The Draft has too many major improvements to list separately. A table in the testimony lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues.

Of course, in a bill this size, we have a few suggestions for ways to make it even better. (You’d be shocked if we didn’t!) But these are minor suggestions compared to the important reforms proposed in the bill:

- We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors.
- If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties. We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition
- Consumers are desperately worried about the high cost of health care. We hope you can do more to obtain savings. We will be forwarding a separate set of ideas for major savings, particularly in the pharmaceutical sector, imaging and self-referral abuse, and ensuring the operation of the Medicare Secondary Payer program, etc.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings.

Mr. Chairman, Members of the Committee: Thank you for inviting Consumers Union to testify on the Tri-Committee Draft health care reform proposal.

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

We not only evaluate consumer products like cars and toasters, we evaluate various health products, and we apply comparative effectiveness research that can save consumers hundreds and even thousands of dollars in purchasing the safest, most effective brand and generic drugs.²

- Since 1939 we have been advocating for an affordable, secure, quality health insurance system for everyone.
- Our national polls have frequently shown that the high cost of health care is one of the greatest concerns for consumers, and many fear they would be bankrupted if a major medical problem hit their family.
- 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 with a financial disaster. One of the most prevalent stories we have heard from our readers is that they thought they had good insurance—until they had a major health problem, and then it was too late.
- Our about-to-be-released August issue includes a 10-page special editorial feature, using examples of families across the country, on why American consumers so desperately need comprehensive reform. We’ve attached a copy of this special issue.

Tri-Committee Draft

Therefore, we strongly endorse the approach taken in the Tri-Committee draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, “peace of mind” health insurance for every American.

The Draft has too many major improvements to list separately. The following table lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues.

Consumer Union Goals in Health Reform	Tri-Committee Draft
Ensure health access to every American: Make insurance simple by creating a national health insurance exchange where one can always go—regardless of one's health or situation in life—to choose a private or public plan, with sliding scale subsidies based on income to make it affordable.	The Health Insurance Exchange, with reformed private policies (guaranteed issue, no pre-existing conditions) and a public plan option, with premium and cost-sharing subsidies phasing out at 400% of poverty, achieve this goal. Those who have good plans today can keep what they have.
The insurance offered should be comprehensive, bringing financial security and peace of mind.	The minimum standard benefit package (and at least 2 distinct, more valuable options), with no yearly or life-time limits and with out-of-pocket catastrophic protection at \$5,000 for an individual and \$10,000 for a couple, would achieve this goal. The low-income get even more protection.
Coverage should be especially good for preventive care.	The packages all include comprehensive preventive services; Medicare is improved to make preventive care more affordable; and a new Wellness and Prevention Trust Fund would help spur community wellness.
Eliminating pre-existing conditions and guaranteeing issue can't work for insurers, unless everyone has to have insurance. But we can't force people to buy policies they can't afford or that are inadequate, so subsidies are needed. And a public plan option working on a level playing field can use competition to minimize the need for subsidies by holding costs down and driving quality up.	The individual mandate to have at least the 'Essential' benefit plan, coupled with subsidies, and efforts to control cost, achieve this goal. Cost containment includes the public plan option, medical loss ratio requirements, comparative effectiveness research, form simplification, stepped up anti-fraud, stopping drug and device company 'gifts' to providers, new ways for doctors to deliver quality coordinated care, and implementation of MedPAC recommendations. Consumers Union urges even more be done to control costs.
Increase quality and help consumers choose quality, by making error rates public, particularly infection rates (largely preventable infections kill 100,000 Americans per year).	Division B's Section 1151 reduces payments for hospital readmissions due to poor quality and section 1441 establishes a new center to set priorities for quality improvement. State Medicaid plans are rewarded for not paying for poor care such as infections. We hope it is clearer that infection rates are to be public on a facility specific basis, and that more is done to report 'never events,' and require periodic quality recertification of providers, per the recommendations of the IOM.
Encourage care based on quality, not just quantity, and help spread the use of electronic medical records.	Efforts to develop accountable care organizations and medical homes will help ensure better care coordination. The Stimulus package HIT monies should help productivity over time and improve quality.
Encourage more primary care doctors.	The Draft's major sections on the workforce, graduate medical education, and increased payments to primary care doctors should all help.
Help small businessmen get affordable health insurance for themselves and their employees.	The Health Insurance Exchange will make policies more affordable; subsidies to small and lower wage firms will make it affordable.

Areas Where We Hope More Refinement Can Occur

Of course, in a bill this size, we have a few suggestions for ways to make it even better. (You'd be shocked if we didn't!) But these are minor suggestions compared to the important reforms proposed in the bill.

On quality

We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors. Consumer pressure can inspire providers to focus more on preventing infections and other errors—but first, consumers need to be informed.

Ten years ago, the Institute of Medicine issued its report, *To Err is Human*, noting that medical errors were killing up to 98,000 people a year and costing the health system tens of billions in unnecessary costs. The CDC now says that 100,000 are dying just from largely preventable infections, which add an extra \$35.7 to \$45

billion per year in treatment costs. No one can say whether anything has really improved over the last decade: the IOM's recommendations have been largely ignored.

We urge you, in addition to the 7 hospital re-admission conditions discussed on page 222 of the Draft, to include public reporting of healthcare-acquired infections such as MRSA and other deadly conditions. We also hope you will take another look at the IOM report, and move to require public reporting of 'never events' (like surgery on the wrong part of the body) the way Minnesota has done. It is way past time to adopt the IOM's proposals for periodic quality re-certification of providers. We retest pilots and others for competency—we should retest providers on a periodic basis. Finally, we urge you to consider some of the excellent language in the Senate HELP bill to improve our nation's failing Emergency Medical Systems.

Do More to Help the Consumer in the Health Insurance Exchange

The honest, sad truth is that most of us consumers 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.³

- 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.⁴

- 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 covering the same drugs.⁵

- 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.⁶

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.⁷ Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties as follows:

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition. The Draft bill provides 3 broad categories of policies, and we appreciate the fact that these broad groupings will be helpful to consumers. But like Medigap policies A-L, we urge you to make the policies sold in each of these broad categories identical, so that consumers can shop on the basis of price and quality, and not on tiny, confusing differences (10 rehab visits v. a plan with 12, etc.). To only require these broad groupings to be 'actuarially equivalent' is to invite a Tower of Babel of tiny plan differences, designed by the insurers to attract the healthy and avoid the most expensive—and with the end result of confusing the consumer.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.⁸ 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.⁹ 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.

In the past, 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 prevent the proliferation of many plans with tiny differences that just serve to confuse a consumer's ability to shop on price and quality.

- Require standardization of insurance definitions 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. Attached on the last page of this testimony is an article from our May magazine which demonstrates what radically different coverage two similar sounding policies can provide. It is not clear that the "benefit standards defined" (p. 29, line 11) will guarantee comparability of terms among plans.

- Require insurers to clearly state (in standardized formats) what's covered and what's not in every plan offering, and to estimate out-of-pocket costs under typical treatment scenarios. 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.¹⁰ HR 2427 by Rep. DeLauro and Rep. Courtney and 23 others is excellent language on how to design such 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. 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-Ingenux 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 HIE connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public.

- 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.

- 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 appreciate the requirement in Sec. 132 for ‘fair grievance and appeals mechanisms,’ but urge that the Commissioner, perhaps with the help of the NAIC, develop a model system that all participating insurers have to use.

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, especially if the research takes into consideration relevant differences such as gender, ethnicity, or age. 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 without hassle or delay. The key to this is ensuring that the nation’s insurers have honest, usable exceptions 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 Obtain Savings. Consumers are desperately worried about the high cost of health care. We hope you can do more to obtain savings. We will be forwarding a separate set of ideas for major savings, particularly in the pharmaceutical sector, imaging and self-referral abuse, and ensuring the operation of the Medicare Secondary Payer program, etc.

Conclusion

We thank you again for this opportunity to testify.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings.

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.	<p>Monthly premium for any 55-year-old: \$399</p> <p>Annual deductible: \$2,200</p> <p>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</p> <p>Co-insurance: 20% for some services</p> <p>Out-of-pocket maximum: \$5,000, includes deductible, co-insurance, and all co-payments</p> <p>Exclusions and limits: Cap of 24 mental-health visits, \$3,000 cap on equipment</p> <p>Lifetime benefits: Unlimited</p>	<p>Monthly premium for a healthy 55-year-old: \$246</p> <p>Annual deductible: \$1,000</p> <p>Co-pays: \$25 preventive care office visits</p> <p>Co-insurance: 20% for most covered services</p> <p>Out-of-pocket maximum: \$2,500, includes hospital and surgical co-insurance only</p> <p>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</p> <p>Lifetime benefits: \$5 million</p>

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

⁴ See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.

⁵ Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.

⁶ SeniorJournal.com, March 29, 2009.

⁷ HHS Office of Disease Prevention and Health Promotion

⁸ "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.

⁹ Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

¹⁰ Op. cit., p. 68.

Chairman MILLER. Dr. Moffit.

**STATEMENT OF ROBERT MOFFIT, DIRECTOR, CENTER FOR
HEALTH POLICY STUDIES AT THE HERITAGE FOUNDATION**

Mr. MOFFIT. Thank you very much, Mr. Chairman. I wish to express to you my deep appreciation to present my views this afternoon.

I hasten to add that the views I express today are solely my own. They do not necessarily represent the views of the Heritage Foundation or its officers or board of trustees.

You and your fellow committee members are considering an ambitious and comprehensive health care reform proposal. The draft bill contains both an individual and an employer mandate. As the Congressional Budget Office reported in 1994, an individual mandate on American citizens to purchase health insurance is unprecedented.

I deeply understand and appreciate the rationale for that mandate to offset the cost shifting and to address the free rider problem. Individuals do, in fact, have a personal responsibility to protect themselves and impose no unnecessary costs on the rest of us. Nonetheless, an individual mandate is a restriction on personal liberty; and given the fact that it is such a restriction on personal liberty, I think we ought to look for other opportunities to expand coverage, such as positive incentives combined with mechanisms to facilitate the ease of enrollment in health insurance, and that way achieve a dramatic reduction in health insurance.

I have suggested such alternatives in the Harvard Health Policy Review; and, with your permission, Mr. Chairman, I would like to submit those for the record.

Chairman MILLER. We will make that part of the file of the committee.

[The article, in the spring 2008 issue of the Harvard Health Policy Review, may be accessed at the following Internet address:]

<http://www.hhpr.org/currentissue/>

Mr. MOFFIT. And as for the employer mandate, the costs of an employer mandate are invariably visited upon employees, not employers, in the form of reductions in wages or other compensation or even a reduction in employment. In my view, it is inadvisable to impose a such a mandate, especially during a recession.

In the limited time available to me, I would like to focus my remarks on three key areas of the bill: the national health insurance exchange, the public plan and Federal regulation of insurance.

The concept of a health insurance exchange is hardly new. It has had only limited application at the State level. Some may argue that the Federal Employee Health Benefits Program, a defined contribution arrangement, is analogous to an exchange, a national exchange, but I would note that there is no government-sponsored health plan in the FEHBP, nor does the FEHBP have anything remotely approaching the statutory or regulatory regime that is embodied in the draft bill.

The former Governor of Massachusetts, Mitt Romney, and State officials who framed the major 2006 reform in Massachusetts developed an exchange. One of the key advantages of that State-based

health insurance exchange called the Connector, which one of my colleagues is involved with, is that it would allow employers and employees in small businesses to get access to personal and portable health insurance tax free. In other words, since the coverage would be available through the exchange and because the exchange itself would be considered group coverage, it would enjoy the powerful advantages of the existing Federal tax treatment of health insurance.

In my own view, the health insurance exchange is an excellent idea. It should, however, be aggressively promoted as a State institution at the State level.

With regard to the public plan, the bill proposes that the Secretary of the Department of Health and Human Services establish the public insurance plan and it is to play on a level playing field in plain language of the bill. However, I would add that in basing the public plan's payments to providers on Medicare payment rates, which are routinely set below those of the private sector, as Professor Hacker pointed out, the public plan would enjoy an advantage over competing private health plans. Independent analyses show that the use of Medicare payment rates would result in an erosion of existing private health insurance.

I would add just one more point with regard to this issue of the level playing field. It has been said constantly. If you are serious about a level playing field, that means that all of the rules and regulations that apply to private health insurance must apply, must apply to the public plan. If Congress wishes to achieve a level playing field between public and private health plans, then the public health insurance option—just like any other private option—should be allowed to compete for market share and also be allowed to fail. That means without being kept on artificial life support through the infusion of taxpayers' money. That would be a key test of congressional commitment to a level playing field.

With regard to Federal benefit setting, under Title I of the bill the Congress would require every American to have health insurance coverage that Congress would define as acceptable. The bill specifies various standards.

I would only say in closing that my concern about the Federal benefit setting is that you may very well undermine the creativity of States in an insurance market reform. States as culturally and politically different as Massachusetts and Utah have undertaken some very far-reaching and consequential reforms. Those kinds of experimentation and innovations should be encouraged.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

[The statement of Mr. Moffit follows:]

Prepared Statement of Robert E. Moffit Ph.D., Director, Center for Health Policy Studies, the Heritage Foundation

Mr. Chairman and Members of the Committee: My name is Robert E. Moffit. I am Director of the Center for Health Policy Studies at the Heritage Foundation. I wish to express to you my deep appreciation for the opportunity to present my views to you today on major legislation governing the future of the large and growing health care sector of the American economy, now approximately 17 percent of the Gross Domestic Product. I hasten to add that the views that I express today are solely my own, and they do not necessarily represent the views of the Heritage Foundation, its officers or its Board of Trustees.

The Committee is considering ambitious and comprehensive legislation. It covers an enormous range of policy items and issues. Provisions cover the reform of the health insurance markets, the composition of health insurance benefits packages, and health insurance premium and payment policy; new legal obligations on employers and employees to purchase health insurance; the creation of new federal agencies and entities, such as the Health Choices Administration administered by a Health Choices Commissioner, the creation of a new public health insurance option, and new responsibilities for the Secretary of the United States Department of Health and Human Services; new subsidies for individuals and employers, changes to traditional Medicare and Medicaid, Medicare Advantage and the Medicare prescription drug program; new federal policies governing the provision of primary care, prevention and wellness, mental health care, and coordinated care; new quality initiatives and comparative effectiveness research, new initiatives to combat waste, fraud and abuse; new public health initiatives, public health and workforce development, community health centers, and policies governing the health care workforce.

Needless to say, in the next few days and weeks, a variety of independent analysts, as well as the staff of the Congressional Budget Office and others, will have an opportunity to examine the impact of these and other provisions in greater detail.

The draft bill contains both an individual and employer mandate. As the Congressional Budget Office reported in 1994, an individual mandate on American citizens to purchase health insurance is unprecedented. While President Obama has recently stated that he is open to the imposition of such a mandate, his earlier reasoning for opposition should not be forgotten, as he noted that it would be unenforceable as a mechanism to secure universal coverage and that he thought it inappropriate to force Americans to purchase coverage that they determined they could not afford. I appreciate the rationale for the mandate as a means to offset cost-shifting and as a remedy for the "free-rider" problem; individuals have a personal responsibility to protect themselves and impose no unnecessary costs on the rest of us. Nonetheless, an individual mandate is a restriction on personal liberty, and that the use of positive incentives combined with new mechanisms to facilitate ease of enrollment can achieve the broader goal of dramatically expanded coverage. I have suggested such alternatives, and, with your permission Mr. Chairman, would like to submit them for the record.

Since most Americans under the age of 65 are today enrolled in employment-based health insurance, it is easy to see why so many policymakers are enamored by the idea of an employer mandate. I would simply remind the Committee that the costs of an employer mandate are invariably visited upon employees in the form of reductions in wages or other compensation or even a reduction in employment. It is inadvisable to impose such a mandate, especially during a recession.

In the limited time available to me, I would like to focus my remarks on three key areas: the establishment of a national health insurance exchange, the creation of a public plan to compete with private health plans in that exchange, and the creation of a new authorities for the federal government to standardize and regulate health insurance, and a process for federal officials to define and refine the health benefits that will be available to American citizens.

The Health Insurance Exchange. Under Section 141 of the bill of Title II, Congress would create a new independent agency, the Health Choices Administration. The new agency would be headed by a Health Choice Commissioner appointed by the President with the advice and consent of the Senate. Under Section 142, listed among the many duties of the Commissioner, would be the establishment and operation of a Health Insurance Exchange. Under Section 201 of Title II of the bill, the Congress would create the Health Insurance Exchange in order to "facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable quality health insurance, including a public insurance option."

Under the terms of the provision, the Commissioner would establish "standards for, and accept bids from", "qualified health benefit plans", and negotiate and enter into contracts with these qualified health benefit plans, which must offer at least three different levels of benefits that are statutorily required with a high degree of specificity.

Under Section 202, the bill says that a person is eligible to enroll in the exchange unless that person is enrolled in another qualified health benefit plan or other statutorily defined "acceptable coverage" For the enrollment of eligible employers and employees, and individuals, the bill provides a three year transition period for the categories starting with the smallest employers (with ten or fewer workers), to the smaller employers (20 or fewer workers) and to larger employers. The bill specifies that individuals, with some exceptions, who are enrolled in existing government

programs such as Medicare, Medicaid, the military health programs (“Tri-Care”) and the Veterans Administration (VA) program are ineligible for enrollment in the Health Insurance Exchange. A noteworthy exception to this set of categorical exclusions are what are deemed “Non-Traditional” Medicaid enrollees, persons who had a “qualified health plan” or who were enrolled in a “statutorily grand-fathered” health plan (an individual or group insurance plan) in the previous six months. The several states, under certain conditions, are also given the opportunity to enroll Medicaid beneficiaries in the Exchange.

Under Section 203, The Commissioner “shall specify the benefits” to be made available in the Exchange for “Exchange Participating Plans” each year, but these specifications are to be consistent with other health benefit requirements that are elsewhere established in the statute. The provision also prohibits the Commissioner from entering into a contract with an insurer unless the insurer offers the three benefits levels that are required by statute: the “basic”, “enhanced” or “premium” benefit plans for the service areas in which they offer coverage.

Under Section 204, the Congress would enact standards for the insurers who offer qualified health benefit plans that are eligible to participate in the Exchange. Specifically, they must be licensed under state law where their insurance coverage is offered; they must report data and other information to the Commissioner that he may require; implement the “affordability credits” that are offered to enrollees; accept all eligible enrollees; provide “wrap around coverage” for Medicaid enrollees; participate in pooling mechanisms established by the Commissioner; contract with “essential community providers” as specified by the Commissioner; provide “culturally and linguistically appropriate services and communications” to enrollees; and comply with “other applicable standards” such as billing and premium collection practices, that the Commissioner may specify.

Interestingly, the plans participating in the Health Insurance Exchange would still be required to offer benefit packages within the states that they serve that comply with state legislative requirements for state mandated benefits. This is a significant requirement, inasmuch as there are today more than 2000 state mandated benefits and provider services that are required for inclusion in health insurance offerings. The number and cost, of course, vary significantly from state to state.

For insurers who participate, the initial contract is to be for not less than one year, but subsequent contracts with the Exchange may be automatically renewed from year to year.

Insurers would also be under statutory requirements to comply with “network adequacy” standards that are determined by the Commissioner, and comply with Commissioner’s standards and procedures for “grievances and complaints”. In the enrollment of persons in the Health Insurance Exchange, the Commissioner is not only required to provide comparative plan information, but also “shall establish “outreach activities for particularly “vulnerable” segments of the population, including adults and children with disabilities or cognitive impairments.

Under Section 207 of Title II, the Congress would create a Health Insurance Exchange Trust Fund. This new trust fund would contain monies appropriated by Congress, as well as a class of dedicated funds, including taxes levied on individuals who do not obtain “acceptable coverage” and employers who do not provide “acceptable coverage” to their employees and certain excise taxes on insurance.

Under Section 208, individual states, or a group of states, are permitted to set up a state based health insurance exchange or a multi-state exchange. But they can only initiate such an action with the approval of the Commissioner, and the Commissioner may only approve the creation of a state-based health insurance exchange only if they can demonstrate to the satisfaction of the Commissioner their capacity to undertake such an enterprise; contract with health plans that meet the federal health insurance benefit requirements and standards outlined under Title I of the bill; enroll the eligible employers and employees and individuals; and if they do not have another exchange already operating within the state. If the Commissioner determines that the state health insurance exchange does not meet federal rules and standards, the Commissioner can with notice, terminate the state exchange.

Comment. The concept of a health insurance exchange, to facilitate access to a choice of coverage for individuals and employers, especially small employers, is hardly new. It has had only limited application at the state level, though some may argue that the Federal Employees Health Benefits Program, a defined contribution arrangement that is characterized by a wide variety of private health benefit options (ranging from traditional health plans to health savings accounts, from relatively inexpensive health plans to very expensive benefit offerings), is analogous to a health insurance exchange. Of course, there is no government sponsored health plan in the FEHBP; nor does the FEHBP have anything remotely approaching the statutory or regulatory regime embodied in Title I and Title II of the bill.

In its practical application, a key policy question is whether policymakers want the health insurance exchange to serve as an administrative body or a regulatory body. They are widely different in their conception and practical effects. As an administrative body, an exchange would provide comparative information on prices, plans and benefits, facilitate enrollment of individuals and employees, collect and transmit premiums payments, and thus reduce the administrative costs for small businesses and thus the premium costs of the individuals and families employed by them. As an administrative body, the exchange would serve as a mechanism to permit a defined contribution on the part of employers for their employees, enabling them to pick and choose the health insurance plan of their choice while securing the existing tax advantages of group health insurance. This would enable individuals to buy and own the health plan they determine as best for them, and thus be able to take with them from job to job. This added portability in health insurance would, in and of itself, result in a dramatic reduction in the number of the uninsured, most of whom are persons who had coverage and lost it, and experience spells of un-insurance, in what is clearly an unstable and deficient health insurance market.

If the exchange is conceived as more than an administrative body, and is designed as another regulatory agency, it can become a mechanism to constrain personal choice and frustrate competition by limiting the kind and number of suppliers that can enter the market, and thus increase the costs of coverage.

It is not necessary to create a national health insurance exchange for the purpose of creating a national market for health insurance. The United States already has a national market for a variety of goods and services, and the distribution of those services is not contingent upon the creation of anything remotely resembling a national exchange for these goods and services. If Congress wanted to create a national market for health insurance, all it would have to do is repeal existing federal laws that are a barrier to such a market, and exercise its authority to promote interstate commerce under Article I section 8 of the Constitution, and authorize the U.S. Department of Commerce to issue such regulations as are necessary to ensure that promotion.

For state officials, such as those who framed the major 2006 reform in Massachusetts, one of the key advantages of a state based health insurance exchange (called "the connector") was that it would allow employers and employees in small business to get access to personal and portable health insurance tax free, since the coverage available through the exchange would be considered group coverage and thus enjoy the powerful advantages of the existing federal tax treatment of health insurance. If Congress wanted to assist individuals and families, particularly those employed in small businesses who do not have access to group coverage, and who are penalized by the federal tax treatment of health insurance if they attempt secure coverage outside of the place of work, then all Congress would have to do is to reform the federal tax treatment of health insurance, and guarantee tax breaks for individuals regardless of where they work, eliminate the inequities and disparities in the tax code and thus make health insurance affordable and available for everyone.

For lower income persons, those who do not have federal tax liabilities, the correct remedy would of course be the provision of generous assistance, either in the form of premium assistance, some sort of refundable tax credit or direct, income related subsidy to offset the cost of health insurance and thus guarantee coverage.

Health insurance markets differ radically from state to state. For some states, a health insurance exchange may be appropriate; for others, there may be other, perhaps more innovative options. Federal policy should recognize and accommodate that diversity among the states, and foster state creativity in finding workable solutions to coverage, especially for the most vulnerable, the poorest and the sickest who need the most help.

Finally, I would note that the draft bill vests extraordinary power in the hands of the Commissioner, including the power to decide what state or group of states can or cannot set up or manage or maintain a state health insurance exchange. Federalism is a remarkable constitutional achievement. It means that the national government and the state governments are each supreme in their respective constitutional spheres; that the encroachment of one upon the other violates the spirit of federalism, the unique division of power enshrined in our Constitution. This is not a federal state partnership; it is federal domination of the states. It is also a prescription that could, and probably would, undermine much needed innovation in the provision of new health insurance options.

The Public Plan Under Title II, Subtitle B, Section 221 of the draft bill, Congress would require the Secretary of the U.S. Department of Health and Human Services to establish a "public health insurance option" in the national health insurance exchange. In the language of the legislative text, the option is designed to ensure

“choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle.”

The range of competition for the new public plan is to be limited to the national health insurance exchange. In competing with private health plans, the public plan is to play on “a level playing field.” In the language of the legislative text: “The public plan shall comply with the requirements that are applicable under this title to an exchange participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.” Like private health plans competing in the exchange, the new public plan is to offer three types of coverage: basic, enhanced and premium coverage.

In terms of the rights of enrollees, the legislative text specifies that the same rights that are enjoyed by Medicare beneficiaries today will be extended to enrollees in the new public plan, and that these enrollees will have access to the federal courts for the enforcement of their rights in the same way that Medicare beneficiaries have access to the courts. This is a key provision defining the range of action available to enrollees in the public plan.

Under Section 221, the Secretary can enter into contracts for the administration of the public plan, but that contractual arrangement with these entities cannot “involve the transfer of insurance risk to such entity.” This is also a key provision.

The Secretary is also authorized to set premiums for the public plan: “The Secretary shall collect such data as may be required to establish premium and payment rates for the public insurance option and for other purposes of this subtitle, including to improve quality and to reduce racial and ethnic disparities in health care.” Under Section 222, the authors of the bill further specify that the Secretary “shall establish” geographically adjusted premium rates for the public plan that comply with the premium rules set by the Commissioner for private plans at a level “sufficient to fully finance” the costs of the benefits, the administrative costs and “contingency margins” of the new public plan. Within the Department of the Treasury, Congress would create an account to handle receipts and disbursements for the operation of the public plan, including the funds necessary for start up costs. Under Section 222, there is no other authorization for additional appropriations for the account. This is also a noteworthy provision, though there is nothing to prevent Congress from appropriating additional funds to the account.

Under Section 223, the Secretary is to establish payment rates for services and procedures under the public plan. Initially, these payment rates, under Section 223(2)(a) are to be based on the payment rates for medical services and providers under Medicare Parts A and B. The Secretary is given some leeway in adjusting or modifying payments rates, particularly for services, such as well child visits, that are obviously not covered under Medicare. Moreover, the rates for payment for prescription drugs will be “negotiated” directly by the Secretary. The Secretary is also to adopt anticipated payment reforms for the public plan, based on those initiated in the Medicare program designed to secure better value for taxpayer dollars.

Comment. In a normally functioning, consumer-driven private market, the price of goods and services is determined dynamically by the conditions of supply and demand, the goods and services available by suppliers and the demand for those goods and services. In a consumer driven health insurance market, the premium payments reflect a reasonable relationship between the benefits that are offered, including any discounted payments to providers, and the demand for those benefits.

In this case, the Secretary is to set premium payments in such a way that they would fully finance the benefits, as well as meet other goals, such as the provision of quality care and the reduction in racial and ethnic disparities. This would require the Secretary to go beyond an assessment of prevailing market conditions, and also do so in accordance with rules for premium payment set by the Commissioner. This is likely to be a challenge.

In basing the public plan’s payment to providers on the Medicare payment rates, which are routinely set below those of the private sector payment rates, the public plan would naturally enjoy an advantage over competing private health plans. Because, by law, the payment rates would be set at such a level, rather than at the market rates that would otherwise prevail on a level playing field, the public plan would be given a legal advantage in competition with the private sector plans. This would undercut the claim of a level playing field. Under Medicare, physicians, for example, are paid at a rate of 81 percent of average market rates. Independent analyses, by the Lewin Group and others, have shown that the use of Medicare payment rates would not only result in a significant reduction in revenues for doctors and hospitals, but also an erosion of private health insurance coverage.

The simplest way to achieve the stated goal of the level playing field is to require the public plan to compete for doctors and hospitals and other medical professionals

by negotiating market rates with such providers just like the officials of private health plans do routinely.

If one of the stated goals of the bill is to ensure a “level playing field”, there are other features of this legislation to be addressed. In Section 221, as noted, Medicare enrollees are to be given access to the federal courts in the same way as Medicare beneficiaries in securing their rights under the Medicare entitlement, presumably over the same range of questions and controversies as routinely apply in these cases. This may be necessary, but it is not a sufficient legal protection. First, private health plans are everywhere subject to various laws governing torts and contracts, and private health plans and their officers can be sued for contract violations or torts. To secure a level playing field, the same should apply to the public plan and its officers. This point should be clarified in statute, assuming the range of legal actions available to enrollees in the public plan are not to be limited. Second, private health insurance companies, as with other private firms, are subject to strict accounting standards governing liabilities and financial standards. Perhaps this is implied within the broad authority of the Commissioner to set rules for plan participation in the exchange; nonetheless, it should also be clarified that the public plan is subject to the same rules. Specifically, Congress should, under no circumstances, allow the public plan to accumulate the kind of massive un-funded liabilities that burden the current Medicare program, and threaten a crisis in the government’s entitlement programs. Third, as specified under Section 221, the Secretary is authorized to contract with administrators to carry out the functions of the public plan, but that contractual authority cannot involve the transfer of risk. This obviously means that the entire risk of the public plan will remain with the taxpayers, not the public plan itself, as a government-sponsored enterprise. Since private health plans competing with the public plan have no such taxpayer guarantee, regardless of the wisdom or folly of providing such a guarantee, the public plan would have an advantage incompatible with the goal of a level playing field.

In the final analysis, in competitive markets, where consumers’ preferences prevail, some firms are extraordinarily successful in offering individuals and families what they want, and other firms are not. On the level playing field, some firms are highly profitable and other firms rack up losses. In the field of health insurance, the history of the Federal Employees Health Benefits Program (FEHBP) is one of a free entry and exit of health plans. If Congress wishes to achieve a level playing field between public and private health plans, then the public health insurance option, just like any private health option, should also be allowed to fail, without being kept on artificial life support through the infusion of taxpayer monies. That would be a key test of congressional commitment to a level playing field.

Federal Benefit Setting. Under Division A, Title I of the bill, the Congress would require every American to have health insurance coverage that Congress would define as “acceptable coverage”. This is defined in Section 202 as coverage in a series of categories: a “qualified health benefits plan;” a “grand-fathered” health insurance plan (individual and group coverage in effect for individuals and groups during a specified period of time); coverage under Part A of Medicare, Medicaid, “Tri-care”, the Veterans Administration program, and “other such coverage” as the Commissioner, in consultation with the Secretaries of Treasury and Labor, shall define as “acceptable coverage”.

Under Title I, the bill specifies the various standards that must apply for a plan to be acceptable coverage, including “grand-fathered” coverage. Grand-fathered coverage, as noted, is coverage that persons and employers would have and would be in effect for a time to be specified, and it would be subject to specific limitations. There would be limitations on the enrollment in such a plan, limit on changes to any terms and conditions of coverage and premium increases. After a given period of time, individual health insurance, as it exists today, would no longer qualify as “acceptable coverage”. For group insurance, however, there would be a “grace period” for current group health coverage before such coverage would have to meet the new federal standards to be considered “qualified health benefits plans” that are in accord with federal benefit standards and levels.

Under Title I, Subtitle B, Sections 111-116, the Congress specifies standards for access for a plan to be designated as a “qualified health benefits plan”. These include a prohibition on pre-existing condition exclusions; guaranteed issue and guaranteed renewability of coverage; insurance rating limited to age, geography and family enrollment; “non-discrimination standards” to be set by the Commissioner; the adequacy of provider networks, to be determined by the Commissioner; and a federal minimum loss ratio.

Under Title I, Subtitle C, the bill specifies standards for access to “essential benefits”. Under Section 121, there is a distinction between standards for health plans that participate in the national Health Insurance Exchange and those who do not.

For plans that do not participate, they may offer coverage in addition to the “essential benefits” that are defined in statute. For health plans that participate in the Exchange, the health plans are required to offer “specified levels of benefits;” a more detailed and higher standard of compliance.

Under Section 122, the bill defines “essential benefits”. The provisions are subject to other provisions of the bill, however, that impose limits on cost sharing for covered items and services, and it would eliminate both “annual and lifetime” limits on services or covered health care items. The “minimum services” to be covered are: hospitalization; outpatient services; physicians services and the services of other health professionals; supplies and equipment incident to the provision of physician and hospital services; drugs; rehabilitative services; mental health and substance abuse; preventive services; maternity benefits; well baby and well child care; oral, vision and hearing services and equipment and supplies for children under 21 years of age. The bill specifies that there is to be no cost sharing for preventive services and well baby and well child care. It also specifies that preventive services are to be updated on the basis of the recommendations of the U.S. Preventive Services Task Force and vaccines to be included are those to be recommended by the Director of the Center for Disease Control and Prevention.

Under Section 123, the bill establishes a Health Benefits Advisory Committee, comprised of federal and non-federal employees, and chaired by the Surgeon General of the United States. The Committee would make recommendations on benefit standards, and specify the kinds of cost sharing that should be adopted in the basic, enhanced and premium health plans packages that participate in the Health Insurance Exchange. According to the legislative language, the Committee, in making its recommendations, “will take into account innovations in health care” and work to “ensure that the essential benefits coverage does not lead to rationing in health care”. This is a key provision.

Under Section 124, the bill specifies how the benefit recommendations are to be adopted. The Advisory Committee makes its recommendation to the Secretary of HHS. The Secretary then must review these within 45 days, and determine whether or not to adopt them and publish them in the Federal Register to become applicable to qualified health benefit plans. For health plans participating in the Health Insurance Exchange, the Commissioner would enforce federal benefit standards.

Comment. Health insurance is one of the most highly regulated sectors of the American economy. Today, with the exception of the ERISA and the provisions of the Health Insurance Portability and Accountability Act, the bulk of this regulation is within the jurisdiction of the states. The bill would concentrate enormous regulatory authority over health insurance in the federal government, where the content of health benefit packages, and even the levels of these benefits, would be under the direct authority of the Secretary of HHS and the Advisory Committee. The obvious problem is that this centralization of decision-making and the attendant special interest lobbying that must and will accompany it will almost certainly result in dynamics similar to what has taken place in state legislatures and agencies, where health benefit decisions are often highly politicized.

As in so many other areas of domestic policy, the states have been leaders in reform efforts, whether it has been education reform or welfare reform, providing graphic examples of progress, and a platform for change that can be further encouraged by federal authorities. In a search for a federal remedy, Congress ought to be wary of pre-empting progress in the 50 state capitols of this vast and very diverse country.

In health care reform, states as different, culturally and politically, as Massachusetts and Utah, have embarked on profoundly consequential and far-reaching health care reforms. Whatever one may think of the specific reforms in either state, there is no doubt that they are serious and they hold lessons for other states.

Finally, I would ask the Committee to consider the large areas of agreement that exist in Congress and the nation at large on health care reform. Americans agree that all citizens should have adequate coverage to protect them and their families against the financial devastation of catastrophic illness. Americans generally agree that the working Americans who have no health insurance at the place of work, particularly low income working Americans, should be the beneficiaries of direct assistance to enable them to get health insurance coverage. There is also increasing agreement, across the political spectrum, that we must end the inequities of the existing tax treatment of health insurance. No taxpayer should be denied tax relief, merely because of an accident of her employment.

Within Congress, there is widespread agreement, stretching the ideological spectrum from Democratic Representative Tammy Baldwin of Wisconsin to Republican Representative Tom Price of Georgia—that Congress would do well to encourage in concrete ways, with generous grants and technical assistance, state experimentation

and promote innovation in coverage expansions, improvements in quality of care, and the adoption of health policy proposals that best accommodate the very different cultural and political dynamics of the several states.

Thank you Mr. Chairman and Members of the Committee, I would be happy to answer any questions you may have.

Chairman MILLER. Ms. Young.

**STATEMENT OF RE SHONDA YOUNG, SMALL BUSINESS OWNER,
ALPHA EXPRESS, INC., ON BEHALF OF THE MAIN STREET AL-
LIANCE**

Ms. YOUNG. Chairman Miller, Ranking Member Kline, and other members of the committee. I am honored to be here today. I thank you for inviting me.

My name is ReShonda Young. I serve as operation's manager for my father's small business in Waterloo, Iowa. I am also a member of the Iowa Main Street Alliance, which is a coalition of small businesses across Iowa working for a solution on health care.

I am here today to share some experiences of an actual small business desperately trying to provide health care coverage for our employees.

My father started Alpha Express 20 years ago. When he started, it was him and one other person. Since then, we have grown to almost 40 employees. Now that my father is 68 years old, he is ready to retire for a second time; and we are hoping that my oldest brother will come back and help to run the business, because I do not want to do it by myself.

So as operation's manager for the business, I am constantly thinking of how to provide health insurance for our employees.

We have 33 total employees, 13 of whom are full-time employees. The quotes that I have been getting since 2006 are only for our full-time employees; and, even with that, the quotes that I got in 2006 raised our payroll expenses by 13 percent, which was absolutely unaffordable to us at that time. So, instead, we were left offering a small stipend to employees who decided to purchase health insurance on their own to help them out a little bit. Even with doing that, most of them could not afford the coverage. Actually, there are only three people right now who are purchasing their own health insurance because they can afford it.

My father has retiree coverage from his days of working at John Deere, and I have coverage through my husband, so neither one of us are worried about our own personal health insurance. But most of our employees are not in that position, and we have a really tight-knit group of people. We have husband-and-wife teams and other people who are like our family members, and we really want to be responsible to them and for them and be able to provide them with coverage.

The other thing is my brother, who is wanting to come back from St. Louis to help out in the family business. He has a family and two small children and cannot afford to go without health care. And a decision that should be really easy to come back and help to run the family business and leave a legacy is really becoming really complicated because he can't afford to without the health insurance.

So from a small business perspective, after looking at the draft proposal, I believe legislation that has been drafted by this and the other two House committees is a major step forward in addressing the health insurance problems that we face. It meets the priorities identified by the Main Street Small Business Owners, and I hope that action will be taken sooner rather than later to help with passage by the full House of Representatives.

A thing I think is most important with insurance market reform is the creation of a really strong public health insurance option. Having a public insurance option that will compete on a fair basis with the private plans will be a huge benefit to small businesses, and it will guarantee that even in local insurance markets that are dominated by only one or two private insurers that we will still have real choices and the leverage that comes with being able to take our business elsewhere if we don't like the ones that are offered.

When I was looking for plans this past year, I got eight quotes; and all eight quotes were from one company, which was Wellmark. There are no other companies that would provide quotes for our business within our area. And in our area, there are really only two companies that really hold the market share, which is Wellmark and United Health Care.

So small businesses across Iowa are really looking to Congress to act quickly on the House reform, to rein in costs and increase the competition, to give us some real choices instead of just one company with just eight plans. We are looking to you for leadership, and we need your support to enact some real health care reform that will help solve this problem.

[The statement of Ms. Young follows:]

Prepared Statement of ReShonda Young, Alpha Express, Inc.

Chairman Miller, Ranking Member Kline and members of the Committee, thank you for inviting me to be here today and to testify on behalf of my business and small businesses across Iowa. My name is ReShonda Young, and I serve as Operations Manager for my family's business, Alpha Express, Inc, based in Waterloo, Iowa. I am also a leader with the Iowa Main Street Alliance—a coalition of small businesses across Iowa working for a solution on health care.

I will make some specific comments on the committee's discussion draft proposal from a small business perspective. First, I want to share briefly about our business's experience with health care.

Alpha Express, Inc and the Realities of Health Care

Alpha Express is a transportation and contracting business. We provide transportation services across the U.S. and Canada, contract work for companies like John Deere, and exterior property maintenance services.

Our business is a true family business. My father started the company 20 years ago—back then it was just him and one partner—and my dad has grown the business to almost 40 employees. Now my dad is 68 and ready to retire. We're hoping my brother will come back and help run the business.

As Operations Manager for the business, I think about health insurance for our employees all the time. It's been years since we've been able to afford group health insurance. When I came in full-time with my dad in 2006, we got quotes from a couple different places, but the quotes came in at about 13 percent of our payroll. We're willing to pay our fair share of the cost of coverage, but we just couldn't afford 13 percent and there weren't any affordable options for us.

So instead, we're left offering a small stipend to help employees who buy insurance on their own. But most of them still can't afford the cost of coverage on the individual market. My father has retiree coverage from his days working at John Deere, and I've got coverage for myself through my husband. But most of our people

are not in that position—if they can't get health coverage through our business, they're not going to be able to get it anywhere.

This spring, I started looking into group plans again, but the plans we've looked at would mean at least a 12 percent increase in our payroll expenses. And the plan would include a waiting period of 12 to 18 months before any pre-existing conditions would be covered, so the money we put out in premiums wouldn't even cover some of the medical expenses we would incur. We also had no guarantee the premium will remain stable from one year to the next, and in fact they could ratchet up the premium the second year and drive us out of the market again. I received eight bids for coverage for our employees—but they were all from the same insurance company, Wellmark. In Waterloo-Cedar Falls and in most of Iowa, there are one or maybe two health insurers to choose from. That's not competition, and it's not giving us affordable choices.

Providing health insurance has always been something my father has wanted to do, something that's important to us. We have a couple of husband and wife teams who work for us. They need insurance for themselves and their kids. We have long-time employees who are like family members to us. This makes it especially important that our employees are healthy and well taken care of. Some nights I lay awake just worrying about health care.

Health care creates real problems for family businesses. My brother, who wants to move back from St. Louis to help run the business, can't afford to go without health coverage for his family. Because of health care costs, decisions that should be easy for my family to make have become complicated.

That's why I'm here today, and that's why it's so important that you are taking leadership in addressing the health care challenges we face.

Comments on the Committee's Discussion Draft

From the small business perspective, I believe the legislation drafted by this and the two other House committees is a major step forward in addressing the health insurance problems we face. It meets the priorities identified by Main Street small business owners, and I hope this committee will take action soon to approve it and encourage its passage by the full House of Representatives.

Specifically, given that new insurance options will be opened up to small business, either through the insurance market reforms or through the Exchange, the Main Street Alliance supports the shared responsibility provisions under Title III that require individuals and employers to play their part in ensuring that everyone has health care coverage.

I agree with the idea of giving employers the option of providing coverage or contributing funds on our workers' behalf. I think the bill would create a really good system, encouraging employers to be responsible for their employees by whichever approach makes the most sense in their circumstances. As I mentioned earlier, our firm faces health insurance premium expenditures that would add 12–13 percent to our payroll expenses in order to provide health insurance for our workers. The contribution level in the bill—even without the small business tax credit—would reduce our contribution amount by one third, to 8 percent of payroll. And the insurance package would actually cover our health care costs, with no preexisting condition exclusions. This is a tremendous improvement over our current options.

I'm glad to see the provisions of the bill that will establish a tax credit to help small employers bear the cost of providing coverage for their workers. A 50 percent credit will provide important assistance to businesses with 10 or fewer employees whose average annual employee compensation is \$20,000. And the small business assistance is extended on a sliding scale to firms with average wages up to \$40,000 and up to 25 employees. This, too, offers significant help in improving our current health insurance options.

Representatives of the Main Street Alliance look forward to continuing to work with you to assess the interaction of the various small business related provisions in the bill to ensure there is affordability across the range of small businesses, whether they directly provide coverage for their workers or contribute to helping workers buy their own coverage through an exchange.

The shared responsibility called for in the bill for funding health insurance is first made workable by the expanded options created in the bill for purchasing affordable health insurance coverage. The legislation does this by creating a Health Insurance Exchange to provide a more competitive, transparent marketplace that will offer real coverage choices for individuals and small businesses. In the Exchange, we will actually be able to compare the insurance plans being offered because the benefit packages will be standardized and the differences in the plans will be disclosed.

I'm also happy to see the provisions in the draft legislation that will reform practices in the insurance market to prohibit discriminatory coverage and rating poli-

cies. These changes are long overdue—I wish it were not necessary for the federal government to have to step in and pass laws and impose regulations to get insurers to stop these unfair practices, but if that’s what it takes I support putting them in place as soon as possible.

But I think the most important insurance market reform—and the one that will go the farthest in ensuring competition among health plans—is the creation of a strong public health insurance option. Having a public plan that will compete on a fair basis with private plans will be a huge benefit to small businesses. It will guarantee that even in local insurance markets dominated by one or two private insurers, we will have real choices and the leverage that comes with the ability to take your business elsewhere if you don’t like the insurance plan you have.

I think a public health insurance plan is also critical to encourage innovation in coverage and affordability in a competitive marketplace. I know that our business is always looking for ways to serve our customers better, more efficiently, at lower prices, and we’re driven by the competition from other businesses. As a purchaser of health insurance coverage, I want my insurer to have to compete for my business as hard as I have to compete for my customers.

The bill includes a phase-in of which businesses are eligible to secure coverage through the exchange, and through the exchange gain access to the public health insurance option, with firms with 10 or fewer employees eligible in year one and firms with 20 or fewer employees eligible in year two. I understand the intention with the phase-in is to be cautious and not create unintended consequences by moving too quickly. But from my vantage point, we can’t have the public option and the other private plan options available too soon. I would encourage the committee to consider accelerating the phase-in of the employers who can access the exchange.

Small Businesses Need Real Health Reform

Small businesses across Iowa and across the country are looking to Congress to act quickly on health reform to rein in costs, increase competition and give us real choices. Last fall, our coalition in Iowa participated in a national small business survey where surveyors went door to door and asked Main Street business owners face to face what should be done to fix health care.

The results of this survey, reported in “Taking the Pulse of Main Street: Small Businesses, Health Insurance, and Priorities for Reform” (full report available at <http://mainstreetalliance.org/wordpress/home/publications/>), are worth noting in three key areas:

1. Small business owners’ willingness to contribute toward health coverage: When asked if we were willing to contribute for health coverage for our employees, more than two thirds (73 percent) of small employers said yes.

2. Support for real choices, including the choice of a public health insurance plan: When asked to choose between a proposal with a public health insurance option and a proposal with only private options, responding business owners chose the proposal with a public plan option by a margin of over two to one (59 percent to 26 percent).

3. Views on the role of government in making health care work: When asked about public oversight and the role of government, small business owners supported more public oversight of the insurance industry by almost six to one (75 to 13 percent), and a stronger government role in guaranteeing access to quality, affordable health coverage by over four to one (70 to 16 percent).

We are looking to you for leadership. We need your support to enact real health care reform that will solve this problem for family businesses like mine and allow us to continue creating jobs and serving the needs of communities across America. Thank you.

Chairman MILLER. Dr. Mullan.

STATEMENT OF DR. FITZHUGH MULLAN, MURDOCK HEAD PROFESSOR OF MEDICINE AND HEALTH POLICY, GEORGE WASHINGTON UNIVERSITY

Dr. MULLAN. Chairman Miller, thank you. You certainly get kudos for stick-to-it-iveness—not only writing the bill but as much testimony as you have had. A credit to you.

My name is Fitzhugh Mullan. I am a pediatrician. I am a medical educator. I once was in the National Health Service Corps. I once ran the National Health Service Corps. Today, I am a pro-

fessor at Health Policy and Pediatrics at George Washington, and workforce is my area, and I am happy to bring that to the deliberations today.

This bill comes with context, and I want to give a little bit of workforce context very quickly.

In the United States, we have large numbers of health professionals, large numbers of physicians. In my judgment, we have an adequate number of physicians. We need to grow the physician workforce as the population grows, and we need to make much better use of it.

The workforce is not well distributed. It tends to be in urban areas. It tends to be in areas that are well-to-do. Rural areas and poor areas have great trouble not only with physicians and nurses but other health workers.

One out of three positions in the United States is in primary care, two-thirds are specialists, and interest and commitment to primary care is flagging in the pipeline.

Good evidence suggests across the board that primary care is associated with better outcomes and less cost. Nurse practitioners and physicians' assistants are very important components of our workforce today, and they need to be grown, as this bill suggests they do.

And, finally, in terms of the context, we do very little planning. One-sixth of our economy is in health. We have a large health workforce. We do little or no downstream planning. No business would run like this. We need to put more brain power and more data and more thoughtful deliberation with what we invest in in regard to the workforce.

I want to suggest a way to look at the workforce. The last graphic that I have in my testimony suggests three parts to the life cycle of a health professional. The first would be the pre-service, the training, medical school in the context of physicians. The second would be post-graduate or specialized training, graduate medical education; and the third is practice. If we are going to reform the workforce and build the workforce that is more aligned with our needs, particularly with regard to primary care, we need to move in all three sectors. Same for the other health professions. Very important concept. And I will talk about the bill in regard to those three areas of the workforce.

The committees have done, in my judgment, a very creative job of putting many ideas to work in the proposed legislation that would move us considerably in terms of building a better workforce.

The National Health Service Corps, a very tried and proven program, has increased support for title VII and VIII. That is training in medicine for MPs and PAs, and diversity is upscaled and reinvigorated.

In terms of graduate education, Medicare funding graduate education, unused slots, funded slots are repurposed for primary care. There is a teaching health center demonstration proposal which would put young doctors to work in community health settings. There are significant payment improvements for primary care physicians, something very important in terms of a demoralized and underpaid workforce.

There is support for new instruments, new structures to organize the workforce, primary care medical homes as well as accountable care organizations. And there is attention to planning and brain trust, and that is an Advisory Committee for Health Workforce Evaluation and Assessment and a National Center for Health Workforce Analysis.

Concerns. The National Health Service Corps is funded insufficiently in the judgment of many. I would agree. Great unmet needs. And many, many young people in medicine and other health professions prepared to do community service for reduction of student debt could be a much more effective instrument even as—more so than proposed in the bill.

Teaching health centers, as I mentioned, are an important instrument. They are a demonstration project. Many feel that having them as an actual part of how we do business would be important, along with startup funds to get health centers able to host residencies and residency programs.

Primary care payment, while upgraded, is modestly so, 5 percent on the basic E&M services for primary care, which nets out to about \$2,000 to \$3,000 per primary care provider, hardly the kind of incentive that we want to have thousands of more of our young physicians choose primary care. A 50 percent upgrade, which sounds like a lot, would net about \$25,000, arguably a pretty good incentive. That would cost about six-tenths of one percent of Medicare. So it would cost rather modest, because, of course, primary care space is very modest.

A primary care extension program has been proposed. Like the agricultural extension program, it would help translate new findings and new ways of doing business, including better organization of practice, health IT from the universities, from the centers of knowledge and innovation into primary care practice. Not in the bill. Something worth considering.

And, finally, the planning activity, I would like to see it not an advisory committee but a national commission level. This is the level of importance that I think it deserves.

Once again, I think this bill is a great start. It does bring to the legislative agenda, the national agenda ideas that have floated around but not really been taken seriously or codified previously and sets the stage for what could be a very important renovation in our health force thinking to build a base for the overall bill and the overall efforts.

Chairman MILLER. Thank you.

[The statement of Dr. Mullan follows:]

Prepared Statement of Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University

Background Perspectives on Health Workforce

Improving access to health care in the United States will require modifications in the structure of the US health workforce, the foremost of which will be the construction of a strong primary care delivery base.

The distribution of physicians (and other health professionals) in the U.S. heavily favors urban areas. Metropolitan areas have 2-5 times as many physicians as non-metropolitan areas. Economically disadvantaged areas have significant physician access problems.

Two-thirds of the U.S. physician workforce practice as specialists. The number of young physicians indicating an interest in primary care is declining. Approximately

100,000 nurse practitioners (NPs) and 70,000 physician assistants (PAs) are practicing in the United States today. This represents an important asset for service delivery.

Today's physician-to-population ratio is in the zone of adequacy and should be maintained with appropriate growth in the number of physicians trained to parallel growth in the population. Increased requirements for patient care due to the aging of the population or the inclusion of more Americans as a result of health care reform legislation should be met by more strategic distribution of physicians, both geographically and across the primary care—specialty spectrum, and the expanded use of physician assistants and nurse practitioners. The role of PAs and NPs should be in both the generalist and specialist sectors of the care delivery system.

Medical schools—The current expansion of medical schools is welcome but Title VII legislation needs to be reinvigorated and up-funded to augment primary care training in medical schools.

Graduate Medical Education—The current number of Medicare funded slots is sufficient to maintain workforce numbers. However, reforms need to be made in current legislation to prioritize and incentivize community-based and ambulatory training. Support for Teaching Health Centers would significantly advance this goal. Beyond that, serious consideration needs to be given to aligning Medicare GME with the workforce needs of the country.

Medical Practice—Primary care payment reform, support for new practice organizations such as primary care medical homes, and investment in health information technology are all important reforms that will help to promote a strong primary care practice base in the country.

Data and leadership in the field of U.S. health workforce development is insufficient. A National Center for Health Workforce Studies and a National Health Workforce Commission would both be important assets at the federal level in managing health care workforce reform.

Summary of Testimony

The Tri-Committee draft legislation takes a significant step towards establishing a health care workforce which will sustain a high-quality, cost-effective, fully accessible health care system. Moves to establish an Advisory Committee on Health Workforce Evaluation and Assessment, re-invest in the National Health Service Corps and Title VII of the Public Health Service Act, redistribute unused Medicare GME positions to primary care programs and establish teaching health centers, and address payment and practice challenges to primary care through the medical home and accountable care organization pilot programs are all positive moves towards a sustainable health care workforce. However, to fully achieve workforce reform, the following are recommended:

Promoting the Advisory Committee on Health Workforce Evaluation and Assessment to a "National Commission on the Health Workforce", providing it with an authorization and clarifying its role in reporting to Congress, including addressing Medicare GME payments.

Fully supporting the Teaching Health Centers program, converting it to at minimum a pilot program rather than a demonstration project and creating a Teaching Health Centers Development Grant within Title VII.

Further increasing National Health Service Corps authorization for appropriations to maximize the program's full potential to provide health care in the most underserved areas.

Increasing primary care bonus payments and SGR target growth rate to ensure effective maintenance and incentives for primary care.

Invest in a primary care extension program to provide technical assistance and training programs for strengthening primary care practice.

Introduction

Thank you Mr. Chairman for this opportunity to testify today. During the 40 years since I graduated from medical school, I have been a member of the health care workforce of the United States working as a pediatrician; I have directed workforce programs such as the National Health Service Corps while serving as a member of the United States Public Health Service Commissioned Corps; and I have been a student of and commentator on U.S. workforce policy in my current role as a Professor of Health Policy at The George Washington University.

Therefore, it is with experience as a practitioner, administrator, and scholar that I come before you this morning.

Background

The Health care workforce is a necessary component to any health care system and addressing the deficiencies in the current workforce is critical to ensuring any form of health care reform succeeds.

Primary care, in particular, is essential to a cost-effective, quality, fully accessible health care system. This is supported by:

The Dartmouth group—examined differences in Medicare spending in different regions in the U.S. Found regional differences largely explained by more inpatient and specialist-oriented practice in higher spending regions.

Barbara Starfield et al—showed primary care is associated with improved health outcomes

Massachusetts example—MA health care reform increased coverage but failed to address workforce and therefore access, featured in the New York Times article, “In Massachusetts, Universal Coverage Strains Care”

GAO report February 2008—“Ample research concludes in recent years that the nation’s over reliance on specialty care services at the expense of primary care leads to a health system that is less efficient * * * research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve better health outcomes and cost savings.”

Primary care is declining (Figure 1) due to:

Large payment disparities between primary care and specialties—Median annual salary of a primary care physician is \$190,000 compared to a dermatologist (\$345,000), a cardiologist (\$380,000), a radiologist (\$462,000) and an orthopedic surgeon (\$450,000) (Figure 2).

Practice conditions which make primary care less attractive to future physicians— $\frac{2}{3}$ of primary care practitioners work in practices of 4 or fewer physicians and the institutional infrastructure to drive practice improvements doesn’t exist.

Declining support for primary care educational and pipeline programs, such as Title VII of the Public Health Service Act (Figure 3).

The Career Lifecycle of a Physician

Before considering questions of the sufficiency of the workforce or policy options to modify its direction, I would like to suggest a framework for considering physician careers. I call this the career lifecycle of a physician. It has three phases—one of which is educational, one of which is transitional and the final one of which is vocational (Figure 4). The phases are medical school, graduate medical education, and practice. The first two might be considered “pipeline phases” since they determine the quantity and nature of physicians prepared for practice. The final phase is the “payout” phase when the physicians are actually providing health care to the nation.

This framework allows us to consider capacity, cost and performance in three separate but interlinked longitudinal phases of the career path of physicians.

The Tri-Committee Draft Bill

The House Committees on Education and Labor, Energy and Commerce, and Ways and Means are to be commended on the Tri-Committee Draft Bill that we are discussing today. It proposes legislative action that would go a long way toward providing a floor of access to quality health care for all Americans—a major unmet American agenda. The workforce components of this bill will do a great deal to rebalance the health professions training systems of the country to produce a healthcare workforce more aligned with the needs of the American people and the coverage envisioned in this bill. The particularly important issues that this bill addresses are: (1) the need for expanded incentives and support for primary care education and practice, (2) strong measures to build the health workforce in areas of chronic need and underservice, and (3) support for a broad spectrum of health workers, including physicians, nurses, physician assistants, and public health professionals. Finally, this bill envisions better deliberations on the future of the workforce through the Advisory Committee on Health Workforce Evaluation and Assessment and better information through the National Center for Health Workforce Analysis.

Tri-Committee Draft Legislation Recommendations

Advisory Committee

The draft legislation proposes an Advisory Committee on Health Workforce Evaluation and Assessment. Given that the health workforce of our country staffs $\frac{1}{6}$ of our national economy, it is an area where we need to be smart, agile, and prescient. Virtually all health professional education programs receive public support, and as such, we have a particular responsibility to manage those human and financial re-

sources with prudence and intelligence. At the present, there is no national deliberative body that looks ahead at national needs and informs the Congress or the Administration on a regular basis about broad directions and preferable investment strategies. Therefore, the National Advisory Committee proposed is a major step ahead.

However, the term "Advisory Committee" connotes a body whose influence is considerably less than that of a "National Commission". Moreover, the details of this Advisory Committee do not distinguish it substantially from a number of other advisory committees (listed in the legislation) whose reach is generally modest. The legislation provides no specific authorization level for its work. Consideration should be given to making the Advisory Committee on Health Workforce Evaluation and Assessment to a "National Commission on the Health Workforce", providing it with an authorization, and clarifying its role in reporting to Congress.

National Health Service Corps

The draft legislation increases National Health Service Corps scholarship and loan repayment funding levels to \$300,000,000 annually, effectively maintaining the ARRA funding for NHSC and increasing the total NHSC from approximately 4,000 providers to 8,000 providers. However, the NHSC has the potential for further growth. Last year, over 4,500 health care providers applied for NHSC positions. Only 950 positions (20% of applicants) were awarded due to funding limitations.

Physician Assistants and Nurse Practitioners

The United States is a global pioneer in the creation of new categories of health professionals who contribute to the delivery of clinical services. Separate pilot programs in the 1960s introduced the world to the idea of the nurse practitioner (NP) and the physician assistant (PA). Since those early programs, both professions have grown enormously in size, stature and public acceptance. Approximately 125,000 nurse practitioners have been trained in the United States, the majority of whom are engaged in clinical practice. There are almost 70,000 certified physician assistants in the United States and more than 100 training programs.

Both of these professions are associated with primary care and practice in rural and underserved areas. About 25% of all nurse practitioners are located in non-metropolitan areas and an estimated 85% of them practice primary care. Physician assistants are active across the spectrum of medical specialties with more than one third of them working in primary care practices and approximately one fifth of them working in rural areas.

The Tri-Committee bill addresses the importance of these two professions, and this is particularly important in the context of the current workforce shortages in primary care. Specifically, I commend the bill's support to expand nursing education, practice and retention programs, nursing faculty loan repayment programs, and the training of advanced practice nurses who will deliver care in shortage areas. The bill also supports and gives preference to the development of physician assistantship training programs with demonstrated success in producing primary care providers and providers from underrepresented racial and ethnic groups and disadvantaged backgrounds. Additionally, the bill provides grants to programs that promote interdisciplinary and team-based models of care as well as coordination with academic health centers and across health professions settings for training and practice. Building out the nursing and PA workforce will, in the face of the primary care crisis, help support a robust primary care delivery system.

Diversity in the Workforce

Diversity in the physician workforce is critical to adequate, accessible, and culturally responsive care. Health professionals from racial and ethnic minority groups are more likely to enter primary care, practice in health profession shortage areas, and care for minority, poor, underinsured, and uninsured individuals than their white counterparts.¹ One national survey reported that while African American physicians comprise only 4% of the workforce, they serve more than 20% of African American patients in the U.S.² Another study found that African American physicians practice in high density African American communities, and Hispanic physicians practice in high density Hispanic communities.³ Finally, diversity among physicians help with efforts to improve cross-cultural training and competencies

¹ Council on Graduate Medical Education, Twelfth Report Minorities in Medicine, 1998.

² S. Saha et al, "Do Patients Choose Physicians of Their Own Race?" *Health Affairs* 19, no. 4 (2000): 76-84.

³ M. Kamaromy et al. "The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations," *New England Journal of Medicine* 334, no. 20 (1996): 1305-1310.

throughout the profession by broadening physician perspectives regarding racial, ethnic and cultural differences.

The Tri-Committee bill recognizes the unique importance of training a diverse health professions workforce to meet the expanding and evolving needs of the current health system and the population it serves. It supports the development of primary care training programs that have a record of training individuals from under-represented groups as well as disadvantaged backgrounds, strengthens existing programs that promote diversity in the health care workforce, and increases funding to support the training of individuals from disadvantaged backgrounds.

Teaching Health Centers

The proposed Demonstration Project for Approved Teaching Health Centers represents an important preliminary step towards aligning our graduate medical education system with our nation's primary care workforce needs. Through this Demonstration Project, teaching health centers including FQHCs and rural health clinics would be eligible for direct Medicare GME funding to train medical residents in community-based clinical settings. Not only will these programs better prepare the next generation of physicians to cost-effectively serve our nation's health care needs and expand access to primary care services, they have also been shown to improve recruitment and retention of physicians in underserved areas.^{4,5}

Medicare Graduate Medical Education

The Committee also deserves great credit for resisting pressure to lift the Medicare cap on graduate medical education. By dedicating the reassignment of unused residency positions to primary care, the Committee has sent an important signal that smart growth in federally funded graduate medical education should focus on primary care specialties. Any expansion of Medicare-sponsored GME should, at a minimum, be tied to medical school expansion and focus future support on carefully documented national needs.

The \$8.6 billion that Medicare currently pays to teaching hospitals in the United States for Graduate Medical Education represents by far the largest federal investment in medical education at any level. This system is of great value for hospitals since it provides stable funding for their residency workforce with minimal reporting requirements. Moreover, the program is an entitlement under Medicare legislation driven by formulas for direct and indirect payments. Hospitals have been able to train the types of residents that meet their needs without either application or outcomes reporting. Since the teaching hospitals of the country are the training grounds for the physician workforce, the workforce of the country is effectively determined by the staffing needs of teaching hospitals. This circumstance has resulted in a workforce that is, by all measures, highly subspecialized and weak in primary care. It tends to be located closer to medical centers and areas of advanced technology, and not as well represented in rural and financially disadvantaged areas of the country.

This situation is not new and has been subject to increasing calls for scrutiny and reconsideration. While no single alternative to the current GME funding system has gained a consensus among medical educators and policy makers, the Medicare GME system needs a thoughtful reexamination at the highest levels of government. This task might be specifically assigned to the Advisory Committee on Health Workforce Evaluation and Assessment, to MEDPAC, or to a specially constituted commission. The Tri-Committee draft bill would be greatly strengthened by addressing this important issue.

National Health Service Corps

The draft legislation increases National Health Service Corps scholarship and loan repayment funding levels to \$300,000,000 annually, effectively maintaining the ARRA funding for NHSC and increasing the total NHSC from approximately 4,000 providers to 8,000 providers. However, the NHSC has the potential for further growth. Last year, over 4,500 health care providers applied for NHSC positions. Only 950 positions (20% of applicants) were awarded due to funding limitations.

Practice Reform

A number of provisions in the House draft legislation support primary care through programs which will promote practice and payment reform. The conversion of the Medicare Medical Home Demonstration Project to a pilot program and the

⁴Morris CG et al. Training Family Physicians in Community Health Centers: A Health Workforce Solution. *Fam Med.* 2008 Apr;40(4):271-6.

⁵Ferguson WJ et al. Family Medicine Residency Characteristics Associated With Practice in a Health Professions Shortage Area. *Fam Med.* 2009 Jun;41(6):405-10.

establishment of a Medicaid Medical Home pilot program further patient-centered, comprehensive, coordinated and accessible health care which is largely primary care focused. The establishment of a Medicare Accountable Care Organization pilot program promotes accountability in the health care system and provides an incentive for high quality, efficient care—and recognizes the importance of primary care through requirements of qualifying ACO groups to include “sufficient number of primary care physicians” and “patient-centered processes of care.”

Draft legislation includes a Medicare primary care bonus for designated services provided by primary care practitioners—5% in general or 10% if the practitioner practices in a health professional shortage area. The Medicare Sustainable Growth Rate (SGR) is also rebased at the 2009 level for calculating future update adjustments and divided into 2 “service categories”—one including evaluation and management services (including primary care services), the other including all other services—with a separate target growth rate increase of 2% annually rather than 1% for all other services.

These changes begin to address both the practice and payment disparities which have contributed to the decline of primary care in the U.S. However, recent work done by the Robert Graham Center indicates a 5% primary care bonus will translate to only a \$2,500 annual revenue increase for family medicine physicians.⁶ When faced with primary care to specialist payment gaps over \$200,000, this primary care bonus is unlikely to influence future physician career choices. A 50% primary care bonus, or a \$25,000 annual revenue increase, is more likely to achieve the desired effect. Additional analysis by the Graham Center evaluating separate service categories for SGR calculations indicate that a target growth rate of GDP+2% will be insufficient to maintain current trends in increasing evaluation and management payments, which will surely increase even more with increasing health care coverage. GDP+3% for primary care services will prevent future cuts to primary care payments.

Finally, while medical homes and accountable care organizations provide incentives for strengthening primary care practice, they do little to provide the technical assistance and training needed to transform the current struggling primary care system into a high-functioning quality care system. A primary care extension program modeled off of the agricultural cooperative extension program would link the Department of Health and Human Services to State level hubs and local extension offices which could then provide the technical assistance and training programs needed to establish a higher quality and more cost-efficient primary care health care service network in the U.S.

Conclusion

The Tri-Committee draft legislation takes a significant step towards establishing a health care workforce which will sustain a high-quality, cost-effective, fully accessible health care system. Moves to establish an Advisory Committee on Health Workforce Evaluation and Assessment, re-invest in the National Health Service Corps and Title VII of the Public Health Service Act, redistribute unused Medicare GME positions to primary care programs and establish teaching health centers, and address payment and practice challenges to primary care through the medical home and accountable care organization pilot programs are all positive moves towards a sustainable health care workforce. However, to fully achieve workforce reform, the following are recommended:

Promoting the Advisory Committee on Health Workforce Evaluation and Assessment to a “National Commission on the Health Workforce”, providing it with an authorization and clarifying its role in reporting to Congress, including addressing Medicare GME payments.

Fully supporting the Teaching Health Centers program, converting it to at minimum a pilot program rather than a demonstration project and creating a Teaching Health Centers Development Grant within Title VII.

Further increasing National Health Service Corps authorization for appropriations to maximize the program’s full potential to provide health care in the most underserved areas.

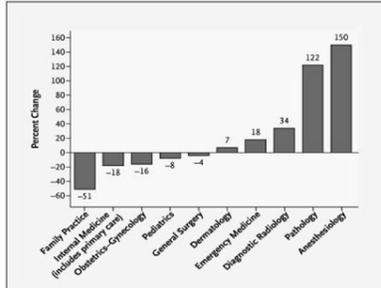
Increasing primary care bonus payments and SGR target growth rate to ensure effective maintenance and incentives for primary care.

Invest in a primary care extension program to provide technical assistance and training programs for strengthening primary care practice.

Thank you.

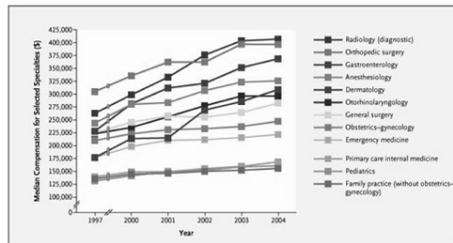
⁶The Robert Graham Center. Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges: White Paper. May, 2009

Figure 1: Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.



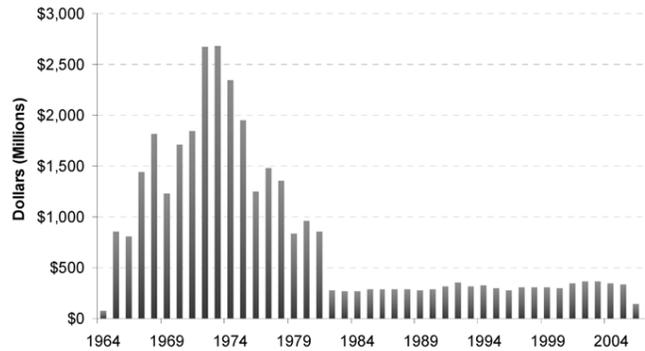
Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9), August 31, 2006.864-866.

Figure 2: Median Compensation for Selected Medical Specialties



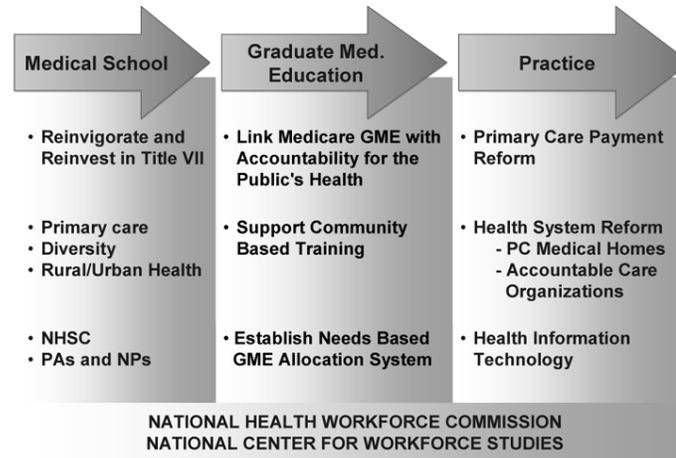
Source: Medical Group Management Association Physician Compensation and Production Survey, 1998 and 2005. From: Woo: N Engl J Med, Volume 355(9), August 31, 2006.864-866

Figure 3: Title VII Funding Levels, Adjusted to 2008 Dollars.



Source: Data provided by HRSA

Figure 4: Primary Care Workforce Reform



Chairman MILLER. Mr. Kildee.

Mr. KILDEE. Mr. Klein and Mr. Vaughan have both spoke of quality issues, and we all understand the ethical aspect of quality in health care. Can both of you address the fiscal aspect of quality in this field?

Mr. Klein.

Mr. KLEIN. The fiscal aspect of it? Thank you for that terrific question, some of which is elaborated more fully in the written statement.

Admittedly, this is a very difficult area to quantify, but it is one we really urge Congress to pay attention to if it is serious about these quality initiatives, which we believe you genuinely are.

There is every reason to believe that there would be substantial savings through the kinds of things that we have talked about:

comparative effectiveness efforts. Health care is the one product or service in this country where we pay as much, if not more, for poor quality as we do for good quality. We wouldn't tolerate that in any other area of our commerce.

Having disclosure about outcomes and aligning what we pay providers based upon those outcomes, those are all examples. And, again, I can't give you a specific dollar amount to it, but those are all examples of where efforts that are geared toward improving quality will also achieve savings.

Mr. KILDEE. Mr. Vaughan.

Mr. VAUGHAN. Just in March the CDC said, on the infections alone that kill about 100,000 a year, the extra cost of treating people—and there is like 2 million people get some infection—treating that is \$35.7 to \$45 billion extra a year, and that is in the infection area.

And there are some great quotes. Dr. Thompson out of Pennsylvania, of hospital administrators saying, we didn't like this public reporting thing right away, but we find out if we do it right the first time, if we keep that infection from happening, we are saving money.

So we think quality is a big saver, sir.

Mr. KILDEE. Mr. Klein, you mentioned that I think the better part of the bill was the quality control. Do you think we have touched that adequately in this committee bill?

Mr. KLEIN. We would like to examine it more fully, quite honestly, having just received it. I think there definitely are provisions in there around comparative effectiveness and around some wellness promotion efforts as well I didn't see. So forgive me if I have sort of overlooked it in my review of that part.

But chronic disease management programs, having a sort of a whole safe harbor protection for practitioners who follow evidence-based standards, all of those kinds of things would be areas that, if they are not fully developed, need to be included as part of that.

Mr. KILDEE. Mr. Vaughan, how close do we come to achieving a good level of quality control?

Mr. VAUGHAN. Well, we think the bill is a great step forward, and we are very excited about it. We would just urge as a technical amendment but in the seven conditions that the bill calls for when you are readmitted to the hospital for bad quality, tell the public. Tell the public what the readmission rates are so that the public can go out there and say to a local hospital, hey, how come you are not as good as the hospital in the next county?

So we would like more public. But that is a tricky thing. It is a good bill, sir.

Mr. KLEIN. Mr. Kildee, one additional one in response to your question.

Right now, a lot of employers would like some clarity from Congress that, as part of the health risk assessments that they conduct of their workforce, that asking certain kinds of information relative to family history and other kinds of conditions like that do not violate the terms of the Genetic Information Nondiscrimination Act. So clarity around something like that, which has definitely shown these health risk assessments can play a meaningful role in promoting good health, would be a very, very helpful feature.

Chairman MILLER. Mr. Kline.

Mr. KLINE. Mr. Klein, you mentioned comparative effective research that Dr. Price was talking about earlier. I am not sure—it is 852 pages. I am not sure how many of you have had a chance to look at this. But I was looking a little bit deeper into this comparative effectiveness research, and I am a little bit concerned about it.

This says, in title IV, that a Center for Comparative Effective Research is established, gives a number of duties. There are 17 members, I think. Dr. Price will be very relieved to know that one of the 17 is indeed a physician, and I know he will be doubly relieved to know that that includes surgeons in the physicians category.

In the language, it says there will be a perspective advisory panel for each research priority determined under subparagraph, so forth; that says they will advise the center on research questions and methods for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

And I am a little bit concerned there. Because I think where Dr. Price was going earlier, I don't see the language in here that says this cannot be prescriptive for doctors providing care. And it seems to me that that would be, if I were a physician—and we have a whole row of them here—that would be useful to make sure you have the protection that says that this panel and this center will not be prescribing which treatment you have to use.

And I have another concern with that, that even if it doesn't, if it prescribes or puts out standards from the government, from this panel, hard to argue with that the physicians who choose not to opt for that would be exposing themselves to some serious litigation.

I don't know if any of you have had a chance to look at that and would like to comment. If so, please do. If not, I will move on to something else.

Mr. KLEIN. I think that those are all legitimate points, and the issue here has to be not on overarching prescriptive regulation but on making sure that we have much better information for people to make decisions around. So I think that all of the concerns that you referenced are ones that would benefit if there is any lack of clarity in the legislation.

Mr. KLINE. Thank you. I think that having research by experts is very useful, but I am concerned that it leaves us sort of open-ended. It may be exposing physicians to some liability.

Mr. VAUGHAN, you wanted to comment. Go ahead, please.

Mr. VAUGHAN. In the earlier part of the bill where they set up in these insurance plans that there has to be—it doesn't say model, but there has to be grievance and appeals and exceptions processes. And it sort of gets us back to the old patient's bill of rights discussions. Most medicines will—that generic will work for most people in most States. But it might not work for everybody, and that person ought to be able to get an exception real quickly. And I would urge that people work on that language a little bit more and maybe worry less that the knowledge of having more data in comparative effectiveness is going to be some sort of stranglehold.

What we need to do is take that science and make it usable, and if it is wrong for a person—

Mr. KLINE. Reclaiming my time, don't you think it would be useful to have language like that in the bill, that it cannot be used to dictate a treatment? I mean, I really would like to have the research done out there that gives you some ideas of standards, but we want to make sure that physicians are allowed to use their art and skill in a way that they see fit with the patients.

I am about out of time.

I want to go back to Mr. Klein very quickly because we have talked a lot here in the hearing today about President Obama's quote, "If you like your health plan, you will be able to keep your health care plan." And you started to make some comments that you were concerned that that wasn't specifically covered and there may be some reasons why employees or employers would part.

Mr. KLEIN. I guess my point really is that it is not enough to simply say that as a technical, legal matter that under this legislation or any legislation that the employer-based system would continue to exist.

The issue really is a more practical one. Looking at the totality of the changes that would have to be made, the establishment of a public plan, the existence of a pay-or-play mandate and the nature of it—we, by the way, happen to agree with the importance of having an individual mandate—the possible tax consequences to individuals and all of that, will it lead to a system where the employers simply don't want to participate anymore?

If the structure is such that because the public plan, for example, is less expensive that people opt in or the nature of the subsidies will be such that younger and healthier employees, for example, will do better by going into the plan through an exchange and getting a subsidy than staying with their employer, that will clearly destabilize the employer-based system.

So it will exist as a legal matter, but it will suffer very significant consequences as a practical matter.

Chairman MILLER. Mr. Andrews.

Mr. ANDREWS. Thank you.

It strikes me that we have had a lot of expert testimony all day about how small employers can buy health insurance. We have had one person, Ms. Young, speak very authoritatively about what it is really like because she has tried to do it. If I heard her testimony correctly, she put out bids for her business and got eight proposals, all from the same insurance company. And in her testimony, she says, in her area, which is Waterloo, Cedar Falls, in Iowa, there are one or maybe two health insurers to choose from. That is not competition.

Dr. Moffit, I want to ask you about the idea of a public option being available to people like Ms. Young and her colleagues to have some competition. And I read through your testimony and I identified some criteria that you have identified that would constitute a level playing field, if I read this correctly.

You say the simplest way to achieve the stated goal of a level playing field is to require the public plan to compete for doctors and hospitals by negotiating market rates. That is what the bill

does, doesn't it? It doesn't require anyone to take the public option, does it?

Mr. MOFFIT. Doesn't require anyone to take the public rate, but if the plan is going to pay Medicare rates, the plan is going to have an advantage over private competitors.

Mr. ANDREWS. It is going to pay them for a while, but, as I read the bill, there is no hospital or doctor required to take a public plan participant. They can negotiate and say, no, we don't want that; isn't that right?

Mr. MOFFIT. It is my understanding, too, though—

Mr. ANDREWS. Am I right or am I wrong?

Mr. VAUGHAN. Yes, you are right.

Mr. ANDREWS. Okay.

Let's see. Your second criteria that you talk about is the tort liability, a very subtle point, that the public option would have to have the same tort liability and not be able to hide behind 11th amendment sovereign immunity. I agree with that. It is an arcane point that we would have to work out.

The third thing that you talk about is the accounting standards, the FASB and other standards that the insurers have to deal with that the public plan would have to as well. I think that is basically right. I think the bill takes us in that direction. Probably is not a hundred percent there, but takes us in that direction.

And, finally, you say that the public health insurance option, just like any other private health option, should also be allowed the fail without being kept on artificial life support through the infusion of taxpayer moneys. It is correct, though, isn't it that the draft before us, the only public appropriation that is mentioned in the bill would be some start-up capital to get them started, and would you support the public option if we required that to be repaid out of revenues?

Mr. MOFFIT. That would not be the only reason to support the public option. But let me just make one other—let me make a clarification on this. What I noticed is—I noticed that, and I marked it when I was reading it. And I thought to myself, well, there is nothing in this account. Of course, the next sentence in my testimony is, the question is whether there is nothing in the bill that doesn't prevent Congress basically from coming back and doing precisely that.

Mr. ANDREWS. Well, of course there is nothing that prevents us from appropriating funds to Bank of America. We did that too.

Mr. MOFFIT. You read my mind.

Mr. ANDREWS. But you do agree with me here that the present bill before us contemplates the public option of having two sources of revenue: premiums it earns, and investment income on those premiums, just like any other insurance company. Isn't that right?

Mr. MOFFIT. Yes, but there is one other issue.

Mr. ANDREWS. What issue is that?

Mr. MOFFIT. Well, I will tell you. When the Secretary is given the authority to contract for administrators—and I am thinking the idea here of contracting for the administrators is to contract out with maybe some third-party carrier to carry out the functions of the public plan. But one thing I noticed about that was that in any contractual agreement, the Secretary cannot make a contractual

agreement that would involve the transfer of risk. Which means that in the public plan, the taxpayer assumes all of the risk of the plan. The private sector health plans do not—are not in the same wavelength in that sense. They are going to have to assume risk on their own. My view is—

Mr. ANDREWS. Okay. I just want to be clear that you do agree that the proposal before us does not require anyone to take a public plan participant, a doctor or hospital.

Tort liability, I agree, there is some work that has to be done on that. The same accounting rules, I think we are basically in the same place. And that the only revenues that the public plan option gets is the premiums and the earned investment income. So doesn't it meet your criteria? Are you now for the public option?

Mr. MOFFIT. No, I am not for the public option.

Mr. ANDREWS. Why not?

Mr. MOFFIT. Let me say this to you. Maybe I will answer the question with a question.

Mr. ANDREWS. I rather you answer it with an answer. Why aren't you for the public option? It meets your criteria, doesn't it?

Mr. MOFFIT. My view is that if all of the health plans basically are on the same level playing field, we all have the same rules, everybody is guaranteed access to affordable health insurance, and that is true everywhere, why would you need a public option?

Mr. ANDREWS. Well, maybe because of what Ms. Young was talking about that, you know, in 36 States the three largest providers have at least 65 percent of the market. Maybe that is why.

Mr. MOFFIT. Well, I would say that there are a lot of other ways to promote competition than just creating a public option. In fact, Congressman, one of the problems I have with Professor Hacker's views on this is he is saying we have a problem with consolidation in the health insurance market. My difficulty with Professor Hacker's argument, and implicitly perhaps yours, is that the public option doesn't necessarily solve that problem of consolidation. In fact, it may make it worse because you may even have a greater erosion of private health insurance options.

Mr. ANDREWS. My time is expired. I appreciate that. Thank you very much.

Chairman MILLER. Dr. Price.

Dr. PRICE. Thank you, Mr. Chairman. I want to continue to go down this thought line, because I think it is incredibly important that the fact of the matter is that no public option can be on a level playing field with private industry, just virtually by definition.

Dr. Moffit, in the bill, will the public option or the government-run program be required to pay local, State and Federal taxes?

Mr. MOFFIT. It is not clear in the bill that they would.

Dr. PRICE. And if it weren't, wouldn't that be a subsidy to the public plan and therefore put it on a nonlevel playing field?

Mr. MOFFIT. Yes, Congressman, it would in effect.

Dr. PRICE. Mr. Klein, would you agree with that?

Mr. KLEIN. I was just reading my notes here about the payment rates. I want to make sure I am responsive to your question. But under the public option—and one of the reasons that we have tremendous concerns about it, quite frankly, is that the public plan would get to use these Medicare payment rates for the first 3 years

to pay providers, generally—as we heard on the earlier panel—at a substantially lower level than private payers would pay them. And then after 3 years there is really no requirement that the public plan set its rates competitively at all.

Dr. PRICE. My question was as to whether or not the public plan, the government-run plan, would have to pay local, State and Federal tax.

Mr. KLEIN. It is hard to see how it would, or how you could even make the same type of reserve requirements.

Dr. PRICE. And, therefore, it would have an unfair advantage over some private plans.

Mr. KLEIN. Yes.

Dr. PRICE. I think it is also important to point out that sometimes Medicare rates are thrown out there as the panacea. In fact, new Medicare patients all across this land are having extreme difficulty finding a Medicare provider because of the rates that are paid.

So just because the government-run program would pay Medicare rates for a period of 3 years—and then who knows what—ought not give anybody warm fuzzies about the availability of physicians out there being able to care for these patients.

Dr. Moffit, I want to talk also about the government-defined parameters for the benefits package in the bill. My reading of the bill is that within a period of 5 years, every single plan offered out there must comply with the government-defined parameters for a benefits package; is that correct?

Mr. MOFFIT. That is correct.

Dr. PRICE. And therefore, there must be individuals out there in society right now, I believe, who are happy, content, desirous of a plan that doesn't necessarily fulfill all of the options that would be present in a government-defined program; is that correct?

Mr. MOFFIT. I am quite sure that is true, Congressman.

Dr. PRICE. Do you believe in your reading of the bill, then, that those individuals would not even be able to find those policies out there in the marketplace?

Mr. MOFFIT. There seems to be in the bill, if I read it correctly—it was good beach reading this weekend—but if I read it correctly, it seems like in the bill there is a grace period for the small group market, and there is a limitation that is unspecified for individual insurance. And at a certain point in time, the bill was very, very specific that the individual insurance policy will no longer be acceptable coverage under the terms of the bill. That is in black and white.

Dr. PRICE. And, Mr. Klein, would you agree with that?

Mr. KLEIN. That is right. I also would like to clarify one other point.

Dr. PRICE. Please.

Mr. KLEIN. When I cited the Medicare reimbursement rates for the first 3 years, it was not to suggest that that should give any great comfort. It is to the contrary; that they traditionally are substantially lower, and we in the employer purchaser private sector world end up being the recipients of that cost shift. And the problem is that after the 3 years, they are not even bound by the Medicare rate even.

Dr. PRICE. You are absolutely right. I would also like to just point out that the President, apparently today in his news conference, said this line that has been used by so many, "If you like the plan that you have, you can keep it." In fact what he said is that that is not actually the case. It would be that the government wouldn't mandate that you had to give it up.

But if, for example, the plan that you like is no longer available in the marketplace, then you can't keep it, right? Wouldn't that be the case? In fact, doesn't that get to your issue of crowding out not by law, Mr. Klein, but by effect of the rules put in place?

Mr. KLEIN. Yeah, we would like to—that is correct. We would like to have the plurality multiple choices from among which people can select. And I think that is the stated goal of the legislation, but I don't know that it is necessarily the outcome.

Dr. PRICE. Thank you. Thank you, Mr. Chairman.

Chairman MILLER. Thank you. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Ms. Young, how many employees, again, do you have?

Ms. YOUNG. We have 33 full- and part-time; 13 full-time.

Mr. HARE. If there was a public plan available, would you be able to provide insurance for your employees?

Ms. YOUNG. Yes.

Mr. HARE. For all of them?

Ms. YOUNG. Yes.

Mr. HARE. And you can't do that now because the insurance companies—there is no competition. You have two to pick from, if I understand.

Ms. YOUNG. We have one to choose one.

Mr. HARE. Wow. That is real competition out there. Those poor insurance companies, I don't know how they do it every day. So you have one person, right—one company right now, and you can't afford that. In the public plan you could provide those 33 people with health care.

Ms. YOUNG. Yes.

Mr. HARE. For them, their spouse, and their families.

Ms. YOUNG. Yes.

Mr. HARE. So while we nitpick this public plan, the fact of the matter is those people go without health care because you have no other option.

Ms. YOUNG. We have no other option.

Mr. HARE. I just sit here today, and I just feel so bad for our friends in the insurance company. I don't know, I suppose I will have to send them a card.

Professor Pollitz and Mr. Vaughan, I have a district that is very rural in west central Illinois. And the majority of individuals live in communities, in rural communities, yet access to mental health treatment is limited. Of those 1,700 federally designated mental health professional shortage areas, more than 85 percent of those are designated as rural.

So my question is to maybe both of you. In light of that, do you think we should expand the capacity of frontline community mental health centers to offer safety net providers for mental health care. Because that hasn't come up at all today but I think it is clearly something that we need to be looking at here, and something I like

in the bill is the mental health perspective. But in a rural community it is just very tough to get access there.

Mr. VAUGHAN. Absolutely. And one of the neat things in this bill is in efficient areas, like Iowa, low-cost areas, there is going to be a bonus for all primary care docs, and I think that is important.

Mr. HARE. Professor.

Ms. POLLITZ. And I remember seeing in the bill requirements to contract—for plans to contract with essential community providers that would include those very providers.

Mr. HARE. Ms. Wcislo, you were going say something?

Ms. WCISLO. Yes. In Massachusetts we have a log for that and in fact require that they have an adequate contract with mental health providers as well as community health centers. So we have done it already, and I think it is an important point to raise.

Mr. HARE. If you wouldn't mind for just one second, could you repeat the numbers in your testimony again that you talked about for the people that—the insured people you were talking about? I am sorry, I didn't write them down.

Ms. WCISLO. Some 650,000 were uninsured at the beginning of reform.

Mr. HARE. Six hundred fifty thousand were uninsured.

Ms. WCISLO. Right. Four hundred forty have now been insured, of which 191 are paying for it themselves or through their employers. So 44 percent of the ones we have insured have come through business or through the individual market where we have lowered the rate for individuals because we have pooled them with small businesses.

Mr. HARE. Wow. That actually can work.

Ms. WCISLO. And we only had three plans for small businesses, and you had the choice of—you could only pick one. So exactly what she is saying is true. And you had to have 75 of your employees to sign up or they wouldn't take you.

Mr. HARE. Dr. Mullan, just a quick question. Do you believe that the draft bill provides doctors and hospitals with enough incentives to encourage participation of the providers?

Dr. MULLAN. Well, in regard to the incentives for payment around primary care, yes. Beyond that, in terms of hospital incentives I don't think I saw that in the bill in a way that would directly—the bill didn't directly direct those payments.

I think what they provide, or what the strategy is in the bill, is to try to provide incentives for those areas of the system which we know are in short supply. And that is particularly rural areas, underserved areas, and primary care providers. So there is an effort to upscale the incentives in practice and also in training, particularly around loan repayments for, you know, work in very tough areas, National Health Service Corps, or there is also loan repayment for people who go into primary care who don't necessarily want to go into the most remote rural areas or the toughest inner city. There is also loan repayment there.

So it is a strategy to incentivize loan repayment, and yet the most benefit if you are willing to serve in the toughest areas.

Mr. HARE. I just have one quick question, Mr. Chairman. Dr. Moffit, I just want to know—and we can agree to disagree here—you don't support the public plan. My question would be to you, for

people who lose their jobs and they close a factory and move it someplace, if there is no public option for these people to go into, they are forced to either have COBRA or something, what do they do?

Mr. MOFFIT. Well, I actually strongly believe that what you have just talked about is the core of reform of the health insurance market. And that is one of the reasons why I was involved with Governor Romney in creating the Connector in the State of Massachusetts, where in fact you don't have a public plan; what you have is you have health insurance that is available to people within the market, and they can pick and choose the plans they want and take it with them. It is not necessarily dependent upon their place of work. What we need is portability in health insurance.

We don't have that today, Congressman. If we had portability in health insurance, even without spending any money, because we know an awful lot about the uninsured, if we had portability in health insurance where people could—where the insurance was tied to the person, not just simply the place where they work, the numbers of the uninsured would drop dramatically.

That is what we have to do. That is where we have to get to. Believe me, I agree with you entirely on this issue. We have too many people who are moving jobs, leaving jobs, going from one place to another, and they lose their health insurance. They don't lose their life insurance or their auto insurance or their homeowners insurance, but they lose their health insurance. And that is, frankly, terrible social policy and we should fix it. And I would like to see it fixed.

Chairman MILLER. Dr. Cassidy.

Dr. CASSIDY. A couple of things, Mr. Vaughan. I love what Consumer Report does. I subscribe, at least on line I do, when I need to buy a new washing machine.

Mr. VAUGHAN. You pay my salary.

Dr. CASSIDY. But let me say that one of my concerns about this bill, you have always been very consumer-oriented and you were speaking earlier about, my gosh, if the purple pill didn't work, do we have an intervention process? And in this 865 pages, which was plane reading for me, there is one paragraph about an ombudsman. And so my concern is that this is more about government than it is about the patient.

That said, Mr. Moffit, going back to the point of whether or not there is an additional subsidy, frankly theoretically until a year ago, we didn't give an additional taxpayer subsidy to Fannie Mae or Freddie Mac, correct?

Mr. MOFFIT. I don't recall.

Dr. CASSIDY. Yeah, it didn't. It was GFE, government whatever. And so in this document where we don't require that—there is one line that says that the public health insurance plan must have a contingency, very kind of ill-defined.

Mr. MOFFIT. A "contingency margin" was the phrase.

Dr. CASSIDY. Yeah. And Mr. Hacker in his document says that it would be backed by the full faith and credit of the Federal Government.

Mr. MOFFIT. Well, that is it; and the taxpayer is on the hook, of course. That is why I raised the question earlier in response to Congressman Andrews.

Dr. CASSIDY. Hang on there. We are in agreement. I just wanted to make that point because we are all on the hook whether or not—and in Medicare, as of 2018, will be.

Dr. MULLAN, up until like 6 months ago, man, I was full-time teaching young internists hepatology. He is the only guy in here who knows hepatology. And so I am very familiar with the fact that these young folks are not going into primary care.

Let me give you a scenario and you tell me how reasonable it is. It has been what I have learned, is that if you go to the pediatrician and you tell her, listen, we are going decrease your reimbursement by 5 percent because we now have a public health option plan which quite overtly is going to negotiate down and save money by hard-balling you, so she has got a fixed overhead, and she has got to see patients, but now she is getting paid less per patient, her only option is to increase volume.

Now, if she is increasing volume and spending less time with that patient, she is going to make more referrals and she is going to order more tests. She has just got to move patients, because otherwise she goes out of business.

Now, that has been my observation in primary care. In fact, I will say it is kind of like when I inflate a helium balloon for my daughter. I press the spigot, you know, I am squeezing that cost a little bit. The public health option is going to just, man, get that ounce of blood out of her. And then costs inflate because she is making so many referrals and she is ordering so many tests because she has to move that many more patients.

Paradoxically when public health, Medicaid, or Medicare squeezes the primary care doctor, spending goes up. Would you agree with that or would you dispute that?

Dr. MULLAN. I think the law speaks to Medicare payments which are within the parameter of the law and the Federal Government. And indeed the proposal within the law is to create two buckets of funding. One would be for primary care, the other would be for all other services. To the extent there is squeezing to be done, it is not in pediatrics where there is no money to begin with, either on the practitioner side or the government side.

Dr. CASSIDY. So if they squeeze more—and that is what they say quite overtly, we are going save money by using our monopsony power, our bargaining power, to bring down what we pay providers. What you are saying, they are already being squeezed and we are going to squeeze a little bit more?

Dr. MULLAN. I mean, Medicare is constructed with a sustainable growth rate, with a relative—with the annual upgrades and the various aspects that control or attempt to control physician costs within Medicare. That is in law already. That is not at issue in the bill in particular. And the public health option does not speak to that directly.

Dr. CASSIDY. Except it does say—and quite overtly—that it is going to use the Medicare-type paradigm, and it is just going to now apply to pediatrics. And, again, going back to what Dr. Hacker had to say in his paper—which again is the inspiration to this—

is that they would use their bargaining power to lower rates to reimbursements. He had one reference he cited that it is the prices, stupid; meaning that we are paying too much, stupid; and therefore if we just squeeze those providers a little bit more, we save money. Now, that actually seems a recipe for disaster for the average pediatrician.

Dr. MULLAN. Well, we do have a problem with the cost of Medicare, I think we all agree, and with the cost of a system in general. And there have been over the years a history of attempting to—

Dr. CASSIDY. But let me ask you again, if they reduced reimbursement to the average pediatrician, what would that do to our practice?

Dr. MULLAN. Well, there is a long history of increasing volume when the fees are limited. That has largely not been in the primary care sector. That has largely been in the specialty sector where fees are much larger and volume has grown much more rapidly, and that has distorted the system.

Dr. CASSIDY. Isn't it fair to say that is because the internist or primary care physician has such limited time? There is only so much you can stack in, but they have stacked in.

Dr. MULLAN. Well, to the extent that all of us are being required to be accountable for our time, it is a tight day. And the pediatrician's day, the primary care day, is a tight day. And people are not happy with that. But the question of how you control cost is one that is not the problem of the public health plan or the problem of Medicare. It is a problem of all of ours, I think, in terms of how we manage it. It has been out of hand for a long time, and I think there are efforts which are in this bill to try to get a better handle on that.

Dr. CASSIDY. That is more of the same in my book. It hasn't worked in the past. We are trying for a hopeful experience. Thank you. I yield back.

Chairman MILLER. Thank you. Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman.

A couple of things. To start with, Ms. Young, I certainly appreciate the fact that I have been in small business my entire career also. I think that competition is a good thing. There is no question about it, it makes me better as a physician. But because there is a public option there, that doesn't necessarily mean the price will be less. It might be, but it might not be.

And what my concern is that every single government plan we have right now relies on the private sector to pick up their not paying their fair share of the costs. TennCare, for instance, our Tennessee Medicaid system, pays only 60 percent. Now, the person getting the care could care less. They are getting their care, and it is being taken care of. And that is a prescription for overutilization.

I can tell you that is exactly what we saw where we were. Medicare does not pay its total expense. I mean, the Medicare payments are not paying the costs, at least in Tennessee, of providing the care.

And what Dr. Cassidy and others have said, I did a lot of pelvic reconstructive surgery, and I had a difficult time finding a primary care physician for my patients.

So, a lot of this plan that I like in here. Certainly there needs to be insurance reform; I have no question about that. But that doesn't necessarily mean that it would be—that your costs would be less. I would hope they would be, but that doesn't necessarily mean that they would be.

Ms. YOUNG. And I agree with that. Before working with my father, I worked in the insurance industry for 12 years, so I am really knowledgeable about how the insurance industry works. And I do agree that there does need to be a fix to Medicare, but there absolutely does need to be a fix to the private health insurance industry as well. Because it is very unfair for the little person, like us, to have to try and compete with the big businesses or whoever else for competitive rates, because we are not getting them.

Dr. ROE. No question. I think one of the things that you can do—this is an extremely complex plan. Let me just give you one little view here of the affordable health care choices of the private insurance market, just the individual market—is that insurance purchased on the individual market after the bill's effective date would not be considered acceptable coverage for the purpose of compliance for Federal mandates. These plans would also be prohibited from enrolling new members, ensuring that their risk pools can only get sicker and older, increasing the cost of coverage under the plan, which means you are going to shift people to the government plan.

I guess the question to the panel is, what happens when they don't pay the cost of care? What happens? And here you are—I mean, the patient doesn't care, but the facility has got to provide that care and get the money from somewhere.

Mr. KLEIN. Two things. One, I think that a lot of this dialogue has led to a point that hasn't maybe been explicitly stated. And that is, it makes no sense to argue on behalf of the need for a public plan based upon the current flaws of the insurance system when everyone, Republican and Democratic alike, employer community, the insurance industry itself, acknowledges that there have to be widespread and fundamental reforms to insurance rules: no pre-existing condition exclusions; guaranteed issue and renewability and all of those things. So it is a bit of a false straw man.

And to answer your question, the answer is that someone else in the system ends up paying for it.

Dr. ROE. Either the taxpayer, or it is shifted. Last year I worked for myself in a medical practice. We had 70 providers, 350 employees. I retired and ran for Congress. The next day I have to pay first dollar for my health insurance. It makes no sense to me to not make that tax deductible for an individual. That would make health care cheaper for, what, 21 million I heard, automatically.

Ms. Young, even if you couldn't afford whatever, it would lower whatever your tax rate is; it would lower your cost that much, like a large business can do. Any comments on that?

Mr. VAUGHAN. Well, sir, I would like to say the March MedPAC report to Congress, one of the most pages in it is page 67 where basically they found an eighth of the Nation's hospitals that are the best in terms of getting people well and not killing you and not giving you infection, they make money on Medicare. And the point of MedPAC is the private insurers are paying 132 percent of cost. We keep saying, oh, gosh, Medicare doesn't pay enough. Maybe it is the

private guys who aren't able to manage and aren't able to get a handle on cost.

Dr. ROE. I would argue, Mr. Vaughan—my time is short—I would argue they are paying 132 percent of cost because of what Medicare and the others are not doing. And I think you won't find that across the country. I will be glad to look at that later.

One other quick comment. Until we get our malpractice under control in this country—when I began my practice, it was \$4,000 a year. When I left, it was \$72,000 for an obstetrician. We have got to do something to help the doctors and the providers out there to be able to provide affordable care.

I yield back the balance of my time.

Chairman MILLER. The gentleman yields back. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. I want to thank the panel for all of your contributions this afternoon. It is an important debate, important discussion, and I appreciate your expertise and experiences.

Dr. Pollitz, from your remarks and looking at your submitted testimony, you talk about coverage adequacy and about—and I agree that is important. That was part of my frustration as a health care manager administrator with health care, the inadequacy at times. But the way I read it—I want to make sure I am portraying it accurately—that you see that the government entity to be created as a competitor is something that would assure that coverage adequacy, as you addressed in your testimony.

Ms. POLLITZ. The public plan option would have to offer the same essential benefit standard that every private insurance plan and employer plan would have to offer. It would be subject to the exact same coverage rules.

Mr. THOMPSON. As a starting point, my concern is—I mean, if you had looked at the record of denial, which essentially speaks to coverage adequacy of, frankly, cost-effective care by Medicare A and Medicare B.

Ms. POLLITZ. I am sorry, the rate of coverage denial?

Mr. THOMPSON. The rate of, yeah, coverage denial under the current—two of the, well, I guess consolidated under one, Medicare, Medicare Part A and Medicare Part B, the rate of denial of coverage were many times what I consider cost-effective care.

Ms. POLLITZ. I am sorry, I can't answer that question for you.

Mr. THOMPSON. Okay. Well, my point being—I mean, that is an area for me, the source of frustration in the different health care areas where I practice in. And frankly, unfortunately, it fell on me to do many of the appeals and different levels of appeals of what I thought was very cost-effective care that was being denied under our current government plan. And the appeal process was and continues to be pretty challenging to get that coverage covered.

And my concern that going forward, that frankly I don't think there is any assurance when the government gets involved in providing a plan. As we are looking at now, the coverage adequacy is going to continue. That won't be resolved.

Ms. POLLITZ. But, Mr. Thompson, I do believe, I haven't been a Medicare expert for many years, I have sort of shifted more to private insurance over the last ten years. But it continues to be the case that Medicare contracts out to private insurers, different ones,

one in each State, and that the coverage decisions often get made by the private insurers, and they often get made differently.

That has been a long-running problem with the Medicare program; that the carrier in Indiana may say something is not covered when it is covered in 48 other States. So I think consistency in coverage decisions is certainly important.

And the question that was being asked earlier, I think, about denials and the importance of getting people good coverage and other good consumer protections, is an important problem that is addressed in this plan. In particular, in this bill the standards for prompt and available appeals programs for everybody. Those aren't available for everybody now. And particularly external appeals are not available to a lot of people, and most people in employer-sponsored plans. And prompt payment of claims standards, I think those are incredibly important.

I had my daughter play soccer. She broke her arm in a soccer game 2 years ago when she was 12. And I had to fight with my insurance company for 10 months to get that claim paid. They said I had to send it to Workers Comp, and I had to fight about that for ten months. That was just silly.

So I mean, I think when we talk about changing, not leveling the playing field so much as changing the playing field, and just starting from the assumption that health insurance is going to take care of people and it is going to pay their claims, and if we could get that across the board, I think that would be just a tremendous thing for Americans.

Mr. THOMPSON. I agree that we need change. But I would come back to my original statement. We need the right change, and to do this in a systemic way that we are really designing this.

Just real quickly, because I am running out of time, Mr. Klein, can you please explain how new State law privilege—or I am sorry, State law private rights of action would apply to coverage offered through the health insurance exchanges?

Mr. KLEIN. Yes. The tri-committee draft legislation permits really varied and unlimited types of remedies that would be prescribed under State law for those plans that are sold through the exchange. So it could be punitive and compensatory damages. All the types of remedies that are not currently available under the ERISA regime, nor would be prescribed, nor, frankly, necessarily available under the public plan, that would be offered through the exchange.

Where the Medicare remedial scheme would apply, that also, for example, does not provide for compensatory or punitive damages. So it really sets up a dual standard within the exchange.

Mr. THOMPSON. Thank you.

Chairman MILLER. Thank you. Of course, you understand that the people in the exchange aren't in ERISA. There are not ERISA plans in the exchange.

Mr. KLEIN. Right.

Chairman MILLER. Right. So that would be existing law.

Mr. KLEIN. Exactly. In my oral remarks, there would be certain standards.

Chairman MILLER. So the privates would be treated as privates and publics would be treated as privates for the purpose of the discussion draft, and that is existing law.

Mr. KLEIN. Except that employers who want to purchase coverage for their employees through the exchange, then they would be subjected to those new remedies.

Chairman MILLER. That would be a decision that an ERISA employer would have to make 5 years from now.

Mr. KLEIN. Right.

Chairman MILLER. But you tried to suggest that somehow this was a new level of exposure; the fact is that is existing law.

Mr. KLEIN. Well, what I was trying to demonstrate was there are two different standards.

Chairman MILLER. No, the people in the public sector today would be treated—if you created a public plan—would be treated as if it was a public plan. You guys keep calling it Medicare so it would be treated like Medicare, and the private parts of the exchange would be treated as private plans are today under State law.

Mr. KLEIN. Right. My concern, though, is if there is a recognition that those kinds of remedies are not needed or appropriate in Medicare or under the new public plan, why then apply it to the other carriers?

Chairman MILLER. Well, we will see. That is the purpose of the mark; that we treat likes like. For the purposes of the discussion, the committees will make those decisions.

Ms. Wcislo, if I might, could you respond again, what has happened to the unemployed in Massachusetts? You cited some figures in responding.

Ms. WCISLO. In fact, if you get laid off and you can't afford COBRA—let's say that is the full freight of the insurance—you can in fact come into the Connector and stay there for 3 months until you find another job, or 6 months until you are under their coverage. We meet a lot of the needs of those people going in and out of the market in transition.

Chairman MILLER. And most of those people came through the job from the private sector. They lost their jobs and that is how you are picking them.

Ms. WCISLO. And so they have COBRA, and now their family plan is costing them \$1,200 a month, but they can't afford it because they are unemployed. That is not considered health insurance for purposes of us, and they can stay there as long as they don't have employer-sponsored insurance. Once they have employer-sponsored insurance, they sign up at work, and we are the safety net for them.

Chairman MILLER. So if you go into—you have lost your job. You had insurance, you lost your job, you go into the Connector—you go to COBRA, then go to the Connector, and then you take a new job. And if they don't provide insurance, you stay in the Connector?

Ms. WCISLO. If you are low income, you can stay in the Connector or you can stay in ComChoice, which is the nonsubsidized piece. If your employer offers it, you have to take what your employer offers, as long as it is affordable.

Chairman MILLER. And if your employer doesn't offer it, how is that shared?

Ms. WCISLO. If the employer doesn't offer it and you are low income, you can stay in the Connector products and you can have

them subsidized, or you can sign up for one of our three levels in the private sector. And that is where a lot of the individual market has gone. They have joined up through the Connector in the individual market, because we have lowered the rates paid by 30 percent in their premiums, and they have been declining, and now they are going back up.

Chairman MILLER. I think in our draft, if I am correct, we grandfathered the individual plans. People can keep them as long as they want.

Ms. WCISLO. Right. And we allow people to keep them. But if they choose to come into one, and they are all private insurance unless they are subsidized, they can come in or they can keep what they have.

Chairman MILLER. Now, what has happened with employers in this? You have a \$300 penalty.

Ms. WCISLO. Yeah. And employers are starting to pay the penalty. In fact, we have such a high insurance rate now, it is now up to 72 percent, very few of them are having to pay the penalty. And what we found is that almost half of our new insured folks are through the private sector. Our employers have stepped up to the plate.

Chairman MILLER. I guess I don't think \$300 to give up the cost of insurance for an employee is much of a penalty. But that is what you decided on because you had ERISA.

Ms. WCISLO. We decided on that just because of ERISA. There was a list of limitations and we were afraid of the challenge. And the political wisdom was we don't want the whole financing of it thrown out. You have the advantage of being able to do a larger penalty. If we had a larger penalty, in fact, the 2½ that remain uninsured could be insured. We are down to 2½ percent uninsurance now. We could do the rest of it.

Chairman MILLER. But employers who continued to offer insurance turned out to be stickier than people suggested, right? There was a lot of suggestion that \$300, they are out of there.

Ms. WCISLO. We found a lot of people would drop it. If you had asked me, I wasn't—when I was placed on this panel, the Connector, I thought the individual mandate is going to blow up; the employer thing is going to mean employers are going to dump all their employees into it.

The exact opposite has happened. And I think it really is a shared responsibility. Everyone in our State understands we all have to be part of the solution. The employers did the right thing and are continuing to do the right thing. Individuals have bought and are continuing to do the right thing. And the government stepped up to subsidize for low-income people. Because we are all in it together, everyone is trying to make it work. And so far it has been successful.

Chairman MILLER. So what is your take on the pay-or-play here?

Ms. WCISLO. I think it is important, because we were a very unusual State. We had 68 percent, as we were going into it, already offering insurance. We got it to go up. We were able to convince the business community. I know other States are much worse. And I think getting business to rethink what their responsibility is,

someone is going to pay for it. Employers should be paying their share, individuals should, and not just government.

And I think a balanced shared responsibility approach, like your bill says, is the way to go after that. You see, everyone has to be a part of this system. You can't just transfer it over to government to pay for everything. You can't just transfer it to individuals, because they can't afford it. All three of us have to pay it together. And I think your proposal is right on.

Chairman MILLER. Thank you. Well, thank you very much. Excuse me. Mr. Scott, I am sorry.

Mr. SCOTT. Thank you, Mr. Chairman. I appreciate it. I had been detained at another meeting, and I just wanted to ask one question just for the record.

Prenatal and well child care is an extremely important element to this plan. Does anybody disagree with that? Medicaid right now has a state-of-the-art kind of benefit package called EPSDT. Does anybody question whether or not that good package would be appropriate for the public plan or the entire choices, private or public choices? I thank you. Thank you, Mr. Chairman.

Chairman MILLER. Mr. Vaughan.

Mr. VAUGHAN. I would just urge—it is on page 25 of the discussion where they say the things to be covered are well baby and well child and the oral health, vision, hearing services, equipment and supplies, at least for children under 21 years of age. At least in report language, you may want to flesh that out a little bit more to make the parallel to EPSDT. But it sure smells like EPSDT to me.

Mr. SCOTT. That is what we are hoping. Thank you.

Mr. KLEIN. Congressman, I would just respond to your question by saying I think the one thing you would want to avoid is the experience that has developed over decades now in the States where every imaginable provider group, or group that wants to cover some specific disease or condition or treatment, comes and advocates for why its particular treatment or condition has to be covered.

What you do want in terms of a minimum benefit package that, for example, would be applied to the individual mandate, would be to allow for actuarial equivalency. And I think there is some suggestion and direction to try to go there as well. So be very, very cautious about enumerating specific things.

Mr. SCOTT. But the EPSDT doesn't enumerate the providers or anything. It is just a comprehensive set of benefits, early periodic diagnostic treatment to make sure that they are covered with all necessary medical treatment.

Chairman MILLER. Ms. Wcislo, did you want to comment?

Ms. WCISLO. Well, we just ruled in the Connector that—I beg to disagree with him. Some ERISA plans in our State will provide a family plan, but if the young daughter gets pregnant, too bad; you are out of luck, we are not covering it.

And I think setting a minimal standard about prenatal care, about maternity for all individuals covered by any plan, is really important. And that is a flaw in the ERISA system. On one hand, they make choices. We as a union are in ERISA plans and often make choices, but we need to—as a government and as a people—know that someone is going to be covered, and that one business

can't decide, oh, by the way, your daughter can't be covered, even though the rest of your family and your wife is.

We need to make sure those are covered for health care costs in the long term for the wellness of that baby and for the impact a baby that wasn't treated appropriately has on the school system and the health care system later. I think that standard is really important to have.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman.

Chairman MILLER. Thank you. Thank you very much. Thank you for your patience, but more importantly, thank you for your testimony and your answers to the committee members' questions, and your experience.

With that, the committee will stand adjourned. The record is open for 14 days for all members. And, again, if members have questions that they want to submit for the record we would appreciate if you could get back to us.

[The information follows:]

Questions for the Record Submitted to Dr. Hacker

Thank you for testifying at the Tuesday, June 23, 2009, Committee on Education and Labor hearing on "The Tri-Committee Draft Proposal for Health Care Reform."

One of the Committee members had additional questions for which he would like written responses from you for the hearing record.

Congressman Bill Cassidy (R-LA) asks the following questions:

During a speech you gave on July 21, 2008, you stated, "Someone once said to me this is a Trojan horse for single payer and I said well it's not a Trojan horse, right? It's just right there. I am telling you, we are going to get there over time, slowly, but we will move away slowly from reliance on employer-based health insurance. As we should. But, we will do it in a way that we aren't going to frighten people into thinking they are going to lose their private insurance."

Many advocates of a public health insurance plan deny that it will lead to a single payer system. However, you do not appear to be one of them as your quote acknowledges quite clearly that the inclusion of a public health insurance plan option will create such a system.

1. Is this good or bad for the American health system?
2. Do you think Americans would be happy to learn that they would lose their private health insurance coverage if a public health insurance plan option is widely available?

Please send your written response to the Committee on Education and Labor staff by COB on Tuesday, July 24, 2009—the date on which the hearing record will close. If you have any questions, please contact the Committee. Once again, we greatly appreciate your testimony at this hearing.

Sincerely,

GEORGE MILLER, *Chairman*.

Responses to Questions for the Record From Dr. Hacker

Thank you for your question. I have argued repeatedly that I do not believe that a new public plan will evolve into a single payer covering the whole nation—by which I mean a single public insurer paying doctors and hospitals directly. My comment at this 2008 forum was that the new public plan is not a hidden "Trojan Horse." The public plan is right out in the open, as it should be, since most Americans say they want the choice of a new public plan. As I said in my testimony to the committee, I believe that this new public plan should work alongside employment-based health insurance. It should also be required to compete on a level playing field with private health plans within a new national insurance exchange. The Congressional Budget Office (CBO), in its July 14 letter to Chairman Rangel on the House legislation, projects that the national insurance exchange will enroll approximately 37 million Americans. According to the CBO, a third of those in the exchange would enroll in the new public plan, which would mean that less than 5 percent of the U.S. population would be covered by the new public plan.

[Additional submission of Mr. Miller follows:]
 [The statement of the HR Policy Association may be accessed at the following Internet address:]

<http://www.hrpolicy.org/downloads/2009/Healthcare%20Tri-Committee%20bill%20-%20Education%20and%20Labor%20-%20Statement%20of%20HR%20Policy%20Association.pdf>

Mr. SCOTT. Mr. Chairman, there is a report on EPSDT, a policy brief by the Department of Health Policy. I would like this entered for the record.

Chairman MILLER. It will be made part of the file of the hearing. Thank you.

[Policy brief by the George Washington University Department of Health Policy follows:]



National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT

Sara Rosenbaum^a
 D. Richard Mauery^b
 Peter Shin^c
 Julia Hidalgo^d

Executive Summary

Medicaid has touched the lives of half of all of the low income young adults of prime military service age. The roots of Medicaid's unique child health eligibility and coverage policies can be traced to a seminal, 1964 government study entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. This study analyzed the underlying causes of the astounding 50 percent rejection rate among the young men drafted into the military in 1962. It documented pervasive evidence of treatable and correctable physical, mental, and developmental conditions, and its findings influenced the course of Medicaid legislation for children, particularly the comprehensive coverage available to children under the EPSDT program. This 1964 report remains relevant in a modern era of national security concern and serves to underscore Medicaid's ongoing importance to children and adolescents.

Introduction

One in every two young adults between the ages of 18 and 24 and of prime military service age comes from a low-income family.¹ Among this group, there is a one-in-two chance that Medicaid will have touched their lives at some point during childhood.²

^a Hirsh Professor and Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services, Washington D.C. We wish to thank David Rousseau of the Kaiser Commission on Medicaid and the Uninsured for his insights and assistance in preparing this report.

^b Senior Research Scientist, Department of Health Policy, The George Washington University School of Public Health and Health Services, Washington D.C.

^c Assistant Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services.

^d Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services.

¹ Twice the Federal poverty level (FPL) is \$32,180 for a family of three in 2005. See HHS poverty guidelines at <http://aspe.hhs.gov/poverty/05fedreg.htm>. The percentages of low-income adults aged 18-24 varies by percentage of FPL. According to the March 2004 Annual Social and Economic Supplement of the Current Population Survey, in 2003, 37.3% of adults aged 18-24 (10.4 million) lived at 200% of the FPL, 55.8% (15.5 million) lived at 300% of the FPL, and 69.2% (19.3 million) lived at 400% of the FPL. Source: U.S. Bureau of the Census, Current Population Survey, (2004). "POV01. Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race." Available at: http://pubdb3.census.gov/macro/052004/pov/new01_000.htm. See also the Appendix to this policy brief presenting a special analysis of the March 2004 CPS Supplement by age group of children and young adults at 200% and 400% of the FPL prepared by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute. At 200% FPL, 38% of 18-year-olds and 17% of 19-to-24-year-olds were covered by Medicaid; at 400% FPL 23% of 18-year-olds and 14% of 19-to-24 year-olds were covered by Medicaid.

This Policy Brief is part of a project funded by the Robert Wood Johnson Foundation's program to study Changes in Health Care Financing and Organization (HCFO); its purpose is to examine Medicaid's role in financing health care for members of the U.S. military and their families. This analysis explores Medicaid's child health policy roots in national security.

Although Medicaid's importance for children has been extensively documented,³ these national security roots have been forgotten by most. Indeed, the Medicaid child health eligibility expansions enacted during the Reagan and first Bush Administrations,⁴ which virtually doubled program coverage, are the direct descendants of this history, which in great measure can be traced to a seminal Presidential study that documented the poor health status of young military recruits.

The imperative to focus on Medicaid's role in child health policy is considerable because of Medicaid's sheer reach into the child population. Single-year enrollment numbers show that Medicaid now reaches more than 25 percent of all children, 60 percent of poor children (at or below 100% of the Federal poverty level), and 39 percent of near-poor children (between 100% and 200% of the Federal poverty level).⁵ But even these figures understate Medicaid's reach over time into the population of lower-income children and adolescents from whom the U.S. military forces disproportionately are drawn.⁶

Child health policy has been a pivotal theme in Medicaid since its original enactment. Attention originally was focused on eligibility; within two years, however, this focus would be extended to the actual range and depth of Medicaid coverage for children and adolescents. Evidence of the poor health status of young military recruits played a powerful role in this set of policy reforms,

² See Appendix for methodology used to calculate this estimate.

³ See, e.g., Children's Defense Fund, *EPSDT: Does it Spell Health Care for Poor Children?* (Children's Defense Fund, Washington D.C., 1977); Children's Defense Fund, *Doctors and Dollars are Not Enough* (Washington D.C., 1977); Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid* (MIT Press, Cambridge, MA, 1981); Herz EJ, Chawla AJ, Gavin NI. (1998). Preventive Services for Children Under Medicaid, 1989 and 1992. *Health Care Financing Review* 19(4):25-44; Sardell A, and Johnson K. (1998). The Politics of EPSDT in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits. *The Milbank Quarterly* 76(2): 175-205; Rosenbaum S and Sonosky CA. (2001). Medicaid Reforms and SCHIP: Health Care Coverage and the Changing Policy Environment. In C. J. DeVita & R. Mosher-Williams (Eds), *Who Speaks for America's Children? The Role of Child Advocates in Public Policy* (pp. 81-104). Washington, DC: Urban Institute Press; Klerman, LV. (1991). "Alive and Well? A Research and Policy Review of Health Programs for Poor Young Children." New York, NY: National Center for Children in Poverty; O'Connell M., Watson, S. (2001). "Medicaid and EPSDT." Neighborhood Legal Services, Buffalo, NY Available at: <http://www.nls.org/conf/epsdt.htm>; Olson K, Perkins J, Pate T. (1998). "Children's Health Under Medicaid: A National Review of Early Periodic Screening, Diagnosis, and Treatment." National Health Law Program. Available at: <http://www.healthlaw.org/pubs/child1998healthsum.html>.

⁴ Rowland, D., Salganicoff, A., Keenan, PK. (1999). The key to the door: Medicaid's role in improving health care for women and children. *Ann. Rev. Public Health* 20:403-26.

⁵ Kaiser Commission on Medicaid and the Uninsured. (2004). "Key Facts: Health Coverage for Low-Income Children -- September 2004 Update." Available at: <http://www.kff.org/uninsured/2144-04.cfm>. Accessed April 25, 2005.

⁶ See footnote 1 supra and the Appendix for estimates of poverty rates by age group as well as a discussion of the income estimates derived from the 1998 Department of Defense Population Report (available at: http://www.dod.mil/p/home/poprep98/html/7-index_scores.html). Accessed April 25, 2005.

and at a time when national security and preparedness concerns have once again become prominent features of U. S. policy landscape, this historical context is worth exploring.

This Policy Brief begins with a brief overview of Medicaid and child health, examining both its early eligibility structure as well as the advent of Medicaid's special benefit for children, which is known as "early and periodic screening, diagnosis and treatment (EPSDT)." The Brief then describes the findings from this pivotal 1964 study that so strikingly influenced Medicaid's child health policy: *One Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. The Brief concludes with a discussion of the continued relevance of this history to Medicaid reform.

Background and Overview: Medicaid Child Health Policy

Beginning in 1965, Medicaid was designed to cover low-income children from birth through young adulthood. Consistent with welfare program eligibility rules of the time,⁷ the original Medicaid legislation made coverage of children under age 21 living in families who received Aid to Families with Dependent Children (AFDC). At the same time, the statute also gave states the option to extend coverage to all children under age 21 living in low-income families who did not qualify for cash welfare. This state option to extend coverage to all low-income children was unanimously adopted by the Senate in response to a Floor amendment offered by Senator Abraham Ribicoff of Connecticut.⁸ By the early 1980s, when the modern period of Medicaid child health expansion commenced, approximately half of all states had pursued this option.⁹

Although the original Medicaid legislation provided states with an option to expand eligibility, the original Act did not provide for special standards related to the coverage of children; no minimum preventive and developmental benefit package was specified, nor were there requirements related to outreach to families and support in securing services.

The Medicaid EPSDT amendments were part of a larger package of reforms sent to Congress by President Johnson in 1967, which were aimed at improving the availability and quality of pediatric health care throughout the U.S.¹⁰ In his Letter to Congress transmitting his child health recommendations, the President stated:

Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder—

⁷ In 1981 the maximum age limit for AFDC benefits was reduced from 21 to 18. (1981 Omnibus Budget Reconciliation Act, Public Law 97-35). In 1996 AFDC was repealed and replaced with the Temporary Aid to Needy Families (TANF) program. The maximum age limit for children under TANF is set at 18 (or 19 if child is a full-time student in a secondary school (or in the equivalent level of vocational or technical training)). (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193).

⁸ Anne Marie Foltz, *An Ounce of Prevention: Child Health Politics Under Medicaid*, supra note 3, pp. 18-19.

⁹ Sara Rosenbaum and David Rousseau, "Medicaid at Thirty Five" St. Louis University Law Journal 45:1 pp. 1-71 (Winter, 2001). See also, *The Deficit Reduction Act of 1984*, House of Representatives Conference Report no. 98-861, GPO 35-426 0 (Washington, D.C.: US GPO, 23 June 1984) for a discussion of how many states opted to extend coverage to poor children regardless of their family's work status or family composition.

¹⁰ United States House of Representatives, Committee on Ways and Means, Hearings on the President's Proposals for Revisions in the Social Security System. (GPO, Washington D.C., 1967).

these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear—to give every child the chance to fulfill his promise. Even during these years of unparalleled prosperity: [...] more than four million children will suffer physical handicaps and another two million will fall victim to preventable accidents or disease...

*Under the Medicaid program enacted in 1965, the 25 states now in partnership with the Federal Government will help pay hospital costs and doctors' bills for more than 3.5 million poor children this year. By next year, we expect 23 more states to join Medicaid. I am requesting increased funds for ... Medicaid program, including ... legislation to expand the timely examination and treatment of ... poor children...*¹¹

These sweeping recommendations, which became the EPSDT amendments, were enacted as part of the Social Security Act Amendments of 1967.¹² Termed “altogether different in kind and style”¹³ from anything that preceded them, the Medicaid EPSDT amendment provided for such early and periodic screening and diagnosis of individuals who are eligible [for Medicaid] and under the age of 21, to ascertain their physical and mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby.¹⁴

In sum, within two years of enactment, the President and Congress had come to understand Medicaid’s singular potential to promote child health and development, not merely to finance treatment for diagnosed illnesses. Medicaid’s special relationship to childhood growth and development among low income children was crystallized in the EPSDT amendments.

The continuing evolution of EPSDT has spanned nearly four decades, with important modifications in 1972, and again in 1981 under the Reagan Administration, to add specific outreach and family support requirements to promote health care access.¹⁵ Amendments under the first Bush Administration in 1989 further broadened medical assistance coverage to ensure full coverage for all physical, mental, and developmental conditions. Today EPSDT ensures coverage for all medically necessary diagnostic and treatment services that fall within the federal definition of “medical assistance” for virtually all Medicaid enrolled children. With very limited exceptions for “medically needy children,” EPSDT is a service requirement for children who qualify for Medicaid on either a mandatory or optional basis.¹⁶

Several aspects of the EPSDT benefit make it unique. First, the range and depth of the periodic and interperiodic health examinations provided under the program are striking, with explicit requirements to assess growth and development as an essential part of the screening (i.e., assessment) process.

¹¹ Lyndon B. Johnson. Special Message to the Congress Recommending a 12-Point Program for America’s Children and Youth, February 8, 1967. Transcript available at <http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&tl=Johnson>.

¹² Pub. L. 90-248.

¹³ *Welfare Medicine in America*, supra note 4, p. 248.

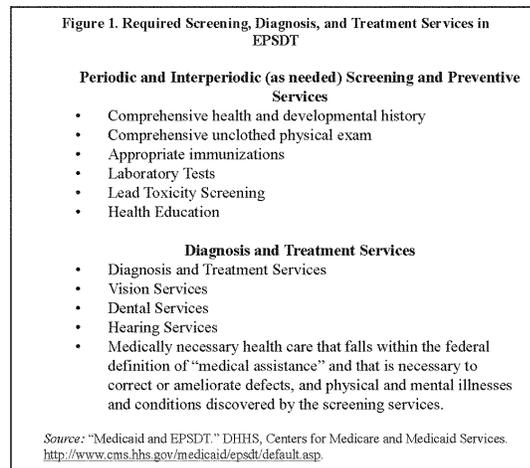
¹⁴ *An Ounce of Prevention*, supra note 3, pp. 22-25.

¹⁵ Social Security Amendments of 1972. October 30, 1972. Pub. L. 92-603.

¹⁶ EPSDT is an optional benefit only in the case of children whose eligibility is based on their “medically needy” status. 42 U.S.C. §1396a(a)(10)(C). This change was made in 1981.

Second, EPSDT covers an unparalleled range of diagnostic and treatment services for children whose examinations reveal potential physical, mental, or developmental conditions. Unlike conventional commercial insurance, these special coverage standards do not distinguish between acute conditions that can be cured and lifelong and chronic conditions whose effects and severity can be "ameliorated" through health care. Third, from its inception in 1967, EPSDT has been governed by a special medical necessity standard whose scope derives directly from the statutory terms "early" and "ameliorate."¹⁷ Federal agencies and courts alike have interpreted these terms to require health care interventions at the earliest possible time, when needed to ameliorate (i.e., lessen) the effects of conditions, both physical and mental, that potentially could impair childhood growth and development.¹⁸

Figure 1 summarizes all required screening diagnosis and treatment services covered under EPSDT.



¹⁷ §1905(r)(5) of the Social Security Act, 42 USC §1396d(r)(5).

¹⁸ "Medicaid at Thirty-Five." *op. cit.*

The Historical Context for Medicaid Child Health Policy

*The findings of this Task Force are dramatic evidence that poverty is still with us, still exacting its price in spoiled lives and failed expectations. For entirely too many Americans the promise of American life is not being kept. * * * I wish to see an America in which no young person, whatever the circumstances, shall reach the age of 21 without the health, education, and skills that will give him an opportunity to be an effective citizen and a self-supporting individual. * * ** [Lyndon B. Johnson, January 5, 1964]¹⁹

One historical study in particular sheds light on how federal policy makers might have come to structure within Medicaid such a broad and unprecedented health policy for low income children. Entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*,²⁰ the study shed overpowering light on the health status of young military draftees. Among its most significant findings: the majority of young men rejected for compulsory military service in the early 1960s failed as a result of physical and mental health conditions, many of which could have been diagnosed and successfully treated in childhood and adolescence. These young adults typically came from impoverished families and had experienced unrelenting deprivation in health care, education, and employment. The report's findings provided compelling evidence for an underlying tenet of President Johnson's conclusion that improving the health and well being of the nation's poor required strategies aimed at ameliorating the effects of social, economic, and health disparities.

The Task Force on Manpower Conservation: Establishment, Charge and Findings

On September 30, 1963, President John F. Kennedy established the Task Force on Manpower Conservation to investigate why, in 1962, an astonishing 49.8 percent of 306,073 Selective Service draftees failed their pre-induction peacetime medical and/or mental aptitude examinations, thus disqualifying them for military service. Beyond its obvious implications for national military preparedness, in the President's view²¹ these figures presented arresting evidence of both the diminished, yet preventable, health status of low-income children and the long-term strength and productivity of the nation.

The President directed that the Secretaries of Defense, Labor, and Health, Education, and Welfare (HEW, predecessor of DHHS) lead a Task Force that would "prepare a program for the guidance, testing, counseling, training and rehabilitation of youths found disqualified because of failure to meet the physical or mental standards of the Armed Forces, and to make such recommendation as their survey of this situation suggests."²² The Task Force was ordered to submit a final report no later than January 1, 1964.²²

¹⁹ Statement on the report, *One-Third of a Nation*. Cited in: The health status of American youth: A report on young men found unqualified for military service." *Clinical Pediatrics*. 3(11):625-628. November 1964.

²⁰ The President's Task Force on Manpower Conservation. *One-Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. The White House. Washington, DC. January 1, 1964.

²¹ Statement by the President [Kennedy]: Establishing the Task Force on Manpower Conservation. September 30, 1963. Cited in *One-Third of a Nation: A Report of Young Men Found Unqualified for Military Service*. pages A-1 - A-2.

Two months after Kennedy's directive, the Task Force issued its final report, which concluded that the military draft failure rate provided powerful evidence of "the unfinished business of the Nation."²³ The information presented in the report offered a sobering look into the health conditions and socio-economic characteristics of the young men rejected for military service. Reasons for rejection included "medical," "mental," and "administrative or moral." Medical examinations included both physical and psychological criteria designed to identify men whose conditions "may endanger the health of other individuals, cause excessive loss of time from duty, excessive restrictions on location of assignment, or become aggravated through performance of military duty." Mental examinations were conducted through administration of the Armed Forces Qualification Test (AFQT), a written exam designed to test mental aptitude for military service, including questions on vocabulary, reading, writing, arithmetic, and mechanical understanding. Men rejected for administrative or moral reasons included those who had "significant criminal records, anti-social tendencies, such as alcoholism or drug addiction, or for other traits of character which would make them unfit in a military environment."²⁴

In reviewing the records of all categories of examinations for military service between August 1958 and June 1960, the Department of Defense calculated the overall rate of reasons for rejection at 31.7 percent. The Task Force report, using updated information, estimated that the overall rejection rate had since increased to 35-36 percent. This overall rejection rate included both voluntary enlistees and draftees; the 49.8 percent rejection rate noted above was for 1962 draftees only.²⁵

Table 1 shows that among the reasons for rejection, "administrative" reasons accounted for less than four percent of the failure rate among enlistees and draftees and less than three percent of the failure rate among draftees only. Far more important in terms of the high rejection rates were failure rates for medical examinations and mental tests, which (not surprisingly) were particularly elevated among the draftee-only group, since enlistees could be expected to self-select from a healthier socioeconomic pool.

²² *Ibid.*

²³ Letter of Transmittal, President's Task Force on Manpower Conservation. Reprinted in *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. January 1, 1964.

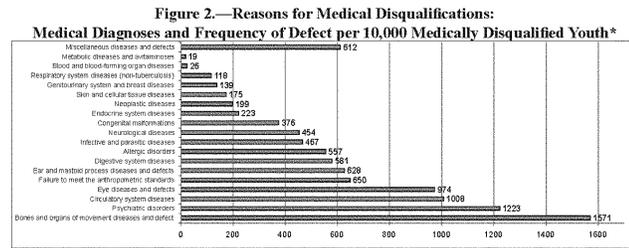
²⁴ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. *op. cit.* pp. 9-10.

²⁵ The report attributed the differential to large numbers of young men who were examined and accepted for voluntary enlistment or officer training programs at younger ages, before reaching the age of referral for draftee examinations.

Table 1.—Percentages of Military Rejections by Reason, 1958-1962

Reason for Rejection	Enlistees and Draftees, 1958-60	Draftees Only, 1962
	Percent	
Failed medical examination only	14.8	24.5
Failed mental tests only	11.5	22.7
Failed both medical and mental tests	1.5	1.5
Administrative reasons	3.9	2.6
Total rejected	31.7	49.8

Figure 2 presents the reasons for medical rejection noted in the report. Most frequently noted were diseases and disorders of bones and organs of movement, psychiatric disorders, circulatory diseases, eye diseases, and failure to meet anthropometric standards (height and weight).



* Based on examinations conducted between August 1953 through July 1958. Source: Bernard D. Karpinos, "Qualifications of American Volunteers for Military Service." Medical Statistics Division, Office of the Surgeon General, Department of the Army, 1962. Reprinted in *One-Third of a Nation*, p. 26.

Within these diagnostic categories, the report detailed the most frequent specific causes for medical disqualification, as shown in Table 2

Table 2.—Frequently Mentioned Causes for Medical Disqualification

Diagnostic Category	Main Causes of Disqualification
Psychiatric disorders	Character and behavior disorders
Neurological diseases	Epilepsy
Infective and parasitic diseases	Acute poliomyelitis and tuberculosis

<i>Diagnostic Category</i>	<i>Main Causes of Disqualification</i>
Neoplastic diseases	Pilonidal cyst ²⁸
Allergic disorders	Asthma
Circulatory system diseases	Chronic rheumatic heart disease and
Digestive system diseases	Hernia of the abdominal cavity
Anthropometric standards	Overweight
Defects of bones and organs of movement	Deformities or impairments and amputation of extremities

The Task Force noted that these conditions represented a spectrum of severity and potential for treatment. The report concluded that one out of ten medical rejectees had conditions entirely correctable with medical intervention, ranging from serious infectious diseases like syphilis and tuberculosis to hernias and cleft palates. One out of five rejectees had more chronic conditions requiring longer term treatment such as epilepsy, asthma, and heart disease. Another one out of four rejectees had need of intensive treatment services for conditions such as deafness, loss of limbs, spinal curvature, and serious congenital malformations. Finally, the Task Force noted that one in four medical rejectees had conditions for which medical treatment was not the answer. This included men who were totally blind, or too tall or too short to meet military standards.

In addition to the 24.5 percent of draftees who were rejected for medical reasons, the report noted that another 22.7 percent were rejected for failing the AFQT for mental aptitude for military service. These were men who scored in "mental groups" IV and V (30th percentile or less) in the AFQT scoring system:

<i>Mental Group</i>	<i>Required Correct Answers</i>	<i>Corresponding Percentile Score</i>
I.	89 – 100	93 – 100
II.	74 – 88	65 – 92
III.	53 – 73	31 – 64
IV.	25 – 52	10 – 30
V.	24 or less	9 or below

²⁸ "A pilonidal cyst is a cyst at the bottom of the tailbone (coccyx) that can become infected and filled with pus. Once infected, the technical term is pilonidal abscess. [One] theory is that pilonidal cysts appear after trauma to the sacrococcygeal region (the region relating to both the sacrum [the lower vertebrae] and coccyx). During World War II, more than 80,000 soldiers developed pilonidal cysts that required a hospital stay. People thought the cysts were due to irritation from riding in bumpy Jeeps. For a while, the condition was actually called 'Jeep disease'." <http://www.emedicinehealth.com/articles/20243-1.asp>. Accessed Feb. 5, 2005.

To investigate the reasons for this high failure rate of the AFQT among draftees, the Task Force commissioned the Department of Labor and the Selective Service System to interview a national sample of 2,500 recent AFQT rejectees to develop a deeper understanding of the socio-economic conditions that may have affected their lack of educational performance. Much of the Task Force report provides detailed information about these AFQT rejectees' lives, including their incomes, family history, marital status, education, and employment. The common themes that emerged were extreme poverty, limited education, and families living under conditions of significant stress and poverty. Significant disparities by race and national origin were evident in the data as well, with far deeper poverty, higher rates of unemployment, and lower educational attainment among minority rejectees.

The Task Force also found wide variations in rejection rates among the states, particularly for mental rejectees, ranging from as low as 3 percent in some states to as high as 50 percent in others. Southeastern states generally had higher rates of mental rejectees compared to states in the Mountain, Great Plains, and Far West regions, where medical reasons were more common. The Task Force attributed this variation to variations in demographic and socioeconomic status and overall living conditions for the poor.²⁷

Despite the evidence of pervasive harm to children documented in the report, the Task Force concluded that:

*...in every generation, talent appears at every social stratum, in every geographic area. Given equal opportunity, * * * the poor will prove their worth at an early age and go on to live lives of substantial achievement. However, this process can easily be thwarted, and * * * [T]here is little question that the process has not worked for a great many of them young men who fail to meet the mental requirements for military service in the United States today²⁸*

Most of the Task Force's recommendations focused on the development of compensatory programs for young low-income adults rejected from the military draft. However, the Task Force also made recommendations regarding improvements in screening, diagnosis, and treatment of diseases and conditions in early childhood and adolescence, with a strong emphasis on the placement of programs in schools.^{29,30}

The work of the Task Force in combination with subsequent studies on the health status of infants, children, and children with disabilities,³¹ formed the contextual basis for the President's 1967 child health recommendations to Congress.³² Immediately following their submission, the President's

²⁷ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 12.

²⁸ *One-Third of a Nation: A Report on Young Men Found Unqualified for Military Service. op. cit.* p. 15.

²⁹ *Ibid.* p. 29.

³⁰ *Ibid.* p. 35.

³¹ *An Ounce of Prevention; EPSDT: Does it Spell Health Care for Poor Children? Supra*, note 3.

³² Lyndon B. Johnson, Special Message to the Congress Recommending a 12-Point Program for America's Children and Youth, February 8, 1967. *op. cit.*

recommendations were translated into legislative language providing for the amendments to the Social Security Act that incorporated the EPSDT program and its standards into Medicaid.³³

Conclusion

For 40 years, Medicaid has provided essential health coverage to tens of millions of low-income children and youth. Medicaid is a dominant force in the U.S. health care system and its early policy roots are often difficult to discern. This Policy Brief has explored the national security study that lies at the foundations of Medicaid child health policy. The findings of *One Third of a Nation*, as well as the language of the Medicaid statute itself, serve to underscore the fact that Medicaid child health policy hardly has been happenstance. From its virtual enactment, Medicaid aimed to cover all low income children with the broadest possible developmental health benefits. By 1967, the very concept of coverage itself had been transformed, and this transformation has continued throughout Medicaid's history.

The need for a continued Medicaid child health policy that aims at growth and development, not merely treatment of episodic illness, continues to reverberate, not only in a broader health policy context, but as a matter of national security. During a March 12, 1998 hearing before the House Armed Services Committee, Mark E. Gebicke, Director of Military Operations & Capabilities Issues for GAO's National Security & International Affairs Division, stated, "Of the 25,430 enlistees who entered the services in fiscal year 1994 and were discharged in their first 6 months, 29 percent failed to meet minimum performance standards, 27 percent were found medically unqualified for military service and 14 percent had character or behavior disorders."³⁴ The importance of a continuing commitment to broad child health policy endures, even as the health system itself is transformed. National security depends on the growth and development of children; in view of the demographics of those who serve, this dependence is particularly striking in the case of the low-income children who are at greatest risk for poor health outcomes. In this respect, Medicaid's role in reducing health disparities among low-income and minority children remains a paramount national concern.

³³ Social Security Amendments Act of 1967, Pub. L. 90-248.

³⁴ Testimony of Mr. Mark E. Gebicke, Director, Military Operations & Capabilities Issues, National Security & International Affairs Division, U.S. General Accounting Office. Available at: <http://www.house.gov/hase/testimony/105thcongress/3-12-98gebicke.htm>. Accessed April 6, 2005.

APPENDIX

Statistical Methodology for Calculating the Proportion of Military Recruits Who May Have Been Covered by Medicaid at Some Point in Their Lives Prior to Recruitment

The purpose of this analysis was to estimate the proportion of military recruits who may have been covered by Medicaid at some point in their lives prior to recruitment. Ideally, longitudinal data would be used to track health insurance coverage of a cohort of individuals from time of birth to recruitment and identify at least one point in time in which they were covered by Medicaid.³⁵ From such data, a simple calculation can be made by counting the number of recruits covered by Medicaid at any time in their youth and dividing it by the total number of recruits. Although the Department of Defense (DOD) and services collect demographic data on recruits, limited information was publicly available. Unfortunately, none focused on or detailed medical history or health insurance information of recruits.³⁶

Alternatively, data from the 2003 Current Population Survey (CPS) and the 2002 socioeconomic information from the 1998 DOD *Population Representation in the Military* reports were used to estimate the population pool from which individuals are likely to have been recruited. Specifically, the 2002 DOD report shows the average age of recruits is 20 years, and over half of the activity duty force is between 17-24 years.³⁷ This information was used to focus the analysis of the CPS data on persons aged 24 years and younger.³⁸ Table 1 shows the proportion of individuals with incomes less than 200 percent of the Federal poverty level (FPL) covered by Medicaid.

Table 1. Percent Covered by Medicaid, 200% FPL

Age	Percent
Under 1	61%
1-5	59%
6-17	48%
18 only	32%
19-24	17%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

These estimates may be considered too high because of the lower income threshold; and the 1998 DOD *Population Representation* report suggests recruits may not come primarily from the low

³⁵ Creswell JW, *Research Design: Qualitative and Quantitative Approaches* (Thousand Oaks, CA: Sage Publications) 1994.

³⁶ The DOD may collect information on insurer prior to recruitment. *Military personnel: first-term recruiting and attribution continue to require focused attention.* Testimony of Rabkin NJ before the Subcommittee on Personnel, Committee on Armed Services, United States Senate, February 24, 2000 (<http://www.gao.gov/cgi-bin/gettrpt?GAO/T-NSIAD-00-102>).

³⁷ <http://www.dod.mil/prhome/poprep2002/> (Accessed April 5, 2004).

³⁸ The 2004 Federal poverty guideline for a family of three was \$15,670.

end of the socioeconomic spectrum.³⁹ Therefore, the income limit was expanded to 400 percent of FPL, or \$60,000 per year for a family of three.⁴⁰ Table 2 shows the proportion of the population covered by Medicaid and likely to be targeted by the military for service.

Table 2. Percent Covered by Medicaid, 400% FPL

Age	Percent
Under 1	46%
1-5	42%
6-17	33%
18 only	23%
19-24	14%

Source: KCMU and Urban Institute analysis of the March 2004 Current Population Survey, 2005

Based on the population pool eligible for military service, Medicaid covers approximately one in two persons at some point prior to recruitment. That is, at least 46 percent of recruits may have received Medicaid during infancy, and this estimate may be higher as some individuals become eligible in later years. Given that the data provides only a single point-in-time estimate and does not include the actual cohort of individuals recruited, the one-in-two proportion is given as a conservative estimate for the purpose of this analysis.

³⁹ http://www.dod.mil/prhome/poprep98/html/7-index_scores.html (Accessed April 5, 2004).

⁴⁰ The 1998 DOD report indicated "both active and reserve recruits are primarily from families in the middle and lower middle socioeconomic strata," which is adjusted by a higher level of education and reading skills compared to their civilian counterparts in addition to employment status, occupation, and home ownership. For purposes of a more conservative estimate, the population pool of potential recruits is adjusted to 400 percent of FPL.

[Additional submissions of Mr. Scott follow:]

EPSDT Amendment Proposed by Mr. Scott

Application of Medicaid EPSDT benefit requirements to all health programs.

At the appropriate place in the bill, insert the following:

"Sec. _____. Coverage of EPSDT benefits for all children

"Notwithstanding any other provision of law, every individual under the age of 21 eligible for health coverage under this or any other Act, including the Children's Health Insurance Program under title XXI of the Social Security Act, shall be entitled to benefits for all medically necessary health care, including early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act) consistent with the requirements of section 1902 (a)(43) of that Act."

300 Percent Amendment Proposed by Mr. Scott

Providing a national eligibility floor for children and pregnant women up to 300% of the federal poverty level.

At the appropriate place in the bill, insert the following:

“Sec. ____ . Eligibility of children and pregnant women whose family income does not exceed 300 percent of the federal poverty line for Medicaid or CHIP.

“As a condition of participating in the programs established under this Act and under titles XIX and XXI of the Social Security Act, a state shall ensure that all children under the age of 21 and pregnant women whose family income does not exceed 300 percent of the federal poverty line shall be eligible to enroll in the state’s Medicaid or Children’s Health Insurance Program as established under the Social Security Act.”

Medicaid and CHIP Amendment Proposed by Mr. Scott

Provisions relating to prompt enrollment of children into Medicaid, CHIP, and the programs established under this Act.

At the appropriate place in the bill, insert the following:

“Sec. ____ . Simplified, Automatic Enrollment Systems.

“(a) Finding. Congress finds that approximately 6 million children currently uninsured are eligible for but unenrolled in Medicaid and CHIP, and prompt enrollment of all children in health coverage programs is critical.

“(b) Purpose. The purpose of this section is to require states to simplify systems for enrolling low-income children and pregnant women in Medicaid and CHIP, retaining eligible children and pregnant women in those programs, and helping ensure that all children receive health coverage in a timely fashion, without lapses in coverage.

“(c) State plans. Each state plan provided for under title XVIII and title XXI of the Social Security Act shall provide for a system of streamlined enrollment of children below the age of 21 that includes the following (as specified by the Secretary):

(1) A simple, short joint application form translated into multiple languages that can be used for both Medicaid and CHIP.

(2) Applicant self-attestation of eligibility, subject to verification, random audits, or both.

(3) The option for applications to be submitted in-person, online, by mail, or as part of applications for other programs.

(4) Express lane enrollment, as provided for in section 203 of the Children’s Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(5) 12-month continuous eligibility

(6) Presumptive eligibility during an interim period of coverage for individuals who appear to qualify for assistance under this title, on the basis of preliminary information.

(7) A determination of continued eligibility at the end of the individual’s eligibility period, based on all data available to the State. If such determination cannot be made, the individual or family shall be contacted for additional information, but only to the extent such information is not available to State officials from other sources. The family shall be notified of all determinations and findings and given an opportunity to contest and appeal them. An individual’s eligibility shall continue until the redetermination process is complete.

Provided that such plan may not impose an asset test or waiting period for enrollment of children.

“(d) Automatic enrollment systems for all children. The Secretary shall establish mechanisms to ensure the prompt enrollment of a child in a public or private health program upon establishment of the child’s eligibility to participate in any federally-funded program, the birth of a child in the United States, the assignment of a social security account for a child, a visit with any health care provider eligible to participate in the programs established under this Act, enrollment in any public elementary or secondary school or any other elementary or secondary school subject to mandatory immunization requirements, enrollment in a publicly-subsidized child care program, upon discharge of a child from a public institution or other institution where the child has been confined, and such other points of enrollment as the Secretary may establish.”

[Submission of Mr. Andrews follows:]



Statement
on Behalf of Hewitt Associates LLC

by

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for

U.S. House of Representatives
Committee on Education and Labor

on

Hearing on the Tri-Committee Proposal for Health Care Reform
June 23, 2009

Hewitt Statement

Mr. Chairman and Members of the Committee: Thank you for the opportunity to submit our response to the Discussion Draft of the House Tri-Committee Health Reform Proposal, addressing the reform of America's health care system and expansion of health care coverage. Hewitt Associates is a global human resources outsourcing and consulting company, providing services to major employers in more than 30 countries and employing 23,000 associates worldwide. Headquartered in Lincolnshire, Illinois, we serve more than 2,000 U.S. employers from offices in 18 states plus the District of Columbia.

As the nation pursues a path leading to universal coverage, we can learn a great deal from the experience of large employers. Employers are the single largest provider of coverage for working Americans and their families, and the system is highly valued by both employers and employees. Nationwide, employer-sponsored health care plans provide health care coverage to 160 million participants. The latest data from the Kaiser Family Foundation from 2008 shows that 99 percent of employers with 200 or more employees offered health benefits in 2008.¹ As we look to expand coverage and improve the health of all Americans, we believe the most important consideration is how to accomplish this worthy goal in a way that preserves, strengthens, and stabilizes existing employer-based coverage.

Hewitt commends the Committee for putting forward a Discussion Draft to enable the collection of further input as the legislative process advances. Our statement focuses on four key provisions in the Discussion Draft, with recommendations on how to avoid disrupting existing employer provided health insurance:

- I. **Insurance Market Reform**
- II. **Public Health Insurance Option**
- III. **Shared Responsibility**
- IV. **ERISA**

Our statement draws from Hewitt's proprietary data and the experience of Hewitt's consultants and actuaries who have extensive knowledge of—and direct experience with—the employer-sponsored health care system. Health care reform is clearly needed and welcomed by large employers if it achieves the objectives of expanding access to high-quality, affordable health care to all Americans. We are pleased to continue to make available our comprehensive data and extensive knowledge of the large-employer marketplace, coverage, and cost drivers.

I. Insurance Market Reform

We commend the Committee for developing an extensive reform proposal for the individual and group health insurance markets. We believe that the rating requirements and guarantees of availability and renewability of coverage in the Discussion Draft will broaden access to health care coverage within a framework that generally seeks to continue to support employer-based coverage. Additionally, we strongly support the requirement that all Americans have an individual responsibility to secure acceptable health care coverage when it is both available and affordable.

The employer-sponsored model works well because it allows the pooling of risks and because large-scale group purchasing lowers costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. As proposed, the Exchanges would extend these advantages that employees of large employers currently enjoy to individuals and small groups. Employer-based plans offer coverage that is guaranteed and renewable, typically waives pre-existing condition exclusions, and does not increase

¹ 2008 Kaiser/HRET Employer Health Benefits Survey

premiums or limit coverage based on health status. Incorporating an individual coverage requirement into the broader insurance market will level the playing field between large-employer plans and other forms of coverage. It will also provide more coverage choices to Americans.

Proposed Requirements of Health Insurance Plans

Insurance market reforms are indispensable for creating a viable Exchange and a balanced health insurance marketplace. However, Hewitt believes that these reforms should not apply to large employers providing coverage outside the Exchange. Hewitt recommends the Committees consider the following refinements to the proposed reform requirements:

- **Permit rating variations based on tobacco use and adherence to programs promoting wellness and disease prevention.** Large employers have experimented with both of these approaches in an effort to influence employee behavior and reduce the health risk in their populations. We believe employers would support other health insurance programs following similar rating approaches.

- **Reconsider the rebate requirement for insurers whose medical loss ratios exceed the allowable limits.** While insurers should be expected to provide coverage commensurate to the premium payments they receive, the rebate requirement is likely to unintentionally increase costs to all participants. Managing the rebate payments will increase insurers' administrative costs, and insurers may increase their risk charges to build extra reserves to fund the rebate payments.

At a minimum, employer-sponsored group health plans that are self-insured should not be subject to this requirement because the goal of the rebate mechanism—to preserve affordable coverage to employees and their dependents—is already in practice in the self-insured marketplace. The provisions of ERISA prohibit any excess contributions to be used for any purpose other than benefits for employees and their dependents. Our experience has been that when actual claim costs prove to be lower than expected in a self-insured group health plan, employers reflect the benefit of this favorable experience by not increasing payroll contributions and/or cost-sharing provisions in the following year. To impose onerous rebate requirements on these plans would simply add administrative cost with no substantive benefit. Health insurers that are contracted to provide administrative services under these plans, similar to the third-party contracts in place for the Medicare program, do not receive any additional benefit from favorable self-insured loss ratios.

- **Preserve flexibility for ERISA group health plans outside the Exchange.** Employers are in the best position to determine their employees' health care needs. We recognize and support the idea of an actuarially determined minimum benefit for plans provided through the Exchanges, but recommend that no specific benefit requirements or designs be imposed on large employers outside the Exchange. For this particular group, which already offers near universal group health plan coverage for their workforces, we recommend that the option of sponsoring such plans continue to be voluntary. Accordingly, we suggest that the market reforms not apply to ERISA group health plans.

- **Improve the application of the Grace Period.** Employers will need substantial time to adjust their plans, and it will take time to implement individual and small-group market reforms. To avoid disruption of employer group health plans and added costs, we suggest that the proposed grace period apply to all employer-sponsored plans, including flexible spending accounts (FSAs). We also believe any rules in the Discussion Draft should only be applied after the expiration of the grace period. Additionally, we recommend that any individual enrolled in an employer-sponsored group health plan during the grace period should be deemed to have satisfied the Individual Responsibility requirement in the Discussion Draft.

Health Insurance Exchanges

We support the Committee's suggestion that Exchanges be designed to address access to coverage for small businesses and individuals—precisely the group that could most benefit from this concept.

There is much to be learned from the Massachusetts Connector model, a pioneering Health Insurance Exchange. A May 2008 review of the Massachusetts health care reform plan by the Kaiser Family Foundation estimated the number of people with insurance in Massachusetts has increased by more than 340,000 since late 2006, representing more than half of the estimated 650,000 people who were previously uninsured.²

We also strongly support the ability of private entities to facilitate Exchanges because they can best leverage existing processes, technology, and relationships to quickly and efficiently deliver the educational, informational, and enrollment assistance to support the participants of the Exchanges. As such, we also support the non-regulatory role that the proposed Exchanges will assume and suggest that oversight and regulation reside at the State or Federal level with independent, non-partisan agencies.

Benefit Plan Values and Requirements

Hewitt's extensive actuarial and consulting experience with large employers may assist the Committees in defining minimum coverage that would ensure a broad range of medical benefits are provided by the health insurance plans offered in the Health Insurance Exchanges.

We suggest that all health care benefits be subject to a reasonable and objective standard of medical necessity to prevent over-utilization of services. This is particularly important in the area of diagnostic imaging and screening. As new technologies have become readily accessible, the industry has seen large increases in cost and utilization without conclusive evidence of commensurate effectiveness.

We have identified several concerns with the Committees' proposed benefit tiers and associated actuarial values and make the following recommendations:

■ Combine actuarial value with a benchmark plan design.

We suggest that any proposed benefit levels in employer-sponsored group health plans be determined by combining an overall actuarial value percentage with a reference to a published benchmark plan design. While the overall actuarial value percentage concept proposed in the Discussion Draft is valid, different actuarial models used to determine the percentage of charges paid may vary. This could lead to a cliff effect with plans satisfying or failing the requirements depending on the actuary valuing the plans. Our approach could mitigate this issue by allowing for a small range of overall actuarial values, e.g., the stipulated percentage actuarial value plus or minus 2 percent, combined with referencing a stated actuarial value to a known and public plan design (e.g., the Federal Employees Health Benefit Plan Standard option).

There is precedent for this approach. Both Medicare Part D and Massachusetts Health Reform minimize the differences in actuarial variation by using a reference plan approach to define appropriate actuarial values. Combining the absolute percentage requirement with a reference plan ensures that various actuarial models are consistent in their measurement. Exhibit 1 provides an illustration of this combination and some examples of reference plans.

² *Massachusetts Health Care Reform: Two Years Later*, Kaiser Commission on Medicaid and the Uninsured, May 2008. Others note that at the same time, the costs of the Massachusetts program have risen as well, requiring subsequent and likely ongoing adjustments.

Exhibit 1: Illustrative Reference Plans at Different Actuarial Values

Plan Provision	HMO Design Actuarial Value: 95%	PPO Design Actuarial Value: 85%	PPO Design Actuarial Value: 70%
Copayment: Primary Care Physician	\$15	N/A	N/A
Copayment: Specialty Care Physician	\$25	N/A	N/A
Copayment: Hospital Admission	\$200	N/A	N/A
Annual Deductible	None	\$300 per individual	\$2,000 per individual
Coinsurance (paid by plan)	100%	80% for in-network services	80% for in-network services
Out-of-Pocket Maximum	N/A	\$2,000 per individual	\$4,000 per individual
Copayment: Generic Drugs	\$2	\$5	Subject to deductible and coinsurance
Copayment: Preferred Brand Drugs	\$8	\$15	Subject to deductible and coinsurance
Copayment: Non-Preferred Brand Drugs	\$16	\$30	Subject to deductible and coinsurance

We also suggest that actuarial value determinations specifically exclude out-of-network providers for any health plan that meets standards to ensure network adequacy. The recent Congressional Research Service paper uses only in-network benefits design in its actuarial value calculations³. Under other circumstances, for any plan that does not meet the network adequacy standard and where a significant percentage of care is delivered outside the network (e.g., more than ten percent), it may be appropriate to include out-of-network expenses in the determination of the plan's actuarial value.

It is also important to define the types of services that should be included in the actuarial valuation. For example, major service categories such as dental, vision, and hearing, and alternative medical services should be specifically identified, as should contraceptives and high-cost biotech pharmaceuticals for the prescription drug benefit.

■ Implement An Additional Benefit Tier

Hewitt has actuarially valued the health care plans of the 325 large employers that participate in the Hewitt Health Value Initiative™ (HHVI), a database containing detailed census, cost, and plan design data representing 13.1 million participants and \$51 billion in 2009 health care spending. The data in Exhibit 2 shows that the majority of large employers offer benefit plans that are at least as comprehensive as the Committees' suggested basic plan. Note that less than 2 percent of employees are enrolled in plans with an actuarial value equal or greater to 95 percent, and nearly 4 percent of employees are currently enrolled in plans that would fail to meet the 70 percent actuarial value standard in the Discussion Draft.⁴

³ Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, R40491, April 6, 2009.

⁴ Actuarial value calculated using an assumption of covered expenses paid by the plan.

Exhibit 2: Comparison of Actuarial Value of Large Employer Plans to the Proposed Basic Plan

Plans with an Actuarial Value of:	Percentage of Employees Enrolled
Less than 65%	0.7%
65-69%	3.0%
70-74%	9.2%
75-79%	18.4%
80-84%	25.4%
85-89%	28.7%
90-94%	12.8%
95% or more	1.8%

We suggest adding an additional benefit tier using an actuarial value of 65 percent to accommodate those individuals and small employers who prefer to enroll in lower-value plans to pay less in monthly premiums. Such a design would provide comprehensive insurance protection against catastrophic loss, while providing a more affordable monthly premium than higher-valued options. Providing this flexibility would avoid forcing individuals and small businesses to provide coverage that they cannot afford and do not feel they need. The Massachusetts health care program includes similar options in their Bronze plans. If a 62 percent tier were adopted, it would permit certain Bronze plan options available through the Massachusetts Connector to meet the minimum value requirement.

Many High-Deductible Health Plans (HDHPs) would fall below this benchmark if contributions made to Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs) are not taken into account when calculating actuarial value. We strongly recommend that such contributions be considered in determining actuarial value. IRS rules provide guidance for the maximum deductible and out-of-pocket expenses allowed for HDHPs within an HSA. The 2009 limits are a minimum individual deductible of \$1,200 (\$2,400 family) and a maximum out-of-pocket of \$5,950 (\$11,900 family). A plan with these deductibles and out-of-pocket maximums would have an actuarial value of 71 percent using Hewitt's actuarial model. Any contribution an employer makes to the HSA should also be considered in the actuarial value calculation and would further raise the value. Every \$100 contributed to an HSA as part of the plan raises the actuarial value by about 1 percentage point, assuming all coverage tiers are given the same contribution.

■ **Apply minimum health benefit standards to total actuarial value and revisit cost sharing provisions**

For employer-sponsored group health plans, we suggest that the standard be based on the total actuarial value of the plan design, not on specific benefit-by-benefit comparisons. The use of total actuarial value should also include certain provisions to prevent "gaming" of the values. For example, for health plans offered in the open market and through the Exchange, we encourage the Committees to take steps to prevent insurers from developing plan designs that meet the total benefit percentage requirements but limit some services in order to prevent high-risk individuals from joining. Total actuarial equivalence is currently used for Medicare Part D employer health plan comparisons, while plans marketed to individuals are required to perform more detailed comparisons. Massachusetts also uses a total actuarial value approach.

We encourage the Committee to remove the copayment language from the Discussion Draft and allow for both copayment and coinsurance provisions as deemed appropriate by the health plan sponsor. The Discussion Draft suggests that the Essential Benefits Package should use copayments in lieu of coinsurance whenever possible. While copayments are administratively easier for both the individual and the medical provider, this practice removes all transparency around the cost of the service being provided. Employers have successfully used coinsurance designs in prescription drug coverage, for example, to educate employees about the cost of brand-name drugs versus lower-cost alternatives. Using coinsurance provisions, the Medicare Part D program experienced an 88 percent generic substitution rate in its first six months of operation that significantly contributed to the favorable cost experience of the program.⁵

The Discussion Draft allows a variation of up to 10 percent in cost-sharing between basic, enhanced, and premium plans. In our experience with large employers and the options provided to their employees, this range will not be wide enough to allow for meaningful premium differences. In general, there should be an 8–10 percent difference in actuarial value between each plan level in order to offer meaningful choice. Limiting the variation as proposed will not provide this degree of actuarial value difference and corresponding premium savings to the individual.

■ **Preserve existing employer plan options**

We suggest the Committees be mindful that a wide range of health care plan designs exist today. We recommend that the requirements should be flexible enough to allow employees to keep their existing plans if they so choose. We support the Committee’s proposal of a five-year grace period for group plans. As previously noted, we suggest that the grace period apply for all purposes and to all employer plans, including FSAs.

Many large employers offer participants a choice of health care plans with varying employee premium contributions for greater cost sharing in health care services at point of care. These are often choices of delivery model (HMO or PPO) or choices of plan cost-sharing. This is similar to the Federal Employee Health Benefit Plan Basic and Standard options. Typically, HMO plans have richer benefits, with lower copayments and no deductibles. PPO plans generally have up-front deductibles and coinsurance. Exhibit 3 shows typical plan provisions of HMO and PPO designs, and their associated actuarial values for the network benefit design.

Exhibit 3: Typical Plan Provisions for HMO and PPO Plan Designs

Plan Provision	HMO Design Actuarial Value: 89%	PPO Design Actuarial Value: 81%
Copayment: Primary Care Physician	\$25	N/A
Copayment: Specialty Care Physician	\$30	N/A
Copayment: Hospital Admission	\$250	N/A
Annual Deductible	None	\$500 per individual
Coinsurance (paid by plan)	100%	90% for in-network services
Out-of-Pocket Maximum	N/A	\$2,500 per individual
Copayment: Generic Drugs	\$10	\$10
Copayment: Preferred Brand Drugs	\$25	\$25
Copayment: Non-Preferred Brand Drugs	\$40	\$40

⁵ Generic Drug Utilization in the Medicare Part D Program, Office of the Inspector General, Department of Health and Human Service, November 2007.

Note that the designs shown in Exhibit 3 are representative of typical designs today with 50 percent of large employers offering an HMO plan and 85 percent offering a PPO plan. Both of these designs have lower actuarial values than the proposed Premium option in the Discussion Draft. Other popular plan types include Health Reimbursement Arrangements (19 percent) and Health Savings Accounts (30 percent).

In addition, IRS rules provide guidance for the maximum deductible and out-of-pocket expenses allowed for HDHPs with HSAs. The 2010 limits are a minimum individual deductible of \$1,200 (\$2,400 family) and a maximum out-of-pocket of \$5,950 (\$11,900 family). Within these limits, a broad range of plan design values could apply. The richest HDHP-qualifying plan, for example, would have a \$1,200 deductible and pay 100 percent benefits after that point. The actuarial value for a plan such as this would be 84 percent under Hewitt's actuarial model. Conversely, the leanest HDHP-qualifying plan would have a \$5,950 deductible and pay 100 percent benefits after that point, and have an actuarial value of 50 percent. An employer contribution to an HSA would raise the actuarial value, assuming this was allowed in the methodology.

II. Public Health Insurance Option

There has been much debate about the merits of a public health insurance option to compete with private insurance plans. While the Committee has proposed options for a public plan for both individuals and small businesses through the Exchanges, the market dynamics of any public plan will likely extend to large employers outside the Exchanges.

It is well known that private payers are subject to cost-shifting from hospitals and doctors to compensate for below-market reimbursements from Medicare and Medicaid. The Lewin Group estimates that Medicare reimburses hospitals 71 percent of private-plan payments; for doctors it is 81 percent.⁶ Structuring a public plan option with payments equal to or slightly greater than Medicare rates would only further exacerbate current cost-shifting. As private-plan costs continue to rise under this pressure, more employers will be squeezed out of the employer health care system as coverage becomes unaffordable. Over time, this cost-shifting cycle threatens to unravel the entire employer-based system.

In light of the risks associated with a public plan and the expected availability of competitive options through the Exchanges, we recommend the Committees remove the public plan as a feature of health care reform. Alternatives to the public plan, such as a trigger mechanism where a public plan is implemented only if targeted goals are not reached within 5 years (e.g., if sufficient competition does not exist in a market) may be appropriate if insurance reforms do not fully meet the needs of individuals in certain markets. Additionally, any public plan triggered by insufficient competition should be required to play by the same rules as commercial health insurance carriers. The Blue Dog Coalition provided a list of minimum conditions that we also support, especially the conditions of free market adherence and a level playing field with private plans.

III. Shared Responsibility

Large employers have widely differing opinions on a proposed employer mandate to provide health insurance coverage. Almost all large employers already offer and subsidize comprehensive coverage, (either voluntarily or through collective bargaining agreements) for employees and their dependents. About half of the total cost of this coverage benefits spouses and children. Large employers tend to absorb a larger proportion of these costs—either because the spouse is not employed, the spouse's employer does not offer coverage, or the large-employer's plans are more comprehensive. The 2008 Kaiser/HRET survey shows that 58 percent of employees working for larger employers (those with 200 or more workers) enroll dependents, compared to 47 percent of employees working for smaller employers (those with less than 200

⁶ The Cost and Coverage Impacts of a Public Plan: Alternative Design Options, The Lewin Group, April 2009.

workers). Requiring all employers to provide health coverage would reduce some of the costs borne by large companies for dependent coverage, but a mandate on large employers—who are already offering coverage—seems unnecessary based on the near-universal voluntary participation in this market today.

Further, requiring employers to extend health care benefits to part-time employees would have a severe impact on certain industries that are struggling to survive in the current economy. Employers compete for talent based on their work environments, compensation, benefits, career opportunities, and a host of other factors. The decision to offer health care benefits to a part-time workforce must rest with employers. Alternatively, it would be more appropriate to offer individuals who fall into this category access to coverage through the Exchanges, as well as subsidies based on their income if their employer chooses not to subsidize health insurance benefits.

We recommend that the Committees remove the "pay or play" employer requirements in the current proposal and consider alternative mechanisms to ensure employers retain their current health care benefits. Under a "pay or play" scenario, every employer would have no choice but to carefully analyze its cost to provide coverage with the "pay" alternative—be it a dollar assessment or a percentage of payroll. We believe the result will be a bifurcation of the employer-sponsored system. According to Hewitt's database, large-employer health insurance costs are projected to be \$8,863 per employee (including dependents) in 2009. However, there is a broad range around this average, with a low of \$5,323 per employee to a high of \$13,553 per employee. Those with costs above the level of assessment would consider eliminating their employer-sponsored plans, creating adverse selection against the plans in the Exchange and driving up costs for Exchange participants.

The Massachusetts health care program is an example of a "pay or play" approach where most employers have chosen to "play" even though the assessment was relatively minor at \$295 per employee. This was primarily because of the administrative complexity of removing Massachusetts employees from large employers' national programs. We believe the result of a national "pay or play" requirement would be dramatically different, as it would provide incentives for many employers to exit health care entirely if the "pay" alternative was sufficiently attractive.

Due to the concerns outlined above and the potential unintended consequences of an employer mandate, we suggest strong consideration of an individual mandate but no employer mandate at this time.

IV. ERISA

Multi-state employers have been able to build uniform benefits programs for all employees regardless of their work location by relying on the uniform federal regulation offered under ERISA preemption. This allows employers to determine which programs are best for their unique workforce and offer the same programs on a uniform basis in all of the states where they do business. The Discussion Draft proposes subjecting ERISA group health plans to the potential for state insurance mandates if states are willing to contribute toward the costs of those mandates. At the same time, employers become subject to various state rights of action for not meeting the requirements of those mandates. We strongly urge the Committees to reconsider this provision. Weakening ERISA would create a grave risk that large employers would drop their benefits programs as they become overly burdensome and costly to administer.

The Discussion Draft creates a three-tiered system of rights and remedies for employer compliance under federal health care reform. This system creates three problems for employer group health plans:

- First, the availability of compensatory and punitive damages against an employer plan will, at best, encourage the payment of questionable claims to avoid the costs of litigation. At worst, it will provide an incentive for frivolous litigation. Either outcome will result in increase health care costs.

- Second, it is possible that state and federal courts will issue conflicting decisions and develop differing bodies of law regarding similar coverage determinations made by employer group health plans, making it impossible to administer group health plans consistently across state lines and from employee to employee. Even for plans that do not participate in the Exchanges and are not subject to state law remedies, federal courts may rely on decisions made in state courts to reach decisions regarding coverage determinations made by employer group health plans.
- Finally, the public plan option was designed to compete with the private sector on merit, not liability. Employer group health plans will be subject to compensatory and punitive damages that will not apply to the public plan option, which further tilts the playing field in favor of a public plan option.

Conclusion

We applaud the proposals to improve access to affordable health insurance for individuals and small businesses. The creation of Health Insurance Exchanges with insurance market reforms and a viable and competitive insurance marketplace will go a long way toward achieving universal coverage.

We strongly encourage the Committees to reconsider provisions that could draw individuals out of their employer plans and into the individual market or raise employers' costs to unsustainable levels. Inadvertently unwinding the employer-based system would increase, not decrease, overall health care costs, and the effect this would have on a fragile U.S. economy could ultimately turn the public against even the most positive reform efforts.

We hope our observations, data, and suggestions are helpful to the Committees.

[Additional submissions of Dr. Price follow:]

[From *The Hill*, June 10, 2009]

A Back-Door Path to a Government Takeover

By REP. TOM PRICE (R-Ga.)

Amidst all the moving parts of a national healthcare reform package, one simple, but central question must rise above everything else to guide our efforts: Who do we empower to provide the highest quality healthcare—patients and doctors, or the federal government?

With President Obama's recent endorsement of a "public option," it appears his answer is "the federal government." From the editorial page of *The Washington Post* to candid confessions from a handful of congressional Democrats, the truth is out that a "public option" is nothing more than a back-door path to a government takeover of personal and private healthcare.

While patient-centered reforms are needed, the average American appreciates that the quality of our healthcare remains the world's best. Increasing access to this care and lowering costs are important.

However, those with coverage are reliably satisfied with the care they receive. Waiting times are typically short, Americans have access to the most innovative procedures, and we have some of the highest survival rates for critical diseases in the world.

As a physician, I know firsthand that government intervention has a harmful effect on each of these. Yet Democrats are convinced government is the best provider of care. For a glimpse at what a government takeover of our health system would look like, we need only examine how such a system is carried out across the Atlantic Ocean.

In the United Kingdom, the misnamed National Institute for Health and Clinical Excellence (NICE) determines what treatments, procedures and drugs should be made available to patients. (An analogous board, the Comparative Effectiveness Research Council, was created this year in the president's "stimulus" bill.) The NICE board determines whether a remedy meets its fiscal goals. Comparing cost to potential for survival or cure, the board places a government-endorsed price tag on a patient's well-being. It is not unusual for an otherwise effective remedy to be judged too expensive. Care is denied or delayed, and the patient is left out.

Take Pamela Smith of Darlington, England. In 2007, Mrs. Smith petitioned the government to pay for the drug Erbitux to treat her bowel cancer. The drug was already widely used here in the United States and deemed by her oncologist as the best treatment to slow the progression of her disease.

Unfortunately for Mrs. Smith, officials from NICE decided that treating her with Erbitux, as suggested by her doctor, was not cost-effective. She was forced to turn to the supplemental healthcare market to purchase her treatment. The government pencil-pushers only relented when it was clear that Erbitux had significantly reduced the size of her tumor. By that point, Mrs. Smith's life savings had disappeared.

Democrats sell a government option as the ultimate solution to our insufficient level of access. Yet since governments view care in terms of dollars and cents, rather than patients and doctors, they limit care to such a degree that the majority of patients are forced to purchase additional health coverage. In France, for example, 92 percent of patients pay for supplemental health insurance on top of their inadequate federal plan. Even here at home, over 90 percent of people on Medicare, our "public option" for seniors, have some type of extra coverage.

Proponents of a government takeover disingenuously point to studies asserting that nations abroad have healthier populations. This is dangerously misleading. We must not confuse healthy lifestyles with healthcare outcomes. According to a 2008 study by CONCORD, the European NGO Confederation for Relief and Development, five-year survival rates for breast, colon, rectum, colorectal and prostate cancer are all significantly higher in the United States than the United Kingdom.

The five-year survival rate for breast cancer is 83.9 percent in the U.S. but only 69.7 percent in the U.K. The difference in the rate of survival for prostate cancer patients is a shocking 40.8 percentage points, with a U.S. five-year survival rate of 91.9 percent compared to only 51.1 percent in the U.K.!

Healthcare delivery in America needs serious reform, but these stark differences in survival rates clearly show we must increase access to patient-centered and controlled care, not eliminate it.

Positive health system reform will put patients in charge by empowering them with ownership of their coverage. This way, insurers will have to be accountable to the patient rather than the government or a corporation. An improved system must also include reform of the tax code so that it makes financial sense for all Americans to purchase care. This way we can reach universal access to care without inflexible government mandates and lower quality.

The experiences of our friends in the United Kingdom offer valuable lessons about a government takeover of health care. If we choose not to learn from their mistakes, we will surely be doomed to repeat them.

There is a positive solution: Providing all Americans access to affordable, quality healthcare with patients and their families in control—not the government.

Price, M.D., practiced orthopaedic surgery for over 20 years. He chairs the Republican Study Committee.

[From *Politico*, May 3, 2009]

To Reform, Create a Real Marketplace

By REP. TOM PRICE

As chairman of the Republican Study Committee, I have been as vocally concerned as any in Congress about the priorities set forth by President Barack Obama and the Democratic leadership. As a physician, however, one area in which we agree is that we can no longer put off reform of our terribly broken health care system.

Conservatives are energized about the coming debate over health care. Our vision for positive reform is consistent with our principles and singularly focused on that which health care should be all about: the patient.

Where we diverge with our Democratic colleagues is that we believe empowering patients, not Washington, is the key to responsible reform. Our goal must be to create a system that is accessible, affordable, innovative, responsive and of the highest quality. Surely, none of these adjectives describe routine services from the federal government.

Because of Washington's inability to deliver high-quality care, the American people remain wholly opposed to turning control of medical decisions over to the government. To overcome this, Democrats in Congress have begun promoting an innocent-sounding "public option." They claim the public option would simply "compete" with private plans.

Proponents of such a plan assert that the inadequacies of our current health care system are the product of a failed free market. Yet the irrefutable truth is there is no free market in American health care. Market mechanisms have been trampled by governmental involvement in care, primarily through Medicare—the government's public option for seniors. Since it would be backed by the federal treasury, not built upon market principles and efficiencies, any public option would effectively destroy the private insurance market. With the government subsidizing costs through higher taxes, the plan would offer "lower" fees for the services it offers.

But what the plan would actually offer patients is the key.

As Washington bureaucracies view health care in terms of dollars and cents, instead of patients and doctors, this government-run plan would, like Medicare, end up limiting access to treatments, prescriptions and procedures that it deems "ineffective." You may know this process by another word: rationing.

The groundwork for a health rationing bureaucracy has already been laid. The Comparative Effectiveness Research Council created by February's nonstimulus package has been tasked with determining the cost and effectiveness of different treatment options. It is noteworthy that not one of the 15 members of the council is a practicing physician.

While Democrats continue their predictable call for more bureaucracy in the lives of the American people, there is a positive solution to reforming American health care so that patients are put first. This reform must be built upon dual pillars: a tax structure in which care is accessible to all Americans and a system in which care is truly owned and controlled by patients.

First, to ensure that every American has access to health care, we must reform the tax code so it makes financial sense for everyone to have coverage. Measures such as tax equity for the purchase of care, active pooling mechanisms to increase purchasing power and focused use of tax deductions and credits will allow all to obtain coverage that meets their needs. Providing proper incentives, we can achieve universal access to coverage without one-size-fits-all government mandates.

Secondly, we must return purchasing power to patients. Today, most Americans receive coverage through their employer or the government. As a result, coverage is too often designed to meet the needs of a third party, not the patient. The remedy is a structure that gives patients full ownership of their coverage. This will make insurers truly accountable to patients, reduce gaps in coverage resulting from job loss and provide patients greater choice and flexibility. Added benefits will be lower costs and the innovation essential for 21st-century health care.

We stand at a crossroads in American health care. One direction leads to more government interference in personal decisions and, eventually, health care rationing. The other direction will ensure coverage, empower patients, foster innovation of new treatments and coverage options and provide the highest quality care.

The decision we make will reverberate far into the future, and the choice preferred by the American people is obvious. The question is: Will Washington listen?

Rep. Tom Price (R-Ga.) is the chairman of the Republican Study Committee. Before coming to Congress, he practiced orthopedic surgery for two decades.

[From the *Washington Times*, Wednesday, April 1, 2009]

Getting Health Care Reform Right

By TOM PRICE

Conservatives are comfortable with issues like spending and taxes, but reluctant to tackle with similar passion issues like education, energy, the environment and health care.

As a conservative and a physician, I call on my party to transform our terribly broken health care system by making it patient-centered. Our perceived reluctance to address the issue has left many Americans without a basic understanding even of what a conservative approach to health care looks like. Yet the cost of health care continues to rise, and millions of Americans are without adequate coverage.

Health care reform, while an enormous challenge, is perfect for demonstrating the effectiveness of conservative principles. Patient-centered health care is conservative. Empowering that personal relationship between a patient and a physician ensures the finest health care. Our goal must be to provide access to quality, affordable care that preserves this relationship without governmental interference.

As usual, adherents to the “government-as-solution” philosophy advocate more federal supervision and administration. This liberal approach relies on mandates, rationing, bureaucracy and third-party decision-making—all of which interfere with personal, private medical decisions.

Their approach to health care reform is incapable of providing quality care that is accessible, innovative and responsive. Achieving this type of care will require a fundamental change that honors one of the most basic conservative principles—personal ownership. Only when patients truly control their care will we see the positive change Americans desire.

To succeed, our conservative solution should be built on two pillars: access to care for all Americans, and coverage that is truly owned by patients and their families.

First, to provide access, we must reform our tax code so it makes financial sense for all Americans to have health care coverage.

Conservatives understand that consumers respond to incentives. Through the adoption of tax equity for the purchase of insurance, active and robust pooling mechanisms for increased purchasing power, and focused use of tax deductions and credits, we can ensure that it makes financial sense for all Americans to have coverage. Patients should be able to purchase care that fits their needs, not Washington’s.

The second pillar, patient-owned coverage, is vital for a successful patient-centered system. Currently, most Americans get health insurance through a third-party—either their employer or the government.

This system strips patients of their rightful decision-making power and results in a lack of accountability, flexibility and efficiency for you—the patient. To put people in control, rather than bureaucrats, we must create a new delivery structure in which patients have full ownership of their coverage.

When patients have the ability to “vote with their feet,” insurance providers will, of necessity, be more accountable and responsive to patient needs.

These two pillars would provide a platform for a host of positive, patient-centered changes to our health care system based on the conservative principles of choices, competition, ownership and individual control.

With conservatism providing the path, we can offer the American people 21st century health care that is accessible, affordable, innovative, responsive and of the highest quality.

A great debate is upon us about what health care system we will leave for future generations. To ensure patient-centered care is not sacrificed for government control, we must provide principled solutions and communicate them with passion.

In doing so, we will not only succeed in implementing sustainable and long-needed reform, we will renew the faith of the American people that a broad application of conservative ideas will provide solutions to the issues of the day.

It is time for conservatives to expand the comfort zone in which we operate. Our solutions to the many challenges we face are more consistent with what the American people want. By applying positive principles to every problem, we will reinvent conservatism in the eyes of the American people and set the course for a better tomorrow.

Rep. Tom Price, Georgia Republican, is a doctor who practiced orthopedic surgery for more than 20 years. He also is a member of the House Financial Services Committee and chairman of the Republican Study Committee.

[Whereupon, at 5:50 p.m., the committee was adjourned.]

