HEALTH REFORM IN THE 21ST CENTURY: INSURANCE MARKET REFORMS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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HEALTH REFORM IN THE 21ST CENTURY: INSURANCE MARKET REFORMS

WEDNESDAY, APRIL 22, 2009

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

The Committee met, pursuant to notice, at 10:09 a.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 15, 2009
FC–7

CONTACT: (202) 225–3625

Health Reform in the 21st Century: Insurance Market Reforms

House Ways and Means Chairman Charles B. Rangel (D–NY) announced today that the Committee will hold another hearing in the series on reforming the health insurance market. **The hearing will take place at 10:00 a.m. on Wednesday, April 22, 2009, in the main committee hearing room, 1100 Longworth House Office Building.**

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

BACKGROUND:

While more than 253 million Americans have insurance coverage through their employer, Medicare, Medicaid and other programs,[i] the U.S. health insurance market fails to provide affordable, quality health insurance for everyone. Growth in health plan premiums far outpaces increases in family incomes,[ii] and in the past year, roughly one-quarter of American households postponed getting needed health care because of cost concerns.[iii] Almost 46 million people were uninsured at some point in 2007, many from working families.[iv]

Those individuals who do not have coverage through an employer are able to seek insurance in the individual market. However, many policies in this market are characterized by high administrative costs and poor benefits. Furthermore, it is nearly impossible for consumers to gauge the quality of these plans or choose the plan that best meets their needs. Insurance companies have every financial incentive to avoid sick enrollees, and use benefit designs and pricing strategies to attract the young and healthy, and/or refuse to cover people with pre-existing conditions. Bringing reforms to the U.S. health insurance market that will guarantee affordable health care for everyone is a vital step toward restoring the economic health of the country and ensuring a stable future. Making the health insurance market work for consumers will require major reforms, such as requiring insurance companies to offer coverage to everyone, regardless of health status, and limiting rating strategies that can dramatically increase prices for consumers. Other important changes include making health insurance portable, increasing transparency, and giving consumers the ability to make informed decisions about health insurance options. Creating a health insurance "exchange" that offers consumers high quality, affordable public and private health insurance options may begin to solve some of the serious problems with the current insurance marketplace. In announcing the hearing, Chairman Rangel said, "America's health insurance market is dysfunctional. This is evident by the 87 million people who went without health insurance during the past two years and the millions more who have insurance that is increasingly unaffordable

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[i] U.S. Census Bureau. "Health Insurance Coverage: 2007." August 2008. Accessed at *http://www.census.gov/prod/2008pubs/p60-235.pdf.*

[ii] Kaiser Family Foundation. "Employer Health Benefits 2008 Annual Survey." September 2008. Accessed at *http://ehbs.kff.org/.*

[iii] Kaiser Family Foundation. "Kaiser Health Tracking Poll." February 2009. Accessed at *http://www.kff.org/kaiserpolls/upload/7866.pdf.*

[iv] U.S. Census Bureau. "Health Insurance Coverage: 2007." August 2008. Accessed at *http://www.census.gov/prod/2008pubs/p60-235.pdf.*

or inadequate. I am pleased to hold this hearing to examine the problems in our health insurance market and explore long-term solutions for reform."

FOCUS OF THE HEARING:

The hearing will focus on strategies to reform the health insurance market to ensure greater accessibility and affordability.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Committee Hearings*". Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, May 6, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman RANGEL. The Committee will come to order. And without objection, the Chairman of the Trade Subcommittee, the gentleman from Michigan, is recognized.

Mr. LEVIN. Mr. Chairman, I want to wait till more of our colleagues—just give us 10 seconds—sit down.

Mr. Chairman, we have been notified officially by the House historian that as of April 10th of this year, that you and Mr. Stark

became the longest-serving Members in the history of the Ways and Means Committee; in the history of our Committee. And we all want to congratulate you.

[Applause.]

Chairman RANGEL. Well, it is not true that when we came here, that George Washington had black hair. That is just not so.

[Laughter.]

Chairman RANGEL. But thank you. Thank you so much.

The Committee will come to order. This is the third of a series of Committee hearings on health reform. There is no question in my mind that this is not a Democratic Party issue or Republican Party issue.

Our constituents are frustrated in getting access to health care, paying too much for health care, not knowing what is covered by health care, the frustration of not knowing what is in the private sector planned, not knowing where their government is—it has been a very costly experience and a very painful experience.

Peter Stark has worked very hard in making certain that we come up with an overall plan. I have assured the Ranking Member, David Camp, that on issues of health, that we are going to get together starting with staff, starting with Subcommittee chairmen, and making certain that at the end of the day, we may differ in how we resolve the problem, but we are darned sure going to agree that this is a very, very serious national problem.

I would like to yield to the chairman of the Health Subcommittee and thank him publicly for the work that he has done over the years, and congratulate him that we have a President that is now prepared to move in the direction that you had always hoped and dreamed for.

Chairman Stark.

Mr. STARK. Well, as your noble twin at today's celebration, I appreciate your yielding, Mr. Chairman. And I want to restate that this is an important hearing. This isn't just moving ahead to somehow mess around with the private market, despite some feeling by people that that is our motivation.

Health reform has been a priority of the American public for decades, and precisely because the private marketplace doesn't work in the health insurance field today. That is why we have Medicare. The health private market wasn't there, and the government had to step in. That was not an easy accomplishment.

It isn't an optional consumer product. It is something that each of us will need at some point in our lives. And in the current system, those who need it most are the ones who have the most trouble being able to obtain it.

Private health insurance companies make their money by avoiding risk, not managing it. And we will hear today from a number of witnesses who will talk about the problems of our existing system, and the way to fix those problems in order to assume that every person in America has access to affordable, quality health care.

Professor Uwe Reinhardt needs no introduction. He is a renowned health economist, Princeton professor. And he has been trying to help reform the American health system as long as I can remember, which may not be a resounding endorsement. And as a

matter of fact, there are some of us who traveled to Uwe's native state of Germany years ago to have him show us the German system, and found that he has been a great source for this Committee for a long time.

Linda Blumberg is here from the Urban Institute, and she will explain the problems of the existing marketplace and her thoughts on the best avenues toward reform.

We are also going to hear from David Borris, who has a small business in Northbrook, Illinois. Is it Hel's Kitchen?

Mr. BORRIS. Hel's Kitchen.

Mr. STARK. Hel's Kitchen. All right. And so we are going to hear about the problems that Hel's Kitchen has.

We are going to hear from Bill Vaughan, who is well-known to most Members of this Committee. He is with Consumers Union, and he will emphasize the problems consumers face in today's system and what key reforms would help them obtain the coverage they need.

I believe that the—Mr. Ken Sperling is a Republican witness. Am I correct?

Mr. CAMP. Yes.

Mr. STARK. Yes. And he is a Global Health Management Leader, and has been published in numerous trade and financial journals and often quoted in the New York Times. And he will talk to us about services for large employers and the retiree issues.

So we have a good panel. I look forward to hearing from each of our witnesses. And with that, I would yield to the distinguished Ranking Member, Mr. Camp.

Chairman RANGEL. I want to make it clear again.

Mr. STARK. Oh, I am sorry. Well, I missed Mr. Hobson, and I apologize. He is the president and chief executive of the Watts Healthcare Corporation in Los Angeles, and he directs a staff of 300 people, manages a budget of $26 million, and has had many senior management positions in health services. We welcome you. I am sorry, Mr. Hobson.

Chairman RANGEL. Let me make it clear that although Mr. Camp and I hope that we can achieve a goal of a bipartisan agreement, the fact that that may be unattainable is not going to deter us from listening to each other and getting positions or ideas from the witnesses.

And I would want anyone in the audience that has ideas how we can make certain that we have the broadest universal coverage, good coverage at less expense to our Nation, that that is what we both—that is what both parties would want to achieve.

I yield now to Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman, for yielding. And congratulations to you and to Mr. Stark on your distinguished tenure in the Congress and certainly on this Committee. That is a milestone, a tremendous achievement.

Last night I had a telephone town hall meeting with my constituents in northern Michigan, and it was about health care reform. And I just want to begin by sharing the concerns of one of the many people I spoke to last night. And this one particular woman was very—they all were compelling, but one in particular. And I just want to mention what she said to me.

She said, "We are a small business, and of course we pay very high rates for our medical insurance. I am concerned because I am a 44-year-old woman that is scheduled for surgery on Friday, and it is a bad surgery. I guess I am worried that the government or socialized health care or anything that Canada does—I mean, the people that support those types of programs, I have to wonder.

I have to ask: Have they ever been through months and months of doctors and testing, and wondering whether or not you are going to be chosen for surgery, chosen to live? I don't want to be one of those choices.

We choose to pay for our health plan. It is not perfect. We don't get a lot. We have a high deductible. I will be honest, I am terrified. I don't know how we are going to pay for our medical costs we are racking up right now. But I choose to live. We have to do it. There is no other choice."

Well, Mr. Chairman, there ought to be a choice, and it is up to you and me and the Members of this Committee, our colleagues in the Senate, and the President to come with that choice. The time for comprehensive reform is overdue, and I am committed, along with the Members of this Committee, to help making it a reality this year.

In the press advisory announcing today's hearing, Mr. Chairman issued a quote that reads, and I am quoting, "America's health insurance market is dysfunctional. This is evident by the 87 million people who went without health insurance during the past 2 years and the millions more who have insurance that is increasingly unaffordable or inadequate. I am pleased to hold this hearing to examine the problems in our health insurance market and explore long-term solutions for reform."

That is well said. I would like you to know, the Committee Members to know, our witnesses and those in the audience to know, that is a statement I would put my name on any day of the week, and yes, twice on Sunday.

The individual health insurance market is dysfunctional, and costs for both families and businesses and taxpayers are far too high. It says a great deal that Americans such as the woman I spoke to last night are willing to pay these exorbitant costs and are still left with a mountain of bills It says even more that having the Federal Government dictate their health care decisions scares them even more than, and I quote, "bad surgery."

I am confident we can work together on this issue, and I hope we can begin to do just that. Health insurance must be portable. That is, if you change your job or lose your job, you should not lose your health insurance. Transparency is critical, both on the pricing side as well as the quality side.

We must address preexisting conditions, and we must make health insurance more accessible and affordable. On these issues and many others, I think there is bipartisan agreement. The American people want results with regard to health care reform, but they want the right results. As we meet, our Senate colleagues are working collaboratively and in bipartisan manner to produce comprehensive health care reform, and I would like this Committee to do the same.

I think it is time, as we discussed just before this hearing, for our staff to start meeting and begin those discussions, and hopefully begin negotiating. If we do so, I see no reason why we cannot solve this problem in the coming months.

If we do not do so, I fear the debate will disintegrate into the familiar though not necessarily partisan arguments that have prevented comprehensive reform from becoming a reality.

So, Mr. Chairman, I want to take you up on your suggestion. And I also propose that we begin this hearing and that we start talking, our staffs start taking, and more importantly, we start writing a bill that will give every American access to quality affordable health care.

And with that, I yield back the balance of my time.

Chairman RANGEL. The outstanding team of experts that Mr. Stark has suggested, we want to thank you individually and collectively for taking your time to help us through this very complex but important problem that we face.

And we will start off with Dr. Reinhardt, who is a professor of political economy and economics and public affairs at Princeton. We thank you for coming. As you know, we would like to have as much time for questions by the Members as possible, so therefore we have the parliamentary restrictions of 5 minutes. And without objection, your full statements will be entered into the record.

Dr. Reinhardt, let us hear from you.

STATEMENT OF UWE E. REINHARDT, PH.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY AND PROFESSOR OF ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NEW JERSEY

Mr. REINHARDT. Thank you, Mr. Chairman and Members of this panel, for inviting me to this Committee and to participate in this important hearing. My full remarks are in the statement which, as you said, will be submitted into the record.

I begin that statement by listing the five basic functions a health system must perform—financing, risk pooling, purchasing, producing health care, and regulating it. And the question is, who should perform each of these functions, the government or the private sector?

As far as I know, this hearing is really about the first three functions. Who should organize and control the financing, the pooling, and the purchasing of health care? Should it be private insurers only? Should it be government only? Or could there be a mixture of the two?

I might as well say ahead of time that I favor a mixture of the two. As Congressman Camp said, there should be choice. And a choice of a public plan strikes me as one of the choices the American people should be offered, along with the choice of private insurers, which, of course Canadians do not have. A private insurance for services covered by Canadian Medicare are not allowed in Canada. But we, of course, would in fact allow it.

To return to the question of who should perform the five functions mentioned above? It depends on the social goals you pose for health care, particularly the social distributive ethic. If you treat, as many Americans want to, health care like a private good—like

food, for example—then there is a strong bias in leaving that all to the private sector.

If, on the other hand, it is the wish of the American people to treat health care like a social good, like elementary education or secondary education, then it is unavoidable that government pretty much has to control or run the financing and the risk pooling functions, although it could delegate the purchasing functions to private insurance, we do with Medicaid Managed Care or with Medicare Advantage.

So those are the options. But the risk pooling would have to be controlled by the government.

Most OECD countries and Taiwan treat health care as a social good, like elementary education, and they build their systems off that ethic. They have stated their social goal for health care in writing—explicitly. The Romanow report of Canada, for example, puts the social ethic up front.

In the U.S. we do not have a shared, common ethic for health care. Some Americans say it is a purely private good that should be rationed by price and ability to pay. Others say it is a purely social good, like elementary education. And in between, you have incredible intellectual confusion.

Let me illustrate this confusion. I hear nothing but bad-mouthing of socialized medicine in this country. Yet that is exactly the system we Americans preserve for our veterans. My son is a veteran, and I always tease him: We don't like you guys, because we put you into socialized medicine, the VA system. That to me represents a severe case of cognitive dissonance. It is very unhelpful in formulating health reform.

The same cognitive dissonance is manifest when people say that no one has the right to impose a mandate to buy health insurance on individuals, but people have the right to get very expensive health care even if I can't pay for it, should they fall critically ill. That is very confusing to anyone who didn't grow up in this country.

Now, from President Obama's statements, I infer that he leans toward the social-good ethic for healthcare. He would like health care financed primarily by ability to pay, and see it distributed on roughly equal terms. If that be the social ethic we want to pursue, then it can be fairly said, and I think industry members would agree, that the private insurance industry does not now own up to that ethic, nor can it.

I don't think of that industry as evil. Vilifying it, I think, is not the right approach. You just have to recognize that a private insurer has to be actuarially sound. From that it follows that private insurers have to charge higher premium to sicker people. From that it follows that private insurers of the things the industry does that look cruel really are just the business that they are in. They have to deny coverage to very sick people. They have to deny claims that they believe are not covered. That just comes with the turf in which they operate.

So if you want President Obama's social ethic (that many Members of this Committee share) then you really have to take a hold of the financing and risk pooling functions of the health system.

You have to very much regulate this industry with community writing, with guaranteed issue, and so on.

But if you put those two mandates on the industry, you must also mandate the individual to be insured or the market will blow up, as it has in New Jersey. There is famous literature that led to a Nobel laureate that shows these markets will destroy if you do not couple a mandate to be insured with mandated community rating and guaranteed issue.

Now, I don't have time to go into all of the details of my statement. But I hear there is a problem that if you added a public health plan to provide insurers in a reorganized market, that the public plan would have a comparative advantage because it could pay providers the lower rates Medicaid offers.

If you look at my testimony, you will see the range of prices paid by private insurers varies by a factor of six. You have one insurer in a state. Call them up and say, what do you pay for a colonoscopy, and what they pay, depending on which hospital it is, can vary by a factor of six.

So I would flatly assert there is no private payor level. There isn't one. There is only a huge, wide range of thousands of private payer levels—every hospital gets a different fee from different insurers, and every insurer pays different hospitals differently. And sometimes one insurer will pay the same hospital five different rates depending on what the insurance product is—HMO, PPO, indemnity and so on.

So when you say you want to adapt the payment level of a public plan to that of the private industry, I would ask to which level? The lowest? The highest? The median? The average? The weighted average? What region do you average over? That is a huge can of worms. It is not easy to do.

If you took the average, then roughly half the private insurance plans would be advantaged vis a vis the public plan because their prices would be lower than those the public plan must pay. So this is very difficult to do. And it requires a lot more thought.

In conclusion, I would say I believe that after having their retirement—retiree health care blown away, 401(k) savings melt away and seeing once revered companies march toward bankruptcy, along with the debauchment in the financial center that is just nothing short of unspeakable, it could well be that the American people have lost faith in the private sector's ability to provide financial security to individuals and families. Americans might well yearn for a government-run plan that is stable, permanent, and always there for them. That possibility should be considered in debating the fate of the public plan.

After all—I have said it in another Committee—in this country, when the going gets tough, the tough do run to the government. Some jet down here from New York. Some drive cars from Detroit. But they do come to Washington for help because, in the end, government is the only institution Americans truly trust. That tendency implicitly makes the case of the public plan.

So, to deprive Americans of the choice of a public plan would seem to me to require a very strong rationale and defense.

[The prepared statement of Mr. Reinhardt follows:]

Prepared Statement of Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University, Princeton, New Jersey

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University, Princeton, New Jersey. My research work during the past several decades has been focused primarily on health-care economics and policy.

I would like to thank you, Chairman and your colleagues on this Committee for inviting me to present a statement on the problems of structuring a market for individually purchased health insurance in the United States.

After some remarks on the interface between social ethics and health reform, my statement will focus for the most part of ways of reforming the market for health insurance.

I. INTRODUCTION

Any modern health system, regardless of its structure, must perform the following five major functions:

1. **FINANCING** health care, that is, extracting the requisite funds for the health system from individuals and households, who ultimately pay for all of health care. (Government, employers and private insurers are merely pumping stations in the flow of funds from individuals and households to the providers of health care).
2. **POOLING RISKS** for the purpose of protecting individuals and households from the uncertain financial cost of needed health care.
3. **PURCHASING** health care from its providers (doctors, hospitals, and so on), which includes negotiating or setting the prices to be paid for health care and determining the set of goods and services actually needed for the efficient, evidence-based best treatment of given medical conditions (including disease management and chronic care).
4. **PRODUCING** the goods and services required for the proper treatment of given medical conditions, including their diagnosis.
5. **REGULATING** the various clinical and economic activities involved in the operation of the nation's health system so that it works consistently towards socially desired ends.

As I understand it, this hearing is about the allocation of the first three functions between the private and the public sectors. The fifth function, of course, is the natural preserve of government, especially after the financial markets have demonstrated at such great cost to the rest of the world that private markets cannot be trusted to be self-regulating and working in society's interest, a point now grasped even by economists, including libertarian Alan Greenspan.

The allocation of the first three functions between government and the private sector, however, is not so clear-cut. It depends crucially on the social goals society wishes to posit for its health system, including how the financial burden of ill health is to be allocated to members of society and how care is to be distributed among them. I shall therefore offer a few remarks on that facet of a health system.

II. THE SOCIAL GOALS OF HEALTH SYSTEMS

Most industrialized nations in the OECD, along with Taiwan, seek to operate their health systems on the *Principle of Social Solidarity*. It means to them that health care is to be viewed as a so-called "social good," like elementary and secondary education in the United States. That perspective, in turn, implies that the financial burden of health care for the nation as a whole should be allocated to individual members of society roughly in accordance with the individual's ability to pay, and that needed health care should be available to all members of society on toughly equal terms.

If the health system is to operated subject to this distributive social ethic, it requires that government either operate the financing, risk-pooling and purchasing functions directly (as is the case in Canada, Taiwan and the UK, for example) or that government tightly regulate all three functions, even if they are actually performed by private institutions outside of government proper (as is the case in Germany, the Netherlands and Switzerland).

Unfortunately, the United States never has been able to evolve a widely shared consensus on the distributive social ethic that ought to govern the U.S. health system. The bewildering American health system reflects that lack of consensus.

At one end of the ideological spectrum, many Americans appear to believe that health care ought to be treated as a private consumer good that should be distributed on the basis market principles. This means that the financing of health care ought to be viewed primarily as the responsibility of the individual, and only the

poorest members of society ought to be given public assistance in procuring a bare-bones package of health care. In other words, these Americans believe that, for the most part, health care should be rationed among members of American society on the basis of price and ability to pay, like other basic consumer goods, such as housing, clothing and food.

At the other end of the ideological, just as many other Americans share the ethical precepts of other nations in the OECD. These Americans, too, believe that our health system ought to be operated on the *Principle of Social Solidarity*, that is, that health care should be viewed a social good. If rationing of health care there must be, then it ought to be on principles other than price and ability to pay.

In between these distinct but coherent views reigns massive intellectual confusion.

To illustrate, the same citizens and politicians who look askance at "socialized medicine"[1] reserve the purest form of socialized medicine—the VA health system—for the nation's allegedly much admired veterans. A foreigner may be forgiven for finding this cognitive dissonance bizarre.

Similarly, there are many Americans, who believe that government does not have the right to impose on them a mandate to have health insurance, all the while considering it their moral right as Americans to receive even horrendously expensive tertiary health care in case of critical need, even if the recipients have no hope of financing that care with their own resources. Foreigners may be forgiven for shaking their heads at this immature and asocial entitlements mentality, which would be rare in their home countries.

Finally, a good many citizens and politicians who accept with equanimity the rationing of health care by price and ability in this country openly deplore the rationing of health by administrative means in other countries, perhaps not realizing that textbooks in economics explicitly ascribe to market prices the role of rationing scarce resources among unlimited want[2] Why the latter form of rationing is superior to the former is not obvious.

A much mouthed mantra in our debate on health policy is that "we all want the same thing in health care, but merely quibble over the means to get there." Nothing could be further from the truth. That debate has been and continues to be a tenacious ideological fight over the social ethic that ought to govern American health care; but we camouflage it as a technical debate strictly over means.

My plea before this Committee and to the Congress is that any health reform proposal put before the American people be preceded with a preamble that clearly articulates the social goals our health system is supposed to pursue and the social ethic it is to observe. Policy makers in other nations routinely do so and accept the constraints that this preamble imposes on their design of health reform. It would be helpful to have a clearly articulated statement on the social ethics for American health care as well.

With these preliminary remarks, I would now like to turn to the structure of the market for health insurance.

III. THE MARKET FOR PRIVATE HEALTH INSURANCE

The value a health insurance system offers society is the ability to pool the financial risks faced by individuals in order to protect members of that risk pool from uncertainty over the financial inroads of high medical bills in case of illness. In return for receiving that value, individuals make a financial contribution to the risk pool, in the form of taxes (e.g., payroll taxes) or premiums.

Many economists view this risk pooling as the sole proper function of health insurance *per se*. To them, for example, the segmentation of a free market for private health insurance by risk class, with relatively higher insurance premiums charged to patients expected to be relatively sicker over the insured future period, is not only an inevitable outcome of such a market, but is viewed perfectly acceptable. Such

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[1] The formal definition of "socialism," according to my American Heritage Desk Dictionary, is a system in which *government owns the means of production*. "Socialized medicine" thus is a system in which government owns, operates and finances health care, as in the VA health system. It is not the same as "social insurance," which merely is an arrangement under which individuals transfer financial risks they face to a larger collective body, often the government. The limited liability shareholders of corporations enjoy, for example, is one of the oldest forms of social insurance, as is the Federal Government's assistance to states struck by natural disasters, as is the many guarantees government extends to the financial sector and as is, of course, Medicare and Medicaid.

[2] As two well-known authors put it: "*Bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.*" See Michael L. Katz and Harvey S. Rosen, *Microeconomics*, (1991): 15.

premiums are called "actuarially fair." On this view, if society wants greater equity in the financing of health care, then government should provide risk-adjusted subsidies toward the purchase of actuarially priced private insurance.

As a practical matter, however, most people seem to believe that both private and public insurers should not only protect individuals from the variance of their own health spending likely to be incurred by that individual over time, but also incorporate in its premium structure hidden cross subsidies from chronically healthy to chronically sick members of society. Most health insurance systems in the world actually do that, including the Medicare and Medicaid programs in the United States and the private employment-based health insurance system.

A. Employment-Based Insurance

In the market for employment-based group health-insurance, the insurance premium paid the insurer by the employer typically is "experienced rated" over the group of employees being insured. It means that the premium reflects the *average expected (actuarial) cost* of the health care likely to be used collectively by all of that employer's employees, plus a markup-up for the cost of marketing and administration and profits.

In effect, then, the bulk of the risk pooling for employment-based health insurance actually is performed by the employer, not the insurer. The insurer bears only a small fraction of the total risk, a fraction that varies inversely with the size of the insured group.

This is even clearer when the employer overtly self-insures, as most large employers in the United States now do. In that case, the employer bears all of the financial risk of the employees' illness, and private insurance carriers are engaged by the employer merely perform the purchasing function (the third function above) on behalf of the employer-run risk pool, including claims processing.

Economists are persuaded by both theory and empirical evidence that, over the longer run, the full cost of the employer's contribution to the employees' group health insurance is shifted back somehow to employees in the form of lower take-home pay or a reduction in other fringe benefits. The arrangement typically does force chronically healthier employees to cross-subsidize chronically sicker employees, because the reduction in take-home pay within a given skill level is independent of the individual employee's health status.

In a sense, then, employment-based insurance is a form of "social insurance." One may call it "private social insurance," especially for larger employers, as distinct from government-run social insurance. It is one reason that the employment-based system has such strong support among people who would like to see American health care governed by the *Principle of Social Solidarity*. The feature of employment-based insurance that attracts them is the pooling of risks in that system.

A problem, of course, is that this principle is vastly eroded, the smaller the number of employees is over which premiums are experience-rated. For very small firms, employment-based insurance approximates individually purchased insurance.

B. The Market for Individual Insurance

In the market for individually purchased insurance, risk pooling necessarily must take place at the level of the insurance company.

As is well known from a distinguished literature in economics, a price-competitive market of individually sold health insurance will naturally segment itself by risk class. By economic necessity—and not a mean spirit—insurers in such a market have no choice but to engage in "medical underwriting" if they want to survive.

This means that private insurers must (a) determine as best they can the health status and likely future cost to the risk pool that an individual prospective customer will cause and (b) charge the individual a premium that covers that anticipated cost (the "actuarially fair premium") plus a mark-up for the risk pool's cost of marketing and administration and for desired profits. The size of this mark-up is constrained through price competition. As the Lewin Group estimated in a recent report, this mark-up averages 31.7% for private insurers in the individual market.[3]

The general public and the media that informs the public seem insufficiently cognizant of the horrendously complex product insurers sell. A health insurance policy is a so-called "contingent contract" under which the insurer is obligated to pay the insured a specified amount of money—or, alternatively, to purchase for the insured specified medical benefits—should that contingency arise.

The problem has always been to define that "contingency" so that it does not trigger disputes on whether or not the contingency has occurred—e.g., whether a med-

[3] The Lewin group, *The Cost and Coverage Impacts of a Public Plan: Alternative Design Options,* Staff Working Paper # 44, April 6, 2009.

ical procedure was called for on clinical grounds. Furthermore, it should be clear that *both* sides to the contract—the insured and the insurer—have the opportunity to cheat on the contract, if they are so inclined. It is the reason why these types of contingent contracts typically are subject to penetrating government regulation and oversight.

There is a tendency among the critics on the private health insurance industry to vilify it. I find that unfair and unproductive. The important question is whether that industry, as it is currently structured, can serve the social objectives American society may wish to posit for it and, if not, what regulation of the industry would be required to make it march toward the desired social goal.

C. Marrying a Purely Private Insurance Sector to the Principle of Social Solidarity

If the social objective of our health reform is to make health insurance available to all Americans on equal terms—as President Obama's campaign statements clearly imply—then the current private market for individual insurance has three major shortcomings.

The first is the practice of *medical underwriting,* that is, the practice of inquiring deeply into the personal health status of individual applicants for insurance and basing the quoted premium on the individual's health status. This practice could be eliminated by forcing every insurance company to charge the same premium to every one of its customers, with the possible exception of age. Every insurer would charge so-called *community-rated premiums*, although these could vary competitively among insurers.

A second practice at odds with the President's stated social goal for American health care is the practice of denying health insurance to anyone whose expected future medical bills exceed the premium that can be charged the individual, or to rescind insurance *ex post* when medical claims have piled up and he insurer cancels the policy over some flaw belatedly found in the original application for insurance. This practice can be eliminated by imposing *"guaranteed issue"* on the industry. It means every insurer must accept all applicants seeking to buy coverage at the insurer's quoted community-rated premium and may not cancel policies *ex post*.

But as both the theoretical and the empirical literature on this market clearly demonstrate, imposition of *community-rated premiums* and *guaranteed* issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with a third, highly controversial requirement, namely, a *mandate on individual to be insured* for a at lest a specified minimum package of health benefits.[4]

A mandate upon the individual to be insured, however, is likely to be disobeyed by large numbers of low-income individuals unless the government is willing and able to grant those individuals sufficient public subsidies toward the purchase of health insurance. One way to assess the adequacy of these subsides is to reach a political consensus on the maximum percentage X that the individual's (or family's) total outlay for health insurance premiums and out-of-pocket health-care spending takes out of the unit's discretionary income (disposable income minus outlays for other basic necessities, such as food, housing, clothing, etc.). That maximum percentage X probably would have to rise with income. Its proper size is a political call. It would be helpful if Congress could agree on such a number.

With these four features—*(1) community rating, (2) guaranteed issue, (3) mandated insurance* and *(4) adequate public subsidies*—a private, strictly monitored health insurance market for individually purchased health insurance probably could be made to march fairly closely in step with the distributive social ethic professed by the President and by many Members of Congress. It would require very tight regulations and supervision of the industry, however, most likely through the National Health Insurance Exchange provided for in the President's health-reform proposal. Within their ranks of enrollees, both the Medicare Advantage program and the Medicaid Managed Care program are tightly regulated and supervised in roughly this fashion.

IV. THE POTENTIAL ROLE OF A NEW PUBLIC HEALTH PLAN

During his presidential campaign, President Obama firmly and quite explicitly promised not only to reform the market for private, individually sold health insur-

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[4] For a report on how private insurance markets implode when the mandate to be insured is not imposed in a community-rated market with guaranteed issue, see Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "**Community Rating And Sustainable Individual Health Insurance Markets In New Jersey:** Trends in **New Jersey** 's Individual Health Coverage Program reveal troubled times for the program," *Health Affairs*, July/August 2004; 23(4): 167–175.

ance—along the lines outlined above—but to include among the insurance options in this market a new public plan for non-elderly Americans. This public plan would have to compete with private health insurers for enrollees.

A. Why might a Public Plan be attractive to Americans?

One could imagine a sizeable latent demand among the American public for such a public health plan, even in the absence of any significant cost advantage that such a public plan might have.

In recent years, Americans have seen retiree health benefits once promised them by private corporations melt away. They have seen their 401(k) savings in the private sector similarly melt down severely and the value of any other private pension plan vastly eroded. They have lost their employer-based health insurance with their job or, if they have not yet lost it, they fear of losing it. They have seen once revered and seemingly indestructible American corporations stumble toward bankruptcy and extinction, either at the hand of global competition or as a result of mismanagement. Finally, they have seen the once revered leaders of the financial sector behave in so irrational and destructive a manner as to make a mockery of received economic theory, with its instinctive belief in the economic superiority of private markets[5].

After all of this turbulence, destruction and self-immolation in the once hallowed private sector of the economy, many Americans may now seek the comfort of permanence that a fully portable, reliable and permanent government-run health insurance plan would offer them, side by side with the possibility of choosing a private health insurance plan instead. To deny them that opportunity would require a compelling justification.

Advantages of a Public Plan: A public health insurance plan for non-elderly Americans could offer society a number of advantages.

First, it would be likely to have the advantage of large economies of scale. Therefore, it could economically use expensive and powerful health-information technology to simplify claims processing, lower the cost of prudent purchasing ad quality monitoring, and engage in disease management, if it were allowed to do so.

Although a few large private insurers dominate the market in many areas, overall the market for private health insurance remains remarkably splintered, with many insurers carrying on somehow with very small enrollments, often below 20,000 insured[6] It is not clear how such small insurers can harvest the economies of scale of marketing and administration, and especially the benefits of health information technology. One must wonder what features in this market have allowed them to survive to this point. Presumably, the market for private insurance would have to consolidate significantly in a reformed insurance market.

Second, a public plan would not have to include in its premiums an allowance for profits and probably have low or no marketing costs. The previously cited Lewin Group sees that as a significant cost advantage of the public plan, reducing administrative costs as a percent of medical claims to about 13%, relative to 31% for private insurers. That advantage, however, may be exaggerated if private insurers offered their policies through a formal insurance exchange, reducing the cost of commissions to insurance brokers.

A third advantage could be the ability of a public plan to innovate in paying the providers of health care. Medicare already has been remarkably innovative on that front. The case-based DRG system for hospital payment, now being copied around the world, is Medicare's creation, and so is the development of the Resource-Based-Relative-Value Scale (RBRVS) which now forms the basis of negotiations over fees between physicians and private health insurers.

The next step in payment reform has to be a move away from the time-honored but inefficient fee-for-service system that dominates in both the private and public insurance sectors, and round the world, towards bundled, case-based payments for evidence based, clinically integrated care[7] Along with Medicare, a new public plan for non-elderly Americans could play a role in the development of this payment method as, of course, could private insurance plans.

Finally, government has already contributed substantially to the measurement of the quality of health care and websites that disseminate such information to the

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[5] See, for example, George A. Akerlof and Robert J. Shiller, *How human Psychology Drives the Economy, and Why it Matters for Global Capitalism,* Princeton University Press, 2009.

[6] See, for example, Allan Baumgarten, *Texas Managed Care Review* 2006 (available at http://www.allanbaumgarten.com/images/presentations/TX_ManagedCareReview_2006.pdf) and similar reports by that author for other states.

[7] See, for example, the website of Prometheus Payment® Inc., http://www.prometheuspayment.org/

market place and has fielded demonstration projects for disease management, once again side by side with the private sector.

Problems with a Public Plan: As I see it, the main problems with the addition of a public health insurance plan to a menu of competing private insurance options are political, rather than technical.

There is in the realm of politics the overarching question whether government should perform functions that the private sector could also perform, even if the private-sector would use more resources—be more costly—to achieve the same end. We see that question debated now in connection with student loans[8] which, according to the Congressional Budget Office[9], cost taxpayers considerably more when channeled through the private banking sector than when loans are made directly by government to students. The outcome of the current debate over student loans may be an augury for the course of health reform.

But even if the answer to the previous question were "Yes"—that government may indeed intrude as a competitor on economic turf traditionally held by the private sector—there is the question of what would constitute a level playing field in a proposed competition of private insurers with a new public plan.

Private insurers argue that if they are forced to compete with a public plan that can piggy-back its payment system onto the administratively set Medicare fees, they are forced to play on an uneven playing field tilted unfavorably in their direction. This suggests a scenario in which the private insurance plans would be pushed to the wall until eventually the U.S. ends up with a single-payer system. The long queues in Canada for certain types of health care, the low fees paid doctors and tight budgets for hospitals there, along with and the much sparser endowment of Canada's health system with certain high-tech equipment are cited as the inevitable destination of a single-payer system.

At this stage, this scenario is mere conjecture, and I have some difficulties following it.

In Canada, private insurance for services covered by the government-run system is prohibited. It would not be in the United States. Thus, if a public health insurance plan for non-elderly Americans really began to deprive American patients of what they desire in health care, the private insurance industry offering superior benefits at higher premiums would not melt away or, if it had, it would quickly be reborn, just as we now see providers starting to refuse the allegedly low fees paid by large private insurer and resorting again to the indemnity insurance model. Markets work that way.

There does, however, remain the issue of the level playing field, which I would not brush aside so easily. In what follows, I shall offer some comments on that issue.

V. DEFINING A LEVEL PLAYING FIELD

Two major facets define the evenness of the playing field on which insurance companies compete with one another: (1) the risk pool with which the insurer ends up and (2) the level of fees at which the insurer can procure health care from its providers.

Risk Pool: At this time roughly two thirds of the American population obtains health insurance from private insurance carries; but collectively private insurers account for only slightly more than one third of total national health spending. It is so because through its Medicare and Medicaid programs, government covers much higher risks on average than do private carriers.

It is not clear how the allocation of risks to private carriers and a new public plan would work out in a market for individual insurance. Chances are that a somewhat sicker risk pool would gravitate toward the public plan, which by itself would put it at a competitive disadvantage *vis a vis* the private plans, other things being equal.

Whatever the case may turn out to be, this facet of the playing field should be recognized in the debate on health reform. To mitigate any tilting of the playing field by that factor, one would ultimately have to install a differential-risk compensation mechanism, such as those operated in Germany, the Netherlands and Switzerland.

Payment Levels: The previously cited report by the Lewin Group projects that, if a new public health plan for non-elderly American paid Medicare fees, and if the overhead of such a plan were less than half of that experienced by private competi-

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[8] http://www.washington monthly.com/archives/individual/2009_04/017728.php

[9] http://studentlending analytics.typepad.com/student_lending_analytics/2009/03/cbo-significantly-ups-cost-savings-estimate-from-eliminating-ffelp-.html

tors, then the premiums of the public plan would be 21% below those charged by the private plans.

Assuming a premium-elasticity of the demand for health insurance of −2.47 (meaning a 1% decrease in the premium of the public plan vis a vis the premium of private insurers would trigger a 2.47% migration from private to public insurance), the Lewin Group simulates that some 119 million Americans would shift from private insurance to the public plan, a large fraction of whom would be Americans hitherto covered by employment-based insurance in smaller firms. In fact, the Lewin Group estimates that if the public plan were forced to pay at what it calls "private payer levels," enrollment in private insurance would decline only by 12.5 million, rather than 119 million."

Any such simulation, however, is merely the product of a computer algorithm into which researchers feed assumptions that largely drive the predictions. I, for one, believe that the assumed differential of administrative overhead may be too large, if private insurers sold their policies through an organized exchange, rather than through brokers. Furthermore, research based on the Dutch and Swiss experience suggests considerable stickiness of insurance choices, suggesting that the premium-elasticity assumed by the Lewin Group may be too high. In Switzerland, in particular, very large differences in insurance premiums charged by private insurers for the same package in the same Canton exist with only minimal switching by consumers among plans in response to such differentials. A similar experience has been observed in the Netherlands.[10]

Be that as it may, there is the question what the Lewin Group means by "private payment level." Is there actually such a thing? If so, how is it defined and measured?

Table 6.3 below, taken directly from the *Final Report of the New Jersey Commission on Rationalizing Health Care Resources* (2008),[11] illustrates the variance of actual payments made by one large health insurer to different providers for a standard colonoscopy. Table 6.4 exhibits the variation in actual payments made to different New Jersey hospitals for identical hospital services. Finally, table 6.5 below exhibits similar variances for the same procedures paid by a different, large insurer to different hospitals in California.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

[10] See http://www.commonwealthfund.org/~/media/Files/ Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf

[11] http://www.nj.gov/health/rhc/finalreport/index.shtml

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[a]

	Normal Delivery[1]	CABG[2]	Appendectomy[3]	Hip Replacement[4]
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Cost Shifting: Medicare and Medicaid stand accused of shifting costs to private insurers by paying providers, especially hospitals, low prices, often below costs. In a study commissioned by the insurance industry, published in December of 2008, Milliman Inc. estimated the size of this cost shift for 2007 at $51 billion for hospitals and $37.8 billion for physicians, for a total of $88.8 billion.[12]

Although the phenomenon of the cost shift seems real to hospital—and insurance executives, it is less obvious to many economists who have debated the existence of the cost shift for decades among themselves. Indeed, with appeal to empirical data bearing on the issue, Congress' own Medicare Payment Advisory Commission (MedPAC) has cast doubt on the existence of a cost shift before this very Committee in a *Statement for the Record* dated March 2009.[13]

But even if one agreed that there actually were such a cost shift from the public to the private insurance sectors, Tables 6.3 to 6.5 presented above that there must be an even larger cost shift within the private insurance sector among private insurers. It raises the question whether the playing field is level even within that sector.

[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (December, 2008) http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf

[13] See also MedPAC, Medicare Payment Policy: MedPAC's March 2009 Report to Congress: 57–67 available at www.medpac.gov.

As Michael A. Porter and Elizabeth Olmsted Teisberg rightly observe on this point in their book *Redefining Health Care*: [14]

"Within the private sector, patients enrolled in large health plans are perversely subsidized by members of smaller groups, the uninsured and out-of-network patients. . . . The dysfunctional competition that has been created by price discrimination far outweighs any short term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts." [15]

What, then, is the Private Payer Level?: Any proposal to force a new public health plan for non-elderly Americans to pay providers at "private payer levels"—the words used by the Lewin Group—would immediately run into the problem of the rampant price discrimination within the private sector, that is, and the huge variation in fees this price discrimination begets. Every insurer pays vastly different fees to different providers for the same service, and every provider bills different insurers different fees for the same service.

What in the chaos begotten by this system would the "private payer level" be to which a new public health plan should adjust. Would it be the average or the median of the prices paid by private insurers? Would they be simple or weighted averages and medians? If the latter, weighted by what? Over what geographic areas would these averages or medians be calculated?

Finally, if the public plan would have to pay such average or median fees, would it not by sheer arithmetic endow private insurers below that average or median with playing field tilted in its favor?

VI. MAKING THE PUBLIC PLAN FUNCTION LIKE A PRIVATE PLAN

In a recent position paper, Len Nichols and John A. Bertko of the New America Foundation have gone to some length to design a level playing field for private insurers and a new public plan.[16]

Nichols' and Bertko's proposal is inspired by the thirty or so state governments that offer their employees a choice between (a) traditional private insurance plans and (b) and a self-insured public plan operated by the state. The authors would subject the competing private and the public plans to exactly the same rules, monitored by an entity other than the government itself. The public plan would have to be actuarially independent and not get any public subsidies not also available to the private plans. Like the private plans, the public plan would have to negotiate its own fees with providers.

Presumably, unlike Medicare, it would be allowed to exclude particular providers from its network of providers and would be allowed to engage in disease management and other strategies designed to enhance value for the dollar.

The advantage the authors can claim for that proposal is that it might find bipartisan approval. A drawback, however, would be the high administrative cost of forcing the new public plan to negotiate fees with each and every provider.

Furthermore, this approach would perpetuate the rampant price discrimination that should, at some time in the future, be replaced with a more efficient and fairer payment system—perhaps even an all-payer system, such as those used in Germany and Switzerland. As Michael Porter and Elizabeth Olmsted Teisberg [17] and others have argued, it is hard to detect any social value in the chaotic price-discrimination that now characterizes the private health insurance market in the United States.

VII. A MARKET COMPOSED SOLELY OF PRIVATE INSURERS

In the end, the idea of the promised new public plan may be sacrificed on the altar of bipartisan political horse trading. In that case, if one wanted to offer Americans the stability and permanence they are likely to crave and run the market for health insurance on the *Principle of Social Solidarity*, one might structure the market for individually purchased insurance along the lines now used in Germany [18],

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[14] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[15] For a proposal to begin to reduce this price discrimination see Uwe E. Reinhardt, "A More Rational Approach to Hospital pricing," http://economix.blogs.nytimes.com/2009/01/30/a-more-rational-approach-to-hospital-pricing/ and Uwe E. Reinhardt, "**The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,**" *Health Affairs*, January/February 2006; 25(1): 57–69.

[16] Len Nichols and John M. Bertko, "A Modest proposal for a Competing Public Health Plan, The New America Foundation, (March 11, 2009) http://www.newamerica.net/files/CompetingPublicHealthPlan.pdf

[17] Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 66.

[18] See http://www.commonwealthfund.org/~/media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20pdf.pdf and http://content.

the Netherlands and Switzerland [19], all of whom seek to marry the Principle of Social Solidarity with a system of private, non-profit insurance carriers (Germany and Switzerland) or a mixture of non-profit and for-profit insurers (the Netherlands).

As already noted in the introduction, in these systems the first two functions of a health system—financing and risk pooling—is basically under the control of government, either directly or through tight regulation. The purchasing function, however, is delegated to private, competing entities, albeit under tight regulation as well.

In Germany and Switzerland these systems operate on the basis of an all-payer system, in which fees are negotiated, at the regional level of the state (*Land*) between associations of insurers and associations of providers, where after the negotiated fees apply to all payers and providers within the region. In the Netherlands, fees paid can vary among insurers; but the variance across plans is relatively small by American standards.

VIII. CONCLUSION

Even the opponents of a new public health plan for non-elderly Americans will probably concede that the private market for individually purchased health insurance remains underdeveloped and needs a restructuring before it can serve the needs of the American people better than it has heretofore.

As was argued in Sections III and VII above, even if Congress in the end decided not to permit the establishment of a new public health plan, a rather daunting set of new regulations would have to be imposed on that market to meet the social goals posited for our health system by President Obama. It would also require a mandate on individuals to have basic coverage, a proposal eschewed by the President during the election campaign, albeit not by his Democratic rivals.

Chairman RANGEL. Thank you, Doctor.

We would now like to hear from Bill Vaughan. I join with Chairman Stark in congratulating you and Consumers Union for the contribution you have made to our Congress over the years. And we would like to hear you.

STATEMENT OF WILLIAM VAUGHAN, SENIOR POLICY ANALYST, CONSUMERS UNION

Mr. VAUGHAN. Well, thank you very much, sir, and thank you for inviting us to testify. Consumers Union is the independent, nonprofit publisher of Consumer Reports, and we don't just test toasters. We try to help people with health issues, and we are big, big fans of comparative effectiveness research, which we are using to save people, we think, millions of dollars in getting the most effective, safest, best buy drugs out there.

If Dante were alive writing about the independent health insurance market, it would be in the eighth circle just above where the uninsured are stuck. And it is exhibit number one for what is wrong with American health care.

I was going to go into that, but I think the opening statements of Mr. Camp, Mr. Stark, that is coals to Newcastle. Our statement documents why it is all goofed up, and has some very moving,

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healthaffairs.org/cgi/content/abstract/27/3/771?ijkey=DsTX9syExLZLc&keytype=ref&siteid=healthaff

[19] See http://content.healthaffairs.org/cgi/content/full/27/3/w204) and (http://www.commonwealthfund.org/~E/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swiss dutchhltinssystems_1220%20pdf.pdf and http://www.allhealth.org/BriefingMaterials/JAMA-Uwe-1183.pdfhttp://content.healthaffairs.org/cgi/content/full/27/3/w204) (http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/ The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pd and http://www.allhealth.org/Briefing Materials/JAMA-Uwe-1183.pdf

heart-rending horror stories from people around the country stuck in that market.

It is easy to see why it is a dysfunctional market. First, you have basically for-profit insurance companies, whose fiduciary duty is to make money for their stockholders. That is just a fact. And then you have the distribution of health care costs.

Let's pretend that this Ways and Means Committee is the entire American health care system. The 40 of you are it. And we are going to spend $2.4 trillion this year taking care of you guys.

And let's say the 50 percent of you who are the healthiest, Mr. Rangel over to Mr. Pomeroy, Mr. Camp over to Ms. Brown-Waite, would be 20 of you, 50 percent healthiest. We would spend 3 percent, $72 billion, on you 20.

And, God forbid, I hope it never happens, but let me pick on the junior Members, Mr. Yarmuth, Mr. Roskam. Let's say if you were the 5 percent least healthy, we would spent $1,200 billion on you two. $1.2 trillion on you two, $72 billion on the 20 in the upper row. It is the privilege of seniority, I guess.

But you can try to regulate that. You could try to get these for-profit insurers to try to cover you. It is like leading a horse to water. They won't always drink. It will always be a hassle. It is like, for a consumer point of view, you lose frequently. It is like a constant game of Whack-a-Mole, and it is just no fun.

And that is why Consumers Union would like to see a public plan option out there, somebody whose fiduciary duty is to you in Congress, to the American public, and who would be delighted to insure you two.

Switching subjects a little bit, I have to say, unfortunately, on behalf of consumers, most of us are lousy insurance shoppers. We don't get a good deal. The evidence is everywhere—in FEHBP, in Part D. This is not something you go tripping off on a Saturday afternoon: Let's go insurance shopping. We don't do a good job.

If you want to have consumers help drive this system toward value and savings and quality, we are going to need some help big time. Our statement gets into it, but basically, we are looking for an office that can help with what is the quality of insurers; a place where you can go to complain, find out what others are complaining about; a place where you can get cost comparisons; and very, very important, we need a place—maybe it is NAIC—but the definitions of these terms.

Our current magazine issue has the story of a couple. Thought they had hospitalization. Fine print: Starts on the second day, after the lab tests, after the surgical room fees. They get stuck with a big bill. Hospitalization should be hospitalization. Drug coverage should mean drug coverage, chemotherapy, anti-emetic, the common sense stuff that consumers need. And we need to define those carefully so the public knows them.

The most important thing you can do is give us a manageable number of choices, not this 40, 50, 60, even 80 choices of minor little differences that just confuse the marketplace. We need something like Medigap, which has A through L. Even that is too much.

Get it down to some meaningful choices—and yes, Mr. Camp, choices. But they could be A through G, meaningful choices. And before a person signs up and becomes eligible in whatever plan you

guys put together, the person has to see the cost and the quality ratings of the comparable plans that are out there. I bet you CBO would give you a ton of scorings savings for that.

Let me conclude but just say I hope this Congress can become one of the great historical Congresses of our nation's history by finally, after an almost 100-year struggle, bringing every American affordable, secure, health care. Thank you very much.

[The prepared statement of Mr. Vaughan follows:]

Prepared Statement of Bill Vaughan, Senior Policy Analyst, Consumers Union

Thank you for inviting Consumers Union to testify on insurance market reforms and in particular, problems in the individual insurance market. Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1]

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

The Problem of the Individual Insurance Market

The individual insurance market is Exhibit A for why America needs health reform. It is the epitome of everything wrong with the system (and when you think about it, the very term "individual insurance" is really an oxymoron):

—if it provides good coverage, it is too expensive for many who need it most;
—pre-existing condition exclusions and medical underwriting mean it often doesn't cover the costs consumers are most likely to incur;
—many policies have gaps in coverage, that consumers often don't understand;
—all too often it is a hassle to collect on a policy, and
—all too often, if you use it, you lose it, because of future huge increases in premiums.

Real Examples of Problems with the Individual Insurance Market

Appendix 1 to my statement documents these points.

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

If you only look at one, as a Medicare Committee, look at the first one: Tom from Hutchinson, Minnesota, who delays—at considerable pain and extra cost—hip surgery until he is on Medicare. An amazing number of these stories include people saying, "I'll just have to tough it out until I'm eligible for Medicare." If you enact legislation insuring all Americans, CBO ought to give you some savings in Medicare!

Why the Individual Insurance Market is so Flawed

For decades, individual insurance has been what economists call a 'residual' market—something to buy only when you have run out of other options. The problem is that the high cost of treatment in the U.S., which has the world's most expensive health-care system, puts truly affordable, comprehensive coverage out of the reach of people who don't have either deep pockets or a generous employer. Insurers tend to provide this choice: comprehensive coverage with a high monthly premium or skimpy coverage at a low monthly premium within the reach of middle—and low-income consumers. Particularly in this recession, more and more consumers are forced to choose the skimpy coverage/low premium policies.

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[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

It is understandable why the insurance market, particularly the individual insurance market, behaves the way it does. Most big insurers are for-profit or quasi-for-profit and have a fiduciary duty to their stockholders to return a profit. Historically, the least healthy 10 percent of the population consumes about 64 percent of the health dollar. The healthiest 50 percent of the population uses only 3 percent.[3] You don't need an MBA to figure out that the best way to make your shareholders happy is to avoid those sickest ten percent or charge them a very very high premium to cover their expected high costs. Add this basic economic fact to uneven and weak regulation of insurers, and consumers who need health insurance are constantly vulnerable.

Solutions

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

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

It is in that marketplace of enrollment that we ask you to provide critical consumer protection and assistance.

Why Consumers Need Help Shopping for Insurance

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

The proof is all around you. While provider network and local pharmacy and reputation are all factors, the fact is that many us spend more money than we have to on insurance products that are similar or even inferior to other products in the marketplace.

—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.[4]

—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.[5]

—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.[6]

—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.[7]

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.[8] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc., ad nauseum.

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

Consumers Union recommends including the following in any legislation you enact:

Empower Consumers in a New Health Insurance Marketplace

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

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

We need a Medicare Compare-type website (with some improvements) applied to all health insurance sectors where policies can be compared on price and quality.

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[3] AHRQ, Issue #19, June 2006.
[4] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.
[5] See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.
[6] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[7] SeniorJournal.com, March 29, 2009.
[8] HHS Office of Disease Prevention and Health Promotion

Extending this comparison site to all insurance would help stop the waste in the Medigap market where seniors are talked into buying a standard policy that may be up to 1600 percent of the cost of the low-cost plan in their state.

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

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

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

- Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under a set of 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.[9]

- Maintain an insurance information and complaint hotline, and compile Federal and state data on insurance complaints and report this data publicly.

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

- Institute and operate quality rating programs of all 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 all consumers, not just the Medicare population.

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

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

- Like Medigap, include an optimal number of plan choices—not too few and not too many.
- Limit excessive variations in benefit design so that plans compete more on price and quality.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[10] Fewer offerings of meaningful insurance 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.[11] The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people hav-

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

[10] "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.

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

ing picked a Part D plan, do not review their plan and make rational, advantageous economic changes during the open enrollment period.

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

We hope you will enact a core package which all Americans will always have. If people want to buy additional coverage, there would be identical packages of extra coverage (as in the Medigap program) that many different companies could offer for sale. Consumers would have to be shown the pricing and quality ratings of those different packages before purchase. (Chairman Stark's AmeriCare bill includes much of this concept.[12])

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition.[13]

- Require information on price and quality to be presented in consumer-friendly formats.

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

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

In Medicare Part D, we saw plans advertise certain costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

- Protect against marketing abuses and punish insurers that mislead consumers.

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

- Ensure that consumer co-payments for out-of-network care are based on honest, audited data.

The recent report by the NY Attorney General is a shocking indictment of the nation's major insurers: "The current industry model for reimbursing out-of-network care is fraudulent."[14] The Attorney General calls for an independent, verifiable system of determining usual and customary charges so that consumers and doctors are not gamed out of millions of dollars a year in out-of-network payments. In addition, such usual and customary data should be transparent—available on a website—so consumers have some advance idea of what their out-of-network costs are likely to be.

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[12] HR 193, Sec. 2266(c)(2) SIMPLIFICATION OF BENEFITS—

"(A) IN GENERAL—Each AmeriCare supplemental policy shall only offer benefits consistent with the standards, promulgated by the Secretary, that provide—

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

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

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

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

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

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

[14] " Health Care Report: The Consumer Reimbursement System is Code Blue," State of NY, Office of the Attorney General, January 13, 2009.

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

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

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

Conclusion

We thank you again for this opportunity to testify. The American health care system can be fixed, but consumers need tools to help drive the system toward quality and cost savings. The reforms we have suggested are keys to this goal.

Appendix I

Examples of why America needs comprehensive health care reform

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

"Insurance" with adequate benefits and coverage

Tom from Hutchinson, MN

Tom and his wife own their own pottery studio and have paid for their own health insurance over the years. About five years ago, Tom developed a debilitating hip condition. The pain got so bad that his doctor recommended that he undergo hip replacement surgery. Under his insurance policy, Tom would have had to pay $10,000 for the surgery, which he could not afford. He ended up putting off his surgery for three years until he qualified for Medicare. Two days after he turned 65, Tom had his surgery and his costs under Medicare were just one-third of what he would have paid under his individual insurance plan. Delaying the procedure had its own cost: his muscles atrophied considerably and it took him longer to recover from his surgery.

Gina from St. Joseph, MO

Gina and her husband own their own delivery company and have purchased an individual health insurance policy for their family. Gina recently had a miscarriage and decided not to seek medical treatment because they have a high $3,500 deductible and she couldn't afford to see the doctor. When Gina gave birth to her son a few years ago, the insurance company refused to pay for her C-section because they maintained it was elective (even though her son was born breeched). She had to fight with the insurance company to get them to pay for these medical costs. In the meantime, the insurance company sent their bill to collections. The insurance company eventually paid six months after Gina had paid her full deductible.

Kristin from Beaverton, OR

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

Molly from Nashville, TN

After being diagnosed with uterine cancer last year, Molly had to undergo three surgeries and six months of chemotherapy and was unable to work for about eight months. Her insurance policy covered catastrophic medical expenses, but she still had about $25,000 in out-of-pocket medical expenses for the care she received. Her friends were able to help her pay many of her bills, but she was left with about $12,000 in unpaid medical debt and a damaged credit record. "The stress of my illness was enough for me to deal with, but then seeing all the bills I had to pay was just too much for me to handle," Molly says.

Tina from Pittsburgh, PA

When Tina was pregnant a couple of years ago she found out that her individual health insurance policy did not cover any of her maternity expenses. She developed preclampsia and diabetes during her pregnancy and none of the care she required for these conditions was covered. Tina faced the prospect of having to pay nearly $50,000 in pregnancy-related expenses out of pocket. Fortunately, a local journalist took up her cause and contacted the insurance company. Her insurer agreed to cover her expenses through her baby's one-month appointment. Her policy was then cancelled but now her husband has a new job that provides coverage for her family.

Sandra from Portland, ME

Sandra is disabled with chronic fatigue syndrome and needs a scooter to get around. At first, her insurance company decided to only provide partial payment for her scooter and then later said it would only pay for a manual wheelchair. Sandra had to provide further documentation from her doctor that she couldn't use a wheelchair. The appeals process with her insurance company took more than one year. Sandra continues to incur major out-of-pocket medical expenses, including $25,000 last year.

Catherine from San Francisco, CA

"Four years ago I was diagnosed with breast cancer. As a 31 year old freelance documentary producer, I barely had enough money to pay my bills and eat, let alone afford the private health insurance that allowed me access the to quality, but high-cost health care that I believe saved my life. I signed up for insurance because I was afraid I'd get hurt snowboarding, not managing a long-term illness. Private health insurance covered the basics, but I still paid over $50,000 for all the care I received. I'm still paying it off. Sometimes I wonder how bad off I would be if I hadn't gotten it in the first place."

Sarah from Los Angeles, CA

"In 2001, I paid $135 per month for individual health insurance coverage. Co-pays were $20.00 per visit and $5.00 for Rx. Now, I pay $603.00 per month, $40.00 co-pay per visit and $10. per RX, and a $4000 per year deductible. I have no chronic health problems. Three years ago I suffered a bout of severe sciatica (I had never experienced this before) which sent me to the ER for 12 hours. My insurance company refused to cover the ambulance bill and refused 50% of the ER fees. My out of pocket expenses for that one episode came to over $2,500.00. This after paying $549.00 per month (at that time) for coverage. Consequently, I never got the full PT that I probably needed and as a result have some permanent nerve damage in my leg."

High cost of individual market insurance

Melinda from Lakewood, OH

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

viding for myself—including paying for my health care during both my working and retirement years. I do not expect a "free ride". I want guaranteed access to competitively priced health care/insurance and I am willing to pay for it. I just need help leveling the playing field. No denial of coverage. No exorbitant premiums. No limited benefits—just because I am an individual with pre-existing conditions."

Jamie from Clio, MI

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

Joel from Brooklyn, NY

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

Jan from Lebanon, CT

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

Grace from Danielson, CT

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

Bea from Charlotte, NC

After she was laid off from her county social worker job, Bea opened her own practice but has struggled to afford adequate health insurance. She can only afford catastrophic coverage which does not cover her pre-existing conditions, including her ar-

thritis. "I quickly realized that the American dream of owning your business is only for the young and healthy."

Pre-existing Conditions: the Cost of Exclusions

Keith from Lakewood, OH

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

Neil from Pepper Pike, OH

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

Carolyn from Media, PA

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

Michael from Iowa City, IA

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

Kim, from Minneapolis, MN

Kim's husband was having a difficult time sleeping so he saw his doctor who sent him home with a 3 week sample pack of anti-depressants. Her husband had no previous history of depression, but five weeks later he took his own life. After her husband's death, Kim saw a therapist for grief counseling. Kim ended up leaving her job in advertising to devote her time to drug safety advocacy and do freelance work. She paid for 18 months of COBRA coverage and then shopped around for an indi-

vidual health plan. Since she had no serious health issues in her past, she expected her coverage would be affordable. But the insurer she had received coverage through previously refused to issue her an individual policy because they said that her participation in grief counseling was an indication of possible mental illness. Kim was able to get coverage through a second insurer but only on the condition that she would not file any claims for counseling for two years.

The "gotcha" of out-of-network limitations

John from Pelham, AL

This twenty-three year old young father had an accident on a four wheel vehicle in a rural area. When the ambulance arrived, the EMT decided he needed to be taken to the hospital by helicopter. John spent three days in the hospital recovering from his injuries and left with a $9,000 bill because his insurance company said the ambulance and helicopter were not preferred providers.

Charles from Alma, GA

Charles ("Buddy") was diagnosed with prostate cancer but his insurance company denied payment for the services from the doctor who diagnosed him. While the doctor's office on the first floor is part of his insurance company's network, the second floor where biopsies are done is not part of the network. When Charles needed surgery he had a very difficult time finding doctors that belonged to his insurer's network who could perform the surgery in hospitals that were also part of the network. It was only after his state legislator intervened on his behalf that Charles was able to resolve his issues with his insurance company. "It's not the cancer that is going to kill me, it's the insurance company."

Andrea from Murphy, TX

Andrea's son was having difficulty breathing shortly after he was born and was rushed to the hospital's Neo-Natal Intensive Care Unit (NICU) for treatment. Two days later he was doing fine and discharged to go home. Andrea was then informed by her insurance company that the Doctor who treated her son in the NICU was not part of the insurer's network. Less than half of the $1,145 NICU bill was covered by her plan even though he needed emergency care. When she had to bring her son back a second time to the ER, she was charged $600 for his care. Andrea discovered that there are no hospital emergency rooms in Texas that will take her insurance. Her family spends $7,000 annually on health insurance.

Chairman RANGEL. Mr. Hobson, President and CEO of Watts Healthcare Corporation from Los Angeles. Thank you so much for making that trip to be with us this morning.

STATEMENT OF WILLIAM D. HOBSON, JR., M.S., PRESIDENT AND CEO, WATTS HEALTHCARE CORPORATION, LOS ANGELES, CALIFORNIA

Mr. HOBSON. Thank you and good morning, Chairman Rangel, Ranking Member Camp, and distinguished Members of the Committee, you have received a copy of my written testimony, so I will be brief with my remarks.

My name again is William Hobson, and I am president and CEO of the Watts Healthcare Corporation in South Los Angeles, where we operate the historic Watts Health Center, one of the very first community health centers in the country.

Over the past 40 years, which has been my entire professional career, I have worked with the community health centers across the country, starting in Cincinnati, Ohio, moving to Seattle, and most recently to California. And I have worked on the development and implementation of high-quality health care services for the uninsured and at-risk populations in those communities.

For 2 years I oversaw the Federal health center program at the Department of Health and Human Services as well. I had several years of Federal service.

On behalf of the 18 million patients served by community health centers nationwide, I would like to take this opportunity to thank you for the Committee's unyielding support for the national health centers program. In this time of enormous challenges to our health care system and our economy, your faith in us and your support through the Recovery Act will allow us to rise and meet these challenges and continue to excel.

My testimony today will focus on health centers' role in the health care delivery system for the publicly insured, and on the experiences of safety net providers in the insurance market.

Last year the Watts Health Center was a health care home to more than 23,000 patients, and we provided 98,600 medical, dental, mental health, and other specialty medical visits at three sites. Approximately 55 percent of our patients are African American, and approximately 40 percent are Latino. A total of 96 percent of our patients have incomes below 200 percent of poverty, which is quite poor when you look at the cost of living in Los Angeles County.

Our public hospital recently closed, so the community has lost access to specialty care providers and an emergency room. So now we see patients coming to us sicker and with more complex health problems than ever before.

Of the more than 23,000 patients that we saw in 2008, approximately 62 percent had no insurance coverage. These uninsured patients pay what they can out of their own pocket, and we use Federal, state, and local grant funding and private donations to supplement the cost of their primary health care coverage.

Less than 1 percent of our patients had any form of private insurance coverage, and when they did have private insurance coverage, it mostly covered hospitalization and really did not cover primary care at all. The rest of our patients are covered by public programs such as Medicaid, Medicare, and SCHIP. These programs reimburse our health centers at very close to the cost of care through a health center-specific payment rate.

From the perspective of the nation's health centers, our current public programs—Medicare, Medicaid, and SCHIP—are uniquely qualified to meet the needs of the most vulnerable communities. Not only are our current public programs the only insurers that cover services necessary to meet the unique health needs of low income and underserved people, they are also quite often the only payors that recognize the unique role of the safety net providers like health centers, and the only insurance that pays them adequately.

By contrast, nationwide the private insurance market pays health centers less than 50 cents on the dollar for the care that they furnish to the 3 million people nationwide that our health center program sees that are privately insured.

For all of these reasons, we believe that there is a real value in including a public health insurance plan as a part of any health care reform effort that this Committee undertakes. The current third party insurance payment structure disincentivizes many health care providers from offering patients coordinated case man-

agement and other enabling services which quite often make the difference as to whether the care that is provided is effective.

By contrast, the prospective payment system under which health centers operate appropriately and predictably reimburses health centers for the comprehensive care that we provide. The same should be required in any expanded health insurance model, whether public or private.

In Los Angeles County, we have formed an independent practice association to provide Medicaid managed care services. Through that, we hold contracts with most of the HMOs that provide Medicaid managed care in the county. Though we are paid reasonable rates for our services by the county-owned plan, almost all of the private plans pay lower rates and are much more difficult business partners, from my perspective.

The private plans often move to exclude both hospitals and specialty networks that are the most geographically accessible for our patients. We also experience poor customer service and difficult patient care management protocols with most of the private plans.

In conclusion, I would say that in my opinion there is a need for a public health insurance plan to assure that the most vulnerable populations and communities are not marginalized or redlined.

I believe that Members of this Committee recognize the health center program as an unprecedented health care delivery success, improving patient outcomes and reducing health disparities in communities nationwide while at the same time providing quality care and estimated cost savings of approximately $18 billion annually to our health care system and to taxpayers.

I hope that as you examine potential reforms, you will look to health centers as a model and consider the unique challenges health centers and other safety net providers face in the health insurance marketplace.

Thank you for your time. I look forward to taking any questions that you might have.

[The prepared statement of Mr. Hobson follows:]

Prepared Statement of William D. Hobson, Jr., MS, President and CEO, Watts Healthcare Corporation, Los Angeles, California

Chairman Rangel, Ranking Member Camp, and Distinguished Members of the Committee thank you for this opportunity to address you today:

My name is William Hobson and I am the President/CEO of Watts Health Care Corporation in South Los Angeles where we operate the historic Watts Health Center, one of the first community health centers in the country. I have worked with community health programs professionally since 1970 and have focused my entire career on the development and implementation of high quality health care services for uninsured and at-risk populations.

As this committee has jurisdiction over programs under the Social Security Act, including Medicare, my testimony today will focus on health centers' role in the health delivery system for the publicly insured.

On behalf of the 18 million patients served by community health centers nationwide, as well as the volunteer board members, staff, and countless members of the health center movement, I want to thank you for this Committee's unyielding support for health centers and your dedication to the health center mission of providing affordable, accessible primary health care to all Americans. In this time of enormous challenges to our health care system and our economy, your faith in us and your support through the Recovery Act will allow us to rise and meet these challenges and continue to excel. With your ongoing support, our cost-effective, high quality system of care can continue to expand, reaching our goal of serving 30 million Americans by 2015, and eventually every individual in need of a health care home.

Community Health Centers and Health Reform

Over the past 43 years, the Health Centers program has grown from a small demonstration project to an essential element of our nation's primary care infrastructure. Today, health centers serve as the primary health care safety net in thousands of communities and, thanks to bipartisan support in Congress and the current and past administration, the Federal Health Centers program enables more low-income and uninsured patients to receive care each year. Health centers currently serve as the family doctor and health care home for one in eight uninsured individuals, and one in every five low-income children. Health centers are helping thousands of communities to address a range of increasingly costly health problems including prenatal and infant health development, childhood obesity, chronic illnesses, mental health, substance addiction, oral health, domestic violence and HIV/AIDS.

Federal law requires that every health center be governed by a patient majority board, which means that care is truly patient-centered and patient-driven. Each health center must be located in a federally designated Medically Underserved Area (MUA), and must provide comprehensive primary care services to anyone who comes in the door, regardless of ability to pay. Because of these characteristics, the insurance status of health center patients differs dramatically from those of other primary care providers. As a result, the role of public revenues is substantial. Federal grant dollars, which make up roughly twenty-one percent of health centers' operating revenues on average, go toward covering the costs of serving uninsured patients and delivering care effectively to our medically underserved patients and communities. Just over 40% of health centers' revenues are from reimbursement through Federal insurance programs, principally Medicare and Medicaid. The balance of revenues come from State and community partnerships, privately insured individuals, and low-income uninsured patients' sliding-fee payments.

In discussions about reforming the health care system, one element remains constant across all platforms and proposals; the need to invest in accessible, affordable, high-quality primary care for all as a down payment on a more effective and efficient health care system. **Currently, 60 million people nationwide** lack access to primary care because of shortages of physicians and other providers in their communities; we refer to these individuals as "medically disenfranchised." They and millions of others who confront additional barriers to care require a source of regular, continuous, primary and preventive care, a "health care home," to maximize the value of our investments in health reform.

From the perspective of the nation's health centers, our current public programs—Medicare, Medicaid and CHIP—are uniquely qualified to meet the needs of our most vulnerable communities. Patients can access not just primary care, but a full spectrum of services tailored to meet their individual and family needs including case management, transportation and language assistance as well as dental care, mental health services and prescription assistance programs. Community Health Centers strongly support expanding Medicaid to cover at least everyone with incomes up to the Federal poverty level without restriction, and higher if possible. These are the very people who most need the services and benefits offered through Medicaid. But as coverage expands, we must also ensure patients have access to doctors who will treat them. Health centers support adequate and reliable primary care provider reimbursement by all public and private payers to reflect the value—in system-wide cost savings and improved health outcomes—that these doctors provide. We also support making Medicare coverage available to those over age 55 or even age 50, who do not have access to employer or other public coverage, on a "buy-in" basis. This generation is currently the fastest-growing age group of health center patients, and far too many have NO access to affordable coverage.

For all of these reasons, there is a real value to including a public plan option as part of any health care reform effort this Committee undertakes. Not only, as noted above, are current public programs the **ONLY** insurers that cover services necessary to meet the unique health care needs of low-income and underserved people. They are also the **ONLY** payers that both recognized the unique role of safety net providers like Health Centers in serving their beneficiaries and the only insurers that pay them adequately. By contrast, nationwide, the private insurance market pays health centers less than 50 cents on the dollar for the care they furnish to the 3 million privately-insured individuals they serve.

Watts Health Center: A Health Care Home for the Underserved

Watts Health Center is a "health care home" for 23,000 patients, providing 98,600 medical, dental, mental health and other specialty care visits at 3 sites. Approximately 55% of our patients are African-American and 40% are Latino. Approximately 96% of our patients have incomes below 200% of the Federal Poverty Level. Over 3,000 of our patients have diabetes and other chronic conditions and our

health centers provide case management, translation and other enabling services, as well as health education and preventive screenings and treatment. We pride ourselves on the bilingual health education sessions that we offer each week that cover everything from smoking cessation, to diabetes management to exercise. Our public hospital closed recently, so our community has lost access to specialty care providers and an emergency room and our patients are coming to us sicker, with more complex health problems.

Of our 23,284 patients in 2008, approximately 62% had no insurance coverage. These uninsured patients pay what they can out of their own pocket and we use state, Federal and local grant funding and private donations to supplement the cost of their primary care. Less than 1 percent of our patients had any private insurance coverage. Third-party insurance typically pays our health center about half the cost of these patients' care and, like the uninsured, we supplement the cost of care to these patients with Federal, state and local dollars and donations. The rest of our patients are covered by public programs—either Medicaid, Medicare or CHIP. These programs reimburse our health centers at or very close to the cost of care through the FQHC Prospective Payment System, allowing us to provide the full spectrum of services our patients need.

Health Center Participation and Payment in Public and Private Insurance Plans

America's health centers provide care to more than one million medically underserved Medicare beneficiaries, and that number is increasing rapidly. Our health center, like health centers nationwide, has seen an increase in our Medicare patient population in recent years, as well as an upsurge in 'near-elderly' patients—those between the ages of 45 and 64. Medicare patients are now between 8–20% of all health center patients—a number that will only continue to increase over time.Many of the residents of our community do not live long enough to be Medicare eligible and those that do often have no personal automobile and have multiple chronic diseases. We offer free patient transportation services to both our facilities and to specialty referrals including dialysis centers. Our Internal Medicine Department is highly skilled in treating the elderly many of whom have been Watts Health Center patients for 40-years. We offer podiatry, physical therapy, radiology and ophthalmology services on site so that our senior patients can receive "comprehensive" health services in a single location. We essentially subsidize much of the service that we provide to our Medicare clients as much of the case management and care coordination services that we provide are not reimbursable but I am sure that they save the Medicare program costly visits to the emergency room and unnecessary hospitalizations.

The PPS structure ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate that balances both higher and lower costs for all of the services they provide to the publicly insured patients they see. The current third-party insurance payment structure dis-incentivizes many health care providers from offering patients coordinated case management and other enabling services, as well as the cost-effective preventive care that health centers provide, and which has been proven to save the health care system money overall. The PPS structure for health centers appropriately and predictably reimburses health centers for the comprehensive care we provide. **The same should be ensured in any expanded insurance model, whether public or private.**

Many of the health centers in Los Angeles County have formed an Independent Practice Association (IPA) to more efficiently contract for the provision of Medicaid managed care services. Our IPA holds contracts with most of the HMOs that provide Medicaid managed care services in LA County. Although we are paid reasonable rates for our services by the County-owned (public) plan almost all of the private plans pay lower rates and are "difficult" business partners. The private plans often move to exclude both hospitals and specialty networks that are the most geographically-accessible to our patients. We also experience poor customer service and difficult patient care management protocols with most private plans. In my opinion there is a need for a public plan to assure that the most vulnerable populations and the most difficult to serve communities are not marginalized under any new system established by your efforts at health reform. The only alternative would be strict network adequacy standards to ensure that insurers would not be able to redline communities, denying or restricting their access to care.

Our history with private plans has not been particularly good with respect to cost containment, quality improvement and customer relations. I feel that the use of a private plan as an alternative can assist in moving us toward a more patient-friendly, high-quality and evidence-based medicine driven system.

And, lest I leave you thinking that we're only asking for a hand-out, allow me to point to the literally dozens of studies done over the past 25 years, right up to this past year, which conclude that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for ambulatory care-sensitive (that is, avoidable) conditions, and are therefore less expensive to treat than patients treated elsewhere.[i] In fact, a recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41% lower total health care expenditures than people who get most of their care elsewhere.[ii] As a result, health centers saved the healthcare system up to $18 billion last year alone. Thus, in effect, the investment in primary and preventive care that Medicaid and CHIP, and for the most part Medicare, make in paying health centers adequately for their care yields significant savings to the health care system and to taxpayers as well. Under a reliable and fair payment structure, health centers stand ready to provide low-cost, highly effective care to millions more individuals and families in need. Health centers also look forward to health reform, and we are eager to do our part to ensure that with improved coverage, there is also access to care. Reimbursing health center providers appropriately for the comprehensive, coordinated care we provide will help to grow the primary care infrastructure that is essential to ensuring that investments in health reform translate into improved health and wellness for the nation.

Conclusion

I know that the Members of this Committee are well aware that the Health Centers program is an unprecedented health care success story, improving patient outcomes and reducing health disparities in communities nationwide. Entities ranging from OMB to IOM to GAO recognize the efficiency and effectiveness of our model, which hinges on our ability to provide comprehensive primary care to all patients. We believe that health reform should strive to achieve universal coverage that is available and affordable to everyone, especially low income individuals and families. We believe this care must be comprehensive, including medical, dental and mental health services with an emphasis on prevention and primary care. And we believe that reform must strive to guarantee that everyone—especially the 60 million medically disenfranchised Americans—has access to a medical or health care home where they can receive high quality, cost-effective care for their health needs.

Thank you for your time, and I'll look forward to taking your questions.

Chairman RANGEL. Thank you. And you might want to share with us what it is with the community health centers that make you so popular so that when you do come to Washington, I am amazed at the bipartisan support that the Congress gives what you do. And so the quality of care, but most importantly, the consumer sense of credibility of those that service them is absolutely amazing.

David Borris, the owner of Hel's Kitchen Catering from Illinois. I look forward to seeing the connection. Thank you for coming.

STATEMENT OF DAVID BORRIS, OWNER, HEL'S KITCHEN CATERING, NORTHBROOK, ILLINOIS

Mr. BORRIS. Thank you, Chairman Rangel, Ranking Member Camp, distinguished Members of the Committee, for the invitation to testify this morning on my experience with health insurance as a small businessowner. My name is David Borris, and I am the

[i] McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. *www.mpca.net*. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January—March 2006 *Journal of Ambulatory Care Management* 29(1):24–35. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551–56.

[ii] NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff*. August 2007. www.nachc.com/access-reports.cfm.

owner of Hel's Kitchen Catering, a 24-year-old off-premise catering company located along suburban Chicago's north shore in Northbrook, Illinois.

Our business was born in a 900-square-foot storefront with one employee, my wife, myself, and a handful of my mother's and my wife's recipes. My wife and I both left good-paying jobs in the hospitality industry to take our shot at the American dream of owning our own business.

Believe me, there were times—mopping the floor at the end of a 16-hour day, with one baby and then two in the playpen in the office, when we weren't sure we had made the right decision. But 24 years and three grown children later, we have a thriving business that now occupies 8,000 square feet. I would say it has worked out pretty darn well.

I now employ 25 full-time employees, and have been offering health insurance to my staff since 1992. When we began offering this benefit, we had grown to eight full-time employees, and felt a moral obligation to do right by the people who were making our life's work theirs as well. Employees contributed 50 percent of the premium in their first year of coverage, and Hel's Kitchen picked up the entire premium after that.

Beginning around 2002, though, we began to experience a series of annual premium increases that, taken together, now have us paying double per employee what we paid then—2004, 21 percent; 2005, 10 percent; 2006, 16 percent; and 2007, 17 percent, and a change in carriers to avoid the quoted 26 percent renewal fee. In 2008, we were finally forced to ask long-time employees to again begin paying a portion of the premiums, as the 17-percent increase was simply too much for us to absorb.

I currently insure only 13 of my 25 full-time employees. I spent 13 percent of my covered employees' payroll on health insurance premiums last year, and have no idea what the renewal is going to look like when it comes due this November. Undoubtedly, we will be forced to increase employees' contributions again, an effective pay cut only further reducing their disposable income. This is no way to run a growing business.

Six weeks ago I was speaking with a number of my fellow businessowners at a Chamber of Commerce networking function, and I was in the process of negotiating a renewal of our lease at the same time. I asked them, when we work on these lease deals, we look at three-year, 5-year, 10-year, 20-year terms.

How many of us would sign a lease with a landlord who said, I will tell you what. I will give you a one-year lease, and after 11 months, I will let you know how much your rent is going to be for next year. Maybe it will go up 3 percent, maybe 22 percent. I don't know. I will let you know then. How many of us would sign a deal like that?

Well, you can imagine their response. And yet that is precisely the situation we have with health insurance every year. I will pay approximately the same amount of money to insure half of my full-time staff as I pay in rent in 2009. Surely this is deeply broken. There must be a better way.

The small group insurance market is simply not working for small business. Let me share with you how the premium renewal

shopping game works in the current all-private health insurance market for small business.

About four to 6 weeks before the year is up, our broker brings us quotes from five or six insurers. We go over the benefit differences and the quoted premiums, and we choose the plan that we hope will work best for a majority of our employees.

Then we are asked to collect and submit health histories from those employees. Two to 3 weeks later we get the real premium. It could be 10 percent, 20 percent, or 66 percent more. We are not supposed to know why.

But we are small businesses. Our employees are like our family. We know. We know that our 62-year-old general manager's wife has a kidney problem. We know that the chef's son is taking human growth hormone for his condition. We know.

Because of the industry's routine discrimination against employees with health issues, small business owners like myself are faced with a moral dilemma that should not be ours to bear. Are we to measure retention and hiring now with a yardstick that includes health insurance costs? Is a valued employee's job to be less secure because they have the misfortune to have a sick child or a wife with cancer? These sorts of choices in the wealthiest nation in the world, it is unconscionable.

I want to make one thing perfectly clear as I conclude. As a small businessowner, I am willing to contribute to get good health coverage for my employees. But leaving cost containment and reform in the hands of the private health insurance industry, we have tried that and it has failed.

We need a public plan that will re-energize true competition in the marketplace, set the bar for comprehensive benefits and cost controls, provide a quality alternative if the private market doesn't meet our needs. The choice of a public health insurance plan can put the focus back on health outcomes and the quality of life, not profits and corporate bonuses.

It can reinforce the best of what America has to offer, the promise that we all have responsibilities toward each other. We have waited long enough. The American economic recovery, the prosperity of businesses like mine, and our commitment to the employees that make our businesses what they are, all hang in the balance.

Thank you.

[The prepared statement of Mr. Borris follows:]

Prepared Statement of David Borris, Owner, Hel's Kitchen Catering, Northbrook, Illinois

Chairman Rangel, Ranking Member Camp, and Members of the Committee, thank you for the invitation to testify this morning on my experience with health insurance as a small business owner.

My name is David Borris and I am the owner of Hel's Kitchen Catering, a 24 year old off-premise catering company located along suburban Chicago's north shore in Northbrook, Illinois.

Our business was born in a 900 square foot storefront with one employee, my wife, myself and a handful of my mother and my wife's recipes. My wife and I both left good paying jobs in the hospitality industry to take our shot at the American dream of owning our own business. Believe me, there were times mopping the floor at the end of a 16 hour day, with a baby and then two in the playpen in the office, when we weren't sure we had made the right decision. But 24 years later, with

three grown children, and a thriving business that now occupies 8,000 square feet—I would say it's worked out pretty darn well.

I now employ 25 full time employees, and have been offering health insurance to my staff since 1992. When we began offering this benefit, we had grown to 8 full time employees, and felt a moral obligation to do right by the people who were making our life's work theirs as well. We implemented a structure whereby employees would contribute 50% of the premium in their first year of coverage, and Hel's Kitchen would pick up the entire premium thereafter. We continued to grow and expand and this structure worked well for some time.

Beginning around 2002, though, we began to experience a series of annual premium increases that, taken together, now have us paying double per employee what we paid then. In 2004, it was a 21% increase; in 2005,10%; 2006, 16%; 2007, 17% and a change in carriers to avoid the quoted 26% increase. And in 2008, we were finally forced to ask **long time** employees to recontribute as the 17% increase was simply too much for us to absorb. I currently insure only 13 of my 25 full time employees—the other 12 cannot afford the 50% in the first year—and we could not afford to maintain our current structure if they all opted in. I spent almost 13% of my covered employees' payroll on health insurance premiums last year ($79,494 / $625,448)—and have no idea what the annual renewal will look like when it comes due this November. Undoubtedly, we will be forced to increase employees' contributions once again—an effective pay cut only further reducing their disposable income in an already critically contracted economy. This is no way to run a growing business.

Six weeks ago, I was speaking with a number of my fellow business owners at a Chamber of Commerce networking function, and I was in the process of negotiating a renewal of our lease at the same time. I asked them, "When we work on these lease deals, we look at 3 year, 5 year, 10 or 20 year terms. How many of us would sign a lease with a landlord who said, 'I'll give you a one year lease, and then after 11 months, with only 4 weeks to go, I'll let you know how much your rent will be for the next year. It might go up 3%, or 8%, or 22%—I'll just let you know then.' How many of us would sign a deal like that?" You can imagine their response. And yet, that is precisely the situation we have with health insurance premiums every year. I will pay approximately the same amount to insure half of my full time staff as I pay in rent in 2009. Surely, this is deeply broken. There must be a better way.

The figures for rising costs are only one measure of the problems we face as small businesses in the current small group insurance market. A major part of this cost problem stems from the fact that we as small businesses, and our employees, are subject to routine (and perfectly legal) discrimination in the small group market.

Let me share with you how the premium renewal/shopping game works in the current all-private health insurance market for small businesses. Approximately 4–6 weeks before the term is up, our broker brings us quotes from 5 or 6 insurers. We go over the benefit differences and the quoted premiums and we choose the plan that we hope will work best for a majority of our employees. Then we are asked to collect and submit health histories from each employee. About 2–3 weeks later—the clock is ticking and our current policy will expire in less than a month—we get the real premium, which could be 10%, 20% or as high as 66% more. We're not supposed to know why—but we are small businesses, our employees are like our family, we know. We know that our 62 year old general manager's wife has a kidney problem. We know that the chef's son is taking human growth hormone for his condition. We know.

And so we as small business owners must face our employees with a moral dilemma that should not be ours to bear—we face them with the predicament of now measuring retention with a yardstick that includes their health insurance costs simply because they had the misfortune of having a wife with a disease or a sick child. These sorts of choices—in the wealthiest nation in the world—it's unconscionable.

The American entrepreneurial spirit has created the most powerful economic engine the world has ever known—and self employed entrepreneurs and small business will ultimately be the ones to lead us out of this crippling recession. But we need to be able to count on a premium schedule that is predictable if we are to create the 2.4 million private sector jobs we need to in the next 18–24 months. We need to be able to make hiring and retention decisions based on merit and performance, and not have to consider health history as a primary determinant.

I know my story of crushing premium increases and being forced to pass on more costs to employees is by no means unique. The annual Kaiser Family Foundation survey released in September of 2008 reported that the average worker contributed nearly $3,400 to their health insurance premiums—$1,600 more than they did in 1999, and 12 percent more than they did just one year prior, in 2007. And just six weeks ago, Hewitt Associates released a survey stating nearly 1/5 of U.S. employers

will stop offering health benefits in the next 3–5 years if current trends continue—that's more than 5 times the number that reported that just last year. The health care system we have now is not working for American business, large or small.

I want to make one thing perfectly clear: as a small business owner, I'm willing to contribute to get good health coverage for my employees. I want to be able to do that, but it's becoming all too obvious for me that I'm not going to be able to keep doing it alone. That's why I support the idea of a system of shared responsibility—where businesses, employees, government, providers—where we all pitch in to make it work.

As small businesses, we desperately need more choices—good choices—in health care. We already have enough bad choices—high-deductible, low-benefit plans that are barely worth the paper they're written on. We need good choices. That's why I believe we should have a choice between private and public health insurance plans. Let us decide what works for us: keeping what we've got, or opting for something new. For businesses that don't have good options now, offer the choice of a public health insurance plan. This will give us greater bargaining power and encourage competition among insurers to make costs affordable.

Leaving cost containment and quality improvements solely in the hands of the private health insurance industry—we've tried that and it's failed. As a small business, the success of my business is built on trust. But the insurance industry has broken our trust. And so for me, the solution is clear. We need a public plan that will reenergize true competition in the marketplace, set the bar for comprehensive benefits and cost controls, provide a backup if the private market doesn't offer something that works for us, and push private insurers to reexamine their profit models.

In combination with other reforms, the choice of a public health insurance plan can help drive innovation in health care and put the focus back on health and quality of life, not profits and corporate bonuses. It can reinforce the best of what America has to offer—the promise that we all have responsibilities toward each other—the innate understanding that our strength, both as a community and as an economy, is greater than the mere sum of its parts.

It is time for comprehensive reform in health care. Small businesses have waited long enough, and the cost we truly cannot afford now is the cost of inaction. The American economic recovery, the prosperity of businesses like mine, and our commitment to the employees that make our businesses what they are—all are hanging in the balance.

Chairman RANGEL. Thank you so much.

I look forward to the testimony of Kenneth Sperling on behalf of the National Coalition on Benefits. It may appear as though the witnesses outnumber your view, but I intend to spend a little time I have in giving you an opportunity to express yourself beyond your testimony.

STATEMENT OF KENNETH L. SPERLING, GLOBAL HEALTH MANAGEMENT LEADER, HEWITT ASSOCIATES, ON BEHALF OF NATIONAL COALITION ON BENEFITS

Mr. SPERLING. Thank you, Mr. Chairman, Ranking Member Camp, and Members of the Committee. Thank you for the opportunity to testify at this important hearing on insurance market reform. My name is Ken Sperling, and I lead Hewitt Associates' global health care consulting practice. Hewitt Associates is a human resources company serving more than 2,000 U.S. employers from offices in 30 states.

I have been asked to testify on behalf of the National Coalition on Benefits, a group of 180 employers and business trade associations who have joined together to work with Congress to enact reforms that preserves ERISA and maintains uniform health and retirement benefits to employees and retirees across state and local boundaries.

We will discuss some of the issues we encourage you to think about as you consider rules governing the health insurance marketplace. We thank the Committee for your leadership in preserving the employer-based system, and we appreciate your acknowledgment that many Americans want and should be able to keep the coverage that they have today.

NCB supports the need for health reform, but believes that reform should be careful not to disrupt or destabilize existing employer-sponsored coverage that most Americans rely on. Nationwide, the majority of Americans—177 million—participate in employer-sponsored health care plans.

This model works well because it allows broad pooling of risk, enables participation by all regardless of health status, and creates efficient large-scale purchasing. Even more important, employers have a vested interest in the health and productivity of their workforce, and use the employer-based system to consistently produce innovative health care solutions that improve productivity, reduce absence from work, and lower disability costs.

But as good as it is, this system is increasingly at great risk, given the combination of cumulative increases in health care costs and the current economic downturn. Despite the positive actions of many employers, there are many problems yet to solve.

Federal health care reform must focus on several important priorities.

First, preserve and promote the employer-based health care system. Reform should seek to both protect and expand the number of employers who provide health care benefits for their employees.

The employer-based system has encouraged companies to be innovators of health care solutions, and recent examples include extensive health coaching programs, incentives for wellness and pharmaceutical compliance, and efforts to improve cost and quality transparency. There are promising outcomes emerging from programs that encourage people to engage in healthy activities, understand their risks, and manage their illness.

Employees also understand and appreciate the employer's role in offering and financing health care benefits. And a recent survey showed that three out of every four respondents valued health insurance as their most important employee benefit, and an equal number said they would prefer to have their employer provide this benefit rather than being provided a salary increase to purchase health coverage on their own.

Second, preserve and strengthen Federal ERISA preemption of state laws to promote uniformity in coverage and reduce administrative costs. Approximately 55 percent of employees who participate in employer-sponsored plans are in self-insured arrangements, and 45 percent are in insured programs.

All of these plans are covered by ERISA. Many of the employers who voluntarily sponsor these plans operate across state lines, and they must be able to continue to offer uniform benefit packages to their employees. Requiring employers to comply with a multitude of state—and/or local government-imposed administrative requirements and benefit mandates would raise employer costs even further, and result in unequal benefits for employees.

ERISA preemption gives each employer the flexibility to design coverage that meets the changing needs and disease burden of their unique workforce, and apply these programs efficiently to all work locations.

Third, reform the insurance marketplace so that individuals and small employers can have access to affordable insurance products. Insurance market reform is necessary so that small businesses and individuals can find affordable health insurance coverage.

Many large employers fear that rising health care costs may encourage smaller businesses to drop health coverage, and such a trend would lead to large employers assuming an even greater economic burden through increased cost-shifting.

And fourth, build on the efficiencies that will come from continued investment in health information technology, including the adoption of uniform Federal standards to improve efficiency and patient safety.

In closing, on behalf of the National Coalition on Benefits, we support the employment-based system and the preservation of ERISA so that employers have the ability to offer and maintain comprehensive and uniform benefit plans. We believe that employers should remain an integral part of the U.S. health care system, and that reforms that lead to lower health care costs will go a long way toward keeping American companies competitive.

Congress has the challenge of sorting through the details of how that would be accomplished, with many competing views. As a member of the National Coalition on Benefits and independently, Hewitt would be pleased to offer its expertise, data, and tools to help the Committee evaluate the impact of detailed reform plans on coverage provided by employers today.

Thank you for your interest, and I would be pleased to respond to your questions.

[The prepared statement of Mr. Sperling follows:]

Hewitt

Testimony
By Kenneth L. Sperling
Global Health Management Leader

of Hewitt Associates LLC

On behalf of the National Coalition On Benefits

Before

U.S. House of Representatives

Committee on Ways and Means
Hearing on

Health Reform in the 21st Century: Insurance Market Reform

April 22, 2009

Hewitt Offices—U.S.

March 2009

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About Hewitt Associates

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt consults with companies to design and implement a wide range of human resources, retirement, investment management, health management, compensation, and talent management strategies. As a leading outsourcing provider, Hewitt administers health care, retirement, payroll, and other HR programs to millions of employees, their families, and retirees. With a history of exceptional client service since 1940, Hewitt has offices in 33 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

I. Introduction

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to testify at this important hearing on the future of America's employer-based health care system. My name is Ken Sperling, and I am Hewitt Associates' Global Health Management Leader. I have been asked to testify on behalf of the National Coalition on Benefits ("NCB") to discuss the importance of preserving ERISA in providing employer-sponsored benefits.

I am here today on behalf of a Coalition of 180 business trade associations and employers who have joined together to work with Congress to maintain uniform health and retirement benefits to employees and retirees across states and localities. The National Coalition on Benefits along with over 190 companies and associations recently wrote to President Obama applauding his commitment to comprehensive, bipartisan health care reform to all Americans and access to affordable health care coverage.[1] I have included that letter in my written testimony. The Coalition calls on Congress to enact reform that includes, as its foundation, controlling costs and preserving ERISA. Nationwide, employer-sponsored health care plans provide health care coverage to over 177million participants – approximately 56% of employees are covered under self-insured plans, while 45% of employees receive coverage under fully insured products. Data from the Kaiser Family Foundation shows that 99% of employers with 200 or more employees offered health benefits in 2008, the latest data available.[2] Today, I will also discuss our experiences in working with employers to offer health insurance coverage to their workers.

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 30 states, including many of the states represented by the members of this distinguished Committee.

As one of the world's premier human resources services companies, Hewitt Associates consults with large employers to design their health plans and evaluate bids by competing health providers. In addition, we are the leading provider in Benefits Outsourcing services, administering health and welfare plans for 195 clients representing more than 7.5 million participants. Our access to large employers led us to create the Hewitt Health Value Initiative™ database, which contains detailed information on more than 1,800 health plans throughout the U.S., including 350 major employers and more than 13 million health plan participants. This rich data source allows us to analyze the impact of rapidly rising health care costs on employers, employees, dependents, and retirees.

II. View of the Challenges

Mr. Chairman, Rep. Camp and members of the Committee, we thank you for your leadership in preserving the employer-based system. We appreciate your acknowledgment that many Americans want and should be able to keep the coverage that they have today. We agree, Mr. Chairman, with the view that the employer-based health care system must be preserved and strengthened as part of any viable health reform plan. The National Coalition on Benefits supports the need for health reform and the objective of providing universal coverage – with the confidence that reform will not disrupt their existing coverage. Many NCB members support the goal of universal coverage. Hewitt has found that large employers support universal coverage -- there is not yet consensus on the best way to achieve it.

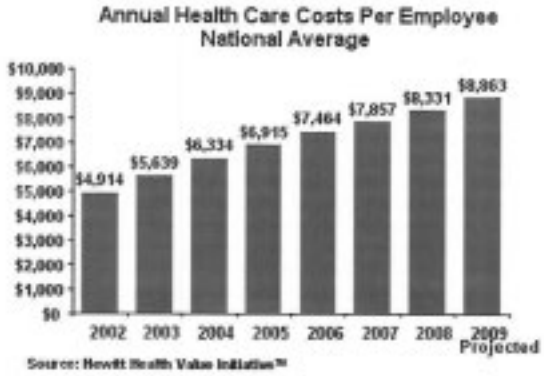
[1] Letter to President Obama, April 1, 2009, attached to testimony.
[2] Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2008.

Today's testimony will focus on the importance of ERISA preemption in preserving uniform and comprehensive employer-sponsored coverage and discuss some of issues we encourage you to evaluate as you consider rules governing the health insurance marketplace. A reformed health care system should address the cost shifting that current exists to employer-sponsored plans through an increasing burden of uncompensated care and the inadequacy of public reimbursement, but this reformed system should preserve the ability to provide equal benefits to all employees using ERISA as its foundation.

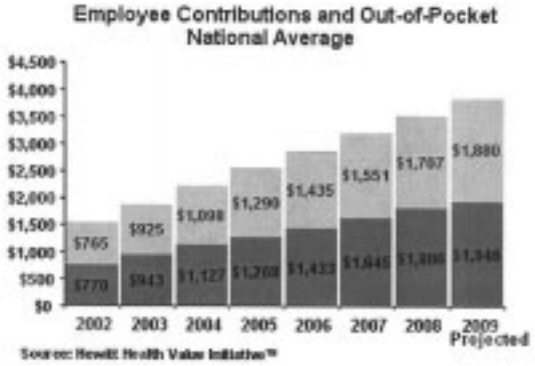
The employer-sponsored model works well because it allows the pooling of risks and because group purchasing lowers health care costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. Employer-based plans typically waive pre-existing conditions and cannot increase premiums or limit coverage based on individual health status. HIPAA regulations ensure that people can move from job to job without concern for being denied coverage due to health status. More importantly, employers have a vested interest in the health and productivity of their workforce, and the employer-based system has consistently produced innovative health care solutions that improve productivity, reduce absence from work, and lower disability costs.

As good as it is, this system is increasingly at great risk, given the combination of cumulative increases in health care costs and the current severe economic downturn. Despite the positive actions of many employers, there are many problems to solve in the current U.S. health care system. Among the most pressing:

- **Health care is too costly.** The National Coalition on Benefits believes that controlling spiraling health care costs benefits every American seeking access to quality, affordable care and makes it possible for employers to continue their role as voluntary sponsors of health plans for their employees. Employers want health care reform. According to Hewitt data, annual large-employer health care costs (i.e., total costs for all health plan participants divided by the number of employees) have more than doubled since 2001 and are projected to reach $8,863 in 2009. Over the same period, annual employee contributions and out-of-pocket costs are expected to increase by 190% to $3,826.[1]



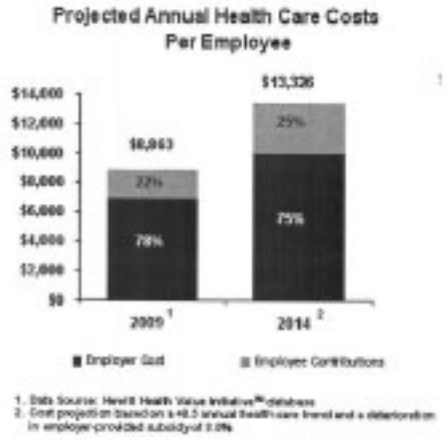
[1] Estimates calculated from the Hewitt Health Value Initiative (HHVI) database.



- **State mandates increase the overall cost of health care coverage**. Some sources calculate there are nearly 2,000 separate mandated benefits and provider regulations across the 50 states. Estimates of how much this patchwork quilt of benefit requirements increases cost to the overall health care system vary, but a 2006 report by the Massachusetts Division of Health Care Finance and Policy estimated the cost of state mandates to be approximately 12% of premium, and the State of Maryland found that the total cost of its benefit mandates were about 14% of premium. Large employers' reliance on ERISA preemption to provide a uniform set of benefits to all employees is not only inherently fair, but also keeps costs down for both employer and employees who share in the total cost of coverage.

- **Changes to the payment system are needed.** Systemic changes must be made in our health care delivery system if we hope to mitigate or reverse the current cost acceleration. For example, our health care system rewards physicians when they provide more services for sick care, rather than rewarding them equally for spending time to help patients avoid the 80% of illnesses that are lifestyle-related. Employers and health plans must work together to radically change the payment system to reimburse physicians and hospitals for excellent primary care supplemented with appropriate specialty care and chronic care management. Without meaningful change soon, large employers fear that rising costs will make health care unaffordable for millions more Americans. According to Hewitt data, on their current trajectory, average annual health care costs per employee will rise from $8,863 per person in 2009 to $13,326 per employee by 2014.[4] Employers will have difficulty subsidizing the additional cost, and employees will increasingly be unable to afford the increasing contributions.

[4] Estimates calculated from the Hewitt Health Value Initiative (HHVI) database.



1. Data Source: Hewitt Health Value Initiative℠ database.
2. Cost projection based on a +8.5 annual health care trend and a deterioration in employer-provided subsidy of 3.0%.

III. Expanding Coverage Through Market Reform Needs to Address Cost Shifts

The cost of health care for large employers and their employees is high partly due to differences in reimbursement rates between public and private health care programs. Under the current system, the cost of health care for employers offering good health coverage to their employees is higher than it "should be" due to a combination of the following factors:

- **Private payers are charged somewhat higher fees to offset a portion of the costs for uncompensated care.**

Economists who have studied the costs shifted to private plans by providers seeking to offset uncompensated-care costs have estimated different ranges. A recent Congressional Budget Office report put the cost of uncompensated care at 5% of hospital costs and 1% of physician costs.[3] We believe it is reasonably conservative to assume that the additional cost incurred by private plans to offset provider costs for uncompensated care is about 2% to 3% of an employer's health care costs. Based on the current data, economists do not agree, with some projecting higher ranges and some projecting lower ranges.[4]

- **Providers shift costs to employer-sponsored plans to make up for reimbursements from public programs that are lower than the total costs of providing care.**

Employers also see higher price tags in their medical plans because Medicare and Medicaid payment rates are set by law and are comparatively lower than rates for employer-sponsored group health plans. It is no secret that providers receive much higher payments from private insurance plans than from public plans. Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents "cost shifting" from public to private plans. But the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example,

[3] Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals report, December 2008.
[4] For different views on the degree to which uncompensated care increases the cost for private payers, see, for example, The Kaiser Family Foundation analysis at http://www.kff.org/uninsured/upload/7830.pdf and the Families USA report at http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html.

according to a 2008 Milliman actuarial study,[7] Medicare reimburses hospitals at an average of 70% of private plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 87% of private plan rates and pays physicians at an average of 53% of private plan rates.

It is desirable, but perhaps not fiscally feasible, to close this gap in public/private reimbursement rates to providers. At a minimum, health reform should ensure that the payment differential does not worsen further, because this would create even more cost-shifting pressure on private payers and potentially lead to a two-tier system where employers offering their own plans are at a significant cost disadvantage.

IV. Core Efforts For Health Care Reform

Comprehensive health care reform must start by first addressing the very real issues that drive up cost, preventing more employers from participating and more individuals from taking advantage of the public and private health care programs available to them.

Federal health care reform must focus on the following priorities:

1. **Preserve and promote the employer-based health care system.** Reform should seek to both protect and expand the number of employers who provide health care for their employees. Over the years, the system has encouraged employers to be innovators of health care solutions. Recent innovations include extensive health coaching programs, value-based design, cost and quality transparency, and consumer-oriented incentives. There are promising outcomes emerging from extensive wellness and disease management programs that encourage participants to engage in healthy activities, identify their health risks, and manage their illnesses. By investing in the health of their workforce, employers help improve the quality of life for employees and their families, while also gaining better control over health care costs and employee absences. The employer-based system has also preserved broad access to primary care, specialists, and hospitals, as well as on-site services and pharmacies. Employees also understand the importance of employer-sponsored health coverage and the employer's role in financing a substantial portion of the cost. The National Business Group on Health's 2007 survey indicated three out of every four respondents valued their health insurance as their most important benefit from their employer, and an equal number said they would prefer to have their employer provide this benefit rather than being provided a salary increase to purchase health coverage on their own.

2. **Preserve and strengthen federal ERISA pre-emption of state laws to promote uniformity in coverage and reduce administrative costs.** The vast majority of large employers operate across multiple states and they must be able to continue to offer uniform benefit packages to their employees. Allowing states to require these employers to comply with varying state and/or local government mandates would raise employer costs even further and result in unequal benefits for their employees. This would create an unnecessarily costly and complex administrative burden with conflicting reporting, withholding, and disclosure requirements from jurisdiction to jurisdiction. At worst, weakening ERISA would provide incentives to employers to do business only in those states that had less burdensome health care mandates. ERISA pre-emption also gives each employer the flexibility to design coverage that meets the changing needs and disease burden of their unique workforce, which is critical for employers to provide programs that will optimize employee health and productivity and compete in a global marketplace.

3. **Reform the insurance marketplace so that individuals and small employers can have access to affordable insurance products.** Insurance market reform is necessary so that small- and medium sized businesses and individuals can find affordable health insurance options. Many large employers fear that rising health care costs may encourage small- and medium-sized businesses to drop health

[7] Milliman, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers* study, December 2008.

coverage to keep their business competitive, especially during this severe economic downturn. Such a trend will lead to large employers (who are doing the right thing in offering and heavily subsidizing coverage) having to assume an even larger economic burden because of a variety of factors, including increased costs they pick up indirectly through cost shifting.

This is a major reason why we need to find ways to improve the insurance marketplace to provide affordable, quality health plans for small employers and individuals. For all employers, having access to broad coverage opportunities for all employees is a critical element of health care reform. The current insurance marketplace is afflicted with dueling mandates, rules and regulations. Many in the Coalition support national rules governing the private insurance marketplace so that there is a better marketplace for Americans who work for small and medium-sized business and for individuals to get affordable health insurance coverage.

4. **Invest in Health Information Technology, including the adoption of uniform federal standards, to improve efficiency and patient safety**. Consistent and efficient health information technology will help reduce overall health care costs and improve the quality of care. An integrated health system would provide quality reporting, improve health care outcomes, and reduce duplication and medical errors. The health care system would benefit enormously from the kinds of dramatic productivity gains achievable through appropriate health IT and related business process re-engineering that has transformed business and industry throughout the world. Employers have led the way in driving for a higher quality, evidence-based health care system and have an urgent interest in finding solutions that foster continuous quality improvement.

VI. Conclusion

In closing, Mr. Chairman and Members of the Committee, on behalf of the National Coalition of Benefits, we support the employment-based system and the preservation of ERISA so that employers have the ability to offer and maintain uniform benefit plans. We believe that employers should remain in the health care system and that reforms that lead to lower health care costs will go a long way toward enhancing the employer-based health care system. Congress has the challenge of sorting through the details of how that would be accomplished, with many competing views. As a member of the National Coalition on Benefits, and independently, Hewitt would be pleased to offer its data analysis, experience, and consulting and administrative expertise in helping the Committee evaluate the impact of detailed reform plans on coverage provided by large employers today.

Chairman RANGEL. Well, thank you for your invitation of making a contribution to try to unwind some of the complex issues we are faced with dealing with energy and commerce, and also dealing with the Senate.

I do hope that you might submit a paper, as I invite all of the witnesses to, as you see the direction that we are going—not that we are going to adopt it, but if we see that there is a sharp conflict and we have alternatives, I wish you would submit a paper and not

wait to be called. And that goes for all of you, but especially your organization that has such a wide membership.

Linda Blumberg, Dr. Blumberg, who is a senior fellow at the Urban Institute. Thank you for being with us.

STATEMENT OF LINDA BLUMBERG, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. BLUMBERG. Mr. Chairman and distinguished Members of the Committee, thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its funders, or its trustees.

Current health insurance markets suffer from many shortcomings. I am going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them.

First, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service.

Second, individuals and employers voluntarily participate as purchasers. But too often, those who would like to buy coverage face barriers to doing so, including problems of affordability and discrimination based on health status.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years, fueling the growth in insurance premiums.

Insurance market reforms and subsidies to make coverage affordable for the modest income population within the context of a more organized health insurance market are essential strategies to address these problems.

A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance option available to purchasers can further promote competition in insurance markets, and could be an effective strategy for slowing health care cost growth.

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. Insurance market regulations are required to prevent risk-selecting behavior by insurers. States allow insurers to risk-select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those that are most likely to seek coverage.

However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many who have some type of insurance may not have adequate coverage to meet their health care needs.

In the context of a health care system that is universal, where everyone is insured all of the time, there would no longer be any reason to allow discrimination by health status, and coverage denials, benefit riders, preexisting condition exclusions, and medical

underwriting can be prohibited, with the costs of those with high medical needs spread broadly across the population.

In such a context, an exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations. An exchange can also provide for risk adjustment to account for any uneven distribution of risk across insurers.

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of reform intended to make coverage affordable for all incomes. Centralizing into a single agency, such as an exchange, the subsidy determination and the payments of subsidies to insurers would be a much more efficient approach to administration that under the HCTC experience we are having today. The exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage.

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. An exchange can be given the authority to negotiate with health insurers over premiums.

Other cost-containment strategies would include requiring similar benefit packages be offered within an exchange to make it easier for consumers to compare prices for like policies, providing improved information materials, and incentives to choose lower-cost plan options. An exchange could also reduce administrative costs due to lower churning across insurance plans.

Adding a public plan option to those offered within an exchange would significantly increase the cost containment potential of reform. A public plan could be modeled after the traditional Medicare Program, paying providers based upon the payment systems Medicare uses, but with different cost-sharing rules and possibly some differences in covered benefits. Payment rates could be set between Medicare and private rates.

Medicare payment policies have been shown to reduce cost growth relative to private insurers. A public plan could create competitive pressures necessary to induce private insurers to be tougher negotiators with the providers and their plans.

The public plan could also be an innovator in the development of other cost-containment mechanisms. It would also create a lower-administrative-cost option for purchasers, putting pressure on private insurers to hold down their own costs.

I do not believe that a public plan option would destroy the private insurance market or lead to a government takeover of insurance, as some fear. Those plans that offer high-quality services and good access to providers would survive. Those that innovate and offer limited networks may even be able to offer lower-cost plans than the public option.

I consider the public plan a very promising catalyst for cost containment, and one that I think would be considerably less of a dramatic change than other effective options, such as having the exchange negotiate rates on behalf of all participating plans, or moving to an all-payor rate-setting system.

Thank you very much, and I am happy to answer any questions that you might have.

[The prepared statement of Ms. Blumberg follows:]

Improving Health Insurance Markets and Promoting Competition Under Health Care Reform

Statement of

Linda J. Blumberg, Ph.D.

Senior Fellow
The Urban Institute

Committee on Ways and Means
United States House of Representatives

April 22, 2009

Sections of this testimony are taken from John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reforms?" Urban Institute Health Policy Center Issue Brief, 2008, available at http://www.healthpolicycenter.org, and Linda J. Blumberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals," Timely Analysis of Immediate Health Policy Issues brief, forthcoming, 2009.

Mr. Chairman and distinguished Members of the Committee: Thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

Current health insurance markets suffer from many shortcomings. I'm going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them. First the private insurance system is a voluntarily one for both employers and insurers, but too often those who would like to buy coverage face significant barriers to doing so, including lack of affordability and discrimination based on health status. These barriers contribute to the growing population of uninsured. Second, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service. The lack of cohesive information on comparability of plan options limits the ability of purchasers to make cost-effective choices for their coverage.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years. With little incentive on the part of large consolidated providers to negotiate over price with insurers, and insurers with large market shares being able to pass on these costs to purchasers while continuing to increase their own profits, rapid growth in insurance premiums is fueled.

I believe that comprehensive health care reform will be necessary to address these problems. Insurance market reforms and subsidies to make coverage affordable for the modest-income population within the context of a more organized health insurance

market are essential strategies. A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance plan option available to purchasers can further promote competition in insurance markets and could be an effective strategy for slowing health care cost growth.

Spreading Health Care Risk

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. With a highly skewed distribution of health expenditures—the top 10 percent of spenders account for nearly two-thirds of total health expenditures[1]—the gains to insurers from excluding high-cost enrollees is tremendous. Insurance market regulations are required to prevent risk-selecting behavior by insurers. However, states allow insurers to risk select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those who are most likely to seek coverage. Without such leeway on the part of insurers, individuals may wait to purchase coverage until they know they need medical care, creating strong disincentives for the healthy to enroll. This dynamic would lead to very high premiums, reflecting a high-cost group of enrollees, and compromising the long-run stability of insurance pools. However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many more who have some type of insurance may not have adequate coverage to meet their health care needs.

[1] Samuel Zuvekas and Joel Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, vol. 26, no. 1 (2007): 249–57.

In the context of a health care system that is universal—where everyone is insured all of the time—there is no longer any reason to allow discrimination by health status. Consequently, coverage denials, benefit riders, pre-existing condition exclusions, and medical underwriting can be prohibited, and the costs of those with high medical needs can be spread broadly across the population. Without universal coverage, insurer discrimination by health status can only be eliminated in tandem with broad-based subsidization of the high medical need population, ideally using a source of revenue that is unrelated to the decision to purchase insurance coverage.[2]

In a context of universal or near-universal coverage that includes subsidies for the low-income population and possibly for the high-risk population and prohibits insurer discrimination by health status, an exchange can play an important role related to ensuring the broad-based spreading of health care risk. An exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations through informal means. Requiring enrollment through a centralized place, for example, can prevent carriers from denying coverage to particular groups with poor risk profiles or actively marketing only to the healthy. An exchange can also provide for risk adjustment to account for any uneven distribution of enrollee risks across insurers, requiring participating insurers to provide sufficient data on their health plan enrollees. With more accurate risk adjusters, exchanges can maintain a more diverse group of plan options, including highly managed and less tightly managed plans.

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[2] See for example, John Holahan, Len Nichols, and Linda Blumberg, "Expanding Health Insurance Coverage: A New Federal/State Approach," in *Covering America – Real Remedies for the Uninsured*, Jack Meyer and Elliot Wicks, eds., Economic and Social Research Institute, 2001, *available at* http://www.urban.org/UploadedPDF/1000224_holahaninsuredproposal.pdf.

If the exchange is the exclusive health insurance marketplace for some portion of the population (e.g., individual purchasers and some small groups), then opportunities for steering risks to alternative markets are eliminated. However, if insurers and purchasers can choose whether to participate in the exchange or whether to purchase coverage elsewhere, some risk segmentation potential will remain. In such a case, careful monitoring of the health risks of the enrolling and disenrolling populations will be important for the exchange to maintain, as risk adjustment between the exchange and non-exchange markets may be necessary to maintain the stability of all pools.

Delivering Health Insurance Subsidies

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of a reform intended to make coverage affordable for all incomes. Centralizing the subsidy determination and the process by which subsidy payments are made to insurers into a single agency, such as an exchange, would be a much more efficient approach to administration than that under the Health Coverage Tax Credit (HCTC) experience. Under the HCTC, a non-means-tested program that subsidizes coverage in the existing varied private insurance markets, roughly 34 percent of total spending for the program is attributable to the costs of administering the subsidy.[5] Processes for determining eligibility and for making appropriate payments to hundreds of different health plans require many separate transactions that are performed by multiple agencies under that program.

Having all of these processes centralized in one place could appreciably increase the efficiency of delivering subsidies. This one-stop-shopping approach has been taken

[5] Stan Dorn, "Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons," Urban Institute Health Policy Center issue brief, 2008, http://www.urban.org/url.cfm?ID=411608.

on by the Massachusetts Connector—an example of one type of exchange—with much success. Allowing the exchange to standardize plans, limit the number of vendors, and reduce the number of transactions would also lower administrative costs.

Ensuring Meaningful Coverage

The exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage. Such minimum coverage standards will also reinforce risk spreading. If a common set of benefits are covered by all plans, but some variation in cost-sharing requirements is allowed, individuals will be less likely to choose plans based upon their health status. Conversely, allowing healthy individuals to opt out of coverage for benefits that will be needed by those with serious health conditions—for example, prescription drugs—will tend to separate purchasers into different plans by expected use of services. Over time, that segmentation will increase, making it difficult to maintain the type of coverage that meets the needs of those with serious conditions, as the average cost of those policies that include the extra benefits would quickly rise. On the other hand, if all individuals—healthy and sick—have policies that include these benefits, the marginal cost of the benefit for each individual can be quite low.

Of course, agreement on the definition of "adequate" coverage will be politically controversial. An exchange could be delegated the responsibility of determining adequate coverage (as was the case in Massachusetts), or that role could be played by another independent agency. The exchange would be responsible for determining that all coverage sold within it meets minimum adequacy standards. Other minimum standards

might include requirements for provider networks, prompt claims payment, appeal and grievance procedures, and so on, all of which could be verified by the exchange.

Cost Containment

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. Insurance markets are dominated by a small number of larger insurers. Robinson showed that in 2003, in all but 14 states, three or fewer insurers accounted for 65 percent of the commercial insurance market.[4] He also found that 34 states had Herfindahl-Hirschman Indices of greater than 1,800, the level at which the Department of Justice and the Federal Trade Commission guidelines deem markets of antitrust concern. The Robinson analysis also found that while medical care costs grew significantly faster than inflation during the 2000 to 2003 period, private insurer revenue grew even faster. In other words, the insurers' market power allowed them to pass on health care costs to purchasers and increase their own profitability at the same time.

Meanwhile, the dominant insurers do not seem to use their market power to drive down provider prices. First, they do not believe that they can maintain market share without the flagship hospitals, making those providers unwilling to negotiate. Second, lack of information in the market doesn't allow individuals to effectively shop for plans based upon benefits, price, and quality, diminishing the need to aggressively bargain with providers. Third, small insurers appear to follow the pricing lead of the large ones, not lower prices in an attempt to gain market share. And fourth, hospital system consolidation severely limits insurers' ability to negotiate for lower rates. In fact, 88

[4] James C. Robinson, "Consolidation and Transformation of Competing in Health Insurance," *Health Affairs*, vol. 23, no. 6 (2004): 11–24.

percent of large metropolitan areas are in highly concentrated hospital markets as defined by the Federal Trade Commission and the Department of Justice.[5]

An exchange can be given the authority to negotiate with health insurers over premiums. They could also be allowed to exclude insurers from exchange participation based upon premium price or growth. Both of these tools would provider greater incentives for insurers to negotiate lower prices with providers and to hold down premium rates relative to current trends. Such rate negotiation is not done by state insurance departments. If an exchange required plans to offer similar insurance packages, this would also promote greater competition, as purchasers would have the ability to more easily compare price differences across plans. Understanding of plan options could be further enhanced by the exchange providing improved information materials to consumers.

Employers participating in an exchange can be required to make fixed contributions for their workers, regardless of which plan they choose. This approach would provide incentives for workers to choose lower-cost plans, as they would have to pay the difference for more expensive options out of pocket. To the extent that an exchange could also reduce marketing expenses associated with insurance by centralizing this function, costs could be reduced further.

A Public Plan Option within an Exchange. Adding a public plan option to those offered *within* an exchange would significantly increase the cost-containment potential of reform. A public plan could be modeled after the traditional Medicare program, paying

[5] V. R. Vogt and R. Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson Foundation Research synthesis report 9, February 2006; and Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, 2004, http://www.usdoj.gov/atr/public/health_care/204694.htm.

providers based upon the payment systems Medicare uses, but with different cost-sharing rules and possibly some differences in covered benefits. The latter would be necessary to make the plan(s) consistent with benefit and cost-sharing requirements within the exchange. Payment rates could be set between Medicare and private rates, at least in the early years of reform. Medicare payment policies have been shown to reduce cost growth relative to private insurers.[6]

A public plan with significant market share could create the competitive pressures necessary to induce private insurers to be tougher negotiators with their participating providers. The public plan could also be an innovator in the development of other cost-containment mechanisms; given its role as an arm of the federal government, it would have a strong interest in doing so. A public plan would also provide a lower–administrative cost option for purchasers, as several analyses have shown the existing public plans have significantly lower administrative costs than private plans.[7] Such an option would likely put pressure on private insurers to hold down their own costs.

Of course there are limits to the extent of savings that can be achieved through adopting Medicare payment strategies for the nonelderly population as well as limits to the administrative savings available. The government is unlikely to use all of the market power that it has available because it also has the responsibility of maintaining a stable health care system. If payments to providers are held down too much, there is a risk of hospital closures, slowing the dispersion of new technologies more than is desirable and

[6] Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs*, vol. 22, no. 2 (2003): 230–37; Chapin White, "Why Did Medicare Spending Growth Slow Down?" *Health Affairs*, vol. 27, no. 5 (2008): 793–802.

[7] See, for example, Merrill Matthews, *Medicare's Hidden Administrative Costs: A Comparison of Medicare to the Private Sector* (Council for Affordable Health Insurance, 2006); and Congressional Budget Office, *Designing a Premium Support System for Medicare* (November 2006).

limiting access to physician services. Political pressure also tends to limit the willingness of government to aggressively contain costs. This is evident from recent experience with the sustainable growth-rate policy, approval of computed tomography angiography by Medicare carriers (despite limited research evidence to support it), and unwillingness to let Medicare negotiate with drug companies over prescription drug prices. On the administrative-cost side, any public plan will still require claims processing, claims and utilization review, care management, premium collection, and marketing. Thus, while administrative costs would likely be lower in a new public plan than in private insurance, they probably would not be as low as in current public plans. Market reforms would also reduce some administrative costs in private plans.

For these reasons I do not believe that a public plan option would destroy the private insurance market or lead to a government takeover of insurance, as some fear. Nor would it be fully successful in controlling cost growth. Realistically, a public plan would most likely lead to some cost control but would be limited to some extent by the issues raised above. In such an environment, those private plans that offer high-quality services and good access to providers would survive the competition, even some with higher costs than the public option. Those that innovate and offer limited networks may even be able to offer lower-cost plans than the public alternative. The continuing presence of private plans would constrain how aggressive a public plan could be in holding down payment rates—if providers are not kept reasonably happy, enrollees would move to private plans. Meanwhile, the presence of the public plan would force private insurers to compete on price, which does not happen much today. Those private insurers not adding much value are likely to disappear from the market in the face of real

competition, but those offering a superior product through efficiency, consumer satisfaction, and ease of access to high-quality services will survive in the face of it. Innovation in cost containment should be enhanced among private plans as well.

Conclusion

The significant shortcomings of current health insurance markets mean that the list of goals for reform is lengthy. Insurance market regulations that would substantially broaden the spreading of health care risk, subsidies to make coverage affordable for all incomes, and greater organization of health care markets should be considered essential components of reform. Serious cost-containment measures will be critical to ensuring the long-run stability of any comprehensive system of reforms. Establishing a health insurance exchange can facilitate the spreading of health care risk, delivering health care subsidies, ensuring meaningful coverage, and containing health care costs. Adding a public insurance plan option to the exchange is a very promising catalyst for cost containment, and one that would be a considerably less dramatic change than other promising options, such as having the exchange negotiate rates on behalf of all participating plans or moving to an all-payer rate-setting system.

Chairman RANGEL. Thank you.

Mr. Sperling, does your general testimony support a public plan option?

Mr. SPERLING. First, let me clarify, Mr. Chairman, that the National Coalition on Benefits does, to my knowledge, not have a position on a public plan.

I can speak from our experience at Hewitt working with large employers, and employers are generally wary of a public plan option because of the potential there is for cost-shifting from public to private if such a public plan option's reimbursements were set at current public plan rates. And the details——

Chairman RANGEL. Well, I would have thought that your group, with all of the complexities and conflicts we have with an honest attempt to give the broadest possible, best service at the least amount of expense, that your group would have—not you, but—not just employers, but that you would have given us the benefit of your group's feeling so that if you could persuade us to not have a public plan, that we would have solidarity or whatever.

But let me ask you, then, if you are speaking for the employers, that if we have a transportation problem, say, that we have in the city and state of New York, and we are fighting desperately hard to have a set rate so that everybody would be able to go from one location to the other with quality service at the least consumer cost; and then we had a private limousine service that said, we can kick up the quality of service, but you have to pay more—is that a poor analogy as relates to health care, that someone really wants to get the quality care at a community health center because it has a great reputation, but others may not want to be seen at a public place, and so they want to pay higher but to get a different quality or feel more comfortable with it, and they would go to an unregulated limousine service, that its whole design is to make a profit. I mean, that is their job.

What it wrong with that analogy in saying that you stick with what you feel comfortable with; if you want your own services that you feel you are entitled to, pay for it?

Mr. SPERLING. Mr. Chairman, I am probably the wrong person to ask because when I am in New York, I take the subway. And I really enjoy it.

Chairman RANGEL. But you enjoy knowing that if you want to take a cab or a limo, it is there for you.

Mr. SPERLING. Yes, Mr. Chairman. I think the difference is that if the fact that I might want to take a limousine service and others want to take a subway, if the cost of my limousine service goes up because the subsidy toward the subway is not enough to cover its cost, then I might have a problem with that.

And that is the issue that employers have, is whether or not their costs are going to go up by the existence of a public plan that might not——

Chairman RANGEL. What bothers me, though, and I did want to give you all of my time, is that you don't represent employers. That is what bothers me, really. So I don't really think you are the best person to ask the question as: Does an alternative plan adversely affect the private sector in what they do, and for some, do very well as opposed to one size fits all with a public plan that they just may resent the whole idea.

In any event, what group of employers would you suggest we go to to allay their fears that the price would go up by the private sector if there was a responsible, competitive public alternative? Who would I go to that talks to you so that you feel comfortable in expressing their view?

Mr. SPERLING. Here, Mr. Chairman, we have relationships with mainly large employers. And those large employers would be an important constituency to speak to about potential objections to a public plan.

Chairman RANGEL. But how would I invite the larger players without knowing who they are? That is okay. That is all right.

Mr. SPERLING. I am sorry. I am not sure I can answer that question, Mr. Chairman.

Chairman RANGEL. But it is kind of hard to say that that is your view about employers. But we all have different views, and I just want to make certain that our Republican friends who have real serious problems with a public plan would be able to bring those who have talked with employers or those who really believe that it threatens the health delivery system so that there could be not just debate with politician lawmakers, but so that the public would have a better understanding of the difference in views or combination of those things.

So I appreciate your testimony. I yield to Mr. Camp.

Mr. CAMP. Well, thank you.

Chairman RANGEL. And I would like to ask Mr. Stark to provide the direction for the witnesses. Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman. And just for the record, Mr. Sperling is here on behalf of the National Coalition of Benefits. They represent 180 employers.

But I want to go to another point. We are beginning these hearings on health care reform. We had one before the recess. The majority chose six of the seven witnesses. We got one. The majority again is choosing at this hearing five of the six witnesses. We have one.

And I would say on this issue—and that may have been the tradition of this Committee. But I would say on this issue, at this time, on health care only, why don't we try to have a more balanced panel. I mean, actually, there are things that Mr. Vaughan and Mr. Hobson said that I agree with, particularly with regard to transparency, Mr. Vaughan; community health centers, Mr. Hobson.

But for the chairman to then say we don't have the employers here to talk to when we are only given one witness—so I guess I would propose let's do things differently. I know that the chairman has been on the Committee a long time. I know we have done it, when we were in the majority, a certain way. But we have had this historic opportunity on this important of an issue.

And perhaps some more balance. We could have more debate. I mean, clearly whether there is a government-run plan or private option, it is a very contentious issue. Even the White House has signaled that they are not wedded to a public plan in the health care reform issue. So there are a lot of concerns.

I would like to vet that in a more thorough way, simply than us only being able to have one witness who had to cover many other issues. But let me just say——

Chairman RANGEL. Would you yield on that point?

Mr. CAMP. I would be happy to yield.

Chairman RANGEL. Let me say that you are right. I have been stuck by the tradition of the Committee, whether it is Republican or Democrat. But I want you to get your people that are opposed to a so-called public plan, and we would arrange to meet in the library, to invite Republican and Democratic Members to listen.

Mr. CAMP. Yes. The public record would be nice as well. But I would be happy to join the chairman in the library.

Chairman RANGEL. But you selected—this is not—I don't want to use your time at all. But the major issue has been not that we all don't want quality health care, but there has been opposition to the public plan. And I really mistakenly thought that since the witness you selected represented employers, that he would cover it.

So whether it is public record or not, I will do all I can to make certain that we get broader representation on those people who oppose the public plan because I want to make certain I feel comfortable and include them.

Mr. CAMP. Yes.

Chairman RANGEL. Whatever time I have taken——

Mr. LEWIS. Would the ranking Member——

Mr. CAMP. Well, and your comment was—I am reclaiming my time, thank you.

Mr. LEWIS. Will you?

Mr. CAMP. Just in a moment.

Mr. LEWIS. Will you yield?

Mr. CAMP. I will in a minute. But let me just say, Mr. Chairman, you said, the witnesses outnumber your view, to Mr. Sperling. Well, clearly they do because you were able to get the five witnesses.

But look. We have a number of hearings on this. I think we should also focus on some of those areas where we can maybe work together—transparency in pricing and quality. I think Dr. Blumberg mentioned that. That is something that I think we can come together on.

Obviously, preexisting condition. Prevention. Wellness. Care coordination. What does that look like? How is that defined? I think those are areas I think some—if we could have some more diverse testimony, I think it would be helpful. Clearly, information technology is something all of us on both sides have talked about.

But let me just say there is a lot of concern with regard to this because look at Medicare's high readmission rates. The government doesn't always do it perfectly. Most seniors have Medigap because the "public option" isn't quite adequate—65 percent, for example.

Most insurers—many insurers in many states require that their insurance companies be nonprofit. We still have high costs. We still have all of the problems that have been mentioned.

So I guess I would say, as we move forward, I hope that we can have a greater approach. And then, Mr. Lewis, I would be happy to yield to my friend from Georgia.

Mr. LEWIS. Mr. Camp, thank you for yielding. Just sitting here thinking. In the past, did you ever raise the question with—when we were in the minority with Mr.——

Mr. CAMP. Yes.

Mr. LEWIS. And maybe you—wouldn't this be a little bit——

Mr. CAMP. Let me finish. No. Mr. Lewis, what I said was it has been the tradition of this Committee—I wasn't in charge of it, frankly—to have the minority have only one or two witnesses. But this, I think, is a different issue. And I am suggesting for health care only.

So on tax issues, on human services issues, still do the five to one or the six to one or the seven to one. But how about on health care——

Mr. LEWIS. We had a——

Mr. CAMP. How about on this issue only? Let's do something only——

Mr. LEWIS. I think Mr. Stark will correct me here, and maybe Mr. Rangel. How about Medicare? How did you go about doing Medicare? How many witnesses did we have?

Mr. CAMP. I am suggesting on health care reform, let's try something—look, you are in change. You can do what you want. But let me just ask—I have a couple questions I would like to ask.

Mr. Borris, I appreciate your efforts in trying to provide health insurance to your employees and how difficult that must be. And I thought your testimony was very good. I have heard from a number of small businessowners just like you who are finding it very difficult to pay for their health insurance because it is more unaffordable.

I know in your testimony you suggested a choice between private and public plans. So you still would like to have a private plan available to your employees, if they so choose. Is that correct?

Mr. BORRIS. A choice.

Mr. CAMP. A choice. But that private choice that they have, would those costs come down if maybe you were able to team up with other catering companies in Chicago to offer health insurance options to your employees? Do you think that would help you reduce costs for those who chose the private plan?

Mr. BORRIS. Well, we have—I actually had a guy in my office who was talking to me about, you know, could we get some sort of an association together. Would we be interested? I shared with him that I would certainly be interested in looking at it.

But I don't know that getting that together necessarily gives us any benefit in how we really control the costs either in the provider costs or in the costs of our premiums coming down. Nothing has been put in front of me yet that has shown me clearly where that would be a benefit.

Mr. CAMP. But if small businesses were able to join together and pool their risk, is that something—is that a type of reform—I am not saying the only reform, but is that the type of reform you might support?

Mr. BORRIS. My concern is that we have been sufficient under this for about the last—well, for a couple of decades, but particularly in the last six or 8 years.

Mr. CAMP. Yes. Not to the exclusion of other reforms that may be out there, but is this one of many reforms that could occur?

Mr. BORRIS. I would have to look at it and see. But leaving this solely in the hands of the private insurance industry hasn't worked yet, and I am quite skeptical that it will work.

Mr. CAMP. Thank you very much.

I would like to ask Mr. Sperling, you know, we have studies that show that a government-run plan could force as many as 120 million Americans out of their current held employer-sponsored insurance. And obviously, if we have choices, you obviously need to have a private plan as well.

How would the creation of a plan impact the costs of providing employer-provided insurance? And would it exacerbate the so-called cost shift that we have heard about, and how would employer risk pools be affected?

Mr. SPERLING. Yes, Mr. Camp. The studies I think you are referring to, there were several. There was one that was done by the Lewin Group. There was another one that was done by Milliman. They have tried to quantify the cost shift that exists in the current system from uncompensated care in public plans to private payors.

Some estimates quantify that uncompensated care burden as 2 to 3 percent, and the cost shift currently from public to private cost shift as much larger. And those studies assume that a public plan would use Medicare as a basis for reimbursement.

So a new public plan that might draw as much as 120 million Americans into kind of a Medicare-based reimbursement would certainly exacerbate the degree of cost-shifting that goes on today. Lewin estimated that that cost shift might be as much as 30 percent, and put the private plans at a significant cost disadvantage to a public plan.

Now, I can't speak to the accuracy of those numbers. But if this kind of gap were to exist, it would significantly impact the viability of the employer-based system and call into question some employers' ability to be able to continue to offer those kind of benefits to their employees.

Mr. CAMP. Thank you very much. I see my time is expired. Thank you, Mr. Chairman.

Mr. STARK [presiding]. I am going to pass for now. Mr. McDermott, would you like to inquire?

Mr. McDERMOTT. Thank you, Mr. Chairman.

It seems to me that we have assumed for today's hearing that there will be a public option. That may not be true, but let's talk about it as though there is going to be a public option.

My problem with a public option is how to design it so that it does not become a dumping ground for the problem cases of the insurance industry that they want to get rid of. And I would like to ask whomever—maybe Dr. Reinhardt or Bill can start—if Medicare was made the public option, what would be necessary in national insurance regulation to prevent the private companies who want to dump their people who are problematic into—either the private insurance companies or the private manufacturers—into the government plan? What would you have to do to make that so it would actually work?

Mr. REINHARDT. Well, most other nations that have only private insurance options use a risk adjustment mechanism. Germany quite explicitly does that. So after the enrollment period is over, they assess the risks that each plan ended up with, and then have compensation payments. That is, plans that end up with younger people, healthier people, make a payment to this risk equalization fund, and plans with sicker people get a payment from that fund.

So if you had an insurance market with a public plan and private plans, you would use that same mechanism. The Dutch do it. The Germans do it. I think the Swiss do it as well. And the risk adjusters you needed for that are pretty well understood now by health services researchers.

That is the most practical way to do it. So if the public plan actually ended up with a sicker risk pool, private plans with a healthier pool would have to make a payment so that the risk would be equalized. Among plans, I actually refer to that in my statement.

The level playing-field issue is not just about payment of providers. It is also about the risk pool health plans end up with. Those are the two things. And the risk pool gets equalized in these other countries by having this compensation mechanism.

Mr. McDERMOTT. Is it your view that the creation of a public option like Medicare for all would be a—would force people out of the private industry? We heard this number, 30 percent, would be forced out of their private plan and into the public plan. Is that your understanding of such a plan?

Mr. REINHARDT. Well, that is the language that gets used. The Lewin Group doesn't use it but imply it. What that would mean is that many, many employers simply say, we will no longer offer employer-based insurance. Of course, those employees then would still have a choice of the public plan and private plans that sell individually based insurance.

So I find that argument specious. I don't think the word "forced" is the correct English here because yes, you wouldn't get it from the employer any more. But you would still be able to buy private insurance in the individual market, restructured market.

I have never understood this scenario. I don't simply buy the scenario that a public plan would ultimately squish the private plans out of existence. I have heard that argument made by Galen Institute— that the public plan will then deteriorate and give very low quality care, and we end up with the Canadian system.

But if there is the option of a private plan, even if they had shrunk initially, they would grow again. These critics of a public plan don't seem to understand how markets work. And I am an economist. I cannot believe that if a public plan really didn't play well by the American people, that you wouldn't have immediately a private insurance industry growing out of the ground, offering Americans a better deal. Isn't that how markets work?

So somehow, there seems to be a lack of faith in the market.

Mr. McDERMOTT. Mr. Vaughan.

Mr. VAUGHAN. Well, just—the thought is it does become a bit self-correcting, and that Medicare can't get too out of line with the private sector or you get access problems. And I think you guys have done a great job trying to protect Medicare.

The doctor fix that goes on year after year—you are not going to let doctor pay get too far below where it is—and sure, it is below. But it doesn't get too far out. And if it started to, you guys would come in and protect the Medicare beneficiaries.

So in a sense, there is a limit to how much Medicare can become cheaper and so attractive to people that they will all leave the employer system.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Mr. Herger, would you like to inquire?

Mr. HERGER. I would. Thank you, Mr. Chairman. And before I get in my questioning, I just have to say that I share the incredible concern by Congressman Camp, the fact that an issue that is so in-

credibly important to our Nation, health care, that we have a panel that is basically totally biased in one area.

And just saying, that is the way we have always done it, I don't think is the adequate excuse for what we are hearing here this morning. And I just can't state that strongly enough, particularly on an issue when we talk about a public plan, i.e. a government-run plan, and we see what takes place in Canada and every place they have a government plan, how you—how can a private plan complete with that?

But to not hear virtually any testimony on the other side, Mr. Chairman, I think is completely unacceptable on an issue that is this important. And then to come back and say that we are going to meet in the library, in a private area, is there something that the majority party would like to keep from the American public that you want to keep it private? That is my question. But——

Mr. STARK. Would the gentleman yield?

Mr. HERGER. Not at this point. Later I will.

Mr. Hobson, I want you to know that I appreciate all the work that you are doing to provide care to the uninsured and underserved in Los Angeles. And I have been a proud supporter of community health centers for many years, and like you, I believe health centers play a critical role in our health care system and serve as a point of care of those who need it the most.

You state in your testimony that Medicare and Medicaid pay community health centers adequately, while private insurers reimburse you below cost. That runs counter to everything we have heard from hospitals and physicians. So I think it is important for the Committee to understand that the payment system for health centers is really quite unusual.

Specifically, I believe Medicaid is required by law to pay community health centers on a cost basis, which is far better treatment than most providers receive. In fact, in our own state of California, which has the lowest Medicaid rate in the nation, many health care providers get about 50 cents on the dollar. I have critical access hospitals in my district who actually get paid based on cost on Medicare, yet are barely able to stay open because their Medicaid payments are so low.

Mr. Hobson, if Medicaid payments to your center were cut by 50 percent—and again, I think Members should understand that is exactly the situation in which many California health care providers find themselves—how would that affect your budget and your ability to deliver these critically needed medical services to our underserved communities?

Mr. HOBSON. Well, first of all, thank you for your support of our program, Congressman. Congress established a prospective system that allows us to receive what is called a reasonable cost that is developed on a formula basis for reimbursement, for patient visits, for people that are on the MediCal program in our case in California.

What this does is that it leaves the Federal grant dollars that are made available to us for the uninsured to actually go to care for the uninsured. And this program is really designed to serve as a bulwark against a cost shift in the other direction, so to speak.

So if we weren't able to receive a full reasonable-cost reimbursement for our Medicaid patients, then what would happen is that our ability to see a lot of the underinsured and uninsured patients would be diminished. And so that would really be the net effect of, essentially, a change in the reimbursement methodology that we have.

I hope that answers your question.

Mr. HERGER. That does. In other words, you wouldn't be able to continue functioning if you were paid the same way our hospitals are in California. You wouldn't be able to continue the services you have if you had that same type of reimbursement?

Mr. HOBSON. Yes. Right, particularly to the uninsured. Basically, this allows us—when we are able to capture a reasonable cost for the patients who are covered, then we essentially can—our grant dollars then are focused, if you will, on our uninsured patients.

And that is really what Congress intended—at least, that is my understanding—with the grant program that we have for Community Health Centers nationwide. It is really to help provide resources for care of the uninsured. So this is just one methodology that essentially Congress adopted that tried to make sure that the Federal grant dollars are really maximized for care for the uninsured.

Mr. HERGER. Thank you, Mr. Chairman.

Mr. Stark.

Mr. STARK. Thank you, Mr. Herger.

You have an unanimous consent request?

Mr. McDERMOTT. Yes. Mr. Chairman, I ask unanimous consent to enter into the record a letter from the Business Coalition for Benefit Tax Equity. It has to do with the benefits for marital partners, and it represents a number of organizations that are already providing and want some changes in the tax law.

Mr. STARK. Without objection.

[The information follows:]

Business Coalition for Benefits Tax Equity
Statement for the Record
Health Reform in the 21st Century:
Insurance Market Reforms
Committee on Ways and Means
Wednesday, April 22, 2009

Mr. Chairman, in conjunction with the Committee's hearing on health reform, the 55 members of the Business Coalition for Benefits Tax Equity[1] submit these comments regarding current tax code inequities that deter some individuals from utilizing employer-provided health coverage and penalize others who do use such coverage. These inequities would be remedied by bipartisan legislation that Representative Jim McDermott will soon re-introduce: The Tax Equity for Health Plan Beneficiaries Act.[2] The legislation has a number of provisions that will help increase health insurance coverage.

In increasing numbers, employers across the United States have made the business decision to provide health benefits to the domestic partners of their employees. These employers have recognized that the provision of domestic partner health coverage is an essential component of a comprehensive benefits package. This coverage helps employers such as those in our coalition attract and retain qualified employees and provides employees with health security on an equitable basis.

Unfortunately, federal tax law has not kept pace with change in this area and employers that offer such benefits and the employees who receive them are taxed inequitably. Such inequities reduce the number of individuals who utilize employer-provided health coverage and thereby contribute to the problem of the uninsured.

Issues Under Current Law

Currently, the Internal Revenue Code ("Code") excludes from income the value of employer-provided insurance premiums and benefits received by employees for coverage of an employee's spouse and dependents, but does not extend this treatment to coverage of domestic partners or other persons who do not qualify

[1] The Business Coalition for Benefits Tax Equity is a coalition of employers that supports eliminating the federal tax inequities that result when businesses voluntarily provide health care coverage to the domestic partners (and other non-spouse, non-dependent beneficiaries) of their employees. A list of the Coalition members is attached. Questions regarding this statement may be directed to James Delaplane, Davis & Harman LLP, 1455 Pennsylvania Avenue, N.W., Suite 1200, Washington, DC 20004, (202) 347-2230.

[2] This legislation was introduced by Representative McDermott in the prior Congress (H.R. 1820 in the 110th Congress) and was cosponsored by 119 Members of the House.

as a "dependent" (such as certain grown children living at home who are covered under a parent's plan or certain children who receive coverage through a parent's domestic partner). In addition, when calculating payroll tax liability, the value of non-spouse, non-dependent coverage is included in the employee's wages, thereby increasing both the employee's and employer's payroll tax obligations. An employee of median income level who receives employer-provided major medical coverage of average cost for himself and a domestic partner faces an annual tax bill of $4,939 in income and payroll taxes, $1,729 (or 54%) more than that paid by a similarly situated co-worker with spousal coverage. However, this employee has no additional income to meet this higher tax burden. These higher tax levels can lead employees to decline the domestic partner coverage altogether, contributing to the problem of the uninsured.

The current inequitable tax regime also places significant administrative burdens on employers. It requires employers to calculate the portion of their health care contribution attributable to a non-spouse, non-dependent beneficiary and to create and maintain a separate system for the income tax withholding and payroll tax obligations for employees using such coverage. These tax and administrative impediments have discouraged some businesses from offering domestic partner health benefits.

Employers such as those in our Coalition that offer domestic partner benefits want to end these tax inequities so that the benefits we provide cover more Americans and so that all our employees are treated equitably under the tax laws. Ending the tax inequities will also eliminate the need for what are often complex communications to employees about how the tax penalties operate. Moreover, ending the inequities will allow us to jettison the separate and burdensome administrative systems that we must currently establish to track the income tax withholding and payroll tax obligations for employees covering non-spouse, non-dependent beneficiaries.

The McDermott Legislation Provides a Solution

The Tax Equity for Health Plan Beneficiaries Act would end these and other current tax inequities with respect to employer-provided coverage for non-spouse, non-dependent beneficiaries, such as domestic partners. Specifically, the bill would make the following important changes:

1. The value of employer-provided health insurance for a domestic partner or other non-dependent, non-spouse beneficiary would be excludible from the income of the employee if such person is an eligible beneficiary under the employer plan. Employers would retain the current flexibility to establish their own criteria for demonstrating domestic partner status.

2. In a corresponding change, the cost of health coverage for domestic partners or other non-spouse, non-dependent beneficiaries of self-employed individuals would be deductible to the self-employed person. This is not permitted under current law despite the fact that spousal and dependent coverage is deductible.

3. The legislation would make clear that employees paying for health coverage on a pre-tax basis through a cafeteria plan would be able to do so with respect to coverage for a domestic partner or other non-spouse, non-dependent beneficiary.

4. Many employers, particularly in the collectively bargained context, use tax-exempt Voluntary Employees' Beneficiary Associations ("VEBAs") to provide health coverage. Today, VEBAs are prohibited from providing more than *de minimis* benefits to a domestic partner or other non-spouse, non-dependent beneficiary. The legislation would permit a VEBA to provide full benefits to non-spouse, non-dependent beneficiaries without endangering its tax-exempt status.

5. In contrast to current law, employees would be permitted to reimburse medical expenses of a domestic partner or other non-spouse, non-dependent beneficiary from a health reimbursement arrangement ("HRA"), health flexible spending arrangement ("Health FSA") or health savings account ("HSA").

6. The value of employer-provided health coverage for a domestic partner or other non-dependent, non-spouse beneficiary would be excluded from the employee's wages for purposes of determining the employee's and employer's FICA and FUTA payroll tax obligations.

We applaud the Committee for its review of health insurance coverage and market reforms and for giving us an opportunity to share our perspective on an important tax inequity affecting health benefits. We hope to work closely with the Committee to include the Tax Equity for Health Plan Beneficiaries Act in the broader health reform legislation the Committee is developing and to enact this important legislation at the earliest opportunity.

BUSINESS COALITION FOR BENEFITS TAX EQUITY
APRIL 2009

Aetna	Hartford, CT
A.H. Wilder Foundation	St. Paul, MN
Alcoa, Inc.	Pittsburgh, PA
American Benefits Council	Washington, DC
Ameriprise Financial, Inc.	Minneapolis, MN
Bausch & Lomb Inc.	Rochester, NY
Best Buy, Co., Inc.	Richfield, MN
Bingham McCutchen LLP	Boston, MA
BlueCross BlueShield of MN	Eagan, MN
Boehringer Ingelheim USA Corporation	Ridgefield, CT
Capital One Financial Corp.	Falls Church, VA
Carlson Companies	Minneapolis, MN
Charles Schwab & Co, Inc.	San Francisco, CA
The Chubb Corporation	Warren, NJ
Citigroup	New York, NY
CNA Insurance	Chicago, IL
College & University Professional Association for Human Resources (CUPA-HR)	Knoxville, TN
Corning, Inc.	Corning, NY
Cullen Weston Pines & Bach LLP	Madison, WI
Day One	South Portland, ME
Deloitte LLP	New York, NY
The Dow Chemical Co.	Midland, MI
Eastman Kodak	Rochester, NY
Ernst & Young	New York, NY
General Mills Inc.	Minneapolis, MN
HermanMiller	Zeeland, MI
Hewlett-Packard Company	Palo Alto, CA
HSBC North America	Prospect Heights, IL
IBM Corp.	Armonk, NY
ICMA Retirement Corporation	Washington, DC
Intel Corporation	Santa Clara, CA
JP Morgan Chase & Co.	New York, NY
KPMG	Montvale, NJ
Levi Strauss & Co.	San Francisco, CA
Marriott International, Inc.	Washington, DC

Medtronic, Inc.	Minneapolis, MN
Merck & Co., Inc.	Whitehouse Station, NJ
MetLife, Inc.	New York, NY
Microsoft Corporation	Redmond, WA
Miller-Coors Brewing Co.	Golden, CO
Morgan Stanley	New York, NY
Motorola	Schaumburg, IL
Nike Inc.	Beaverton, OR
PG&E Corporation	San Francisco, CA
PricewaterhouseCoopers	New York, NY
Project for Pride in Living	Minneapolis, MN
Prudential Financial	Newark, NJ
Quorum Review, Inc.	Seattle, WA
Replacements, Ltd.	Greensboro, NC
Russell Investment Group	Tacoma, WA
Texas Instruments	Dallas, TX
TIAA-CREF	New York, NY
Time Warner Inc.	New York, NY
Verizon Communications, Inc.	New York, NY
Xerox Corporation	Rochester, NY

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Mr. STARK. Before I recognize Mr. Lewis, I just want the record—because I am afraid Mr. Lewis is going to be upset that we don't have more witnesses representing his issues.

I have not heard from Mr. Camp or Mr. Herger about requesting an additional witness or more witnesses, nor has our staff heard

from the minority staff requesting an additional witness. And I find it somewhat disingenuous to raise that issue at this point.

Mr. Lewis.

Mr. CAMP. Will the gentleman yield?

Mr. STARK. Pardon.

Mr. CAMP. Will the gentleman yield?

Mr. STARK. Yes.

Mr. CAMP. We did, through staff, request more witnesses.

Mr. STARK. The hell you did.

Mr. CAMP. Yes, we did. And we would be glad to get everybody together——

Mr. STARK. That is a lie. You did not.

Mr. CAMP. We did. And if not for this hearing, we will for the future. Let's move forward, then——

Mr. STARK. It would be better if you did it as we have always done it instead of raising the issue here as a political issue in what otherwise was designed to be an informative hearing.

Mr. CAMP. Mr. Chairman? Mr. Chairman, the chairman said, the witnesses outnumber your view, in the opening statement. He is the one who brought this issue up.

Mr. BECERRA. Mr. Chairman, may I just——

Mr. CAMP. And my point really is that this is——

Mr. BECERRA. Mr. Chairman, there are many of us who would like to ask questions.

Mr. STARK. I just wanted to let the record show——

Mr. CAMP. Let the record show that we did request additional witnesses.

Mr. STARK. Tell me requested, of whom.

Mr. CAMP. Both our health staff and also through the staff directly.

Mr. STARK. I deny that.

Mr. LEWIS. Thank you, Mr. Chairman.

Let me thank each of the witnesses for being here today.

[Pause.]

Mr. LEWIS. Mr. Chairman, I want to thank each of the witnesses for being here today.

Dr. Reinhardt, I want to thank you for your brilliant, well-stated statement of your views, this idea of the social good, the common good, that we are all in this thing together. I just think the time has come for us to do more than talk the talk. It is time for us to walk the walk. It is time for us to act.

So I want to ask you: What if we don't pass universal health care coverage? What are the costs if we fail to achieve universal coverage?

Mr. REINHARDT. What are the costs?

Mr. LEWIS. Yes.

Mr. REINHARDT. Well, there are two costs. The first one is that individual families bear incredible financial agony and possibly physical pain as well. There was a front-page story in the New York Times yesterday about a couple that both lost their jobs and have a child with cancer and can't get care. My wife read me the language, and I found it revolting. So there are—and there are too many of these cases. I travel a lot abroad. I speak in Berlin and Beijing, et cetera. And if one relates to them those sad American

stories, they cannot believe this happens in America. But it does. I am ashamed of those stories.

And then there is of course the cost that people postpone early, timely, intervention and get to the emergency room only when they are very sick. And that also is, of course, a major cost.

Finally, the third cost is the "job lock" inherent in employment-based insurance. I am not generally known as an enthusiast of the employer-based system, because a system where you lose your health insurance when you lose your job is really not a very reliable insurance system. In Canada, there is much greater job mobility because you can switch jobs and you don't lose your insurance. Here you don't have that.

So there are these three costs.

Mr. LEWIS. Furthermore, do you accept the idea, the concept, that health care is a right, is a right that should be guaranteed by our government?

Mr. REINHARDT. I certainly believe that certain kinds of health care are a right—obviously, not everything; is cosmetic plastic surgery. But there is a presumption in this country that certain critically needed care is in fact a right or Congress wouldn't have passed EMTALA. But Congress did.

So yes, the bulk of health care that, for example, the kind Members of Congress and their families have, is viewed as a moral right, although a constitutional right. Mind you, I am biased. I grew up in postwar Germany and in Canada. So my soul was programmed substantially there as afar as the social ethic for health care is concerned.

Mr. LEWIS. Would other members of the panel care to comment? Mr. Vaughan.

Mr. VAUGHAN. We certainly agree it is a right. And it is time that it got fixed. I thought you might enjoy, for just 1 second, we wrote our subscribers that, "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. 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."

I am afraid, sir, that is from our 1939 auto issue. I think we analyze cars better than we do the political situation. We supported the Wagner and Dingle bill, and we are still waiting after 70 years. And the sadness is that the Institute of Medicine is half right on the number of deaths that you have because some people are uninsured. They said about 18,000 a year. If they are half right, more Americans have died since we wrote this than were killed in World War II. And that is kind of sad.

Mr. LEWIS. Dr. Blumberg.

Ms. BLUMBERG. From my personal perspective, I do believe that access to affordable, adequate medical care for necessary services should be an ethical right in this country. I think we get caught not so much on the ethics; we get caught on the financing.

And that is really where the rubber meets the road because whenever we are going to make change of the type that we are discussing, it is going to involve a tremendous amount of redistribution. And who is going to pay and how much they are going to pay

is really what catches us, not so much the notion that we want people to get the kind of care that they need. Because I think we could all agree to that.

Mr. LEWIS. Thank you. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

You know, I have said before it is our goal to get every American in this country access to affordable health care. That is universal coverage. Health care coverage of their choice. In order to accomplish that goal, Congress needs to look at the insurance market to see what is keeping everyday Americans from being able to afford health care coverage.

When looking at the demographics of those currently uninsured in this country, we see they are all uninsured for different reasons. Therefore, our solution needs to address each of these problems. It can't be one size fits all.

Mr. Vaughan, as part of your testimony, you recommend a health care reform plan to include a core package of health benefits that must be offered to every single American, a national standard, if you will, for health insurance.

Since I am assuming this national standard would be decided by government bureaucrats sitting around a table in D.C., do you have any advice about what services and providers should be included in this standard? And since you were in the staff earlier, you may have tried to push some of those plans earlier. I don't know.

Mr. VAUGHAN. Yes, sir. Thank you. There are bills out there that say—and this resonates pretty well, that everybody should have access to a health plan kind of like what your Member of Congress gets. I think in the Americare bill, one of the bills put in, it is Blue Cross Blue Shield standard, which is a pretty good package. It is not as good actuarially as the Fortune top 50/Fortune 100. But it is your most popular FEHBP plan.

The other thing to do is turn it over to NAIC. Give them 6 months to—the National Association of Insurance Commissioners. Give it to them for 6 months to come up with a package. But no, I wouldn't expect——

Mr. JOHNSON. They got a lot of money to do that with now.

Mr. VAUGHAN. Oh, they would want a contract to do some bowling and get people in. But yes, sir, it has to be flexible. It has to evolve as technology evolves. But——

Mr. JOHNSON. Yes. But there are things that are covered in some plans that aren't covered in others. I mean, how about mandating every insurance policy cover the cost of orthotic or prosthetic devices, for example? This is already mandated in New Jersey and California.

Mr. VAUGHAN. And it is covered in Medicare. The thing is, the thought—and in my testimony—there would be this core package that everybody would have as a sense of security, that they wouldn't lose their house, they wouldn't go bankrupt, with this core package.

Mr. JOHNSON. Well, I understand that. But what kind of deals are we going to cover? I mean, would we mandate every policy to cover acupuncture, for example?

Mr. VAUGHAN. No. No. But you could buy. In this market I was talking about where we would have some number, A through L or hopefully fewer, A through G, perhaps, you would have packages of extra. In Massachusetts, I think—was it a bronze, silver, and gold package. And one is not too much value, and one is middle, and one is a Cadillac.

Mr. JOHNSON. Well, how can you have a public plan that has various prices?

Mr. VAUGHAN. Oh, that is the core, sir. Everybody——

Mr. JOHNSON. For example, I think a 25-year-old male can purchase an insurance policy for under $1,000 in Kentucky, and that same policy would cost $6,000 in New Jersey.

Mr. VAUGHAN. Yes, sir. Be careful of that Kentucky one. We have done some articles that it doesn't cover too much, perhaps.

But again, sir, the core security. And then, yes, go into the marketplace and buy extra packages and compete on those extras. But everybody at least has a foundation. I hope that makes sense.

Mr. JOHNSON. Thank you.

Mr. VAUGHAN. Thank you, sir.

Mr. JOHNSON. Mr. Hobson, you stated in your testimony that 60 million Americans lack access to primary care because of physician shortage. I have heard from my constituents, doctors—I had a doctors meeting just this week, or last week—it is true in Texas for Medicare.

Recently, I think, the doctors, the seniors in my district, have told me stories where it has taken almost a year to find a doctor that would take them, and then under certain conditions. You know, the Medicare Program is getting to the program where doctors just don't want to take part in it because they don't get reimbursed. Can you talk to that for me?

Mr. HOBSON. Yes, sir. One of the things that we have to do as a community health center in the modern world is provide managed care services. And one of our obligations is to put together a network of specialists that we have to refer our clients to. We do that both for about 600 seniors that we have in a Medicare Advantage plan, and we have about 14,000 individuals in Medicaid managed care plans.

We have a very difficult time trying to find various specialists who will accept Medicaid rates for the services that are really offered. We have to address, in my opinion, as a part of any managed care plan, any kind of health care reform plan is a way of making sure that we can provide a reasonable level of reimbursement for a lot of the providers that we really need to make sure that we have got an integrated system of care operating—with primary care connected to specialty care, to subspecialty care—in treating at least the most difficult-to-treat patients.

And I feel we are spending a lot of money in the system we have today. I think that there are a lot of efficiencies that really can be had in our system that would allow us to pay a lot of the providers better.

Yes, I saw the article in the Wall Street Journal about the fact that there are a number of providers that are dropping out of Medicare today. What that really tells me, though, is that Medicare is in drastic need of a tuneup and modernization——

Mr. JOHNSON. Medicaid is worse.

Mr. HOBSON. Medicaid is even worse—that program as well in order to make it in today's health care marketplace. Some low-income individuals on Medicaid essentially just can't get specialists available to them.

Mr. JOHNSON. Well, Medicaid being worse, that is a public plan, you know.

Mr. HOBSON. Yes, it is.

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate the time.

Mr. STARK. Thank you.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. And thank you to all the panelists for your testimony. As usual, it is enlightening. Many of you have been saying much of what we heard today for quite some time, but we are pleased to have you come here and once again see if we can get it right.

Let me begin with a question to Mr. Hobson. First, by the way, congratulations on the work that you have done over the years. In Los Angeles, we recognize that without some of the work that has been done by your clinic, the foundation, there would be a lot more Americans who would be in far worse condition healthwise. And so we thank you and all those who, at the nonprofit level with very little money, figure out a way to serve people who otherwise have no alternative.

Mr. Hobson, cost-shifting. We hear that there is a big concern about cost-shifting going on in Medicare. You have very little Medicare that you deal with because most of the folks you see don't have insurance or have very little insurance.

Mr. HOBSON. That's correct.

Mr. BECERRA. And I would like to ask you: Do you have any sense about whether you see cost-shifting as a community clinic?

Mr. HOBSON. Well, as I mentioned during my testimony, the rates that we are paid by private insurance really requires us to cost-shift in the other direction, to other sources of revenue, because we can't get paid what it really takes to take care of them. And most of our patients that we have through that are in the managed care area. But essentially, we have—we have very, very few privately insured patients.

But my concern is, really, that we come up with a way of reimbursement for health care services that really recognizes what it really takes to get people well. And if an individual really requires more health care navigation, health care coaching, some of the kinds of things that have been shown through studies that are most successful in preventing the kind of readmission rate that we wind up having in other programs, then we can really address that problem.

Certainly some cost-shifting really occurs. But as I mentioned a little bit earlier, I think that is because some of our systems really need a serious tuneup, to sort of level the playingfield. And I agree with Dr. Reinhardt that basically we have got a situation where we have got the tools and skills in the risk adjustment area that I think could be a major avenue or approach for dealing with this.

Mr. BECERRA. And in essence, we have a system which almost encourages a provider, whether a public insurer, a private insurer, a for-profit insurer, a nonprofit insurer, to figure out how to shift very heavy costs away from them. Otherwise, they won't hang around.

Mr. HOBSON. That's correct.

Mr. BECERRA. And so I think that's where most of us agree with what most of you have said, that we need figure out a system that, one, includes everyone so you can't figure out ways to game the system if you are insurer, and two, which does it in a way that controls the costs that are involved.

Let me ask you all a quick question. Choice. Should someone who has a decent health insurance policy have to be at risk of losing that through some kind of reform done by the Congress, working with the President? Most of us believe that no, if you have got something you really like, we are here to try to improve it, not take it away. So you should have the choice of keeping what you have got.

Is there any reason why we should limit choice—and as Dr. Reinhardt said, meaningful choice, not just a maze of choices but meaningful choice—so that the consumers decide, based on good information which hopefully will get them to become more educated about health care and its costs, but that the consumers make the choice about which plan to use.

And so does anyone disagree with the notion that if we are going to have choice or limit choice, it is the consumer who should limit the choice by the decision he or she makes on what provider to work with? Does anyone disagree with that?

[No response.]

Mr. BECERRA. Okay. Disagree? I don't want to—with my time really short, I don't need you to agree with me. I just want to hear any disagreement. You need your microphone.

Ms. BLUMBERG. I am sorry. I would say that you have to be careful about how much choice you provide.

Mr. BECERRA. I agree, and I said that earlier. You have got to have—as Dr. Reinhardt said, meaningful choice. But otherwise, agree that consumers should have a choice? We should not limit them from the get-go on what choices they have?

Ms. BLUMBERG. I think we need to be careful about choice in insurance markets because when you have a great deal of choice, while there should be some options available to individuals, risk selection becomes a huge problem.

Mr. BECERRA. Okay. Dr. Blumberg, we are not disagreeing. I agree. If you give them a choice, as we have seen so often with Medicare Part D, the prescription drug plan, where there were so many choices people didn't understand what the differences were; and by the time they got into them, some of the plans decided to kill the program. And all of a sudden people had applied to a program because they thought it was the best, it now doesn't exist, and now they have to go through the whole maze of figuring out what's best. That I understand.

But just the notion of choice, but notion of choice belonging to the consumer, not to the government, not to the insurance companies,

but to the consumer—does anyone agree with residing the choice in the hands of the consumer?

[No response.]

Mr. BECERRA. No. Good. And so Mr. Chairman, I know my time is expired, so I'll just ask one quick question of Dr. Reinhardt.

So then if we should have this choice reside with consumers, is there any reason why we would think that the consumers would not be able to make an informed decision on whether to have a plan that is based on a private nonprofit insurer, a private for-profit insurer, or a public health insurance option?

Mr. REINHARDT. No. That is exactly my point. I think that choice should be made available. The analog by not making it available would be to tell the American people, you can't have your elementary and secondary school public any more. You must choose among only private schools. I would consider that limiting choice and wonder what the American people would think of it.

I would have the faith in the consumer to regulate that. If the public plan does not behave well, it would lose customers in this country, particularly if we had the transparency on prices and everything we crave for. It seems to me almost daunting to tell the American people, we don't really care what you want, but you are not going to get this choice of a public plan. So I agree with you.

Mr. BECERRA. Thank you. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Ms. Brown-Waite, would you like to inquire?

Ms. BROWN-WAITE. Yes, I would, sir. Thank you.

First of all, I want you to know I love community health centers. They are—Mr. Hobson, you know, your model is duplicated in so many of our congressional districts, and you do such a great job. Community health centers are a great resource, and my hat is off to you.

Mr. Vaughan, as I read through your testimony and I saw the six pages of stories from people having health insurance policies where they had problems with them—and I don't know how much of this you include in the article in Consumer Reports—but as I read through them, so many of them can and should be resolved through a plan's appeals process.

Mr. VAUGHAN. You would think so, yes.

Ms. BROWN-WAITE. But it is almost like the rest of the story isn't told, like you told part of the story, and the question is, was the appeals process used. One of your statements, it said that a state legislator had to intervene. And I am sure every member of this panel has occasionally had to do that, including which I had to do this past week with the VA.

Mr. VAUGHAN. Sure.

Ms. BROWN-WAITE. Which I know the first panelist mentioned. I mean, I had to do that with the VA in a health care issue relating to a veteran.

So I don't think that any of the plans out there right now are perfect, and I believe that Americans want and deserve better health care and better access to health care. But I just—I question whether or not—and believe me, as a state legislator, I fought for appeals panels and having the absolute right of consumers to be able to have that right.

I am not sure how many other states have laws as pro-consumer as Florida does when it comes to health insurance appeals. But I just have a concern that a lot of these could have and should have been resolved.

So I think my question to you is: Is this the end of the story, or is this the middle of the story? And could you document your comments?

Mr. VAUGHAN. I will certainly get you and your staff the complete story. We went around the country and we collected these, and we asked people to send in stories in their own writing. The only thing I changed was a few grammatical mistakes and typing mistakes.

So those are what I got from our field staff. And I will get you the full story. Yes, that poor guy got in an auto accident, and the air ambulance took him to a hospital. And then he was told it wasn't a preferred air ambulance. He said, wait a minute, you know. That had to be—there had to be a way to fight that through.

Ms. BROWN-WAITE. And sir, I want to point out to you that in clearly the majority of states, that is there because it is up to the ambulance driver, the EMTs, to say, this is a critical situation. We need the nearest available transportation. Insurance companies have to follow through if that medical determination is made.

Mr. VAUGHAN. But that is part of, I think, the lesson in these stories, that the pretty well educated people who responded felt so hassled, felt unable to do it themselves or didn't find a way to get it resolved. The system is so hassle-prone and so I use the term Whack-a-Mole.

We need help by Congress, really, in setting some standards for what grievance and appeals systems should be. And 30 percent—also in the statement—30 percent of the American public is considered health-illiterate. You have got to do things at the sixth grade level, and when an insurance company starts hassling them, a whole lot of people just throw up their hands and give up.

Ms. BROWN-WAITE. Sir, I have to—reclaiming my time, I have to personally agree that we need more education on health insurance, the same way we need on auto insurance or any other kind of insurance. And I come from Florida. We have very high homeowners' insurance rates.

Which brings me to my next question. Mr. Borris, you mentioned the fact that in seeking health coverage for your employees—I'm sorry, Mr. Heller's head is in the way; I don't want to not look directly at you——

Mr. BORRIS. I can see you.

Ms. BROWN-WAITE. In seeking health insurance coverage for your employees, they would only give you a one-year rate. I assume you, like most Americans, have homeowners or renters insurance and/or auto insurance?

Mr. BORRIS. Sure.

Ms. BROWN-WAITE. And, you know, I don't know about where you live in Illinois. But I can't—and Illinois is certainly the home of lots of insurance companies. Most insurance doesn't give you a 2-year rate on auto or home or anything, or a 5-year rate you mentioned, or a 10-year rate. That is not going to happen because it is risk-adjusted.

Mr. BORRIS. Except that our experience, at least my experience, hasn't been—with the auto policies that we have for the fleet of five vehicles that we run, with our general liability coverage that we have for our business that contains content coverage as well as our liability coverage for the food that we bring out to people, we have not seen the kinds of premium increases over the past several years that we have seen in health insurance.

So if there is a conversation about reforming auto insurance and general liability and homeowners insurance, maybe I am not the guy to be here.

Ms. BROWN-WAITE. I think that we fundamentally agree that you can't get a two—or a 5-year insurance policy anyplace for any kind of coverage. Would that be an accurate statement?

Mr. BORRIS. When I——

Ms. BROWN-WAITE. Disregarding cost.

Mr. BORRIS. I understand. But when I am making hiring decisions, right, health care insurance is part of that hiring decision. When I hire people, I know I am going to pay 7.65 percent to my FICA and Medicare. It is a cost that I can count on. It is a cost that I know is there.

If I had a public option that I could count on and understand that there is percentage of my payroll that perhaps—and this would be my choice; I mean, I could leave myself in the private health insurance market—but if I had this choice where I could pay a percentage of my payroll, cover all my employees, not just half my employees, but understand that up front—this was my point—I know—would know what my costs are.

Ms. BROWN-WAITE. But sir, you need to also realize people thought that with Medicare. And their yearly rates go up. So that is a "government plan" and those rates go up. That is not fixed. That is not locked in for three or 5 years, believe me. And somebody with a very high percentage of constituents on Medicare, I hear about it all the time.

Mr. BORRIS. Is their contribution like double what it was in 2002?

Ms. BROWN-WAITE. Health care costs are going up substantially. And I have owned a small business, sir, and I know exactly where you are. You want to help your employees. And every—the majority of small businessowners want to be exactly there.

Mr. BORRIS. So you are saying that we can solve this problem strictly in the private—I mean, is that——

Ms. BROWN-WAITE. No. I think that we can come to a reasonable solution to this without totally freezing out and having taxes go through the roof to subsidize health insurance in the private plan. That is what my constituents say they don't want because what it will do is put small businessowners like you and like I previously was out of business. That is what my constituents are concerned about.

Mr. BORRIS. Well, I would agree that——

Ms. BROWN-WAITE. Thank you, and I yield back the balance of my time.

Mr. STARK. Thank you.

Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Yes, Mr. Chairman. Thank you. I want to begin by complimenting the panel. And Mr. Borris, if your catering is anything like your testimony, you have got a wonderful business. I hope to be able to sample your wares some time. You have done a tremendous job this morning.

Mr. BORRIS. Thank you.

Mr. POMEROY. Appreciate it.

Mr. BORRIS. Thank you.

Mr. POMEROY. And Dr. Reinhardt, I used to be an insurance commissioner in the 1980s. I have enjoyed you and your opining on health care for 20 years. And you haven't lost a step.

Mr. REINHARDT. Thank you.

Mr. POMEROY. So thank you for guiding us.

Bill, good to see you in the Ways and Means Committee again. Okay. Better get to the question.

You know, you try and find—I guess I am going to go off the topic of public plan. I am fascinated about community health centers. I think there has just been so much good accomplished with community health centers, I am surprised health reform debate has not looked at that platform as a way of expanding cost-effective care options to people that are uncovered or to people that are paying premiums that might be able to insure on a community health center and get, therefore, a lower-cost premium because it is a lower-cost provider.

But we really haven't been talking about it. I am not sure why. Mr. Hobson, do you think that there is something there in the framework of community health centers as a care delivery format that could be more broadly applied in this health reform debate?

Mr. HOBSON. Well, thank you very much for those observations. I am here, really, today to essentially—make the point that any kind of health reform option that you consider should make sure that there is a clear place for community health centers in that option because I think that all of the studies that have been done show that we are both cost-effective successful in terms of managing the clinical care of patients——

Mr. POMEROY. I believe that—just because my time is going to run—I would love to have heard a longer part of that answer. But to follow, I agree with you in terms of what you have achieved. I mean, basically if there is a medical home in operation, it is in community health centers.

Mr. HOBSON. Yes.

Mr. POMEROY. If there is chronic care being provided in a coordinated way, it is in community health centers. Many of the innovations we hope to advance through payment reform into health care delivery in this country for the purpose of elevating health care delivery and improving outcomes are already being done in community health centers.

Mr. HOBSON. Absolutely.

Mr. POMEROY. But I have heard at least the thought that maybe mandated insurance, you get everybody coverage, they don't go to community health centers any more. They go to the places that are doing all the elaborate marketing.

Have you seen a dropoff at all in Massachusetts, for example, in utilization of community health centers as people have coverage and are going elsewhere?

Mr. HOBSON. Well, I know in Massachusetts there has been a major increase in the number of patients at community health centers since they adopted their health care reform plan. But I can speak best to Los Angeles County.

Basically, people on Medicaid have an option of a Kaiser plan, a Blue Cross plan, a Molina plan, several different plan options through which they can get care. And so they basically can access any providers that will take a Medicaid patient.

But we have got a very large number of patients in that system voting with their feet, continuing to go to community health centers because, essentially, that is where they feel that they are really best served.

Mr. POMEROY. Professor Reinhardt, do you view—are we missing something here? Why aren't we looking at community health centers more robustly as part of the health reform and coverage answer?

Mr. REINHARDT. I think for a lot of people, that is actually a very good option, particularly if they are endowed with modern health information systems so we can monitor them on cost and quality. In fact, my wife and I help consult with China on health reform. We advised them that for their urban population, those centers are actually a highly efficient way to treat people. You just have to make sure they get adequate funding.

Mr. POMEROY. Right.

Mr. REINHARDT. That is the important thing.

Mr. POMEROY. That is the key.

Mr. REINHARDT. The other thing, in New Jersey, I know, our centers are also very excellent. But they have the same problem of access to specialist care. They are usually very, very good in primary care, but at least in our state, but there isn't the backup with specialist care, which you could either put into the centers or you have to have a referral system.

Mr. POMEROY. In Medicare, we are seeing, for example—we are getting killed with uncoordinated specialty care that proliferates in some places in this country and adds a cost factor almost double to where you don't have such a specialist-prone environment.

But in community health centers, another place where we are federally paying dollars, there is no access to specialists. That is very interesting.

Mr. REINHARDT. Well, there is this "nouvelle vague," the medical home. The community health centers are natural medical homes that could coordinate this care better than the fee-for-service, any fee-for-service plan normally would. So yes, I am very supportive of these centers, too.

Mr. POMEROY. I thank the gentleman. Well, as long as the chairman is preoccupied, I am going to keep going here.

[Laughter.]

Mr. POMEROY. Dr. Blumberg, your observations?

Ms. BLUMBERG. I agree with what Dr. Reinhardt said. I mean, one of the big issues for many of the community health centers is making sure that they get integrated with specialty care and inpa-

tient care, and that when health care reform is done and there is greater financing for those in low-income populations, that could be an infusion into these health centers to help them to do even better work and more work. And we are certainly seeing that in Massachusetts.

Mr. POMEROY. You know, if it was to be structured in a way, Mr. Borris could get a very substantial premium reduction if he is directing, as a preferred provider, the community health center at their lower reimbursement rates.

I see my time is elapsed, Mr. Chairman. I yield back.

Mr. STARK. Thank you.

Mr. Brady, would you like to inquire?

Mr. BRADY. Yes, I would, Mr. Chairman. If you would like to go on and read that book while I do my questioning, I would like a few extra minutes as well.

I think it is important to have this discussion. I do think—I wish it were more balanced. The truth is, we do need serious efforts on reform in health care. And I do believe, though, that the public has serious concerns about a government-run shadow plan that would go with whatever reforms we are trying to make here.

And I am not convinced that Medicare is necessarily the model we should be following. I mean, just take a look at it as it is today. It has serious quality issues to go with its care.

It is rampant with fraud; some believe 20 to 30 percent of the funding is waste within it. It is bankrupt, actuarially unsound, bankrupt here in the next 10 years, making promises it can't possibly hope to keep. Making underpayments to not just providers, not just to doctors, but to hospitals as well that results in cost-shifting to private plans that we all acknowledge.

The cost is not being held down; it is expected to triple over the years. So there is no cost containment as far as price. And no transparency whatsoever. Ask any senior about their Medicare bill, they will tell you about it. And we have had a number of people testifying, sitting in those very same seats, who say that the procedures-based health care package under Medicare is the problem, not the solution, to health care reform in America.

So I have real concerns about a government-run shadow program. And I also, just from a free enterprise system, you know, you wonder, you know, why don't we have government-run options for catering companies? Not all businesses can afford those catering costs, and if we had a government-run option, you wouldn't have to make a profit. They wouldn't have to pay pesky taxes. They wouldn't have to even be actuarially sound; the taxpayers could pick it up. And there would be no overhead because that is just part of the government.

Truth is, I think there are very serious concerns about a government-run plan. Rationing, perhaps, maybe the fear that most people have, that the government will be making decisions on their behalf, especially end-of-life decisions.

Mr. Reinhardt, I know you have testified today that what we need is a more logical form of rationing. Given that other countries' initiatives and government rationing hasn't slowed cost growth, you know, why do you think rationing health care rather than providing medically necessary care is the best option for Americans?

Mr. REINHARDT. Well, there are two forms of rationing. One is by price and ability to pay. As every economics textbook will tell you, the role of prices in a market economy is to ration. And that is one approach which we are using in this country to ration health care.

And the other approach to rationing is to do is through some non-price mechanism, as the Canadians do it. Canada spends only half as much per capita on health care as we do. For that half, you have to admit, you give them high marks for what they do deliver, in spite of the fact that they ration. But yes, they do ration healthcare.

Mr. BRADY. Mr. Reinhardt, Doctor, can I ask you this: Do you see some semblance of rationing already in our current Medicare system? In the sense that if you look at MedPAC's recommendations each year on physician reimbursements, they don't really measure what the cost of those equipment, medicines, and staff would be.

They determine what they think the overall usage should be and utilization of physician services, and then they ration back the price by cutting it 3, 5, 10, 21 percent in order to fit the model that they want to have. The result of that price reimbursement rationing is fewer and fewer physicians willing to see our Medicare patients. So don't we already have a model on rationing occurring in the government-run program we have today?

Mr. REINHARDT. Well, the number I look at is not the price. I look at how much money does the taxpayer give physicians collectively per Medicare beneficiary year after year? And I looked at 1995 to 2005. That amount rose, per year, at 5.8 percent compound over the period—faster than GDP per capita. So that is not a bad growth rate. It is just simply the volume expands so much that the prices have to be kept lower to keep a growth of 5.8 percent per Medicare beneficiary.

Mr. BRADY. But that is my point. In effect, through MedPAC we are rationing reimbursements based on what we believe that dollar amount should be. And I think there is fear that we will do the exact same thing with patient care under a government-run plan that we do today.

And perhaps that can be resolved, but I think it is one of the issues—as we move forward, there is so much in health care we need to improve that we can make better. That is one of those areas I think we have to be especially cautious on.

Mr. REINHARDT. But as Mr. Vaughan said, there is a limit to which fees can be held down. If I could refer you to page 14, 13 and 14, of my testimony. You look at the huge variation here as a California insurer and look at what they pay different hospitals for an appendectomy. Hospital A gets $1800. Hospital E gets $13,000. Now, is that insurer rationing?

Mr. BRADY. Yes.

Mr. REINHARDT. Is that insurer rationing?

Mr. BRADY. So are you thinking that within the Medicare system, where we have vastly different payments from county to county, that that is really a model we ought to be pursuing?

Mr. REINHARDT. Well, you have exactly the same in the private sector. They just don't publish their numbers because they are proprietary. No, I——

Mr. BRADY. So it is not a good model if it occurs in the private system, but it is acceptable if it is in——

Mr. REINHARDT. No. It is neither.

Mr. BRADY. Let me just——

Mr. REINHARDT. What we actually as researchers now are looking at is bundled payments, like the DRG, for example, which is half bundled, at least for the hospital. Very innovative. Copied around the world. And ideally, we would like to have bundled payments for everything.

And once you had bundled payments, you could then compare how much the different regions charge. And I think those bundled payments would sort of converge on a more uniform level.

Mr. BRADY. Mr. Chairman, we ran out of time. One of the points you made, until we move away from this procedures-based reimbursement and align toward the patient, I don't think we will ever get exactly where we want to. So thank you.

Mr. STARK. Thank you, Mr. Brady.

Mr. Thompson, would you like to inquire?

Mr. THOMPSON. I would. Thank you, Mr. Chairman, and thanks to all the witnesses for being here today.

Dr. Blumberg, you mentioned, in your testimony, the issue of meaningful coverage, and Mr. Hobson talked about preventive health care and how important that is, and that's something that I care a great deal about, and so I'd like to direct my questions to the two of you, to begin with.

I believe that preventive health care needs to be a critical component of any health care reform that we do.

I think it's extremely important, and very soon I'm going to be introducing a bill that would require preventive health care for kids from birth through 18 years of age, absent any co-payments or any deductibles that would make that prohibitive for families to provide that type of coverage.

As I say, I think it's the right thing to do, and I think the data clearly shows that it saves a lot of money, for a whole bunch of reasons, everything from catching a problem before it becomes acute, saves money no matter how old you are, and with kids, it saves even more money.

We've seen that preventive health care can provide smoking cessation, successful smoking cessation, intervention, and detect drug use.

I mean, there's just all kinds of reasons why it makes good sense to do that.

I'd like to know from the two of you if you believe it's important to set minimum benefit standards to ensure quality coverage, and whether or not preventive care should be part of that, and then, maybe Dr. Blumberg, from you, how you would suggest we best establish preventive health care standards for kids.

Ms. BLUMBERG. Well, I'll start by saying that preventive care can provide a great deal of value, and increase quality of life, so no doubt it's important to be considering that.

We do need to remember that not all preventive care is cost-reducing. Some of it's cost-increasing. It doesn't necessarily mean it's a bad thing to do. It may be the very right thing to do. But there's a lot of variation in terms of the cost savings. Certain types of preventive care will be cost savings and others will not.

So I just didn't want to lead you astray. The literature is quite variable on that, depending upon the type of preventive care we're talking about.

I do believe that reforms should have minimum standards to make sure that individuals have adequate benefits. Those standards should include necessary care.

To the extent that we leave particular components of medical care out, we leave that to be financed individually by those who need it the most. Once we include it in a package, we spread the risk of that care very broadly, and we allow individuals to get the care that they need for a low marginal cost instead of the cost being left on those who need the care the most.

I do believe we should have particular components of preventive care in that package. I'm not an expert on prevention, and so I wouldn't want to be the one to be telling you which pieces ought to be in and which pieces ought to be out——

Mr. THOMPSON. Is there someplace that we should look to establish what those standards should be?

Ms. BLUMBERG. I definitely think that this ought to be a discussion that's done in conjunction with the organizations—I can provide you with some names afterward, if you like—that focus on preventive care, and also, particularly since you're concerned with children, the American Academy of Pediatrics.

Mr. THOMPSON. Thank you. Mr. Hobson.

Mr. HOBSON. Yes. I concur with many of the comments that have been made.

I think that it's really essential that we make sure that the basic preventive services are part of any benefit package that's really adopted under health care reform.

I feel that, to make sure that we have pediatricians that are really involved in establishing the preventive services for kids, that we have specialists in adult medicine that basically can look at the various age groups and establish essential preventive services, so that the list that would come out of that kind of analysis really wouldn't include everything, but really would include those kinds of things that, based on evidence-based medicine, that you really would not want to leave out.

And it's just been our experience that, all the time, that these items are not necessarily covered, but in addition to that, the kind of information that we can make available by health education classes, like we have every single day of every week at our program, I think are of immense benefit, particularly to patients who are at risk of diabetes and patients who don't basically have the resources for, say for instance, exercise classes. We basically have exercise classes available for our patients free of charge every Thursday at our health center.

Mr. THOMPSON. I don't want to minimize the importance of preventive care for adults. That's important, too, and I'm a proponent of that, but I did want to focus primarily on the kids' stuff.

So thank you both very much. Thank you, Mr. Chairman.

Mr. STARK. Mr. Davis, would you like to inquire?

Mr. DAVIS OF KENTUCKY. Thank you, Mr. Chairman.

I appreciate the time that all of you have taken to prepare and come in today.

I think in particular, when Mr. Vaughan made his comment on Kentucky, I owned a small business, provided a Cadillac plan, 100 percent paid for by me, and when Kentucky House Bill 250 was enacted in 1996, it had the nickname "Hillary Light" in the business community.

It actually drove people off of health insurance, because of the increased state mandates, and in fact, 44 of 47 carriers left the state. I watched my rates nearly triple by the time I came to Congress.

And that was one of the things that made me a political activist, frankly, was the inefficiency of the government plans that actually drove costs up and many people found themselves uninsured as a result of that.

But just shifting over, I appreciate Mr. Borris's comments, as well. Being a businessowner, I think we've shared some of the same things. You tend to get active on the issues you care about. It certainly influenced me.

But just for the record, I just would like to confirm one thing. Are you a Democratic Committeeman back in Illinois?

Mr. BORRIS. Yeah, back in Illinois we have, in our little lake county, in my marine township precinct, yeah, I am a Democratic precinct Committeeman.

Mr. DAVIS OF KENTUCKY. Okay, thank you. I just wanted to confirm for the record that you were in fact an activist, as I was, before I ran for Congress.

Mr. BORRIS. However, I also want to share with you that my customers are both Republicans and Democrats.

Mr. DAVIS OF KENTUCKY. It's always good to maintain bipartisanship in business. I agree with that.

Mr. BORRIS. Right.

Mr. DAVIS OF KENTUCKY. Actually, just shifting over, coming back to the business side for a moment, my question actually is to Mr. Sperling, with the Coalition on Business Benefits.

The Consumer Union supports restricting employers' ability to tailor health care coverage to best meet the needs of employees.

This concerned me, certainly, as a businessowner. I faced many challenges to tailor a plan that we wanted, that didn't necessarily fit with the state mandates, actually different types of coverage.

What do you think about such a proposal, on restricting that flexibility for employers? Do you think maintaining flexibility is important?

Mr. SPERLING. Thank you, Congressman. The coalition that I represent feels very strongly that maintaining the flexibility that ERISA provides is probably their number one issue, and that having state mandates and having to deal with the costs of those state mandates, and the cost of administering and complying with those mandates would cause problems for employers.

It would cause a multitude of issues, moving employees from location to location, because there would be winners and losers. They would want to see equal treatment for all employees.

At the very worst, it would drive employers to make decisions on where they wanted to do business, to states that might have the least burdensome mandates. And at some point, employers would start to rethink whether to continue offering health care benefits at all.

I think your question also gets to kind of standard benefits, if I'm correct, or minimum benefits.

Speaking from a Hewitt standpoint, working with many large employers, employers really value the flexibility that they have in designing their plans tailored specifically to their workforce needs and health concerns, and I think a lot of employers would want to preserve that flexibility and that choice, and prescribing a standard benefit plan would be concerning to many employers, because they don't think of their health care benefits as one size fits all.

In some cases, they have identified health risks in their populations, like cardiovascular risk or diabetes risk, and improved benefits for those types of conditions, to make sure that there is no financial barrier to access care, and employers like having that flexibility.

Mr. DAVIS OF KENTUCKY. Would anybody else on the panel like to comment on that issue of restricting flexibility?

Mr. VAUGHAN. And, sir, our hope would be that there is a minimum level of health care for everybody in this country, and most ERISA plans, I think, I wouldn't—we wouldn't affect, or you wouldn't be in this marketplace I was talking about.

We're talking about for the people who don't have adequate coverage, or are in and out of the market, or whatever. They would have a chance to select among a range of plans, but enough that, or not so many as to be confusing, enough to have choice, enough choice where there could be competition between these plans and people would get a better price.

But for the good ERISA plans, I don't see anything we're saying that would change that, but we do hope there's a minimum.

Mr. DAVIS OF KENTUCKY. I do know my concern with the inefficiencies in the process, the way funding for health care works.

If I look at Center for Medicare Services, for example, part B premiums have doubled since 2001, and we're going to be dealing with spiraling cost increases there, as well.

Would you agree that the Center for Medicare Services doesn't simply need more money, but it needs to be significantly re-engineered to be more efficient in service delivery?

Mr. VAUGHAN. Sir, I think it's the whole American health care system. Medicare just sort of fluctuates around what the private sectors do. We're all in trouble.

Mr. DAVIS OF KENTUCKY. I would disagree with you. I would suggest that every medical provider that I know in my district, which are many, many doctors, hospitals, secondary care, other forms of professional care, are all constrained by the structure that's imposed upon them by the Center for Medicare Services.

Their billing, their overhead, the regulatory framework that produces costs—you know, we could go on and on. And so those costs are going to be carried.

Mr. Borris's business had that, had to deal with that indirectly. My business had to, Ms. Brown-Waite's business.

Wouldn't you agree, though, that if we're going to move into a dialog about improving it overall, that very substantive changes would need to be made to the actual process by which CMS functions to make it more entrepreneurial, that a person in the private sector could actually understand.

Mr. VAUGHAN. I would urge everyone go back and read the MEDPAC testimony, that an eighth of the nation's hospitals, those that are the best hospitals in terms of not killing us and of giving us the best care, they make money on Medicare. It's the other seven eighths whose costs have been unrestrained, and the insurers are not holding costs.

The question is not so much, is Medicare underpaying as that, why aren't these big insurance companies in this country doing a better job of restraining costs?

Mr. DAVIS OF KENTUCKY. Having seen it firsthand with my own mother's death, as she was processed through the Medicare system, I would suggest to you that it's not simply an academic matter, that the reality, what I observed personally, and hundreds of other folks my age, and middle-aged, watching their parents go through the end of life decisions that you mentioned—I think was maybe two of us up here, would consume the majority of costs—the thing that I witnessed, which comes back to this issue of driving costs, were procedures that were driven, that drove costs, and this was entirely within the framework of Medicare. It wasn't in private insurance.

I know I've exceeded my time, and I'll yield back to the chairman. Thank you for your gracious indulgence.

Mr. VAUGHAN. Thank you.

Mr. STARK. Thank you.

Mr. Larson, would you like to inquire?

Mr. LARSON. Yes, I would, Mr. Chairman.

And congratulations on your longevity, and quite a remarkable achievement, Mr. Chairman, and I have a couple of questions for Dr. Blumberg and for Mr. Sperling, and they're in this context.

Of course, the whole notion, as you suggest in your testimony, Dr. Blumberg, about innovation, is something that is very promising for the whole field of health care, and one of the things that has been highlighted is, the creation of a public auction within an insurance exchange will, as you indicate, force insurers to innovate.

Could you elaborate on that, or could you give me any kind of specific illustrative example of what innovations we might see?

Ms. BLUMBERG. Sure. In most markets, what we're finding is that there is very little competitive pressure on private insurers.

There's been a great deal of consolidation, both at the insurer level and at the provider level in recent years, and that has helped to push further the growth in health insurance premiums.

And when we don't have a real competitive market, putting in a public plan actually could be a catalyst for competition, because suddenly then there's a competitor in the marketplace that has the potential, through a number of avenues, through payment rules, through lower administrative costs, to provide a potentially lower cost option in the marketplace.

This should then get those entrepreneurial, creative juices going in the private sector, that have been allowed to atrophy for lack of

need, because the growing costs have been able to have been pushed back on purchasers. It allows us to say, "In order to maintain your market share, you're going to have to think about what's going into your administrative costs, what can you do to hold them down, it's time to get really serious about your negotiations with providers; it's time to look at management techniques that are going to help to lower costs, it's time to be serious about managing high-cost medical cases."

So I think there really are a number of avenues that we value private insurers on, but that we really haven't been able to take advantage of in the marketplace of late——

Mr. LARSON. Mr. Sperling, would you have a different take or would you agree with Dr. Blumberg's assessment?

Mr. SPERLING. I would add, from a Hewitt perspective, working with large employers, where 55 percent of employees are covered by self-insured plans, we're not talking about insurance company money here, we're talking about the money of the corporation, and these companies push their insurance companies extremely hard, and they take it upon themselves to innovate, and we've seen a tremendous amount of innovation coming out of the private sector in terms of health care with, as I mentioned in my testimony, with coaching programs, consumer-oriented designs, value-based benefits.

These innovations have been coming through the private sector to try to improve the health and productivity of the workforce and to try to control costs, and the—I'd say that the employer marketplace supports the concepts that are evident in the large marketplace that work well, like large pooling, to spread risk and purchase efficiently, and if that will end up increasing access to small companies and individuals, those concepts should be considered very seriously, because that works in the private sector.

Mr. LARSON. Well, in Mr. Borris's testimony, he talks, and what I hear most frequently when I'm back in Connecticut, is how small businesses—you mentioned large corporations, but when you talk about a small business, how will this innovation, in essence, help out the small business man?

Will the competition work, or do we, as Mr. Borris suggests in his testimony, does he need to be part of a pooling mechanism that allows him to join with, let's say, municipalities or states, or be able to pool resources in a way that you can lower rates?

Would you agree, disagree? How do we help Mr. Borris out?

Mr. SPERLING. Certainly, mechanisms that would allow small businesses and individuals to come together and purchase like large businesses would be valuable, because it ends up creating more efficiencies in the system.

But the innovations that the private sector has driven, by largely large corporations, find themselves into the small business marketplace, because they're adopted by insurance companies as standard practice.

Mr. LARSON. Dr. Blumberg.

Ms. BLUMBERG. I think that what we need to remember with the small businesses is that they are at a number of disadvantages.

Number one, they have higher administrative costs than the larger businesses, and that affects their premiums.

They also have a much lower ability to pool health care risk than the large businesses who are self-insuring do.

And we also know that they have, by and large, a lower-wage workforce.

And so, really, you need a multi-pronged approach to help the small businesses.

What an exchange can do for you, which an association health care plan cannot, is to bring together a significant portion of the population, the small businesses, the individuals, to pool risk very broadly, not to select based on risk as we see now, not to have prices varying, as Mr. Borris had experienced, as a function of the health status of his particular employees.

And then we also need the support of low-income subsidies, because a lot of these workers are low-wage——

Mr. LARSON. In the final analysis, doesn't the government have to take stock or at least be aggressive in pursuing, if we want to make sure that all pre-existing conditions are covered——

Ms. BLUMBERG. I completely agree.

Mr. LARSON [continuing]. And if we want to make sure that catastrophic care, which of course accounts for the great actuarial swings that people experience, is taken care of, if government takes care of those pieces, can't we allow the entrepreneurial and innovation to take over in the private sector and join collectively with an option plan?

Ms. BLUMBERG. I think what we've seen, by the dominance of a very small number of insurers in most markets, and the consolidation of providers and their strengthening power in the marketplace to avoid having to negotiate rates with the insurance plans, is that we're not really seeing true competition in these private insurance markets that's why I think something more aggressive, such as the introduction of a public plan, could catalyze that.

I think that the public plan option is less aggressive than other options that we might have to pursue down the line if we don't go there, such as all-payer rate-setting.

Mr. LARSON. Thank you. I'm sorry, Mr. Chairman, for——

Mr. STARK. Thank you.

Mr. Reinhardt, would you like to inquire?

Mr. REICHERT. Yes. Thank you, Mr. Chairman.

I thank all of you for your time today.

We all come from, obviously, different backgrounds. My experience in the health care world is from my previous law enforcement experience as the sheriff in the Seattle area.

And with 1,100 employees, and watching my insurance costs go up, trying to provide service to King County, insurance costs were increasing by about 17 percent a year.

So you have to try and balance the budget that's allowed to you by the county council, and of course, all those employees wanting to be covered by health care, and all sorts of questions, and it's now, you know, great to have the opportunity to be here to ask some experts about what their thoughts are on behalf of those people that are back in King County, and Pearce County in Washington State.

Dr. Blumberg, you mentioned cost management. Can you kind of expand on that just a little bit for me?

Ms. BLUMBERG. Sure. For example, we saw that when there were greater financial pressures on the health care system, about 10, 15 years ago, when we saw a greater presence of managed care in the markets, that the insurers took great attention at innovating to finding ways to reduce cost growth in order to gain market share.

So we know that insurers can innovate, they can create management systems that are both going to address the way that care is delivered and the extent to which it's delivered efficiently. They can look at high-cost cases—in particular the largest share of health care dollars are going to a very small segment of the population. How can we better manage those cases efficiently? But right now, there really isn't a lot of incentive for them to do so. But I do——

Mr. REICHERT. Now, we do know that some hospitals are engaged in cost management.

Are you aware of some hospitals and insurance companies, in working with—I just visited last week Children's Hospital in Seattle, who have been frequent visitors over the last year to Japan, to the Toyota productionline there, and looking at how they efficiently run—it sounds a little bit bizarre, but they apply the cost-effective ways of examining their business and how they manage their productionline, and they've applied some of those things to Children's Hospital in Seattle.

Are you aware of any insurance companies or other hospitals that might be engaged in that same sort of process, in looking at sort of a process mapping adventure?

Ms. BLUMBERG. There certainly are hospitals and insurance companies that are thinking about costs, but what I'm suggesting is that the way the market is structured right now, there really isn't a strong incentive for them to do that in a lot of markets.

Some markets are very different. We see certain markets where there is a lot more competition, but the majority of them, there isn't. And so that's why I think we need to do something in order to give them a bit of a stronger incentive to do just what you're discussing.

Mr. REICHERT. In your testimony, you suggested a new government-run plan should implement price controls to keep provider reimbursements under control. Is that correct?

Ms. BLUMBERG. I do believe that we could hold down provider payments below the levels at which they are, and still provide high-quality care, yes.

Mr. REICHERT. But studies, some studies have shown that 120 million Americans could lose their employer-based health coverage if a government plan was created. Are you concerned about that?

Ms. BLUMBERG. I think that what you're referring to is the cost shift argument; is that correct?

Mr. REICHERT. Yes.

Ms. BLUMBERG. Okay. Well, the literature, the economic research literature really does not empirically support the existence of a significant cost-shift.

The Medicare Payment Advisory Commission has just recently come out with a study in March, which looked precisely at this, and also confirmed results of other researchers, colleagues of mine at the Urban Institute, that had done research in this area a number

of years ago, and what they found is really that those hospitals that have high costs are those hospitals that are not in areas in which the financial pressure——

Mr. REICHERT. But that's only for hospitals, right? What about physicians?

Ms. BLUMBERG. Whether there's a specific literature on cost-shift on physicians, I'm not aware, but the big dollars are in the hospital sector. We really——

Mr. REICHERT. The price controls in Medicare, don't they——

Ms. BLUMBERG [continuing.] Find any evidence of price shift in the hospitals.

Mr. REICHERT. Excuse me. In price in Medicare, aren't they expected to result in a 21 percent cut in physician reimbursements for next year?

Ms. BLUMBERG. Well, I think the issue of the sustainable growth rate is an important one, where we think politically about——

Mr. REICHERT. Let me ask you one more question.

Do you believe that a key principle for health reform is that people shouldn't lose what they already have?

Ms. BLUMBERG. I think people should have access to high-quality medical care——

Mr. REICHERT. What about the people that have an insurance program that they already have, that they want to stay with; do you believe that that's a reform—that that should be included in any reform?

Ms. BLUMBERG. I believe that there should be broader-based risk pooling than we have today, and by allowing some people——

Mr. REICHERT. Do you believe that people should be able to keep their current insurance policy that they have, if they choose to keep that insurance policy as a part of a reform, yes or no?

Ms. BLUMBERG. I don't believe that every person needs to have the precise insurance policy that they have today, no.

Mr. REICHERT. So that's a no. Thank you.

Mr. STARK. Thank you.

Mr. Blumenauer, would you like to inquire?

Mr. BLUMENAUER. Thank you, Mr. Chairman.

I was intrigued, Dr. Reinhardt. Your line that you casually offered early in the hearing, where you talked about the health care that we provide our veterans is socialized, by any definition of the term, yet it doesn't appear to be attacked by people. They're either quiet, or in some cases, they are actually out there boosting, helping, protecting.

You talked about a cognitive dissidence here, and I'm curious if you have some sense of why that is. Why do people who get so worked up about Canada or Great Britain and socialized medicine somehow don't—are not concerned about our veterans' health, and its cost control, and its high quality?

Mr. REINHARDT. I really can't answer it. I've asked that many, many times, in a letter in the Wall Street Journal, and people just sidestep it. And it does puzzle me, for sure.

Mr. BLUMENAUER. It is. It's fascinating. I wonder, after having sat through gazillions of hearings, having an earlier life being involved with employee benefits for organizations that I was respon-

sible for, I wonder if some of this complexity that we have layered on our system is just a result of trying to protect some of the aberrant results, that if we really cut to the chase, that it really doesn't have to be this complex, dealing with things like giving people information for end-of-life decisions, for not getting caught up in some of this.

The point of rationing, I mean, we are already rationing right now, by price, by availability, by information. There's a very uneven flow, isn't there, of who gets medical attention in this country, based on factors?

Mr. REINHARDT. There's no question. The Urban Institute scholars that were just mentioned, in their most recent paper, it showed that the uninsured people get roughly about half the health care that equivalently insured Americans get, and then, as an economics teacher, I say that clearly is the effect of rationing by price.

Mr. BLUMENAUER. Well, it's interesting to me that we have people who—there's rationing because of how health insurance policies operate, pricing, as you—another version of pricing; in terms of availability and shifts in the market.

Mr. Vaughan, I was intrigued with some of the data that is provided in your testimony about how hard it is for people to be informed consumers of insurance.

Meaningful choice, we're familiar with you don't sell as much jam with 26 varieties as you do with six. People are confused. In some cases, they go into a shut-down mode. In others, they make poor decisions.

Mr. VAUGHAN. Deer in the headlights kind of effect, yeah.

Mr. BLUMENAUER. Or just, people are overloaded. They've got lots of choices on an ongoing basis, and for some reason, this appears one that people sidestep.

I appreciate your talking about having some specific elements that would be included in all insurance policies, and something that struck me in your testimony that I don't know if it was written or whether you articulated it, but the notion of requiring that people get examples of how the health insurance policy would apply for specific real-life examples, so people know what in the dickens they're getting.

Can you elaborate on that for me?

Mr. VAUGHAN. Yes, sir.

Washington Consumers' Checkbook Guide to Health Plans includes questions like: are you fairly healthy, what this plan will cost, covering your premiums, if you have sort of moderate level of illness, what it will cost, and if you have something horrific, cancer or so forth. And you'll see how the plan actually works.

But even in this feed plan, for educated workers, the editor has to say, unfortunately, the reimbursement structure for many plans is so complicated there is no simple way to present or compare these payments.

So, as you work on legislation, you need to make it—you need to make it simpler. And in the May issue that we just came out with, we compared two plans: one in Massachusetts, monthly premium of $399, and an annual deductible of $2,200; and then in California, a $1,000 deductible and $246 a month premium.

So you'd say, geez, California is going to be better, right? Lower deductible, lower premiums.

If you had breast cancer, if you had a serious cancer, the Massachusetts plan that didn't seem very good, you'd only be out of pocket $7,668. That California plan, you'd be out of pocket $37,767.

So the poor consumer looks at a plan, and it seems like a no-brainer, "Oh, let's go with this California one." But if you get sick, a whole different story.

We've got to get that information to consumers.

Mr. BLUMENAUER. I really appreciate the thrust of the panels, from small business to the academic, in terms of providing the context for the types of decisions that this Committee may be helping to drive with our decisions, and I think you've helped demystify it a little bit.

I hope we can translate that into our legislative product.

Mr. STARK. Thank you.

Mr. Boustany, would you like to inquire?

Mr. BOUSTANY. Thank you.

Mr. Borris, congratulations on your entrepreneurial spirit, and working to feed the American dream, and certainly you've benefited from a market-based economy.

And my question, to start with, is, suppose right across the street, a government-run catering program that could undercut you on cost, prices, wages, and so forth. Can you compete?

Mr. BORRIS. It's an interesting question. Mr. Brady mentioned that in his comments, but didn't have too many comments on it.

I would say that one fundamental difference is that with catering companies, catering a party is not a fundamental human right, so I don't know that we can apply the same market conversation to people——

Mr. BOUSTANY. Reclaiming my time, I think you're dodging the question. We're not talking about whether this is right or not, because there are some disputes.

I'm a medical practitioner, and I do understand the personal responsibility side of health care as well. We can talk about that in the limited time we have. But put that aside for a moment.

Could you—it's a simple question.

Mr. BORRIS. It's a false question. I mean, yeah, I would work toward competing at that, to answer the question for you, until that thing opened, until we really saw what the parameters of it were, and I could make decisions about——

Mr. BOUSTANY. I think you're dodging——

Mr. BORRIS [continuing]. Where my supplies—I'm not dodging the question.

Mr. BOUSTANY. Sir, you're dodging the question.

Mr. BORRIS. Are they going to pay the same amount for chicken and lettuce as I'm going to pay for? If they are, then I could probably compete——

Mr. BOUSTANY. But if they could undercut you on the cost——

Mr. BORRIS. Pardon.

Mr. BOUSTANY. If they could undercut you on those costs, could you compete?

Mr. BORRIS. The question is, how would they undercut me?

Mr. BOUSTANY. Because they control the price.

Mr. BORRIS. If somebody opens up a business that has access to things that I don't have access to, would it be more difficult?

Mr. BOUSTANY. What I'm trying to—reclaiming my time, what I'm trying to highlight is that there are a number of concerns and questions that we have about a government-run option, that being one, whether it is fair competition, and second, whether there are mechanisms in that type of approach that would actually bring down costs and maintain quality.

Certainly given what we've seen with Medicare and Medicaid, where we do have uncontrollable costs, we do have quality issues, we have access problems, and then a whole host of problems.

So I guess the point I'm trying to make here is that we're looking at one particular path that we will look at, that we're going down on health reform without looking at a whole number of other options.

Mr. BORRIS. Could I——

Mr. BOUSTANY. For instance, Dr. Blumberg, I think we were talking—you were mentioning earlier about the need for a connector as being a better source for small businesses. But why not combine a connector with associated health plans?

Ms. BLUMBERG. The problem with the association health plans, sir, is that they tend to create lower prices by risk-selecting, by taking in certain groups that are going to be lower-cost. What that does is take the lower-cost groups out of the mainstream commercial insurance, increasing the cost there.

Now, if you want to spread risk more broadly, that's not the way to do it.

Mr. BOUSTANY. Reclaiming my time, I think the point again is, we're not looking at all the options.

We're not putting all the options on the table, and we're using unfair standards of judgment as we go forward in looking at the positive sides, solely, of the government-run option, and not looking at the positives on some of these other options.

There are many other options that would create an actual real, functioning market in health care, which I will tell you from personal experience, we do not have.

Dr. Reinhardt, do you want to comment?

Mr. REINHARDT. Well, actually, in my statement, I looked at an option of having private insurers only, but then I say the regulation you would need would amaze you.

In fact, I think Bill Thomas, Congressman Thomas, at one point had a plan like that, and he told me privately, there's a lot of regulation of the insurance industry, and to describe what it is—community rates, guaranteed issue, you have to mandate people to be insured.

Look to Germany, look to the Netherlands and Switzerland. Those are functioning markets that work without a public plan.

But unless you're willing to impose that strict regulation on the insurance industry, you would still have the uninsured, you would still have policies, you find out what they cover only when you're sick, and so on.

Plus, it is true that Medicare has very low administrative costs itself, but imposes costs on providers, but everyone who serves on the board of a hospital will tell you that the managed care bureauc-

racy that that causes is much, much higher, because Medicare pays pretty punctually, and the other plans don't.

So one would have to seriously think about reducing the administrative costs of the private system, which are simply disproportionately high.

I think the president of Johns Hopkins mentioned in a speech that this academic health center deals 700 distinct private health insurance (managed care) contracts. I serve on the board of the Duke Health Systems, and we also have that problem, and huge administrative claims processing, which with Medicare is simple, it's automatic, it comes in——

Mr. BOUSTANY. That claims processing——

Mr. REINHARDT. Yes, that's——

Mr. BOUSTANY [continuing]. And that would work, I've seen that in my own practice, where I had to deal with many, many different types of claims processing, but that could be simplified.

Mr. REINHARDT. It should. I tell my friends in the private insurance industry that is their challenge, to reduce the administrative burden they have and they impose on the providers of health care.

McKenzie had a report out showing how much more we pay in administration relative to other countries, and McKenzie attributed the bulk of it to private insurers. And they should have common claims forms, electronic billing, and all of these things. I hope they will, in this decade, go that way.

Mr. BOUSTANY. Thank you.

Mr. Chairman, I know my time is up, but I wanted to ask Dr. Reinhardt if he could offer a clarification on his tables on Page 14.

Mr. STARK. Certainly.

Mr. BOUSTANY. If that's okay.

In looking at the coronary artery bypass grafting column, and you have different payout rates for hospitals, are those averages or actual individual episodes?

Mr. REINHARDT. No, no. Those are what this large insurer pays, the average for a whole bunch——

Mr. BOUSTANY. I see. Okay.

Mr. REINHARDT [continuing]. Of these, and these are not charges, they're actual payments.

Mr. BOUSTANY. Okay. And I guess the other question that follows on that is, did you consider the different cost structure for those hospitals?

In other words, some hospitals employ the surgeons and the anesthesiologists and other services. Others have those separately, where the charges would go separately to those providers.

Mr. REINHARDT. That is a good question. I don't know if it's in here.

Mr. BOUSTANY. That might account for the discrepancy in numbers.

Mr. REINHARDT. Well, I doubt it, because not that many hospitals employ surgeons. They're mainly affiliated.

Mr. BOUSTANY. That's not necessarily true in cardiac surgery. Anyway, thank you, sir.

Mr. STARK. Thank you.

Mr. REINHARDT. Good question, though.

Mr. STARK. Let's see. Mr. Pascrell, would you like to inquire?

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. Sperling, I read your—listened to your testimony and read your testimony, and I agree with a lot of what your testimony is, and even though you're supposed to be one of many, but you made a lot of sense in what you're talking about.

One thing you made sense, I believe, in is you said on Page 5 that, "Our health care system rewards physicians when they provide more services for sick care, rather than rewarding them equally for spending time to help patients avoid the 80 percent of illnesses that are lifestyle related."

I think that's a mouthful. I would agree with you. Much of the debate on health care over the past 15 years has gone to finding money to cover people, rather than getting folks to understand what they're paying for and how we could prevent these kinds of situations. And if that's at the basis of our health care system in the future, we will not be on this one-path that my good friend, Congressman Boustany, talked about very briefly.

I don't agree with you at all on your ERISA comments. I believe they need not only renovation and review, but revamping. A tremendous amount of changes need to happen in those ERISA laws, for us to get on equal footing.

Dr. Reinhardt, there's no debate that the current market for health insurance is failing folks looking to buy health insurance on their own, and small businesses.

Back in 1992, in New Jersey—you're very familiar with New Jersey—New Jersey adopted sweeping health insurance market reforms. We standardized the standardization plan options for small businesses and individuals. We ended discrimination against sick people. And we provided subsidies to people who could not afford to purchase individual coverage. We did a lot of other things, but I think they were the main things that happened in that so-called reform.

These are some of the most progressive policies, supposedly, in the nation. However, healthier individuals disproportionately enrolled in the cheaper, more bare bones options, or dropped coverage altogether. That's a fact. I'm not making this up. It's not conjecture. The numbers indicate that that's exactly what happened. You tell me if I'm missing something.

The premiums quickly began to increase. The subsidies disappeared. And overall enrollment declined.

So I think there's an important lesson here, and if you could define that New Jersey thing very quickly, because that's not my question. Two questions, besides the questions of affordability.

With the experiences of Jersey in mind, and I think it's a good basis here to get off on our discussion about how we're going to change health policy in the country, what are the key pieces of health reform that ensures that healthy and sick people are optimally pooled together and that long-term affordability is sustained; and could you explain to us clearly and concisely the economic need for more standardization and a minimum benefit in terms of risk spreading and adverse selection? But give us a very brief point about why the plan in New Jersey, I think, failed.

Mr. REINHARDT. It failed because it wasn't accompanied by a mandate to be insured for a defined package. It doesn't have to be Cadillac. It should, however, cover what is necessary.

There was an initial study of it by Cathy Schwartz of Harvard, who reported that the New Jersey system worked well, but we, her colleagues argued, "This cannot be true, this will unravel." And sure enough, it did unravel, and I quote a paper here by Monheit et al and others that showed what happened to the New Jersey scheme. It imploded.

Mr. PASCRELL. I'm very proud of the fact that I'm the only legislator that voted against it in New Jersey at the time, and my worst analysis came true, unfortunately.

Mr. REINHARDT. You must be an economist, thought like one, because if those three things don't go together, markets will unravel. It's simply predictable. Young people will not insure, and wait until they can throw themselves on the mercy of a community-rated product.

That's why I favor a mandate, and there are various ways to rig this. One could tell people, "Look, if you postpone insurance and then want to join, you have to have a long waiting period, or your premiums will be higher."

In this country, we invite people to play games with adverse risk selection, because we allow people to change every year or even more frequently. If I had my druthers, I would not allow Medicare beneficiaries to join the private plan and come back within a year. I would say, "You have to do this for five-year periods," somehow to eliminate these games.

But that is what happened in New Jersey, so this is why, in my testimony, I stress those three things do have to go together: guaranteed issue, community rating, and a mandate to be insured, which of course, means you're forcing healthy young people to subsidize older, sicker people.

Mr. PASCRELL. Can I just continue, just for a second?

Mr. Sperling, what would your reaction be to Dr. Reinhardt on the three basic points that this reform of health care must have within it as ingredients, in order to—in Italian we say [Italian word]—in order for this stew to work?

Mr. SPERLING. Congressman, I've been in this business for 30 years. One of the first things I learned is never to argue with Dr. Reinhardt.

[Laughter.]

Mr. SPERLING. The concept of having everybody in, in order to have risk pooling, is something that is unassailable. He's absolutely right.

Mr. PASCRELL. So you agree with that?

Mr. SPERLING. He's absolutely right.

Mr. PASCRELL. You agree with that point?

Mr. SPERLING. Yes.

Mr. PASCRELL. Go ahead. What else?

Mr. SPERLING. Well, I think there's several aspects of the self-insured marketplace that work and can be applied as we try to expand access to——

Mr. PASCRELL. My point is this, that we can come to an agreement. This does not have to be us against them, whoever us is and whoever them is.

We can come to some real, basic common ground here, if we listen to one another, because I think you've said many good things in your presentation, and you were not just a corporate head here. You are listening to our needs, our concerns.

And Dr. Reinhardt does not want to provide a doorway into socialized medicine, but we do have to understand what the imperatives are today.

And on a simple thing like this, Mr. Chairman, we've lost out. When this country moves away from manufacturing, in those jobs, in those particular jobs, there was coverage. The more we moved into the service industries, there was less coverage, and therefore, affected everybody.

There are a lot of particulars here that make it complex, but I think we can come together. That's my opinion. Maybe I'm——

Mr. STARK. Thank you.

Mr. PASCRELL [continuing]. That's what I think.

Mr. STARK. Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Thank you.

And I appreciate the prior dialog, because I do think that there is some agreement. There are lots of specifics that we have yet to really hammer out, and I think that's where some of the different agreements may come.

But I was interested in following up on several of the points that were just made, and ask a few more specifics. I've been sitting here a long time, so I appreciate that, and your willingness to work with us.

But I am interested in the market reforms that we have some agreement on and some that are a little more uncertain.

Many of you talked about everyone being in. I appreciate that. We certainly talked about pre-existing condition exclusions being fairly unacceptable. I think even David Camp put that on his list of what he agrees on, which is huge, for many of my constituents. They can't find insurance.

Or obviously it's a huge issue for small businesses. Somebody gets sick, and it changes it dramatically.

Community rating, talked about that would change things for small businesses, as well. You wouldn't be just the 20 employees you have and the illnesses they may have. It's really very important.

And the ability to have some transparency, that you can really compare apples to apples, if you're looking at different plans, so that, as a recent report showed, someone who got catastrophic coverage, got cancer, thought that was catastrophic, but what catastrophic coverage meant was hospitalization, and most of her care was out-patient, and therefore, not covered. That's pretty unacceptable in this environment, going forward.

My question was a couple that didn't come up, and it has to do very much with people who are employed, who don't take their coverage, and I want to know what you thought about this.

There are people who have waiting periods. Their employer says you have to be employed for 6 months before you can get coverage.

I can understand some of that, because people come in and out of jobs, and they're not covered then for 6 months.

There are others who say you have to sign up in 30 or 60 days, otherwise you can't sign up in the future, ever again.

There are some who say you can sign up if you have a life change—unless you have a life-changing incident, you get married, divorced, someone dies.

So that even those who are employed and want to take coverage can't now get it if they make one little error, sort of. You know, they don't sign up in time. They have a pre-existing condition. Or they move jobs too often. They could have huge gaps in coverage.

So my question for you is, what do you think of requiring those who are employed to sign up? Now, they can opt out if they have coverage elsewhere, or if they want to—but actually making it automatic that when you're employed, you sign up; that's one question.

We did that with 401Ks, by the way, and it changed participation rates by double. It doubled the number of participation rates for 401K plans.

Just say, "You don't have to sign up, we're not going to make it complicated, you're in. You're employed. You know, you get a lunch break and you get health insurance if we provide it." Not saying that employers have to provide it. That's a different question.

So one is, you opt in. What do you think about ending waiting periods? You know, what do you think about, you know the—and of course, we already talked about pre-existing conditions.

And if you do think that we should do all of these changes in the market, are you talking about just making these changes and requirements for those who are in the exchange, or is it for everyone?

So even if you are an employer who decides to continue to provide coverage, and we expect most will, will these market changes, will these consumer protections, however you want to look at it, be true for them, as well?

Because with our constituents, I think that they feel very strongly that they want this insurance to be meaningful and they want—this is a huge struggle for them, coming in and out of their employer situations, and—as we know, more and more employees are going to change jobs over time.

Many of us who got the same job, stayed in the same business for 35 years, and then retired with a pension, it's kind of not the way of the world for the future. People are going to move around in jobs, certainly young people do.

So maybe just really quickly, I would like to start with Dr. Blumberg. Mr. Vaughan, I'd like you to talk about this, and Dr. Reinhardt, if we have time. It would be great to just have a sort of quick response on what do you think about these additional consumer protections, market reforms, and should they apply to everyone, every insurance company, every employer?

Ms. BLUMBERG. I think that we're talking ideally about a context where we have an individual mandate, that everyone is required to have insurance of at least a minimum acceptable amount, and in that context, if everyone is required to be covered, there should be no reason to have situations where you have waiting periods. Everybody is covered. They should be covered all of the time.

So, along with pre-existing conditions, we should be able to get rid of that.

In terms of open enrollment periods, which is the signing up within the 30 to 60 days, I think what we need to do is to make sure that we're making it as easy as possible for people to comply with the mandate.

So doing that would require that we use employers, because we know that people have very high rates of participation in the employment setting, with health insurance.

So to the extent that even if the employer is not contributing, we can use the employer to help facilitate that enrollment, I think we should do that.

If somebody does not enroll in coverage within a determined period of time, and then we look back and say, "Well, you should have signed up at the beginning of the year, but you haven't been covered for the last 2 months," we need to think about at how to create incentives to make sure people are complying at least in the longer term, if not right away after the reform is in place. We——

Ms. SCHWARTZ. Well, you're still saying that if someone did forget to sign up for 30 days—in those 30 days, how do they get in?

Ms. BLUMBERG. We have to let them in, but I think we need to have incentives for them to do it in a timely way so we don't have risk selection problems.

So maybe if I signed up three months late and I went without coverage for 3 months, I have to pay those back three months in premiums. Depending upon my income, I might be subsidized, I wouldn't have to pay the whole thing, but I'd have to pay that back premium——

Ms. SCHWARTZ. So you don't think just having people sign up and then you can opt out if you want to, wouldn't it just be easier to have people signed up?

Ms. BLUMBERG. We need to make it easy for people to sign up, but then we also have to enforce the requirements, and—that is going to require some kind of penalties, but I think we never exclude people under this type of reform.

Ms. SCHWARTZ. Any other quick comments?

Mr. VAUGHAN. I just want to thank you very much for your sponsorship of that bill to eliminate pre-existing conditions on children, which to have children denied care is crazy. So thank you. And agree with what was just said.

Other than a lot of people, the co-pays and their share of premiums in some companies can be high enough that a very low-paid worker just says, "Wow, I can't afford my car."

And so in whatever reform plan is adopted, hopefully everybody has at least a minimum, and it's affordable. And whether that's 5 percent of adjusted gross income, or 10, or something, that's between you and CBO and what you can work out, but it has to be affordable, as well as signing up.

Ms. SCHWARTZ. I think that we hear stories all the time—young people, and I think Dr. Reinhardt referred to the young people thinking that they are not at risk, you know, and they don't sign up, because they also don't think that they can afford the $20 a week, or $40 a week. If they never saw it, maybe they could afford it.

So some of it is helping people to know that they actually can participate in a way that is affordable, and just suddenly getting it, than getting sick and having a bill for $10,000, $20,000, $40,000, that they can never repay is a huge risk to them. I think a lot of people don't understand the risk-benefit to them personally, economically, as well as in terms of getting the right kind of health care.

So I just encourage you to think about this. I want to pursue this a bit more, just so we make sure that when we say everyone is in, they really are, and we make it easier, is the best way, but I think sometimes a lot is on your plate, and people don't sign up, and we ought to make it a whole lot easier for people to sign up by assuming they want health insurance, they get it through their employer, and we don't create obstacles 3 months, 6 months down the road.

Mr. STARK. Thank you.

Mr. Etheridge, would you like to inquire?

Mr. ETHERIDGE. Thank you, Mr. Chairman.

Let me thank each of you. I know you've been seated there a long time, and you've noticed we've been moving around and you've been in the seats, so I thank you for that.

Mr. Vaughan, let me ask you a question very quickly.

You know, we talk about access and others, but it seems to me that, in this country, if you want to drive an automobile, we require you to have car insurance. You know, it varies, depending on what you feel like you can afford and what your exposure might be.

And yet, for our own health care, maintaining our own bodies, we don't require that. It's sort of interesting.

But my question to you is, and probably one of the most complex problems with the health care insurance market is that insurers don't generally—really aren't in the business, I guess, of dealing with people who have the most costly and complex conditions.

By and large, as a result, people who tend to have the worst health care needs, people don't really want to insure them if you're already in, and if you're in, we're going to find a way to get out at some point.

Mr. VAUGHAN. That's the way you compete, if you're——

Mr. ETHERIDGE. I understand that. Rules are written that way, and I'm not blaming the insurance companies, but that's sort of the way the rules are written.

Mr. VAUGHAN. That's capitalism, yeah.

Mr. ETHERIDGE. And you got to be actuarially sound, or you can't make it, and if at some point you have diabetes or breast cancer or heart disease, the companies really don't have a great incentive to share their excellence in management or the cost of the way they help work it in, because there are some excellent things that happen, but it's not in their best interest to go out and share that data, because if they do, they're going to attract more people who have the same condition and——

Mr. VAUGHAN. Amen.

Mr. ETHERIDGE [continuing]. Just sort of, we're sort of working against ourselves.

So my question is this. What can be done to encourage best practices? Because I mean, that's really what we're arguing about, and

we aren't doing it. We don't do it just because our system is set up differently?

And number one, it would benefit the consumer if we had access to this information. And the private market has shown sort of an unwillingness to do it, simply because the rules are stacked against them, and it's not in their best interest to do it.

So how do we do that in terms of making it a better deal for the private sector so they can be in, and benefit all of us who are the consumers?

Mr. VAUGHAN. To the extent that you do get a mandate that everybody has to have a basic package, that gets rid of any need for pre-existing conditions. You'd get rid of that. And you'd risk adjust.

Now, risk adjustment isn't perfect, so they're still going to try to avoid the very sick example.

Mr. ETHERIDGE. Sure.

Mr. VAUGHAN. And this is a long-range solution, but in the comparative effectiveness research, the 1.1 billion you did this winter, and hopefully some more, some of the research requests that are coming in, we understand, might be on systems of how do you best treat complex cases.

And we've got, there must be 1,000 flowers blooming out there of different ways to treat the chronically ill, and we don't have a real good answer in the best one.

And I know research—mañana, mañana—you know, you want a quick answer, but I think we need some more data.

Mr. ETHERIDGE. I agree. I was in a rural health clinic the other day, where they're moving along with IT tied to one of our major hospitals, Wake Med, and there are some very promising stuff there, as we start to gather that data. It's very early, but they've already seen this driving some of their costs down in that regard, and I think that's the whole problem.

Mr. Hobson, in the limited time I have, let me move to another one, because in the past 2 years, my home state of North Carolina, the uninsured numbers have climbed to 22.5 percent, which is one of the biggest jumps in the nation.

And according to the analysis done by the North Carolina Institute of Medicine, nationwide, about 22 percent of adults do not have health insurance. In my home state, it's about 25 percent. As a result of the unemployment numbers climbing, we're the fourth highest in the nation now being unemployed. That means that all these numbers are getting even worse. There's about 10.7 percent.

So my question is, we're using rural health clinics in our state, and they're now seeing their numbers climb markedly, simply because people who are uninsured are finding this is an avenue to go, and we are, at the Federal level, putting some money in to help offset some of that, and at the same time, it doesn't totally offset.

So my question is, as we look at CHCs as a possible ingredient in all this, we don't—someone mentioned it earlier—we don't talk about it a lot, but whatever we do, we have a lot of rural, isolated areas, who invariably are going to be uninsured or under-insured, no matter what we do, because we don't have enough primary care physicians, and more and more people want to move to rural areas.

Is this an avenue for the CHCs to at least have a role in this process?

Mr. HOBSON. Absolutely. I think that rural health centers play a role of a key access point as medical homes, in some of the areas where fewer options are available to all of our citizens.

And when I talk to my colleagues, both from rural and urban parts of California, we're starting to see a greater percentage of people coming in who had some insurance coverage through their employment, but basically lost it during the past year, either because they lost their jobs, or because the economy has driven their employer to drop the health insurance option.

So I really feel that we may look at down the road is essentially that the resources that we have on the table for health centers might get stretched with this increasing new population of patients who seem to be finding their way to our doors, given the state of the economy that we're seeing today.

Mr. ETHERIDGE. Thank you.

Thank you, Mr. Chairman. I yield.

Mr. STARK. Mr. Yarmuth, would you like to inquire?

Mr. YARMUTH. Thank you, Mr. Chairman.

I may be in bad shape, but I hung around long enough to ask questions.

There's a point that's been made here a couple of times, and it's been used to make—or in fact, a prediction that has been used to support two arguments that I don't quite get.

One, and this is the idea that if we have a public plan, that 120 million or so people are going to move from the private insurance arena into the public plan.

Mr. Boustany used it to support saying that private insurers can't compete with the government, which I think is kind of ironic, because many times, my colleagues on that side are making the argument that the private sector is the ultimate competitor. They're saying they can't compete with the government.

But Mr. Sperling also used it to talk about how it would increase costs on the private employer-based plans.

But I also wonder whether, if it's true that a huge proportion of people who are now insured in the private arena moved to the public plan, doesn't that undermine your point that the private employer-based system is so popular?

And doesn't it underscore the need for a public plan, if so many people would move to a public plan? Doesn't that kind of, prima facie, support the case for a public plan?

Mr. SPERLING. Well, speaking on behalf of Hewitt and our experience with employers, sir, I think the study that Lewin and others have done, looking at a public plan, modeled those enrollment shifts based on the fact that the public plan and the private plan are not competing on an equal footing.

So it's comparable coverage, but people would move to a public plan because the cost is so much lower, not because it's more efficient——

Mr. YARMUTH. And that's a bad thing?

Mr. SPERLING [continuing]. But because it's paying the providers less.

Mr. YARMUTH. Isn't that one of the objectives that we're trying, presumably all of us are interested in achieving, is lower cost?

Mr. SPERLING. Well, I think we're trying for greater efficiency, but I think the study that was done looks at the fact that the reimbursements under the public plan would be so much lower that those two programs would not compete on a level playingfield and would undermine the employer system——

Mr. YARMUTH. Okay. I don't actually argue with that.

Second question. You talked about the polls that show that people prefer their coverage coming through their employer.

And I've talked to pollsters about the first question, are they satisfied with their insurance; and basically, they're satisfied that they have insurance, not necessarily that it comes through their employer.

And isn't one reason they prefer to have it through their employer is because they doubt if they're not getting it through their employer, that they can get good insurance? Isn't that a possibility, anyway?

Mr. SPERLING. What we hear from employees is that employees look to their employers to do some of the decisionmaking for them, because the insurance marketplace is fairly complex.

Mr. YARMUTH. Right.

Mr. SPERLING. So having that——

Mr. YARMUTH. I don't argue that——

Mr. SPERLING [continuing]. Ability of the experts to make those choices is something that employees value.

Mr. YARMUTH. I don't argue that, either.

One other question about a point you made, and that was that, and I agree, many private insurance plans, employer-based plans, do promote wellness and exercise and smoking cessation programs, and so forth.

You wouldn't argue that those things are impossible to do outside of an employer-based system, are they?

Mr. SPERLING. No.

Mr. YARMUTH. You don't make that argument.

I had a young woman who worked for me several years ago, and she was—had just gotten out of college, and just become—she's aged out of her family policy.

She had a lifelong allergy situation which required her to take medication that was $500 or more a month, and when she went into the private system, the only insurance she could get anywhere in Kentucky was something that excluded her medications.

Would you say that she would be in better shape with the existence of a public plan, in a competitive situation involving a public plan, or under a system that resembles the current system that we have now?

Dr. Reinhardt, Dr. Vaughan—I mean, Mr. Vaughan, would you specifically respond to that?

Mr. VAUGHAN. I think she would, and again, though, if the core benefit package is pharmaceuticals and hospitalization, the private sector may have to provide it, too.

Again, if she's real expensive, there will be an effort to hassle her to go somewhere else, and that's where it would be nice to have the public plan that would welcome her with open arms.

Mr. YARMUTH. Dr. Reinhardt.

Mr. REINHARDT. Yes, of course, in its present shape, the private market for individual policies really doesn't serve the needs of the American people, so there would have to be very stringent reforms, including a defined benefit package, in this case. This probably would be in there.

I just want to comment on this idea, that the Lewin study, which I actually have here, that people somehow would lose their private insurance. When I married my wife, I didn't lose all these other women. I chose my wife.

[Laughter.]

Mr. REICHERT. So I'm an immigrant, and I don't speak English too good, but I don't understand the word "lose" in this case.

The idea is that people would favor the public plan, because not only the money, they might because it's permanent, that if they lose their job, they lose. I'm a unique American, because I'm a tenured Ivy League professor. I'm not really part of the American experience. And therefore, this has never faced me.

But I look at all kinds of people. When they lose their employment, the minute you lose your employment coverage, the employer no longer cares about you, whether you're well or not. That's it.

And that kind of insurance, I think, cannot forever be preferred by people. They would want to have an insurance that, even if they lost a job in X Corporation, they would still have insurance. But now they don't.

And I think that's the big challenge of the employer, how could you provide some sense of permanence here, so that when you're down, the worst time in your life—I met two journalists the other day. Both lost their jobs, and they don't have insurance, and they just had a baby.

Now, I think that's a terrible situation for them, in this fix where they don't have income, also not to have insurance.

And this is why, in general, I think there has to be a stable plan, and if the private insurance industry could guarantee it, good for them, but if they can't, you have to ultimately own up to this public plan.

Mr. YARMUTH. I agree totally with you. Thank you for your testimony. I thank all of you.

Thank you, Mr. Chairman.

Mr. STARK. Thank you, and I want to thank all witnesses for your patience, your endurance, as we ground through this all today. It was very helpful.

And I hope you'll continue to give us your input as you hear from time to time which direction we're going over the next couple of months, as we attempt to come up with some kind of a plan that will provide affordable, quality health care to every American.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 1:22 p.m., the Committee was adjourned.]

[Submissions for the Record follow:]

America's Health Insurance Plans, Statement

Introduction

America's Health Insurance Plans (AHIP) is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products

in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We thank the committee for holding this hearing on the topic of insurance market reforms, and we appreciate this opportunity to outline our proposals for addressing this critically important issue. We also applaud President Obama for laying out a bold framework for comprehensive health care reform. We believe that legislation needs to be enacted and signed into law this year, and we are committed to playing a productive role in this debate.

In December 2008, AHIP announced a comprehensive proposal for moving the nation toward a restructured health care system that achieves universal coverage, reduces the growth of health care costs, and improves the quality of medical care. In March 2009, we announced our support for additional steps with respect to rating reforms, addressing the needs of small businesses, achieving cost containment, and reforming delivery and payment structures. Recognizing that the issues of coverage, affordability, and quality are interconnected, we believe they must be addressed simultaneously with market reforms that build upon the strengths of the current system and recognize that both the private sector and public programs have a role to play in meeting these challenges.

AHIP's proposals are the culmination of three years of policy work by our Board of Directors, which has focused on developing workable solutions to the health care challenges facing the nation. They also respond to the concerns and incorporate the ideas that were raised by the American people during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." This listening tour included roundtable discussions involving Americans from all walks of life, including people with and without insurance, small business owners and their employees, union leaders and members, elected officials, and community leaders.

The statement we are submitting for this hearing discusses insurance market reforms we are proposing in an effort to ensure that no one falls through the cracks of the U.S. health care system. These policy changes, if implemented in coordination with strategies to contain costs and enhance value, will help build a high quality, affordable health care system for all Americans.

II. Ensuring Portability and Continuity of Coverage for Consumers in the Individual Market

We are proposing to combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating preexisting condition exclusions and eliminating rating based on health status in the individual market.

We envision a rating system based on the following demographic factors: geography, age, and benefit design (or product type). We encourage Congress to provide flexibility for plans to offer premium discounts to individuals who make healthy choices, such as not smoking, participating in wellness programs, and adhering to treatment programs for chronic conditions. We also are exploring the development of a risk-spreading mechanism to protect consumers from the unintended consequences associated with these reforms.

Another key element of our proposal calls for premium assistance to ensure that coverage is affordable for lower-income individuals and working families. We are proposing refundable, advanceable tax credits that would be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level.

This approach recognizes that for guarantee-issue to work, it is necessary to bring everyone into the system. It demonstrates that health insurance plans have taken responsibility to advance reforms. At the same time, consumers have a personal responsibility to obtain coverage and the government has a responsibility to provide assistance to make coverage affordable.

Developments in the states demonstrate why it is important for individual market reforms to be pursued in conjunction with universal coverage. A report by Milliman, Inc. found that the enactment of guarantee issue and rating restrictions in the absence of an individual coverage requirement encourages people to defer seeking coverage until they have health problems—a situation which unfairly penalizes those who are currently insured and pay higher premiums because the costs of caring for the uninsured are shifted by providers to people who have coverage. According to the Milliman report, states that implemented these guarantee issue and rating restriction laws without adopting a policy that requires all individuals to participate in the system, experienced a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

III. Helping Small Business Provide Health Care Coverage More Affordably

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative functions. In March 2009, AHIP's Board of Directors approved a policy statement outlining solutions to help small business based on the following three core principles:

Affordability

- **Essential Benefits Plan:** As discussed below, we propose the creation of new health plan options that are affordable for small employers and their employees. These "essential benefits plans" would be available nationwide and provide comprehensive coverage for prevention and wellness as well as chronic and acute care. In addition, these plans would be subject to state regulation, but would not be subject to varying and conflicting state benefit mandates that result in increased costs to small businesses (and that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements).
- **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of Tax Code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.
- **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

Flexibility

We are committed to working with the small business community to ensure that small businesses have access to a range of options and tools that better assist them in helping their employees obtain health care coverage. One size does not fit all, as the needs of diverse small firms vary greatly.

- **Micro-firms:** As an example, "micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.
- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This "one-stop shop" could also allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

Simplicity

Small businesses may find the current system difficult to navigate with a lack of simple, streamlined information about multiple coverage and care options and related assistance programs. We propose modifications to introduce greater simplicity to the system through technology and regulatory reform and the creation of a one-

stop information source as described above. These proposed efforts will benefit all participants in the health care system, including the small business community.

- **Technological advances:** In our December 2008 Board statement, we emphasized that any health care reform proposal should include recommendations to streamline administrative processes across the health care system. Success will require advances in automating routine administrative procedures, expanding the use of decision support tools in clinical settings, and implementing interoperable electronic health records. Using technology to help streamline administrative processes will improve care delivery, enhance the provider and patient experience, and speed claims submission and payment. Done right, streamlining can also help reduce costs system-wide, leading to improved affordability.
- **Regulatory reform:** Regulatory structures should be rethought so that they work better and provide for a more consistent approach in areas such as external review, benefit plan filings, and market conduct exams. In a reformed market, policymakers should be driven by striking a balance between the traditional roles of the Federal Government and the states, and the objectives of achieving clearer and "smarter" regulation that promotes competition and avoids duplication of existing functions. Greater consistency in regulation and focusing on what works best will enhance consumer protections across states and help improve quality, increase transparency, and increase efficiency leading to reduced administrative costs.

IV. Strengthening the Large Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee morale. Thus, as a first priority, the nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that would reduce employer coverage. Focus should be placed on retaining a national structure for the large group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

V. Establishing an Essential Benefits Plan

Individuals and small businesses should have access to an affordable "essential benefits plan" available in all states that provides coverage for prevention and wellness as well as acute and chronic care. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates.

An essential benefits plan should include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, it should include coverage that is at least actuarially equivalent to the minimum Federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management.

Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve based upon new innovations in benefit design and the latest clinical evidence.

VI. Confronting the Cost-Shifting Surtax and Moving Toward a System That Pays for Value Rather than Volume

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance. A December 2008 study by Milliman, Inc. projects that this cost shifting essentially imposes a surtax of $88.8 billion annually on privately insured patients, increasing their hospital and physician costs by 15 percent. This study concluded that annual health care spending for an average family of four is $1,788 higher than it would be if all payers paid equivalent

rates to hospitals and physicians. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

The impact of cost-shifting is dramatically illustrated by the tables below, which use real data showing that hospitals in California recorded significant losses in 2007 by serving Medicare and Medicaid beneficiaries. These losses are offset, however, by higher costs charged to commercial payers. This cost shifting translates into higher premiums for working families and employers.

WAITING FOR RESPONSE FROM COMMITTEE RE: TABLES

In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care. This too results in cost-shifting to those with coverage in the form of higher premiums and other related costs. According to a 2005 Families USA study, the cost-shift due to uncompensated care adds $922 annually to family premiums. When these costs associated with uncompensated care are combined with the cost shifting that results from the underfunding of Medicare and Medicaid, the impact for families with private coverage is an overall surtax of $2,710 annually due to cost-shifting.

Ultimately, the success of health reform and getting all Americans covered will depend upon implementation of strategies that enhance value by improving quality and reducing costs, in conjunction with key insurance market reforms. Only by realigning incentives that drive improved outcomes will the system be placed on a long-term sustainable path. A recent monograph released by AHIP, entitled "Innovations in Recognizing and Rewarding Quality," highlights key private sector initiatives that have been implemented throughout the country to move the system toward a value-based structure. This publication demonstrates that innovative care coordination programs that enhance outcomes and reform payment incentives are in place in a private market with appropriate infrastructure, which is often lacking in public programs, to reform the health care system.

VII. Conclusion

AHIP appreciates this opportunity to outline our suggestions for enacting insurance market reforms as part of a comprehensive health care reform package. Our complete set of policy proposals—including innovative strategies to contain costs and improve quality—are outlined in a series of Board statements we have released since December 2008. We are strongly committed to working with Committee Members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.

David C. Goering, M.D., Letter

Dear Congressman Rangel,

As the health of our economy continues to worsen by the day, the deteriorating health of our citizens is overshadowed by the panic of the moment. As millions of Americans become unemployed—and uninsured—the need for reform is vital. Every year, more than 20,000 uninsured adults die because of delayed or denied health care due to unaffordable premiums or pre-existing conditions. There is indeed a golden opportunity to transform our health care system, and there may never again occur the confluence of a Democratic majority in Congress and a brilliant, progressive President who could guarantee the health care needs of all of our citizens.

President Obama has promised to sign health care financing legislation that will ensure access to affordable health care for all Americans. But how will this be accomplished? Thus far, there have been several "Healthcare Summits" held in Washington and around the nation. There has been a predominance of opinions from those in the private sector who are offering their expertise which is too often self-serving. Sadly, these "experts" have excluded the voices of tens of thousands of health care providers and millions of citizens who are calling for justice in health care financing. This would start with the elimination of the profit motive by corporations and their executives who are lavished with multimillion-dollar salaries derived from the premium payments of individuals and business.

President Obama was brought into power on the promise of change and the reduction of influence in government by wealthy individuals and corporations. Indeed, this influence, coupled with very reactionary conservative ideals, has obstructed the achievement of universal health care access in our Nation for decades. Our dysfunctional health care system, much of which is dependent on employer-based private insurance plans, is unable to control escalating costs, and has little incentive to do

so, as the private insurance industry has for years simply passed on higher costs to consumers by raising the premiums by large percentages each year. Furthermore, private insurance companies are inherently inefficient, with overheads between 15% and 30%, due to costs of advertising, underwriting, layers of bureaucratic management, highly paid executive and expectant investors in the case of for-profit insurance companies.

A single payer system would be far more efficient, modeled after Medicare, which has an overhead of about 3%. A single payer system would be equitable, treating all citizens with the same dignity and respect. A single payer system would give the government tremendous power to negotiate with providers in order to control health care costs. A single payer system would allow freedom of choice of providers by the patient who would not be restricted to certain panels of "preferred providers." A single payer system would relieve the mounting burden on business and industry that is wearing down our economy and hampering our ability to compete with foreign nations that have no anachronistic obligations of their employers. A single payer system would markedly reduce the complexity and expense that every provider, from the smallest physician practice to the largest hospital system, must endure in the current system of thousands of private insurance companies and multiple plans therein.

A single payer plan would be publicly financed, but privately delivered, just as Medicare is today. The Medicare payment system does not dictate how a physician practices medicine, but rather facilitates the adoption of quality measures and practices that lead to greater patient safety and improved health. President Obama does not have to draft this legislation, as there are already proposals in Congress that would provide the needed mechanisms to reform our health care system that is fragmentary and inefficient, and which allows hard-earned dollars from individuals and businesses to support, through premiums and tax subsidies, a private industry that puts profits before patients. This is not only unfair, but is immoral. Furthermore, the public sector collectively pays, through entitlement programs, tax subsidies and tax deductions, for over 60% of the 2.3 trillion dollar national health care expenditures.

Therefore, a transition to a single payer system would simply provide all citizens with the same health care benefits, and ensure, not insure, access to health care: everyone in, no one left out. The ultimate fair solution is clearly a single-payer system of financing that would be modeled after Medicare, an American system of publicly financed, privately delivered health care that has served our nation for over 40 years. In our current weakened economy, single-payer financing would save billions of dollars while providing coverage for all Americans. I respectfully suggest that Congress and President Obama strongly consider endorsing, promoting and passing legislation for single payer health care financing reform in our Nation.

Sincerely,

David C. Goering, M.D.
Kansas Health Care For All

Petaluma Health Center, Letter

Dear Honorable Members of the Committee on Ways and Means,

The Board, Staff and 14,000 patients of the Petaluma Health Center would like to provide some insight about how health care reform could affect our community and ensure greater accessibility and affordability of health care services locally.

A recent survey revealed that 12,000 people, or 10% of our community residents, have no health insurance and no medical home. These residents currently use the emergency room at our local hospital for episodic care.

Another 10% of our community have annual deductibles of between $1,000–5,000 per year. Most of our patients who have these very high deductibles face significant financial barriers to engaging in a "medical home" model of care. They can only afford to seek care when they have an illness that incapacitates them, or is catastrophic.

We have two full-time staff members who do nothing but help patients apply for Medicaid and various other programs that pay for episodic services. They are overwhelmed and need additional support during these difficult economic times.

Our community desperately needs health reform. We need all members of our community to have access to care:

1) In a real medical home like we offer at the Petaluma Health Center.

2) With a full range of services including primary medical, dental and men1al health care,
3) That is culturally and linguistically appropriate,
4) And without large deductibles and co-pays that become barriers to care.

We urge you to support Federally Qualified Health Centers to serve as a foundation of community health care services in every community, and tailor a health reform package that ensures access for all.

Sincerely,

Kathryn E. Powell, MA, MSHA
Chief Executive Officer

Phil Caper M.D. and Joe Lendvai, Letter 2

Health Care Reform—Build on What Works!

H.R. 676 The "Expanded and Improved Medicare for All Act"

On January 26th, 2009 Representative John Conyers (D–Michigan) introduced HR 676, The Expanded and Improved Medicare for All Act. The legislation would create a publicly funded, privately delivered health care system that improves and expands the already existing Medicare program to all U.S. residents. Perhaps its most reassuring feature is that it builds on Medicare, a program that already works, and is one of the most popular Federal programs in existence. It's not an experiment. It's a known, successful quantity.

The goal of the legislation is to ensure that all Americans will have access, guaranteed by law, to high quality cost effective health care services regardless of their employment, income or health care status. This program will cover all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, hearing services, long term care, palliative care, podiatric care, mental health services, dentistry, eye care, chiropractic, and substance abuse treatment. Patients have their choice of physicians, providers, hospitals, clinics, and practices. There are no co-pays or deductibles under this act.

Families will pay less under the new U.S. National Health Care Act, but equally important, so will businesses. Employer Health Benefits 2006 Annual Survey states that health insurers charged employers an average of $11,500 for a health plan for a family of four. On average, the employer paid 74% of this premium, or $8,510 per year. This figure does not include the additional 1.45% payroll tax levied on employers for Medicare. Under H.R. 676, employers would pay a 4.75% payroll tax for all health care costs. For an employee making the median family income of $56,200 per year, the employer would pay about $2,700.

Annual savings from enacting HR 676 are estimated at $387 billion. By focusing on illness prevention, simplified access to services, integrated chronic care, unified administration, electronic patient records, reduction of medical errors, less liability litigation, automated billing, and elimination of waste, enormous savings will be realized.

Expanded coverage can be almost completely financed through the savings listed above, and those achieved by eliminating the administrative costs, profits, marketing, claims payment and adjudication costs imposed on employers, employees and individual policyholders as well as providers by the existing private health insurance system. Those costs are estimated by credible sources to be as much as forty percent of total insurance company revenues and are one significant factor in explaining why Americans pay almost 50% more per-capita than the residents of any other country for medical care. Profits from private health insurance alone are estimated to be $150 billion a year. Not only that, but "Improved Medicare For All" will relieve both doctors and sick patients of the tremendous physical and emotional burden of fighting insurance company exclusions and denials.

Our Representatives in Congress need our help in resisting the financial and political power of the insurance lobby, and assuring that a publicly administered option to the private insurance market is an integral part of any reform package. Widespread support for HR 676 will provide that help. To that end, at their March 19 meeting the Hancock County Democratic Committee expressed its support and voted unanimously for a resolution that calls upon Federal legislators to co-sponsor HR 676, and work towards its enactment within the current Congress.

At this writing HR676 has 69 co-sponsors, including Maine's newly elected Representative Chelly Pingree, with many more expected in the coming weeks. Given

the current composition of the Senate, we here in Maine have a special responsibility to persuade the remaining three members of our congressional delegation, *Congressman Michaud and Senators Collins and Snowe (a similar bill has been introduced in the Senate by Senator Sanders), to support "Medicare For All" in order to make our existing profit-driven, fragmented health care system a thing of the past, and put our health care crisis behind us once and for all.*

The best part and greatest benefit of enacting HR 676 is that we, as a nation, will finally solve our health care crises. For the same total dollar amount we're now spending, an estimated $2.3 trillion in 2008, we will provide guaranteed health care to all Americans, including the 47 million uninsured and 50 million underinsured, many of whom are one unexpected illness away from personal bankruptcy or even homelessness.

It is time to make real change in our health care system, a change that works, a change that is fair and affordable and serves all Americans. Ask your representatives to be a co-sponsor for HR 676, The Expanded and Improved Medicare for All Act.

For more details about HR 676 please visit Congressman John Conyers website http://conyers.house.gov or www.pnhp.org or www.guaranteedhealthcare.org.

Phil Caper M.D.
Joe Lendvai

This Commentary appeared in the Ellsworth American on April 1, 2009.

Phil Caper, M.D. and Joe Lendvai, Letter

The health reform bandwagon is rolling in Washington. Committees in both houses of Congress are at work on health care reform, and many politicians are saying "now is the time." But meaningful reform is about a lot more than getting a few more people "covered." It must also be about reigning in the out-of-control cost, making sure health care is affordable and accessible by everyone and assuring that the right number and types of health professionals are there to care for the millions who are doing without decent health care.

Some in Congress want to require every American to buy private health insurance as a way to reach the goal of universal coverage. But private for-profit insurance is the wrong way to finance a universal system of health care. The insurance model is simply incompatible with the goals described above. Contrary to their branding efforts, health insurance companies are not really in the health care business. They are financial services companies. Their business model resembles those of banks more than of health care companies.

As if they were trying to prove this, when Maine enacted legislation some years ago requiring insurers to accept anybody who applied (guaranteed issue) and charge all policyholders in the same class the same premiums (community rating), most health insurers withdrew from the state. Anthem, Maine's only remaining for-profit insurer offering policies to individual policy holders, is now asking for permission to raise premiums between 17% and 34% above their already high levels.

Health insurers lack the capacity to control underlying medical costs. They also lack the will to do so, as their profitability is closely linked to their cash flow—the more money they process, the higher their opportunities for profits.

They maximize profits by "managing risk," that is by avoiding insuring sick people, and by denying the claims for payment of people they do insure. That is not an aberration, but is core part of their business model. That business model is fundamentally incompatible with the goals of a humane health care system.

America needs a system that does not rely on the insurance industry to provide basic health care. We need a system more like Canada's. Even though there is some minor grumbling by a few Canadians about waiting times for some discretionary services, their system is enormously popular. No Canadian faces crushing health care bills or bankruptcy due to unexpected medical costs. Canadians proudly view their health care system as being "the highest expression of caring for each other."

We already spend almost twice as much per person as the Canadians. That should be enough to provide high quality health care to all Americans. Sixty percent of the total costs of the dysfunctional U.S. health care system is already publicly financed. This figure includes huge tax subsidies that now amount to over $250 billion a year for the purchase of private insurance, but only if it is a fringe benefit of employment.

Only a simple tax-based system administered by an independent national healthcare trust fund is capable of controlling overall health care costs. The fund

would negotiate standard, reasonable and timely payments with all health care providers. No exclusions, no denials, no hassle. Everyone would have access to guaranteed health care. Instead of wasting time arguing with insurance companies about payments, doctors and nurses could focus on providing services to patients. A publicly financed, privately delivered system would also make the real costs of our system more visible and make true accountability possible.

Caring for each other. It is time for the American health care system to return to its roots—driven by mission rather than money. There are proposals in the Congress that would begin to move us toward that goal and rescue our failing health care system. They are the Conyers bill, H.R. 676 in the House, and the Sanders bill, S. 703 in the Senate. Congresswoman Pingree is already a co-sponsor of HR 676. We urge you to contact Congressman Michaud and ask him to join her as a co-sponsor of H.R. 676, and Senators Snowe and Collins to urge them to cosponsor S. 703.

In that way, we can join every other industrial country in the world in making access to affordable health care a right.

Phil Caper, M.D.
Joe Lendvai
Brooklin, Maine

This commentary appeared in the Bangor Daily News on April 17, 2009.

The American Academy of Actuaries, Statement

The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

As Congress considers various proposals to reform the individual health insurance market, the American Academy of Actuaries'[1] Health Practice Council appreciates this opportunity to submit written testimony outlining an actuarial perspective on market reforms. According to the latest estimates from the U.S. Census Bureau, about 45 million Americans under age 65, or 17 percent of the nonelderly population, lacked health insurance in 2007. The economic downturn has most likely led to an increase in the number of uninsured. Increasing access to health insurance coverage depends on making insurance more affordable, to individuals as well as to states and the Federal Government. Instituting health insurance market reforms are increasingly viewed as a method of increasing the availability of affordable insurance coverage. Although the potential impact of any given reform will depend on its specific details, actuarial considerations will be vital when determining whether particular proposals will lead to improved markets with increased access to affordable coverage. In particular:

- For insurance markets to be viable, they must attract a broad cross section of risks.
- Market competition requires a level playing field.
- For long-term sustainability, health spending growth must be reduced.

Insurance markets must attract a broad cross section of risks

For health insurance markets to be viable, they must attract a broad cross section of risks. In other words, they must not enroll only high risks; they must enroll low risks as well. If an insurance plan draws only those with high expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk. Adverse selection is a byproduct of a voluntary health insurance market. People can choose whether or not to purchase insurance coverage, depending in part on how their expectations for health care needs compare to the insurance premium charged. The higher premiums that result from adverse selection, in turn, may lead to more low risks opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding such spirals requires minimizing adverse selection and instead at-

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

tracting a broad base of low-risk individuals, over which the costs of high-risk individuals can be spread. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

How the various rules and regulations that apply to health insurance markets are defined can affect the degree of adverse selection. For instance, guaranteed-issue provisions can exacerbate adverse selection concerns, by giving individuals the ability and incentive to delay purchasing insurance until they have health care needs.[2] Likewise, pure community rating and adjusted community rating rules can raise the premiums for healthy individuals, relative to what they would pay if health status could be used as a rating factor.[3] This could cause healthy individuals to opt out of coverage, leaving a higher-risk insured population. Allowing insurers to deny coverage or to charge higher premiums to high-risk individuals can help reduce adverse selection by making insurance more attractive to healthy risks, but at the cost of reduced access to coverage and higher premiums for the higher-risk population.

Increasing overall participation in health insurance plans could be an effective way to minimize adverse selection. Requiring individuals to have insurance coverage is one way to increase participation rates, especially among low-risk individuals, and thereby reduce adverse selection risk. Other types of incentives are also available to increase participation, including: limiting open-enrollment periods with penalties for delayed enrollment, subsidizing premiums, and instituting automatic enrollment (i.e., opt-out rather than opt-in provisions). Medicare Parts B and D include some of these incentives. Nevertheless, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives.

In the absence of universal coverage, some degree of adverse selection is inevitable. And even with universal coverage, some insurance plans could end up with a disproportionate share of high-risk individuals. If plan premiums do not reflect this, the plan could be at risk for large losses. As a result, plans could develop strategies to avoid enrolling less healthy individuals. Risk adjustment could be used to adjust plan payments to take into account the health status of plan participants. This would reduce the incentive an insurer might have to avoid enrolling higher-risk individuals. In addition, some type of reinsurance mechanism could limit insurers' downside risk by protecting against unexpected high-cost claims.

Market competition requires a level playing field

For health insurance markets to be viable, plans trying to enroll the same participants must operate under the same rules. If one set of plans or insurers operate under rules that are more advantageous to high-risk individuals, then they will migrate to those plans; low-risk individuals will migrate to the plans more advantageous to them. In other words, the plans that have rules more amenable to high-risk individuals will suffer from adverse selection. Over time, the premiums for these plans will increase to reflect this, leading to more adverse selection and threatening the viability of those plans.

For example, if a regional health exchange or connector is created, and plans are offered inside and outside the exchange, the rules governing plans inside and outside of the exchange need to be the same. Otherwise either the plans inside the exchange or outside the exchange could get a disproportionate share of high-risk individuals, depending on which set of plans is subject to rules that are more advantageous to those in poorer health.

Similarly, adverse selection can occur when insurance is allowed to be purchased across state lines. High-risk individuals will purchase plans from states with stricter regulations (e.g., those mandating guaranteed issue and community rating), and low-risk individuals will purchase plans from states with looser regulations (e.g., allowing underwriting and premium variations by health status). Premiums for the plans in states with stricter regulations will increase accordingly, which could lead to even fewer insurance purchases among the low-risk population.

For long-term sustainability, health spending growth must be reduced

According to National Health Expenditure data, health care spending increased 6.1 percent in 2007. Although this is the lowest growth rate in a decade, it far exceeds the rate of inflation, and exceeds the growth in the overall economy as well.

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[2] Guaranteed issue provisions require that all health insurance applicants must be offered coverage, regardless of their health status or likelihood of large medical expenditures.

[3] Under pure community rating, every insured under a particular insurance plan pays the same premium; premiums cannot vary by factors such as age, gender, and health status. Under modified (or adjusted) community rating, premiums are allowed to vary, often within limits, by certain characteristics, such as age and gender. However, premiums are not allowed to vary by health status.

If health spending continues to grow at this pace, as projected, health insurance premiums will continue to increase as well. Unless health care costs are controlled, efforts to achieve universal coverage may be in vain. Reining in health insurance premiums in the near term will be for naught if rising health spending means that premiums will return to their original levels within a few years, and continue to rise rapidly thereafter. Therefore, to have the potential for sustainable success, health reform proposals need to focus on controlling the rate of health spending growth. And because there is mounting evidence that the money being spent for health care is not providing enough value and that the vast variations in health spending across the country aren't correlated with variations in health care outcomes, spending growth should be addressed within the context of quality and value reforms.

Several factors contribute to the growth in health spending, and there are options to address many of them, each offering promising opportunities to improve quality while reducing costs. The introduction of new technology and treatments can increase health care spending by increasing utilization, particularly of higher-intensity services. More comparative effectiveness research should be conducted to better ensure that new technologies and treatments add value, not just costs. Another driver of health spending growth is that current provider payment systems do not align provider financial incentives with the goal of maximizing the quality and value of health care provided. Instead, the most common provider payment mechanisms reward more care, and more intense care. Restructuring provider payment systems could result in more coordinated, cost-effective, and quality care.

Comprehensive insurance benefits, by lowering the cost of care to the insured, can also result in increased utilization of health care services. Although some of the utilization increases are for necessary care, some are not. Benefit design features such as cost-sharing requirements can be used to encourage more effective use of health care services. However, any incentives to make the insured, particularly those with chronic conditions, more sensitive to benefit costs should be balanced so that individuals are not discouraged from seeking needed care. Value Based Insurance Design (VBID), a relatively new concept in insurance benefit design, attempts to better target cost-shsaring requirements so they more effectively encourage needed care, yet discourage unnecessary care.

Conclusion

Health insurance market reforms have the potential to increase the availability of affordable health insurance coverage and, thereby reduce the number of uninsured Americans. However, for reforms to be viable, they must adhere to actuarial principles. In particular, insurance markets must attract a broad cross section of risks, especially low-risk individuals. Otherwise, adverse selection will result, potentially leading to a premium spiral. In addition, market competition requires a level playing field. Subjecting market competition to the same rules and regulations will help minimize adverse selection between plans and markets. And finally, health spending growth must be curtailed in order to ensure long-term sustainability.

The American Medical Association, Statement

The American Medical Association (AMA) appreciates the opportunity to present the views of our physician and medical student members regarding reforming the health insurance market to ensure greater accessibility and affordability. We commend Chairman Rangel, Ranking Member Camp, and members of the Ways and Means Committee for your leadership in recognizing the need to examine the problems in the health insurance market. The AMA agrees that major reforms are required to make the health insurance market work better for both physicians and their patients.

Covering the uninsured is a top priority of the AMA. The AMA believes that we must enact comprehensive health system reform that will cover the uninsured, improve our health care delivery system, and place affordable, high quality care within reach of all Americans. As advocates for patients, physicians have a particular stake in finding viable, effective approaches to these issues, especially the challenge of covering the uninsured. The AMA's comprehensive proposal to expand health insurance coverage and choice addresses the needs of all patients, regardless of income, and builds on the current employer-based system to promote individual choice and ownership of health insurance coverage.

The AMA proposal allows for the continuation of employment-based insurance in the private sector, while encouraging new sources of health insurance that would

be available to both the uninsured and the currently insured. Under our proposal, individuals who are satisfied with their existing coverage will be able to maintain that coverage. Those who are uninsured or dissatisfied with their current coverage will be able to purchase the coverage they want. One of the goals of our proposal is to give patients more control over their choice of health coverage and their own care and to preserve and improve the patient-physician relationship.

The AMA proposal is based on three pillars designed to expand health insurance coverage and choice: 1) helping people buy health insurance through tax credits or vouchers; 2) choice for individuals and families in what health plan to join; and 3) fostering insurance market reforms that establish fair ground rules and encourage the creation of innovative and affordable health insurance options. In addition, the AMA supports individual responsibility for Americans who have incomes of more than 500 percent of the Federal poverty level and can afford to purchase coverage. Those who cannot afford it and do not qualify for public programs should receive tax credits for the purchase of health insurance. Once affordable, everyone should have the responsibility to obtain health insurance.

The AMA proposes streamlined, more uniform health insurance market regulation, in tandem with targeted government subsidies for coverage of high-risk patients. Market regulations must establish fair ground rules in order for the private insurance market to function properly while also protecting high-risk patients without driving up health insurance premiums for the rest of the population. The sheer number and variety of state and Federal market regulations make it unnecessarily costly to provide health insurance in many markets. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of submarket (i.e., large group, small group, individual), geographic location, or type of health plan. Appropriate regulations would permit market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing, and premiums. Limited state variation in market regulation should be permitted as long as it does not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances or create adverse selection across states.

Health Insurance Exchanges

The AMA supports the creation of new opportunities to buy health insurance individually or as part of a group, such as health insurance exchanges modeled after the Federal Employees Health Benefits Program (FEHBP), small employer purchasing alliances, or health plans offered through professional, trade, religious, or alumni organizations. Insurance must be portable and individuals must have a choice among insurance options that best suit their needs. For those individuals who do not have access to or do not select employer-based insurance, the AMA supports establishing a health insurance purchasing exchange to increase choice, facilitate plan comparisons, and streamline enrollment that will assist individuals in choosing coverage that best suits their needs. Insurers should provide understandable and comparable information about their policies, benefits, and costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice.

Modified Community Rating

Strict community rating should be replaced with modified community rating. By allowing some degree of premium variation based on individual risk factors, but limiting premium differences within specified risk bands, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. Some degree of age rating is acceptable, as are lower premiums for nonsmokers, but an individual's genetic information should not be used to determine premiums or eligibility for coverage.

Guaranteed Renewability

The AMA supports the replacement of guaranteed issue regulations with guaranteed renewability. Guaranteed issue requires insurers to accept all applicants regardless of pre-existing conditions, even if they are uninsured. Similarly, prohibiting insurers from imposing pre-existing condition limitations means that insurers must offer the same level of benefits coverage to all applicants. In the context of the current market, which does not have an individual mandate, these regulations permit people to "free-ride" by waiting until they need medical attention to buy health insurance, exposing insurers and all those who have maintained their insurance coverage to unfair risk (once everyone has coverage through individual responsibility or an individual mandate, the concern about guaranteed issue is resolved). As an alternative, the AMA supports guaranteed renewability. Guaranteed renewability would protect individuals from losing coverage or being singled out for premium

hikes due to changes in health status, rewarding people for obtaining and maintaining coverage. Similarly, people who wish to switch health plans should face limited underwriting and pre-existing condition limitations, compared with those who are newly seeking coverage.

Individual Responsibility

The AMA supports requiring individuals and families who can afford coverage to obtain health insurance. Those earning greater than 500 percent of the Federal poverty level should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. The requirement would extend to people of all incomes only after implementation of subsidies for those who need financial assistance obtaining coverage (i.e., sliding-scale, refundable tax credits or vouchers to buy insurance). A requirement to have insurance would enable insurers to move toward community rating. Simplified, automated underwriting would result in de facto modified community rating, as the natural byproduct of market function rather than as a result of market regulation.

Targeted Subsidies for High-Risk Individuals

The AMA believes that insurance market reform must include protections for high-risk patients. The AMA advocates explicit, targeted government subsidies to help high-risk people obtain coverage without paying prohibitively high premiums. Risk-based subsidies make high-risk patients more attractive to insurers without driving up premiums for the general population. Such subsidies can take the form of high-risk pools, reinsurance, and risk adjustment. For example, providing subsidized coverage through high-risk pools gives insurers reassurance that they are unlikely to insure an unfavorable selection of high-cost enrollees in the regular market, allowing them to offer lower premiums and making coverage attractive to the young and healthy. Financing risk-based subsidies with general tax revenues rather than through premiums avoids the unintended consequences of driving up premiums and distorting health insurance markets.

Health Insurer Transparency

We believe that health insurance market reform must include efforts to improve transparency for patients and physicians. The AMA has long supported efforts to promote transparency in health care. We believe that empowering patients with understandable price information and incentives to make prudent choices will strengthen the health care market. To that end, we believe that all methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service. Disclosure of price information, however, can only be meaningful if, in addition to disclosure of physician fees, there is disclosure of insurance claims processing and payment practices. Without transparency on the part of health plans and insurers, both patients and physicians suffer.

Insurers must make available to enrollees and prospective enrollees information, in a standard format, about the amount of payment provided toward each type of service identified as a covered benefit. In addition, health plans and insurers should make medical payment policies, claim edits, and benefit plan provisions embedded in their fee schedules or "negotiated rates" available to patients. Physicians must also have access to health plan pricing information. Without this information, it is impossible for patients to know what their costs will be.

It is critical that employers and consumers have a clear understanding of how health care premiums are allocated by health insurance companies, and in particular how much of their premium dollar is spent on health care services as opposed to administration, profit, or other purposes. Full transparency of how health care insurance premiums are spent will empower patients, employers, and other health insurance purchasers to make more informed decisions, foster competition, and reward companies that minimize administrative waste.

Clarifying and illuminating health care claims payment and adjudication is the only way to ensure that patients will have accurate, current information at their disposal. Such information will enable them to make informed decisions about the most priceless thing in life—their health. Moreover, bringing health care pricing information out of the dark will allow physicians to regain some control over their practices and focus on what they were trained for—treating and healing their patients.

There are a number of claims processing and payment issues that have contributed to the incredibly difficult climate for physicians attempting to be paid promptly, accurately, and fairly by insurers. Failure to comply with state prompt payment claims and attempts to delay and improperly discount physician payments can financially debilitating effects on small physician practices and can severely limit pa-

tient access. Yet often, patients and physicians have little, if any, recourse to challenge health plan actions.

Efforts should be made to deal with prompt payment and other critical insurer payment practices. One-sided contract terms, lack of transparency or conformity in payer payment rules, repricing of physician claims, refusal to accept valid assignments of benefits, and other manipulative payment practices represent egregious business practices. These practices would be unacceptable in any other business context and should not be permitted to continue and flourish in the health insurance industry.

In conclusion, the AMA looks forward to working with you and your colleagues in Congress as you develop health system reform legislation. Thank you again for your strong leadership in this important endeavor.

The National Association of Health Underwriters, Statement

The National Association of Health Underwriters (NAHU) is a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. They have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and are in a unique position to report on which of these efforts have worked the best.

NAHU strongly feels that any health reform effort should be centered around employer sponsored plans, which efficiently provide comprehensive coverage to over 160 million Americans. However, employer-sponsored coverage is not the right choice for everyone; approximately 14.5 million Americans have private health insurance coverage that is not connected with an employer-sponsored plan.[1]

In terms of needed health insurance market reforms, NAHU believes the current individual health insurance marketplace is not always serving consumers in the most effective manner. In our work helping consumers from all over the country obtain private health coverage, we have observed that problems relating to access, preexisting conditions and affordability are prevalent nationwide. Since each state's individual market is uniquely regulated, consumers in some states are faring better than in others, but no state's individual health insurance market is problem-free.

Coverage for Everyone

One of the greatest problems with individual health insurance today is that not all Americans are able to purchase coverage. In some states, people with serious medical conditions who do not have access to employer-sponsored plans cannot buy individual coverage at any price.

One of the simplest ways to address the access issue in the individual market would be to require that all individual health insurance policies be issued on a guaranteed issue basis, without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. It would be unwise to require insurers to guarantee issue individual coverage to all applicants unless a system where nearly all Americans have coverage and full participation in the insurance risk pool has been achieved. Due to their small size and the propensity towards adverse selection, state individual health insurance markets are very fragile and price sensitive. Also, there currently is no controlled means of entry and exit into the individual health insurance market independent of health status, like there is with employer-group coverage. Without near universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. This, in turn, would undermine the core principle of insurance—spreading risk amongst a large population. The result

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements) http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3

would be exorbitant premiums like we currently see in states that already require guaranteed issue of individual policies, but do not require universal coverage or have a financial backstop in place.

Great care needs to be taken when implementing market reforms on a national level to not inadvertently cause costly damage to the existing private-market system. No matter how "fair" a market-reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

Recommendations to Achieve Near Universal Coverage

To bring everyone into the health coverage system, NAHU believes that Congress would be wise to look at our existing system for holes and examine what the states have done to successfully fill those coverage gaps. A few simple reform measures would go a long way toward extending health insurance coverage to millions of Americans. State small group health insurance markets and consumers ultimately benefited from the passage of Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); a similar measure that preserves state regulation and consumer protections for individual-market consumers but would also make coverage options more consistent and affordable is warranted.

Such requirements could either be enacted as part of a transition process to complete guaranteed issuance of coverage or they could be stand-alone requirements. In either case, NAHU believes that the following policy recommendations would have a profoundly positive impact on individual health insurance market access and affordability nationwide.

Recommendation 1: Require Guarantee Access to Individual Coverage with Qualified State-level Financial Back-stops for Catastrophic Risks to Keep Coverage Affordable

Federal access protections in HIPAA ensure that small-group health insurance customers and individuals leaving group health insurance coverage under specified circumstances must have at least one guaranteed-purchasing option. But these Federal protections do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer's plan do not have Federal guaranteed-issue rights. That means right now, in a number of states, there are people with serious medical conditions who cannot buy health insurance at any price.

Furthermore, in many of the 45 states[2] that have independently established at least one mandatory guaranteed-purchasing option for individual-market consumers with serious health problems, there are still access problems due to design flaws. For example, some states have required that all people be guaranteed access to all coverage on an immediate basis, without regard to health status. Unfortunately, merely requiring guaranteed issuance of individual coverage has led to adverse selection and, consequently, very high premium rates that create a barrier to entry for most consumers. On the other hand, in some states that allow for the consideration of health status, there can be a great deal of inconsistency in what types of risks are deemed to be uninsurable by individual carriers. Also, states with a high-risk health insurance pool often have funding difficulties that can result in high premiums and pool instability, both of which can be a barrier to entry.

While the mechanism for access to health care coverage may vary from state to state, access should not be denied to any American. The Federal Government should *immediately* require that all states have at least one guaranteed-purchasing option for all individual health insurance market consumers. But, beyond that, the Federal Government should also stipulate that a guaranteed-issue mandate, a designated carrier of last resort or a high-risk health insurance or reinsurance pool alone may not be a sufficient means of providing guaranteed access.

The best solution is a partnership between the private individual market and the mechanism for guaranteed access. A state's high-risk pool or reinsurance mechanism could serve as a backstop to insulate the traditional market against catastrophic claims costs. The Federal Government should establish broad guidelines for qualified state-level financial backstops (i.e., capped rates for high-risk individuals) to allow for state innovation but also ensure consistency of access and affordability.

Several states have been able to successfully combine a guaranteed-issue approach with universal underwriting criteria for all carriers and either a traditional high-risk pool or a reinsurance mechanism. When establishing state guarantee ac-

[2] The states without a guaranteed access mechanism are Arizona, Delaware, Georgia, Nevada and Hawaii. Furthermore, Florida's high-risk pool has been closed to new applicants since 1992, so it effectively also has no access mechanism for new medically uninsurable individuals.

cess requirements coupled with a financial backstop, two states in particular should be looked at as potential models:

Idaho

One of the most interesting arrangements is from Idaho. It is a hybrid arrangement—the only one of its kind—known as an individual high-risk reinsurance pool. Although the idea of reinsurance isn't new, Idaho is using it in a manner that is different than what has been done before. In Idaho, if a person's health status based on a medical questionnaire meets a certain threshold, the carrier can cede a large part of the financial risk for the individual to the reinsurance pool. Individuals who are insured in this manner are still issued a policy through the insurer they applied for coverage with, but must select one of four standard options. The coverage is still comprehensive, but the more limited benefit choices make administration of the reinsurance mechanism simpler. The carrier pays a premium to the pool in exchange for the pool taking on the risk of the individual's high claims. The individual consumer pays premiums to the insurer and has coverage issued by that insurer, not the pool itself. So the reinsurance mechanism is largely invisible to the consumer, although the premium is somewhat higher than the consumer would have otherwise paid. This program is funded through several mechanisms. First, the state's premium tax, paid by all insurers in the state, is the primary funding source and this is considered a stable funding source since it is not a state appropriation. In addition, when a carrier cedes risk to the pool, it pays a premium to the pool. Finally, the pool has the ability to assess insurance carriers for funding but, so far, it hasn't needed to do so. The Idaho pool is one of the few state programs that has more than enough funds to operate on a consistent basis.

New York

Another twist on the reinsurance concept is New York with its Healthy New York program. Small employers, sole proprietors and uninsured working individuals, regardless of health status, who meet set eligibility criteria and participation rules can purchase a limited range of comprehensive coverage options offered through private carriers and backstopped with a state-level reinsurance pool for extraordinary claims. This is a different kind of reinsurance than in Idaho, since it works on a retrospective basis but it is a great example of why a backstop can increase affordability. Although New York is a guaranteed issue state, it still uses this mechanism to spread the risk of higher risk participants. If we compare the rates for similar coverage in New Jersey, also a guaranteed issue state but with no financial backstop, it becomes clear that although premiums are higher than in non-guarantee issue states, the financial backstop provided by the reinsurance mechanism has improved affordability there.

Recommendation 2: Give Pre-existing Condition Credit for Prior Individual Market Coverage to Ensure True Heath Insurance Portability

The issue of pre-existing conditions and individual market coverage portability has been repeatedly identified as a problem. And it's not just a problem for people who have a serious medical condition when they apply for coverage. People who have obtained individual coverage when healthy and then acquired medical conditions over time can be limited in their ability to switch coverage plans due to pre-existing conditions and medical underwriting requirements.

To solve this problem, individual market health insurance carriers should be required to give individual health insurance market consumers credit for prior individual coverage, when changing insurance plans, if there is no greater than a 63-day break in coverage, just as is required in the group market by HIPAA. This means that existing individual-market consumers who wanted to switch health insurance products and/or health insurance carriers would be given credit against any pre-existing condition look-back or exclusionary periods equal to the amount of prior coverage they have. Furthermore, NAHU believes that the 63-day coverage window provisions should be amended to specify credit should be granted as long as the individual *applies* for coverage within 63-days, to protect individuals in cases where coverage cannot be issued immediately upon application.

However, to protect against adverse selection, a provision would also need to be included to address situations where individual-market consumers were substantially changing their level of coverage and/or benefits. In these cases, while credit for prior coverage would be applicable, carriers would still be able to assess for insurable risk when determining initial premium rates.

Recommendation 3: Standardize State-Level Requirements Regarding the Consideration of Pre-existing Conditions

Right now, state exclusionary and look-back periods for pre-existing conditions in the individual market range from none at all to five years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a Federal maximum look-back window of six months and a 12-month exclusionary period was established for the states. Having a pre-existing conditions rule that is consistent in both the individual and group model would also be much simpler for consumers to understand.

In the absence of a *fully implemented* and *enforceable* individual purchase mandate, plans and high-risk options must be able to look back at a new applicant's medical history and impose reasonable waiting periods in order to mitigate adverse selection. Until implementation is complete, greater standardization of limitations is necessary and warranted.

Recommendation 4: Improve Federal Group-to-Individual Coverage Portability Protections So that People Can Transition Directly From Employer Coverage to Individual without Hurdles

HIPAA attempts to provide individuals who are leaving group health insurance coverage with portability protections to make it easier for them to purchase coverage in the individual market. Unfortunately, the protections are confusing and many consumers unintentionally invalidate their HIPAA guarantee issue rights without realizing it and then risk being denied coverage when they apply for individual coverage.

Under current law, individuals who are leaving group coverage must exhaust either COBRA continuation coverage or any state-mandated continuation of coverage option if COBRA is not applicable before they have any group-to-individual rights under HIPAA. Once the consumer exhausts these options if available, then he or she can purchase certain types of individual coverage on a guaranteed-issue basis, provided that there is no more than a 63-day break in coverage. Each state was required under HIPAA to develop a mechanism for providing this coverage. The two most common state elections are to either allow HIPAA-eligible people to purchase coverage through a state high-risk health insurance pool, or to require all individual market carriers to guarantee issue HIPAA-eligible consumers at least two products, which are often priced higher than traditional individual coverage.

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

Recommendation 5: Stabilize Individual Market Rates by Requiring More Standardization as to How Individual Market Carriers Determine Pricing

Another inconsistency among both individual and small-group state individual health insurance markets is the way that premium rates are determined at the time of application. Most states allow for the use of medical history or health status as an underwriting factor. In a few states, the laws require that rates be the same for everyone regardless of gender, age, health status or geographic location (community rating). In a number of others, rating factors are determined by the state but are limited in nature (i.e., age, gender, industry, wellness, etc.), which is known as modified community rating. However, even in states with modified community rating, the rating factors and how they may be applied vary significantly by state. It is NAHU's view that state individual health insurance markets would benefit from greater standardization as to how premium rates are determined.

The first step to greater standardization would be for states to adopt a uniform application for applying for individual insurance coverage. A clear and understandable uniform application would assure full disclosure of accurate and consistent information when individuals apply for coverage. It would also be easier for consumers when applying for coverage with several different insurance carriers.

The Federal Government could also require that all states meet a minimum standard of rate stabilization by requiring modified community rating instead of health status rating. However, this would need to be undertaken slowly in order to

protect against extreme rate shock to some populations, especially younger individuals. Additionally, it is extremely important that wide adjustments be allowed for non-health measures. At a minimum, variations need to be allowed for applicant age of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should be allowed for other factors such as wellness plan participation, smoking status, industry, family composition and geography. Since we know that up to 50 percent of health status is determined by personal behavior choices [3], in order to have effective cost containment, we need to be able to reward healthy behavioral choices.

Recommendation 6: Increase Consumer Protections Regarding Individual Market Coverage Rescissions

All states should be required to develop an independent medical review process to resolve disputes concerning policy rescissions and/or pre-existing condition determinations. In addition, health plans should be required to limit rescissions to only material omissions and misrepresentations on the uniform insurance application. Health plans should be responsible for reviewing all applications received for clarity and completeness at the time off application and not after the policy is issued. If a carrier does not conduct a review of listed medical conditions on the application upon submission, it should not be allowed to use any subsequently obtained health information as a standard for a rescission, unless fraud or deceit has occurred. Health plan consumers should be clearly informed of their rights relative to rescissions and pre-existing condition determinations. Consumers also should be informed of their obligation to provide complete and accurate responses on health plan applications and to provide additional information at the time of application upon request of the health plan.

Recommendation 7: Making it Easier for Employers to Help People Purchase Individual Coverage

One of the biggest complaints about the individual market is that coverage is too difficult to purchase independently, and one of the greatest advantages of employer-group coverage is its ease of enrollment and payment. Many employers would like to offer their employees traditional health insurance coverage but simply can't afford to do so under current economic conditions or have an employee base that is difficult to cover under a traditional group scenario. As an alternative, employers should be allowed to work with licensed insurance agents and brokers to help employees purchase and pay for individual coverage by setting up a Section 125 plan, deducting premiums from wages, aggregating premiums and sending them to the insurer, and possibly providing a defined contribution. This would be a particularly appropriate coverage option for certain types of businesses that are rarely able to offer benefits to all employees (for example, restaurants and some small retail establishments) and for employees who may not be eligible for an employer's group plan, such as part-time or contract workers. This could help to draw many uninsured individuals into the private health coverage system. In addition, it could expand the size of the individual market, making it less fragile and, therefore, less costly.

However, current Federal law requires that all individual health insurance policies sold in a group setting are subject to ERISA and all of the HIPAA consumer protections relative to *group* health insurance plans, including the group guaranteed-issue and pre-existing requirements and all nondiscrimination provisions. Under current market conditions, practically no individual market policies can meet all of the HIPAA small-group protections since they are not designed for a product that is marketed to individual consumers. In addition, the sale of list-billed policies, which are individual policies where the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premium, is specifically prohibited by some states.

Congress should overturn state bans of the sale of list-billed policies and clarify that individual health insurance policies purchased by employees are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA or ERISA but rather the newly reformed rules for the individual market In addition, employees own these policies and they stay in force when workers leave their job. In particular, the Federal requirements regarding individual policies sold on a list-bill basis need to be clarified, since even mini-

[3] Mercer Management Journal 18. "The Case for Consumerism in Health Care" http://www.oliverwyman.com/ow/pdf_files/MMJ18_Case_Consumerism_Healthcare.pdf

mal involvement on the part of the employer could trigger group health plan requirements.

Congress should also establish that all individual health insurance policies sold under a list-billed arrangement are subject to all insurance regulations governing the issuance of traditional individual insurance policies in the state in which the policy was sold. This would include rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers, among other consumer protections.

Recommendation 8: Provide Federal Financial Assistance to Keep Individual Health Insurance Coverage Affordable

The most critical problem that we see in state individual health insurance markets is affordability, particularly for those individuals who have medical conditions. The high cost of coverage for these people often doubles as an access barrier.

There are clear broad-scale solutions that NAHU supports relative to coverage affordability. The most important of these is acting on the true underlying problem with our existing system: the cost of medical care. Health care delivery costs are the key driver of rising health insurance premiums, and they are putting the cost of health insurance coverage beyond the reach of many Americans.[4] Addressing the cost of care and its impact on the cost of coverage is critical in every market.

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

NAHU also supports targeted premium-assistance programs for low-income individuals purchasing private coverage, and we feel that the Federal Government should help finance such programs. A subsidy program could be national in scope, or each state could be required to create one that suits the unique needs of its citizens in partnership with the Federal Government. Several states like Oregon and Oklahoma have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform.

Finally, we support even more targeted means of providing Federal affordability assistance to individual market consumers, particularly to individuals with serious medical conditions. Since in any insurance pool of risk a small number of insureds incur the majority of claims, NAHU's access solutions alone, by guaranteeing that the highest-risk individuals are covered in a financially separate private-market pool will help lower costs for all consumers. But even more could be done to help lower costs.

Current limited Federal grant funds for high-risk pools have enabled a number of state high-risk pools to lower premiums and even start low-income subsidy programs. NAHU believes this funding should not only continue, but it should also be increased and expanded to the new qualified access mechanisms outlined in Recommendation 1.

Funding could be conditional upon a state's ability to meet federally established broad criteria regarding the framework of a qualified program. This may be the biggest bargain for Federal dollars that exists. A small amount of funding will go a long way, and the current $75 million grant has helped many pools establish low-income subsidy programs and disease management and other important programs for pool participants. New funding would be used to help subsidize premiums for the high-risk beneficiaries because, regardless of the backstop option the state creates, premiums alone in a state high-risk option will never be enough to satisfy claims, and premiums for participants in these programs must be at reasonable levels to ensure adequate participation. Funding could also be used as an additional backstop to state high-risk options that meet specified requirements for those rare individuals whose medical expenses are so great they would exceed high-risk pool lifetime caps.

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[4] PricewaterhouseCoopers. "The Factors Fueling Rising Health Care Costs, 2008." http://www.americanhealthsolution.org/assets/Uploads/risinghealthcarecostsfactors2008.pdf

Recommendation 9: Getting Everyone Covered

NAHU believes that implementing recommendations 1 through 8 will bring our country much closer to all Americans having health coverage. But an additional way to achieve the standard of near-complete coverage that is necessary for stand-alone guarantee issuance of coverage as well as controlled entry and exit into the individual insurance market is through the implementation of an enforceable and effective individual mandate.

NAHU has historically approached the idea of an individual mandate to obtain health insurance coverage with great caution. Similar mandates for auto insurance coverage have failed to reduce the number of uninsured motorists.[5] Also, subsidies, as well as benefit standards and enforcement mechanisms, would need to be created to fairly implement such a mandate. However, if such barriers could be overcome, enough people would be covered to mitigate the problem of adverse selection and its resulting cost consequences.

If the Federal Government were to require an individual mandate to obtain coverage, NAHU feels that it must be structured appropriately. The following elements are crucial to an effective and enforceable individual mandate:

- While the mandate may need to be phased in over time, starting with perhaps select populations like children age 25 and under, ultimately it must apply to all populations equally.
- An individual mandate must be accompanied by a national qualified guarantee access mechanism with a financial backstop as described in Recommendation 1 so that all individuals have cost-effective private health coverage options available to them. This is especially critical during the transition period, where the mandate is being put into place and the entire population is not yet insured.
- An individual mandate should not be accompanied by overly rigid coverage standards that would make coverage unaffordable and inhibit private plan design innovations.
- Subsidies in the form of direct private coverage premium assistance or refundable advanceable tax credits for the purchase of private coverage must be made available to low-income consumers.
- An effective coverage verification system must be created, with multiple points of verification.
- An effective enforcement mechanism would need to be implemented with multiple enforcement points and effective penalties for noncompliance.
- Each state must be responsible for enforcement of the mandate for its own population. The United States is too large and diverse a country for such a mandate to work otherwise.

Recommendation 10: Allow State Implementation with a Federal Fallback Enforcement Mechanism

States should be given a finite timeframe of several years to achieve these reforms through legislative or regulatory means. If a state cannot adopt the necessary reforms in the timeframe allotted, Federal enforcement through CMS should be the fallback, similar to the way CMS serves as the Federal fallback enforcement authority for HIPAA's small-group market requirements.

Conclusion

NAHU members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. We also help clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. We have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and we have based these individual market health reform policy recommendations on what we believe would be the most beneficial changes for individual health insurance consumers.

The NAHU membership urges Congress to carefully consider these ideas to improve individual health insurance coverage options for consumers nationwide. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look forward

[5] Insurance Research Council. "IRC Estimates that more than 14 Percent of Drivers are Uninsured." http://www.ircweb.org/news/20060628.pdf

to working with Federal and state policymakers to fill the gaps in our nation's coverage system and to make private individual health insurance coverage more affordable and accessible for all Americans.

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