

HEALTHCARE REFORM ROUNDTABLE (PART I)

HEARING
OF THE
COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS
FIRST SESSION
ON
EXAMINING HEALTH CARE

JUNE 11, 2009

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HEALTHCARE REFORM ROUNDTABLE (PART I)

THURSDAY, JUNE 11, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 3:09 p.m. in Room 216, Hart Senate Office Building, Hon. Christopher J. Dodd, presiding.

Present: Senators Dodd, Harkin, Mikulski, Bingaman, Sanders, Casey, Merkley, Enzi, Isakson, McCain, Alexander, and Hatch.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The committee will come to order.

Let me thank all of you for being here and I apologize for being a couple minutes late. We just finished a vote for the Senate, let me thank my colleagues, as well, for those who are supportive of that last effort. It's a long time coming and no one, more than I do, wishes that Senator Kennedy was sitting in this chair and banging down that gavel. He has a great relationship with every member of this committee and we all wish him the very, very best, the speediest of recoveries, and the hopes that he'll be back in this chair with this gavel in his hand before this process is over.

I want to thank my colleague from Wyoming, thank him for his support on this last vote we had on the tobacco issue, an historic moment that we're finally going to be able to regulate and control tobacco products which may be one of the major steps we can make in prevention and healthcare and begin to reduce the number of children who start smoking every day, the 3,000 to 4,000 that begin that habit.

I don't ever recall in my 29 years in this committee having a panel this large. I thought you were the audience when I walked in with this many people, but obviously we have a lot of ground to cover and so I want to be very brief in my opening comments, turn to my colleague from Wyoming for any opening comments he wishes to make, and then I'll introduce our witnesses, and we'll begin the process of hearing from each of you about this most important issue.

As Mike Enzi has said and I'm sure he may repeat it again, but it deserves being said by all of us, I don't know of another issue that any of us either have dealt with or will deal with that will have an impact on every one of our citizens in this country.

There are other issues that are huge and cover an awful lot of people, but this one touches 100 percent of Americans and every business, every consumer, every provider, as well, and so it's important we get this right. I'm very conscious of that, the magnitude of the job in front of us, to work in concert with the Finance Committee, Senator Max Baucus and Senator Chuck Grassley. I'm determined to achieve that same sense of comity and civility in this committee that's been a hallmark of the success in the past, to sit with each other, to listen to each other in these coming days as we try to fashion a product that all Americans can be proud of.

That doesn't mean there won't be differences that we'll have to confront and deal with, but to the extent we can work with each other and achieve the common ground and unanimity on many issues that I believe we can, we can make major steps forward in the achievement of the healthcare reform that I think all of us are so anxious to achieve.

Let me begin, as I said a moment ago, that there is no one who wishes our dear friend Ted Kennedy was sitting at this gavel more than I do. Many of us have been preparing for this moment for a long time but none longer than the chairman of this committee. Four decades, at least, he's been an advocate of healthcare reform.

Reforming our system so that every American has access to affordable, high-quality healthcare has been the cause of his life. He's been a leader on this issue for 40 years and he continues to be a leader in so many different ways and that doesn't depend upon location per se.

Today, we address an issue that affects, as I said, 100 percent of our fellow citizens. For far too many Americans, the costs are too high, the quality of care is inadequate, and too many of our citizens, one in every six, have no health insurance at all, and in today's economy, too many of our families find that the cost of healthcare puts stress on a family budget, to put it mildly.

We spend more than \$2 trillion on healthcare each and every year in our Nation, more than 18 percent of our Gross Domestic Product. By the year 2040, we're told by many experts, 34 cents of every dollar we spend could be on healthcare. That is not simply unacceptable, I hope, to all of us, it's unsustainable and therefore the sense of urgency that we share about this moment.

Premiums and out-of-pocket costs for individuals and families alike continue to skyrocket. In my home State of Connecticut, healthcare costs have shot up 42 percent in the last 8 years and today there are 322,000 people in my State that lack insurance.

It is wrong that so many families in any State and across our country go to sleep at night wondering what they will do if their children get sick or how they'll care for an ailing parent. It's a worry that we all can share from time to time.

Over the last few months, I have held town hall meetings, as many of my colleagues have, throughout my State. Ron Williams, by the way, of Aetna was a panelist at one of them and I thank him immensely. He's the CEO of a major insurance company, and he was there, listening to the concerns of people in Connecticut.

At one event in Connecticut, I met a mother terrified about what losing her health insurance could mean for her disabled toddler's future. At another, I spoke with a cancer survivor who now pays

as much for her healthcare as she does for the mortgage on her home because her husband passed away from leukemia and she's lost her employer-sponsored health insurance.

In fact, more than half of the families that go through bankruptcy in our country say that healthcare costs have contributed to putting them there. That's not the America we should be. I share and I believe that all of us share that goal.

We know that health reform is a difficult issue. If it were easy, we would have reformed our country's healthcare system years ago to assure quality affordable health coverage for all Americans, but we owe it to our citizens to bring about the change they need so desperately and finally today we have a president who has made it a priority, and a Congress who's poised to act.

If there is no other message out of today's hearing, it should be this: we will act to cut the skyrocketing costs of healthcare to our healthcare system, and we will at long last make quality affordable health insurance available to every man, woman and child in the United States of America.

Our goal is to protect people's choice of doctors, their choice of hospitals and of insurance plans, reduce the costs for families, businesses and government, and to assure affordable high-quality healthcare for every one of our citizens.

Our goal is also to strengthen what works and to fix what doesn't. If you like the insurance you have today, you should be able to keep it. If you don't like what you have today, we'll give you a better choice, including a public option for healthcare.

No longer will a pre-existing condition, such as a heart attack, cancer or even being the victim of domestic violence, prevent you from obtaining insurance. No longer will costs be a barrier to coverage.

Our approach will be to offer affordable options for Americans struggling under the skyrocketing costs of healthcare.

We have proposed a piece of legislation that we think will accomplish this great purpose. This is the first committee in Congress that will act on this important goal and as every single American will be affected by what we do in the coming weeks, we want to hear from a great variety of Americans on their views of how best to meet those goals and so we look forward to hearing from our witnesses today and witnesses tomorrow, as well, but even more importantly, we look forward to enacting real healthcare reform, that we'll be able to say to our citizens that we've advanced the cause of healthcare for every single American in our Nation. Delay or inaction is simply not an option for any of us. Healthcare reform cannot and must not wait.

With that, again I thank my colleagues, and the staff, for the tremendous amount of work that's already been done over the past many months on this issue. This is not the first time that we've gathered and our determination again is to work together and achieve, if we can and I believe we can, a strong bipartisan piece of legislation.

With that, let me turn to Senator Enzi.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you. I have a full statement that I'd like to have put in the record.

But I want to reserve as much time as possible for the roundtable and I do want to make some comments, besides what I have down here.

I know all of you have been asked to take a look at the bill that we're marking up and that kind of disturbs me. You know, you can't have a bipartisan bill that's written by one side and that's what it is.

We've been having a walk-through and I thank the Senator from Connecticut, Senator Dodd, for the tremendous way that he's working with us, so that we have an opportunity to look at options from everybody.

I have been working on this for several years. A couple of years ago Senator Kennedy and I sat down and listed out some principles and then because higher education was a very high priority and he dedicated most of his time to that, I collected ideas from both sides of the aisle to come up with a way that we could take care of everybody with healthcare. I called it a 10-step plan and I did 10 stops in Wyoming and promoted it and learned a lot more from that part of the process, as well, and I'm not the only one that's been working on that.

A lot of other people have put together proposals and all of those need to be considered. I have worked on a lot of bills with Senator Kennedy and with Senator Dodd. I have never worked on one that was as comprehensive as this one. This one will affect every single American. This will affect every business, every provider and every consumer.

We've never had a bill with so many moving parts and they have to be there in order to take care of the goal that we've set and I think both sides of the aisle have that goal of taking care of every American. How we get there, there's some differences on that, and our walk-through is pointing out some of those differences, some of the alternative ideas, and we've had some agreement through that process.

In fact, I find it to work a lot better than the normal mark-up process where you have to put up a certain amendment and then you can argue about pieces of the amendment or the whole amendment and vote them up or down.

This is a lot more constructive where staff have a chance to work on some specific language apart from the concept that we're doing and that's real important.

If we don't get this right, America will suffer. If we get it right, it'll be a great thing and we do have an opportunity to get it right. We shouldn't be subject just to time tables. We should be subject to getting it right and that may take a little bit longer, but I think it's important for us to do that.

I'm anxious to hear your ideas, whether they are in the bill or not. As you probably noticed, there are three major sections that are blank and we will find out what's in those later. Unfortunately, we have to have amendments in probably Monday, and those are extremely critical and I understand the reason that Senator Dodd

left those out was because there is some controversy over those and we need to have the time to put them together. That's what we're all hoping we can have, and that is some time to put it together. [The prepared statement of Senator Enzi follows:]

PREPARED STATEMENT OF SENATOR ENZI

Mr. Chairman, I firmly believe an ounce of prevention is worth a pound of cure. Congress has a unique opportunity to improve our health care system, but this bill misses the mark.

As the Senate's only accountant, and the only Senator to serve on the HELP, Finance and Budget Committees, which share jurisdiction over health care reform, I am concerned about the vast amounts of wasteful spending in the health care reform bill released by HELP Committee Democrats this week. This bill will pave sidewalks, build jungle gyms, and open grocery stores, but it won't bring down health care costs or make quality coverage more affordable. In a time of record debt and deficits, how can you justify the wasteful spending in this bill?

I believe we should instead focus on rooting out the waste, fraud and abuse that is driving up health care costs. Creating a whole slew of new wasteful programs will indeed bend the cost curve, but in the wrong direction.

Instead of providing mandatory spending on a vast array of public health programs, we should provide the CDC with a Director's fund, similar to the NIH common fund, which the Director can use to set priorities. A Director's fund improves CDC's planning, because the Director would have a consistent funding source, and clear authority to set priorities.

I agree that we need to be able to target funding towards specific public health issues, like obesity. But instead of taking multiple attempts at trying everything we can think of, we should be both more selective and more flexible in our approach. Consolidating programs allows more funds to be used on a bigger picture goal rather than small amounts of funds for smaller goals. Targeting spending will result in better outcomes because the experts with boots on the ground decide how to spend the money, not politicians.

We should allow States to streamline all health promotion and disease prevention funding to target the top 3 chronic conditions that cost that State the most. This provides the States with the flexibility to target their Federal grant dollars on the most costly chronic conditions. Finally, while States must be held accountable for spending Federal funds, they cannot achieve programmatic goals with multiple mandates.

I believe we should be thinking and planning for the long term, instead of praying for a quick fix and throwing money at the problem in a knee-jerk reaction. For example, many chronic health problems are caused by behavior, and are therefore preventable. But changing behavior, whether it is quitting tobacco, eating healthier, or exercising more, is one of the hardest things to achieve. One way to tip the balance toward change is to incentivize the behaviors we want to see. I think we should be able to use the health care system to provide incentives to keep people healthy, both on an individual level, and on a system-wide level. Unfortu-

nately, I don't see any of that in the bill we are scheduled to mark up.

Some of the programs proposed in this bill may have value, but this is the wrong bill and the wrong process. With our Nation's health and economy at stake, this bill must not turn into a Christmas wish list for every partisan interest group in Washington. I urge my colleagues to reconsider this scattershot approach and work with me to tackle our biggest health problems in a targeted, prioritized way.

Thank you.

Senator DODD. And we will do that. Let me just say to Senator Enzi and our colleagues, the goal is obviously to spend some time not only with you today listening to your thoughts and ideas on all of this and then tomorrow with another panel. This evening we will go back to our walk-through again as we listen to Senator Mikulski, who's got some thoughts, as well as Senator Murray, on the workforce issues and quality issues, and to revisit these other questions that have come up. As Senator Enzi pointed out, we left a couple of these sections blank very simply because they are controversial. Rather than trying to write something that could be seen as almost confrontational, I tried just to deal with the issues where I think there is at least some unanimity around purpose.

There are obviously differences in how to achieve those purposes. We will continue in that vein and my hope is that we can eliminate a lot of the dissent in certain areas, achieve a common language, and then in those areas where we can't, we will have to engage in that kind of a debate. Our purpose is to try and achieve as much bipartisanship as we possibly can in this effort.

Let me begin by thanking our witnesses. You are all very gracious to be here. A lot of you spent a lot of time on these issues and I want to introduce you all very briefly. My introductions of you will not do justice to your careers and your background and the experience you've brought to the positions you are in.

Dr. Margaret Flowers is a Maryland pediatrician, represents Physicians for a National Health Program where she has tirelessly advocated the benefits of a single-payer system, and we thank you very much, Doctor, for being with us.

I have already mentioned Ron Williams, the CEO of the Aetna Insurance Company, where he has focused on innovation and industry to improve access and affordability. I mentioned he's attended one of my very well-attended town hall meetings—700 people at one, 500–600 at others—as an insurance company executive to listen to people and respond to their concerns.

Mental health parity was one issue which Aetna took a leadership role on and again Senator Kennedy was a champion of that issue, but Aetna played a very constructive role in that, Ron.

Publicly, I want you to know how much we appreciate the efforts your company made in that regard.

Randel Johnson is the Vice President of Labor, Immigration, and Employee Benefits at the U.S. Chamber of Commerce, and is primarily responsible for employee benefits issues pending before the Congress and Federal agencies. We thank you, as well, for being with us.

Mr. William Dennis is a Senior Research Fellow at the National Federation of Independent Businesses, and he can provide insight on key healthcare issues that affect small business and that's been a major subject of our conversations. So we thank you, as well.

Mary Andrus is the Co-Chair of Health Care Task force with a Consortium for Citizens with Disabilities as well as Vice President for Government Relations at Easter Seals and has been a strong advocate throughout this process for individuals who face extra challenges.

Dr. Samantha Rosman is a member of the American Medical Association's Board of Trustees, has been a relentless physician advocate, even during medical school, for healthcare access to all, and we thank you, as well, for being with us.

Ray Scheppach—is that how you pronounce that? Ray Scheppach is the Executive Director of the National Governors' Association, has expertise in State and Federal budgets as they relate to healthcare policy, very important issue for us, as well.

Dennis Rivera. Where is Dennis? Dennis, good to see you. He's a good friend, is chair of the Healthcare at SEIU, has worked tirelessly for the United Healthcare Workers in an effort to fix our Nation's broken system.

Dr. Katherine Baicker—did I pronounce that correctly—is a Professor of Economics at Harvard University School of Public Health where her research focuses on the effectiveness of public and private health insurance.

Dr. Jonathan Gruber is the Professor of Economics at MIT and has been appointed to the Board of the Massachusetts Insurance Connector. I have been talking about Massachusetts a lot over the last 7 or 8 hours as we have asked questions all the time about how are things working in Massachusetts. We appreciate your presence here today.

Janet Trautwein, as well, is the CEO and Executive Vice President of the National Association of Health Underwriters and has a particular expertise in issues related to the uninsured, long-term care, and high-risk pools.

Commissioner Sandy Praeger. Commissioner, we thank you for being with us. Ms. Praeger is the Commissioner of Insurance in the State of Kansas, has been responsible for regulating all insurance sold in Kansas which includes overseeing nearly 1,700 insurance companies and 90,000 licensed agents. Is it a requirement to have white hair to be in Kansas? Kathy Sebelius, our new—

Ms. PRAEGER. [Off microphone.]

Senator DODD. Well, I love to see younger people with white hair. I have a bias.

Scott Gottlieb is a practicing physician and Resident Fellow at the American Enterprise Institute, has served as a senior policy advisor at CMS, and we thank you very much.

And closing out, I missed—oh, I'm sorry. Gerald Shea, AFL-CIO. Gerald, I apologize. Where are you? There you are. I apologize. I went right by you. Thank you. I apologize. Thank you for being with us.

Closing our first panel is Steve Burd—we heard from him at lunch today, the Democrats did—who is the Chairman, President and CEO of Safeway, and incidentally, as I mentioned at lunch

with the Democrats today in our Policy Committee lunch, left a very strong impression about what he's been able to do at Safeway, and thank you for being here with us, and we're anxious again to hear you today in this panel. Thank you, Steve, very much.

I'm going to ask you to keep opening statements brief, if you would. I know many have supporting documents. Let me say to all my colleagues, any opening statements, comments, supporting material will be included in the record and that includes our witnesses, and so we begin with you, Doctor, and again thank you for joining us.

STATEMENT OF MARGARET FLOWERS, M.D., MARYLAND CO-CHAIR, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, CHICAGO, IL

Dr. FLOWERS. Thank you, Senator Dodd and to the other Senators, for inviting me to speak to you today.

I speak on behalf of the majority of people living in America who desire a national health program. For decades, healthcare providers have struggled to provide care in an increasingly-difficult environment and it is taking a toll.

Doctors are leaving practice, refusing to accept health insurance, and there's a new category of physicians, disruptive physicians, who are expressing the dysfunction of a healthcare situation that places obstacles between them and the treatment of their patients.

The greatest obstacle is the private health insurance industry. This industry detracts from the health of our Nation rather than adding value to it.

We have reached a point in American history which allows us to finish what President Franklin Delano Roosevelt set out to accomplish almost 75 years ago with the Social Security Act, a national health system.

The lack of a coordinated and comprehensive nonprofit national health system sets us apart from other industrialized nations and we're seeing the results in increased costs and poor health outcomes.

For decades, reliance on the market and efforts to patch together a system using a public and private mix has failed to guarantee quality healthcare to all Americans. This reliance on the market dates back to the 1960s when there was a strong belief that America was so different from the other nations that our unique American market would solve our healthcare problems. We were wrong then and it's disappointing to see us continue to cling to this idea. This is not the time for more tinkering.

The healthcare market has allowed private health insurers to rake in obscene profits while nearly 50 million Americans lack health insurance and tens of millions more are underinsured. We are ranked the worst out of 19 industrialized nations in terms of preventable deaths which means a 101,000 preventable deaths in this country every year.

Healthcare in our country is already rationed based on ability to pay. Patients are waiting months to get in to see their doctors and some of them never even make it through the door. We provide little employment security, however we tie health insurance to em-

ployment. When people are most vulnerable, they are least protected.

In what other country do patients hold bake sales in order to pay for life-saving treatment? What other industrialized Nation allows millions of people to go into bankruptcy due to medical debt every year?

In 1809, Thomas Jefferson said, "The care of human life and happiness, not their destruction, is the legitimate responsibility of good government."

We have a moral imperative to create a health system that provides healthcare to all people, and I want to emphasize care, not insurance. The plan being put forth at present may be considered to be politically expedient but it will not address the fundamental problems in America today.

We need to have a full, open and honest discussion and I'm thankful for the opportunity to start that today. However, here are many experts who could help in the deliberations of this and I hope that we'll have a hearing on the topic of a national health program based on single-payer financing.

The price we are paying for the profit-driven healthcare market is the squandering of our economic, mental and physical health as a Nation. The market is the wrong model. Healthcare is not a commodity. It is a human right.

We must ask ourselves as we go through this process of reviewing health legislation today what are the results that we want to see. We consider success to be health security which means that every person will wake up knowing that if they need healthcare, they can get it, plain and simple, because it is their right and not their privilege.

Thank you.

[The prepared statement of Dr. Flowers follows:]

PREPARED STATEMENT OF MARGARET FLOWERS, M.D.

Dear Chairman Kennedy and Senators, thank you for inviting me to speak to you today from the perspective of a physician and activist. I am a pediatrician with experience both as the director of a hospitalist program and chair of pediatrics at a rural hospital and in community-based private practice. I am currently co-chair of the Maryland chapter of Physicians for a National Health Program (PNHP). PNHP has over 16,000 members nationwide. I also sit on the steering committee of the Leadership Conference for Guaranteed Health Care/National Single Payer Alliance which represents over 20 million people nationwide. I know that today I am speaking on behalf of the majority of people living in America who desire a national health program.

For several decades now we have seen the health care situation in this country deteriorate. Health care providers have struggled to provide care in this increasingly difficult environment and it has taken a toll. We are seeing doctors, like myself, leaving practice, doctors who are refusing to accept health insurance and a new category of doctors, disruptive physicians. These *demoralized physicians who become angry with their staff or patients* are expressing the dysfunction of a health care situation that places obstacles between them and the treatment of their patients. The greatest obstacle is the private health insurance industry. This industry detracts from the health of our Nation rather than adding value.

We have reached a unique point in American history and we have an opportunity for real health care reform. The economic downturn, the millions of Americans who can't get needed care and the election of a President who understands that health care is a human right place us in the position to finish what President Franklin Delano Roosevelt hoped to accomplish almost 75 years ago in the Social Security Act: a national health system. The lack of a coordinated and comprehensive national

health system sets us apart from the other industrialized nations and we see the results in markedly increased costs and poor health outcomes.

Current expectations are high. People are craving change. For decades, reliance on the market and efforts to patch together a system using a public and private mix have failed to guarantee quality health care to every person in America. The reliance on the market dates back to the 1960s when there was a strong belief that America was so different from the other nations that our uniquely American market would solve our health care problems. We were wrong then and it is disappointing to see us continue to cling to this idea. This is not the time for more tinkering. We cannot continue this Ponzi scheme of health insurance bailouts. This is the time to step back and look at the big picture.

The health care market has produced a situation in which private health insurers rake in obscene profits while nearly 50 million Americans lack health insurance, and tens of millions more with insurance still cannot afford the care they need. We are ranked the worst of 19 industrialized nations in terms of preventable deaths, over 101,000 each year. We have the highest infant and maternal mortalities. Health care in our country is already rationed based on ability to pay, even for those with insurance. Patients without insurance or with bare bones insurance may have to wait months to see a doctor, and many patients never even make it through the door. We provide little employment security compared to other nations, yet we tie health insurance to employment. As a result, when people have to stop working due to an illness or when a recession causes them to lose their jobs, they lose their health insurance as well. In other words, when people are most vulnerable, they are the least protected. In what other country do people hold bake sales to pay for life-saving treatments? What other country allows millions of people to go into bankruptcy because of medical debt? Almost two thirds of bankruptcies are related to illness or medical bills in this country. Shockingly, over three quarters of those who go bankrupt *had health insurance* at the start of their illness.

In 1809, 200 years ago, Thomas Jefferson said, "The care of human life and happiness, not their destruction, is the legitimate responsibility of good government." It is time to end the destruction of human life in this Nation. We have a moral imperative to create a health system that provides health care to all people. Senator Kennedy, I know that you and others who are seated here today understand this and hold this same belief.

The briefing paper put forth by this committee contains reform ideas that would improve health outcomes if they were part of a national system. However, the current reforms will not reach the goals of providing affordable high quality care for all people in America. These reforms will not be universal and will increase health care costs. I have outlined the reasons for this in my submitted testimony.

The plan being put forth at present may be considered to be politically feasible, although I question even that. It will not be practically feasible in that it will not address the fundamental problems in America today. In order to create a national health system that improves health, we need to have a full, open and honest discussion about it. I am thankful that we will start this discussion today. However, there is much to be considered and many people who can provide you with the data that you need in order to have a full deliberation about a national health program based on single-payer financing. The LCGHC respectfully requests that your committee and the Senate Finance Committee hold a joint hearing on the merits of a national single-payer health system in order to accomplish this. Also, we request that the Congressional Budget Office score a single-payer bill, either S. 703 or H.R. 676, against any other reform proposals.

The market has been very successful in providing enormous income to the few who administer and invest in the health industry. The price we pay for this is the squandering of our economic, mental and physical health as a nation. The market has failed to improve health and control costs because it is the wrong model. Health care is not a commodity, it is a human right. The United States signed the Universal Declaration of Human Rights in 1948. The other industrialized nations who have followed this human rights approach spend less and have better outcomes.

We must ask ourselves, as we go through this process of reviewing health legislation today, what are the results that we want to see? Will we continue down this path that has failed us for decades? Will we continue to fear the power of the medical-industrial complex? Or will we grasp this opportunity for real change? Will we create a health system based upon these few principles: that everybody has access to the same standard of care, that there are no financial barriers to care or financial consequences as a result of getting needed care and that medical decisions are made by patients in consultation with their medical providers based upon what is best for the patient rather than what they can afford? Will we provide health security, as embodied in the American Health Security Act of 2009, so that every person will

wake up in the morning knowing that if they need health care, they can get it, plain and simple, because it is their right and not a privilege?

COMMENTS ON THE LEGISLATIVE BRIEFING PAPER

The proposed reform is based on the belief that all we need to do is strengthen what works and fix what doesn't. While this sounds simple, it amounts to tinkering with a failed system rather than stepping back and looking at the root problems and addressing them. It is akin to continuing to add transmission fluid when what you really need is an overhaul. It isn't sustainable.

The reason that the reform is becoming so complex is because we refuse to stop and examine what it would take to create a health system. Instead, we are trying to apply a case of band aids to hold a failing health hodgepodge together. We will add bureaucracy, regulate and throw money at the private insurance industry in the hope that we can get it to act the way traditional Medicare already acts. There is no evidence to show that this will be successful and much evidence to show that it will fail. Are we willing to continue to allow thousands of Americans to die while we try this experiment? Is that morally right when we have a proven solution that will not only provide care to each person and prevent death, but will also save money? The solution is to create a national health system that is coordinated and comprehensive and that is based on single-payer financing. It is the only fiscally responsible solution. The solution is health care, not health insurance coverage. The solution is everybody in and nobody out. It is that simple.

President Obama said recently that we should make health insurance affordable, but exempt those who can't afford it. He also said that employers should have to share in the cost of health care, but that small businesses should also be exempt. We know that for 80 percent of the uninsured, the head of the household is employed, predominantly in small business. So we must ask what this would really accomplish. These exemptions mean that many of those who are currently left out will continue to be left out. This is not a solution.

The President also stated that "pouring money into a broken system only perpetuates its inefficiencies." Yet, pouring money into a broken system is exactly what is being proposed. As long as there is a multipayer system, even one that includes a "public option," there will be the added costs of determining who is eligible for which plan, who gets subsidies, who can go where and receive what treatment, who pays co-pays and deductibles and what happens if you lose your job or move. There are also the added costs of billing and regulating multiple insurers. A single health system will greatly simplify administration and will allow transparency and public accountability. A single health system will allow everybody to receive care and may not even mean any increased spending, according to the Congressional Budget Office and General Accountability Office.

I would like to discuss these revised legislative priorities:

1. Assure a single standard of high quality and affordable health care to all people in America.
2. Improve quality of health care by removing financial barriers to care so that patients can seek care early in their illness and receive needed treatment and simplify the administration/reimbursement of health care so that patients and providers spend less time on paperwork and authorization and more time discussing care.
3. Build a public health system that promotes wellness and prevention.
4. Create a durable structure of long-term supports and services for all people who need them.
5. Prevent fraud and abuse.
6. Remove financial consequences such as bankruptcy from medical debt and establish a progressive method of financing health care.

Assure a single standard of high quality and affordable health care to all people in America.

There are people who have health insurance and like it. However, no person with health insurance in America has health security. That is why even well-insured Americans who face job loss will lose their health insurance and may find themselves uninsurable. And that is why even those who are satisfied with their insurance are finding their ability to pay for it unsustainable. So one would ask, why the fact that they like their insurance means that we should build a system around it. There are people who like to drive without wearing seatbelts, but that didn't stop us from passing seatbelt laws because the evidence shows that it saves lives.

Americans often believe that they are well-insured, until they actually need to use their insurance and then encounter the complexities of it and the restrictions. The majority of people have low healthcare needs. In fact, 80 percent of the population

is relatively healthy and hasn't faced the difficulties of navigating the health insurance maze.

What Americans want is their choice of health provider and choice of treatment, not a choice of health insurance plan. Nobody is able to look at the different health plans and choose one that is "right" for them because health needs can change unpredictably. That is why one plan that covers all medically necessary care is the "right" plan. It is there when you need it and allows the patient to choose their medical provider and facility and to choose their treatment without interference from insurance administrators. A national health plan allows people to wake up in the morning and know that if they need health care that day, they can get it simply without having to search through provider networks and without waiting on the phone to get preauthorization for care.

The idea of adding a health insurance exchange adds cost (4 percent to every premium in Massachusetts) and perpetuates the idea that people can find the "plan that is right for them." And the idea of regulating insurance companies so that they will actually do what they are supposed to do, adds cost and administrative complexity. And, based on recent experience, regulation of health insurance companies is likely to fail to change their behavior.

The current private health insurance business model in the United States is designed to create profit by collecting premiums and restricting and denying care. Changing our for-profit and "not-for-profit" insurers into social insurance agencies, like there are in Europe, would require a radical amount of regulation and oversight. This seems like a lot of waste in order to preserve an entity that adds no value to health care.

Rather than adding expense in the form of regulation and an exchange, we could save an estimated \$350 billion on administrative and non-healthcare costs by creating a national single-payer system. These dollars would be applied to the delivery of actual health care.

It was stated in the briefing paper that the public plan being proposed is necessary because it will provide fiscal discipline and full accountability. Private health insurance must be removed from the national health system because it has raised costs and been abusive to patients and providers for too long without accountability.

Improve quality of health care by removing financial barriers to care so that patients can seek care early in their illness and receive needed treatment and simplify the administration/reimbursement of health care so that patients and providers spend less time on paperwork and authorization and more time discussing care.

Under a national health system, every person will receive a medical card that they have for life. The card is accepted at every facility so that no matter where a person is (at home or traveling), they can get health care.

There are multiple benefits to creating a national single-payer health plan:

- Every person has guaranteed care from the time that they are born until they die.
- There are no gaps or cracks to fall through so that care can be continuous.
- Patients can have a medical home because they will no longer be forced to change their doctor simply because they changed jobs, their employer changed plans or the plan changed its network.
- Out-of-pocket spending is reduced so that patients can get needed care. Currently about 53 percent of Americans delay getting care or filling prescriptions because of the cost. Multiple studies show that co-pays and deductibles usually lead Americans to make choices that are bad for their health.
- Health care costs are predictable and transparent for individuals, businesses, providers and facilities. Medical bankruptcies will end. Businesses, providers and health facilities will be able to devote their time and resources to doing what they do best: growing their businesses and taking care of patients.
- Medical decisions are made by the people who have received medical training rather than faceless insurance administrators who are looking at a computer screen rather than a patient. The doctor-patient relationship will be restored and improved as both work together to promote health.
- Patient privacy will be restored because administrators will not have access to clinical records in order to find pre-existing conditions that can be used to deny payment for care.
- Fewer providers will leave clinical practice and fewer providers will become disruptive under a system that is simpler to use and allows them to practice their medical skills.
- Public policy will be directed towards policies that improve health because there will be an incentive to invest in the health of the population being served by the system. It improves health outcomes and increases public approval.

Build a public health system that promotes wellness and prevention.

When every person is in the same plan, there is greater incentive to make it a high quality plan. At present, people who have low incomes are sometimes able to receive Medicaid, but across the United States, the quality of care under Medicaid is substandard. There is a saying that "a program for the poor is a poor program." And this is unacceptable. We cannot be healthy as a nation if there are disparities in access to care. Unfortunately, health disparities in the United States are increasing, especially for those with chronic disease.

Wellness will increase because care can be coordinated more easily when all providers are in the same network, similar to the way care is coordinated in the VA system. There is improved communication and less duplication of tests and treatments.

Under a national system, there will be a large database of health information that can be used to determine best practices and to allocate health resources to areas that need them.

Rather than wasting billions of dollars on administration, profits and marketing, we can use those dollars for public health education and prevention efforts.

The Federal Prevention and Public Health Council will be a valuable part of a national health system.

Create a durable structure of long-term supports and services for all people who need them.

There is certainly a need for people in the United States to receive supports and services so that they can be productive members of society and lead high-quality lives. The idea of a debit card that can be used to pay for these services will be greatly simplified under a national health system that is transparent and accountable.

The idea to retain a role for private insurance in long-term supports and services is questionable. One must ask why private insurance, which adds cost without adding value, is necessary. And one must also question why there would be a policy of requiring payment into the system for a number of years before receiving benefits. Our goal should be to meet the needs of everyone, not to exclude people. Such exclusions lead to poorer outcomes and less productive and satisfied lives.

Prevent fraud and abuse.

It is true that for any system, there must be a method to reduce or prevent fraud and abuse. A national health system will be transparent and held accountable, which will facilitate this process. The incentive for fraud and abuse decreases when the business model changes from the creation of profit to the provision of care.

Under a multipayer system, a new bureaucracy will need to be created in order to investigate fraud and abuse. This will add more cost and will be of questionable effectiveness. Despite current regulation of health insurers, it is difficult to discover and prosecute their acts of fraud and abuse. We could have a series of Senate hearings on the fraudulent and abusive practices of for-profit insurers.

The solution is not more regulation. The solution is to remove private insurers from involvement in paying for the provision of needed health care and create a publicly funded and privately delivered health care system.

Remove financial consequences such as bankruptcy from medical debt and establish a progressive method of financing health care.

The position paper speaks of shared responsibility, which can be translated to say that individuals must purchase health insurance. This is in itself abusive and not the type of shared responsibility that will improve our health outcomes and make us a better Nation.

To mandate that people purchase an over-priced product (private health insurance) that will still leave them at risk of medical bankruptcy if they become ill is cruel. It borders on extortion. In the States that have previously mandated the purchase of health insurance, such as Massachusetts, it has left people unable to afford health care and has required them to keep their income below a certain level in order to receive subsidies so they can afford insurance. More people (86 percent of the uninsured and 37 percent of the insured) are reporting difficulty affording health care in Massachusetts now than they were before the reform (85 percent uninsured and 29 percent insured).

In addition, the United States ranks 54th in the world for fairness in financing of health care. Health care financing is very regressive, with those of lower income paying a greater proportion of their income for health care. Given the widening gap between the rich and the poor in this Nation, this must change.

For years now, we have seen health insurers and employers shift more of the cost of health care onto the individual in the form of increased premiums, increased cost-sharing in payment for the premiums and increased co-pays and deductibles coupled with restrictions and caps on paying for care. The result is more uninsured people,

more medically bankrupt people, more people skipping needed care, more people facing difficult choices of getting needed care or providing for their family's needs and more people suffering and dying.

It is time to stop shifting the burden onto the individual for health care that should be treated as a human right and part of the social contract. Providing health care for the population is part of the social infrastructure that exists in civilized nations.

The optimal form of shared responsibility is to create a single publicly funded and privately delivered health care system in which everybody participates based on their ability to pay (with exemptions for those with the lowest incomes) and everybody receives the health care that they need when they need it. This is how we will lift our Nation out of poverty and become productive and healthy once again.

ATTACHMENT.—MEDICAL BANKRUPTCY IN THE UNITED STATES, 2007:
RESULTS OF A NATIONAL STUDY

(By David U. Himmelstein, M.D.,* Deborah Thorne, Ph.D.,† Elizabeth Warren, J.D.,‡ Steffie Woolhandler, M.D., MPH*)

ABSTRACT

Background: Our 2001 study in 5 States found that medical problems contributed to at least 46.2 percent of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened.

Methods: We surveyed a random national sample of 2,314 bankruptcy filers in 2007, abstracted their court records, and interviewed 1,032 of them. We designated bankruptcies as “medical” based on debtors’ stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

Results: Using a conservative definition, 62.1 percent of all bankruptcies in 2007 were medical; 92 percent of these medical debtors had medical debts over \$5,000, or 10 percent of pre-tax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well-educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6 percent. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001.

Conclusions: Illness and medical bills contribute to a large and increasing share of U.S. bankruptcies. © 2009 Elsevier Inc. All rights reserved. • *The American Journal of Medicine* (2009) xx, xxx.

Keywords: Bankruptcy; Health care costs; Health economics.

As recently as 1981, only 8 percent of families filing for bankruptcy did so in the aftermath of a serious medical problem.¹

By contrast, our 2001 study in 5 States found that illness or medical bills contributed to about half of bankruptcies.²

Since then, the number of un- and underinsured Americans has grown³; health costs have increased; and Congress tightened the bankruptcy laws.⁴

Here we report the first-ever national random-sample survey of bankruptcy filers.

METHODS

We used 3 data sources: questionnaires mailed to debtors immediately after bankruptcy filing; court records; and telephone interviews with a sub-sample of debtors.

Sample Design

Between January 25 and April 11, 2007, we obtained from Automated Access to Court Electronic Records, a list of all 118,308 bankruptcy petitions filed in the United States. We excluded filings in Guam and Puerto Rico, nonpersonal bankruptcies, and cases missing a name or address. Within 2 weeks of their filings, we mailed introductory letters to 5,251 randomly selected debtors; 275 were returned as undeliverable. We then mailed self-administered questionnaires to the 4,976 debtors with valid addresses; 2,314 (46.5 percent) were completed and returned; 124

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were returned incomplete (2.5 percent) and 83 (1.7 percent) declined to participate; 2,455 (49.3 percent of those with valid addresses) did not respond.

We compared court records (described below) of respondents with a random sample of 99 nonrespondents. Nonrespondents resembled respondents in income, assets, debts, net worth, market value of homes, and history of prior bankruptcy.

Questionnaire

Introductory letters described the study and offered debtors the option of obtaining a Spanish-language version of the questionnaire. The questionnaire and \$2 were mailed a few days later. Nonrespondents received replacement questionnaires, another \$2, and were invited to respond via telephone or on-line. Subsequently, we offered nonrespondents \$50 to complete the questionnaire.

The questionnaire asked about demographics, health insurance and gaps in coverage, occupation, employment, housing, and efforts to cope financially before filing. It also asked about specific reasons for filing for bankruptcy; the range of out-of-pocket medical expense (none, \$1–\$999, \$1,000–\$5,000, or >\$5,000); loss of work-related income; and borrowing to pay medical bills. Finally, it asked respondents if, for \$50, they would be willing to complete a follow-up interview.

Court Records

We obtained the public bankruptcy court records of respondents and the sample of nonrespondents from the Federal court's electronic filing system. Research assistants (mainly law students) abstracted each record.

The court records included the chapter of filing, income, assets, and debts outstanding at the time of filing. These records indicate the creditor to whom money is owed, but not why the debt was incurred.

Telephone Interviews

There were 2,314 debtors who completed questionnaires, 2007 of whom were willing to be interviewed. By February 2008, research assistants had completed telephone interviews (in English or Spanish) with 1,032 of them; 69 debtors no longer wished to be interviewed. We were unable to reach 906.

Interviewers collected additional detail about employment, finances, housing, borrowing to pay medical bills, and whether medical bills or income loss due to illness had contributed to their bankruptcy (questions we used to verify written questionnaire responses from the entire sample of 2,314 debtors).

The 1,032 telephone interviews identified 639 patients (debtors or dependents) whose health problems contributed to bankruptcy; details about medical expenses, health insurance, and diagnoses were obtained. Two physicians grouped diagnoses into 14 categories.

Telephone survey participants resembled other respondents on most financial and demographic characteristics. They were slightly older and better educated.

Clinical Significance

- 62.1 percent of all bankruptcies have a medical cause.
- Most medical debtors were well-educated and middle class; three quarters had health insurance.
- The share of bankruptcies attributable to medical problems rose by 50 percent between 2001 and 2007.

Data Analysis

We used data from the questionnaires and court records to analyze demographics, health insurance coverage at the time of filing, and gaps in coverage.

The questionnaires were the basis for our 2001–2007 time trend analysis. For this analysis, we replicated the most conservative definition employed in the 2001 study, which designated as “medically bankrupt” debtors citing illness or medical bills as a specific reason for bankruptcy; OR reporting uncovered medical bills >\$1,000 in the past 2 years; OR who lost at least 2 weeks of work-related income due to illness/injury; OR who mortgaged a home to pay medical bills. Debtors who gave no answers regarding reasons for their bankruptcy were excluded from analyses.

For all other analyses (i.e., those not reporting time trends) we adopted a definition of medical bankruptcy that utilizes the more detailed 2007 data. We altered the 2001 criteria to include debtors who had been forced to quit work due to illness or injury. We also reconsidered the question of how large out-of-pocket medical expenses should be before those debts should be considered contributors to the family's bankruptcy. Although we needed to use the threshold of \$1,000 in out-of-pocket medical bills for consistency in the time trend analyses, we adopted a more conservative threshold—\$5,000 or 10 percent of household income—for all other analyses.

Adopting these more conservative criteria reduced the estimate of the proportion of bankruptcies due to illness or medical bills by 7 percentage points.

To arrive at nationally representative estimates, we weighted the data to adjust for the slight underrepresentation of respondents who filed under Chapter 13 (bankruptcies with repayment plans). In calculating mean out-of-pocket medical expenses from our telephone interviews, we trimmed outliers at \$100,000.

Chi-squared and 2-tailed *t* tests were used for univariate analyses. We used forward stepwise logistic regression analysis on the 2007 cohort to assess predictors of medical bankruptcy and predictors of home loss or foreclosure among homeowners. Finally, we performed logistic regression using the combined 2001 and 2007 cohorts to examine whether the odds of a bankruptcy being medical were higher in 2007 than in 2001, after controlling for demographics, income, and insurance status. SAS Version 9.1 (SAS Institute Inc., Cary, NC) was used for all analyses.

Table 1.—Demographic Characteristics of 2314 Bankruptcy Filers and Comparison of Medical and Nonmedical Filers, 2007*

| | All bankruptcies | Medical bankruptcies | Nonmedical bankruptcies | P Value medical vs. nonmedical bankruptcies |
|---|----------------------|----------------------|-------------------------|---|
| Mean age | 44.4 years | 44.9 years | 43.3 years | .01 |
| Debtor or spouse/partner male | 44.5% | 44.9% | 44.3% | NS |
| Married | 43.9% | 46.3% | 40.1% | .02 |
| Mean family size—debtors + dependents | 2.71 | 2.79 | 2.63 | .02 |
| Attended college | 61.9% | 60.3% | 65.8% | .02 |
| Homeowner or lost home within 5 years | 66.7% | 66.4% | 67.8% | NS |
| Current homeowner | 52.3% | 52.0% | 53.2% | NS |
| Occupational prestige score >20 | 87.3% | 86.1% | 89.8% | .01 |
| Mean (median) monthly household income at time of bankruptcy filing | \$2,676 (\$2,299) | \$2,586 (\$2,225) | \$2,851 (\$2,478) | .002 |
| Debtor or spouse/partner currently employed | 79.2% | 75.5% | 85.0% | .001 |
| Debtor or spouse/partner active duty (military or veteran) | 19.4% | 20.1% | 18.4% | NS |
| Market value of home (mean) | \$147,776 | \$141,861 | \$159,145 | .03 |
| Mean net worth (assets—debts) | −\$41,474 | −\$44,622 | −\$37,650 | NS |

* Bankruptcies meeting at least one of the following criteria: illness, injury or medical bills listed as specific reason for filing OR uncovered medical bills >\$5000 or >10 percent of annual family income OR, lost \geq 2 weeks of work-related income due to illness/injury, OR depleted home equity to pay medical bills.

Human subject committees at Harvard Law School and The Cambridge Health Alliance approved the project.

RESULTS

The demographic characteristics of our sample are shown in Table 1. Most debtors were middle aged, middle class (by occupational prestige),⁵ and had gone to college. Their modest incomes reflect the financial setbacks common in the peri-bankruptcy period. Two thirds were homeowners.

Compared with other debtors, medical debtors had slightly lower incomes, educational attainment, and occupational prestige scores; more were married and fewer were employed (reflecting more disability). Medical debtors were older and had larger families. Although similar proportions were homeowners, medical debtors' homes had 11 percent lower market value. The average net worth was similar (and negative) for medical and nonmedical debtors (−\$44,622 vs −\$37,650, $P > .05$).

Medical Causes of Bankruptcy

Illness or medical bills contributed to 62.1 percent of all bankruptcies in 2007 (Table 2).

Unaffordable medical bills and income shortfalls due to illness were common; 57.1 percent of the entire sample (92 percent of the medically bankrupt) had high medical bills, proportions that did not vary by insurance status; 5.7 percent of homeowners had mortgaged their homes to pay medical bills; 40.3 percent of the entire sample had lost income due to illness; 95 percent of the lost-income debtors also had high medical bills.

Data from the detailed telephone survey yielded confirmatory results. When asked about problems that contributed very much or somewhat to their bankruptcy, 41.8 percent of interviewees specifically identified a health problem, 54.9 percent cited medical or drug costs, and 37.8 percent blamed income loss due to illness. Overall,

68.8 percent cited at least one of these medical causes. An additional 6.8 percent had recently borrowed money to pay medical bills.

Insurance Status of Debtors and Dependents

Less than one quarter of debtors—whether medical or nonmedical—were uninsured when they filed for bankruptcy; an additional 7 percent had uninsured family members (Table 3). Medically bankrupted families, however, had more often experienced a lapse in coverage during the 2 years before filing (40.0 percent vs 34.1 percent, $P = .005$).

Table 2.—Medical Causes of Bankruptcy, 2007*

| | Percent of all bankruptcies (In percent) |
|---|---|
| Debtor said medical bills were reason for bankruptcy | 29.0 |
| Medical bills >\$5,000 or >10 percent of annual family income | 34.7 |
| Mortgaged home to pay medical bills | 5.7 |
| Medical bill problems (any of above 3) | 57.1 |
| Debtor or spouse lost \geq 2 weeks of income due to illness or became completely disabled | 38.2 |
| Debtor or spouse lost \geq 2 weeks of income to care for ill family member | 6.8 |
| Income loss due to illness (either of above 2) | 40.3 |
| Debtor said medical problem of self or spouse was reason for bankruptcy | 32.1 |
| Debtor said medical problem of other family member was reason for bankruptcy | 10.8 |
| Any of above | 62.1 |

*Percentage based on recent homeowners rather than all debtors.

Table 3.—Health Insurance Status of Debtor Households With and Without Medical Causes of Bankruptcy

| | Medical Bankruptcy (In percent) | Nonmedical Bankruptcy (In percent) | P Value |
|---|------------------------------------|---------------------------------------|---------|
| Debtor or a dependent uninsured at time of bankruptcy filing | 30.8 | 30.7 | .93 |
| Debtor or a dependent had a lapse in coverage during 2 years before bankruptcy filing | 40.0 | 34.1 | .005 |

In multivariate analysis, being uninsured at filing did not predict a medical cause of bankruptcy, while a gap in coverage did (odds ratio [OR] = 1.35, $P = .002$). Other predictors included: older age (OR = 1.016/year, $P = .0001$), married (OR = 1.59, $P = .0001$), female (OR = 1.34, $P = .002$), larger household (OR = 1.97/household member, $P = .01$), and lower income quartile (OR = 1.30, $P = .0001$).

Medical debtors' court records identified more debt owed directly to doctors and hospitals than did nonmedical debtors', a mean of \$4,988 vs \$256, respectively ($P < .0001$). Medical debtors with coverage gaps owed providers a mean of \$8,338, vs \$2,740 ($P < .0001$) for medical debtors with continuous coverage. Nonmedical debtors had few medical debts, averaging under \$300 regardless of insurance status. (Medical debts financed through credit cards or other borrowing, or owed to collection agencies are not included because they cannot be identified through court records.)

Patients Whose Illness Contributed to Bankruptcy

Telephone interviews identified 639 patients whose illness contributed to bankruptcy: the debtor or spouse in 77.9 percent of cases; a child in 14.6 percent; and a parent, sibling or other adult in 7.5 percent. At illness onset, 77.9 percent were insured: 60.3 percent had private insurance as their primary coverage; 10.2 percent had Medicare; 5.4 percent had Medicaid; and 2 percent had Veterans Affairs/military coverage. Few of the uninsured lacked coverage because of a pre-existing condition (2.8 percent) or belief that coverage was unnecessary (0.3 percent); nearly all cited economic reasons.

By the time of bankruptcy, the proportion of patients with private coverage had fallen to 54.1 percent, while the percentage with Medicare and Medicaid had increased to 16.4 percent and 9.9 percent, respectively. The proportion whose employers contributed to coverage decreased from 43.2 percent to 36.6 percent.

Out-of-pocket medical costs averaged \$17,943 for all medically bankrupt families: \$26,971 for uninsured patients, \$17,749 for those with private insurance at the outset, \$14,633 for those with Medicaid, \$12,021 for those with Medicare, and \$6,545

for those with Veterans Affairs/military coverage. For patients who initially had private coverage but lost it, the family's out-of-pocket expenses averaged \$22,568.

Among common diagnoses, nonstroke neurologic illnesses such as multiple sclerosis were associated with the highest out-of-pocket expenditures (mean \$34,167), followed by diabetes (\$26,971), injuries (\$25,096), stroke (\$23,380), mental illnesses (\$23,178), and heart disease (\$21,955).

Hospital bills were the largest single out-of-pocket expense for 48.0 percent of patients, prescription drugs for 18.6 percent, doctors' bills for 15.1 percent, and premiums for 4.1 percent. The remainder cited expenses such as medical equipment and nursing homes. While hospital costs loomed largest for all diagnostic groups, for about one third of patients with pulmonary, cardiac, or psychiatric illnesses, prescription drugs were the largest expense.

Our telephone interviews indicated the severity of job problems caused by illness. In 37.9 percent of patients' families, someone had lost or quit a job because of the medical event; 24.4 percent had been fired, and 37.1 percent subsequently regained employment. In 19.9 percent of families suffering a job loss, the job loser was a caregiver.

Changes in Medical Bankruptcy, 2001 to 2007

In our 2007 study, 69.1 percent of the debtors met the legacy definition of medical bankruptcy employed in our 2001 study, a 22.9 percentage point absolute increase (49.6 percent relative increase) from 2001, when 46.2 percent met this definition ($P < .0001$). (Inflation, which might edge families over our \$1,000 medical debt threshold, did not account for this change. An analysis that used all criteria except the size of medical debts found a 48.7 percent relative increase. An analysis limited to the 5 States in our 2001 study yielded virtually identical findings.)

In multivariate analysis, a medical cause of bankruptcy was more likely in 2007 than in 2001 (OR = 2.38, $P < .0001$) (Table 4).

Table 4.—Multivariate Predictors of Medical Causes of Bankruptcy, 2001 and 2007 Combined

| | Odds ratio | 95 percent confidence interval | <i>P</i> Value |
|--|------------|--------------------------------|----------------|
| Age | 1.02 | 1.01–1.02 | .0001 |
| Married | 1.32 | 1.13–1.55 | .0006 |
| Own home now or in past 5 years | 1.10 | 0.93–1.30 | NS |
| All family members insured at time of filing | 1.23 | 1.03–1.46 | .02 |
| Gap in health insurance coverage for any family member within past 2 years ... | 1.64 | 1.38–1.94 | .0001 |
| Income quartile | .99 | .82–1.07 | NS |
| Attended college | 1.02 | .87–1.18 | NS |
| Year of bankruptcy filing, 2007 vs. 2001 | 2.38 | 2.05–2.77 | .0001 |

DISCUSSION

In 2007, before the current economic downturn, an American family filed for bankruptcy in the aftermath of illness every 90 seconds; three quarters of them were insured.

Since 2001, the proportion of all bankruptcies attributable to medical problems has increased by 50 percent. Nearly two thirds of all bankruptcies are now linked to illness.

How did medical problems propel so many middle-class, insured Americans toward bankruptcy? For 92 percent of the medically bankrupt, high medical bills directly contributed to their bankruptcy. Many families with continuous coverage found themselves under-insured, responsible for thousands of dollars in out-of-pocket costs. Others had private coverage but lost it when they became too sick to work. Nationally, a quarter of firms cancel coverage immediately when an employee suffers a disabling illness; another quarter do so within a year.⁶ Income loss due to illness also was common, but nearly always coupled with high medical bills.

The present study and our 2001 analysis provide the only data on large cohorts of bankruptcy filers derived from in-depth surveys. As with any survey, we depend on respondents' candor. However, we also had independent checks—from court records filed under penalty of perjury—on many responses. Because questionnaires and court records were available for our entire sample, we used them for most calculations. The lowest plausible estimate of the medical bankruptcy rate from these sources is 44.4 percent—the proportion who directly said that either illness or medical bills were a reason for bankruptcy. But many others gave reasons such as “aggressive collection efforts” or “lost income due to illness” and had large medical

debts. Indeed, detailed telephone interview data available for 1,032 debtors revealed an even higher rate of medical bankruptcy than our 62.1 percent estimate—at least 68.8 percent of all filers.

Our current methods address concerns expressed about our previous survey. We assembled a random, national sample and asked far more detailed questions. In addition, we adopted more stringent criteria for medical bankruptcy. Adopting an even more stringent threshold for medical debts (e.g., eliminating those with medical debts below 10 percent of family income) would reduce our estimate by <1 percent.

Teasing causation from cross-sectional data is challenging. Multiple factors push families into bankruptcy. Yet, our data clearly establish that illness and medical bills play an important role in a large and growing proportion of bankruptcies.

Changes in the Law

Between our 2001 and 2007 surveys, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which instituted an income screen and procedural barriers that made filing more difficult and expensive.

The number of filings spiked in mid-2005 in anticipation of the new law, then plummeted. Since then, filings have increased each quarter. They are likely to exceed 1 million households in 2008, representing about 2.7 million people.

BAPCPA's effects appear nonselective. Current filers differ from past ones mainly in having struggled longer with their debts.⁷ New restrictions fall equally on medical and nonmedical bankruptcies, with no preferences for medical debts or sick debtors. It is implausible to ascribe the growing predominance of medical causes of bankruptcy to BAPCPA.

Conversely, there is ample evidence that the financial burden of illness is increasing. The number of under-insured increased from 15.6 million in 2003 to 25.2 million in 2007.³ Of low- and middle-income households with credit card balances, 29 percent use credit card borrowing to pay off medical expenses over time.⁸ Collection agencies contacted 37.2 million Americans about medical bills in 2003.⁹ Between 2005 and 2007, the proportion of nonelderly adults reporting medical debts or problems paying medical bills rose from 34 percent to 41 percent.¹⁰

Adding to Other Studies

We have reviewed elsewhere the older studies on medical bankruptcy.^{2 11} Most rely exclusively on court records where many medical debts are invisible, disguised as credit card debt or mortgages. In our cohort, most medical debtors had charged unaffordable medical care to credit cards.

Similarly, debts turned over to collection agencies by doctors or hospitals may be unrecognizable on court records. Moreover, income loss due to illness cannot be identified. In short, even though such studies find substantial rates of medical bankruptcy,^{12 13} estimates based solely on court records understate medical bankruptcies.⁹

Population-based studies also are problematic because many debtors are unwilling to admit to filing. Thus, a study based on the Panel Survey of Income Dynamics could identify only 74 bankruptcies (0.4 percent of respondents), half the actual filing rate among the national population from which the sample was drawn.¹³

A few studies employed novel methods to analyze medical bankruptcy. One found a high bankruptcy filing rate in a cohort of patients with serious neurologic injuries.¹⁴ A survey of cancer patients documented a 3 percent bankruptcy rate; 7 percent had taken a second mortgage to pay for treatments.¹⁵ A questionnaire-based study found medical contributors to 61 percent of Utah bankruptcies; 58 percent of families seeking help at bankruptcy clinics in upstate New York reported outstanding medical debts.¹⁶

Medical impoverishment, although common in poor nations,^{17 18} is almost unheard of in wealthy countries other than the United States.¹⁹ Most provide a stronger safety net of disability income support. All have some form of national health insurance.

The U.S. health care financing system is broken, and not only for the poor and uninsured. Middle-class families frequently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones.

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COVERAGE MANDATE WILL FAIL AS A HEALTH-CARE REFORM PLAN

(By Rose Ann DeMoro)

It's time for Congress to stop getting carried away with financial bailouts for big industries, especially when it comes to some of the most-profitable and least-responsible companies: the health-insurance giants.

Two major trade lobbies, America's Health Insurance Plans and the Blue Cross-Blue Shield Association, have announced that they would be willing to end their disgraceful practice of excluding people from coverage based on their health or age. In exchange, they want the Federal Government to force uninsured Americans to buy private insurance.

That would be exactly the wrong direction for health-care reform. Proposing mandatory coverage as the solution overlooks the one-fourth of insured Americans who are rationing their own medical care because they can't afford to pay the bills. One in eight late-stage cancer patients turns down recommended care because of the cost, according to a recent report in *USA Today*.

And let's not forget the insured patients who are denied needed treatments that their insurers don't want to pay for.

A mandate for individuals turns the challenge of health-care reform on its head. It would be a massive bailout for one of the most merciless industries in America—and one that's already rolling in cash. The 18 biggest insurers reported \$16 billion in profit last year.

Now, in exchange for promising the coverage they should have provided all along, these insurers are demanding additional billions of dollars in profit from people who would face fines or other penalties if they didn't hand over the cash.

The insurance giants' proposal came in concert with one by Senator Max Baucus (D., MT), the chairman of the influential Senate Finance Committee, who wants to make an individual mandate part of health-care reform. There is speculation that Senator Ted Kennedy (D., MA), the other leading Senate voice on health-care reform, is considering including an individual mandate in whatever measure emerges from his Health, Education, Labor, and Pensions Committee.

Mandatory coverage also was a component of Senator Hillary Clinton's health-care proposal when she sought the Democratic presidential nomination. Barack Obama wisely opposed the idea during the primaries.

A coverage mandate is the centerpiece of the Massachusetts health care law that many see as Kennedy's model. But the mandate is an unpopular disaster in Massachusetts; in California, public opposition to it helped kill a similar proposal.

Coupled with Massachusetts' failure to rein in insurance price-gouging, the State's mandate forces the typical middle-aged adult to spend more than \$6,000 out-of-pocket on premiums and deductibles before medical expenses are covered.

No wonder the insurers like it. Tony Soprano would, too.

Ultimately, any reform plan that relies on such a mandate to establish "universal" coverage will fail.

Without restraints on skyrocketing insurance premiums and out-of-pocket costs, many families will face further economic distress, with little additional health security to show for it. And without tough regulatory oversight of insurers, patients will continue to endure inhumane denials of care.

The most effective way to fix our broken health-care system would look like Medicare, but improved and expanded to cover everyone. A single-payer, Medicare-for-all bill sponsored by Rep. John Conyers (D., MI) had more than 90 co-sponsors in the last Congress—more than any other reform bill. It is expected to be reintroduced early next year.

Such a program is the only way to control costs through negotiated fee schedules, global budgets, bulk purchasing, a huge cut in administrative waste, and other measures. And it's the only way to wrest control of our health from the insurers.

Senator DODD. Thank you very much.

Mr. Williams.

**STATEMENT OF RONALD A. WILLIAMS, CEO, AETNA, INC.,
HARTFORD, CT**

Mr. WILLIAMS. Thank you, Vice Chairman Dodd.

This committee is to be commended for its efforts to address not just the access for the uninsured but also affordability and quality of care.

Having been a senior executive in both nonprofit health plans and for-profit health plans and having operated in the individual, small group and large employer marketplace, I would like to briefly comment on the issues as they are at the core of this committee's and other committees' legislative work.

I want to start by talking about the approximately 250 million people who have healthcare coverage today. There is a highly competitive insurance market with over 1,300 plans and I know firsthand from our customers that there is a high satisfaction rate with the coverage.

One hundred and seventy-five million Americans are insured through the commercial market, divided nearly evenly between for-profit and not-for-profit plans. More than 95 percent of the employers polled in a recent Conference Board Business Council Survey overwhelmingly want to continue to provide their employees this type of coverage.

It is the employers' long-term commitment to their employees' health that has driven much of the innovation that we have today in terms of services. For example, we support significant insurance reforms that provide uniform access across the country, but these reforms cannot work without a companion requirement that requires all Americans to be part of the insurance system.

Congress must also make certain that there is comprehensive affordable coverage that's available and subsidize it for those who cannot afford it. Simply put, we need a comprehensive package with guaranteed issue of insurance and everyone in the insurance pool.

Insurance premiums are a direct reflection of underlying services in healthcare. In 2007, the cost of healthcare services grew at an annual rate of 6.4 percent. Premiums therefore increased at 6.1 percent. Making insurance affordable will require us to bend the healthcare cost curve and we insurers are committed to continuing our ongoing efforts as part of the president's overall cost reduction.

Today, most experts agree that 30 percent of care is unnecessary and yet the majority of Americans believe they don't get the tests and treatment they need. Fifty-five percent of Americans say insurers should pay for what a doctor recommends, even if a treatment has not been proven.

If our collective goal is to achieve affordable coverage for Americans, it is essential that we reach a consensus on these issues and make delivery system reform happen.

In terms of the individual and under 10 small group markets, by reforming the individual market which should also include small businesses fewer than 10, we can tell our insurance market solutions to effectively address the needs of the uninsured, many of whom would see coverage in these markets without disrupting or possibly unraveling the entire insurance market.

There is risk in every great endeavor, but if the primary objective is to fix what is broken and provide comprehensive coverage for the uninsured, Congress must take care not to shift those who

pay for insurance today into an untested structure that could cost more than they now pay.

We can cover the uninsured if we guarantee issue insurance, strongly align it with an individual coverage requirement, subsidize those that truly need healthcare and provide affordable coverage options which improve choices and reduce complexity.

Congress must also deal with the issue of cross subsidization. In making the decisions, we need to be mindful of how reforms impact different segments of the population. While the purpose of every insurance pool is to spread risk, how much should a 23-year-old with a lower average income pay to lower the rate of a 60-year-old with higher-than-average income? These are the policy decisions that must be made.

For groups of businesses between 10 and 50, 85 percent of whom offer employees health insurance, we need a package of solutions that make the current market work better. I believe the intent of the SHOP Act is the right approach as it provides a package of solutions intended to address the major issues of these larger small businesses which are rate volatility and affordability of coverage.

I would call on the committee to leave some details to regulation, understanding that making our new model work will require time, experience and course corrections.

Thank you for the chance to comment, and we look forward to working with you.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF RONALD A. WILLIAMS

Good Morning Vice-Chairman Dodd, Senator Enzi and members of the committee. My name is Ronald A. Williams, and I am the Chairman and CEO of Aetna, Inc.

I want to thank you for this opportunity to appear before you to discuss health care reform, something we feel passionate about at Aetna. I applaud Chairman Kennedy, Ranking Member Senator Enzi, and the full committee for your leadership in the effort to make health care work for all Americans.

I also want to thank Vice-Chairman Dodd from Connecticut, my home State, for his leadership. This spring, I had the opportunity to participate in two of Senator Dodd's Connecticut town halls on health care reform and listened as several hundred seniors, students, parents and everyday citizens shared their experiences with the health care system and their desire for reform. We may not have all agreed on the details of reform, but we did and can agree that great nations do not have 45 million people who are uninsured.

The committee is to be commended for its effort to address not just the issue of access for the uninsured, but to also focus on affordability and quality of care. I would like to briefly comment on these issues as they are at the core of this committee's and other committees' legislative proposals.

COMPANION SOLUTIONS

I want to start by talking about the approximately 250 million people who have health care coverage today. There is a competitive insurance market with over 1,300 plans, which are nearly equally divided between for-profit and not-for-profit plans. I know first hand from our customers that there is a very high satisfaction rate with this coverage:

- 175 million Americans are insured through the commercial market with coverage sponsored and subsidized by their employers.
- More than 95 percent of employers polled in a recent survey overwhelmingly want to continue to provide their employees this type of coverage.
- It is the employers' long-term commitment to their employees' health that has driven much of the innovation we have today in terms of services that help improve and sustain employee health.

- And although we know health care insurance works for many, it does not work for everyone. Therefore, we must work together to develop targeted solutions that address access, affordability and quality for all Americans.
- For example, we support significant insurance reforms that are uniform across the country. But these very reforms cannot work without a “companion” requirement that requires all Americans to be part of the insurance system.
- Congress must also make sure affordable coverage is available and to subsidize those who cannot afford it.
- Simply put, it all must be part of the same package.

COST AND QUALITY

Insurance premiums are a direct reflection of underlying services in health care such as provider costs. In 2007, the cost of health care services grew at an annual rate of 6.4 percent. As a result, premiums also increased 6.1 percent.

Making insurance affordable will require us to bend the health care cost curve, and we insurers are committed to continuing our on-going effort as part of the President’s overall cost reduction plan. This also means reforming a provider payment system currently based on volume and quantity, and moving to a system based on outcomes and quality.

Today most experts agree that 30 percent of care is unnecessary, and yet, the majority of Americans believe they don’t get the tests and treatment they need. Fifty-five percent of Americans say insurers should pay for what a doctor recommends even if a treatment has not been proven to be more effective than a cheaper one. If our collective goal is to achieve affordable coverage for all Americans, it is essential that we address these issues and make delivery system reform happen.

SPECIFIC SOLUTIONS FOR THE INDIVIDUAL AND UNDER 10 SMALL GROUP MARKETS

By reforming the individual market which should also include small businesses with fewer than 10 employees, we can tailor insurance market solutions to effectively address the needs of the uninsured, many of whom would seek coverage in these markets, without disrupting or possibly unraveling the entire insurance market. There is risk in every great endeavor, but if the primary objective is to fix what is broken and provide comprehensive coverage for the uninsured, Congress must take care not to shift those who pay for insurance today into an untested structure that could cost them more than they pay now.

We can cover the uninsured if we:

- Guarantee issue of insurance and strongly align it with an individual coverage requirement;
- Subsidize those that truly need help; and
- Provide affordable coverage options which improve choice and reduce complexity.

Congress must also deal with the issue of cross subsidization. In making policy decisions, we need to be mindful of how reforms may impact different segments of the population. While the very purpose of an insurance pool is to spread risk, how much should a 23-year-old with a lower than average income pay to lower the rate for a 60-year-old with a higher than average income? It’s only when we truly reduce the cost of care that we will be able to provide affordable coverage and reduce overall health care spending.

SMALL GROUP 10 TO 50

For small businesses with between 10 and 50 employees, 85 percent of whom offer their employees health insurance, we need a package of solutions that makes the current market work better. I believe the intent of the SHOP act is the right approach as it provides a package of solutions intended to address the major issues for these small businesses, which are rate volatility and affordability of coverage. We would propose some important changes to this bill that we believe would not jeopardize the desired result.

I would call on the committee to leave some details to regulation understanding that making our new model work will require time and experience. This will allow greater flexibility in meeting different consumer needs and expectations. Examples on this point include benefit package design, where we need not legislate in a “one-size-fits-all” manner. Rate banding is another example; while moving to a national standard is advisable, we need to allow for flexibility in designing rate bands that are based on actuarial modeling and reflect our collective intent to expand access and increase affordability. This may take some experience with a new system to get right.

Thank you for the chance to comment and we look forward to working with you to pass reform that addresses affordability, access and quality.

Senator DODD. Thanks very much.

Mr. Johnson.

**STATEMENT OF RANDEL K. JOHNSON, VICE PRESIDENT FOR
LABOR, IMMIGRATION, AND EMPLOYEE BENEFITS, U.S.
CHAMBER OF COMMERCE, WASHINGTON, DC**

Mr. JOHNSON. Thank you, Senator Dodd.

While there's been much focus in the press and elsewhere on the so-called public plan option, Senator Dodd, which certainly the Chamber has concerns with, I'd like to, today, focus on the new employer mandate which I realize is not spelled out in the bill but is sketched out in actually the Savings Clause, and I think this is highly ironic, given that this is, let's be clear, a sweeping new burden on employers of unprecedented proportion in the benefits area.

Now, in contrast to the process before us, the Congress spent almost a decade in consideration of the Family Medical Leave Act which you were very much involved in, which provided for 12 weeks of unpaid leave, but that essentially was a process that stretched out over 7 to 10 years.

Now the Congress is considering imposing a potentially sweeping new healthcare mandate on employers in less than 4 months and with regard to process, I have to agree with Senator Enzi.

I have to note that I was on the Hill when Mrs. Clinton's plan was being considered and she came under much criticism for drafting the plan behind closed doors, as you will recall, and then presenting the plan to Congress.

However, there were many hearings on that bill. I was at many of those, at one committee, and I would have to argue that it was a model of transparency and full deliberative process compared to the accelerated process we are now apparently facing when people are talking about a final piece of legislation by September or October.

I would also urge that the committee consider these new healthcare mandates not just in the context of the healthcare debate but in the context of the many other bills pending in front of this committee dealing with paid family leave, expansion of OSHA, uncapped punitive and compensatory damages, et cetera, and this is on top of a huge regulatory burden that our employers already have to face.

Now, we don't know what an employer mandate's going to cost, but there are some studies out there. The RAND Corporation has come out with one study, and I'm just going to quote this,

"From our model, we estimate that firms newly offering coverage will spend \$9 billion to \$17 billion on premium contributions and penalty payments, under the pay or play, will spend \$4 to \$12 billion."

That's not chump change to our members.

Now this is already against a backdrop of where employers are providing coverage to 170 million Americans. They're already spending \$500 billion on healthcare on a voluntary basis and I guess I would say that employers already are underwater on this and they have been for a long time. I think we're doing our part.

Now this is not to say that every employer is providing health insurance to their employees. Many simply cannot afford to do so and a new government mandate requiring that employers provide some level of healthcare benefits, apparently here to be determined by government boards, subject only to disapproval by Congress or pay an undetermined civil penalty, is not going to change this reality.

Moses could change the Nile and make it run red but we cannot wave a wand and create profits. The payments will come off the bottom line, as these various studies have testified to. It will result in lower wages and job losses and in some cases, and this may sound apocryphal, but in some cases some businesses may go out of business.

I'm just requesting that we refocus on the employer mandate. Let's go slowly on this issue and I appreciate your time, Senator. [The prepared statement of Mr. Johnson follows:]

PREPARED STATEMENT OF RANDEL K. JOHNSON, ON BEHALF OF
THE U.S. CHAMBER OF COMMERCE

SUMMARY

The Chamber stands ready to work with Congress to enact health reform, this year. However, proposals being floated are not reform—they would make the system even worse for employers and those who value free-market competition. The Chamber urges this committee to reconsider the approach it is taking.

After meeting with stakeholders behind closed doors for nearly a year, the committee released a proposal that bears almost no resemblance to the points of consensus reached, which raises significant concerns to the employer community as a whole.

The committee's draft proposal is focused largely on ideological efforts that will not solve the real problems Americans are facing in health care. Rather than focusing on improving quality and lowering cost, the proposal centers on creating new burdens on America's job creators, significantly expanding public programs, and a new government-run insurance company.

The Chamber is gravely concerned by the process and the product thus far. As badly as reform is needed, we cannot support reform just for the sake of reform. Ironically, the current process has been less open and transparent than reform efforts in 1994, which involved more hearings, more time to consider legislation, and more public vetting of options than has been contemplated here. We, and the business community at-large, are still eager to work with Congress to develop a workable product that can garner broad bipartisan support, preserves the parts of the system that work, is fiscally responsible, and expands coverage, increases quality, and lowers costs. However, the products coming out of this committee over the past 7 days do not meet any of these goals, and would make the system, and America's overall financial situation, worse, not better.

The U.S. Chamber of Commerce is the world's largest business federation, representing more than 3 million businesses and organizations of every size, sector and region.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees. Yet, virtually all of the Nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at-large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—numbers more than 10,000 members. Also, the Chamber has substantial membership in all 50 States.

The Chamber's international reach is substantial as well. We believe that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 101 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and

services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. Currently, some 1,800 business people participate in this process.

The U.S. Chamber of Commerce would like to thank the Chairman and Ranking Member, and other members of the committee for the opportunity to participate in today's roundtable and to submit this statement for the record. The Chamber appreciates your efforts to achieve access to affordable coverage for all Americans. The U.S. Chamber of Commerce is the world's largest business federation, representing more than 3 million businesses and organizations of every size, sector, and region.

The employer-based system voluntarily provides health benefits to over 178 million Americans. Overwhelmingly, employees are satisfied with these benefits and want their employers to continue providing it to them. Further, employers are currently spending over \$500 billion on health benefits each year.

According to the U.S. Census Bureau, nearly 46 million Americans lack health insurance. The Chamber believes that this number is misleading, and that we must acknowledge the difference between those that cannot afford to purchase coverage, and those that can afford coverage, but choose not to do so. This committee seeks to get both of these groups into the system.

Covering those who cannot afford coverage does necessitate a myriad of approaches. The Chamber believes it is paramount to begin with a greater focus on enrolling those who are already eligible for government-subsidized or free insurance—and steps to use Gateways to accomplish this goal are a great stride in the right direction. An estimated 10 million people are currently eligible, but Federal and State agencies have not done an adequate job of streamlining procedures, putting boots on the ground, and signing them up. Nearly another 9 million of the uninsured are non-citizens; a solution for them will necessitate reopening the question of immigration reform.

About 15 million of the 46 million uninsured have high enough incomes that they likely could afford insurance, if they chose to purchase it. Their reasons for going without could range from feeling young and invincible, lacking appealing insurance options (they are often uninterested in gold-plated PPO plans), being boxed in by State insurance mandates that limit their purchasing options, or lacking an understanding of the necessity of obtaining coverage. There are many proposals designed to prevent these individuals from opting out of the system, and to force them to shoulder their "fair share" of the expenses of providing medical care to the Nation. However, policymakers have a responsibility to address their concerns if these individuals are to be obligated to purchase coverage.

This committee needs to make a U-turn on these issues—rather than defining a dangerously high actuarial value to determine the qualifications of a health insurance plan, Congress should only require that individuals have comprehensive catastrophic coverage that offers first dollar coverage of prevention. The creation of a Medical Advisory Council, a proposal that Tom Daschle dubbed the "Federal Health Board" when he invented it, would be disastrous and possibly unconstitutional. No new bureaucracy should be given the power to impose law without proper checks and balances—and requiring a joint resolution of disapproval is unduly burdensome. Advisory bodies should advise and make suggestions, not make law.

If Congress creates an individual obligation to purchase coverage, we must first ensure that individuals will be able to obtain affordable coverage. This will require significant market reforms, new pooling options, removing State benefit mandates, and making available a full range of insurance options that will appeal to the young and healthy. All potential coverage solutions for the uninsured will be unsustainable unless Congress enacts meaningful delivery system, payment, financing, and entitlement reform. Some proposals to cover the uninsured are alarming and may well make the system worse, not better.

The small group and individual insurance markets are in serious need of significant reform. Currently regulated at the State level, the costly and burdensome benefit mandates coupled with an arguable lack of competition have led to the need for Federal reform of the individual and small group markets. The Chamber has long supported granting small businesses the ability to pool risk and to offer uniform benefits across State lines to address these problems, to no avail. Large businesses have been successful in offering comprehensive benefits primarily because Federal law (ERISA) protects them from the patchwork of inconsistent State laws and regulations, and the vast majority of individuals enrolled in ERISA plans report a high

level of satisfaction with their plans. Plans to limit self-insurance to only companies with more than 250 employees are a step in the wrong direction, and further changes to ERISA and new requirements to apply to ERISA plans will weaken the part of the system that is working well.

A national insurance Gateway should serve as a marketplace where individuals and small businesses can go to obtain coverage that meets the new standards. This Gateway must facilitate meaningful pooling options for these individuals so that their risks can be shared, their premiums can be predictable, and their costs lower. Further, having learned from the arguable lack of competition and problems encountered at the State level, the Gateway must allow for a high amount of plan flexibility, greater risk pooling, and a range of options.

The plans sold in the Gateway will have to meet some minimum benefit standard, and the Chamber feels the best course of action for designing this standard would be to look at existing high-deductible health plan products that offer first-dollar coverage of preventative services. It is absolutely essential that individuals have both access to and incentive to use preventative services, but also that the remaining parts of the plan be up to consumers—make the minimum a catastrophic plan, allow individuals and purchasers to determine how much richer of a plan they would like to select. This will provide appropriate safeguards against financial difficulties and ensure access to appropriate care.

If Congress manages to maneuver these challenges in a way that successfully encourages individuals who can afford coverage to opt in, and also successfully enrolls those who are already eligible for free or subsidized care, there would still be about 10 million uninsured. This group is comprised of individuals who cannot afford coverage, the people who are driving the need for coverage reform in the health care system. Covering them will entail many challenges.

The proposal to give Federal subsidies to individuals making up to 500 percent of the Federal Poverty Level (FPL)—that would be \$110,250 for a family of four. Subsidies of this size are extremely fiscally irresponsible, unsustainable, and only feed into the growing cost problem. Expanding Medicaid to 150 percent of FPL will increase the program's fiscal woes. Relief for those who cannot afford insurance must be targeted, fiscally responsible, and in coordination with other reforms that lower costs and fix the insurance market.

The Chamber does not believe that a mandate on employers to sponsor health insurance will make serious headway to cover the uninsured, but rather could lead to a loss of jobs. Employers who can afford to sponsor health insurance typically provide generous benefits—and most large employers do. Employers who cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so—small employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits.

The decision to force employers to sponsor government-approved health plans is not one that should be taken so lightly. Congress spent nearly a decade debating policies relating to mandatory family leave—unpaid leave at that. Under the Federal ERISA framework, very few new mandates have reached consensus to be forced upon employer-sponsored plans. Congress generally recognizes the importance of employer flexibility, autonomy, and ability to make the financial choices and take the necessary risks to create jobs, boost the economy, and drive the engine of prosperity.

Employers have been great innovators in health care, and in many reforms we have led the way and have kept the unsustainable rising costs of health insurance from reaching the breaking point. A mandate on employers is sure to reduce flexibility and choice, while raising costs and providing little benefit. Existing mandates have proven inadequate in determining the scope of plans, helping to cover the uninsured, or properly distinguishing the good players from so-called free-riders. The push for a coverage mandate on employers is an ideological one, not a pragmatic one, and should not be viewed as a way to cover the uninsured.

Employers support the notion of “shared responsibility,” when viewed through the lens of realism. Any objective observer would conclude that employers, who currently cover more than 178 million Americans and pay over \$500 billion per year, are indeed being responsible. Mandating further “responsibility” on their part would exhibit confusion about the economic realities employers face. An employer mandate would be a job-killer, because it would force struggling employers to spend money they don't have.

Another concerning proposal is the creation of a new government-run health plan, euphemistically referred to as the “public option,” or brazenly referred to as “consumer-driven.” Proponents say that this is necessary to “keep private insurers honest,” yet proposed market reforms should accomplish this goal without the creation of a new entitlement plan. Proponents claim that a government-run plan can com-

pete on an equal playing field with private plans, but this would put the government in the position of being both a team owner and the referee; inevitably the government would move to give unfair advantages to the "public option," just as they are considering doing now with the public financing of student loans.

Even the op-ed page of the *Washington Post* has cited the "public option" as a backdoor way to bring the Nation to single-payer, socialized medicine. The President's promise that Americans will be able to keep the health insurance they have cannot be kept if we move to such a system—which we inevitably would if, as the Lewin Group estimates, up to 130 million people are shifted into this public plan.

Employers are especially concerned with the prospect of a new government-run plan because of the bad experience we have had with current government-run plans. According to a recent study by Milliman, employer plans' costs are increased by an estimated 20 to 30 percent due to cost-shifting from Medicare and Medicaid. "Public option" proponents will say that this is denied by MedPAC, or that the new plan will not engage in this cost-shifting, but these assurances ring hollow—especially when we consider the incredible unfunded liabilities currently shrugged off by current government-run plans.

The Chamber is gravely concerned by the process and the product thus far. As badly as reform is needed, we cannot support reform just for the sake of reform. Ironically, the current process has been less open and transparent than reform efforts in 1994, which involved more hearings, more time to consider legislation, and more public vetting of options than has been contemplated here. We, and the business community at-large, are still eager to work with Congress to develop a workable product that can garner broad bipartisan support, preserves the parts of the system that work, is fiscally responsible, and expands coverage, increases quality, and lowers costs. However, the products coming out of this committee over the past 7 days do not meet any of these goals, and would make the system, and America's overall financial situation, worse, not better.

When you get past the ideological arguments, Democrats, Republicans, and business all want the same reforms—lower costs, improved quality, and better outcomes. We believe a key to accomplishing this is reforming the payment system to incent providers to give the best, most efficient care. The Chamber will strongly support Congress in enacting these needed reforms.

The Chamber is eager to work with you to enact reform, but urges your consideration and caution when crafting proposals that could prove harmful to U.S. companies. If structured properly, a Gateway could be a boon to small business. Subsidies could realign Federal dollars in a way that seriously reduces the uninsured. Entitlement programs could be reformed, revamped, and improved. Even better, the coverage currently enjoyed by more than 250 million Americans could be secure and sustainable, have better quality, and be more affordable.

The Chamber looks forward to working with Congress on this and other initiatives that will help more individuals, small businesses, the self-employed, and others gain access to the highest quality, most affordable, and most accessible health care possible. But we will not support reform for the sake of reform—it must be market-driven, preserve and boost the economy, and truly protect the parts of the system that work.

Senator DODD. Thank you very much. I'm glad you remember the Family Medical Leave Act. Nice of you to do so. By the way, the final version of it passed in 2 weeks.

Mr. JOHNSON. After about two vetoes and many, many years.

Senator DODD. Thanks for remembering the vetoes.

Mr. Dennis.

STATEMENT OF WILLIAM J. DENNIS, Jr., SENIOR RESEARCH FELLOW, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC

Mr. DENNIS. Thank you, Senator.

Small business has been primarily concerned about the costs of health insurance to America's small employers and considers it a major reason for the increasing coverage problem.

The importance of costs can be seen actually in Massachusetts. After coverage reforms, health spending jumped almost 25 percent in 2 years compared to 11 percent nationally. The reduction uncov-

ered was 3 to 4 percentage points. I guess there's some dispute as to exactly how much these days, but anyway what happens in a State like Texas, where we already have 33 percent lacking coverage rather than Massachusetts which was like eight or nine before the reforms came in.

Small business and NFBI have consistently opposed the employer mandate. We have two principle reasons for the opposition. The first is that employees ultimately bear the cost of their health insurance through lower employment, depressed wages and the loss of other economic opportunities.

Congress must ask itself do we want an employer mandate that effectively requires low-wage employees to indirectly and opaquely pay for their own health insurance or do we want to face the problem directly and transparently and provide subsidies for the low-income to purchase it?

The second reason that NFBI has consistently opposed the employer mandate is that in the initial costs, the up-front costs, before they can be transferred to employees, they must be borne by employers. Small employers particularly have difficulties with all these up front costs.

Finally, NFBI supports and helped develop the SHOP Act sponsored by Senators Durbin, Snowe and Lincoln. The committee's draft captures the essence of SHOP in its market reform provisions, most prominently guaranteed issue and renewal, the disallowance of medical underwriting and modified community rating.

In addition, the gateway connector concept is a positive step to facilitate small employers increasing their provisions of employee health insurance. Gateways perform a clearing house function, part of the small employers' HR function and insurance information functions. All substantially ease the small employers' search information and transactions costs directly addressing the actuarial value of small group plans.

In addition, its section 125 capabilities also bring efficiencies and equity to affected employees and employers.

Thank you very much, Senator.

[The prepared statement of Mr. Dennis follows:]

PREPARED STATEMENT OF WILLIAM J. DENNIS, JR.

Small business has been primarily concerned about the cost of health insurance to American small employers and considers it a major reason for the increasing coverage problem. The committee draft appears not to address the cost problem to the extent necessary, and typically cannot expect results until well after substantial new demand is placed on the system. For example, NFIB does not consider the public option a means to control the increase in prices. Similarly, the concept of medical loss ratios, while designed to address an important problem for smaller firms may prove counter-productive, if for no other reason than administrative personnel assigned to ferret out waste and fraud, can reduce net costs rather than increase them. Electronic records are fine as are other committee recommended measures, but there are more including built in cross-subsidies that foul prices signals, reimportation of prescription drugs that mean Americans subsidize the prescriptions of consumers in other developed countries, medical liability that yields unnecessary tests and procedures, and a host of others.

Small business and NFIB have consistently opposed the employer mandate. We have two principal reasons for opposition, though there are others. The first is that employees ultimately bear the cost of their health insurance through lower employment, depressed wages, and the loss of economic opportunities. So, the Congress must ask itself: Do we want an employer mandate that effectively requires low-wage employees to indirectly and opaquely pay for their own health insurance? Or, do we

want to face the problem directly and transparently and provide subsidies for the low-income to purchase it? The second reason NFIB has consistently opposed the employer mandate is that the initial costs, costs before they can be transferred to employees, are borne by employers. In effect, employers must "front" or initially lend the money for employees to purchase their health insurance. Many simply cannot do that.

NFIB supports, and helped develop, the SHOP Act sponsored by Senators Durbin, Snowe, and Lincoln. The committee's draft captures the essence of SHOP in its market reform provisions, most prominently guaranteed issue and renewal, the disallowance of medical underwriting, and modified community rating. In addition, the Gateway/Connector concept is a positive step to facilitate small employers increasing their provision of employee health insurance. Gateways perform a clearinghouse function, part of a small employer's HR function, and insurance information functions. All substantially ease the small employer's search, information, and transaction costs, directly addressing the actuarial value of small group plans. Its section 125 capabilities also bring efficiencies and equity to affected employers and employees.

Senator DODD. Thank you. Thank you very much.

Mary, if you could bring that microphone close. I think members are having a hard time hearing.

STATEMENT OF MARY ANDRUS, CO-CHAIR OF THE HEALTH CARE TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES, WASHINGTON, DC

Ms. ANDRUS. OK. Senator Dodd—

Senator DODD. Thank you.

Ms. ANDRUS [continuing]. Members of the HELP Committee, thank you for this opportunity to testify.

I am Mary Andrus, Assistant Vice President for Government Relations at Easter Seals and I'm here today as a Co-Chair of the Health Care Task force on the Consortium for Citizens with Disabilities.

For people with disabilities and chronic conditions of all ages, the goal of healthcare reform is to have access to high-quality, comprehensive and affordable healthcare that allows a person to be healthy and to live as independently as possible and participate in his or her community.

This legislative proposal makes major positive changes in the insurance market. The proposal would require guaranteed issue, requiring insurance to be issued without regard to health status, and guaranteed renewal so coverage couldn't be dropped because of a change in someone's health status.

The proposal would prohibit health status from being used in determining premium rates, making insurance more affordable for people with disabilities and chronic conditions.

The prohibition of annual and lifetime insurance caps and limits on out-of-pocket spending would immediately widen the opportunity for people with disabilities to obtain and to retain quality insurance coverage.

We strongly support the rehabilitation and habilitation as well as mental health services that were included in the outline of categories in the draft. However, we are concerned that the existing categories may not include the durable medical equipment, like wheelchairs or prosthetics, orthotics or other assistive devices, that are primary needs for people with disabilities.

CCD enthusiastically supports inclusion of the Community Living Assistance Services and Support Section. The CLASS proposal

would create a new national insurance program to help adults who have or who develop functional impairments to get the support that they need to remain employed and independent.

The financing for that proposal is through a modest voluntary payroll deduction and would provide a cash benefit to be used for things that health insurance may not cover, such as housing modification, personal assistance services or transportation, to allow someone to remain in their home, to continue to go to work, and to be part of their community.

Any one of us could become disabled any day and the cash benefit could provide access to a wide range of services to continue to function within families and communities.

Alternatively, many people will continue to have to spend down their savings and go on to Medicaid. We support self-sufficiency and independence rather than requiring people to impoverish themselves to get the services that are needed.

We understand that one of the options under discussion is to make adjustments to the current tax structure to incentivize the purchase of long-term insurance. We believe that these changes are not comprehensive enough to address the number of people who need coverage and the consequences to an individual or a family if these services are needed over the long haul.

Let me close with the idea that as you look at proposals for healthcare reform, look at them through the experience of a person with a disability and if the proposal meets those needs, it's highly likely to meet the needs of the rest of the population.

Thank you.

[The prepared statement of Ms. Andrus follows:]

PREPARED STATEMENT OF MARY ANDRUS

Members of the HELP Committee, thank you very much for this opportunity to tell you about how changes in our health care system could impact people with disabilities. I am Mary Andrus, Assistant Vice President for Government Relations at Easter Seals, and I am here today as a co-chair of the Health Care Task Force and a representative of the Long Term Services and Support Task Force of the Consortium for Citizens with Disabilities (CCD), a coalition of national consumer, advocacy, provider and professional organizations who advocate on behalf of people of all ages with physical and mental disabilities and chronic conditions, and their families.

OVERVIEW

CCD believes that the goal of health care reform should be to assure that all Americans, including people with disabilities and chronic conditions, have access to high quality, comprehensive, affordable health care and long-term services and supports that meets their individual needs and enables them to be healthy, functional, live as independently as possible, and participate in the community.

INSURANCE MARKET REFORMS

The legislation that the HELP Committee has put forward, the Affordable Choices Act of 2009, contains very constructive changes regarding insurance market reform. These improvements to the private health insurance market have significant positive implications on the ability of all Americans to access affordable health insurance regardless of their health status. Specifically, providing guaranteed issue and guaranteed renewal rules on coverage in the individual and small group market and prohibiting pre-existing health condition exclusions in these markets would immediately widen the opportunity for people with disabilities to obtain and retain quality insurance coverage. To assure that insurance is not just available to people with disabilities and chronic conditions, but to commit to seeing that it is affordable, this legislation initiates restrictions on premium rating practices in these markets to prohibit the use of health status in determining premium rates.

The combination of these modifications to the way business is currently conducted would constitute significant improvements for people with disabilities. But this proposal takes another big step toward protecting people from being overwhelmed by the cost of illness. CCD strongly supports the prohibition of annual and lifetime insurance caps. In addition, we strongly support limits on out-of-pocket spending to meaningfully address either catastrophic medical events or the accumulation of costs over years of living with a disability or chronic condition. It is important for medically necessary prescribed treatments and services that are eligible medical expenses under the IRS rules to be considered out-of-pocket expenses. Many people with disabilities and chronic diseases will be left without protections from catastrophic financial costs for services or treatments that their doctor prescribes but their plan fails to cover.

BENEFIT CATEGORIES

One of the most critical aspects of the health care reform debate for the disability community is the assurance of an appropriate set of benefits to meet the needs of people with disabilities and chronic conditions. This community understands that the benefits package is not defined in the legislative proposal and we enthusiastically support the inclusion of rehabilitation and habilitation services as a category for further definition of what would be covered. Provision of acute and post-acute rehabilitation and habilitation services in multiple settings of care to match the level of intensity of services needed by individuals to return them to their home and community as quickly as possible is key to the goal of overall health care reform.

CCD strongly urges the committee to include a category that provides a full complement of durable medical equipment (such as wheelchairs), prosthetics, orthotics (DMEPOS) and other assistive devices and related services. Such devices are critical in enabling people with disabilities to function. Without access to proper and affordable equipment of this nature, people with disabilities and chronic conditions can not have their needs met by private insurance and will, ultimately, be forced to avail themselves of the public programs that do offer such coverage. This result would not look a lot different from the status quo and is not consistent with the goals of this remarkable effort. We can not state strongly enough the importance of the inclusion of coverage of DMEPOS and assistive equipment as a general category in defining the essential health care benefits.

COMMUNITY LIVING ASSISTANCE SUPPORTS AND SERVICES PROPOSAL

An essential element of health care reform is ensuring that vulnerable populations have access to coverage that meets their care needs. For persons with disabilities and chronically ill older Americans—arguably the most vulnerable populations in the Nation—long-term services and supports are their primary unmet care need, and are critical to promoting health and preventing illness. While approximately 45 million Americans do not have medical insurance, over 200 million adult Americans lack any insurance protection against the cost of long-term services and supports. The inclusion of the Community Living Assistance Services and Supports (CLASS) language in this proposal is the threshold to meaningful change ensuring that individuals are able to function as independently as possible within their homes, families, and their communities. We strongly support the inclusion of the CLASS proposal. This provision should be retained as the legislative process moves forward.

Many Americans who are born with or develop severe functional impairments can access coverage for the long-term services critical to their independence (such as personal assistance, assistive technologies, long-term therapies, and training in basic skills) only through the Federal/State Medicaid program. The Medicaid program has become the default long-term services program and the last resort for millions of individuals and families who have nowhere else to turn to have their long-term needs met. Families must impoverish themselves by spending down their life savings before they can access the care they need under Medicaid. To a family struggling to make ends meet, there is no difference between spending \$20,000 on hospital care and spending \$20,000 on home care or nursing home care. It is still \$20,000 coming out of their pockets.

The CLASS provision would create a new national insurance program to help adults who have or develop severe functional impairments to remain independent, employed, and stay a part of their community. To qualify for CLASS benefits, individuals must be at least 18 years old and have contributed to the program for a minimum “vesting” period of 5 years. Eligibility for benefits would be determined by State disability determination centers and will be limited to individuals who are

unable to perform two or more activities of daily living (ADL) (e.g. eating, bathing, dressing) or its equivalent.

Financed through modest voluntary payroll deductions (with opt-out enrollment like Medicare Part B), this measure would help remove barriers to choice and independence (e.g., housing modification, assistive technologies, personal assistance services, transportation) that can be overwhelmingly costly, by providing a cash benefit to those individuals who need support for basic functions. The large risk pool to be created by this approach would make added coverage affordable. It would give individuals added choice and access to supports without requiring them to become impoverished to qualify for Medicaid. This should have a significant beneficial impact on the Medicaid program in the future as fewer people find it necessary to spend-down to become Medicaid eligible. Furthermore, many beneficiaries of working age could continue to remain in the workforce. We also believe that individuals could supplement their CLASS coverage through the private insurance market.

We believe that Option A would fail to make any progress in this critical area. While some of the provisions of Option B would be worthwhile in a limited market, it is not comprehensive enough and would do little to increase essential insurance coverage throughout the population.

MEDIGAP COVERAGE FOR MEDICARE BENEFICIARIES UNDER 65

People below age 65 become Medicare beneficiaries if they can no longer work due to disability and receive benefits under the Social Security Disability Income (SSDI) program, or if they require kidney dialysis due to end stage renal disease (ESRD). However, these Medicare beneficiaries have no Federal right to access supplemental insurance through Medigap as seniors do. The need for this supplemental insurance has been recognized by 27 States which mandate some level of Medigap access to Medicare enrollees under 65.

As Congress considers how to improve the existing health care system, the guaranteed issue of Medigap policies to all Medicare beneficiaries with disabilities and ESRD below the age of 65 to bring access to Medigap policies in line with seniors on Medicare, would provide needed coverage to these individuals. Medigap policies should be accessible and affordable to all Medicare beneficiaries regardless of age or health condition.

NON-DISCRIMINATION IN INSURANCE MARKETS AND PRODUCTS

CCD appreciates the protections in this proposal to prohibit discrimination for insurance eligibility and marketing. We would like to suggest the addition of language that strengthens the protections and prohibits plan coverage designs that would discriminate against people with disabilities and chronic disease. Many people with disabilities and chronic conditions are uninsured and under-insured. With the consideration of this health care proposal, there is the opportunity to better ensure that the design of plans and their benefits (including any formulary and tiered formulary structure) do not substantially discourage enrollment by individuals with disabilities or chronic diseases.

Thank you again for the opportunity to address this committee and for all the work you are doing to truly make a difference in the way people with disabilities and chronic conditions can live, learn, work and play in their communities.

For additional information, please contact any of the individuals below.

CCD Health Task Force Co-Chairs

- Mary Andrus, Easter Seals, (202) 347-3066.
- Tim Nanof, American Occupational Therapy Association, (301) 652-6611, Ext. 2100.
- Angela Ostrom, Epilepsy Foundation of America, (301) 918-3766.
- Peter Thomas, American Academy of Physical Medicine & Rehabilitation, (202) 466-6550.
- Liz Savage, The Arc of the United States and United Cerebral Palsy, (202) 783-2229.

CCD Long-Term Services and Supports Co-Chairs

- Joe Caldwell, Association of University Centers on Disabilities (301) 588-8252.
- Marty Ford, The Arc and United Cerebral Palsy (202) 783-2229.
- Suellen Galbraith, American Network of Community Options and Resources (703) 535-7850.
- Lee Page, Paralyzed Veterans of America (202) 416-7694.

Senator DODD. Thank you very much.
Dr. Rosman. Did I pronounce—

Dr. ROSMAN. It's Rosman, yes.
 Senator DODD. Rosman.

STATEMENT OF SAMANTHA ROSMAN, M.D., BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL

Dr. ROSMAN. Thank you. Thank you, Mr. Chairman.

My name is Samantha Rosman, and I'm a member of the American Medical Association Board of Trustees and a Fellow in Pediatric Emergency Medicine in Boston.

As an emergency physician in a city hospital, I see uninsured kids every day who are sicker than they need to be because they could not afford to seek care at the start of their illness.

The AMA strongly supports making affordable health insurance available to all Americans. This can best be achieved through a combination of insurance market reforms and healthcare exchanges that offer a variety of affordable private insurance plans.

A health insurance exchange would increase individual choice, simplify plan comparisons, and streamline enrollment to help individuals in choosing coverage that best suits their needs.

The AMA strongly opposes a public health insurance plan operated by the Federal Government with a pay schedule that's based on Medicare. Insurance is about more than coverage. It's about access. Too often I see kids with public insurance and yet no access because the clinics treating them are under-funded and overwhelmed and so instead they end up in my emergency department.

We also oppose proposals to compel physicians to participate in a publicly sponsored plan as a condition of continuing to see their Medicare patients. However, the AMA is open to consideration of a new health insurance option that's market-based and not run by government. Those several concepts have been publicly discussed. No legislative details have yet been put forth and we do look forward to reviewing those ideas.

Finally, the AMA strongly supports providing tax credits or subsidies that are inversely related to income, are refundable and payable in advance to low-income individuals who need financial assistance to purchase private health insurance.

The AMA believes that once sufficient subsidies or tax credits are in place so that every American has the means to afford coverage, that every American should then have the responsibility to obtain health insurance.

In closing, I would add that access to care for millions of patients remains in danger without action to eliminate a scheduled 21 percent cut in Medicare physician fees. Temporary patches that serve only to make the problem worse are not the answer.

This is the time to repeal the failed SGR formula and ensure that our seniors will continue to have access to quality healthcare.

Thank you.

[The prepared statement of Dr. Rosman follows:]

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION (AMA),
 PRESENTED BY SAMANTHA ROSMAN, M.D.

SUMMARY

We support making affordable health insurance available to all Americans. This can best be achieved through a combination of insurance market

reforms and health care exchanges offering a variety of affordable private insurance plans.

Insurance market reforms are needed to ensure greater accessibility and affordability and to make the health insurance market work better for both patients and physicians.

The AMA supports streamlined, more uniform health insurance market regulation that establishes fair ground rules, while also protecting high-risk patients without driving up health insurance premiums for the rest of the population.

The AMA supports establishing a health insurance exchange or exchanges to increase individual choice, facilitate plan comparisons, and streamline enrollment that will assist individuals in choosing coverage that best suits their needs.

Public Health Insurance Option: The AMA strongly opposes proposed Option A—a public health insurance plan operated by the Federal Government with a payment schedule that is set in statute and is based on Medicare. The AMA is open to consideration of a new health insurance option that is market-based, not run by the government, does not compel physician participation, and truly competes on a level playing field. Though several potential ideas have been publicly discussed, no legislative details have been put forth. We look forward to reviewing these ideas.

Upon implementation of subsidies or tax credits for those who need financial assistance obtaining coverage, the AMA believes everyone should have the responsibility to obtain health insurance.

The AMA supports helping low-income individuals obtain health insurance coverage, and believes the safety net provided by public programs needs to be maintained and strengthened.

The AMA supports providing tax credits or subsidies that are inversely related to income, refundable, and payable in advance to low-income individuals who need financial assistance to purchase private health insurance.

The AMA is committed to working with the HELP Committee, Congress, the Administration, and other stakeholders to advance proposals that expand coverage, improve quality, reform government programs, reduce costs, increase focus on wellness and prevention, and provide payment and delivery reforms.

HEALTH INSURANCE AND MARKET REFORMS

We support making affordable health insurance available to all Americans. This can best be achieved through a combination of insurance market reforms and health care exchanges offering a variety of affordable private insurance plans.

Insurance market reforms are needed to ensure greater accessibility and affordability and to make the health insurance market work better for both patients and physicians.

- The goal of market reform should be to create a competitive insurance market in which plans compete on price and quality, and patients gain more control over their choice of health coverage and their own care.

- To that end, we support modified community rating, with some degree of premium variation based on individual risk factors. Some degree of age rating is acceptable, as are lower premiums for nonsmokers.

- Insured individuals should be protected from losing coverage or being singled out for premium increases due to changes in health status.

The AMA supports streamlined, more uniform health insurance market regulation that establishes fair ground rules, while also protecting high-risk patients without driving up health insurance premiums for the rest of the population.

- Explicit, targeted government subsidies should be provided to help high-risk people obtain coverage without paying prohibitively high premiums. Such subsidies could take the form of high-risk pools, reinsurance, and risk adjustment. 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.

AVAILABLE COVERAGE FOR ALL AMERICANS

The AMA supports establishing a health insurance exchange or exchanges to increase individual 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 administrative costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice.

Public Health Insurance Option

The AMA strongly opposes proposed Option A—a public health insurance plan operated by the Federal Government with a payment schedule that is set in statute and is based on Medicare.

- The AMA does not believe that creating a public health insurance option for non-disabled individuals under the age of 65 is the best way to expand health insurance coverage and lower costs across the health care system.

- The AMA does not support expanding Medicare enrollment to younger or non-disabled populations. Medicare is projected to experience solvency problems in the next decade under existing obligations.

- The AMA opposes linking payment rates in a government-sponsored plan to the Medicare fee schedule. Payment rates should be negotiated with physicians and other providers on a level playing field.

- The AMA strongly opposes proposals to compel physicians to accept patients in a publicly sponsored plan as a condition to see Medicare patients.

- The AMA strongly supports improvements in the private health insurance market. In a reformed private health insurance market, with a health insurance exchange like the Federal Employee Health Benefits Program that provides a variety of plans from which to choose, a public plan option is unnecessary.

Option B.—The AMA is open to consideration of a new health insurance option that is market-based, not run by the government, does not compel physician participation, and truly competes on a level playing field. Though several potential ideas have been publicly discussed, no legislative details have been put forth. We look forward to reviewing these ideas.

Option C.—The AMA believes that with properly regulated private plans offered through an exchange, and made affordable through individual tax credits inversely related to income, a government run health plan option is not necessary to ensure access to health insurance.

INDIVIDUAL AND EMPLOYER RESPONSIBILITY

Upon implementation of subsidies or tax credits for those who need financial assistance obtaining coverage, the AMA believes everyone should have the responsibility to obtain health insurance.

The American Medical Association has no position on an employer mandate.

COVERAGE EXPANSIONS AND SUBSIDIES

The AMA supports helping low-income individuals obtain health insurance coverage, and believes the safety net provided by public programs needs to be maintained and strengthened.

- There should be greater equity within the Medicaid program through the creation of basic national standards of uniform eligibility for all persons below the poverty line, and the elimination of the existing categorical requirements, which would allow for the coverage of low-income individuals based solely on financial need.

- We also support allowing the use of public funds (through tax credits or subsidies) to allow acute care patients to purchase coverage individually and through programs available through an exchange.

- Access to care for Medicaid (and Medicare) beneficiaries becomes more limited when physicians cannot afford to accept them as patients. Limited access to care significantly impacts the level, frequency, and location (e.g., emergency room) of care recipients receive, potentially resulting in increased costs and poorer health outcomes. The AMA supports setting Medicaid payment rates at a level that encourages widespread physician participation in the program.

The AMA supports providing tax credits or subsidies that are inversely related to income, refundable, and payable in advance to low-income indi-

viduals who need financial assistance to purchase private health insurance.

- Individuals and families who can afford coverage should be required to obtain it. Those earning more than 500 percent of the Federal poverty level should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. Check with Rob about signalling that this threshold should be lowered as other reforms are implemented to increase the affordability of health insurance for those earning less than 500 percent of FPL.
- Those who cannot afford it and do not qualify for public programs should receive tax credits for the purchase of health insurance.

Senator DODD. Thank you very much.
Dr. Scheppach.

STATEMENT OF RAYMOND C. SCHEPPACH, Ph.D., EXECUTIVE DIRECTOR, NATIONAL GOVERNORS' ASSOCIATION, WASHINGTON, DC

Mr. SCHEPPACH. Mr. Chairman, I'm pleased to be here on behalf of the Nation's governors. I'd like to comment on four issues in your draft legislation and options paper: insurance regulation, gateways, Medicaid, and implementation.

With respect to insurance reform, NGA is supportive of the framework included in the draft legislation which has the Federal Government setting market rules while giving States time to conform but also leaving the overall State regulatory structure in place.

There are a number of technical issues or problems in the current draft with respect to grandfathering in individuals and allowing providers to sell nonqualified plans outside the gateway. These are potential impediments to the market. It's also true that the draft is unclear whether the rate plans are maximum or minimums that States can exceed.

With respect to the State role in gateways, NGA is supportive of this structure and I believe States can make it work well.

We do have some concerns regarding the ability to integrate health IT into the gateway within 4 years and there are also some concerns about the degree of Federal oversight. The bottom line, however, is that the State role in creating and designing gateways is appropriate.

On Medicaid, it seems that expanding to a 150 percent of poverty is too high. It would bring in another 18 million into Medicaid, bringing the total up to 76 million.

We also have a problem with providing temporary financial assistance for the expansion. States are struggling to fund the existing program and therefore need permanent financial assistance.

While we support choice of individuals in Medicaid and SCHIP, we are concerned about whether we would have to continue EPSDT and all the wrap-around services if these populations were to go through a gateway.

Overall, it may be better to leave this issue to the Senate Finance Committee as opposed to this committee.

Finally, with respect to implementation, we appreciate the State grants to build capacity and the flexibility for States to implement when ready. However, if the final bill includes individual mandates and corporate mandates and tax credits for small business, work needs to be done to make sure that these are synchronized by States.

It's important to perhaps set several benchmarks and certifications of governors when the insurance market is ready to receive the gateway and when subsidized populations come in needs to be synchronized with the mandates and so on. It seems to me additional work needs to be done in terms of the implementation.

I thank you, and I look forward to working with the committee. [The prepared statement of Mr. Scheppach follows:]

PREPARED STATEMENT OF RAYMOND C. SCHEPPACH, PH.D.

SUMMARY

NEED FOR COMPREHENSIVE REFORM

Governors understand the vital role that health plays in productivity, competitiveness and quality of life and have made providing cost-effective health care to their citizens a top priority. Given its unsustainable course, significant reforms of the health care system are necessary. Health reform proposals must recognize that changing any one component will have direct and indirect impacts on other aspects of the health care system, and therefore, reform must move on parallel tracks to expand coverage, improve quality, and contain costs.

GOVERNORS' VIEWS ON HEALTH CARE REFORM

Medicaid. The primary Medicaid issue for most Governors is how the expansions will be financed. Governors oppose changes to Medicaid that result in unfunded mandates and therefore any additional costs must be 100 percent federally financed. Because future projections of State fiscal capacity show weak growth in the long run, a permanent increase in the Federal share of the program is also necessary. The other key issue for Governors is how Medicaid will be operated. The program needs greater State flexibility, not less. For example, States need greater flexibility to develop evidence-based benefit packages.

Long-Term Care and the Dual Eligibles. Long-term care must be a robust component of health care reform. Reforms should include greater State flexibility and financial incentives within Medicaid to operate home and community-based services programs. However, true long-term care reform must acknowledge that Medicaid cannot continue to provide the majority of services. Governors support the provisions creating more options and tools for States to improve care for the dual eligibles and reduce overall government costs for their health care at the same time.

State Regulatory Authority. State authority to regulate insurance must be preserved. While States are supportive of having the Federal Government establish certain insurance market reforms on such issues as the individual mandate and guaranteed issue, health care reform should not diminish or impede the long standing establishment of State regulation of health insurance. States need to maintain the authority to: protect consumers; ensure solvency of insurance plans and licensure of providers; and enact more stringent rating rules and other insurance laws above established Federal minimums.

Support for State-Based Connectors or Other Exchange Mechanisms. States should have the ability to design the structure, specify the functions, and determine how insurance products operate within the exchange. Exchanges need to be established, operated, and regulated at the State, not Federal, level. States should also be able to choose to participate in a voluntary multistate exchange. No more than one exchange should be allowed to operate in any given State in order to avoid behavior based on risk avoidance. State authority to collect health insurance premium taxes must be preserved. There should be Federal support for the start-up costs for State and multi-state based exchanges.

Transition Periods. Significant health care reforms require a lengthy process of State, Federal, and market changes. These cannot be accomplished overnight.

Mr. Chairman and members of the committee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to be a part of this panel on behalf of the Nation's Governors to discuss health reform and specifically the important issues involving health care coverage. We are prepared to work with Federal policymakers to ensure that reforms are workable, cost-efficient, and sustainable over the long-term.

NEED FOR COMPREHENSIVE REFORM

Governors understand the vital role that health plays in productivity, competitiveness and quality of life and have made providing cost-effective health care to their citizens a top priority. Given its unsustainable course, significant reforms of the health care system are necessary.

More than 45 million Americans are currently uninsured, and millions more are underinsured. Achieving greater access to affordable, quality health care is a critically important goal. However, health reform proposals must recognize that changing any one component will have direct and indirect impacts on other aspects of the health care system, and therefore, reform must move on parallel tracks to expand coverage, improve quality, and contain costs.

GOVERNORS' VIEWS ON HEALTH CARE REFORM

Within the discussion on health care coverage, we wish to share the views of governors in five basic areas:

1. Insurance Regulation
2. Medicaid
3. Exchange Mechanisms
4. Long-Term Care and the Dual Eligibles
5. Transition Timelines

1. Insurance Regulation

While States are supportive of having the Federal Government establish certain insurance market reforms on such issues as guaranteed issue, health care reform should not diminish or impede the long standing establishment of State regulation of health insurance.

States strongly encourage Federal policymakers to avoid measures that would pre-empt stronger State laws and regulations, and urge that any Federal standards operate as floors rather than ceilings. Among the many regulatory authorities that should remain under State determination are to ensure the solvency of health insurance plans, and the enforcement of marketing requirements on those plans; the proper licensure of providers; and the protection of consumer rights and benefits.

2. Medicaid

Governors recognize Medicaid's important role in meeting the needs of our most vulnerable populations and they are committed to modernizing the program so that it better responds to their needs. There are several aspects of this transformation that I wish to highlight.

Governors understand that proposals under consideration would eliminate the categorical nature of the Medicaid program for individuals under a certain income threshold. While there is a reasonable case for streamlining eligibility policies, proposals to mandate a significant expansion of the Medicaid program raise important questions and some concerns.

Medicaid (Costs)—First of all is the cost. Governors oppose changes to the Medicaid program that will result in an unfunded mandate imposed on the States. Any increase in the mandatory minimum eligibility threshold will cost States tens of billions of dollars per year. States must take into consideration not only the actual cost of including additional individuals on the rolls, but also the complex interaction of reimbursement rates and access.

With any coverage expansion, States must consider the direct and indirect impact on provider reimbursement rates as well as health care workforce capacity, particularly primary care providers. There simply are not enough providers willing to treat additional Medicaid enrollees with complex conditions and situations at current reimbursement rates. Currently, Medicaid reimbursement rates average 72 percent of Medicare rates nationwide, and Medicare rates are often significantly lower than rates paid by private insurance. Those States that have already experimented with expanding Medicaid coverage broadly have demonstrated that Medicaid reimbursement rates must be increased to approximately Medicare rates to ensure access.

Combining the existing program expenditures with those required to meet new requirements and needs, without other changes to the program or adequate Federal funding, could overwhelm States' budgets. Our initial estimate of the State impact of the Medicaid expansion as described in the Senate Finance Committee's proposal, including the reimbursement rates increases that would be necessary to ensure access would cost tens of billions of dollars per year in State funds alone. This would represent a significant percentage of total State general revenues.

Finally, Medicaid has become the Nation's *de factor* source of long-term care coverage as well as a critical source of coverage for individuals eligible for both the

Medicare and Medicaid program—known as the dual eligibles. I will discuss those two issues later, but it is critical to remember that Medicaid's continued coverage of these responsibilities may be fiscally incompatible with an increased role in coverage of all low-income Americans.

States are in dire financial straits now and any additional costs in the short run must be 100 percent federally financed. Furthermore, future projections of State fiscal capacity show a slow recovery and weak growth in the long run. This will necessitate permanently increasing the Federal share of the program to account for not only the increased eligibility and reimbursement rates, but also the demographic trends for long-term care, which alone could bankrupt the States.

Medicaid (reforms)—States would also like to work with Federal policymakers to do more to streamline the Medicaid program and eliminate cumbersome requirements which make the program difficult to administer and sometimes work against the interests of both beneficiaries and taxpayers. For example, the committee's proposals seek to limit the use of categorical eligibility determinations, but still leave in place a patchwork system for determining eligibility for the program and for specific services.

Should Federal policymakers approve mandatory income eligibility changes, these must be balanced by the pressing need to modernize the Medicaid program as well as establish a path to incorporate State innovations as permanent parts of the State Medicaid plan. States require new flexibilities to administer a more efficient Medicaid program that better meets today's needs of low-income and vulnerable populations and reduces costs for both States and the Federal Government.

Specifically, States support providing new flexibility to develop evidence-based benefit packages. This could minimize complexity in determining which services are medically necessary. States need flexibility to determine which services are purchased and how they are delivered. This would help ensure that expansion populations have access to the Medicaid services they need while providing States flexibility to improve the value of services offered to beneficiaries and manage costs. In addition, if the exchange is used to connect any low-income population to Medicaid coverage, new State flexibility will be needed to break down barriers to building systems of care and supporting care coordination.

3. Health Insurance Exchanges

A properly designed health insurance exchange can help correct inefficiencies in the existing health insurance markets and should be considered in the context of other proposed reforms. If Federal policymakers adopt the exchange concept, States support the following approaches for developing the exchange framework:

- Exchange mechanisms should be established, operated, and regulated at the state-level. States also should retain the right to establish and participate in no more than one multistate-based exchange. Enhancing the ability of States to establish such mechanisms could help realize efficiencies in the health insurance marketplace as well as coordination between Medicaid and other subsidized populations.
- The number of exchanges in a State should be limited to one and no other exchange should pre-empt, compete, or interfere with State and multistate-based exchanges. The presence of multiple exchanges in a State is likely to perpetuate competition based on risk minimization.
- State flexibility is needed to design the structure, specify the functions, and determine how insurance products operate within a marketplace that has an exchange. This state-based approach can minimize disruption in the marketplace, ease the transition of market reforms for all stakeholders, leverage existing State infrastructure and public-private partnerships, and avoid disruption of the reforms already underway in some States.
- Provide Federal support for start-up costs for State and multistate-based exchanges.
- Preserve the right of States to collect health insurance premium taxes on insurance businesses offered through the exchange.

4. Long-Term Care and the Dual Eligibles

It is clear that Medicaid can no longer be the financing mechanism for the Nation's long-term care costs and other costs for individuals eligible for Medicare and Medicaid—known as the dual eligibles. The demographic changes and escalating costs make it critical for States to begin to transition to the Federal Government much of their current financial responsibility in Medicaid for financing of long-term care. As stated in my testimony to the Subcommittee on Health of the Finance Committee earlier this year, postponing the discussion on long-term care perpetuates the fragmented system of care that exists today. Efforts to improve the financing mechanisms, care coordination and quality of long-term care services can be complemen-

tary and very important in the efforts related to strengthening the rest of our health care system.

Additionally, more than 7 million Americans are dually eligible for full Medicare and Medicaid benefits, and nearly 2 million others receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent just 18 percent of Medicaid's caseload, and despite the fact that they are fully insured by Medicare, a disproportionate percent of all Medicaid expenditures is consumed by filling in the gaps in Medicare services. In fact, they are responsible for over 42 percent of all Medicaid expenditures and 24 percent of Medicare expenditures (\$250 billion in fiscal year 2008).

Health care reform must include a streamlining of the current dysfunctional silos that dual eligibles currently access. There are at least two options for approaching this challenge. Full federalization of financing the care for this population would serve many policy goals, including creating enormous efficiencies and savings for both States and the Federal Government and treating the most medically fragile citizens in a holistic manner that dramatically improves the quality of their health care.

Alternatively, if the Federal Government does not provide the financing to improve the care of these beneficiaries, provide States with the tools to do so. Despite recent State and Federal efforts to address structural problems, the existing system for dual eligibles is predominantly a fragmented, uncoordinated, and inefficient system of care. Misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the Federal and State governments as well as an uncoordinated system of care for beneficiaries remain. Specifically, States must be credited for generating savings to Medicare when making Medicaid investments for this population. States also should have a certain level of influence over the coverage and financial decisions being made for the duals. And certain administrative rules and policies between Medicare and Medicaid must be streamlined to improve care for the dual eligibles.

In addition to specific reforms to improve care for the dual eligibles, a stronger, more equitable partnership between Medicare and States is essential to the success of health reform efforts. Medicare has significant influence in shaping cost and coverage decisions in the public and private domain and thus has a tremendous impact on health care trends. Yet Medicare largely is not engaged in State specific health reform initiatives which involve both public and private stakeholders.

5. Transition Timetable

Federal policymakers should work with States and the territories to determine an appropriate transition and implementation timeline for all health care reform changes. This includes changes both to State administered programs such as Medicaid and the Children's Health Insurance Program (CHIP), as well as any national reforms to the health insurance marketplace. It also may be helpful to have early planning grants to States while the Federal Government promulgates rules. It also would involve general certifications by governors at given benchmarks.

Significant health care reforms will require a lengthy process of State, Federal, and market changes. This includes sufficient transition time for any coverage expansions, the proposed removal of income disregards, changes to benefit package requirements and services, new requirements which may involve a health insurance exchange entity, and other changes being considered.

States also urge Federal policymakers to consider the health care workforce capacity, particularly with regard to the implementation of any coverage expansions that may be approved. Proposed coverage and delivery system reforms must be coupled with Federal support for developing and retaining health care workers who are prepared to deliver quality care across the health care spectrum.

CONCLUSION

Any reforms approved at the Federal level must allow States flexibility to adapt to local conditions and retain the primary State roles of administration, regulation, and consumer protection. It is also important that this framework support the role that States play in innovations around delivery system reform and value-based purchasing.

If a Federal framework is developed it should include sustainable, sufficient financing mechanisms (through a combination of public programs and private sector incentives) to ensure that coverage and delivery system reform goals can be met. On their own, States are not well-positioned to sustain increases in their health care budgets.

Governors look forward to working with our Federal partners on a bipartisan basis to address these important issues.

Senator DODD. Thank you very, very much.
Mr. Shea.

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

Mr. SHEA. Thank you, Senator Dodd, and thank you and Senator Enzi and all the members of the committee and, of course, Chairman Kennedy, for the commitment you have shown and for your focus on this issue.

It is past time that we take up this issue and I think we have a historic moment before us that we dare not let pass.

The current system, as you said, Senator Dodd, is truly unsustainable, and America's unions have long supported a social insurance model for healthcare provision and if we had our druthers that's what we'd be focusing on today, but we've also had a lot of experience in bargaining health benefits.

We negotiate health benefits every year for some 40-million Americans and so if you're going to base this on the employment-based system with public supplements, then I want to comment on a few points that we think are essential, and my main message is that you need to focus on stabilizing employment-based coverage because right now employment-based coverage has survived surprisingly long under the cost pressures but it won't survive forever and in fact we're losing people out of employment-based coverage very rapidly and other people are just shouldering enormous costs.

You have to start, first of all, with cost containment and I want to congratulate the committee for, in your draft, addressing what to us are absolutely crucial long-term structural issues in healthcare.

We need to reorganize healthcare, to modernize it, and to improve the delivery so it is focused on quality and your draft really reflects a lot of what has been done not by government particularly, although government's been involved, but by practitioners in the health field and what we've learned in that process over the last 10 years. There have been tremendous strides made in the last 10 years in improving the way healthcare is delivered and they have great implications not just for quality of care but also for efficiency and cost long-term.

The second point on cost containment is, we think that, as soon as feasible, an immediate implementation of a public health insurance plan option is essential.

We have to put competition into the insurance market. The private insurers have had plenty of opportunity to do this on their own and they have failed to do it. I take at their word that they want to do different and they're ready to change. I think we need, as the president says, a way to keep them honest.

Second, in terms of stabilizing employment-based coverage, we have to have everybody participate. All workers should participate and all employers should participate. Most employers do now, as you know well, and those employers who don't largely are in markets where most employers don't provide coverage. It's not as if you're going to be disadvantaging those employers by making or asking them to provide coverage. They'd be in the same set of employers and, of course, many of them are low-wage small employers

who would require subsidies and that would be absolutely appropriate, but it's essential from our point of view to have everyone in.

I would say, by the way, that we particularly are pleased with the provisions in the bill for pre-Medicare retirees that you've put in. Employers who've been doing the good job of providing healthcare for their retirees need relief from high health costs and your re-insurance mechanism is one way, we think it's a very good way to go at this issue and we would congratulate you.

Last, in terms of financing, I just want to note that there's much talk today about using health benefits and taxing them as the basis for financing.

There is no surprise why this is being discussed. It is a very large pot of money, as you know. It's the largest loss to the Treasury, larger than the home mortgage deduction. It's just a very large amount of money. But bear in mind that the people who have sleepless nights over being able to afford healthcare coverage now often have health insurance that is too expensive for them to use. To ask them to pay more money for that health coverage is not only unfair, we think it is really politically very volatile.

Plus, as employer after employer has told us and testified at various hearings before Congress, it is the sort of thing that really could destabilize the entire employment-based market.

With that, I thank the committee for your attention and appreciate the opportunity to present to you.

[The prepared statement of Mr. Shea follows:]

PREPARED STATEMENT OF GERALD SHEA

Thank you for the invitation to participate in this roundtable discussion and offer our perspective, on behalf of working women and men, on the committee's draft legislative options for health care reform. The AFL-CIO represents 11 million members, including 2.5 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health benefits for more than 50 years. Our members have a significant stake in health care reform as consumers and, for some, as sponsors of coverage and health care workers.

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

The AFL-CIO was the leading lobby force behind the enactment of Medicare in 1965, and we have backed many legislative efforts since then to expand coverage. We continue to believe that a social insurance model is the simplest and most cost-effective way to provide benefits for all.

It is in our national interest to assure health coverage for everyone, from active workers to retirees, to those who lose their jobs and those unable to work due to disability. Clearly, it would make sense to cover everyone through the same program and system of coverage. We regret that the social insurance approach to health care has been marginalized to a great extent in the health care debate in Washington, even as it remains very popular around the country.

But our health care situation is too problematic and too important for those of us lucky enough to have good coverage to debate what would be the best approach to health reform. And health reform has been stymied for far too long by those who advocate one approach and reject all the others.

Health care costs are hobbling American business and bankrupting American families. Even those with good coverage worry about what will happen next year if cost increases remain unchecked as they have for decades.

It's time—indeed, its past time—for the comprehensive health care reform that most in Congress and our President have called for.

So, in 2009, our members are ready to stand with President Obama and Congress for a plan that builds on what works in our system while creating new options for obtaining coverage and lowering health care costs for families, business and government at all levels.

On behalf of America's working families, I want to thank the committee, especially Chairman Kennedy, Senator Dodd, and Ranking Member Enzi, for the leadership, commitment and determination you've shown in assuring quality, affordable health care for all.

America's working families need comprehensive reform to constrain the cost increases that are killing good jobs, to ensure people who currently have coverage can afford it in the future, to bring everyone into coverage, and to modernize the delivery of health care in America. The draft "Affordable Health Choices Act" is a very strong start on that path.

Employer-based coverage is the backbone of our health care financing and coverage system. The majority of non-elderly Americans obtain coverage through employer-sponsored health plans. And despite its flaws—including higher cost sharing and the hassles and outright denials they have come to expect from insurance companies—most Americans are happy with their employer-based health benefits, in large part because they know it is still far superior to being on their own in the individual insurance market. Building on this core piece of our health care system will both minimize disruption and garner greater public support. Our comments on the options will focus on this element, particularly since it is an area on which the committee has said they are seeking input.

We strongly support the committee's proposal to stabilize the employment-based system with "Shared Responsibility" and a requirement that employers either offer coverage to their workers or pay into a fund to subsidize coverage for uninsured workers. There are significant benefits of this approach, sometimes called "pay or play." First, it will create a more level playing field between firms that offer health benefits and those that don't. It will also eliminate the cost shift that occurs when employers offering good family coverage see their costs rise when they provide coverage for spouses employed in firms that either offer too costly coverage or no coverage at all. To the extent policymakers may choose to construct pay or play in a way that allows families to be enrolled in the same employer plan, we believe one approach to consider would be to require a dependent's employer to make a contribution to the employer covering the whole family.

Furthermore, given other policy elements under consideration and the Federal fiscal challenges affecting health reform, pay or play will be a necessary component if health reform is to succeed. If reform includes a new requirement that all individuals obtain coverage, expanding employer-based health benefits will be key to making coverage affordable for workers that do not qualify for income-based public subsidies. It will also generate revenue to help fund subsidies for low-income individuals and extend coverage to many of the uninsured since most are in families with at least one full-time worker. Finally, without a requirement that employers participate in the new system, health reform that includes publicly subsidized coverage for low-wage workers will prompt many employers of low-wage workers to eliminate their coverage to take advantage of public subsidies. The resulting increase in Federal costs may well doom reform efforts.

The design issues involved in a pay or play approach are critical, as they can create both opportunities and limits. Employers opting to "play" must be required to offer benefits that are at least adequate enough to allow their employees to meet an individual requirement to purchase coverage. The "play" test should also require employers to make a defined minimum contribution to the premiums for that coverage.

For those firms not offering coverage, a "pay" requirement could take a number of forms, from a payroll tax to an amount per worker, and there are tradeoffs associated with each. Setting the contribution rate based on payroll would lessen the impact on low-wage workers and would be a better measure of a firm's capacity to contribute to health benefits than the number of employees. Alternatively, a requirement tied to each individual employee will be more effective at reaching the entire workforce than a requirement tied to a percentage of total payroll, since it will protect against an employer meeting the percent of payroll test by offering relatively generous benefits to only a share of their workforce. However, such an approach, if applied only to full-time workers, would create incentives for employers in certain sectors to hire part-time workers or reduce workers' hours to minimize the application of the contribution rate. We support the approach included in the summary of legislative options, in which the contribution rate is prorated for part-time workers in order to protect workers and to ensure adequate revenue for subsidized coverage.

Policymakers will also have to prescribe which firms are covered under an employer obligation to offer coverage. While many proposals exempt small businesses, since those firms face higher premiums in the current market, we believe this ignores important factors. First and foremost, the number of employees is a poor predictor of a firm's ability to pay: a doctor's office or small law firm may have more capacity than a larger restaurant or store. A carve out for small firms also creates a potentially costly hurdle for firms near the threshold to hire additional employees. In addition, the committee's legislative options include a proposal that would allow small businesses to meet the "play" requirement by allowing them to buy coverage that meets fair rating rules through a newly constructed "Gateway," including a public health insurance plan that would make coverage more affordable and a proposal to give low-wage employers additional subsidies. If policymakers choose to treat small business differently in the application of pay or play, we would prefer an approach that sets the threshold based on payroll rather than number of employees. If set at an appropriate level, a payroll threshold could effectively eliminate small, low-wage firms from the employer requirement while protecting against the cliffs associated with a requirement based on number of employees.

Opponents to including an employer requirement in health reform will raise objections based on new costs for firms. However, the vast majority of firms will likely meet any new coverage requirement and the impact on businesses that would be affected would vary depending on whether they are currently offering health coverage or if they are offering coverage that is inadequate. Those firms that do not offer health benefits would be directly affected by a new "pay" requirement, and others will have to spend more on the benefits they now offer in order to meet the requirement. These objections are misplaced.

Opponents may argue that employers subject to new health care costs may be less likely to raise wages in the short term; however, the widely endorsed economic view is that these employers would still raise wages over the long term. Opponents may also argue that employers subject to new health care costs may eliminate jobs or hire more slowly. However, we can expect results similar to the experience with raising the minimum wage. Recent studies of minimum wage raises have found no measurable impact on employment.¹ Furthermore, economists often note that employers faced with higher costs under a minimum wage increase can offset some of the costs with savings associated with higher productivity, decreased turnover and absenteeism, and increased worker morale.² We can expect similar results with a pay or play requirement.

There are other factors that will compensate for any increase in employer cost. First, the majority of firms that currently do not offer health benefits are in markets where their competitors also do not provide benefits, so they would see increases similar to those of their competitors. Second, firms that will pay more for health care than they currently do will see at least some of those costs offset by a healthier workforce. Third, broadening the pool of employers that would contribute to health financing could improve competition among firms within sectors by creating a more level playing field based on health benefit costs. Fourth, to the extent there is currently a shift of uncompensated care costs to employer-sponsored plans, all firms now offering coverage will see their costs decrease as we expand coverage. Finally, our economy as a whole will benefit from more rational job mobility and a better match of workers' skills to jobs when health benefits are no longer influencing employment decisions.

Another element on which the committee is seeking input is the inclusion of a public health insurance option, which we strongly support. A public health insurance plan will be key to holding down costs for consumers and government. It will make coverage more affordable with lower administrative costs and will inject needed competition into an imperfect market. And it can help drive delivery system reforms in conjunction with private payers, as Medicare has done with the quality improvement work underway already. Two of the options included in the committee's summary in our view are not necessarily mutually exclusive. We support a level playing field for a public health insurance option to compete alongside private plans but believe the payment schedule should be set at a fair and reasonable level that ensures access to providers. The key will be to not hamstring the public health in-

¹A. Dube, T.W. Lester, M. Reich, "Minimum Wage Effects Across State Border: Estimates Using Contiguous Counties," Institute for Research on Labor and Employment Working Paper Series No. iirwps-157-07, August 1, 2007.

²J. Bernstein, J. Schmitt, "Making Work Pay: The Impact of the 1996-1997 Minimum Wage Increase," Economic Policy Institute (1998); D. Card, A. Krueger, "Myth and Measurement: The New Economics of the Minimum Wage," Princeton University Press, 1995.

surance plan so that it can't produce the savings or competition that are essential to the success of the plan and health reform.

In addition, we applaud the committee's comprehensive plan to foster innovation in health care delivery by building on the significant quality measurement and improvement underway within health care in recent years. Title II of the draft legislation, "Improving the Quality and Efficiency of Health Care," provides a blueprint for how we can greatly expand this work and take a giant step towards a truly 21st Century health system. It would put into place a system of broad consultation with consumers, purchasers, physicians, insurers and health care organizations in setting national priorities for health care quality improvement and in implementing standardized measures of quality throughout health care. With quality measurement as a foundation, it empowers those who deliver care, pay for care and oversee care to work with those who receive care to innovate and modernize health service delivery.

The draft legislation also calls for the use of quality measurement and improvement processes in private health insurance. There is very strong support for this among insurers and purchasers. I would call the committee's attention to the need for the legislation to link the quality approaches in the private sector to those you've proposed for the public sectors. We believe this could and should be more explicit in the final legislation than in the draft released earlier this week. Title II provides a comprehensive framework for quality measurement and improvement that should—indeed must, in order to drive the kind of systemic change that is necessary for improvement to take place—be applied to private as well as public purchasing of coverage.

Beyond these elements, there are laudable provisions that lay the groundwork for comprehensive, affordable coverage for all. The market reforms for all buying coverage in the individual and group market will make coverage more fair, transparent, affordable and secure. We fully support the prohibition on rating based on health status, gender and class of business, as well as the prohibition on the imposition of pre-existing condition exclusions, guaranteed issue and renewal, and greater transparency and limits on plans' non-claims costs. While we would prefer a prohibition on rating based on age, we believe the proposal to limit age rating to 2 to 1 is a strong alternative. Any variation allowed above that limit threatens to make coverage unaffordable for older individuals.

We strongly support the proposal to establish a temporary, federally funded re-insurance program for employers that provide health benefits to retirees age 55 to 64. This provision represents a positive initiative to address the health care needs of this vulnerable population. We also support the Gateway proposal as a mechanism for simplifying enrollment in coverage and applying standards for plans regarding benefits, affordability, transparency and quality. We applaud the committee's proposal to extend Medicaid coverage to all under 150 percent of poverty, with sufficient resources to States to offset new costs, and to provide subsidies for coverage to those with incomes up to 500 percent of poverty. We also support the inclusion of a new Medical Advisory Council to make recommendations for evidence-based benefits that plans in the Gateway would be required to cover. And we support the inclusion of long-term care services and supports and in particular, the Community Living Assistance Services and Supports (CLASS) Act.

I want to offer one final note of caution. Some of your colleagues in the Finance Committee are considering changes to the current exclusion of health benefits from income and payroll taxes. We believe this would be a step in the wrong direction. A cap on the tax exclusion would disproportionately affect firms with higher cost plans because of factors other than the level of coverage, including a higher percentage of older workers, higher risk in the industry and firm size. There is also likely to be some employer response even to capping the exclusion, including increases to employee cost-sharing to a level where they may become unaffordable for low-wage workers. Finally, capping the tax exclusion would undermine the place where most Americans now get their coverage before we have built a proven effective, sustainable alternative to employer-based plans.

Thank you for the opportunity to offer our comments and participate in this roundtable discussion. We commend the committee for your commitment to enacting legislation that will guarantee quality, affordable health care for all. We agree that we can no longer wait for reform—our economy depends on the success of reform—and we stand ready to help move this legislation forward. We thank you for the leadership you are providing on this vital issue.

Senator DODD. Thank you very much.
Mr. Rivera, thank you for coming.

**STATEMENT OF DENNIS RIVERA, CHAIR, SEIU HEALTHCARE,
SEIU, WASHINGTON, DC**

Mr. RIVERA. I'm here today on behalf of 2.2 million members and their families of SEIU, members like Pat DeLong of Libby, MT, who works as a homecare aid.

Pat and her husband Dan were ranchers but had a hard time finding affordable coverage and were uninsured when he was diagnosed with Hodgkin's Lymphoma in 2000. The medical bills pile up for Pat and Dan and eventually forcing them to sell the land they love and that they had been in Dan's family for over four generations. Dan succumbed to cancer and Pat remains uninsured.

This is America. We can, we must do better for hard-working families like the DeLongs. The American people will judge what you do on healthcare reform based on whether it provides Pat with the choice of affordable quality private and public healthcare coverage.

Reform will be meaningless if working people cannot afford to purchase coverage or cannot afford to get the care they need once they are covered. American families must be protected for unaffordable out-of-pocket costs and unaffordable premiums.

The reality of what our broken healthcare system is costing American families is staggering. Over 60 percent of bankruptcies filed in 2007 were largely attributable to medical expenses and nearly 80 percent of those who filed for bankruptcy had insurance coverage. Healthcare costs must be reined in for all Americans. The best way to make this happen is through a public health insurance plan.

Give Americans a choice: the choice to keep their current plan or to join a public health insurance option that encourages competition and guarantees everyone access to better, more affordable healthcare solutions.

A public health insurance plan not only gives Americans more choices, it will drive down costs for working families, small businesses, everyone, by increasing bargaining power and spreading risk, providing families savings and putting resources directly toward healthcare.

Business, government and individuals must come together and share responsibility in solving America's healthcare crisis. Building on the employer-based system will help people keep their healthcare if they like it. One in every five American workers are currently uninsured, having increased by about 6 million in 10 years.

Employers who choose not to provide coverage for their employees are putting responsible business at a competitive disadvantage and increasing costs for everyone. Employers should offer and continue to contribute meaningful coverage for their employees or pay into a fund, a pay or play requirement. A share responsibility will have minimal disruption to our economy while providing greater security for worker stability.

Small businesses should be guaranteed protection to help control costs and keep them competitive. Small businesses should receive tax credits and the smallest businesses should be exempt.

True healthcare reform means giving Americans the freedom of choice to keep their current plan, including their current doctor, or

choose another private plan or to choose a quality affordable public health insurance plan. True health reform means families are guaranteed coverage—guaranteed coverage if they had an illness 5 years ago or some other pre-existing condition, guaranteed coverage if they are laid off and can't afford payments, or guaranteed coverage, if they can't afford, that provides quality care.

True healthcare reform means individuals, government and business all share in the responsibility for a uniquely American solution that gives Americans peace of mind that they will always have quality affordable healthcare.

The American Healthcare Choice Act is an opportunity to put policies aside and stand up for the American people by increasing their healthcare choices and providing them with quality care while addressing the cost crisis that is creeping at our economy and driving working families into financial ruin.

Thank you.

Senator DODD. Thank you very much.

Katherine Baicker.

**STATEMENT OF KATHERINE BAICKER, PROFESSOR OF
HEALTH ECONOMICS, HARVARD SCHOOL OF PUBLIC
HEALTH, BOSTON, MA**

Ms. BAICKER. Yes. Thank you for the opportunity.

The focus on both coverage and value that the committee has I think is crucial to the success of any health reform and high-quality, high-value care is not just about insurance but it's about the healthcare that Americans receive even when they are insured.

There has been a lot in the news lately about the geographic variation that we see in healthcare and having started my research career at Dartmouth, I'm a huge fan of that body of work that shows us that even people with insurance coverage have very different quality of care and have a very different amount of money spent on their healthcare to achieve very similar outcomes. That highlights for us the importance of driving people into high-value insurance that provides high-value care.

Dennis and I sat together on a commission that examined other inputs into health outcomes, besides healthcare. Public investments that the bill touches on could be a really key component in driving better health outcomes for everyone, in addition to the health insurance reforms that you're talking about.

High-value health insurance means ensuring that everybody has access to the crucial financial protections that insurance provides, not just today, for expenses you might incur because of a sudden illness but against the risk of incurring high costs for years going forward if you have an expensive disease and that involves innovative disease management and innovative insurance products that people can choose among to meet the needs of their families as best they can.

That also means, I believe, providing a social insurance component that transfers risks between high-risk groups and low-risk groups, so that groups that face high and persistent health costs are subsidized, but that needs to be coupled with risk protection on the back end for insurers so that they don't have an incentive to avoid enrolling high-risk enrollees and so that those high health

cost people, once insured, are guaranteed access to high-quality services, so that insurers continue to provide them access to the best specialists and the best care that they can in the context of high-value disease management.

Achieving that high-value system is both about the insurance product that people get and the care that they consume when they're in it and public dollars can drive higher value in both of those dimensions by directing resources toward care that promotes long happy lives and reducing subsidies for care that's of questionable medical value.

[The prepared statement of Dr. Baicker follows:]

PREPARED STATEMENT OF KATHERINE BAICKER

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Senator Kennedy, Senator Enzi, and the members of the committee for giving me the opportunity to participate in this discussion of how we can address the crucial policy challenge of comprehensive health care reform.

I would like to discuss several general principles about the nature of health insurance that may be helpful in thinking about the impact of particular provisions on cost and coverage, including how well insurance markets pool risk and the value of care delivered. This testimony is derived in large part from recent academic work with my colleague Amitabh Chandra that appeared in the journal *Health Affairs*.

A key distinction can be made between health care and health insurance. Insurance works by pooling risks: many pay a premium up front, and then those who face a bad outcome (getting sick, being in a car accident, having their home burn down) get paid out of those collected premiums. The premium is the expected average cost of treatment for everyone in the pool, not just the cost of treating the sick. Because not everyone will fall sick at the same time, it is possible to make payments to those who do fall sick even though their care costs more than their premium. And this is also why it is particularly important for people to get insured when they are healthy—to protect against the risk of needing extra resources to devote to health care if they fall ill.

Uncertainty about when we may fall sick and need more health care is the reason that we purchase insurance—not just because health care is expensive (which it is). Many other things are expensive, including housing and college tuition, but we do not have insurance to help us purchase them because they are not uncertain in the way that potentially needing very expensive medical care is. The more uncertainty there is, the valuable insurance is.

THE PROBLEM OF THE SICK AND UNINSURED

Insured sick people and uninsured sick people present very different issues of public policy. People who have already purchased insurance and then fall sick pose a particular policy challenge: insurance is not just about protecting against unexpected high expenses this year, but also about protecting against the risk of persistently higher expenses in the case of chronic illness. This kind of protection means that once insured, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, suggesting a strong role for regulation protecting them. Nor are insurers held responsible when inadequate coverage raises the costs of a future insurer, such as Medicare for those over 65. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the conflation of health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health *care* more than health *insurance*. Insurance is about reducing uncertainty in spending. It is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty. If you were to try to purchase auto insurance that covered replacement of a car that had already been totaled in an accident, the premium would equal the cost of a new car. You would not be buying car insurance—you would be buying a car. Similarly, uninsured people with known high health costs do not need health insurance—they need health care. Private health insurers can no more charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low-income uninsured sick people have the resources they need to ob-

tain what society deems an acceptable level of care and ideally, as discussed below, to minimize the number of people in this situation.

This highlights one of the many reasons that health insurance is different from car insurance: the underlying good, health care, is viewed by many as a right. Furthermore, we may want to redistribute money from the healthy to the sick, in the same way that we redistribute money from the rich to the poor. This kind of redistribution is fundamentally different from private insurance: it is social insurance, and it is hard to achieve through private markets alone.¹ Medicare, which insures the aged and disabled, is an example of a social insurance program. Private markets can pool risk among people starting out with similar health risks, and regulations can ensure that when some members of those risk pools fall ill, insurers cannot deny them care or raise their premiums, but transferring resources to people who are already sick and uninsured or transferring resources from lower health risk groups to higher health risk groups requires social insurance.

How then do we provide the sick and uninsured with socially acceptable care? Private health insurance alone is unlikely to achieve this goal: no insurer will be willing to charge a premium less than enrollees' likely health costs. Instead, they could be provided with health care directly or a premium subsidy equal to their expected health care costs. Alternatively, we could force sick people and healthy people to pool their risks, such as through community rating coupled with insurance mandates (to preclude healthy people from opting out of subsidizing sick ones). These kind of transfers are based on social choices about redistribution.

The advantage of social insurance programs, including a nationalized health care system, is that they can achieve redistribution that private markets alone cannot. They may also provide benefits with lower administrative costs (although, in the case of moving to a single payer system, the size of administrative savings relative to overall health care cost growth is likely to be small).² There are, of course, costs associated with social insurance programs as well. First, there is the drag on the economy imposed by raising revenues to finance them. Second, there is the loss of competition, diverse offerings for diverse preferences, and market discipline that private provision brings—and that promote higher value and innovation. This means that the social insurance program may be both expensive and inefficient, and thus impose an even larger burden on already strained public budgets. These pressures have, perhaps unsurprisingly, spawned additional misconceptions that suggest that the costs of expanded insurance are lower and the benefits higher than the data support.

THE COST OF COVERING THE UNINSURED

A common and deceptively appealing argument for expanding insurance coverage is that we could both spend less and achieve better health by replacing the inefficient emergency room care received by the uninsured with an insurance plan. Unfortunately, this argument finds little empirical support. ER care for the uninsured is indeed inefficient and might have been avoided through more diligent preventive care and disease management. Diabetes treatment is a good example; it is much cheaper to manage diabetes well than wait for a hospitalization which requires a leg amputation. Having health insurance may lower the costs of ER and other publicly provided care used by the uninsured through better prevention and medical management. But empirical research also demonstrates that insured people consume more care (and have better health outcomes) than uninsured people—so universal insurance is likely to increase, not reduce, overall health spending.³

Why does insurance cause greater consumption of health care? Insurance, particularly insurance with low cost-sharing, means that patients do not bear the full cost of the health resources they use. This is a good thing—having just made the case for the importance of the financial protections that insurance provides—but comes with the side-effect of promoting greater consumption of health resources, even when their health benefit is low. This well-documented phenomenon is known as “moral hazard,” even though there is nothing moral or immoral about it. The RAND Health Insurance Experiment (HIE), one of the largest and most famous experiments in social science, measured people's responsiveness to the price of health care. Contrary to the view of many non-economists that consuming health care is unpleasant and thus not likely to be responsive to prices, the HIE found otherwise: people who paid nothing for health care consumed 30 percent more care than those with high deductibles.⁴ This is not done in bad faith: patients and their physicians evaluate whether the care is of sufficient value to the patient to be worth the out-of-pocket costs. The increase in care that individual patients use because of insurance has even greater system-wide ramifications. R&D in new medical technologies responds to the changes in aggregate incentives driven by health insurance. While

these technologies may improve welfare, they also raise premiums because of larger armamentarium of treatments available to the sick. There is evidence of these system-wide effects: when Medicare was introduced in 1965, providers made spectacular investments in high-tech care, and hospital spending surged over 25 percent in 5 years.⁵

Even increases in preventive care do not usually pay for themselves: in general prevention is good for health, but does not reduce spending. Some preventive care has been shown to be cost-saving—such as flu vaccines for toddlers or targeted investments like initial colonoscopy screening for men aged 60–64—but most preventative care results in greater spending along with better health outcomes. Indeed, some money spent on preventive care may not only cost money, but may be no more cost-effective than some “high-tech” medical care. For example, screening all 65-year-olds for diabetes, as opposed to only those with hypertension, may improve health but costs so much (about \$600,000 per Quality Adjusted Life Year) that that money might be better spent elsewhere.⁶

All of this suggests that insuring the uninsured would raise total spending. This doesn't mean that it would not be money well spent (which I believe it would be). Spending more to attain universal insurance is not a problem if it generates more value than it costs, and the view that health care is a right is not inconsistent with this framework. First, and sometimes overlooked, is the security that insurance provides against the uncertainty of unknown health care expenses. The value of this financial smoothing alone is estimated to be almost as much as the cost of providing people with insurance.⁷ Second, much of the additional health care that the newly insured would receive is likely to improve health. (But this is by no means automatic, for as discussed below, being insured is not enough to guarantee good health care.) Extending health insurance coverage is worth it for these reasons—but not because it would save money.

GETTING HIGH-VALUE CARE

Having insurance may increase the quantity of care patients receive, but it is no guarantee that they will receive high quality care. A recent study found that Americans received less than 60 percent of recommended care, including preventive, acute, and chronic care, and including such low-cost interventions as flu vaccines and antibiotics for surgical patients.⁹ Beginning with the work of John Wennberg at Dartmouth, an immense literature in medicine and economics has found that even among Medicare enrollees, there are enormous differences in the quality of care received: in fact, in areas where the *most* is spent on Medicare beneficiaries, they are the *least* likely to get high quality care. The use of mammograms, flu-shots, beta-blockers and aspirin for heart attack patients, rapid antibiotics for pneumonia patients, and simple laboratory tests to evaluate the management of diabetes are all lower in higher-spending areas.¹⁰ Higher spending is not even associated with lower mortality, which suggests that more generous insurance provision does not necessarily translate to better care or outcomes.

When these results showing the lack of relationship between spending and quality were first reported there were two predictable responses by skeptics: that high spending areas had sicker patients who were (appropriately) less likely to receive these therapies, and that patients in high-spending had higher satisfaction even if their measurable health outcomes were the same. Neither claim is supported by the evidence.

What, then, do patients in high-spending areas get? Evidence suggests that this higher intensity is driven by greater use of procedures with questionable clinical value—that may even be associated with underuse of high value, less-intensive care. Patients in high-spending areas are no more likely to receive surgery, but see more specialists more frequently, have more diagnostic and imaging services, and get more intensive care in the end of the life—none of which has been shown through clinical trials to improve health.¹¹ “Coordination failures” in delivery may both raise costs and lower quality, even among the insured. Investments in health services research can help shed light on how we can consistently deliver higher-value care.

Thus, while health insurance increases the quantity of care patients receive, being insured alone is not sufficient to ensure high quality care. Insuring the uninsured will give them access to the sort of health care that the rest of us receive: a combination of valuable care, overuse of some costly interventions with little proven benefit, and underuse of some vitally important therapies, care that is sometimes coordinated but often fragmented. This is better than no care, but it highlights the problem of collapsing the entire debate about U.S. health care reform down to the issue of uninsurance: health insurance alone does not guarantee good health care.

THE ROLE OF EMPLOYERS

Employees ultimately pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company. The view that we can get employers to shoulder the cost of providing health insurance stems from the misconception that employers pay for benefits out of a reservoir of profits. Regardless of a firm's profits, valued benefits are paid primarily out of workers wages.¹² While workers may not even be aware of the cost of their total health premium, employers make hiring and salary decisions based on the total cost of employment, including both wages and benefits such as health insurance, maternity leave, disability and retirement benefits.¹³ They provide health insurance not out of generosity of spirit, but as a way to attract workers—just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers bearing the cost of their benefits in the form of lower wages.¹⁴

The uncomfortable arithmetic of this wage-fringe offset is seen in other contexts—for example, workers bear the costs of workers compensation, and mandated maternity benefits primarily reduce the wages of women of child-bearing age.¹⁵ When it is not possible to reduce wages, employers may respond in other ways: employment can be reduced for workers whose wages cannot be lowered, outsourcing and a reliance on temp-agencies may increase, and workers can be moved into part-time jobs where mandates do not apply. These adjustments are neither instantaneous nor one-for-one for every person (depending, for example, on wage rigidities, how much individuals value the insurance benefit, and how heterogeneous the employees' income and health are)—a fact that obscures the underlying connection. This also means that the claimed connection between health care costs and the “international competitiveness” of U.S. industry is murky at best: higher health costs primarily lower current workers' non-health compensation, rather than firms' profitability (although the same trade-off cannot operate in retiree health benefits, making their effects more complicated).¹⁶

Why, then, do we have a private health insurance system based primarily on policies offered through employers? There is a preference in the tax code for premiums paid by employers relative to premiums paid by individuals or direct payments for health care. This tax preference drives both the predominance of employment-based policies and the prevalence of policies with low cost-sharing, because care paid for in the form of higher employer premiums comes at a lower after-tax price than care paid for out-of-pocket. Of course, this tie between employment and insurance comes at a well-known cost: workers who leave or lose a job risk losing their insurance or facing much higher premiums, sometimes forcing them to stay in a job to retain health insurance.¹⁷ Furthermore, differences in rating regulations in the large-group, small-group, and individual insurance markets can undermine risk-pooling, which is particularly harmful for those with high health costs who must find a new insurance policy.

This is not to say that there are not important advantages to getting insurance through an employer instead of on the individual non-group insurance market (especially given the current state of individual market), including better pricing and risk pooling. The employer market is the primary mechanism for maintaining cross-subsidization from low-risk populations to high-risk ones, with tax subsidies adding an element of social insurance (albeit one that is not particularly progressive).¹⁸ It is these benefits that are the main advantages of access to employer policies, not the fact that employers nominally pay part of the premium.

EFFICIENT INSURANCE

Greater patient cost-sharing could help improve the efficiency of health care spending, but it is not a cure-all. It is certainly true that first-dollar insurance coverage (that is, insurance coverage for the first dollar of health care expenditures or insurance with very low cost-sharing more broadly) encourages use of care with very low marginal benefit and that greater cost-sharing would help reduce the use of discretionary care of questionable value. But there is also evidence that patients underutilize drugs with very high value when confronted with greater cost-sharing (whether because they lack resources or information). Worse, there is evidence that even \$5–\$10 increases in copayments for outpatient care can result in some patients getting hospitalized as a result of cutting back too much on valuable care, offsetting the reduced spending.¹⁹ Capping total insurance benefits is also short-sighted and imprudent: not only does evidence suggest that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs, but the presence of caps means that patients are not insured against catastrophic costs—exactly what insurance is supposed to protect against the most.

There is no reason to think that the optimal insurance structure would look like the typical high-deductible plan. Rather, it might subsidize high-value care such as treatments to manage diabetes or asthma, while imposing greater cost-sharing on care of lower value, such as elective surgeries with limited health benefits. People would choose the insurance plans that offered them the best benefit mix—trading off higher premiums for plans that covered care of diminishing marginal value. Of course, what may be valuable to one patient could be wasteful for another, and the key challenge for “value-based insurance design” policies is to differentiate these cases. Many firms are experimenting with these plans.²⁰ Focusing exclusively on high-deductible plans that rely on a blunt structure of patient cost-sharing and perfectly forward-looking patients may forestall the development of even more innovative plans.

This does not mean that competition and cost-sharing have no role in driving higher value spending, however. Competition between insurers to offer plans that have the mix of benefits enrollees find most valuable could drive the kind of innovative plans described above. Increased cost-sharing such as that promoted by high deductible policies coupled with health savings accounts can also be an important tool for improving the value of care. As the evidence from the RAND HIE discussed above shows, the low-cost sharing plans fostered by the current tax treatment of health insurance (which look more like pre-paid health care than true insurance) promote the use of care that is of limited health benefit. While most spending is indeed done by people with very high total costs, well-designed cost-sharing programs could still have substantial effects on spending decisions. Most spending is not done in emergency settings, and even limited cost-sharing can have an effect on a substantial share of total spending.²¹ This suggests that carefully designed incentives could have a big effect on improving the value of care delivered.

CONCLUSION

We know that our health care system is not delivering the consistently high-quality, high-value care that we should expect. While there are many open questions in the design of the ideal system, with millions uninsured and rising costs threatening to swamp public and private budgets alike, we cannot afford to wait to act.

Focusing on the underlying issues discussed here suggests that the fundamental problems facing our health insurance system are unlikely to be cured by the extremes of either a single payer system or an unfettered marketplace. On the one hand, the unregulated marketplace is unlikely to provide long-run stable insurance. Private insurers will always have an incentive to try to shed their highest cost enrollees, so without regulatory safeguards even the insured sick will be at risk of losing the insurance protections to which they are entitled. Private insurance fundamentally cannot provide the kind of redistribution based on underlying health risk or income that social insurance can. On the other hand, a single payer system does not automatically provide high quality care: the provision of low-value care is as pervasive in the single payer Medicare system as it is elsewhere. Single-payer systems are also slow to innovate—as suggested by the fact that it took Medicare 40 years to add a prescription drug benefit, long after most private insurers had done so. Nor do calculations of the costs of a single-payer system measure the utility loss from forcing people with different preferences into a monolithic health insurance plan. The private facilities that have sprung up in Canada to meet the demands of those who want more health care than the public system provides fundamentally undermine the “single payer” nature of the system.

How one balances these trade-offs is likely driven as much by philosophy as economics, and any reform will involve tough choices between competing values. Serious reforms would focus not exclusively on lowering costs, but on increasing the value that we get from health insurance and health care.²² Reforms that promoted higher-value insurance could both extend coverage so that more people benefit from the protections that insurance affords and ensure that those protections are secure for those who fall ill. These reforms would not be enough to achieve uniformly high-quality care, however. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. That many nations, including both the United States and Canada, struggle with these challenges suggests that reforms of the payment system alone are unlikely to solve all of these problems. A comprehensive reform proposal that aimed both to extend insurance protections to those who lack them and to improve the value of care received by those who are insured would be more likely to succeed at each goal than proposals that focused on just one.

Thank you again for the opportunity to meet with you. I would be happy to answer any questions that you might have.

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Senator DODD. Thank you.

Dr. Jonathan Gruber.

**STATEMENT OF JONATHAN GRUBER, Ph.D., ASSOCIATE HEAD,
MIT DEPARTMENT OF ECONOMICS, CAMBRIDGE, MA**

Mr. GRUBER. Thank you very much, Senator, and to the other Senators for inviting me here today.

I'd like to congratulate the committee on a draft bill which really provides a terrific framework for fundamentally transforming healthcare in the United States. This really builds on the success we've had in Massachusetts where we've shown that such transformation can work and let me give you some solid facts on this.

First of all, the uninsurance rate in Massachusetts is down by more than two-thirds. We've now got fewer than 3 percent of our population uninsured.

Second of all, employer-sponsored insurance is up in Massachusetts by a 150,000 people. We don't have crowd-out, we have crowd-in in Massachusetts.

Third, the costs within budget. If you don't believe me, you can look at a report from the Mass Taxpayers Foundation, an organization which is not inclined to be friendly toward big government interventions, which has said we actually came in under budget with our insurance reform.

Fourth, the mandate is working. We had mandated compliance rates above 98 percent in the very first year, and fifth, it's popular. We have 75 percent public support for our reform.

Now that said, the options memo before us today raises a number of issues and I just want to hit the highlights on things which I discuss in more detail in my written testimony.

First of all, medical underwriting in health insurance must be banned. With guaranteed issue of insurance and modified community rating that ensures real insurance coverage through time for those who suffer adverse health shocks.

Second, lifetime and annual limits on services in insurance contracts should be banned as well as other restrictions that take

place in many med plans which fool people into thinking they have real coverage when they don't.

Third, there's no reason to have multiple competing State exchanges. Exchange or gateway is a great process but there's no reason to have more than one. Have the competition within the exchanges, not artificially across them.

Fourth, and I think most important, an individual purchase requirement or individual mandate is central to reform. Without an individual mandate, a number of States have tried to reform the insurance market and failed. You cannot fundamentally reform insurance markets without individual mandate.

Fifth, private coverage subsidies must be part of this bill and they must extend to four times the Federal poverty line. In Massachusetts, our subsidies, probably the biggest failure of our law, is that our subsidies only extend to three times the poverty line. That's left some individuals unable to afford health insurance in our State and we have to exempt them from our mandate.

Fifth and finally, I would say that small business credits should be offered and should be targeted most tightly to those firms that are least likely to offer health insurance and that's the smallest and lowest wage companies, not just the smallest and smallest wage companies.

I think with a strong credit, small business can be a big winner from this reform. In fact, just today the Small Business Majority released a report for which I did the analysis which showed that healthcare reform is a very positive feature of our small businesses, not a negative as has sometimes been suggested.

Healthcare reform can end job lock, freeing entrepreneurs to leave companies and start their own small businesses. It can provide continuous coverage in this most dynamic sector of our economy as small businesses open and close, ensuring their employees are constantly covered, and it can lead to major savings through more effective administration of insurance and bending the cost curve.

The bottom line is that small business has nothing to fear from this reform. This can be a positive benefit for small business if we look at the entire picture.

Thank you.

[The prepared statement of Mr. Gruber follows:]

PREPARED STATEMENT OF JONATHAN GRUBER, PH.D.

SUMMARY

Thank you very much for allowing me to testify today on Health Care Reform Legislative Options. To summarize, my conclusions are:

- Medical underwriting in health insurance markets must be banned, with guaranteed issue of insurance and modified community rating that ensures real insurance coverage through time to those who suffer adverse health shocks.
- Insurance prices should be allowed to vary based on tobacco use or other lifestyle elements that are unambiguously associated with higher health care costs.
- Lifetime and annual limits on services in insurance contracts should be banned, as well as adding other restrictions that rid the market of "mini-med" plans that don't provide real financial protection against catastrophe.
- Legislation must contain anti-discrimination provisions that ensure that employer cannot charge lower income workers more than higher income workers for their insurance.

- *Gateway* must undertake selective contracting to obtain the best prices and avoid confusion among consumers facing an enormous range of choices.
- There is no reason to have multiple competing exchanges; a single State exchange should selectively contract and allow choice within the exchange.
- A monopoly exchange (with no competing outside nongroup market) is necessary for proper risk adjustment. If the exchange is not a monopoly, it can only function properly if the same regulatory reforms are imposed on the exchange and the outside market.
- Very low-income individuals should remain in, and become eligible for, public insurance rather than coming into the exchange. This will ensure that they receive the most cost-efficient coverage and reduce erosion of group insurance.
- Low-income employees who are income eligible for subsidies should be allowed to come into the exchange, but should bring with them their employer contributions as a “voucher” to offset government costs.
- An effective individual purchase requirement is central to reform. Without this requirement fundamental market reform is impossible, as has been illustrated by a number of States that have undertaken reforms of their non-group markets. Auto-enrollment is a complement to, not a substitute for, this requirement.
- Private coverage subsidies should extend to 400 percent of the Federal Poverty Line or some individuals will be unable to afford health insurance coverage.
- Subsidies should be expressed as a rising share of income. Subsidies should not be determined by the percentage of the premium that the individual pays, or there will be enormous inequities by age and family structure, with older individuals and families paying a much higher percentage of income.
- Small business credits should be tightly targeted to the smallest and lowest wage firms, with credits phasing out with both firm size and wages.

Thank you very much for allowing me to testify today on Health Care Reform Legislative Options. Your committee, and the Congress as a whole, has before it a historic opportunity to fundamentally reform the health care system in the United States, covering all of our uninsured citizens, controlling health care costs, and improving health care quality. That said, there are a number of hard choices that must be made before this opportunity can be grasped. I am pleased that you have set up this opportunity to allow myself and other experts to weigh in on those hard decisions.

Your options memo lays out a number of key questions about reform. In this testimony I will provide comment on some of them.

SUBTITLE A: HEALTH INSURANCE MARKET REFORMS

1. No Medical Underwriting

I think it would be appropriate and useful to have premium variation based on both tobacco use and adherence to wellness/lifestyle programs. We know that financial incentives can induce proper behavior in these arenas. Indeed, the recent reform in Massachusetts allowed insurers in the State for the first time to differentiate premiums by smoker status.

It is important to note that some have suggested not varying premiums, but rather varying cost-sharing within insurance plans (e.g. deductibles), based on these factors. That would be a mistake. The level of cost-sharing within a plan is a crucial determinant of medical access and utilization. Making those who smoke, or who do not undertake wellness activities, face a higher marginal price of medical care could be inefficient. If financial incentives are to be used, they should be used on the up-front premium.

2. Modified Community Rating

A crucial accomplishment of this legislation must be to remove underwriting on the basis of health. Insurance markets that allow insurers to charge individuals much more based on unanticipated and unpredictable health shocks is an insurance market that doesn't work. A key goal for this legislation should be to provide “insurance for insurance.” to make sure that all can access insurance at affordable prices, even if they get sick.

Age variation is a somewhat different issue because age is predictable. As such, the decision to charge more or less to workers of different ages is simply a question of redistribution from younger to older insured. A restriction that age bands be narrow invokes larger redistribution from young to old than does a restriction that age bands be broad.

But there is one other consideration with age rating: the interaction with low-income subsidies. Most low-income subsidy schemes would charge individuals an income-dependent amount, regardless of age. But when subsidies end individuals are facing a market with age-varying prices. If there is large age variation, then older individuals could see a particularly large jump in their premiums when subsidies run out.

This section also discusses consumer rebates based on insufficient medical loss ratios. I do not think this is a good idea, at least initially. Medical loss ratios are complicated because (a) it is very hard to define what is a legitimate medical care/management-related expense and (b) the insurance companies will always be one step ahead of the government in figuring out how to make these loss ratios look favorable. I think a much more sensible starting point would be with reporting requirements on medical loss ratios, and to revisit this issue down the road rather than impose rebates now.

3. Other Reforms

No Lifetime or Annual Limits: To my mind this is one of the most important aspects of insurance reform. Many individuals buy insurance today where they do not understand the risk they are taking on by accepting limits on the insurance company's exposure either on a lifetime or annual basis. Real insurance reform requires that individuals be protected against extreme health shocks, and that in turn requires that insurance be an open-ended commitment to pay the medical bills associated with those shocks.

Moreover, I would amend this section to say that the government should more broadly rule out "mini-med" or "indemnity" plans that don't necessarily include annual or lifetime limits, but instead impose a reimbursement schedule to the consumer which is well below the likely cost of the service. Plans which only cover, for example, \$500/day towards the cost of a hospital stay place consumers at needless and unanticipated risk.

More generally, I would suggest you follow what is currently in the regulations for minimum creditable coverage (MCC) in Massachusetts. These regulations rule out indemnity schedules of benefits, which is defined as "A fixed dollar amount per service, set forth in the subscriber's certificate of coverage as the maximum amount that a health plan is required to pay to the beneficiary or to reimburse the provider of that service." The Massachusetts regulations also rule out:

1. an overall annual maximum benefit limitation for the plan that applies to all covered services collectively;
2. an overall annual maximum benefit limitation based on dollar amount or utilization that caps covered core services for any single illness or condition, except as otherwise may be permitted by applicable law.

Incentives for Quality Care. My only comment here is that I think allowing premiums to vary by tobacco use and other wellness elements provides an appropriate financial incentive, as noted above.

Equitable Treatment for All Workers. This section must not be dropped and is a key element of reform which strives to maintain employer-based insurance—and minimize government costs. If firms are allowed to discriminate across workers on the basis of wages or income, then the savvy employer will charge his low-income workers (who are now eligible for government subsidies) a much higher contribution rate than his higher income workers. In this way the employer can induce his low-income workers to leave the plan and take government subsidies, eroding the workplace pool and raising government costs.

SUBTITLE B: AVAILABLE COVERAGE FOR ALL AMERICANS

1. Connector/Gateway

Establishing the Gateway: There are a number of important issues here:

- a. It is critically important that *Gateways* do selective contracting, based on providing value and access, for subsidized consumers to readily compare options—to allow hundreds of licensed carriers to offer thousands of different benefits packages will miss the opportunity for price competition and will only confuse low-income consumers.
- b. There are a number of activities that can be coordinated at the Federal level to provide economies of scale to State connectors:
 - The development of comparison shopping tools (Web site, decision-support, physician-finder software, etc.) that can be given to the State *gateways*.
 - A federally established annual open enrollment period will significantly reduce the costs and confusion of giving consumers choice.

- A federally established risk-adjustment process and software will focus competition among carriers on value, access and quality of care rather than risk selection.

c. Multiple, competing exchanges would create confusion, administrative waste, and undermine any exchange's ability to improve purchasing with Federal and private dollars. There is simply no reason for multiple competing exchanges.

Market Regulation: The exchange will function best if it has monopoly power in the nongroup (and perhaps small group) market. If it does not, it is hard to conceive of doing proper risk adjustment. Risk adjustment involves taking from plans with healthy enrollees and redistributing to plans with less healthy enrollees. But if this risk adjustment occurs only within an exchange, and not outside, then there will be a natural tendency for less healthy individuals to select the exchange (where they are cross-subsidized) and more healthy individuals to stay outside of the exchange (where they do not have to cross-subsidize). This will destabilize the exchange and undo the notion of market reform.

If the exchange does not have monopoly power, it is critical that the regulations on insurance be the same inside the exchange and in the outside market. If not, this will further exacerbate the adverse selection problem noted above. For example, if health underwriting is allowed outside the exchange, but not within the exchange, then it will further skew prices downward for the healthy if they stay outside the exchange, raising prices inside the exchange and undoing market reforms there.

Qualified Individual: It would be a mistake to allow low-income individuals eligible for Medicaid into the exchange. This is for three reasons:

a. Medicaid coverage is less expensive than coverage in the exchange for this population because of low provider rates under Medicaid and tight management of some benefits (e.g. pharmacy).

b. Low-income individuals who obtain coverage from their employer will be more likely to exit that coverage and move to employer-like exchange coverage than they would be to exit that coverage to move to a government-run Medicaid program (since the exchange would appear to be a closer substitute to what they already have). As such, if the entitlement for low-income individuals is to an exchange, disruption of existing employer insurance arrangements will be higher than if it is to a Medicaid.

c. It is not clear how well consumer choice and structured competition can work for the lowest income populations who cannot afford to pay differentials across health plans.

In light of these considerations, I would suggest a clear breakline for public insurance eligibility below which individuals are eligible for free public insurance, and above which they can come into the exchange.

Eligible Employee: One of the thorniest issues with subsidized exchanges is how to address the problem of low-income individuals who are offered employer-sponsored insurance, but at a cost that may be unaffordable. There are essentially three options here:

a. A "firewall:" exclude such individuals from eligibility for exchange subsidies. This is by far the least expensive option—but also may leave millions of low-income Americans unable to afford insurance.

b. Allow low-income individuals into the subsidized exchange if their employer-sponsored insurance is deemed unaffordable. This option addresses the fundamental inequity noted in (a), but at a high cost.

c. An employer "voucher:" Allow low-income individuals into the subsidized exchange if their employer-sponsored insurance is deemed unaffordable, but their employer in this case must send to the exchange the monies they would have otherwise spent insuring that individual. This option addresses the fundamental inequity noted in (a), but at a lower government cost than (b). This seems to me to be the best option.

SUBTITLE D: INDIVIDUAL AND EMPLOYER RESPONSIBILITY

1. Individual Responsibility

Shared Responsibility Payments: An individual requirement to purchase insurance is the centerpiece of successful reform. Without this requirement market reform may not be possible. *Every State* that has tried to community rate its non-group market without a mandate has in the process dramatically raised prices and restricted the size of the market.

An effective individual requirement means an effective penalty on those who do not comply. There is no "right answer" as to how large that penalty has to be. The penalty in Massachusetts for noncompliance is 50 percent of the lowest cost insur-

ance option available to individuals. This penalty has been sufficient to motivate at least two-thirds of our uninsured to obtain coverage in the very first year.

Auto enrollment of individuals should be considered as a complement to the individual mandate, not as a substitute. Auto enrollment does not reach many of the crucial uninsured who will determine the success or failure of market reform.

Reporting of Health Insurance Coverage: A fundamental failure in the market for employer-sponsored insurance is that employees have no idea of the cost of insurance they are purchasing, limiting their role as advocates for lower cost coverage. Including that cost on the worker's W-2 form would help mitigate this problem.

SUBTITLE C: COVERAGE EXPANSIONS AND SUBSIDIES

1. Medicaid Expansion

As noted earlier, dropping the Medicaid expansion and enrolling individuals in the exchange would, in my view, be a mistake. Medicaid expansions are cheaper and reduce disruption of existing employer relationships, and many low-income individuals do not have the disposable income necessary to shop across multiple options.

2. Private Coverage Subsidies

Premium Credits: The fundamental affordability problem facing the uninsured cannot be resolved without sizeable credits towards the purchase of insurance. Given the high cost of insurance, such subsidies must extend to 400 percent of the Federal Poverty Line. Below that level, insurance may be unaffordable for many, in particular older persons and families within an age-rated system. In Massachusetts, where we were restricted from extending subsidies beyond 300 percent of the Federal Poverty Line, we were forced to exempt many individuals above that level from the mandate because of affordability issues.

It is critical that credits be based on income and *not* be determined as a share of premium costs. That is, the tradeoff with low-income subsidies should be all about affordability, to the individual vs. to the government. This suggests that the debate should be over what percentage of income individuals are required to pay. This debate has *nothing* to do with the premium rates actually facing those individuals.

For example, a sensible credit scheme would be one where individuals pay a percentage of their income that rises with income (e.g. 1 percent of income at 100 percent of poverty to 10 percent of income at 400 percent of poverty). Such a system would ensure affordability for the individual, and the levels could be set based on the interplay between individual affordability and government budgetary needs.

A much less sensible scheme would be one where individuals receive a subsidy as a percentage of the average premium in their area, which can lead to enormous differences in what individuals pay as a percentage of income based on age and family structure. Consider, for example, individuals with income of \$25,000. Imagine that a single policy for someone who is 40 years old is \$4,000. Suppose we decide that someone at that level should be paying 6 percent of income based on affordability considerations. This would imply that everyone at that income level charged a premium of \$1,500. That same target could be obtained with a subsidy that is a percentage of premiums of 62.5 percent; if the government pays 62.5 percent of the costs of insurance, then the 40-year-old individual pays \$1,500.

While this example works for this particular individual, it leads to huge underlying differences across individuals. Suppose that the market allows 3:1 age rating. This would imply that, for example, the premium for a 64-year-old is \$9,000 and the premium for a 25-year-old is \$3,000. If you offer each the same percentage subsidy (they each get 62.5 percent off the price of insurance), then the 25-year-old pays \$1,125 (which is 4.5 percent of income) and the 64-year-old pays \$3,375 (which is 13.5 percent of income). So you could end up with individuals earning only \$25,000 a year who have to pay 13.5 percent of their income towards premiums, which is much too high. This problem is only exacerbated when you consider differences across couples and families.

For this reason, when we discuss low-income credits, the conversation should be focused on the percentage of income that individuals have to pay, and not on the subsidy rate towards the cost of insurance.

3. Small Employer Credits

Small business credits can be an integral part of reform by promoting health insurance offering among small firms. But there is a clear efficiency gain to targeting such credits to those firms least likely to offer without the credit. These types of firms are clear: small *and* low wage firms. Firms that are above 25 employees, or firms where average wages are more than \$40,000 per year, are much more likely to offer insurance.

Moreover, the amount that the firm contributes towards insurance does not much determine the likelihood that individuals enroll in that insurance. Numerous studies over the past decade have shown that employee participation decisions in employer-sponsored insurance are fairly in-sensitive to the prices charged those employees.

These two considerations suggest that small business credits focus on small- and low-wage firms, and do not focus much on how much those firms contribute towards health insurance (subject to contributing some minimum percentage of the cost, say 50 percent). Given these suggestions, there are some flaws with the small business credit proposed here.

- The credit should be focused on firms with fewer than 25 employees, not 50 employees, which is where non-offering is most concentrated. In particular, the bulk of any new dollars should flow to firms with fewer than 10 employees. Among firms with fewer than 10 employees, the rates of insurance offering in 2008 were below 50 percent; for those firms 10–24 employees, the rate was 78 percent, and for those firms 25–49 employees, the rate of offering was 90 percent. Thus, the more that credits can be focused on the smallest firms, the more effective they will be.

- The credit amounts should decline with firm average wages, or otherwise be targeted to the lowest wage employees in a firm. A cutoff at a fixed wage level such as \$50,000 can lead to adverse firm behaviors when paying a worker \$1 more can lead to thousands of dollars less in employer subsidies. A more sensible scheme would phase the credit out smoothly as worker wages rise rather than having such a “cliff”.

- Bonus payments for higher employer contributions do little to increase coverage. Available funds should be spent solely on encouraging employers to offer insurance since that is the key determinant of coverage.

Senator DODD. Very good. Thank you very much, Doctor. That was very helpful.

Janet, thank you for joining us.

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

Ms. TRAUTWEIN. Well, thank you very much for inviting me. I do want to stress that we do believe this is an historic opportunity to put in place real solutions to improve quality, to reduce costs, if we do things the right way.

Given that we’re under a very short time table, given the mark-ups that are coming, I would like to talk about all the things that could be done the right way, but I think I need to comment very specifically on some of the things that are in this bill that we find particularly troubling and that need to be changed.

First of all, where we observe change being needed is in the individual and small employer market. The market that’s larger than that works pretty well already today and so I want to comment very specifically on some things that we think are—I believe, I’m hoping that they are—unintentional in this legislation and I want to comment on those.

First of all, one thing that I think is not unintentional are the rating rules that do apply to the 2 to 50 market. They’re currently listed as 2:1 age bans and this is really—this would cause significant rate shock for people that are trying to get coverage and for people that are covered already today.

Given the grandfathering rules and the way they’re structured, it would dump a lot of people in. They wouldn’t be able to be grandfathered for very long.

Now, I want to specifically talk, though, about the size definitions. One thing that was very interesting in this legislation is that typically we see things like this addressed to the individual market, the small group market, the large group market, and that’s not

what happened in this bill. It was the individual market and the group market and I'm sure that some of this was done intentionally so that we would bring some of the reforms into all markets and we would support some of those reforms being in all markets, but the rating reforms are what I want to focus on right now.

We would specifically request that you change the legislation to allow claims experience to be used in groups of over 50. Now, I often hear people say, well, "employer markets already use community rating" and that's true, but let me explain to you how the community rating works.

The community rate their own group of employees, based on the claims experience of their own group of employees. The way this legislation is written today, any group that chose to fully insure, and there are many groups over 50, over 250, over a thousand, that for whatever reason fully insure their policies, they would be subject to the same modified community rating rules that an individual would be subject to and this would cause significant rate shock. It would be horrible for employers. The cost increases for them and their employees would be dramatic, and I highly encourage you and would be happy to work with you on how to change this provision so that we don't have this severe unintended consequence.

I also want to remark on the navigators that are in the bill. You know, we're really unclear on exactly what the purpose of the navigators is. The role of the navigators is already played by agents, brokers, and consultants in the market today.

We really question whether entrusting organizations that have absolutely no health experience at all, to advise people about their insurance decisions is really a very good idea and at best, it seems a giant duplicative waste of money that could better be used to subsidize people who really can't afford to buy coverage.

Beyond that, I would be remiss to not mention that we have serious concerns about the creation of a government-run public health insurance plan and the corrosive consequences it would have on the private health insurance market and we do not believe that a level playing field can be established or maintained for a number of reasons.

And finally, I do want to re-inforce that we do support change. We are very much in favor of an enforceable and effective individual mandate and a mandate for those individuals is one thing. A mandate for employers is something else all together.

We know that this is well-intentioned. We believe this would hurt American workers, particularly in the format that it's been recommended, and we can't really imagine one that wouldn't do that. We're concerned that it would actually harm current insurance levels and it would decrease jobs and economic growth and we don't think that's what we need in today's economy.

Thank you very much.

[The prepared statement of Ms. Trautwein follows:]

PREPARED STATEMENT OF JANET STOKES TRAUTWEIN

EXECUTIVE SUMMARY

The National Association of Health Underwriters (NAHU) is pleased to be able to play a constructive role in crafting bipartisan, comprehensive health care reform

legislation this year. We have an historic opportunity to put in place real solutions to reduce costs, improve quality and ensure choice and access for all Americans in a way that will strengthen our health system and our economy.

There are a number of desirable improvements to our health care delivery system that are included in *The Affordable Health Choices Act*, however other proposals should be considered further, as our experience reveals they could pose unforeseen and unintended problems in health insurance marketplaces.

Our first concern is the rating reforms that have been proposed. NAHU believes that these should only apply to individual health insurance products and fully insured small group plans of 2-50 lives. The rating rules need to allow variations for applicant age at the natural age breakdown rate of at least 5 to 1 with additional variations allowed for participation in wellness programs, smoking status and geography. We also specifically request that groups over 50 be permitted to use claims experience. This is different than prospective health status rating and is the way all large groups develop premiums today. When we hear that large groups "community rate" their employees, what this really means is that the group develops rates that are the same for all participants in their employer group based on that employer's claims experience. Eliminating the ability to develop premiums in this manner will result in *significant rate shock* for many employers and their employees.

NAHU is unclear on the purpose health insurance navigators will serve and feels that their functionality is duplicative of some of the role licensed agents and brokers already serve in the marketplace. Many services provided by agents and brokers would never be able to be assumed by a navigator because they lack the expertise to perform those functions. NAHU questions the wisdom of entrusting organizations with no prior health insurance background with the authority to advise individuals on their insurance decisions. It is doubtful that community organizations with no relevant health care background can deliver the policy knowledge, service, value, and accountability that distinguishes the professionally licensed and trained agent, broker, and benefit specialist. If a State feels the need to establish navigators as part of its *Gateway*, then NAHU feels that such navigators should be subject to the same rigorous licensing and continuing education requirements that licensed agents and brokers are required to abide by. Concerning the proposed *Gateways*, any subsidies or other insurance requirements should mirror to the largest extent possible existing State laws and regulations. This is discussed further in our primary testimony.

NAHU has significant concerns about the creation of a government-run public health insurance plan and the likely corrosive consequences it would have on private insurance markets because a "level playing field" cannot be established or maintained. Would a government plan comply with the many requirements placed on private plans, such as State licensure, capital requirements, financial solvency, provider network adequacy standards, rate approval, and Federal and State taxes and assessments, just to name a few?

The idea of an enforceable and effective individual responsibility requirement for all Americans to purchase health insurance could help with adverse selection issues which exist in our current system and we support this concept. A mandate to force employers to provide health insurance to their employees is another matter. While well intentioned, this could actually hurt American workers and health insurance coverage levels. It would decrease jobs and economic growth and do little to address the current uninsured population compared to other initiatives.

Our full testimony follows.

As an association representing more than 100,000 health insurance agents, brokers and benefit specialists from every State in the country, the members of the National Association of Health Underwriters (NAHU) work with both individual and corporate health insurance consumers to help provide them with high-quality affordable health plans specifically suited to their unique needs. NAHU has analyzed the proposed *American Health Choices Act* and has the following questions, comments and concerns.

There are a number of desirable improvements to our health care delivery system that are included in *The Affordable Health Choice Act*, such as promoting health prevention initiative, enhancing nutrition labeling, increasing our health care workforce, setting up more mechanisms to combat health care fraud and abuse, and providing for the development of follow-on or generic biologics.

PROPOSED MARKET REFORMS

The legislation creates significant market reforms to both the individual and group insurance markets. It would require all health plans, whether fully insured or self-funded, to accept enrollees regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. For all fully insured plans, *regardless of size*, it would impose strict modified community rating standards consisting of variances only by family structure, community rating area (defined by the HHS Secretary based on the recommendation of the NAIC), actuarial value of the benefit and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of 2 to 1. No premium variations would be permitted for health status, gender, class of business, claims experience or any other factor not specifically described in the legislation.

NAHU has very significant concerns about the proposed reforms, particularly that there is no distinction between small and large employer groups, as there is in today's marketplace. Under current law, fully insured employer groups over 50 lives are treated very differently than the small group market, and these groups are typically rated based on their past claims experience. This market is the health insurance market working best today, and the rating reforms proposed by this measure, which would apply to all fully insured groups regardless of their size would significantly increase costs in this market. It also would create adverse selection to the fully insured market, as the larger groups that chose to fully insure would only do so if they had concerns about their group's claims experience. NAHU does agree that reforms need to be made to the individual and small group markets concerning the way that premium rates are determined at the time of application. It is NAHU's view that these markets would benefit from greater premium standardization. The first step should be a uniform application for coverage. A clear and understandable uniform application would ensure full disclosure of accurate and consistent information, and it would make the process easier for consumers applying for coverage with several different insurance carriers.

The second issue is that the rating reforms proposed should only apply to individual health insurance products and fully-insured small group plans of 2-50 lives. Furthermore, in order to protect against runaway costs, the Federal Government should ensure that wide-enough adjustments may be made for several key factors. At a minimum, variations need to be allowed for applicant age at the natural age breakdown rate of at least 5 to 1 (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 also be allowed for participation in wellness programs, smoking status and geography.

Finally, we specifically request that groups over 50 be permitted to use claims experience. This is different than prospective health status rating and is the way all large groups develop premiums today. When we hear that large groups "community rate" their employees, what this really means is that the group develops rates that are the same for all participants in their employer group based on the employer's claims experience. Eliminating the ability to develop premiums in this manner will result in significant rate shock for many employers and their employees.

We are pleased that the 250 employer size limitation on self-funding was removed from the bill and we hope that change is permanent. The decision whether or not to self-fund or partially self-fund an employer group plan is based on many financial and other factors, group size being only one of them. A financial business decision of this magnitude should be left to the individual discretion of the employer, and should not be subject to an arbitrary cap imposed by the Federal Government.

We do urge caution in eliminating annual limits on benefits. This could be a problem for services that have appropriate durational limits. It would be important if this is done to have a strong provision to allow limits based on medical necessity to avoid overuse of some services. We feel similarly about the elimination of lifetime caps. Lifetime caps are rarely met, even by the sickest individuals, but they do help provide a control on pricing for medical costs for all covered individuals. Private re-insurance for an unlimited maximum is expensive for both health plans and self-funded employers and will impact premium levels. While we do not want any individual to have coverage arbitrarily cut off due to a lifetime limit, we wonder whether a Federal financing/re-insurance backstop for those rare individuals whose medical expenses are so great they would exceed lifetime caps might not better serve the affordability goals we share for all consumers.

In a similar vein, we would advise that a different mechanism be used than the risk adjustment system proposed. Especially during the time that market reforms are being put into place and the individual mandate is being enforced, a better sys-

tem would be a system of re-insurance at the State level, with some Federal funding assistance. This would ensure a much more stable transition to the new system. Once all of the reforms are in place, the issue of risk adjustment can be re-addressed to determine the best approach to long-term risk selection issues.

MINIMUM LOSS RATIOS

For all fully insured health plans the legislation specifies minimum loss ratios. The measure requires insurers to track reimbursements for clinical services, activities that improve health care quality and all other non-claims costs. The Secretary will determine what ratios are appropriate for the individual and group markets. If non-claims costs cannot exceed those percentages, beneficiaries must be rebated on a pro-rata basis for the excess.

NAHU has concerns about a minimum loss ratio requirement, as it does not address the true problem that is driving health insurance premium costs—the skyrocketing cost of medical care. The definition of administrative expenses in the bill is quite broad and may encompass many services that actually benefit consumers. In addition to profits and marketing, non-claims expenses include quality management, disease management programs, health information technology investment, claims processing, legal compliance, Federal and State taxes, employee salaries, consumer education, etc. A 2005 Price Waterhouse Coopers study found that health plan administrative costs were not a factor contributing to health care cost increases, rather increased utilization of services, an aging population, lifestyle choices, and new technologies were the primary cost drivers. In States that have adopted high loss ratio standards, consumers have suffered from less competition, fewer choices, and higher premiums.

GATEWAYS

This provision requires each State to establish a variation of a health insurance connector or exchange which is termed a *Gateway*. If a State does not establish a *Gateway* within 4 years, the Secretary must establish one for them. The *Gateways* will use risk adjustment mechanisms to remove incentives for plans to avoid offering coverage to those with serious health needs. The stated purpose of the *Gateway* is to facilitate the purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups (including self-employed individuals). The legislation specifically allows for group and individual private market coverage to exist outside of the *Gateway*. If individuals like their current coverage, they can keep it. State insurance regulators will perform their traditional obligations regarding consumer protection and market conduct.

NAHU believes that if *Gateways* are part of greater health reform, it is critical that they be structured in such a way that does not damage or eliminate the traditional private insurance marketplace. While we appreciate the state-level approach concerning the structure of the *Gateways*, NAHU is concerned that this measure may still result in the creation of multiple state-level bricks-and-mortar institutions. This approach has proven costly in Massachusetts and is duplicative of existing private-market functions.

It is important to keep in mind that a *Gateway* would not truly pool the risk of all participants. The structure of a *Gateway* would be more as an aggregator of plans. In this type of arrangement where multiple plans from different insurers compete, there is no common pooling among plans. For example, a pool with 5,000 participants that has 500 enrollees in each of 10 different plans does not get a discount for having 5,000 participants. Even before the Massachusetts model, group purchasing arrangements like this were tried by many States, and few survived due to anti-selection issues among participating carriers, and the fact that they were unable to offer a less expensive product through the grouped arrangement. That's why pools have historically not been very successful in lowering cost, although they may provide choices for individual employees in small-group plans. Of course the cost of this choice has been more limited options than were available outside of the purchasing arrangement, resulting in most of these programs only being able to offer HMO coverage. The most successful State purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable.

With these facts in mind, we are concerned about any expectations some may have that a *Gateway* is going to lower cost, and even more important, to be sure it is not structured in such a way that it might increase cost. For this reason, we

have grave concerns about attempting to create a single pool of risk within the *Gateways* for individual and group purchasers. Our experience in States that permit self-employed individuals to be a part of their small employer market is that small group rates are higher in those markets. This seems an unfair burden on small employers and we hope that if both individuals and small groups are permitted to participate in *Gateways* it will continue to be permissible to pool them separately.

We feel strongly that *Gateway* subsidies and other requirements should mirror State laws outside the *Gateways*, otherwise adverse selection will be rampant. National experience with purchasing pools of all kinds shows that pools that operate at the State level that also fairly compete with plans outside the pool are the least disruptive to the market.

NAVIGATORS

The legislation allows States to enter into contracts with “navigators” and provides them with Federal support to do so. Health coverage navigators could be private and public entities that could assist employers, workers, and self-employed individuals seeking to obtain quality and affordable coverage through *Gateways*. Entities eligible to become navigators could include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, and others. The navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. Health insurers or parties that receive financial support from insurers to assist with enrollment are ineligible to serve as navigators.

NAHU is troubled by a number of aspects of these recommendations. Many of the roles described for navigators are already performed by licensed agents and brokers in every State. We know that the services of agents and brokers will be needed more than ever in a *Gateway*, and that they will continue to be needed to serve as counselors and advocates for the American consumer. Since agents and brokers are clearly an integral part of the health insurance market regardless of the setting, and are already performing these services as a normal course of business, we question the wisdom of spending precious financial resources on a new system such as the navigators described in the bill.

Licensed specialists design benefit plans, explain coordination issues of public and private benefits to individuals/employees, and solve problems that may occur once coverage is in place. They are also at the forefront of helping to design and implement cutting-edge health promotion and wellness programs for employers—a focus that everyone agrees is key to combating increasing health care costs.

Agents and brokers are subject to rigorous licensing and continuing education requirements and serve a proud and important role as advocates for their clients. They perform extensive needs analyses for their clients, and help them gain coverage matched to their unique needs. After coverage is placed, they provide extensive assistance to ensure that claims are paid on a timely basis, that questions are answered, and that their clients’ specific needs are met.

NAHU is unclear on the purpose of health insurance navigators will serve and feels that their functionality is duplicative of some of the role licensed agents and brokers already serve in the marketplace. And many services provided by agents and brokers would never be able to be assumed by a navigator because they lack the expertise to perform those functions. If a State feels the need to establish navigators as part of its *Gateway*, then NAHU feels that such navigators should be subject to the same rigorous licensing and continuing education requirements that licensed agents and brokers are required to abide by. In addition, NAHU feels that navigators, if used, should be limited to entities with prior experience in this area such as the SHIPs that provide seniors with assistance relative to the Medicare program.

MEDICAL ADVISORY COUNCIL

The measure provides for the creation of a Medical Advisory Council by the Secretary of HHS, in consultation with NIH, CDC and others for the purpose of making recommendations on: (1) the schedule of items and services that constitute the essential health care benefits eligible for credits including the amount, duration, and scope of such items and services; (2) the coverage that should be considered minimum qualifying coverage and (3) the conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels.

Although we are supportive of new research that could be done to gather more information about best practices and better information on the efficacy of different treatments, NAHU has concerns about a creation of a new government-run entity

tasked with making coverage determinations for the American people. In addition, we are unsure that this is an appropriate role for the NIH and CDC, as they have no expertise in the area of private insurance.

Concerning the standard for minimum creditable coverage, we believe the goal should be one of ensuring that basic appropriate services are available. The standard should merely list those services, rather than the quantity of those services to preserve plan, employer and individual consumer flexibility. Just as an example, the standard should require inpatient and outpatient hospital services, physician services, lab and x-ray, and prescription drugs. The quickest implementation standard would be to use an existing definition, like the definition for HIPAA creditable coverage. Using this standard would ensure comprehensive coverage and would allow States to be of immediate assistance in helping with enforcement because this is a standard that is already embedded in law for all States.

GOVERNMENT-RUN PUBLIC PLAN

The legislation leaves the structure of a public plan option to be determined. The initial draft of the legislation included a public plan option to be known as *Affordable Access* to be sold through the *Gateway*. If a provider accepts Medicare it must accept as payment in full the amount of the payment from an Affordable Access plan and the Affordable Access plans will pay Medicare rates plus 10 percent. The measure specifies that Affordable Access premiums must be an amount that will cover the costs of the plan.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. A government-run public plan could never compete fairly with the private market, nor would it be financially feasible in the long-run. The legislation, as proposed, would likely displace tens of millions of happily insured Americans from the conventional marketplace and exacerbate the worst elements of the current system: gross inefficiency, high costs and bureaucracy. NAHU believes that a far better use of Federal efforts and monies would be helping lower income Americans afford the cost of private coverage.

INDIVIDUAL SUBSIDIES

The legislation creates a complicated system of sliding scale subsidies for people purchasing coverage through the *Gateway* with incomes between 100–500 percent of the Federal poverty level (FPL).

NAHU has serious concerns about limiting the use of the credit to products purchased through the *Gateway*. The credit should apply regardless of the place of purchase; otherwise the result will be an unlevel playing field of some kind. If subsidies are available only inside the *Gateway*, “crowd out” from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the *Gateway* can also result in higher-than-expected costs for those in the *Gateway* and an apparent larger number of uninsured than actually exist.

Past market-reform experience clearly shows that whenever an unlevel playing field is created through a financial incentive or other means, one of the coverage options is always selected against, which ultimately harms the viability of all coverage options in the market. By allowing for an unlevel playing field between the *Gateway* and the rest of the private market, we are concerned that these options set the stage for long-term market failure.

NAHU also objects to subsidies for families earning up to 500 percent of the Federal Poverty Line (FPL), which for a family of four would be \$110,000. We believe that this is far too great of an expansion of government assistance, particularly considering the current state of the Federal budget deficit. Similarly we also have concerns about the provisions that also would expand Medicaid to 150 percent of the FPL when the current Medicaid program is financially unsustainable, particularly for the individual States. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100 percent of the FPL. Furthermore, to prevent reducing the crowd out of the private market that could occur with a Medicaid expansion, NAHU supports mandatory premium assistance when private coverage is available.

INDIVIDUAL MANDATE

The legislation creates an individual mandate for coverage with a Federal income tax penalty on any individual who does not have in effect qualifying coverage for any month during the year. Health plans must provide a return to individuals as documentation of coverage.

Exemptions will also be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an excep-

tional financial hardship. The Secretary of the Treasury in consultation with DHHS will determine the minimum penalty needed to accomplish the goal of substantially increasing coverage. The mandate is not applicable in States where *Gateways* are not yet operating.

NAHU supports the concept of individual responsibility in health coverage reform and believes that, in order to achieve universal coverage and ensure that market reforms are successful, an enforceable and effective individual mandate to obtain health insurance coverage is necessary.

Concerning the consequences of non-coverage, NAHU believes these penalties may not be sufficient to ensure adequate compliance. An individual mandate needs to be both effective and enforceable to make other market-reform ideas work. To improve this mandate's chance of success, we believe the Federal reporting by individuals and insurers should be accompanied by measures at the State level, including enforcement through schools and drivers' license bureaus, late enrollment penalties, and auto-enrollment and requirement of proof of coverage through employers.

EMPLOYER MANDATE

The measure establishes definitions for an employer mandate or some other form of shared employer responsibility but leaves the policy details of this section to be determined. There is an exemption for employers in Hawaii.

NAHU believes that the employer-based system must be at the core of any health reform effort. However, we believe that the provision of benefits must be a voluntary action on the part of the employer. We are opposed to an employer mandate as it would impact job availability, suppress wages and could result in some employers actually contributing a lower percentage of the premium for their employees' coverage than they had in the past.

HEALTH IT

NAHU supports the measures efforts to extend health IT financial incentives to a broader range of providers as we feel that increased utilization of health IT will help reduce health care expenses and lead to higher-quality care for American consumers by reducing errors and improving patient satisfaction. In addition, we support the specification that interoperable technology be used, so that all record systems and providers are able to communicate with one another and individual health records are always up to date and complete.

LONG-TERM CARE/DISABILITY PROGRAM

The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living.

To promote the purchase of private long-term care insurance, the bill allows LTC insurance premiums to be included in section 125 plans.

NAHU believes the cost of providing long-term care to our aging population is one of the greatest burdens on our national medical safety-net. But rather than the creation of a large-scale government program, NAHU would prefer to see Congress enact some simple reforms and tax incentives to make it easier for people to purchase private long-term care insurance and ease the strain of providing long-term care coverage on the Medicaid system. In addition to the inclusion of LTC insurance premiums in section 125 plans, NAHU also believes that Congress should allow a tax deduction from gross income for long-term care insurance premiums and include long-term care insurance in flexible spending arrangements.

We appreciate the opportunity to provide comments and look forward to any questions you may have.

For questions following the hearing, please contact me at (703) 276-3800, jtrautwein@nahu.org, or contact Jessica Waltman, Senior Vice President of Government Affairs, jwaltman@nahu.org, (703) 276-3817.

Senator DODD. Thank you very much, Janet.

Ms. Praeger.

STATEMENT OF SANDY PRAEGER, KANSAS INSURANCE COMMISSIONER, TOPEKA, KS

Ms. PRAEGER. Thank you, Senator Dodd, Senator Enzi, and members of the committee.

I am Sandy Praeger. I'm the Insurance Commissioner in Kansas, and I also Chair the National Association of Insurance Commissioners Health Insurance and Managed Care Committee.

I really thank you for the opportunity to participate in the roundtable and to present the views of State insurance regulators who will be responsible for implementing much of the legislation that's before the committee, and I just want to tell you I believe we are up to the task.

I want to applaud the committee for its recognition in the bill that health reform will be a State and Federal partnership and thank you, too, for preserving the State oversight of the health insurance industry.

State regulators are closer to the consumers that they are protecting and have over a 135 years of experience regulating insurance products in the United States.

We appreciate that most of the reforms contained in the bill will be implemented at the State level and we're pleased to see that the gateways envisioned through which millions of Americans would purchase their coverage will also be based at the State level.

We also applaud the committee for enacting some long overdue reforms in the individual market to ensure that health insurance coverage is available to all Americans, reforms that are not possible without including a strong enforceable individual responsibility requirement.

Now while there are many good pieces to the bill, I want to take—and I do believe it does take a very important step in realizing the committee's goal of expanding coverage, reducing costs, improving quality and protecting consumers, we've identified a few areas where we do believe some technical improvements can be made to avoid adverse selection issues and to smooth the implementation of the reforms.

First, we would recommend that the implementation timeframe of the bill be extended to allow States 4 years from the date on which the final regulations are published in the Federal Register rather than from the date of enactment, as the bill is currently drafted, and I think that 4-year timeframe is critical and the States need to know what the rules are before they can really begin the implementation process.

We would also suggest that the committee think carefully about how the insurance marketplace outside of the gateways will interact with the markets within the gateways and ensure that there is no room for the two markets to be played off one another, so there is uniformity and level a playing field.

And finally, we'd recommend that the States be closely involved in the drafting of the rules that will apply to coverage sold through the gateway for marketing and network adequacy and would recommend a model similar to the regulation of Medicare Supplemental Insurance, one that the former Commissioner in Kansas Kathleen Sebelius, she's that other person with the white hair. She's quite familiar, quite familiar with the way the States have worked over the years and are still working to develop the Medicare Supplemental policies.

I would just remind the members of the committee, too, that we've expressed concerns over the last several years about the

Medicare Advantage products that are sold through Medicare where we don't have oversight and regulatory authority and we have identified marketing abuses.

Again, I want to thank you for the opportunity to join in this conversation this afternoon and for the seriousness with which you have approached this historic opportunity to improve the health of our Nation.

I look forward to the discussion and we look forward to working with the committee in enacting comprehensive reforms this year.

Senator DODD. Thank you very much, Ms. Praeger.

Dr. Gottlieb.

**STATEMENT OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW,
AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC**

Dr. GOTTLIEB. Thank you for the opportunity to be here today.

The American healthcare system is capable of delivering unparalleled care. Our medical product sector is the world's source of innovation, but as you noted, for too many people these opportunities are inaccessible.

When I worked at the Centers for Medicare and Medicaid Services, I spent my weeks at the agency here in Washington and my weekends back home practicing medicine in an acute setting of a busy urban hospital.

I can tell you firsthand that our perception of the problems inside the Humphrey Building often didn't comport with what was really taking place on the wards and as you'd expect neither did our policy prescriptions for fixing what was wrong.

For example, you look at data on all the variation that exists in the way doctors in different geographies approach similar problems and it's easy to conclude that supply must be creating its own demand. More cardiologists must mean more catheterizations. The solution seems obvious. We need to closely regulate pay to shift money between providers. We need to limit the number of specialists we train. We need to restrict certain services at point of demographics while based on comparative data we develop a new agency or guidelines we write on another one.

I would suggest that the data isn't so clear and it shows that we can identify the variations but we don't really understand its causes nearly as well as we think we do.

There are complex factors that go into local medical conventions. There are misaligned incentives driving medical behavior that have corroded over many years of shortsighted payment rules. Problems exist precisely because of fixed rules and pay schemes hashed here in Washington, not in spite of them.

As the largest purchaser of healthcare services, Medicare shapes the entire market by its pricing schemes. It's not the medical decisionmaking that's flawed but the incentives driving those judgments, incentives detached from the outcomes we want to achieve.

Or take for example the refrain around the need for more comparative data. There is no question many important clinical questions remain unanswered but the reasons are often complex. A lot of uncertainty about the relative benefits of two treatments remains in doubt because answering those questions is very hard. It takes very long and large clinical trials to discern small differences

between active treatments, yet we are proposing to do shorter, cheaper studies based on backward-looking databases rather than forward-looking trials to probe these questions.

We should pay for rigorous trials out of public funds but we shouldn't cheat ourselves to believe that simple and cheap studies can resolve questions that persist despite close attention. Proponents of comparative effectiveness research almost all point to the treatment of back pain or early prostate cancer as two areas in need of more research.

On PubMed there are literally thousands of studies addressing these topics. Questions persist because none of the studies are large enough and long enough to provide definitive answers that address all the variations in patient conditions.

Managing disease isn't a commodity service amenable to designs and workforce rules hatched here in Washington. This isn't like building cars. The current proposals for fixing healthcare rely on a lot of the usual patches. They increase political rather than individual controlled medicine through a collection of new commissions, boards and agencies.

The plan before this committee shifts to the government and probably Medicare where more of the clinical decisions are properly left to people and their doctors.

Thank you.

[The prepared statement of Dr. Gottlieb follows:]

PREPARED STATEMENT OF SCOTT GOTTLIEB, M.D.¹

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to share my testimony with the committee. The American healthcare system is capable of delivering unparalleled care. Our medical products sector is the world's source of innovation.

But for too many people, these opportunities are inaccessible. The same system capable of delivering innovative, intensive services sometimes fails to provide for the most routine care. High technology medical products that extend lives are leaving some families bankrupt.

There is no single cause for these shortcomings, and no straightforward solutions. But as we embark on an effort to take the best attributes of our system and make these benefits more accessible and affordable to people closed out of these opportunities, we need to be mindful not to embrace solutions whose abiding quality isn't that they are optimal, but just undemanding.

When I worked at the Centers for Medicare and Medicaid Services (CMS), I spent my weeks at the agency here in Washington, and my weekends back home, practicing in the acute setting of a busy, urban hospital. I can tell you first hand, our perception of problems from inside the Humphrey Building often didn't comport with what was really taking place on the wards. As you'd expect, neither did our policy prescriptions for "fixing" what was wrong.

For example, look at data on all of the variation that exists in the way doctors in different geographies approach similar problems and it's easy to conclude that supply must be creating its own demand. More cardiologists mean more catheterizations. The solution seems obvious. We need to more closely regulate pay to shift money between providers. We need to limit the number of specialists we train. We need to restrict certain services according to demographics, or based on "comparative" data we develop in a new agency, or guidelines we write up in another one.

I would suggest the data also shows that we can identify the variation, but we don't understand its causes nearly as well as we think we do.

There are complex factors that go into local medical conventions. There are misaligned incentives driving medical behavior that have corroded over many years of short-sighted payments rules. There are, as well, equal quantities of research that

¹The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

suggests that much of the geographic variation in health spending can be explained by differences in peoples' characteristics.

Our problems exist precisely because of fixed rules and pay schemes hatched here in Washington, not in spite of them. As the largest purchaser of healthcare services, Medicare shapes the entire market by its pricing schemes. It's not the medical decisionmaking that is flawed. It's the incentives driving those judgments, incentives detached from the outcomes we want to achieve.

Moreover, every hospital can't be a Mayo Clinic or Geisinger Health System. There are plenty of poorly performing hospitals, for example, which hobble along with the crutch of their not-for-profit status. I doubt that is going away. Paying for episodes of care rather than procedures—as many private insurers are increasingly doing—would better align incentives. But here again, politics has been the enemy of the optimal. I doubt Congress is willing to “capitate” doctors. Or exclude poor performing physicians from participation in Medicare. Or turn over care to private plans better able to implement payment reforms, as well as manage local delivery of care.

Another idea for fixing Medicare is risk-adjusted or capitated payments that can adjust with quality, so people or Medicare would pay more for better overall quality. Right now, you can be certain that setting more payment and practice rules here in Congress, or at a new Federal Health Board, will shift the volumes but won't change the outcomes.

Or take, for example, the refrain around the need for more comparative data. There is no question many important clinical questions remain unanswered. But the reasons are often complex. A lot of uncertainty about the relative benefits of two treatments remain in doubt because answering these questions is very hard. It takes long and large trials to discern small differences between two active treatments. Yet we are proposing to do shorter, cheaper studies based on backward looking databases rather than forward-looking trials to probe these questions.

The knowledge we glean from looking back through databases of patient information adds context to these clinical questions. But it won't definitively answer them.

If it were so easy to resolve these issues, simply by sifting through existing information, you'd think insurers or academic researchers would gather the \$2 million it takes to do a really good database study. In many cases, definitive answers won't even come from a single study.

We should pay for these rigorous studies out of public funds. But we shouldn't delude ourselves to believe that simple and cheap studies can resolve questions that persist despite close attention. Proponents of comparative research almost all point to the treatment of back pain or early prostate cancer as two areas in need of more research. On PubMed there are literally thousands of studies addressing these topics. Questions persist because none of the studies are large enough and long enough to provide definitive answers that address all the variation in patients' conditions.

Getting those answers is going to be harder than sifting through payer claims. Simply placing the government's imprint on a finding won't close off scientific debate either. The underlying evidence needs to be rigorous. If we're going to set binding rules in Washington based on the results, we need to do these things with precision.

This means we need to invest in a better infrastructure for doing more rigorous research, modeled perhaps after the success of the National Cancer Institute's (NCI) cancer cooperative groups. We need to make it less expensive, and easier to do these more rigorous investigations. But getting real answers that endure scrutiny isn't going to be nearly as easy as our policy proposals envision.

Finally, take the catch phrases around “access to affordable insurance.” If you read the *Washington Post*, you'd think that insurance is synonymous with good healthcare. That is hardly true. But insurance has become the end in itself, paying no heed along the way to serious problems with our current programs.

Medicaid recipients technically have insurance. But in some parts of this country, they might as well be uninsured when it comes to their ability to access specialized services or expensive procedures. Some of the most vulnerable Americans are confined to an insurance product that is healthcare in name only.

Payment rates are so low, and regulations so burdensome, many doctors opt out of Medicaid entirely. More are also declining Medicare. As we supplant Federal for State regulation of health insurance, or create a new “public” plan modeled off Medicare, the best doctors may leave the system entirely, especially in urban markets that will support cash-only practice.

Our efforts to fashion a more egalitarian system are creating more tiers of care based on income.

In Medicaid, as in all these challenges, it seems our solutions always involve more rules. We call for more regulation of medical practice and more payment changes.

When I was at Medicare, we compared this policy behavior to the carnival game “whack-a-mole.” As soon as we spotted a problem, we passed a rule to fix it, only to find that our solution wasn’t the repair we expected. We had only caused a new problem to pop up somewhere else.

Managing disease isn’t a commodity service amenable to designs and workforce rules hatched here in Washington. This isn’t like building cars. We shouldn’t mislead ourselves to thinking we can understand all the reasons treatments often deviate from guidelines or to set treatment plans here in Washington to smooth out these variations. Agencies like Medicare can’t even keep up with the guidelines as technology and science changes. By the time CMS issues a coverage or coding change, sometimes the standard of care has already changed.

The current proposals for “fixing” healthcare rely on a lot of the usual patches. They increase political, rather than individual, control of the medicine, through a collection of new commissions, boards, and agencies. The plan before this committee shifts to the government, and probably Medicare, more of the clinical decisions previously left to people and their doctors.

That means my colleagues at CMS, and all 20 of the agency’s doctors, are going to be calling more of the shots on what patients can get access to. That’s the rub. More political control, through Federal regulation or a public plan that displaces individual decisionmaking, doesn’t mean better decisions. Medicare made 165 decisions about covering, and not covering, certain cancer products since 2000 without a single oncologist on its staff. We shouldn’t let that kind of a process displace individual control over medical decisions by patients acting through private insurance.

Senator DODD. Thank you very much, Doctor.

And last, the last witness, and thank you again, Mr. Burd, for being with us.

STATEMENT OF STEVE BURD, PRESIDENT AND CEO, SAFEWAY, INC., PLEASANTON, CA

Mr. BURD. You are welcome. I, too, appreciate the opportunity to share the experience we have at Safeway and also maybe share a few ideas.

I have been a long-time advocate of healthcare reform, going back some 15 years, getting everybody in the insured system and I feel that we’re on the precipice of getting that done and I applaud the Senate for addressing that in a bipartisan fashion.

I want to address something that I don’t think any of the other panelists have yet addressed. I want to talk about bending the cost curve because it’s important to get everybody in but we also need to control these costs and that’s where Safeway’s had a tremendously positive experience.

About 4 years ago, we realized that about 70 percent of all healthcare costs are driven by behaviors and as a business guy that was good news because it said if we could influence the behavior of our 200,000 employees, we could actually bend that cost curve and improve the health of our employees.

The bottom line is if you don’t improve the health of Americans, you won’t control healthcare costs. We designed a healthcare plan that focused on the fact that about 75 percent of all healthcare costs are confined to four chronic conditions: cardiovascular disease which is about 80 percent preventable, cancer which is about 60 percent preventable, diabetes, particularly Type II, that’s at least 80 percent preventable and reversible, and then, finally, conditions of overweight and obesity.

We designed an incentive plan that has a premium difference between people that have the healthiest behaviors and those that don’t have as healthy behaviors. So, there’s that large dose of personal responsibility.

There is a little known provision in HIPAA that allows for that. There is an overlay that ADA has on top of that to further constrain you, but one of the things that I would suggest to the Senate here is that we create more ability to do that.

We've had a remarkable experience. In the last 4 years, we've held our healthcare costs flat and we didn't do that by terminating 20 percent of our workers. That is the per capital healthcare cost is flat and for the healthiest employees in our organization, their contribution to healthcare is down some 25 percent.

If the entire country had taken Safeway's plan design in 2004, by my calculation, since they're up by about 38 percent, we would have a healthcare bill in this Nation that's \$600 billion lower than it is today. So, the cost curve can in fact be bent.

The other thing I would focus on is transparency. I think everybody here has come to understand that there are vast differences in charges for some standard procedures. Within 30 minutes of our general office in California, there's a tenfold difference in the cost of a colonoscopy. Within 10 minutes of our offices a fivefold difference in the cost of a blood test.

The only thing we've done to flat-line our costs is focused on plan design and behavior and its role in driving costs and the health of Americans. We're cobbling together transparency. We could get some help from the Senate on that and you would see another dramatic step down.

If we do healthcare reform correctly, I believe you can take 45 percent of the costs out of the system because it's terribly inefficient and I believe you can cover all of the Americans that are not covered today.

Senator DODD. Well, that's very exciting news. Congratulations on what you've been able to achieve with your company.

Well, this has been very, very helpful, and again it's a large group of witnesses and I'm grateful to all of you for sharing your thoughts with us here.

Let me put the clock on here for 5 minutes and I'll try and move through these quickly, if I can, and then turn to my colleagues for their comments and thoughts, as well.

Let me begin, if I can, with Dr. Rosman, of the AMA. They made some news today by talking about how the AMA would oppose a government-sponsored insurance plan and yet in your testimony and the press release that went out, you left the door open, it seems to me, a bit, as well.

As I read it, and again I don't want to put words in your mouth or that of the AMA, obviously the position of the AMA is important, but you indicated you're open to consideration of some new health insurance options that are market-based, not run by the government, do not compel physician participation, truly competes on a level playing field and that you haven't seen some of these.

There have been several ideas. Our colleague, Senator Conrad, has been talking about a cooperative option. Senator Jack Reed, who's not here right now, has been talking about using state-based health organizations that already have experience in this as a possibility.

There are ideas of contracting out, where the government would contract out with, say, a non-profit BlueCross BlueShield where there's some experience.

Give us some ideas, put a little bit more flesh on this, if you will, other than just sort of the vague concept here that you're willing to support something other than a public option.

Dr. ROSMAN. Yes. Thank you, Senator. I think that you stated it very accurately, that we are very committed to getting everybody affordable coverage. Our position is that we think this can be done with market reforms in the private insurance market, but we're very interested in some of these alternatives that have been put out there. As you mentioned, Senator Conrad's co-ops.

I think that we really need to see more details of those plans before we can comment specifically, but we are certainly interested in those as options for covering everybody.

Senator DODD. Options for what? Options for what are we talking about? What do you see as the value in having an alternative idea? What is the point?

Dr. ROSMAN. Well, again, I think we need to see more details before we can comment on the specifics. We believe that everybody can be covered by—in a private insurance market with tax subsidies or tax credits to allow people who cannot afford coverage to purchase into that private insurance market, choose the plan that works best for themselves and their families.

We believe that with that, we can give everybody access to affordable coverage and not only coverage but, most importantly, access to the care that they need.

Senator DODD. What I wanted to get at here is do you see any value in an alternative idea—using your definitional terms—that alternative idea to be a cost bender? There is cost obviously in bending that curve. There is a tremendous interest, overwhelming interest obviously.

As Mr. Burd has pointed out and others, if we don't bend the cost down here, and just go through and adding cost to the system, then obviously we've achieved nothing. In fact, the fears of reaching 30 or 34 percent of GDP become far more real.

The value in this idea to those of us who are advocating something like this is to bend that cost. I'm presuming you're seeing a bending cost value to these alternative ideas, as well?

Dr. ROSMAN. Again, I think we need to see details of the plan—

Senator DODD. I understand.

Dr. ROSMAN [continuing]. Before we can comment to that, but we are very committed to reducing health costs and excited to work on mechanisms through quality measures, and best practices, to reduce the gross of health costs.

Senator DODD. Let me jump quickly here to, if I can, Dr. Gruber, as well, and we thank you for your work in Massachusetts and there's been a lot of conversation over the last number of days about Massachusetts as we're meeting among ourselves.

There is a pay or play provision in the Massachusetts healthcare plan, is that correct?

Mr. GRUBER. A very modest one.

Senator DODD. Well, tell me how it's working and how modest is it and what's the effect of this in terms of employers that are participating or non-participating and the like?

Mr. GRUBER. Sure. We have a pay or play requirement which says that employers with more than 10 employees who do not offer health insurance have to pay \$300 per employee per year. It's a very modest pay or play requirement. We've not collected much revenue from it and, quite frankly, we don't think it's having a very big influence on the market.

We think the main reason that employer-sponsored insurance is up in Massachusetts is not the pay or play component but the individual mandate which has led individuals to go to their employers and ask for insurance coverage so they can meet that legal requirement.

Senator DODD. So what is the number? How did you come up with \$300? Where did that number come from?

Mr. GRUBER. That was basically a compromise. Initially, there was desire to have a higher level among some, none among others, and it was viewed as a compromise to where it was a real employer contribution. It was substantive but not viewed as too onerous by the business community.

Senator DODD. Mr. Dennis, of the NFIB, I wonder if you might comment. One of the suggestions here that's being talked about is to provide tax credits for smaller businesses. There has been constant complaints here from all of our constituents for providing some tax relief for them obviously if they're going to take on these additional costs in an environment like this and yet there be a requirement, I suppose, if you're going to get these tax advantages, that you also then provide some basic healthcare for these employees.

What's your reaction to that?

Mr. DENNIS. Well, it seems to me that if you're going to do—why would you give tax incentives if—excuse me. Let me reverse that.

Why would you require somebody to do something if you're going to turn around and give them tax incentives to pay for the same thing? In other words, it's like putting it in one pocket and pulling it out of the other pocket. That doesn't seem to make a lot of sense.

One of the things you're trying to do with the taxes that I have seen is that you're focusing those tax provisions you do have on certain employers which employ lower-wage employees and they're the ones that tend not to provide insurance.

One of the things to remember is that the small employers who don't provide insurance also tend to be those employers who don't take very much out of their businesses and their flexibility is severely limited. In fact, there's a direct relationship between what an employer takes out of his business, smaller businesses now, what they take out of their business, the wages they pay—whether or not they have a pension plan and whether or not they provide insurance.

When you're targeting those tax subsidies on folks who tend not to pay very much, you certainly have the right target.

Senator DODD. All right. My time has expired.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman, and I want to thank everybody that testified.

This is a huge panel. What you may not know is that you volunteered to answer questions that Senators may submit, as well, and hopefully you will do that in a timely manner so that we can use your information as we go through the legislation and we're on a fast track to get the legislation done, too, and that was the message Senator Coburn asked me as he left.

Senator DODD. Can I make a suggestion in that regard, too, by the way?

All of you have made some various suggestions and some technical ideas and it's awfully hard just listening to this, in addition to your testimony, if you've got some of those ideas, you could submit them to the committee as quickly as you could. It would be very helpful to us in these coming days to have those ideas in front of us.

I apologize.

Senator ENZI. That's fine. Mr. Burd, I wanted you to go into a little bit more how—I know that there's a proximity of different prices in the market that your employees can tap.

Can you tell me a little bit more how that transparency of prices helps out?

Mr. BURD. The transparency component is something that we're just building now, but let me tell you how we framed it.

In the local Bay Area of San Francisco, there's this—you can get a colonoscopy for \$700 and one for \$7,000, and so we did some research with the help of our claims processor to determine what was the right set of quality and costs that would be a reasonable cost and there was a time when we paid 80 percent of the costs for colonoscopy. We stepped that up to a 100 but we were paying a 100 even for the \$7,000 colonoscopy.

We now believe that a \$1,500 colonoscopy in that market is the appropriate number and so we pay 100 percent because we think it's preventative to have that colonoscopy done and if someone wants the \$7,000, the other \$5,500 is essentially on them.

We're using our own claims data to cobble together a transparency system. Our employees will go on our Web site, they'll put in their zip code, a 30-mile radius will be drawn, and they'll be told what it costs for the procedure that they're looking at in each of those items.

Senator ENZI. Thank you. I know that's just one small idea, one big idea from a number of them, and I appreciate the time that you've taken on the Hill to help educate us all on possibilities for really bending that cost curve because that's one of the things we're wrestling with in the bill.

Mr. Johnson, could you tell me what impact the employer mandate would have with your members and their ability to create jobs, particularly at this time in the market?

Mr. JOHNSON. Well, of course, we are dealing with a bit of an unknown since it's not spelled out in the bill, but when you have a mandate on employers and it costs X amount of money, that X amount of money is not just going to be created. It's going to come out of some other pocket of the employer, whether it's profit margins or operating expenses or money he set aside to expand.

Studies, ranging from CBO to the RAND Corporation have said that this will result in some job loss, particularly impacting lower-income workers, because the money has to come from somewhere. There is not a free ride here.

It's tough to extrapolate exactly what the effect would be on it, but when the RAND study is talking in terms of \$9 to \$12 billion, \$9 to \$17 billion for premium contributions and penalty payments and, of course, there's the play part and then there's the pay part and I'll call it a civil fine which is what I think it would be. For penalty payments ranging from \$4 to \$12 billion, that's going to have an impact and it's not a new concept, that when the Congress imposes a mandate in one area, that's going to be paid for from another area.

Senator ENZI. Thank you. Dr. Baicker, I'm hearing some concern that if we do a government-run health plan, we'll wind up with something like Fannie Mae or Freddie Mac.

Are those concerns that a government-run health plan could have with the private market?

Ms. BAICKER. I think there are a number of concerns one might have with the public plan. Clearly the devil is in the details in terms of whether it would provide real competition for private plans or inhibit competition with private plans because it had either unfair advantages or unfair disadvantages.

I think the key things that I would look at to figuring that out are the pricing that the public option can use. Is it negotiating based on additional clout beyond which private plans wouldn't be able to compete or is it required to take on sicker enrollees and subject to worst risk selection and those issues show up as well in the Medicare Advantage Plans which maybe provide a model of what you might expect from a public-private hybrid.

I would look to that to see, first of all, the potential success of risk adjustment. We do have a risk-adjustment element in the Medicare Advantage Plans that I think is really promising for thinking about risk adjustment among private insurers, if we look out at a reform that lets people go to a variety of different insurers but also then the risk of administered pricing where the variation that we see in the cost of care for Medicare beneficiaries in high-cost parts of the country relative to low-cost parts of the country can be a factor of two or three times as much for care that doesn't seem to go to patients that start out sicker or end up healthier.

It's very hard to explain that level of variation in care through any story about efficiency. It looks more like extra money is going into parts of the country that practice a more intensive style of medicine in a way that the government regulation is not inhibiting.

That makes me very nervous about a monolithic public plan.

Senator ENZI. Thank you. My time has expired. I have questions for everybody and I'll get those out.

Senator DODD. Thank you very much, Senator Enzi.

Senator Harkin.

STATEMENT OF SENATOR HARKIN

Senator HARKIN. Thank you, Mr. Chairman.

Again, it comes as no surprise for anyone here that I have a great deal of admiration for Mr. Burd and what he's done at

Safeway because I think the only way we're ever going to bend this cost curve is keeping people healthier in the first place. I don't mean to get on my soapbox but—as long as we continue to dance around this issue—but unless and until we put more emphasis on prevention and wellness, we're just pouring money—we're just throwing it out there and we'll never get our costs under control.

Mr. Burd is right. That's the only way to bend our cost curve and we've got to put more on prevention and wellness and we just haven't done this in the past. None of us, none of us have done it.

It seems to me in this health care reform that that really ought to be a central part. That's what we ought to be focused on. How do we incentivize healthy behavior? All the incentives now in our health care system is to patch and fix and mend. It's pills, surgery, hospitalization, disability. Why don't we put more incentives up front? We know how to do it. Safeway did it. They know how to incentivize this. Pitney-Bowes did it. They know how to do it and there are other smaller companies out there that have done this and yet we keep wrestling with all this when the focus ought to be, I think, on how we keep people healthy in the first place and provide those incentives out there and move those incentives up front.

Dean Ornish has this famous cartoon he uses all the time. There is a sink and it's overflowing. The faucets are on. The water's going on the floor and there's two guys furiously mopping up the floor. His point is, that we got to shut the faucets off and we haven't been very good at doing that but we know, we've got good data on this.

In the next panel, we have the Trust for America's Health coming on and they have done some really good work on that, but a lot of our private businesses have done this, and I'll just throw that out there that we've got to pay more attention to that.

Mr. Williams, you and I have talked about this in the past from Aetna. You're an insurance company. What do you think about this? Should we put more into prevention and wellness or should we just keep jacking up insurance rates?

Mr. WILLIAMS. Taken in the spirit in which it's offered, sir.

I think that there is a fundamentally important opportunity to focus on wellness and prevention. We do it with our own employees. Every Aetna employee can earn \$1,200 of credits for participating, voluntarily, in wellness programs where they know their numbers in terms of blood pressure, their statins levels, cholesterol, and their BMI, and participating in fitness and wellness programs. There is an opportunity to earn \$1,200, \$600 for the employee and \$600 for the spouse, and what we saw last year was our medical costs go up 3 percent. No benefit changes, strictly based on the engagement of the employees in their own wellness and fitness.

I have heard Steve Burd many times, and I agree 100 percent, that there's a huge opportunity to focus on prevention, focus on wellness. Now that's not the whole problem and there's much more we have to do. We have to get everybody covered. We have to make it affordable for people. We have to make certain people have good solid coverage, not just coverage.

Senator HARKIN. Yes.

Mr. WILLIAMS. I do believe wellness is absolutely important and prevention is absolutely important and the individual really has to get in the game and within the appropriate level of their participation be able to help participate.

Senator HARKIN. The problem is we can address this on a clinical basis, but if we don't address it outside the clinic, it doesn't do much good. If people don't have access to better foods, to better exercise, having more of a knowledge base on how to stay healthy, you can do all the clinical work, but if our communities are unhealthy and our schools are unhealthy and our workplaces are unhealthy, it doesn't do much good to have it clinically-based.

That's why I keep saying that prevention and wellness must be clinically-based, community-based, school-based, workplace-based.

Mr. WILLIAMS. It has to be a holistic program, Senator, as you're describing. Of our 19 million members, we have 2.2 million members who are identified as in chronic disease management programs where they have diabetes, hypertension, asthma, allergies, but the object is to avoid the creation of the next 2.2 million which is exactly through the mechanisms you're describing.

Senator HARKIN. I'm out of time.

Dr. FLOWERS. Do I have time to speak?

Senator DODD. Quickly.

Dr. FLOWERS. I wanted to make the comment from the perspective of a primary care provider on prevention.

I mean, the reason that having a national health system would actually improve our public health is that the incentives completely change. Right now, so much of our healthcare is driven by profit.

When you have a national health system, it's actually driven by providing better health and we see this in other countries around the world that have national systems. They know that if they have a healthier population, they spend less money on their population's health and since they're responsible for paying that money, it makes it more of a responsibility for them to save money and so there's a greater incentive to create these public policies that you're talking about, like improving transportation, improving food, but also in this country we have a shortage of primary care doctors and a lot of that is because, as I left practice, we're not reimbursed easily by the health insurance companies for the work that we do.

We're required to see more patients and spend less time with them and spend less time doing, for me, well-child visits where I could actually take the time to explain to parents the things that they need to know to raise healthy children and so we've got to change that so that again if we're fighting for reimbursement and having to see more and more patients and spend less time with them, we're not going to have a healthy population.

Thank you.

Senator DODD. Senator McCain.

Senator MCCAIN. Senator Hatch.

Senator DODD. Fine. All right. I'm just following the Kennedy rules here. I apologize.

Orrin, you've been chair of this committee.

Senator MCCAIN. Senator Hatch has been very patient.

Senator DODD. All right. Fine. Orrin, welcome.

Senator HATCH. I have to defer to John. It's fine with me.

Senator DODD. Speak in there, Orrin. These microphones are not very good. So I apologize.

STATEMENT OF SENATOR HATCH

Senator HATCH. Ms. Trautwein, there's been a lot of talk recently about creating a level playing field between a government-run plan and private plans. First of all, I personally think that's impossible because of all the State and Federal regulations that are imposed on private plans that a government plan would never be subjected to, including paying State assessments in all 50 States, for example, along with Federal taxes.

History already teaches us this lesson. In 1965, Medicare started as a political compromise where it would pay the same rates as the private sector. Faced with rising budgetary concerns, Congress soon decided to implement price controls in the program and today, as you know, it pays doctors 20 percent less and hospitals 30 percent less than the private sector.

Now, do you think it's possible ever to really truly create a level playing field between a government-run plan and the private plans?

Ms. TRAUTWEIN. Well, I don't think it's possible, but I'm not just saying that for some sort of philosophical perspective. This is a reality.

There are many things that we can do. We could say that everyone had to pay the providers the same price. We could have a whole list of ways that we tried to make things equal.

One of the ways that I don't think that it will ever be equal is something just as simple as State premium tax. Now, I can't imagine a Federal or a State public program paying State premium taxes as just one item of those to a State. I can't see that happening.

Maybe Ms. Praeger could comment more on that, but it's a significant amount of money and when they don't pay equally, what happens is the cost shift increases and we have that much more that's shifted over to the private sector and then that is an undue—it's completely at odds with these affordability goals that we have.

Senator HATCH. That's just one idea.

Mr. Williams, what do you have to say about that question?

Mr. WILLIAMS. Yes, I would say that I have tried to avoid a philosophical response to the notion of the government plan to really wait to see the specific proposals that have come forward and based on what I have seen so far, I would be opposed to a government plan.

I think there's a great confusion about profit in the for-profit sector. The total profits of the publicly traded healthcare sector is about \$12 billion. The taxes that we pay are roughly equal to what we earn in profits. In our case, we earn about 6 percent in profit and we pay in State, Federal and premium taxes 5 percent, and we believe the value that we add in the system more than makes up for the 1 percent difference.

You have to also look at the fact that only half of the members are in plans that are for profit. I think we get diverted from the fundamental issue which is how do we get and keep individuals

and small groups covered and focus on the particular barriers to accomplishing that and develop meaningful and substantive programs along with prevention and wellness, including changing the reimbursement structure so that we do pay primary care better and pediatricians better.

Senator HATCH. Let me ask Randy Johnson and Dr. Baicker this next question.

Our national unemployment rate is almost 10 percent and it's rising. It's the highest rate in decades and one of the policies being discussed here, of course, is the employer mandate, where employers would be charged a penalty if they don't provide a defined level of coverage.

According to a 2007 National Bureau of Economic Research, imposing an employer mandate could result in the loss of more than 220,000 jobs in this country. In an environment where we should be creating jobs, I'm afraid that we're simply creating more incentives for employers to actually stop offering jobs and move their operations overseas, as some have already done, and I'd like your thoughts very briefly on this, both of you.

Mr. JOHNSON. Well, I certainly agree with your observations, Senator Hatch. I think there is the cost that a smaller business or any business would have to bear under this. Either the new healthcare mandate or pay the civil penalty, which—I have to take some disagreement with others who have pretended the Massachusetts miracle is in fact—they had lots of other studies that have shown there's problems with Massachusetts, including the pay or play mandate and we could submit some follow-up studies on that.

There is another problem, also, Senator, with regard to even companies that provide a generous package. One of the questions that's come up as we've talked to members of my Employees Benefits Committee is with their plan, which is seen as generous by their employees, fit the definition of what the play part of the mandate would be.

In other words, they could have X-plus, but that X-plus may not fit exactly what—how this medical board under the legislation is going to define as the minimum benefits package.

People think it's easy to define these plans as actuarial values, but we've been told it's really not that easy. There is the question of cost and can smaller employers bear that, and then for our larger employers, will what they do for their employees now fit the so-called play part of the pay or play mandate?

Senator HATCH. Dr. Baicker.

Ms. BAICKER. Thank you. I think there's a real difference between employer mandates and individual mandates and the real risk of the employer mandate is that employers don't pay for health insurance premiums, employees do, either in the form of lower wages because, as healthcare costs rise, their wages rise more slowly than they would otherwise or even fall, or in the form of fewer jobs. If healthcare costs rise so high, then employers can no longer afford to offer a job with benefits and they either cut down on their workforce or move workers from full-time jobs with benefits to part-time jobs without benefits.

I think employer mandates really are about shifting the burden of who's bearing costs among employees and risking low-wage

workers in particular losing their jobs rather than getting more employer dollars in the game because I don't think employer dollars are in the game to begin with. Those costs are borne by workers. That's a real risk of employer mandates, particularly for smaller firms that are on the cusp of offering insurance already.

Senator HATCH. Thank you. My time is up, Mr. Chairman.

Senator HARKIN. I'm sorry. I guess I'm now in charge.

Senator MIKULSKI. Senator Barb.

Senator HARKIN. Senator Barb.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Senator Barb is OK. Senator Barb's OK.

First of all, I want to thank everyone here for participating in the roundtable. You did it on a very short notice and with very content-rich presentations. I think we could engage in substantive conversation with each and every one of you.

My questions, I'm going to start with Mr. Burd, go to Dr. Flowers and, if time, to Dr. Rosman.

Mr. Burd, first of all, as a Marylander, I would like to thank Safeway for having the guts to have a presence in cities. We've had a terrible time in Baltimore being able to attract and retain grocery stores and the only ones who've shown a very visible and aggressive presence have been you and Giant.

I want to thank you for that because in many of our communities, we can talk about fruits and vegetables and healthy foods and body mass and so on, but if all you have available for your food is going to convenience stores to buy potato chips or fast food stores to buy fast food, you've got a tough job.

I want to thank you for your presence in two neighborhoods, Canton and Charles Village, neighborhoods that were teeter-tottering. The mere fact that you are there helped turn those neighborhoods around.

Mr. BURD. I appreciate that.

Senator MIKULSKI. So you helped do healthy habitat.

Now, the other thing that I'd like to ask because it's come up as we worked on quality which was my job, prevention, along with Senator Harkin, is behavior and you identified that 70 percent of your employees' issues were related to behavior, particularly the chronic conditions.

How did you impact on behavior? Did you use a carrot? Did you use a stick? Are you a nanny corporation with school-marmish admonitions?

Mr. BURD. Sure. I'd be happy to answer that. The statement I gave earlier was across this Nation 70 percent of the healthcare costs are driven by behaviors and that really is one of the keys to cracking the code here for how to bend the cost curve.

Because we're self-insured, which means we pay every dollar, there really is no insurance company. The insurance company behind us really processes claims. We're free, as are all other large companies, people with over a thousand employees, to design their own healthcare plans. That's what we did.

We focused on the chronic conditions and the behaviors that lead to them and we set up a series of incentives. We structured it as

a carrot, but I would quickly tell you that the carrot is nothing more than the mirror image of a stick and vice versa.

Senator MIKULSKI. What were they?

Mr. BURD. We have a program we call Healthy Measures which you opt into. Seventy-four percent of our organization has opted in and we measure body mass index. We measure smoking. I mean, we actually test for it. Cotton swab tests. High blood pressure and high cholesterol levels.

In the Healthy Measure effort this last year, 17 percent of our employees discovered that they had hypertension. That was a good thing because we could prevent some future event.

The way our program works, if you are a smoker, you will pay more for your insurance. You will pay roughly a little over \$300 more than a nonsmoker. Then we provide 100 percent of the cessation products that you typically buy to wean yourself away from smoking and if you quit smoking by the end of the year or if your body mass index is reduced by 10 percent or if your hypertension is under control or if your cholesterol is under control, we write you a refund check equal to the elevated premium.

Senator MIKULSKI. Do you have a health coach? In other words, say "stop smoking", "here's, the patch", or "do you actually have health coaches"? "What is it that you do?"

Mr. BURD. We have a—you know, in 3 minutes, it's hard to describe the whole system—but we have a very elaborate holistic approach to healthcare that includes calorie information in the cafeteria, subsidies only for healthy food, although we have cheeseburger and fries. We have a 17,000-square foot fitness center on campus with a nurse practitioner. We have a 24/7 hotline for any issue that may develop 7 days a week. We have a med expert service that deals with chronic conditions. We have nutrition coaches. We have counseling coaches.

We allow employees to work out midday if they have a weight issue. We actually believe, I know this sounds bold, but we believe that we've cracked the code on obesity and we actually think we can continue to reduce the obesity levels in our company. Our obesity rate is 28 percent. The Nation's is 40. Our smoking rate is 14 percent, the Nation's—

Senator MIKULSKI. And that's in a grocery store?

Mr. BURD. Yes.

Senator MIKULSKI. You got a lot of temptation. I'm in your stores.

Mr. BURD. I know.

Senator MIKULSKI. The ones I have talked about, I know about them.

Mr. BURD. Yes.

Senator MIKULSKI. There have been sightings in them.

Mr. BURD. We've made good progress and I have challenged a couple of other CEOs. We're going to try to bend the obesity curve in this country and I challenged them. I said, "Look, you've got to do it in your own organization first," and I committed that in 120 days I would make further progress on obesity and we just did and so these incentives work.

The problem I have is the incentives that we're able to put in place don't come anywhere close to matching the cost implications.

A smoker is \$1,400 a year. Toby Cosgrove is here. He'll give you a number that's probably close to \$3,000. It's at least \$1,400 and yet the premium difference is only \$300.

I took notice when the tobacco taxes went into effect. They were raised the equivalent of about \$300 a year for a one pack a day smoker. In the State of Michigan, the cessation centers that offer free products for quitting smoking had a 19-percent increase in their calls. California, which has the second lowest smoking rate in the country, had a 300-percent increase in their calls.

You know, my e-mail box is full of thank yous from employees that have: lost a hundred pounds, 120 pounds, 40 pounds, became marathon runners, or stopped smoking; and they said the incentives were the key. Seventy-eight percent of our employees absolutely love this plan. They said it's good, very good or excellent, and 74 percent asked for changes that were increased financial incentives.

Senator MIKULSKI. Well, thank you. I know my time is up.

Dr. Rosman, actually Senator Dodd asked me to ask some of the questions I would have for you.

Just one quick question for Dr. Flowers. First of all, Dr. Flowers, I wanted you to know, No. 1, you're welcomed here and we really welcome your insights. As a sister Marylander, we're glad to see you.

Dr. FLOWERS. Thank you.

Senator MIKULSKI. Your testimony was excellent. Why doesn't a public option meet your needs, the needs that you've outlined as you articulated the needs for a single payer?

When we do a public option, why wouldn't it accomplish the six things that you talked about?

Dr. FLOWERS. I wish it would, but the reality is, that the problem is that we have about 1,300 different insurance plans in this country, and it's this fragmentation which is keeping us from being able to take all of our dollars and actually use them for healthcare because so much money is wasted to create this fragmentation.

Creating another public plan is going to further fragment our pool and what we've seen—two things. One is that if you look at our experience with Medicare Advantage Plans, and this happens over and over again, is that the private insurers are very good at attracting the healthier patients, we call this cherry-picking, and so the public plans are often left with the patients who have the greater health needs and therefore carry a greater proportion of the burden of the cost. That's one thing that's a problem.

The other is the whole billing infrastructure because there's so much talk about, well, if we go to a uniform billing infrastructure, is this going to help things? We already have that for hospitals, but we still have hospitals with many, many billing employees and what happens for us is one of the first things when we admit a patient to the hospital is we get a visit from the utilization review department and those people have to be employed to be an interface between the insurers and the hospital and that costs a lot of money and so we don't do away with that if we're adding one more plan.

We just can't see the cost savings with the public-private partnership. It further complicates things. If you look at what's hap-

pened in Massachusetts with their connector which you're talking about an exchange, it adds 4 percent to the cost. Those are the problems.

Senator MIKULSKI. Well, thank you. That was a great clarification. I appreciate it. My time's up.

Senator DODD. Senator McCain.

STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman.

Mr. Scheppach, there's been—we're in uncharted waters here as far as a national healthcare program is concerned.

For the record, perhaps you could give us what's been tried in other States, ranging from Massachusetts to various other States. We'd be very interested in knowing because the States are generally the laboratories for this kind of innovation and experimentation and on a number of areas, particularly in healthcare. OK?

Mr. Dennis, as you know, one of the proposals is that the small businesses either provide a certain level that is yet unspecified healthcare for their employees or they pay a certain amount of whatever you want to call it, tax levy or penalty, and that number has been unspecified. But if it's too high, then we know it drives small business people to lay offs and if it's too low they pay it and go on with business as usual.

What's your view on employer health insurance mandates and their impact?

Mr. DENNIS. Well, pay or play is a mandate by another name, but essentially they're opposing it but it's important to remember why. We have to remember what the consequences of this are and that is employees pay the cost of this in the long run and what employees pay for it, it's normally lower income employees that pay for it. So there's a real problem there.

There is a problem initially when a small employer has to absorb the initial cost before they pass it on. That's a problem. A lot of small employers don't have that flexibility and then, finally, there's also another thing and that is that we found in some research that was done over at George Mason in the Experimental Economics Lab that frequently low-margin larger margin employers, I don't mean great big ones, but low-margin larger employers act very much like small employers and some of the more profitable larger employers who basically already provide health insurance tend to act a little bit more like the larger ones.

So you have a marginal profitability issue, as well. Those are the three reasons why I think this doesn't make a lot of sense.

Senator MCCAIN. Dr. Gottlieb, we have the elephant in the room is how we pay for all this. Estimates range from \$1 trillion to \$2 trillion to more trillion dollars.

One of the proposals that's now being bandied about is the taxation of employer-provided healthcare. The proposal I made a long time ago was also accompanied by a \$5,000 refundable tax credit to families in America but now the part that's being considered, although certainly no one has yet confirmed that, is the removal of some or all of the individual tax exclusion for employer-provided healthcare.

What's your view of that particular proposal?

Dr. GOTTLIEB. Well, whether we do it as some kind of tax treatment, a tax rebate or by making the Tax Code equivalent, whether you go out and purchase your insurance in the private market or get it through your employer, I think we need to consider strongly trying to level the playing field between people who are buying insurance in the open market on their own and those who are getting it from their employer.

We know one of the reasons why insurance is so unaffordable in the private market is because people don't have the benefit of the tax subsidy that's being afforded when they purchase it through their workplace.

Generally speaking, we need to consider how we go about trying to level that playing field so people in the private market can have the same benefits as if they were getting it through their employer.

Senator MCCAIN. Ms. Trautwein, same question. What do you believe? Do you believe that the idea of removing the tax exemption for employer-based healthcare benefits is a good idea and taxing it?

Ms. TRAUTWEIN. We have a lot of concerns about doing that, frankly. We're very concerned about unraveling the employer-based system.

You know, having said that, we know that we have to find some money to pay for a lot of the health reform and so we're very interested in looking at the alternate proposals, such as those for putting some caps in and so forth, but we do—I would just agree, though, relative to the individual market, that at a bare minimum, we've got to make sure that we have tax equity in every market so that individuals can have the same benefit that those in employer-sponsored plans have.

Senator MCCAIN. That's not the case today.

Ms. TRAUTWEIN. It's not, and that we would need at a minimum to have that.

Senator MCCAIN. Dr. Gruber.

Mr. GRUBER. Yes, Senator McCain. I actually think that reforming the tax exclusion to employer-provided health insurance is absolutely a win-win source of financing for the kind of bill we're talking about today.

We can take a source of financing which right now is regressive. It's inefficient. It induces excessive health insurance consumption and by capping that in one form or another, we can raise the money we need to achieve the goals we're talking about today. I think it's a terrific direction to go for financing healthcare reform.

Senator MCCAIN. Dr. Baicker, you have—

Ms. BAICKER. I couldn't agree more that the way we finance private health insurance through the Tax Code today subsidizes disproportionately high income people and the least efficient health insurance plans and that if we could capture some of that public expenditure on high-income, high-cost health plans and redirect it toward ensuring everybody has access to at least basic care, that would both improve efficiency and improve progressivity. It seems like a win-win option.

Senator MCCAIN. Mr. Rivera, how are we going to pay for the healthcare reform?

Mr. RIVERA. Well, I think that what we need to do is find the efficiencies in the healthcare system, namely by making it more efficient.

We're spending 17.5 percent, right now probably more than any country in the world, and at the same time when we do studies with other countries in the world, we are getting less in terms of outcomes.

In that sense, we believe that inside the healthcare system we could find efficiencies and savings, particularly in terms of bending the curve going forward.

The other thing that I believe, and going back to what Senator Harkin was saying, is the whole question of wellness. Ms. Baicker and I, we're part of the study of the Robert Wood Johnson Foundation for over a 2-year period which we concluded that we need a new national culture of health which is basically we have a healthcare system which is a curative healthcare system. We've got to prevent people from getting to our hospitals and our healthcare facilities and basically we believe that that's a responsibility of the government, of the individuals, of the communities and we can't even make it happen.

Right now, for example, Senator McCain, the government buys about \$60 billion in food a year. We buy \$40 billion for people who are on food stamps—excuse me, no, children's school breakfasts and school lunches, and we basically don't have any limitations on what food we serve there. Only about 2 percent of the high schools in America have physical education.

I believe this is a very complex issue and I believe that we can find the savings, but it will be—there's no silver bullet. We have to work all the moving parts to make it happen.

Senator MCCAIN. Remarkable. Dr. Rosman.

Dr. ROSMAN. Yes, thank you.

Senator MCCAIN. Do you also believe that efficiencies and then wellness and fitness will solve our problems? That's good. I appreciate that.

Mr. RIVERA. Thank you.

Senator MCCAIN. Go ahead.

Dr. ROSMAN. We believe—

Senator MCCAIN. You're welcome.

Dr. ROSMAN. Is your question about payment or prevention? I'm sorry.

Senator MCCAIN. I'm talking about how we pay for—

Dr. ROSMAN. Yes.

Senator MCCAIN [continuing]. The trillion and two trillion dollars or more of costs associated with any proposal that seems to be being considered now by this committee or by the Finance Committee.

Dr. ROSMAN. I would start by picking up on your former line of questioning. We absolutely support eliminating the tax exclusion and redirecting those funds in the form of tax credits or vouchers on a sliding scale to the low-income and uninsured so that they can afford to purchase health insurance.

As several people mentioned, it is currently a regressive subsidy to the tune of a \$125 billion and we believe that can certainly go a long way in helping to fund coverage for those who need it.

We are working hard on comparative effectiveness research on quality measures. I agree that we certainly need to focus on prevention. One of the most heartbreaking things as a physician is to see—I'm a pediatrician. I'm seeing kids not even barely into their second decade of life who already have serious health consequences of lifestyle issues and that is costing our system beyond the measure at this point. There are a lot of aspects that need to go into this.

Thank you.

Senator MCCAIN. Thank you, Mr. Chairman.

Senator DODD. Thank you, Senator.

Senator Bingaman.

STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Thank you all very much. Dr. Gruber, let me ask you a couple of questions.

You endorsed the idea of premium variation based on both tobacco use and adherence to wellness lifestyle programs. I'm a little unclear as to what you believe we need to do in this legislation to bring that about.

Mr. Burd has certainly described what he's doing which amounts to that. He has indicated that we need to change HIPAA because HIPAA does not allow him to give a sufficient financial incentive, as I understand it, and he would like that change.

What else should be done in this legislation to bring about this or to encourage this premium variation based on tobacco use or advance wellness and lifestyle?

Mr. GRUBER. Senator Bingaman, that's a great question because it has an easy answer which is nothing.

What this legislation should do is not rule out the possibilities of doing what Mr. Burd—

Senator BINGAMAN. Do you think that the community rating that we're talking about does rule that out?

Mr. GRUBER. I believe in the language as it's written, it may rule it out.

Senator BINGAMAN. We need to clarify that nothing we're doing in community rating would interfere with the variation of premium to accomplish these kinds of programs that Mr. Burd talked about?

Mr. GRUBER. Absolutely.

Senator BINGAMAN. OK. You also talk about your view that the proposal to have consumer rebates based on insufficient medical loss ratios is a mistake. It's a mistake to put that in the legislation at this time and instead we should require reporting on medical loss ratios and then come back in the future if we think this is something that the Congress or the government really needs to legislate on, is that right?

Mr. GRUBER. Yes, I believe that's right. I think medical loss ratios are very hard to define because the key question is what defines an acceptable expense. If a company spends money on wellness and management, we clearly think that is an acceptable expense.

How are you going to separate that from other kinds of expenditures, not to mention the fact that companies are very good at figuring out how to make things look like qualified expenditures

versus not, and I think we really need to learn more in a more transparent environment about where companies are spending their money before we dive in and commit to a rebate of this magnitude.

Senator BINGAMAN. Let me ask a question of all the panel. It seems striking to me—we've been talking about differences of opinion that exist—but it's striking to me that it seems to me that there's near uniform agreement on several things.

I know Dr. Flowers feels differently and favors the single-payer program, but with that exception, it seems as though all of the panel are in favor of the various insurance market reforms, at least substantial number of the insurance market reforms that we have—that we contemplate in this draft legislation. All panel members are in favor of the individual mandate which we contemplate in here. Maybe that's wrong.

Mr. Dennis, you are not in favor of an individual mandate?

Mr. DENNIS. We're kind of up in the air. We're open to it, but it depends upon a lot of things.

Senator BINGAMAN. You're agnostic on the question?

Mr. DENNIS. We're agnostic. I like that. Thank you very much.

Senator DODD. So are members of this committee.

Senator BINGAMAN. Are there others who do not favor, yes?

Dr. GOTTLIEB. Senator, we believe that everyone should have health coverage and every employer should offer health coverage and help fund health coverage. In that context, we think individual mandates are appropriate.

To simply rely on individuals, we think is inappropriate and puts the burden on the wrong place.

Senator BINGAMAN. So if we're not able to also require employers to have it, you think we should not require individuals to have it?

Dr. GOTTLIEB. With all due respect, I would put it the other way. You should require both to do it and you can do that.

Senator BINGAMAN. Well, I know that. I know that's your view, but I'm just saying if we were to require it of individuals, would you support that?

Dr. GOTTLIEB. Senator, we would support that if there were substantial subsidies to pay to make it affordable.

Senator BINGAMAN. Right. That was my—

Dr. GOTTLIEB. That is a very expensive prospect.

Senator BINGAMAN. Yes. That was my next question. It seemed to me that all members of the panel were in favor of substantial private coverage subsidies, is that correct? I believe everyone on the panel is in favor of small employer credits to encourage small employers to provide coverage, is that accurate?

Mr. Burd, you're not in favor of that?

Mr. BURD. I'm not. I know that you know, it'll probably upset the Small Business Administration, but the reality is that large businesses that have insurance, like us, are paying the tab for those that do not have it.

I'll give you one example of a local Bay Area hospital that lost \$70 million on their Medicare patients, \$20 million on their Medicaid and underinsured patients and then made a \$110 million on their insured patients for a \$20 million profit and so I don't really

buy into the notion that small business—I like the individual mandate.

I don't buy into the notion that small business, if you go the other way, should in any way be exempted because maybe the cost of cleaning a shirt at the laundry will go up 20 cents but it'll go up 20 cents for everybody and a pizza may normally cost \$8, it may cost \$8.50. That's fair. That's OK.

I don't buy the argument that they'll go out of business. I think they'll adjust their price structure.

Senator BINGAMAN. So your view is there should be an employer mandate, it should apply to all employers—

Mr. BURD. No. My view is that I like what you said originally. I would favor an individual mandate. I think it's cleaner. Senator McCain didn't ask me, but I would not be in favor of eliminating the tax deductibility for business because my first reaction would be if I'm not going to get a tax deduction for that, then what I'll probably do is put it in wages and allow them to buy on the open market, but I will lose my influence and control over their behavior and the reason most larger employers want to stay in this game is they believe that they get additional benefits and productivity from the wellness of their workforce and so there's no one in the Coalition to Advance Healthcare Reform of the 61 companies that are in it that want to get out of the insurance game because they believe that they can fundamentally affect behavior.

If you want to do a mandate, I'm in favor of the individual mandate as opposed to the business mandate because I'm afraid somebody will exempt small business which I think is wrong.

Senator BINGAMAN. Thank you very much.

Senator DODD. Do you agree with that too, Ron?

Mr. WILLIAMS. Yes, I would basically say that I think that the individual mandate is, in fact, the way to go.

I think that there are strong feelings on multiple sides of the employer mandate, and I think the real issue is getting at the individual in the sense that the individual either can afford insurance or that we have mechanisms to really help them come up with insurance.

Just a couple of other critical points I would like to make. There was a question on the whole medical loss ratio question, and I think that one of the points I would make is that if there were to be such a thing, I think you have to have it for health plans. I think you have to have it for hospitals. I think you have to have it for physicians because I think it has to be a level playing field.

I think a big problem with it is that it is a GAAP accounting measure that is created to measure an accounting notion, not a how we direct our resources. If, for example, we have 2 million members who are in chronic disease management programs, under a medical loss ratio definition that would be bad administrative expense that we would be penalized for investing in.

The \$1.8 billion we've spent in the past 4 years investing in health information technology, would be viewed as bad administrative expense, and I think the marketplace is much better able in the form of people like Steve Burd and other sophisticated purchasers to decide whether they're getting value through the overall administrative expense structure we have which, by the way, in

our case is about 11 percent and is nowhere near the allegations that are made in the context of it.

Again, I think it's a red herring. I think we should focus on what we're doing to change the medical trend.

I have got one other quick point I'd like to make, if I may. If I told you that in year one medical costs went up 8 percent, in year two I could take it down to 5 percent, in year three 1.1 percent, and in year four I could make the trend go negative by 1 percent, people would feel that was a pretty good performance, I would assume.

Now the reality is that's what happened in 1992, 1993, 1994, and 1995. Medical costs went negative. Now the problem is that we got there through mechanisms that turned out not to be the right mechanisms. We had mandatory medical homes which we called the gatekeeper. We had bundled payments which we called capitation. We had neural networks that limited the access of members where they couldn't go to the physician they wanted to see. We had coordinated care that we called referrals required, and we had very low cost-sharing because everything was on a co-payment and physicians had great incentives, it was risk-sharing, and there was great concern about the physicians being inappropriately remunerated for denying care as opposed to providing care.

We bent the trend and I think the opportunity as we go forward is to make certain that we do bend the trend through more appropriate mechanisms, like wellness, like administrative simplification where the industry has committed one claim form, one method of providing eligibility information, one method of really interfacing with the whole physician community.

I think there's a lot we can do and I do believe that we can bend the trend because it's been done before, but I think this time we have to do it collaboratively with physicians, with consumers, with the provider community, and the government and regulatory apparatus.

Just a couple of points.

Senator DODD. Thank you. Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman, and——

Mr. JOHNSON. I'm sorry. Just for the record, the medical loss ratio provision has been troublesome to some of our members. It's interpreted as a cap on profits, a governmental cap on profits.

I'm sorry, Senator. Just for the record because Senator Bingaman asked about that.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Mr. Chairman, thank you very much for holding this hearing. I want to thank all the panelists for being here and I especially want to thank you for allowing for the first time in this debate an advocate for a single-payer program to be here tonight.

[Applause.]

Senator DODD. Shh. You may get arrested.

Senator SANDERS. The truth is that of any program out there, single-payer is the most popular. It has the support of most people. There are 15,000 physicians onboard. It has the major nursing or-

ganizations onboard and it's about time that we at least began to hear at least for a few minutes from a single-payer advocate.

The truth of the matter is that our current healthcare system is disintegrating. You have not only 46 million Americans without any health insurance, you have even more who are underinsured and what's not talked about very often is that at a time when we have 60 million who do not have a doctor of their own, close to 18,000 people die every single year because by the time they get to the doctor, it's too late to treat their illnesses.

Meanwhile, in the midst of that disaster, we end up spending far, far more than any other country on earth, all of which guarantee healthcare to all of their people.

I think we can't just tinker with the system. We have to understand the system is fundamentally broken. We have to understand why it is broken and we need a new system.

Now, I want to start off by asking Dr. Flowers a very simple question and that is, tell me in your judgment why it is that our current healthcare nonsystem costs so much and gets so little value, not only in terms of the people who are uninsured and underinsured but in terms of healthcare outcomes, like longevity and low-weight babies and so forth and so on. Why are the outcomes so poor, despite the fact that we spend so much?

Dr. FLOWERS. Right. Thank you very much. We spend two to three times more than what the other industrialized nations spend on healthcare and their health outcomes are much better than ours in terms of infant mortality.

Our maternal mortality is two to three times more what the other industrialized nations have. Our life expectancy is lower and it's because we don't have an actual system. We have this hodge-podge. It's very fragmented. It's very nontransparent.

There are a lot of barriers that are put into place between the patients and their healthcare providers and so our whole incentive is wrong. It's not based on creating better health. It's based on—and I'm sorry, I disagree, Mr. Williams. It is based on profit because the number of these insurance administrators are there to cherry-pick, to deny and to restrict care.

Also, we've linked our health insurance to employment and that leaves us in the most insecure position because when a person becomes ill, if they are unable to work, they lose their job and then they have nothing. They have no access to care, no treatment.

Also, because people will lose their insurance if they change jobs, they won't change jobs. People are now getting married for health insurance.

Senator SANDERS. Right.

Dr. FLOWERS. It's perverse. It's crazy, and so now doctors are spending about—with all this health insurance model, we're spending up to a third of our time on paperwork and telephone calls to get authorization.

What makes it a little crazy is, if you think about it, a doctor writes a prescription for a medication, right, they hand that to the patient, the patient takes it to the pharmacist and then the doctor gets a call from the pharmacist, you have to call the insurance company and get authorization for this patient to have this medi-

cine. Well, doesn't the prescription serve as authorization? Didn't they make that decision?

Senator SANDERS. I have limited time.

Dr. FLOWERS. I'm sorry. OK. Well, anyway, so it's because we don't have coordination. It's not comprehensive.

Senator SANDERS. I want to ask Mr. Williams. He's sitting right next to you.

Dr. FLOWERS. OK.

Senator SANDERS. I want to ask you, sir. What do you think about the appropriateness and morality of private insurance companies denying people coverage because of pre-existing conditions? A woman has breast cancer 3 years ago. Clearly that's what's on her mind and yet there are many insurance companies, I don't know about Aetna, who deny her insurance.

My understanding is that in some cases pregnancy is a pre-existing condition, not to be covered. What sense does that make?

Mr. WILLIAMS. I would say, Senator, that in 2005 I called for the insurance industry to guarantee issue insurance to all comers in order. To assure affordability that requires that everyone be in the insurance market.

In States where—

Senator SANDERS. Wait.

Mr. WILLIAMS. You asked me a question.

Senator SANDERS. I know, but I don't—I have a limited amount of time. I asked you a simple question.

Mr. WILLIAMS. And I want to answer it.

Senator SANDERS. The morality or the appropriateness of denying coverage to somebody because of a pre-existing condition. That's what goes on today. Not what you called for 3 years ago.

Mr. WILLIAMS. Senator, I am personally and as an organization in support of issuing insurance to everyone without a pre-existing condition. If there's another answer you'd like me to give—

Senator SANDERS. That's great. Does that—

Mr. WILLIAMS [continuing]. I'd be glad to give it.

Senator SANDERS. Does that exist today? I'm glad that you believe that, but that reality of denying people coverage to pre-existing conditions exist all over the industry today, does it not?

Mr. WILLIAMS. The answer to your question, Senator, is in many States, based on State laws and regulations and the 60 different entities that regulate the industry, there are many States where health status is a basis for—

Senator SANDERS. Wow.

Mr. WILLIAMS [continuing]. Issuing insurance. That is correct.

Senator SANDERS. OK. Let me ask you this, Mr. Williams. There are 1,300, as I understand it, separate private health insurance companies in this country providing thousands of different plans and at a time when we have a desperate need for primary healthcare doctors and dentists and other healthcare professionals, in the last 30 years the number of administrative personnel, that's the bill collectors, that's the bureaucrats who work for private health insurance companies, has grown by a rate of 25 times greater than the number of physicians in the United States of America.

Do you think it makes sense that we are seeing a rate of increase by 25 times of healthcare bureaucrats who do not deliver one baby,

do not care for one cancer patient, just shuffle paper, driving people crazy about their bills? Do you think that makes sense if we're trying to move toward a cost-effective health insurance program?

Mr. WILLIAMS. Well, Senator, what I can tell you is what I know about Aetna which is 20 percent of the staff who work in our company are clinical personnel who are involved in trying to make certain that our patients who have chronic conditions are identified, that they understand the condition that they have, that they're getting the opportunity to make certain they can have a good constructive dialogue with their physician.

I don't know your numbers. I certainly can't speak to them. I'd be—

Senator SANDERS. A dialogue with their physicians. That sounds to me like what Dr. Flowers was saying, that she prescribes a drug and some bureaucrat working for an insurance company tells her that that's not the right drug. Is that the dialogue we're talking about?

Mr. WILLIAMS. No, Senator. We'd be glad to have you visit and explain what we do and how we do it.

Senator SANDERS. How do you feel—everybody here, regardless of political persuasion, is worried about the soaring costs of healthcare. My understanding is that in California, \$1 out of every \$3 in healthcare goes to administration and bureaucracy. Does this sound like a sensible system to you?

Mr. WILLIAMS. Senator, I would find that hard to believe as a fact personally.

Senator SANDERS. You would?

Mr. WILLIAMS. Yes, our administrative expense is 11 percent.

Senator SANDERS. We will get those—well, it's not only you, it's the people at the other end. There was a study that came out recently that doctors spend 2 weeks a year arguing with insurance companies about forms of therapy. That's an administrative expense. Nurses, every small practice in America has to have somebody who does nothing else but fill out forms. All of that adds up. I think the number of one-third may well be—

Mr. WILLIAMS. Senator, if that's true, I'd love to see it, but what I would say is that whatever we're spending, it's too much. There is—and I think the industry has worked very hard and has a whole series of comprehensive proposals that are designed to significantly enhance administrative expense.

Senator SANDERS. Thank you. Last question is for Dr. Rosman.

A recent poll came out done by the Kaiser Family Foundation which said that 67 percent of Americans either strongly favor or somewhat favor a public health insurance option similar to Medicare to compete with private health insurance plans.

Why do you think two-thirds of the American people want to see at the very least a Medicare-type plan for all Americans, yet the AMA does not think it's a good idea?

Dr. ROSMAN. Senator, I don't think I can speak to those individuals' reasons, but I can tell you the reasons for the AMA's concerns are based on the history that Medicare and Medicaid are public insurance options.

Senator SANDERS. Medicare is a much more popular program than Aetna is, with all due respect.

Dr. ROSMAN. I would absolutely agree that we need an insurance market reform so that we have uniform standards, so that there are high-risk pools, so that people can renew their insurance, even if they develop a health condition. We absolutely agree with those market reforms.

We are concerned with a Medicare-based public plan option because reimbursements aren't high enough that physicians can keep their offices open. My adult colleagues see patients day after day who can't get into a primary care physician. Nobody's accepting their Medicare and they can't find a primary care—

Senator SANDERS. I think we need to take a hard look at reimbursement rates.

Dr. ROSMAN. OK.

Senator SANDERS. Thank you very much, Mr. Chairman.

Senator DODD. Thank you, Senator, very much.

Senator Alexander.

STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thank you, Mr. Chairman. Mr. Burd, as we've talked in the committee, one area where we have great consensus is the importance of prevention and wellness and we, on the Republican and the Democratic side, have heard from you about what Safeway has done.

We were served confirmation today that the Kennedy proposal we're considering would get rid of the 20 percent premium variation in the HIPAA regulation that allows employers like Safeway more flexibility to incent healthy behaviors.

Can you tell us what this would do to your efforts to incent healthy behaviors among employees of Safeway?

Mr. BURD. Let me start my answer by thanking a staff member back in the Bay Area that quantified that number for me.

It would raise our costs \$27 million if we were just prevented from doing what we did right now and I think it would have a fundamental effect on the ability to improve the health of our employees. I really believe that without financial incentives, you have no chance of changing the behavior of Americans to lead a healthier lifestyle. That's how strongly I feel about it.

Senator ALEXANDER. Just to review, in your company, if you could in three sentences just summarize what you've accomplished so far, the number of employees, the savings in the dollars.

Mr. BURD. Yes. We have 200,000 employees, 28,000 of them are on this particular plan because it's an opt-in plan. Most of the incentives that we've applied but not all are focused on the nonunion population, the union population, about 170,000. We're probably about 30 percent the way through getting those incentives placed in the union contracts and I believe, given my discussions with Joe Hansen of the UFCW and other union leaders, that they're eager—

Senator ALEXANDER. And if I may because time is limited, and you've saved how much money?

Mr. BURD. Well, we saved—well, let's see. It's 37 percent. It's about \$60 million.

Senator ALEXANDER. And the results in terms of healthiness among the employees?

Mr. BURD. Obesity 70 percent of the Nation's, smoking rate 70 percent of the Nation, and declining virtually every day.

Senator ALEXANDER. Your testimony at other times is to say rather than get rid of the flexibility you now have to reward healthy behaviors by incentives, you'd like to have more flexibility, is that not right?

Mr. BURD. We would like more flexibility and that translates into more personal responsibility for behavior.

Senator ALEXANDER. How much more flexibility would be helpful to you?

Mr. BURD. You know, given the fact that a smoker costs \$1,400 or more, obesity costs \$800 or more, hypertension costs \$600 or more, you could—not to mention high levels of cholesterol, you could—if you have two family members and you could have more with dependents. Next year we'll measure BMI for dependents.

You could easily reach a number close to \$5,000 which would be closer to a 50 percent premium.

Senator ALEXANDER. Thank you, Mr. Burd.

Mr. BURD. Senator, if I could just ask you, I have a board meeting in 5 minutes and an airplane to catch after that. I'm enjoying the discussion. I hate to walk away, but I would appreciate it if maybe I could be excused.

Senator DODD. We'll let you go.

Senator ALEXANDER. I'd like to be able to ask the rest of my questions after you—

Mr. BURD. We have no pre-existing conditions at Safeway for 200,000 people.

Senator DODD. My other colleagues are here who haven't had a chance, we'll leave the record open so we can submit some answers to their questions.

Mr. BURD. All right. I'll be happy to send you some thoughts that you asked about at the beginning.

Senator DODD. We would appreciate any data and statistics which you think would be helpful to the committee, as well.

Mr. BURD. We'll do it.

Senator DODD. We would appreciate it very much.

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

Senator ALEXANDER. May I take a couple more?

Senator DODD. Yes.

Senator ALEXANDER. Mr. Chairman, I'd like to address a question to Dr. Ray Scheppach, who's been with the National Governors Association for a long time.

Governors have seen firsthand the burden that Medicaid causes. I mean, the fact of the matter is that it's completely out of control and is the main factor, in my view, in terms of bankrupting States, that it is filled with consent decrees, delays, inefficiencies, that the rates of reimbursement for doctors are so low that many Medicaid patients aren't properly served, and that the costs are literally out of control for States because continuous changes in Federal policy imposes new burdens on States.

One of the results is the dramatic deterioration of the American Public University and Senator Mikulski and I are writing a letter to the National Academies to ask them to take a look at the condition of our research universities and our great universities, like the

University of California as an example, are suffering greatly from lack of State support.

What I'm getting to is this. I got some information today from the Governor of Tennessee about what the effect of expansion of Medicaid to 150 percent would mean for our State. If our State picked up its share of the cost, which is about a third, it'd be nearly \$600 million, according to our State. That would be equal to imposing a new State income tax of about 5 percent on the people of Tennessee. We don't know where we'd get that money.

If the Federal Government were to pick it all up, the cost to the Federal Government of just Tennessee's would be \$1.6 billion, unless the bill also requires reimbursing physicians at 110 percent of Medicare and then the cost would be even higher. That would suggest that the cost overall of taking Medicaid to a 150 percent to States is going to cost somebody, either the Federal Government or the State governments, \$4-\$5-\$600 billion over the next 10 years.

I wonder if you'd want to comment about what your view is of increasing the Medicaid expansion to 150 percent of Medicaid and whether you believe that the Federal Government will actually pick that up or whether it's likely to shift the costs back on the States within a few years.

Mr. SCHEPPACH. Well, as you know, Senator, the rate of growth of Medicaid since it came into place has been about 11 percent per year. State revenues have probably grown 5.9 percent per year, and as you indicate, the reimbursement rates for the average State is about 72 percent, but some of the big States, California, New York, New Jersey, are less than 50 percent.

There is clearly great concern when you essentially bring in another 46 million people of whether, in fact, reimbursement rates are going to have to go up to the Medicare rates or even in fact higher than that and, in fact, it's that increase in reimbursement rates on the base that's actually more expensive than the expansion is.

If you go up to a 150 percent of poverty, you're talking about bringing in an additional 18 million individuals, taking Medicaid from 58 million to about 75-76 million.

Our preliminary estimates are that this could cost, depending upon your assumption, \$50 to \$60 billion a year in terms of the State share. To give you a sense of that, that's about 10 percent of general State revenues and both of the bills, of course, essentially do a temporary pick-up of that expansion for about 5 years but then—

Senator ALEXANDER. Excuse me. You said \$50 or \$60 billion a year of the State, would be—

Mr. WILLIAMS. The State—

Senator ALEXANDER [continuing]. An increase in the State share of Medicaid if we go to a 150 percent. So over 10 years that's \$500-\$600 billion?

Mr. WILLIAMS. That's right. That's a very preliminary number.

Senator ALEXANDER. That's the States' share and that's typically about a third, right?

Mr. WILLIAMS. It's probably about 42 percent.

Senator ALEXANDER. About 40 percent. The other 60 percent's going to be paid by the Federal Government?

Mr. WILLIAMS. That's right.

Senator ALEXANDER. And if your figures are right and it's going to cost \$500 or \$600 billion to the State and that's just 42 percent, then you've got \$600 or \$700 billion Federal, so we've already got a Kennedy bill that will cost \$1.2 trillion just with that one provision.

Mr. WILLIAMS. Significant.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator DODD. Thank you. Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you very much, and I want to thank the panel for being here.

We missed the topic here. We haven't said much about children and I realize the next panel's going to deal more with that, but here's the reality that we face with regard to children unless we get this right.

This committee's done incredible things for children in this bill and I want to commend especially Senator Dodd because he's got a long record on this, as do others, but unless we get this right in this committee, but more directly and more in a more determinative way in the Finance Committee, and I favor the lifting of Medicaid to a 150 percent of poverty, but even just by doing that, we could put some poor children and children with special needs at risk.

I think the rule ought to be here not just to go oh and not just a nice thing to do, not just an aspiration, the goal—the rule ought to be here four words when it comes to poor kids and kids with special needs: no kid worse off, no kid worse off. If we fail at that, I think we failed in very large measure. That's just my opinion.

I wanted to get into this question of Medicaid for a second. I want to read something as part of the record. This is a Finance Committee document, but I do want to make sure it's clear here in terms of what States—because I realize governors are wrestling with this and it's a very tough problem for governors. Here's the proposed option with regard to what is called Medicaid Program Payments. It's in that section what they're talking about.

“Through 2015, the Federal Government would, would fully finance all expenditures for benefits provided individuals newly eligible for Medicaid as a result of increases in income eligibility,”

and then it goes the other way.

All right. “The States' share of these costs would be phased in over the next 5-year period,” and then it goes on to say, “after this phase-in period, the States' share of this cost would be equal” and little by little the State would have to continue to pay it at a level.

I understand your concern about at some point down the road States may pay more under this option which is not in the bill. It's not law. It's an option.

The question I have for the governors, the question I have for the AMA, Doctor, and I know you have great experience with children, and the question I also have for anyone else, but Dr. Gruber spoke to this, Dr. Gruber, you said on Page 5 of your testimony, “Drop-

ping the Medicaid expansion and enrolling individuals in the exchange would in my view be a mistake.”

I ask all of you what about kids in this bill, in this bill and in the Finance Committee bill?

Mr. SCHEPPACH. The Finance Committee bill, I think, takes them up, I think, to like 150 percent for women and children and leaves them essentially in Medicaid so that they get the wrap-around and robust benefit packages.

A bigger issue in Medicaid is what do you do with childless adults, I think, and parents. I suspect parents, it's better to keep in the same program with children because evidence indicates that they then go see the doctor.

A bigger question about childless adults of whether they should stay in Medicaid or whether they should go into an exchange or a gateway. I think the big issue there is we're fine if they stay in Medicaid, but I think in this bill, the individual had the option to go out of Medicaid and go into the gateway.

If they bring the wrap-around benefit with them into the exchange, that's just administratively more difficult. It's not so streamlined and it's probably more expensive. It's probably better, excuse me, to leave those populations in Medicaid, maybe not allow that option.

If there are healthier components of that that want to go into the exchange, you may want to offer them to it, but it may be that they give up the wrap-around package.

Senator CASEY. Dr. Gruber.

Mr. GRUBER. Yes, I think I would strongly advocate—I don't know whether the right number is a 150 percent of poverty or a 125 percent of poverty, what it is, but I would strongly advocate that the lowest-income people, both existing eligible populations and newly-eligible populations, like childless adults, I strongly advocate they stay in Medicaid and be made eligible for Medicaid and I say that for three reasons.

First of all, Medicaid is a more cost-effective option for these low-income populations than is private health insurance, largely because Medicaid pays providers less, but nonetheless it's a more cost-effective option.

Second of all, I think the evidence suggests the erosion of employer-sponsored insurance will be smaller if the option is Medicaid which people of employer-sponsored insurance is sort of averse to versus a private exchange which they may find more attractive and be willing to leave their employer-sponsored insurance for.

I think if people below poverty are put in an exchange that will increase erosion of employer-sponsored insurance and, finally, the main advantage of the exchange is to be able to shop across options and that relies on financial incentives.

These low-income people, we can't put financial incentives for them. They can't afford to pay a differential for a more expensive plan. So we lose the main advantage of an exchange. If there's no real financial advantage to shop, why put them in an exchange? Why not just put them in Medicaid?

Senator CASEY. Dr. Rosman, I know that on the next panel, we'll have Dr. Palfrey from the American Academy of Pediatrics—among others, I should say, that will be on that panel.

Just in terms of the AMA, how do you answer the question, the strategy to make sure that this healthcare reform legislation leaves no kid worse off and especially poor kids and kids with special needs?

Dr. ROSMAN. Thank you. We absolutely agree that we don't want to leave any children worse off and in fact hope that we can improve their situation.

We believe that maintaining a safety net is very important as we go forward with these insurance options. We need to maintain that safety net, maintain access to preventive care, maintain a safety net for families and children that may not be eligible or able to effectively utilize an insurance exchange or purchase into those pools, and so we absolutely support greater equity within Medicaid, a uniform standard at poverty level at least for coverage, and I will leave it at that.

Thank you.

Senator CASEY. OK. I know I'm out of time, I think I'm out of time, but I'd say this with respect, I think the AMA should raise its voice on this. We need to hear what you just said more than just in response to a question.

Thank you.

Senator DODD. Gerry, go ahead.

Dr. FLOWERS. May I respond?

Mr. SHEA. Thank you. Senator, I know your question was about Medicaid and we strongly support the strengthening of Medicaid along the lines that's being discussed, but I just wanted to make the point that the increase of the uninsured has come largely among the working population and the biggest increase among the uninsured has been among children of people who are working and so one of the reasons that we strongly support the idea that all employers are to participate and offer is that that is just the most direct way to get children covered in terms of turning back this tide.

I just think that just has to be in the mix.

Dr. FLOWERS. If I could—

Senator DODD. Doctor.

Dr. FLOWERS [continuing]. Comment—thank you—that the fastest growing population of uninsured is that 300 to 500 percent of Federal poverty level who can't afford private insurance but don't fall into the safety net categories and Medicaid, while I understand is valuable to pediatricians, in our State of Maryland which is one of the wealthiest States, we're ranked 47th in the country for quality under Medicaid.

I see that as, there's a quote we often use, a program for the poor, a poor program, and when you look at a national health system based on single-payer financing, the key words to that are everybody in, nobody out. Nobody's left out. From the time that you're born until the time you die, you have access to healthcare, no cracks to fall through, no gaps, and it's fiscally responsible because if we were to take all of our healthcare dollars right now and put them toward healthcare with a very low administrative cost and bargain with pharmaceutical companies, we can actually provide very high-quality care to every person in this country.

I think that rather than tinkering around again, if we could really just go ahead and create a national health system, we would solve all of these problems.

Thank you.

Senator CASEY. Mr. Chairman, I know I'm out of time, but I do want to say, Mr. Rivera, it's not a question, but I know your workforce—we're going to be talking about workforce tonight, later tonight. Your workforce, your members have done great work in training, providing the ground troops for the healthcare delivery system.

We appreciate the work that you've done and your members.

Mr. RIVERA. Thank you so much.

Mr. SCHEPPACH. Senator, can I just add one on the fiscal realities?

Earlier this week I announced, based on a survey of States, what the shortfalls are over the next 3 years. It's over a \$180 billion and States are now recommending from their own tax base about \$26 billion to raise taxes to close gaps and this is after the \$135 billion that was in the Recovery package and I suspect that they're going to have to raise them more than that and so when you begin to implement this particular program from the State perspective, they will have just closed 3 years of gaps of over 10 percent, primarily now because they have been cutting so much on the spending side over the last 2 years and it's primarily going to come on the tax side.

You just need to understand that if, in fact, you're going to only cover this for 5 years and phase it out, it's going to be a huge burden for States.

Senator CASEY. No, and I appreciate that. Look, the States have a very difficult problem, but when I hear around Washington there's no money for this, there's no money for that, somehow the last Administration figured out a way to give a couple hundred billion dollars, I don't know the exact number, I'll get it, but a couple hundred billion dollars to the top 1 percent. Somehow they found it. OK?

There are plenty of resources out there when you can find a couple hundred billion over 8 years for not the top 2 percent or 5 percent but 1 percent.

I hope the governors would, when they're making suggestions to policymakers in Washington, they say how about that tax plan you had for 8 years for a pretty wealthy group of people?

Thank you.

Senator DODD. Thank you, Senator.

Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you very much, Mr. Chair.

Because we have another panel coming, I'm going to try to hold myself to just two questions here.

Sometimes I feel like we lose common sense along the way and I'll give you an example of what I'm talking about.

The numbers that Steve Burd shared with us were that four chronic conditions comprise 74 percent of healthcare costs, those being heart disease, cancer, diabetes, and obesity, and indeed my

brother-in-law was in town this week. He's an occupational therapist, has worked the last 20 years with medical facilities throughout Sioux Falls.

He said, "Jeff, I recently was walking around the hospital and I went to the Heart Center and then to the Pulmonary Center and then I went"—because he deals with occupational therapy—"to the Amputation Center." He said, "Everywhere I went in the hospital, I saw obesity and diabetes—no matter what part of the hospital I was in." These are just a couple of the common sense things I'm talking about.

Right now, the tobacco industry is test marketing tobacco candy in Portland, OR, they are intended to hook a whole new generation on tobacco. Well, that's a huge factor for cancer which is one of those four conditions costing 74 percent of healthcare costs.

A lot of practitioners have talked about the value of breast feeding, getting children off to a good start, that it provides immunity, provides nutrients that are very relevant to the development of the brain, and provides bonding. Yet we haven't done basic workforce efforts, some States have, but we haven't at the national level, to help facilitate breast feeding for moms who go back to work.

These are just a couple of examples. I just wonder if anyone would like to comment on that.

I know we're involved in the financial models, but what about the common sense side of some of the things we could do to take on these four chronic conditions?

Mr. WILLIAMS. I think one of the things that we have to do and what we're working on is early identification and prevention. For example, for children we're seeing diabetes that's occurring, used to be referred to as adult-onset which it's no longer referred to, but what we're beginning to do is we're paying pediatricians to take the extra time to provide nutritional counseling and to be able to bring in a dietician to work with the family in a culturally appropriate way because a dietician has to really understand the culture of the family to really help them and so I think there's a whole generation of what we call "value-based benefit design" that looks at the circumstances of the individual and says you're a diabetic, you need a certain medication, beta blockers, and so in your case, instead of charging you the standard co-pay, we're going to reduce the co-pay and maybe we'll pay you to take the medication because it's that important to help you deal with your particular issues.

I think there's a whole set of technology and a whole set of mind shift around really changing how we think about prevention and wellness much earlier in the process because the people he saw in the hospital are the tip of the iceberg of what's coming as youth and children are really on the same trajectory and so I think those are things that I think we have an opportunity to do and help those people with basic health literacy so they understand their role in treating their condition in terms of being compliant with their medication and really following their doctor's orders.

Senator MERKLEY. Yes, sir.

Mr. SHEA. Senator, there are other countries that address this issue through basic public health programs. They're very cost-effective. You don't see the child obesity problem in a number of European countries with public health, good public health systems be-

cause there is a concerted effort. It's not up to employers. It's not up to local school systems.

There is a concerted effort as a nation to say this is a bad idea. We're going to teach moms when they're in their early child-bearing years about this and make that a value for the family.

So you're talking about this, and I would just say there are only baby steps being proposed in some of the legislation coming forward—in the context of our system—to get at some of these issues, but they're very important to look at.

I would point out in Senate Finance where they have looked at the re-admissions issue and they have said we will pay extra for staff to follow up on hospital stays in order to cut down on the re-admissions rate.

This is a simple problem to solve, but it doesn't get solved if you simply hand the patient a piece of paper or the patient's relative a piece of paper, even with a good talk, as they go out the door and say good luck, don't forget to call your primary care physician.

We know that doesn't happen. It doesn't happen at least for a lot of populations. It is not expensive. In fact, you save money if you have teams and the research on this is very clear. You have teams that follow up people and identify these kind of problems. You do medication management for many of these disease situations.

We know how to solve these problems. We have to change the structures of our payment so that we're paying for quality treatment processes and teamwork processes as opposed to just individual practitioners, this silo, that silo, the other silo. We know how to do it, and I think at least the initial steps are found in some of the legislation. I would encourage you to just push that as far as you can.

Ms. PRAEGER. Is this on now?

Senator DODD. Why don't you introduce yourself, too, for the record, so we know who's talking?

Ms. PRAEGER. I'm Sandy Praeger, the Insurance Commissioner in Kansas but representing also the National Association of Insurance Commissioners.

One issue that hasn't been talked about today, and it's been touched on and I know it's something that Senator Roberts, if he were here, would probably mention, and that's the current payment structure for physicians really encourages—well, first of all, they come out of med school with \$140,000 in debt. They're encouraged while they're in med school to pursue specialty care where they're going to be able to make more money and the payment structure today, the fee-for-service medicine, encourages volume services rather than value services.

We want to be able to have primary care physicians encouraged to take the time to do the counseling, to do the diet counseling, and the current payment mechanism just doesn't allow for that to happen. That's part of the reform that needs to be included.

Senator MERKLEY. I think there are a couple other folks who want to chime in here.

Mr. RIVERA. I just wanted to say before in the exchange with Senator McCain, I wanted to reiterate that Dr. Baicker and myself are part of a group that one of your former colleagues, Senator Frist, participated in with the Robert Wood Johnson Foundation for

2 years. We did a study all across the country about what were the behaviors that absence of medical care that influenced the care of people in the United States and we would love to submit that report to you.

Senator DODD. Please do.

Mr. RIVERA. Because clearly we have not done a good job of circulating it and basically that report has very concrete recommendations about changing and creating a new national culture of health and in the schools and in the jobs, in the communities, basically in almost every—in the workplace, in almost every practice—place in our society, and I believe if we don't do that, we are not going to get to the bottom of it.

Senator MERKLEY. Mr. Johnson, did you want to chime in?

Mr. JOHNSON. Yes, sir. Just that we are very mindful at the U.S. Chamber of wellness and prevention programs, including trying to provide tool kits to our small and mid-sized companies in terms of how to construct wellness programs on a voluntary basis.

I have always been curious as to why all these bills pending in the Congress or about to be introduced haven't included funding for a public education campaign frankly along the lines that John F. Kennedy had in terms of educating people on the importance of physical fitness, et cetera.

It may sound a little anachronistic or old-fashioned, but that's what wellness and prevention is all about and Senator Harkin has his bill with tax credits we support, but again, and the other speakers have commented on this, but let's get back to basics and reminding people about the importance of certain fundamentals of keeping themselves healthy and that has not been part of these—well, maybe it's in there and I have missed it, but it has not been part of the various bills Congress seems to be looking at.

Senator MERKLEY. Well, I'll just wrap up by saying that I appreciate you pointing these things out. The fact that a dietician can be as important as a heart surgeon, that a social worker working to prevent a re-admission, a second heart attack, might be as important as the medical care inside the hospital. I thank you all for your insights and comments. I appreciate that.

Senator DODD. Thank you, Senator, very much.

Just a couple of observations. You've all been very, very patient and very valuable with your comments, as well, and Dennis, we'd like to get—that's a good report. Here I'm asking for your reports.

I was going to recommend, maybe you've looked at it, all of you have looked at it, but I was very impressed with an article written by Dr. Gawande in *The New Yorker*. I'm not here to promote a magazine, but, I found it very insightful. In fact, a group of us went down and met with the President of the United States to talk about healthcare back—what was that, Jeff—a week or so ago, I think, and I brought up the article.

Before I could, the President had already read it. The article, goes to the issue of cost and if you haven't read it, you should, but the point is it looked at one of the poorest counties in the United States, Hildalgo County in Texas, particularly McAllen, TX, and the cost per patient there was about \$16,000 a year, as I recall, in the article, and they compared that with the costs in El Paso, TX, where there was not a substantial difference in poverty levels and

then compared that with northern Minnesota where the Mayo Clinic is, which is about a third of the cost.

The assumption you might draw immediately, well, of course, if you have a very poor area, obviously the costs will be more and given the poorest county in the country, that's the reason the costs are more. That was not the reason for why the costs were higher. It was the number of tests, exams, all these other things that were being conducted in Hidalgo County that drove up that cost, more so than it did in El Paso. Anyway, it was an interesting article.

Leading experts have talked about a third of the savings could occur just by reducing the number of unnecessary tests, exams and the like that are being performed driving costs up.

Obviously there are a lot of ways to save money and I think Mr. Burd's comments, are tremendously exciting. I know at our luncheon today people were very impressed with the idea of what one company in Connecticut, Pitney-Bowes, did with Mr. Critelli there as the CEO—did something very, very similar in driving down costs.

I wanted to raise the question because Senator McCain raised the issue of how do you pay for all of this and that's a very legitimate question. Obviously we need to get these numbers and Senator Alexander raised the cost of 150 percent on Medicaid—what the costs would be.

I mentioned at the outset of my remarks that we're talking about statistics that indicate we could be seeing as much as 30 or 34 percent of GDP be healthcare costs by the year 2040. We know it's about 17 percent today.

We know, from a recent report, that 60 percent or so of bankruptcies are related to healthcare problems that have afflicted people. We know that over 80 percent of growth, and again I listened to Ron Williams talk about this but roughly the numbers of increased costs in healthcare have gone up that much in 10 years.

The question I wanted to sort of ask all of you as sort of a parting question, what if we do nothing? If these numbers are right and we don't do anything and so while the costs of investing in these things and getting this right and bending that curve are not cheap, but my fear is that we'll end up so bogged down in all of this that we end up doing nothing once again and I wanted to raise if there's anyone here who thinks that doing nothing is a better alternative than trying to come up with something here that would allow us to bend that curve.

I'll begin with you.

Dr. FLOWERS. I don't want to say that doing nothing is the wrong thing but doing the wrong thing is the wrong thing because you're talking about regulating health insurance companies to make them act like social insurers which is going to add costs. You're talking about creating an insurance exchange. That's going to add costs.

We're operating under this belief that people want a choice of health insurance but people don't know how to choose health insurance. They don't know what their healthcare needs are because they change.

We have studies from the Congressional Budget Office, from the GAO, and in multiple studies at the State level, by the Lewin Group and also Mathematica, showing that creating a health sys-

tem based on single-payer financing saves money and it's the only one that saves money.

Senator DODD. Mr. Williams.

Mr. WILLIAMS. I think it's clear that doing nothing is unacceptable, that we have to find a way to get and keep everyone covered.

I think at the same time, we need to sharpen our focus so that we are really focusing on the things that make the most important progress and in terms of having a much more inclusive system.

I think the individual market represents a huge opportunity to bring everyone into that market without the need for health status. I think that the small group breaks into two components, the smaller into small group. There is a huge opportunity to address the fundamental fact that small employers don't offer insurance.

In the larger end, it really is much more about rating volatility, meaning those companies between 10 and 50. Eighty percent of them offer insurance. Their big concern is they see a lot of volatility in the rates. I think the SHOP Act gives us a pretty solid foundation to be able to address that.

I think in terms of bending the curve, I think there are a lot of things to do. Every suggestion, every idea ultimately has to be implemented. It turns into real work in terms of how we really incent and align physicians to really focus on long-term outcomes.

I think we've got some great models, and I commend this committee and other committees who are focused on it. I think doing nothing is not an acceptable idea, but I think we have to recognize this is a big lift and if we sharpen our focus on the things that make a big difference, we can get a lot done.

Senator DODD. Dennis, you want to comment on this at all?

Mr. RIVERA. Yes. Well, first of all, it's clear that—and by the way, we had a group which participated, the American Medical Association, Pharma, the AHIP, and the American Hospital Association, and we clearly in those meetings that we have been having—the question was can we become more efficient in the way that we deliver care, and the reality is that we all have an agreement that we could become more effective and that's where it is.

If we spend 17.5 percent of the Gross Domestic Product in this country and are 40th in terms of outcome in the world, and we are spending 6–7 percent more than Japan or Germany, so in that context, we believe that we could find a great chunk of those savings inside the healthcare system by basically becoming more efficient and challenging all of us who are asked as providers to basically become more efficient and I think that's an important issue.

I think that same article that you talked about, the places that had the better outcome were the places that it was cheaper. So in that sense, it wasn't necessarily the places that was higher that were having better outcomes. They got better outcomes in the places that it was cheaper.

Senator DODD. You know, I was going to mention, by the way, I had met last week with the head of Starbucks and the head of Costco who have had rather interesting healthcare programs and to pick up on something Senator Merkley was bringing up, the issue of marketing these ideas and getting people aware of, I was stunned to learn how few—what a small percentage of people actually take advantage of the annual medical exams that are offered

by—the number I think nationally is very low, something like 5 or 6 percent of people who have that kind of coverage actually take advantage of the medical exam.

Is that a reflection of the failure to market these ideas and promote these ideas? I mean, here they're existing within a policy and yet for some reason people are not taking advantage of it. What's the reason for that? Does anyone have an answer to that question? Dr. Gruber, do you have an answer to that question?

Mr. GRUBER. Well, I think there's many things we know that have to be sold. They always say that life insurance is a push, not a pull. You've got to sell life insurance. I think you've got to sell wellness. I think financial—you've got to both have a carrot and a stick, whether you're selling it, but also giving people financial incentives to take advantage of it.

But I come back to your original question—which is the key question—which is the cost of doing nothing.

Senator DODD. Yes.

Mr. GRUBER. I think it's very important to recognize that the cost of covering every single American with health insurance is less than 1 year's growth in our national health bill. These are problems of two totally different magnitudes.

The problem of cost control just dwarfs the problem of coverage in terms of its magnitude. For those who would say we can't spend less than 1 year's growth to cover people until we rein in this entire system, I just think that's inappropriate and in fact I think it's the wrong way to think about it.

The right way to think about it is by covering everyone we'll move closer to that day when we can rein in costs and we've seen that in Massachusetts where once we covered everyone with health insurance, then we got much more serious about cost control and passed a much more serious cost control bill in our State.

I think to say that we have to hold coverage hostage to cost control is to say we're going to hold this small piece hostage to this enormous piece. That's the wrong way to think about it and I think we have to get costs under control but doing coverage first is just a blip on that radar.

Senator DODD. Yes. Yes, Mr. Shea.

Mr. SHEA. Senator, to your question on the physicals, we know that people don't take advantage of a lot of the opportunities they have to understand their health status and then to act on that health status.

We also know that integrated health systems do a good job in many cases, not all cases but do a good job about dealing with that, and we now are developing models that don't require you to be part of an HMO or a Kaiser but talk about bundled payments and the example I gave before about follow-up care for admissions, the medical home notion.

These are all ideas that we need to not simply have a physician, but that you get a physician and you go see the physician and it's up to you to go back to see the physician but it's a more holistic—somebody used the phrase earlier, but on the general question, we see, that is our unions who bargain benefits, see every day the effects of high health costs.

We're bleeding the system to death financially is what's going on. We're losing healthcare. We're also losing good jobs as a result. I mean, we're just lowering the living standards of people because of our political lack of will to tackle this.

I think the reasons to do it are evident and they're overwhelming based on our experience, and let me just last, I know you're going to be working on your legislation quite a bit, but—and as I said at the beginning, if I had my druthers, you'd be doing a different piece of legislation.

Other people on this panel have said similar kinds of things, but I think what you've done is a very good strong start. You've put a number of pieces together. You've built on what is working out there in many cases and you've said let's take the next step forward. That's the way we're going to get this done.

I wish it could be different, but that's the way we're going to get this done. I would just urge you to move ahead along the lines that you've done and strengthen what you do and simply don't take the criticisms too hard. You have a Medical Advisory Council.

People in that public health world have been saying for years we need experts to say here's the basic benefits that people have. Here's the protocols that people need to do. This isn't government control, as some people are now trying to criticize you for. These are just sensible sort of approaches.

I think you put a lot of things in there that are good. We'd urge you to continue. I have spoken to some of the things that we think should be added to your package, but I would really thank you for the immense good start that you've made.

Senator DODD. Thank you. Mary, and then I'll go to you.

Ms. ANDRUS. I wanted to go back to your question about whether or not doing nothing was an option, and I just wanted to point out from the perspective of people with disabilities and the way the current system works, it's not uncommon at all that they have to impoverish themselves and get into Medicaid to get the kind of care that they actually need.

With the proposals we're talking about in the Kennedy legislation and the Finance product, as well, those kinds of changes can really make a difference to how those lives are lived in terms of being able to be in a work setting, be in their homes, be in their own communities.

From our perspective, moving forward, making change, opening those doors, is really key to the future for a large number of people where doing nothing will either freeze them or pull them down, one or the other.

Senator DODD. Yes, Mr. Dennis.

Mr. DENNIS. For over 20 years, we've seen that the cost of health insurance has been the single most important problem among small employers, for over 20 years. We can't go much longer and still have it happen.

Meanwhile, while this problem has been going on, of course, fewer and fewer and fewer employers, particularly small employers, are establishing health insurance plans. We think it's essentially people who are coming in to the market, new employers that are postponing it longer and longer and longer, more so than people dropping it.

In any event, this can't go on forever.

Senator DODD. Yes. Well, let me just say that we need you, as well. This is a very complex issue. I don't know of another issue that we've grappled with as complex as this and one that deserves our undivided attention and the Majority Leader and others are determined that we go forward.

We really need—having heard all of you, basically I don't hear any dissenting voices that the status quo is acceptable. Our job here then is not to let that become the outcome. We need to get this right and so we need your involvement and your participation if we're going to do this and I know Senator Enzi is determined to do it, Senator Kennedy is certainly and in his place I'm going to do everything I can, as well, to keep this together.

We'll leave here. We begin again at 6:30 for another 2 or 3 hours tonight as just people sitting around a table, as colleagues to talk through this and where we are and how we can move this forward and again into next week as we begin and then a process of moving forward.

My experience is unless you have something on the table, it just becomes a lot of talk and we need to get beyond the talking stage of this.

I really appreciate it. You've been here for 3 hours. That's a long time to be sitting here and a large panel where you all didn't get to participate as much as you might like in that time. I'm very grateful to all of you.

I want to say to my colleagues, as well, I want to say to Bob Casey who's taken a tremendous interest in children's issues and I'm very grateful to him. I have worked on those issues for a long time. I saw a study the other day by the way on obesity, since that's one of the four areas we've identified, and I don't know whether, Dr. Rosman, you've seen this or you, Doctor, as well, but there's some correlation between—I wrote the legislation with Lamar Alexander on premature births in the last Congress and now there's some study that's indicating that actually, there is a relationship between premature births and obesity. There may be a direct correlation. I would just point out to my colleague that may be something worthwhile to look at here, as well, because maternal care is something I hope we're really going to get engaged in this process because again the point that you've made, Doctor and others, that Bob Casey made and Jeff Merkley made, that idea of being involved at the earliest stages. I appreciate, Mr. Williams, your comments about those issues, as well, coming from a private carrier, how important that is, as well.

I don't know if my two colleagues have any closing comments you want to make or any additional questions.

If not, we'll leave the record open. This has been tremendously valuable and I want you to know that, and in Senator Kennedy's name, I thank you.

The committee stands adjourned.

[Whereupon, at 6:09 p.m., the hearing was adjourned.]

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