THE ROLL OUT OF HEALTHCARE.GOV: THE LIMITATIONS OF BIG GOVERNMENT

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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CONTENTS

THE ROLL OUT OF HEALTHCARE.GOV: THE LIMITATIONS OF BIG GOVERNMENT

Wednesday, December 4, 2013,

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
WASHINGTON, D.C.

The committee met, pursuant to call, at 9:35 a.m., in Room 2154, Rayburn House Office Building, Hon. Darrell E. Issa [chairman of the committee] presiding.

Present: Representatives Issa, Mica, Turner, Duncan, Walberg, Lankford, Amash, Gosar, DesJarlais, Gowdy, Farenthold, Collins, Meadows, Bentivolio, DeSantis, Cummings, Maloney, Norton, Tierney, Connolly, Speier, Cartwright, Davis, Cardenas, Lujan Grisham, and Kelly.

Staff Present: Molly Boyl, Majority Deputy General Counsel and Parliamentarian; Lawrence J. Brady, Majority Staff Director; Caitlin Carroll, Majority Deputy Press Secretary; John Cuaderes, Majority Deputy Staff Director; Brian Daner, Majority Counsel; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Linda Good, Majority Chief Clerk; Tyler Grimm, Senior Professional Staff Member; Frederick Hill, Majority Deputy Staff Director for Communications and Strategy; Christopher Hixon, Majority Chief Counsel for Oversight; Mark D. Marin, Majority Deputy Staff Director for Oversight; Laura L. Rush, Majority Deputy Chief Clerk; Sarah Vance, Majority Assistant Clerk; Jedd Bellman, Minority Counsel; Krista Boyd, Minority Deputy Director of Legislation/Counsel; Aryele Bradford, Minority Press Secretary; Jennifer Hoffman, Minority Communications Director; Julia Krieger, Minority New Media Press Secretary; Juan McCullum, Minority Clerk; Jason Powell, Minority Senior Counsel; Brian Quinn, Minority Counsel; Dave Rapallo, Minority Staff Director; Daniel Roberts, Minority Staff Assistant/Legislative Correspondent; and Mark Stephenson, Minority Director of Legislation.

Chairman ISSA. The committee will come to order.

The Oversight Committee exists to secure two fundamental principles: first, Americans have a right to know that the money Washington takes from them is well spent and, second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform is to protect these rights. Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have a right to know what they get from their Government. It is our job to work tirelessly in partnership with citizen watchdogs to deliver the facts to the

American people and bring genuine reform to the Federal bureaucracy. It is our mission statement and it is our calling.

Today, when we discuss, once again Healthcare.gov rollout, which has undeniably been, and inarguably, a disaster. It is not a disaster of the making of one man or any one person. In fact, in many ways it is a sign of a failed system that is often seen in the Federal Government and very often seen by this committee.

Nearly two months after the Federal website launched, even as the Administration declares its vast improvements, components of the back end are still unfinished. Customers are told that at least in some cases, many cases, their applications may not have been correctly forwarded to the insurance carrier, meaning they have signed up; they are not going to get the benefit. They may go to the hospital and not be covered. Or, if they are covered, it will only be after weeks, months, or years of paperwork. Additionally, it is now learned that the ability to properly pay insurance companies is in doubt and, as a result, estimates are likely to occur. Estimates not how you do business.

The project's failure raises serious questions on what hindrances Government faces when it intervenes in the private market. President Obama wisely said that startups, business startups, often have these sort of problems; that these are the nature of private sector startups. The difference here is the private sector wasn't just starting up; the private sector was fully up. Rather than leveraging the private sector, Healthcare.gov essentially built a whole new layer, a whole new decision process on top of it.

Before October 1st, the President told Americans that purchasing insurance on Healthcare.gov would be as simple as shopping for airfare at Kayak or Expedia. I have shopped at Kayak and Expedia. The only difficult thing at those sites is choosing from many choices, well defined, and making your decision. In fact, nothing has been more different than Kayak or Expedia at the site. Just yesterday I logged in to the D.C. exchange, where members of Congress must go, and got an error. We do not have either the front end or the back end, not just in the Federal system, but in systems that feed into it, in fact ready.

Can anyone honestly imagine what would happen if you went to buy an airplane ticket on Kayak or Expedia and the site constantly crashed, losing your information, or in fact if they told you leave your personal email and we will email you back in eight or ten hours in order to tell you that it is now a better time to try to log on and find prices?

Healthcare.gov is a monopoly. Healthcare.gov is a mandated tax-end location. For members of Congress, they will either go to Healthcare.gov or they will be without insurance and be fined.

Yet, today no one has been held accountable for spending hundreds of millions of taxpayer dollars on a website that simply didn't serve the President or the American people on his signature legislation.

As someone who spent many years in the private sector, I know that if I had ever staked my business on a product that performed like this, it is unlikely I would have gotten a second chance. In fact, if a company launched like this, they would have to go back down, regroup, remarket, and relaunch. But that is not the case. Most of

the laws stay in place; most of the enforcement stay in place; and, as many of the other committees are looking into, many of the exceptions are not ones which are codified in law or within the purview of the Administration to decide to forgive or delay.

More importantly, the failure of this website, some $640 million invested, will undoubtedly cause a loss of revenue many times that. The actual exposure to the vendors and the individuals may be limited, but to the American taxpayer it will be billions of dollars of lost revenue because of this failure.

I did not vote for the Affordable Care Act. I do not believe that it will drive down the cost and up the availability and affordable to the American people. However, getting the system under the law to work as well as possible and then having a discussion about how to improve healthcare for the American people is our responsibility.

Today we are joined by Dr. Clifford Winston of The Brookings Institute, who wrote in 2006 that government failures appear to be explained by a shortsightedness, inflexibility, conflicting policies of government agencies.

I might note that 2006 was before President Obama was president. As Senator Obama, this was not about his government, this was about the government of his predecessor. Healthcare was broken before President Obama came.

By its very design, the Federal Government may never be efficient or effective or innovative enough to carry out big initiatives like Obamacare, nor should it be. Government should not be picking winners and losers precisely because it has proven to be so bad at it.

More importantly, America is a free market Country, and the free market has worked for the American people time and time again. Americans know that when you close off and create an artificial monopoly, it costs more. It always costs more not to have competition. But, in fact, that is what is happening in healthcare today. Half of healthcare costs to the Federal Government reflects the entire cost of defense. Defense is not something we can outsource to the private sector. Healthcare is something that has always been within the private sector, and should be. We can hire the best and brightest, as administrators have boasted, and still end up with a product that arrives delayed and not working properly.

There are things that are inherently governmental, and this committee will always be absolutely determined to defend the responsibility of Government to do what is governmental, procurement certainly being one of them. Protecting our homeland, securing property rights are just a few of the others. But something as complicated, as complex, as multifaceted as a web portal supposed to rival sites like Amazon.com for healthcare is something the Federal Government clearly was not prepared to take on and do properly.

Government inefficiencies are not limited to massive interventions in the healthcare industry. However, as this committee, which has voted on a unanimous and bipartisan basis the reform of IT procurement, has discovered, we need to make major changes in how we do procurement. We also need to do what is inherently governmental and leverage the private sector to the greatest extent possible. The hearing today will go a ways toward understanding

what Government can do, what it cannot do, what in fact should be expected by our Government and what should be expected to be innovated in the private sector.

The limitations on big government will never include preventing waste in a massive scale; it will always happen. And this committee will do everything it can to reduce it, to organize it. But I believe that, in fact, we have before us an example of something that may be too big to swallow even for the U.S. Federal Government.

With that, I recognize the ranking member for his opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and I welcome our witnesses here today and I look forward to an informative and spirited discussion.

I must say that, Dr. Thomas, I had an opportunity to read your testimony and I think it is appropriate that I start out by just quoting a little bit of it, because this is reading that every single American and every member of Congress needs to read. It is some of the best testimony I have read since I have been in Congress, 17 years.

It says: In 1900, a newborn American citizen had a life expectancy of 47 years. A heartbreaking 10 percent of all infants died before their first birthday, and infant mortality was far higher among the rural and urban poor, whether on southern farms or in northern tenements. By contrast, an American born in 2000 could expect to live 75 years and infant deaths have been cut by 93 percent. You go on to say in all these areas of medical and public health progress, the Federal Government has played a fundamental role as both sponsor and coordinator of a remarkably concerted effort involving communities, States, organizations, and institutions across American society. The Federal Government therefore deserves a great deal of credit for doubling, doubling life expectancy for Americans, as well as for tackling a long and ever-changing list of problems regarded as the worst enemies in the Nation's health, from tuberculosis and polio to cancer and AIDS.

According to the chairman's invitation letters today, the committee will examine the institutional limitations on the efficacy of Government action, and our case study will be the rollout of the Healthcare.gov website. The fundamental presumption underlying this hearing is that the Federal Government is somehow incapable of successfully administering large-scale programs. In fact, the Republican staff briefing memo challenges "Government's ability to effectively design, implement, and administer large-scale projects and programs."

The problem with this presumption is that it does not take into account many extremely successful Government programs that have helped millions of Americans throughout our history. In 1935, President Roosevelt signed into law the Social Security Act, the centerpiece of our social security safety network. When it first launched, critics panned its confusing procedures and less than half of the labor force participated. Over time, however, it has reached 90 percent of American workers and has been expanded to cover the self-employed, to include dependent and survivor benefits, and to provide for cost-of-living adjustments.

Thirty years later, in 1965, President Johnson signed Medicare into law. Like the Social Security rollout, there were challenges initially and the American Medical Association called it "the beginning of socialized medicine." The Federal Government had to negotiate with hospitals, nursing homes, and insurance companies, and had to coordinate with all 50 States. Eventually, 93 percent of eligible seniors enrolled in Medicare and the program has been expanded and improved several times since then.

Forty years after that, in 2005, President Bush signed into law the Prescription Drug Program, on Part D of the Medicare law. Like Social Security and Medicare before this, this drug program also experienced challenges in its rollout. Newspaper headlines were dire, stating: "Confusion Reigns Over Drug Plans," "Not Ready for Prime Time," "Prescription Drug Plan Part D Gets an Early F."

In all of these cases early setbacks were resolved, critics were proved incorrect, and these programs are now immensely popular with the American people. But, more importantly, they prevented our Nation's seniors from dying penniless and homeless. They provide a basic level of security to the American people where the private sector failed to do so. But it also provides something else: it is called dignity.

The same is true of the Affordable Care Act. The private insurance market discriminated for decades against people with preexisting conditions. Insurance companies threw people off existing plans when they discovered evidence of previous illnesses the patients themselves did not even know about. But now, thanks to the ACA, millions of Americans who could not get health insurance in the private market now have access to it.

In terms of today's hearing, I think everyone understands what is going on. The Republicans want to use the initial challenges with the Healthcare.gov website to make a broader argument that the Federal Government cannot administer large-scale programs effectively and that we are all better off leaving it to the private sector. But we have tried that, and it simply does not work.

I believe the premise for today's hearing is fundamentally flawed. Our Country's experience with Social Security in 1935, Medicare in 1965, and the Prescription Drug Program in 2005 demonstrates our Government is fully capable of overcoming the initial problems with the implementation of programs that help millions of people in their daily lives. I remind all Americans that we are a can-do Nation. We are a can-do Nation and we are better than that.

This premise becomes even more absurd when you look at our Nation's broader history. In the 1940s we mobilized our entire Country, our people, our industry, and our workers to defeat the Nazis and the Japanese in World War II. In the 1960s we tapped the best and brightest minds in government and the private sector to build a space program that put a man on the moon for the first time in human history. Our Government does not always work as well as it should, but it is certainly capable of great things when there is a strong commitment to the underlying goals we all share.

In the case of the Affordable Care Act, we know that one component of the rollout, the Healthcare.gov website, did not work as it should have. But we also know from testimony before this com-

mittee that another component, the complicated interagency data hub that most experts worried about, worked much more smoothly, and that is a testament to the strong work of the agencies and contractors involved.

As I close, as we go forward, I hope that we can work together to solve any problems that arise in order to improve the program so that it works effectively and efficiently. It is not about who we fight against. It is not even about who we fight with. It is about what we fight for. What we fight for, and this moment is greater than this moment; it is about generations yet unborn. In that way we can honor the commitment we made in the Affordable Care Act to help people who could not get health insurance to attain it now.

Mr. Chairman, I look forward to today's hearing and I thank you for calling it.

Chairman ISSA. Thank you.

All members may have seven days to submit opening statements and other extraneous material for the record.

We now welcome our distinguished panel of witnesses.

Dr. De Rugy, I always get your first name. It is a lovely name. This is not the first time I have had trouble with it. Dr. De Rugy is Senior Research Fellow at the Mercatus Center at George Mason.

Obviously, Dr. Winston. Welcome. Dr. Clifford Winston is a Trust Senior Fellow at The Brookings Institute.

Dr. Mark Calabria is Director of Financial Regulation Studies at the Cato Institute.

And Dr. Karen Thomas is a Historian and Communications Associate at Johns Hopkins Bloomberg School of Public Health.

Welcome.

Pursuant to the rules, would you all please rise and take the oath, and please raise your right hands?

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Please be seated. Let the record reflect all witnesses answered in the affirmative.

In order to allow time, without objection, your entire opening statements will be placed in the record, and I ask you to observe the lights in front of you and limit your time to five minutes.

Dr. De Rugy.

WITNESS STATEMENTS

STATEMENT OF VERONIQUE DE RUGY

Ms. DE RUGY. Chairman Issa, Member Cummings, members of the committee, it is an honor to appear before you today.

While the Nation is focused on the day-to-day problems related to the ACA's rollout, these are only the most recent and visible signs of the fundamental flaws that plague Government intervention in general. My testimony will focus on why Government intervention is often doomed to fail and it will illustrate this point with the example of a specific loan guarantee program.

The idea that Government fails shouldn't be a surprise to anyone who has read the academic work of public choice economists such as Nobel Laureate James Buchanan, George Stigler, or Vernon Smith. Their work has explained why, despite good intention and nearly unlimited resources, top-down solutions not only fail to address the problem they are trying to address, but also sometimes and often makes the problem worse.

There are many reasons for this, but I would like today to highlight two of them. The first one is that even with the best of intention, the incentive of elected officials and bureaucrats to prudently manage taxpayers' money are very weak. They are not rewarded when they maximize consumer value, nor are they necessarily punished when they take unnecessary risks or fail to minimize costs. In fact, no one in Government, so far as we know, has been fired over the problems with the ACA website. Meanwhile, private companies that misstep are quickly replaced by better competitors.

A key reason for these poor incentives is that Government actors all operate within limited knowledge. While individuals acting in markets are able to use price signals to guide their decisions, Government decision-makers have no such guides. Hence, they have no way of accounting for their value or cost their decision might create for others.

The second reason why Government often fails is that interest groups are able to exploit this environment to obtain their own goal, often at the expense of the public welfare. And for this you don't have to go to look further than the sugar lobby and the tariffs and subsidies they are getting and the increased price of sugar that they impose on all customers.

The bottom line is that in Government intentions do not equal results. More importantly, this is true no mater who is in power, and it is true across many Government programs, not just healthcare.

The Department of Energy's 1705 loan program is a good example of the gap between what a program's proponents claim it will achieve and what it actually does. This policy was put in place under the claim that renewable energy companies do not have access to sufficient credit to support new projects. These alleged imperfections of the credit markets, we are told, are particularly important for small and innovative companies. However, when you look at the data, what you find is that nearly 90 percent of the 1705 loans go to projects that are backed by large and well-connected companies such as NRG Energy or Goldman Sachs. So in that sense it is very hard to argue that the loans are going to small innovative companies that wouldn't have access to credit if indeed their project was viable.

This program is also a good example of Government favoring two distinct interest groups: first, the bank, because the lenders now don't have to face the risk of lending money to a company that may default; and, second, the companies that are now benefitting from very good rates and good borrowing conditions, especially if compared to their competitors.

The taxpayers, on the other hand, bear the risk and shoulder the burden when companies like Solyndra or Abound Solar default on their loans and when they go under. The other losers in this case,

of course, are the companies in that same field who now do not have access to credit, even though they have viable projects, because all the money tends to go to companies that are backed by Government guaranteed independently of the merits of the project.

In addition, like most Government interventions, these programs and, of course, exponentially larger program interventions such as the health care law, create serious and systemic distortion in the market. However, the tragedy is, despite evidence, lawmakers often don't get rid of inefficient programs, and that is because they are more likely to respond to the pressure of vested interest groups than they are to actually try to protect taxpayers, who very often don't even realize the cost of these programs, whether it is directly or indirectly.

Now, there is good news. We have over six decades of research on Government decision-making to help guide policy decisions going forward. In many cases a sensible solution is simply to leave some activities outside of the Government purview. This is not a loss, but a gain for Government. Not only will it prevent the type of Government failures that we have been talking about, but it will also allow the Government to focus on its core function: the provision of public good and the protection of property rights.

Thank you.

[Prepared statement of Ms. De Rugy follows:]

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TESTIMONY

WHY GOVERNMENT INSTITUTIONS FAIL TO DELIVER ON THEIR PROMISES: THE PUBLIC CHOICE EXPLANATION

BY VERONIQUE DE RUGY

House Oversight and Government Reform Committee

December 4, 2013

Chairman Issa, Ranking Member Cummings, thank you for the opportunity to testify today regarding the limitations of government intervention.

Despite Washington's recent focus on the disastrous Affordable Care Act website rollout, policymakers are missing what the rollout glitches symbolize: the fundamental flaws that imbue government intervention.

The work of public choice economists such as Nobel laureate James Buchanan, Gordon Tullock, Mancur Olson, and William Niskanen has shown that, despite good intentions and lavish use of taxpayer resources, government solutions are not only unlikely to solve most of our problems—they often make problems worse.

PUBLIC CHOICE ECONOMICS: POLITICS WITHOUT ROMANCE

Congress spends a great deal of time discussing the need to address market failures such as monopolies and pollution. However, even when such a problem *does* exist, the policies implemented to address it are often ineffective or undesirable.[1] That's because, as public choice economists have pointed out, while there may be market failures, there are also government failures. In his Nobel Prize acceptance speech, popularized in his famous essay "Public Choice: Politics without Romance," James Buchanan explains why looking to government for solutions often results in more harm than good.[2]

Public choice theory applies economic analysis—or the study of how incentives influence behavior—to politics. For instance, economists assume that people interacting in the marketplace are mostly driven by self-interest. That doesn't mean that people aren't concerned about others, or can't act charitably. It simply means that their dominant motive—whether they are employers, employees, or consumers—is a concern for themselves. Public choice economists make the same assumption about government actors. As Jane S. Shaw writes in a primer about public choice economics, "although people acting in the political marketplace have some concern for others, their main motive, whether they are voters, politicians, lobbyists, or bureaucrats, is self-interest."[3]

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1. Kenneth Arrow mathematically demonstrated how political consensus is generated through rule manipulation rather than careful consideration of the issues or constituent needs. See Kenneth Arrow, *Social Choice and Individual Values* (New Haven, CT: Yale University Press, 1951).
2. James M. Buchanan, "Public Choice: Politics without Romance," *Policy Magazine* 19, no. 3 (Centre for Independent Studies, Spring 2003), http://www.cis.org.au/images/stories/policy-magazine/2003-spring/2003-19-3-james-m-buchanan.pdf.
3. Jane S. Shaw, "Public Choice Theory," *The Concise Encyclopedia of Economics* (Library of Economics and Liberty, 1993), http://www.econlib.org/library/Enc1/PublicChoiceTheory.html.

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In other words, unlike many economists before them, public choice economists revolutionized the field of economics by having symmetric assumptions about humans in public and private settings and replacing "romantic and illusory notions about the workings of governments" with more realistic ones.

GOVERNMENT INCENTIVES

In the marketplace, scarcity guarantees that people compete for resources. In that environment, the price system and the risk of losses, combined with the prospect of potential profit, are powerful signals that guide people's decisions to prudently buy, sell, invest, and save.

But unlike in the marketplace, the incentives for good management in government are very weak. For instance, even though lawmakers are expected to pursue the "public interest," they make decisions that use other people's money rather than their own. This means that their exposure to the risk of a bad decision is fairly limited, and there is little to no reward for spending taxpayers' money wisely or providing a service effectively or efficiently.

Furthermore, because each voter bears a very small part of the cost of these bad decisions, and they have their daily lives to manage, voters lack the incentives to sufficiently monitor the government.[4] And, as Shaw explains, voter ignorance can be quite rational:

> Even though the result of an election may be very important, an individual's vote rarely decides an election. Thus, the direct impact of casting a well-informed vote is almost nil; the voter has virtually no chance to determine the outcome of the election. So spending time following the issues is not personally worthwhile for the voter. Evidence for this claim is found in the fact that public opinion polls consistently find that less than half of all voting-age Americans can name their own congressional representative.

That is not, of course, the case in the private sector. Consumers have great incentives to make sure the car or the house they buy is worth the price they will pay for it. Employers also have great incentives to make sure they hire the best employees, as there is a high and direct cost for employing someone who can't perform the job he or she is hired for.

Yet lawmakers—however well-intentioned—face serious difficulties in making the right decision. Many factors come into play, but it is worth highlighting the following two. First, the government does not have better information than private agents operating in the market, whether this be the health care market or any other market (financial, housing, etc.).[5] Making matters worse, government decision-makers are usually insulated from market signals, and thus often lack important information about the problem at hand and the market itself.

Second, the resources government provides are often so enticing that companies may switch their focus from meeting the needs of customers to meeting the wishes of government officials—thus producing a less effective outcome.[6] These effects lead to the malinvestment of taxpayers' money and often of private capital as well.

THE UNHEALTHY MARRIAGE BETWEEN GOVERNMENT AND INTEREST GROUPS

Economists Mancur Olson,[7] Gordon Tullock,[8] and others have also shown that government agents receive more benefits when they act on behalf of special interests (often under the guise of working on behalf of the public good).

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4. One of the first public choice economists to point this out is Anthony Downs in *An Economic Theory of Democracy*. A modern exposition of this "rational irrationality" was produced by Bryan Caplan in his Myth of the Rational Voter. Anthony Downs, *An Economic Theory of Democracy* (New York: Harper and Row, 1957); Bryan Caplan, *The Myth of the Rational Voter: Why Democracies Choose Bad Policies* (Princeton, NJ: Princeton University Press, 2008).
5. F. A. Hayek, "The Use of Knowledge in Society," *American Economic Review* 25, no. 4 (1945): 519–30.
6. William Niskanen, "Bureaucrats and Politicians," *Journal of Law and Economics* 18, no. 3 (1975): 617–43.
7. Mancur Olson, *The Logic of Collective Action* (Cambridge, MA: Harvard University Press, 1971).
8. Gordon Tullock, "Rent Seeking," *New Palgrave Dictionary of Economics*, ed. Steven N. Durlauf and Lawrence E. Blume (Palgrave Macmillan, 2008).

In politics, decisions aren't driven by the profit motive as they are in the marketplace. Instead, they are for the most part driven by the desire to get reelected. One important element in the pursuit of power is the role played by interest groups. First, as I mentioned before, lawmakers face little to no cost for conferring benefits on interest groups, even when it imposes large costs on the majority. In addition, interest groups can provide electoral support (through their votes) and funding for electoral campaigns (through donations), which may be key to winning an election. With so much government money up for grabs, interest groups also have a strong incentive to organize and lobby the government for a piece of the public pie.

Combined with the weak incentives for lawmakers to be good stewards of taxpayers' money, strong incentives to cater to interest groups can explain why government program mechanisms tend to be organized around picking winners and losers instead of rewarding success or punishing failure in the same way as the market.

This behavior explains why Congress continues to vote for sugar tariffs that increase the price of sugar and the profits of US sugar producers at the expense of consumers. It also explains the existence of corn-based ethanol subsidies, which create an artificial market that diverts the grain away from being used for food and toward the subsidized market, and has been widely blamed for increases in global food prices—and seems to make the environment even worse.

In the case of the Affordable Care Act, public choice explains why the program was designed to expand health care insurance coverage rather than to improve health outcomes—a choice that benefits the insurance industry without necessarily producing a better and more affordable health care supply—and how the companies that are well connected usually stand to benefit the most from government interventions.

It also explains why this health care law, like Medicare and Medicare Part D, is yet another law that concentrates benefits on older Americans (who are relatively richer than the rest of the population and more active voters)[9] at the expense of young and healthy ones (who are often relatively poorer and aren't as active voters).[10]

REGULATORY CAPTURE

Public choice economists have also explored the role that bureaucrats play in this cycle of bad decision-making. Economists know how potent this type of lobbying can be. In his seminal 1971 article, "The Theory of Economic Regulation," Nobel laureate George Stigler introduced so-called capture theory.[11] Stigler argued that regulatory agencies are subject to pressure from both interest groups and the electorate at large. But, because interest groups are better able to organize and promote their interests, they hold greater power over what regulations are implemented.

A corollary to regulatory capture is the revolving door phenomenon, where agencies hire from firms they oversee, because, as Stigler also pointed out, regulation requires in-depth industry knowledge. Consider the former secretary of the Treasury, Henry Paulson. The former chairman and chief executive officer of Goldman Sachs played an important role in shaping and directing the government rescue of the financial industry, including Goldman.

GOVERNMENT INSTITUTIONS ARE INHERENTLY PRONE TO BAD DECISION-MAKING, OFTEN INDEPENDENTLY OF WHO IS IN POWER

The problem with the Affordable Care Act rollout is far greater than the website glitches or the fact that millions of Americans cannot—as had been promised—keep their current health insurance policies. Rather, it's

9. According to the combined data on population trends, economics, and health issues from 15 federal agencies, Americans over the age of 65 are in remarkably good shape compared to those of previous generations. Their average net worth has increased almost 80 percent over the past 20 years; they form a larger share of the high-income group and a smaller share in lower-income groups than their predecessors; they are far better educated, and they live longer and healthier lives. They are also doing much better than younger Americans. If anything, the recent financial crisis has only made the gap between older and younger generations wider. Federal Interagency Forum on Aging-Related Statistics, *Older Americans 2008: Key Indicators of Well-Being* (Washington, DC: US Government Printing Office, March 2008), http://www.aoa.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf.

10. US Census Bureau, table 399, "Voting-Age Population—Reported Registration and Voting by Selected Characteristics: 1996 to 2010," from *Statistical Abstract of the United States: 2012*, http://www.census.gov/compendia/statab/2012/tables/12s0399.pdf.

11. George Stigler, "The Theory of Economic Regulation," *The Bell Journal of Economics and Management Science* 2, no. 1 (1971): 3–21.

that government institutions themselves are inherently prone to low-quality decision-making, with a strong incentive to choose the interest of politically favored groups.

Being willing to acknowledge that government intervention often fails is important, but understanding why it fails is far more important for designing better policies. That often means that the government should abstain from intervening altogether. As my colleague Matt Mitchell explains,

> James Buchanan, Gordon Tullock, and the other founders of Public Choice and its close cousin, Constitutional Political Economy, didn't stop their analysis after they found that politicians sometimes behave badly.
>
> Like James Madison before them, they thought of constructive ways to make political actors behave better, sometimes by placing certain decisions beyond their reach.[12]

When the government fails to deliver on the promises it made, many are tempted to argue that if only more money had been spent or if only someone else had been in charge, the promise could have been met. That's unlikely, mostly because the institutions of government themselves are inherently incapable of performing certain tasks well even when the people in power are smart, compassionate, and well-intentioned.[13]

For instance, a massive takeover of the health care market was bound to fail from the start, regardless of who was in charge or how much money the program had been given. It also explains why so many government policies not only fail to fix the problems they confront—the solutions are often worse than the problems. It doesn't mean, of course, that those who hold power don't have some influence on the outcome; it's just that it often isn't the most important factor.

CASE STUDY: THE DEPARTMENT OF ENERGY'S 1705 LOAN PROGRAMS

With that in mind, government officials should understand that the problems with the healthcare.gov rollout are not unique to this particular law. In fact, we can expect these types of negative consequences when the government intervenes in any market—not just health care.

For instance, I have attached a copy of testimony I gave before this committee back in July 2012, that looks at the Department of Energy's 1705 loan guarantee programs. This is what I found:

The 107 loan guarantee program is the program that extended $535 million in loan guarantees to Solyndra, a solar company that went under in 2011 leaving taxpayers with the tab. Since then, two additional companies—Beacon Power Corp and Abound Solar—have announced that they would suspend operations and filed for bankruptcy. Abound had used about $70 million out of the $400 million it got through the DOE program, which is likely to result in a cost of $40 million to $60 million to US taxpayers after Abound's assets are sold and the bankruptcy proceeding is completed.

Despite this, lawmakers on both sides of the aisle refuse to end the program, offering two defenses for its continuation. First, advocates argue that renewable energy companies do not have access to sufficient credit to support new projects. In addition, the DOE argues that encouraging investment in green technology would create up to 5 million jobs.

But these claims don't withstand scrutiny. Although some 1705 loans went to companies that could not get capital without the government guarantee—and clearly shouldn't have in the case of Solyndra—this may be the exception rather than the rule. Indeed, nearly 90 percent of the loans went to subsidize projects backed by large companies such as NRG Energy and Goldman Sachs Group Inc., and would have easily secured access to capital, if the projects were indeed viable.

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12. Matthew Mitchell, "James M. Buchanan: Realistic Optimist," *Neighborhood Effects* (blog), January 11, 2013. http://neighborhoodeffects.mercatus.org/2013/01/11/james-m-buchanan-realistic-optimist/.
13. Through no fault of their own, government actors lack the means to best aggregate dispersed knowledge and make adequate economic calculations because they lack functioning market feedback mechanisms. See Ludwig von Mises, *Socialism: An Economic and Sociological Analysis* (New Haven, CT: Yale University Press, 1951).

Second, under 1705, $16 billion in loans were guaranteed and 2,388 permanent jobs were created. That means that one job was created for every $6.7 million in taxpayer exposure. These numbers dispel the idea that this loan program is an effective jobs program.

However, the real problem with the 1705 loan program lies below these numbers. In fact, the Solyndra failure is the symptom of more fundamental problems that make loan guarantee programs a bad deal for Americans.

First, every loan guarantee program transfers the risk from lenders to taxpayers. This creates what economists call a moral hazard problem: because the loan amount is guaranteed, banks have less incentive to evaluate applicants thoroughly or apply proper oversight. These programs privatize gains and socialize losses—in other words, taxpayers bear the downside risk, but the companies and the banks that receive the guarantees get the upside benefit.

Second, loan guarantees give an incentive to lenders to shift resources toward subsidized projects and away from nonsubsidized ones. This has a cascading effect. For instance, once the government subsidizes a company, that company becomes a relatively safe asset which then attracts private capital, independently of the merits of the projects. That capital is then unavailable to unsubsidized projects, even if they have a much higher probability of success and a more viable business plan. The subsidy can thus hurt the production of green energy, as an unrealistic but subsidized green energy project thrives while other, more viable green energy projects starve.

Finally, every loan guarantee introduces political incentives into business decisions, creating the conditions for businesses to seek financial rewards by pleasing political interests rather than customers. As my colleague Matt Mitchell explains, this can lead to cronyism,[14] and it has real economic consequences.

Whatever the intentions that motivated the program, it just doesn't work. The 1705 loan program does expose taxpayers to Solyndra-like waste. But of more concern are the systematic distortions it introduces into the market and the unintended consequences those can have. Loan guarantees are privileges granted to special interests, and there is no better time than now—as we grapple with mounting public debt—to get rid of them.

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14. Matthew Mitchell, "The Pathology of Privilege: The Economic Consequences of Government Favoritism" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, July 9, 2012), http://mercatus.org/publication/pathology-privilege-economic-consequences-government-favoritism.

ABOUT THE AUTHOR

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Chairman ISSA. Thank you.
Dr. Winston.

STATEMENT OF CLIFFORD WINSTON

Mr. WINSTON. Thank you very much. I am very happy to be here.

Chairman Cummings posed a very challenging question. He raised the issue about successful Government interventions and Government projects. And it is challenging because the issue is how do we determine success. What is the benchmark that we use for success? And if Government does not achieve that benchmark, how should we proceed? So my testimony is really trying to shape that framework and give us some information about what we know about success, the evidence, and alternative ways to proceed.

I am an economist, so I am going to follow the way economists do things: first outlining the theory of why Government intervenes in economic life, what it is trying to do and what it should be doing, and what the empirical evidence is on its interventions; and then given the motivation of this session by the ACA, I will try to draw some basic implications.

All right, the theory. Government intervenes in economic life for two reasons: one, to correct a market failure: monopoly, externalities like collusion. That is what we mean by market failure. The other is to pursue a social goal. The market is efficient, all right? There is nothing wrong with the market in terms of its allocation, but the public doesn't like the allocation that exists, okay? So we want to do things like reduce poverty. All right? The third issue is macro. We are not talking about macro economics here, thankfully.

Market failure involving large projects, where do things go wrong? One, they are simply not supplied. They are not privately profitable, even though they are publically, socially desirable; or there are free riders, so there is an under-supply of that kind of project. Government's role, then, steps in and tries to provide the project, but has to do it efficiently. And when I mean efficiently, I am talking about it prices it right, makes cost-benefit assessments and investments, produces the project at minimum cost, and provides technological advance.

What are social goals? Well, the social goals we are talking about here are what we call merit goods. These are goods and services American society believes that everyone should have, regardless of whether they can afford them. Social insurance is obviously what we are talking about in this case, coverage for healthcare. These usually involve some sort of redistribution. You are going to be taking some resources from some people, giving them to another. This is something, though, that is a democratic decision. That is fine, but it should be done at minimum cost. So there is still an assessment there. Market failures, you are looking to try to maximize efficiency. Social goals, you try to minimize costs.

So what is the evidence that we have on how well Government has done on this? I go through this in detail in my written testimony. What I can say here, in the areas that I have done a lot of work in, in transportation, anywhere from highways, airports, air traffic control, inland waterways, urban transit, passenger rail. Probably as I even say these things you are beginning to think of

the symptoms: congestion, delays, budget deficits. So these actually are symptoms, and they are symptoms of the economic inefficiencies: mispricing, poor investment, production cost overruns. These are all familiar, but these things total up the hundreds of billions of dollars of cost. And, of course, there are other things that we can see as inefficient.

So the question is how can we improve Government in these areas. Social policies are not really my area of expertise, but I think it is pretty much well known that Social Security, Medicare, and so on, regardless of whether they have certainly established, and they have, are they achieving their goals at minimum cost? And obviously that is a high standard, but I think that is really what we are looking at, how can we do these things more efficiently.

All right, so faced with evidence of Government failure trying to correct market failures and pursue social goals, what is the explanation for this? And it has actually already been given by the chairman: certainly agency limitations; technical expertise and a culture where you don't provide the kind of retro assessments to sort of correct where you are going; regulatory constraints. What I found interesting about the ACA matter was actually a provider offered to do the website at no cost, but was told that he couldn't do it because of regulatory constraints. Political forces, obviously, stakeholders, and it is a big part of what public choice is.

So there are well known reasons for failure. What now do we say, pulling this all together for ACA? I think the lessons are there were predictable concerns in rolling out the website, technical issues, lack of ongoing assessment, inflexibility, and various constraints. I think, obviously, the full story hasn't been told yet and we will see other explanations, but I am sure that they will have a familiar ring to it.

The question, though, is the key point of what I am trying to get at. Too much of the discussion has been attacking ACA and, indirectly, the social goal of universal coverage. To me, that is off the table. That has been decided by the democratic process. The President has been elected and re-elected on that position. All right? That is how that has to be decided. The analytical issue and the policy issue, though, is achieving that goal at minimum cost. That is what we ought to be talking about; how can we do this more efficiently? We already see ways that some States are doing it in a better way than others. We should certainly be open to that. But I would also say, too, that we can certainly be open to the private sector having greater involvement.

[Prepared statement of Mr. Winston follows:]

GOVERNMENT IMPLEMENTATION OF LARGE SCALE PROJECTS: GOVERNMENT FAILURE, ITS SOURCES, AND IMPLICATIONS FOR THE ACA WEBSITE LAUNCH

Statement of Clifford Winston

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"Efficacy of Government Actions"

Hearing before the

Committee on Oversight and Government Reform

United States House of Representatives

December 4, 2013

Introduction

The most extensive and contentious recent government intervention in Americans' lives is undoubtedly the 2010 Affordable Care Act (ACA). In light of the federal government's failure to successfully launch its website, www.HeatlthCare.gov, to implement the Act, it is useful to step back and broadly assess government's efforts to implement and manage large projects.

In my testimony, I first discuss the conceptual justification for the government taking on large projects and what its objective should be. I then provide an overview of the available empirical evidence on the economic effects of government's management of a range of projects and offer possible explanations for the findings. I conclude by drawing some implications that pertain to the government's delay in launching the ACA website.

Theory

Two reasons exist to justify government implementation of large projects. The first is to correct a market failure, which could arise when a socially desirable service (that is, one whose social benefits exceed social costs) is not privately offered because it is unprofitable or requires enormous financial capital that may be unavailable in private markets. Public bus transit systems are often alleged as an example of the former and the interstate highway system is alleged as an example of the latter. Market failure also occurs when a service is undersupplied because it is a public good and susceptible to the free rider problem. National defense is a classic example of a pure public good. Innovative activity by firms may also result in free riders by creating positive spillovers to competitors.

The government can increase the nation's welfare by financing socially desirable projects and services, including public goods, which would not be supplied by the private sector. In practice, the government can provide the service or negotiate a contract with a private firm to provide the service. In the ideal case, the government corrects a market failure and maximizes economic efficiency by setting efficient user charges, financing investments that equate marginal benefits and marginal costs, and minimizing production costs. Note that the projects and services requiring the largest investments constitute the nation's physical infrastructure. Government has tried to spur innovation in several ways, including the establishment of a patent system and an array of subsidies for firms.

The second reason that could justify government implementation of large projects is to pursue social goals—that is, American society, like any society, seeks to solve other social problems in addition to correcting market failures and promoting economic efficiency. Those goals can be categorized broadly as attempting to reduce poverty, ensure fairness in labor markets, and provide merit goods—goods that American society believes every citizen is entitled to regardless of whether he or she can afford them, including an education, insurance against certain events that could dramatically lower the quality of life (social insurance), and protection from criminals, hostile countries and terrorists, and natural disasters.

Generally, policies to achieve those goals redistribute resources from one group of people for the benefit of another group of people, but government should nonetheless attempt to achieve those goals at minimum cost to society. The ACA arguably tries to provide a merit good and to some extent correct a market failure.

Evidence

What does the empirical evidence indicate about government's involvement in projects and services to correct market failures and achieve social goals? My 2006 Brookings book, *Government Failure Versus Market Failure*, indicated government's efforts generally resulted in substantial losses in economic efficiency and missed opportunities to benefit society in a cost-efficient manner. Here I provide a brief overview and update of my findings.

The federal government, sometimes in collaboration with state and local governments, is responsible for financing and managing highways, airports, air traffic control, inland waterways, urban transit, and intercity passenger rail. In the appendix, I present a table that summarizes the economic inefficiencies and annual welfare costs from public provision of infrastructure and urban transit that appeared in my *Journal of Economic Literature*, September 2013 survey of the performance of the US transportation system. The total annual cost of the economic efficiencies exceeds $100 billion. The inefficiencies are attributable to the fact that government's provision and management of transportation services has not been guided by economic principles: prices do not reflect social marginal costs, especially a user's contribution to congestion and delays; investments are not based on cost-benefit analysis and on accurate forecasts of costs and benefits and have therefore failed to maximize net benefits; and operating costs are significantly inflated by regulations.

The vast inefficiencies have important implications for transportation-related policies to strengthen the economy. For example, the stimulus program and ongoing calls to increase infrastructure spending must recognize that potential improvements in the nation's productivity and employment are lessened by policy failures in the current transportation system. Similarly, the Obama administration's vision of a high-speed passenger rail network as a transformative investment must consider costs and benefits that have traditionally been overlooked by government. Indeed, Edward Glaeser performed a series of cost-benefit calculations that were published in his 2009 *New York Times* column and consistently found that building such a network would not be socially desirable.

The evidence that I report in *Government Failure* casts strong doubt on whether federal programs to spur innovation have supported socially beneficial programs that would have been undertaken without federal assistance. Moreover, some federal support has resulted in no accomplishments and cost taxpayers billions. The recent Solyndra fiasco harkens back to the Clinton administration's failed effort to produce a high-gas-mileage car using a hybrid propulsion system.

Still other large-scale government projects and services have experienced serious problems including the U.S. postal system and the government's allocation and management of public land for grazing, natural conservation, and recreational activities. The former has continued to struggle financially, with ongoing threats to discontinue Saturday service, and the latter has come under attack after the government shutdown forced national parks to close.

Finally, although I am much less familiar with empirical assessments of government services and programs to pursue social goals, such services and programs are undoubtedly not being provided at minimum social cost and are wasting a vast amount of resources.

Explaining Government Failure

Agency limitations, regulatory constraints, and political forces combine to cause and maintain inefficient policies and to impede efficient reforms. For example, the Federal Aviation Administration (FAA) is at the heart of airport and air traffic control inefficiencies because it lacks organizational independence and is prevented to a significant extent by both the U.S. Department of Transportation and Congress from using its resources—and from encouraging airports to use theirs—more efficiently. Given that it faces opposition from two powerful branches of government, it is not surprising that the FAA finds it so difficult to reform its policies.

Government agencies do little to assess whether their vast public expenditures have been spent efficiently. Transportation officials have told the GAO (GAO-05-172) that little incentive exists for them to direct available funding to performing outcome evaluations, but they have also said that potential risks do exist from finding out that a project is not providing the intended benefits. Thus, because government measures inputs instead of outputs in many venues, transportation agencies tend to declare that a project is a success once it is operating.

Agencies are likely to have status quo bias because they may lack the technical expertise to ensure that new technologies are implemented effectively and efficiently. For example, the Federal Highway Administration has not placed a priority on using advances in information technology to improve highway travel. At the same time, FAA's well-publicized delays in implementing new technology have tarnished its reputation to manage air traffic control effectively.

Of course, special interest politics is transparent in several areas of policy. In transportation, state and local government officials lobby for increased federal assistance for surface transportation grants and increased flexibility on how they use those funds; the American Automobile Association and the American Trucking Association have opposed efficient congestion tolls and axle-weight charges; labor unions have opposed removing Davis-Bacon regulations; and urban transit subsidies have largely been accrued by powerful interests—higher wages to labor and higher profits to suppliers of transit capital. Finally, powerful interest groups are supporting federal funding of a national high-speed rail system.

Implications for ACA Website

The potential for government failure in implementing and managing a large project should be foremost in the mind of the officials of a government agency and department when it takes responsibility for a new project. Accordingly, it is vital for those officials to take steps to anticipate and address potential failure. Based on my preceding discussion, the potential problems facing the government's launching of the ACA website include but are not limited to:

- Limited technical expertise and an over-reliance on contractors;

- Little, if any, rigorous and transparent ongoing assessment because of a fear of exposing problems;

- Status-quo bias and an inflexibility and inability to make important changes in managing a project;

- Constraints that may affect budgeting and adoption of state-of-the-art technology.

The unfortunate result of the functionality problems and delay in launching the federal ACA website is not that the desirability of the social goal of universal coverage is necessarily reduced—the pursuit of that goal is a democratic decision that must be determined by our political system—but that the social costs of achieving this goal are already, and will continue to be, inflated. Indeed, it is my understanding that some states that produced effective ACA websites have also negotiated lower rates with insurance companies for their consumers as compared with the rates obtained by states that are using the federal website and thus did not benefit from rate negotiations. It is also possible that a state that did not produce its own website could reduce the future efficiency costs of using the federal website by arranging to pay a fee to a state that produced an effective ACA enrollment website to expand that website so people from a different state could also use its services to sign up for their insurance.

In sum, the controversy surrounding the Act should not blind policymakers to their obligation to implement the Act at minimum social costs and, if necessary, to explore alternative ways of doing so.

http://pubs.aeaweb.org/doi/pdfplus/10.1257/jel.51.3.773

Appendix

Inefficiencies from the Public Provision of Infrastructure and Urban Transit

Item	**Aggregate Welfare Cost ($2005)**
Increasing travel delays for motorists, truckers, and shippers	Cars and trucks are not charged for contributing to congestion ($45 billion excluding loss to truckers and shippers)
Excessive damage to highway pavements	Truckers are not charged efficient pavement-wear taxes for road use ($10.8 billion)
Excessive structural stress on bridges	n/a
Increasing delays for air travelers and cargo during takeoffs and landings	Runway capacity is suboptimal and congestion tolls are not charged for takeoffs and landings ($16 billion) ; costs do include cargo
Increasing delays for air travelers in congested airspace near airports	n/a
Increasing delays on waterways	n/a
Highways require excessive repairs and repaving	Road thickness thinner than optimal ($12.5 billion) Inferior materials are used to lay asphalt ($1 billion just for California)
Damage to cars and trucks from roads in poor condition	Total damage costs to cars are estimated to be $64 billion; welfare cost n/a
Highway labor costs are inflated	Federal and state regulations raise wages (welfare cost n/a)
The allocation of highway funds is inefficient	Funds are not allocated to the most congested cities to minimize the cost of delays ($13.8 billion)
The cost of investments in airport runway capacity and air traffic control technology is increased by delays in project completion	Regulations and mismanagement increase the costs of runway and air traffic control investments (n/a)
The allocation of funds for airports and air traffic control is inefficient	Funds are not allocated to the most congested airports (ATC facilities $1.1 billionh; airports n/a)

Army Corps'of Engineers waterway investments are inefficient	Investments do not satisfy a cost-benefit test (n/a)
Urban transit requires excessive subsidies	Fares are set below marginal cost and frequencies are excessive ($10.6 billion) "Buy American" regulations; Capital subsidies: Restrictions on releasing employees

Chairman ISSA. Thank you, Dr. Winston.
Dr. Calabria.

STATEMENT OF MARK A. CALABRIA

Mr. CALABRIA. Chairman Issa, Ranking Member Cummings, and distinguished members of the committee, I thank you for the invitation to appear at today's hearing. Let me first commend the chairman for calling today's hearing. All too often in Washington I think we can sometimes get lost in the details of policy and forget some of the basic principles, so I do think that today's hearing offers us that opportunity.

Academics and practitioners have long recognized that governmental action faces a number of institutional limitations. I want to be very clear that these limitations don't change with the party in control, they don't change with the personalities and competencies of political appointees. Certainly, I think anybody could look at, for instance, the response to Hurricane Katrina or the initial rollout of the Iraq war and say that these things did not go smoothly. This is not an issue of party. And, of course, these considerations should always be taken into account, and I think we always should keep in mind that while Government is capable of great good, it is also capable of great harm.

I would also say that, unfortunately, it seems to be often the attitude in Washington is we must do something and leaving that option to the private sector should always be something that should be considered.

I also want to be very clear at the beginning of my comments that nothing I say is meant to imply that markets are perfect. Quite frankly, I don't know of any human institution that is not flawed to some degree, so it is always a choice of flawed institutions. I will note, however, that, to me, the first limitation that Government lacks is the powerful feedback mechanisms we find in the marketplace. Private businesses can rely on a small number of signals, such as sales volume, prices, to determine their success. By contrast, Government programs can spend millions, even billions without any clear signal of success or failure. For instance, few of us would debate whether the iPod or the iPhone has been a success. I think we could all agree on that. But economists continue to debate whether the New Deal actually ended the Great Depression or not, and economists debate whether the 2009 stimulus created jobs or not.

In some degree, these are inherent in the nature of these programs. Certainly, Government programs, social issues have far greater number of causes and, therefore, do make it harder to access. That said, given that all action, public or private, is made in an environment of uncertainty, I do think that the market allows for a greater level of experimentation that reduces that uncertainty in a more timely basis.

Veronique touched upon even if we did know the right solution ahead of time, which, in my opinion, is a big if, there is a whole bunch of different incentives that Government actors face that might mean they might not even pursue the right incentive. For instance, as mentioned, compensation of Government employees is rarely tied to performance. One doesn't get paid more for success,

nor does one get punished for failure. Equally important is the fact that few Government employees suffer in the face of failure. You can look at the area that I look in, financial regulation. I think it is beyond question that various bank regulators failed to do their jobs during the financial crisis. I would go as far as to say there was probably no bigger regulatory failure than at the New York Federal Reserve Bank. But its president at that time, Tim Geithner, rather than being punished, was given a promotion for his performance.

Again, I would be the first to say that the private sector has more than its share of problems, but it is hard to think of any firm or industry that has the Federal Government's track record of rewarding failure.

I need not remind members of the political considerations that often come in mind. Veronique touched upon those. You certainly are very aware of those; you deal with those every day, so I will just skip past those. I will say one of the problems often that we see in Government is conflicting objectives. In general, private businesses have a clear-set measurable objectives; in contrast, Government programs often result in attempts to make numerous parties happy, with the outcome that no party ends up being happy. And while numerous objectives might seem like an benefit, I think it leaves Government programs without a clearer mandate and makes those programs less accountable to both Congress and to the public.

I would say that one of the contrasts between, as the ranking member mentioned, something like Social Security and the current healthcare is Social Security has a fairly clear objective: to raise elderly people out of poverty. You can measure that; you can determine it; you can see whether it is working or not. When you have programs that have multiple objectives, it is far harder to figure out whether those objectives are being met or not.

Let me spend my last few seconds talking about some of my examples from banking regulation, which is my area of expertise, not healthcare. But I do think we need to worry about any time an insurance program where you provide a Government guarantee, are you minimizing the incentive of parties to make responsible choices? We call this moral hazard in the economics literature. But certainly bailing out banks encourages them to make bad decisions; you keep the same banks around. For instance, I am sad to say that I don't think is the last time we bail out Citibank. We will probably bail them out a few more times because we continue to keep them around.

So, again, it is important to keep in mind that failure has to be an important component of the learning process. And just like in the private sector, you need to let firms that don't actually do a very good job go away, you need to let programs that don't do a very good job in the government sector go away so that you can focus on those programs that actually do a good job.

Thank you.

[Prepared statement of Mr. Calabria follows:]

Testimony of Mark A. Calabria, Ph.D.

Director, Financial Regulation Studies, Cato Institute

Before the

U.S. House Committee on Oversight and Government Reform

On "Institutional limitations on the efficacy of government"

Wednesday, December 3, 2013 9:30 AM

2154 Rayburn HOB

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http://www.cato.org/people/mark-calabria

Hearing entitled "Institutional limitations on the efficacy of government"

Wednesday, December 3, 2013 9:30 AM in 2154 Rayburn HOB

Committee on Oversight and Government Reform

United States House of Representatives

Chairman Issa, Ranking Member Cummings, and distinguished members of the Committee, I thank you for the invitation to appear at today's important hearing. I am Mark Calabria, Director of Financial Regulation Studies at the Cato Institute, a nonprofit, non-partisan public policy research institute located here in Washington, DC. Before I begin my testimony, I would like to make clear that my comments are solely my own and do not represent any official policy positions of the Cato Institute. In addition, outside of my interest as a citizen and taxpayer, I have no direct financial interest in the subject matter before the Committee today, nor do I represent any entities that do.

Need for hearing

Let me first commend the Committee for calling today's important hearing. It is commonly the case in Washington that policy-makers spend their time almost exclusively focused on narrow technical or political questions. The starting assumption is always "something must be done" rather than "can government actually solve the problem at hand". I view this hearing as an important opportunity to remind members that government faces several inherent institutional limitations. These limitations do not change with the party in control or personalities and competencies of political appointees. These limitations should always be considered before governmental action is taken. As we have repeatedly learned the hard way, government can do substantial harm. Doing nothing should always be an option, or rather leaving the problem to be solved by the voluntary private sector.

After beginning with a very brief overview of some of the general institutional limitations of government, I will spend the bulk of my testimony focusing on that area with which I am most familiar: financial regulation. The following institutional limitations of government are well and long recognized in the economics and political science literature. As general observations and descriptions of government, they are widely accepted among scholars, even if the degree of their importance is open to debate. Nothing in the below is meant to imply that markets are "perfect" – the choice is always among various flawed human institutions.

Limitations of Government: Lack of knowledge

All action, whether public or private, takes place in an environment of uncertainty. Just as a firm does not know ahead of time how much it can sell and at what price, we do not know *ex ante* whether government programs will achieve their objectives and if they will do so at a reasonable cost. Firms, however, can learn quickly via market signals. If excess goods remain on the shelf, this suggests prices may be too high. It can also suggest consumers are not interested in the product in question. Either way firms can engage in a repetitive interaction with consumers that usually yields important insights as to which behaviors the firm should pursue.

As many government services are not priced, or are provided by monopoly, government lacks this important feedback mechanism. Almost any free service will generate a queue. In Washington, government programs are often judged on their spending levels. Yet spending levels are an input, not an output. Spending millions (or billions or trillions) on a particular problem gives us almost no insight into whether the problem has been alleviated. Businesses can also learn by failure. If there is no consumer interest in a business' services, that business will not last long. Yet as we've repeatedly witnessed government programs can continue for decades regardless of their success or failure.

Limitations of Government: Missing or Perverse Incentives

Government programs can also be undermined by the incentives facing government employees. At one extreme, if government employees value their jobs then they actually face an incentive not to solve the problem they have been tasked with. In fact they have an incentive to allow the problem to grow worse, as such would offer a justification for ever larger budgets and power. That said I do believe most federal employees try in earnest to solve the problems they are tasked with addressing. I also believe, however, that since most federal employees see their compensation having little, if any, relationship to solving the social problem in question, federal employees face fairly weak incentives relative to employees of private businesses.

There is also little incentive to avoid failure among federal employees. Whereas the employees of Lehman Brothers were rightly punished for the failure of their firm, no federal bank regulators have lost their jobs due to the numerous regulatory failings that contributed to the financial crisis. The same holds for companies such as Fannie Mae. Despite its massive failure and rescue, the employees of Fannie Mae were not fired and still enjoy compensation levels in excess of federal employees and most private sector workers. Failure is a vital method of learning in the private sector. Public policy problems are often approached as if simple "engineering" problems; whereas the reality is that the most effective way to do anything, whether public or private, is likely unknown at first. We learn via trial and error. Where failure is suppressed, learning is blunted.

While the issue of "learning" is a critical product of failure, there are also important incentive effects. For too many government employees, misconduct is overlooked and rarely punished. For instance in the recent and continuing stories on NSA spying, to my knowledge, no NSA employee has been disciplined. It is also quite rare to see law enforcement officers held accountable for violations of citizens' basic civil liberties.

The importance of incentives is merely to state the obvious, that when doing something is costly, most people will do less of that action. When doing something is rewarded, most people will do more of that action. This fact has nothing to do with the morality, honesty or laziness of the person in question. One of the worst errors repeatedly made in Washington is to simply assume that if we have the "right" people in government, then good things will happen. All people

respond in varying degrees to incentives. While there is a case to be made about the characteristics of persons attracted to government, the powerful incentives facing governmental actors will swamp those personal characteristics.

Limitations of Government: Political Pressures

I need not remind members that political considerations can often trump policy considerations. Even if we can get the incentives correct and figure out the appropriate policy response, the political support may well be lacking for the policy in question. Just as businesses and government do not know the "right" answers ahead of time, nor does the public. Few members of the public have the time or incentive to become experts on public policy issues. What the public is likely to support or oppose is just as likely to be driven by emotion and misinformation as it is by informed debate and deliberation.

Those who do have a strong incentive to learn the details of a particular public policy are those likely to be highly impacted. I need not remind members that on any particular policy issue they are more likely to receive information from interested, but biased, parties than from those that are disinterested but objective.

An argument can certainly be made that the political process can yield results that mirror what is socially optimal. There is however a long literature in both economics and political science suggesting that this is unlikely to be the case in most instances. I would argue that anyone even remotely familiar with Washington knows that outcomes rarely match what anyone would envision as socially optimal.

Limitations of Government: Conflicting Objectives

Private firms are generally guided by a small number of objectively verifiable standards. For publicly traded companies this includes stock price. All private firms would engage in measurements of profit and loss. Measures of profit and loss would also serve as proxies for important objectives such as consumer satisfaction or loyalty. While one can of course debate both the accuracy and

adequacy of these measures, the point is that they are measurable and give private firms a clear direction of objectives.

In the case of government, conflicting objectives can leave program managers without any clear direction. Trying to achieve conflicting objectives can leave federal employees short of achieving either. Conflicting objectives also reduces government accountability. Failure to achieve one objective can always be attributed to attempts to achieve other objectives. Of course in too many instances government programs fail to achieve any of their stated objectives.

What should be our default?

As mentioned the starting assumption in Washington is almost always that government "must do something". As governmental action is always based upon coercion or the threat of coercion, and market interactions are generally based upon voluntary mutual cooperation, I believe that if we as a society wish to minimize the use of coercion, our default setting should be to prefer private sector solutions over public, in the absence of strong, compelling evidence otherwise.

Government versus Market Regulation of Financial Markets

In what follows I will apply the above, particularly the importance of incentives, to the area of financial market regulation. Let me start off with an important clarification. I will not be making the case for self-regulation. That's a straw-man, at best. No individual, whether a bank CEO, regulator or the President is capable of serving as a judge of their own actions. Unconstrained power generally ends badly.

What I will be making the case for is the regulation of financial companies by other market participants, as opposed to regulation by government. I will also address why the mixed option of both government and market regulation is actually worse than relying on either exclusively government or market-based regulation.

Before we move to the real world, let us begin with a simplified version. In free-market for banking services, the leverage and risk-taking of any one bank is limited by its cost of funds. The more highly leveraged, the mismanaged, or even the more fraudulently managed a bank, the higher the rate at which creditors charge to lend to said bank.

Keep in mind that cost of funding is the most crucial element of finance. The difference of even a few basis points can drive market structure, determining which firms survive and which fail. For those misbehaving firms that face a higher cost of funds, their growth and activities will be limited by this higher cost of funds.

Of course a higher cost of funds is only one element of market discipline. When creditors have substantial funds at risk in any one institution, they face a strong incentive to monitor and intervene in the management of said institution. Quite simply in a world where creditors have their own money on the line, they impose discipline; that is they regulate bank behavior. This is not simply a theoretical curiosity. One of the most robust empirical findings in financial research is the existence of market discipline when creditors are at risk. Another empirical regularity is the lack of market discipline where creditors are protected by government. This is the moral hazard created by government guarantees.

Of course creditors, as well as management, misjudge or make mistakes. Markets are not perfect. But then neither are governments. What makes the market superior at error correction are much stronger incentives facing market participants, as opposed to regulators. Creditors who have lent a bank millions, or billions, have a lot on the line. Regulators, who rarely lose their job because of a financial crisis, have little on the line.

In fact the problem facing regulators is not only weak incentives, but also perverse incentives. As an asset bubble builds, for instance, the broader public and their elected representatives, will pressure regulators not to interfere with the instant wealth creating machine that bubbles appear to be. My own experience, as staff on the Senate Banking Committee, during the growing housing bubble was a chorus of groups and individuals lauding the great wealth creation machine of homeownership. Democracy loves a bubble and whoa the regulator to dares to stand in front of one.

Regulators may also feel that speaking out against a bubble would undermine the confidence pushing said bubble. If confidence did evaporate, and the bubble burst, the regulator would be blamed. This was certainly the lesson the Fed took away from trying to pop the 1920s equities bubble. It is far easier to simply let the bubble build and move in afterwards to clean up the mess. This continues to be the policy of the Fed. Sadly this also reinforces bad behavior.

When regulators come in during a crisis and protect failing firms they stop the market process of eliminating bad behavior. As you are aware, Citibank has, for instance, been rescued four times now. Those rescues have guaranteed that its broken corporate culture will continue to infect our financial markets. Just as nature evolves, so do markets, in the absence of government keeping failed firms in existence.

This again speaks to the incentives facing regulators. While they will not lose their jobs because of a bank failure, they do suffer embarrassment and may even be over-looked for promotion. They incentive facing regulators is to either allow those firms to grow their way out of their problems or else to use taxpayer funds for a rescue of said bank.

Recent studies have found, for instance, that short-sellers, in the aggregate, identify more corporate fraud than does the SEC. Recall that such failed firms as Enron, Fannie Mae, Countrywide, WorldCom and others, were all identified as engaging in misbehavior first by market participants, not regulators.

If anything regulators have been repeatedly rewarded in the aftermath of financial crises by even more power. Probably no institution failed more in responsibilities than the Federal Reserve, yet Dodd-Frank extended the power of the Federal Reserve. If anything, the incentives facing banking regulators are to reward them after a crisis rather than punish them.

Regulators quest for stability and avoiding firm failure has lead regulators to repeatedly restrict competition, protecting incumbent firms and allowing such firms to retain monopoly profits. Today for a new bank to open it must receive approval from regulators and one of the factors which regulators use to approve or disapproval new charters is the competitive impact on incumbents.

The logic is that giving banks some monopoly power encourages them to be more risk-averse and to protect their franchise value. This logic is not without some basis in reality. However the cost of this protection is both higher costs for consumers and the protection of bad business practices that would otherwise be eliminated by competition.

Even when regulators aren't intentionally trying to reduce competition, regulatory barriers can have that impact, often causing tremendous harm. Take for instance the regulation of mortgage brokers, one group associated the financial crisis. Professor Morris Kleiner, at the Humphrey School of Public Affairs of the University of Minnesota, has found that leading up the mortgage crisis, the more stringent was a state's regulation of mortgage brokers, the higher was the rate of mortgage defaults. The lesson here is that regulation, rather than protecting the public good, creates market power, which reduces the effort of incumbent firms. We have witnessed similar results in the federal regulation of credit rating agencies.

Financial regulation is often justified because it is claimed that banks are inherently unstable. Nothing could be further from the truth. The foundation of our federal system of banking regulation, created in the progressive and New Deal periods was a reaction to widespread failures among small banks. The reason for such failures was the restrictions imposed on bank branching by states. Such restrictions reduced both geographic and scale diversification by banks. As recently as the 1990s some states continue to restrict banks to a single location. Obviously that makes said bank highly vulnerable to local economic conditions.

Countries without such restrictions have fared better during times of economic distress. For instance Canada, which suffered a similar decline in GDP during the Great Depression, did not witness one bank failure during that time, and that is despite not having a central bank or deposit insurance at that time. What it did have was a geographically diversified banking system. This is not result is not limited to Canada. Empirical studies of the period support these results across countries. More recent studies from both the IMF and World Bank also find that the more extensive a country's bank safety net, the more frequent and severe are its financial crises.

What we have essentially created in the US is a system of local monopolies, insulated from competition. That would be bad enough if it were not also impossible for politicians to resist redistributing those monopoly profits to favor constituencies, ultimately resulting in financial failures driven by politics, not economics. This is one reason why a mixed system is more unstable. Government cannot resist the temptation to redistribute the monopoly rents created by the barriers to entry it imposes.

Another reason is, as I've mentioned, the regulators incentive to cover up their own mistakes via bailouts reduces market discipline. If creditors know regulators will not allow Citibank to fail, then creditors will reduce their monitoring and disciplining of Citibank. This also creates the perverse incentive for banks to become larger and more complex in order to be perceived as Too-Big-To-Fail.

The last hundred years of banking regulation has been a continued trend of replacing market discipline with regulation. The result has been more bank failures, not less. This year marks the 100th anniversary of the Fed. We have had over twice as many bank failures in the last 100 years than we did in the 100 before the creation of the Fed. This result holds even once you control for number of banks. Even President Obama's first CEA director, Christina Romer, has found that the economy since the Fed has been no more stable than before its founding. We also witnessed those states with their own deposit insurance schemes having higher bank failures during the Great Depression.

In the absences of government provided safety nets, banks and their creditors would take off-setting precautions. We witness similar behavior in the hedge fund industry, where the typical hedge fund is leveraged two to one, whereas the typical bank is leveraged ten to one. Of course bank leverage was not so high before the creation of the federal bank safety net. In fact the closer you are to politics, the more highly leveraged an institution becomes. Freddie Mac's credit guarantee business was leveraged over 200 to 1 during the crisis. In the absence of an implied government guarantee, no company would be allowed by creditors to become so highly leveraged.

One of the rationales given for bank regulation is the possibility of contagion. That is having troubles at one bank spread to another. Let me be crystal clear. There is not one example in US banking history of a healthy, solvent bank failing due to a run. Contagion failures are the unicorns of finance. It's badly managed & insolvent banks that fail and they do not bring others down with them.

Bad policy and macroeconomic disturbances can also create bank failures. The highest year ever for bank failures, 1933 where over 4,000 banks failed, was a direct result of President Roosevelt's move to take the US off the gold standard. Like depositors in Greece today, depositors in 1933 did not wish to see their currency devalued. Recall the FDIC was created under the Banking Act of 1933, signed in June. Bank failures continued throughout that year. The FDIC was created to keep poorly run and undiversified small banks in business. As FDR, who opposed creation of the FDIC, recognized, this would create more failures not less.

I've mentioned that banks can fail in mass due to a common shock, such as currency devaluation or bursting real estate bubble. One characteristic of a stable financial system is one where the probably of failure across institutions is not highly correlated. Quite simply you want a diversity of balance sheets and business models. Regulation has generally pushed for uniformity.

Regulating all the banks, or financial institutions, the same will increase the likelihood they all fail in mass, as they will respond similarly to the same shocks, such as real estate bubbles. Given the appropriate due process and rule of law considerations, I believe US banking regulation will always push for a high degree of uniformity, ultimately turning what would be small shocks into systemic ones.

I've also set aside the question of whether regulators or politicians even know the correct regulatory scheme to implement. Of course no one knows this ex ante. One of the great advantages of markets is their superior ability to create knowledge, because they can coordinate the thinking and opinions of millions of individuals. Given the slowness of regulators to even recognize problems in the housing market, regulators clearly face severe knowledge problems, even assuming they faced appropriate incentives.

Broader lessons

This hearing is occurring in the aftermath of an unsuccessful roll-out of health care reform. While I am not an expert in health care, I believe the preceding offers a few lessons for the structuring of government programs.

First we should always ask whether government should be involved in the particular area. We should also ask ourselves what exactly is the problem we are trying to solve and what is the primary driver of the problem. For instance if the problem is that some people cannot afford a particular good, which we deem to be essential, then the most direct solution is a direct transfer of funds. The evidence is overwhelming that the market can provide health care, housing, education or any number of goods. The problem facing many households is that lack the income to purchase those goods and services. This is not a market failure.

The most important lesson is to get the incentives correct. Failure must be punished and success rewarded. That is only possible if failure and success can be readily observed. Outcomes should be measurable, observable, verifiable and should relate directly to the policy question at hand. Conflicting objectives should be avoided. For instance expanding access to health care, that is increasing demand, is in direct conflict with reducing costs.

As government lacks the feedback mechanisms of market institutions, additional checks and balances should be implemented. This is often achieved via requirements under the Administrative Procedures Act, but those requirements have often been ignored or eroded. Feedback mechanisms can sometimes be reproduced by the use of competition among agencies or service providers. Avoid monopolies. Also avoid government guarantees that result in moral hazard, that is increased risk-taking by individuals because they are not insured against the adverse outcomes of their own actions.

Let me close with a reminder. Analysis must be based upon the actual imperfect workings of real world markets. But analysis must also be grounded upon the actual imperfect workings of government. Identifying market failures is the beginning of analysis, not the end. Thank you.

Chairman ISSA. Thank you.
Dr. Thomas.

STATEMENT OF KAREN KRUSE THOMAS

Ms. THOMAS. Chairman Issa, thank you for the opportunity to testify today regarding the past accomplishments and future potential of Federal intervention in healthcare.

Chairman Issa, during your opening remarks you said that healthcare has always been in the private sector and should be. I would respectfully disagree. Healthcare is one of the most heavily subsidized by government areas of the economy, and if we want to look at a time when healthcare was still largely in the private sector, we would need to go back to pre-1935, and it is a disturbing picture.

Critics of Federal intervention in healthcare, including my fellow panelists, see intervention as interference, and they see the healthcare industry as a group of private actors, health professionals, hospitals, insurance companies, drug manufacturers, and these private actors, would according to them, if left to their own unregulated devices, do a far better job of providing the American people with broad access to quality healthcare. Let the market do its work, they say.

But these criticisms rely on sharp distinctions between the public and private sector, and they misapply the same basic economic principles to all types of markets, whether the product is houses, handbags, or heart surgery. And I can only notice that each of my panelists are economists, and no one has really talked about how the healthcare market operates specifically, so I will try to do that.

Of all the industries that make up the American economy, healthcare most defies the classic model of the private market. Physicians are the quintessential small business owners, and they have traditionally fiercely defended fee-for-service practice as the best system for guarding their patients' health.

Yet, without publicly funded medical education, research, service delivery systems, and other Government-sponsored aspects of medical care, the medical profession would still be the small and struggling band of individualists who began the twentieth century with little scientific understanding of how disease spread, much less how to cure it.

I think one of the best examples of the dollar-for-dollar value of Government investments in medical research were the wartime trials of antimalarial drugs and penicillin. Penicillin was brought to you by the Federal Government, essentially. And I should be very specific to say that the Federal Government has not interfered with the private market so much as it has coordinated many public and private actors.

So in the development of synthetic antimalarial drugs that were very important for protecting the lives of U.S. military personnel, the malaria research program proved to be the largest biomedical undertaking to date, at that time, and it also became the model for post-war scientific medical research that both private and Government research agencies adopted after the war. And that model marshaled the resources of academia, Government, and private industry together to produce things like cortisone and a variety of

other drugs that we now take for granted and many of us use on a regular basis.

So from 1942 to 1946, the Office for the Survey of Antimalarial Drugs conducted tests on birds and yielded precise pharmacological and toxicological data on 14,000 drugs, roughly 10 a day for four years. And the private sector, at that time, simply was not capable of coordinating such a massive effort, and the survey decisively identified a drug called chloroquine as the drug of choice against malaria.

So with my remaining time, the NIH I think is certainly one of the most successful examples of Federal sponsorship of medicine, but Medicare and Medicaid now function as much to preserve the financial status of middle class Americans as to enable the poor to purchase healthcare. So, really, those programs have operated to support the private market in healthcare as much as to undermine it. And I will conclude with that.

[Prepared statement of Ms. Thomas follows:]

Why Federal Intervention in Health Care Works: A Historical Perspective

Testimony before the House Oversight and Government Reform Committee
December 4, 2013

Karen Kruse Thomas, Ph.D.
Historian, Johns Hopkins Bloomberg School of Public Health

Chairman Issa, Ranking Member Cummings, thank you for the opportunity to testify today regarding the past accomplishments and future potential of federal intervention in health care.

In 1900, a newborn American citizen had an average life expectancy of 47 years. A heartbreaking 10 percent of all infants died before their first birthday, and infant mortality was far higher among the rural and urban poor, whether on southern farms or in northern tenements. By contrast, an American born in 2000 could expect to live 75 years, and infant deaths had been cut by 93 percent.[1]

These striking reductions in morbidity and mortality rates resulted from not only a rising standard of living, but also the advent of effective methods for detecting, preventing, and treating disease; new breakthroughs in medical research; and markedly improved access to health facilities and services.

In all these areas of medical and public health progress, the Federal government has played a fundamental role as both sponsor and coordinator of a remarkably concerted effort involving communities, states, organizations, and institutions across American society. The Federal government therefore deserves a great deal of credit for doubling life expectancy for Americans, as well as for tackling a long and ever-changing list of problems regarded as the worst enemies of the nation's health, from tuberculosis and polio to cancer and AIDS.

Yet most critics of federal intervention in health care, particularly critics of the Affordable Care Act, define "intervention" as "interference." They see the health care industry as a group of private actors--health professionals, hospitals, insurance companies, drug manufacturers, etc. These private actors would, if left to their own unregulated devices, supposedly do a far better job of providing the American people with broad access to quality health services than a bunch of bumbling bureaucrats and special-interest politicians. These criticisms rely on sharp distinctions between the public and private sector, and misapply the same basic economic principles to all types of markets, whether the product is houses, handbags, or heart surgery.

Of all the industries that make up the American economy, health care most defies the classic model of the private market. Physicians are quintessential small business-owners who traditionally have fiercely defended fee-for-service practice as the best system for guarding their patients' health. Yet without publicly-funded medical education, research, and service-delivery systems, the medical profession would still be the small and straggling band of individualists who began the twentieth century with little scientific understanding of how disease spread, much less how to cure it.

The ideas presented in this document do not represent official positions of the Bloomberg School of Public Health or Johns Hopkins University.

You cannot sell what people are terrified to buy, and until at least the early 20th century, most American hospitals were charitable institutions where poor people with no family went to die. Paying patients came only after the introduction of anesthesia in childbirth and the first effective medical and surgical treatments for disease. Yet many aspects of health care remained patently unprofitable, particularly for patients with chronic disabilities. For example, by 1950, over half a million Americans were institutionalized in state mental hospitals. The conditions that responded least effectively to profit-driven medicine were ironically those generated by the highly lucrative markets for cigarettes, alcohol, and illegal drugs. In the 1960s and 1970s, drug addiction and alcoholism reached epidemic proportions. Rates of lung cancer rose steadily throughout what has been called "the cigarette century," increasing five-fold in males from 1930 to 1990 and continuing to rise in women.[2]

The Federal government has responded to every major public health problem with legislation and the expertise of agencies such as the Food and Drug Administration, U.S. Public Health Service, National Institutes of Health, and Centers for Disease Control. Government health agencies have worked closely with the so-called private health sector, both for-profit and non-profit, to bring more consumers into the health marketplace while promoting cost savings and coordinating resources, which remains the primary goal of the Affordable Care Act.

For example, public health departments and private physicians cooperated to make mass screening and immunization programs standard for American children--and a pillar of pediatric private practice.[3] By 1920, public health departments in large northern cities provided services including sanitation, communicable disease control, maternal and child health, health education, laboratory tests, and collection of vital statistics. But doctors, hospitals, and public health services were scarce or absent in much of the rural South and West.[4] Federal initiatives helped democratize advances in medicine and public health so that they reached areas of the country with the greatest need. The greatest beneficiary was the South, historically America's most anti-federal region.

A NEW DEAL FOR AMERICAN HEALTH

During the 1930s and 1940s, the federal government assumed the lead in all public health efforts as national and international crises exhausted private sector resources and fostered public-private cooperation to address a new wave of health problems besieging the nation. The Great Depression had a catastrophic impact on the health of Americans who could no longer afford medical care or even adequate diets. Rising levels of unemployment and poverty began to erase the recent gains in health status, particularly among those hit hardest and earliest in the agricultural sector. Between 1925 and 1935, death rates rose from pellagra, pneumonia/influenza, malaria, meningitis, and measles.[5]

New Deal public works programs constructed thousands of miles of water and sewer lines and built new treatment plants at a time when cheap labor was available but local governments could not afford to make improvements. Works Progress Administration (WPA) sanitation projects drastically reduced the incidence of typhoid and dysentery in rural communities, which were also the primary beneficiaries of PHS and WPA malaria control programs. To curtail mosquito breeding, the WPA drained several million acres of swamp and PHS officers sprayed mosquito-ridden areas with larvacides from airplanes and on foot. The incidence of waterborne illnesses dropped steadily, and the national typhoid mortality rate

decreased by 90 percent from 1920 to 1945. These programs made vast areas of the South safe for business and contributed significantly to the rise of the booming Sunbelt economy.[6]

The 1935 Social Security Act is known primarily as a retirement program, but Titles V and VI aided maternal and child health and helped support health departments by providing matching grants to stimulate state and local spending. During the Franklin Roosevelt administration, policymakers increasingly relied on public health programs as a versatile tool to solve a wide range of problems, from reducing rates of loan defaults among farm families (commonly caused by health crises that left farmers unable to work) to ensuring the maximum productivity of defense industry workers and rehabilitating soldiers who had been rejected for military service.[7]

By the late 1930s, New Deal reformers were eager to enact legislation to create a national system of financing health care for all who needed it. The framers of the Social Security Act had considered including health insurance as a benefit, but President Roosevelt had opposed the idea as too controversial.

Many reform groups, however, including organized labor, farmers, civic organizations, and philanthropies, grew more vocal in their calls for federal action to promote broader access to medical and hospital care. Senator Robert Wagner of New York introduced the first comprehensive national health legislation in 1939, and the Wagner-Murray-Dingell National Health Bill, introduced in 1943, was the first proposal for universal health insurance coverage underwritten by the federal government. But the American Medical Association attacked national health insurance as "socialized medicine" that would interfere with the sacred relationship between doctor and patient and result in lower standards of care.[8]

Nonetheless, still-unmet health needs and the success of New Deal public health efforts prompted many doctors to acknowledge, along with North Carolina's state health officer, Carl V. Reynolds, "the government has a definite responsibility in the prevention and cure of disease and the preservation of health."[9]

WORLD WAR II AND THE HEALTH FRONT

The appeal of national health legislation surged after the attack on Pearl Harbor. Rising employment as well as wartime shortages of health professionals increased public demand for health care, the aspect of social policy (along with labor) most critical to national defense. When newspaper headlines announced high rates of draft rejections for various health reasons, national leaders recognized that serious existing health deficiencies threatened America's fighting effectiveness and economic productivity. Draft rejection statistics also revealed that illness and disability disproportionately affected southerners, rural residents, and African Americans, which further fueled the drive for health reform targeted at these groups.

The numbers were sobering: at least 40 percent of the 22 million men of military age were unfit for general military duty, and 4.5 million of these were classified as "IV-F," including half of southern recruits versus only one-third of non-southerners. In North Carolina, which posted the highest rejection rate, 71 percent of black and 49 percent of white recruits were deemed unfit for service.[10]

The wartime drive to pass federal health legislation also fueled civil rights activism. During an era of hostility to any civil rights measures and strict segregation of the private health system North and South, Congressional hearings on the national health legislation of the 1940s

gave representatives of every major national black organization an alternative forum to promote equality and the full inclusion of blacks in federally-sponsored health programs.

The medical civil rights movement succeeded in enacting federally enforced non-discrimination provisions that ensured that black patients could receive equal care in public health clinics and modern new hospitals that accepted federal grants, although southern facilities maintained racial separation by ward or floor. Federal support for training programs such as the Army Cadet Nurse Corps and medical residencies in Veterans Administration Hospitals increased the ranks of health professionals while also offering equal opportunity to Americans of all races and religions.[11] As Surgeon General Thomas Parran put it, "[e]very citizen, North and South, colored and white, rich and poor, has an inalienable right to his citizen's share of health protection."

To develop solutions to high-priority health problems of military importance, the PHS and the Armed Forces Epidemiological Board took responsibility for protecting the health of American troops through measures such as venereal disease and malaria control, tropical disease research, and mental hygiene programs to prevent and treat combat-related disorders. Parran's mobilization of the PHS for the war effort was a master strategic stroke that framed health reform as an urgent matter of national defense and garnered unprecedented federal funding for broad-based programs to support public health and sanitation services, medical research, and hospital construction. Wartime federal spending rose to ten times that for peacetime New Deal programs, and health was among the top beneficiaries.[12]

Dollar for dollar, two of the most valuable investments of federal funding for medical research were the wartime trials of antimalarial drugs and the determination of effective regimens for treating syphilis with penicillin.

The development of synthetic antimalarial drugs was a top priority for the U.S. military, particularly after the supply of quinine was cut off in 1942 by the Japanese offensive in Southeast Asia. The malaria research program proved to be the largest biomedical undertaking to date and it became a model for postwar scientific medical research that marshaled the resources of academia, government, and private industry. From 1942 to 1946, the Office for the Survey of Antimalarial Drugs conducted tests on ducklings and yielded precise pharmacological and toxicological data on over 14,000 drugs, roughly ten a day for four years. The survey decisively identified cloroquine as the drug of choice against malaria.[13]

Along with malaria, syphilis was the disease that posed the greatest threat to the fighting effectiveness of American soldiers. Before methods to mass-produce penicillin were perfected in 1943, the standard treatment regimen for syphilis was long, complicated, and relied on potentially toxic arsenic and mercury compounds. Private physicians struggled to master the skills necessary to inject patients with the right combination of drugs to kill the spirochetes but not the patient. The PHS Venereal Disease Clinic at Hot Springs, Arkansas developed a new, more efficient method of administering intravenous drug therapy for syphilis and gonorrhea to large numbers of in-patients with a minimum number of personnel.

With ample federal funds from the Social Security Act and the 1938 National Venereal Disease Control Act, the number of venereal disease rapid treatment centers had tripled to more than 2,400 by the end of 1939, with 9 million treatments given annually to over 100,000 patients. New syphilis cases declined by over half from 1936 to 1939, and infant deaths from congenital syphilis were halved.[14]

[It should be acknowledged that during this period, the PHS was conducting the longest nontherapeutic medical study in U.S. history, the Tuskegee Study of Untreated Syphilis in the Negro Male, which was grounded in assumptions that reflected the pervasive scientific racism among white medical professionals of the era.[15]]

During the war, the federal Office of Scientific Research and Development's cooperative clinical trials of penicillin to treat early-stage syphilis demonstrated that penicillin could drastically shorten the length of treatment to only ten days for syphilis patients and three days for gonorrhea cases, with some requiring only a single injection. Using the penicillin studies as a guide, the Public Health Service also used randomized controls to evaluate streptomycin in treating tuberculosis.

The PHS energetically promoted VD screening, prevention, and education programs for military and civilian populations, with special attention to military bases and defense production areas. As the country celebrated victory and prepared for demobilization, the PHS announced that rates of venereal disease among civilians had not markedly increased during wartime, as they had in every previous conflict.[16]

After the war, Congress authorized the highest funding levels yet to continue treating VD patients in rapid treatment centers and hospitals, which reduced venereal disease rates to such low figures in the civilian as well as military populations that most rapid treatment centers had closed by the early 1950s.[17]

But venereal disease became a cautionary tale that demonstrated the danger of declaring victory too soon: after the reduction of federal venereal disease control expenditures during the 1950s, rates of syphilis and gonorrhea resurged to epidemic proportions during the 1960s and 1970s, and by 1980, an estimated 20 million Americans had contracted genital herpes.[18]

Federally funded and orchestrated wartime research yielded therapeutic compounds to prevent and cure three of the top killers of all time, malaria, syphilis, and tuberculosis. More than just fighting specific diseases, these efforts made fundamental contributions to the development of basic medical research methodology.

For the modern pharmacopeia from which nearly every American has benefited, we can thank the federally sponsored model of research and development provided by the intensive laboratory evaluations of antimalarial drugs. Likewise, the government-coordinated experiments to test the effectiveness of penicillin set the scientific standard for the modern clinical trial that forms the basis for another essential federal role in health, the regulation of the drug industry to ensure the safety and effectiveness of thousands of new pharmaceutical compounds before they reach the market.[19]

MOTHERS, BABIES, AND HOSPITALS

As the U.S. birth rate topped four million in 1954, the largest category of PHS public health grants to states was for maternal and child health programs. Amendments to the Social Security Act between 1950 and 1963 continuously increased the annual appropriations for maternal and child health and crippled children's services, which rose from a combined $1.9 million the first year of Social Security in 1936-37 to $87.3 million by 1966-67. Congress recognized the importance of maternal and child health research by authorizing the National Institute of Child Health and Human Development in 1962 and by including a research

component in new Social Security initiatives passed in 1963 and 1965 to improve the health of low-income pregnant women and young children who lived in substandard housing and lacked access to primary care. During this era, pediatricians enjoyed both growing financial success and social status, yet their commitment to private practice was compatible with broad support for government-sponsored child health programs. Such positions often put the American Academy of Pediatrics at odds with the more conservative American Medical Association.[20]

Closely related to the problems of maternal and infant health was access to hospital care. In the South in 1941, only one-third of all births took place in hospitals versus three-quarters of non-southern births, and 23 percent of southern babies were delivered by midwives versus only 1.5 percent of non-southern births. In 1938, toxemia killed women in southern states at rates from 50 to 150 percent higher than in the rest of the United States, largely due to lack of medical care. Since most southern hospitals did not admit blacks and many rural counties had no hospital at all, rural black mothers and infants benefited least from the medical advances available from trained professionals in modern hospitals.[21]

From 1947 to 1971 the Hill-Burton Hospital Survey and Construction Act built a modern health care infrastructure with $3.7 billion in federal funds, matched by $9.1 billion from state and local governments, to create space for nearly a half million beds in 10,748 projects, including nursing homes and other specialized facilities.[22] Hill-Burton was among the first and most successful examples of a new postwar brand of federal reform that garnered bipartisan support by blending centralized planning, economic development, and a rationale for domestic spending based on national defense.[23]

In the absence of a national health insurance program, Hill-Burton substantially increased access to charity care by expanding the number of government-owned hospitals and the overall proportion of beds in public hospitals, particularly teaching institutions affiliated with medical schools. This had major implications for the racial desegregation of hospitals, since participation in the Hill-Burton program constituted "state action" that placed private as well as public hospitals under the equal protection clause of the Fourteenth Amendment and obligated them to admit patients without regard to race.[24]

Hill-Burton's provisions benefited the South most of all. The program's graduated, need-based allocation formula paved the way for federal sponsorship of southern health, education, and welfare as well as costly new infrastructure that undergirded Sun Belt prosperity while allowing southern states to maintain low taxes. By 1955, southern states drew 20 percent of their revenues from federal sources, well above the national average of 14 percent.

Ironically Mississippi, the epicenter of antifederal sentiment and the backlash against federally mandated desegregation, tied for fourth with Arkansas among states with the highest percentage of their budgets from federal funds. Today, despite the marked improvement of the southern economy since the Great Depression, many southern states receive more in federal aid than they pay in federal taxes. As the culmination of the post-1938 New Deal that targeted federal resources to the South, Hill-Burton was the last and most progressive expression of redistributive mid-century liberalism.[25]

ON THE CUTTING EDGE OF RESEARCH: THE NIH

In 1930, the PHS Hygienic Laboratory was renamed the National Institute of Health (NIH), which signaled an increased federal investment in medical research, particularly on

chronic diseases, which had replaced infectious diseases as the most common killers. The National Cancer Institute was the first disease-specific institute to be established, in 1937. Since the end of World War II, the NIH along with the CDC have been the main channels through which the federal government has invested in protecting and promoting the health of Americans through research, training, and disease tracking programs.

After World War II, the NIH (with "institutes" now a plural) grew rapidly to become the world's single largest funder of biomedical research on cancer, heart disease, microbiology, dentistry, mental health, neurological diseases and blindness, and arthritis and metabolic diseases. From the 1950s on, the agency emphasized basic science research, particularly the cellular and molecular biology of disease, which in turn underwrote the establishment and expansion of a nationwide network of academic medical centers whose primary mission was research. These centers partnered closely with private drug firms, who employed a steady stream of top-notch graduates subsidized by federal training grants, the G.I. Bill, and the 1958 National Defense Education Act.

Of all arms of federal health policy, the NIH has enjoyed the largest and most consistent appropriations and the greatest bipartisan support. Unlike other areas of federal research and development funding, which have fluctuated based on external events, the NIH budget has grown steadily decade after decade. Its annual appropriation increased from $81 million in 1954 to $1.6 billion by 1968. By 2004, it had reached nearly $28 billion.

Yet if there was a special interest in Congress that could rival biomedical research, it was Big Tobacco. The majority of credit for reducing rates of cancer (as opposed to treating it) goes to the 1964 Surgeon General's Report on Smoking and Health, which definitively linked cigarette smoking with significantly higher risks of lung cancer as well as heart disease, emphysema, and bronchitis. Annual per capita cigarette consumption increased from 54 cigarettes in 1900 to an astounding 4345 cigarettes in 1963, but then slowly decreased to 2261 in 1998.[26]

Despite the tobacco industry's best efforts, the report was widely distributed and reported in the media, creating the necessary atmosphere for public health officials to pursue regulations. These included placing the now-ubiquitous Surgeon General's warnings on packaging, and Federal bans on cigarette advertising on radio, television, or billboards. The 1964 Surgeon General's Report set a precedent for establishing and publicizing all types of health risks, as well as for the scientific resolution of controversial issues via the collective, objective review of evidence. Finally, the report accorded the Surgeon General and the federal government a powerful new level of authority in protecting national health.[27]

NATIONAL HEALTH INSURANCE: A DREAM DEFERRED?

During the 1960s and 1970s, a highly favorable social and political climate fostered innovation and expansion in federal health programs. As a keystone of President Lyndon B. Johnson's Great Society, the 1965 Medicare-Medicaid amendments to Social Security together helped to extend medical and hospital care to millions of Americans who had been excluded from the private health system on the basis of both race and income. By the mid-1960s, more than 40 million of America's 193 million people--nearly 20 percent--remained uninsured. Not only did Medicare-Medicaid remove financial barriers for the elderly and many (but not all) of those under 65 who could not afford care, it also brought about the racial desegregation of

health care by requiring compliance with the 1964 Civil Rights Act for all participating hospitals.[28]

Medicare and Medicaid, originally intended to include the two largest groups of uninsured who lacked employer-based coverage, now function as much to preserve the financial status of middle-class Americans as to enable the poor to purchase health care. Many middle-class individuals become beneficiaries of both Medicare and Medicaid, which pays at least part of costs for 70 percent of nursing home residents, thereby sparing them from having to rely as heavily on their families' resources. Medicare foots the bill for health care at the age when it is typically most expensive, while Medicaid subsidizes the long-term care needs of the nation's elderly and chronically disabled. Medical and nursing home care rank alongside postsecondary education and home mortgages as the most expensive items that most Americans will buy in their lifetimes. All three are federally subsidized, but college loans and mortgage interest are less universal and the federal government pays a much lower share of the total than for long-term care and medical costs over age 65.[29]

With the passage of the 2010 Affordable Care Act, President Barack Obama signed into law a major milestone in federal health reform. While it still fell short of the long-pursued goal of universal comprehensive health coverage, the act won important concessions from the insurance industry, such as ending the practice of denying coverage to children under nineteen based on a pre-existing health condition, enabling parents to keep their children as beneficiaries on their health insurance up to age twenty-six, ending lifetime and most annual limits on care, and providing free access to recommended preventive services such as colonoscopies and mammograms. The law also offered tax credits to encourage small businesses to insure more workers and grants to enable states to establish affordable insurance exchanges designed to increase competition among health insurance providers.[30]

The Affordable Care Act's passage marked a historical first: the American Medical Association solidly endorsed federal health insurance legislation, although it opposed the president's public option plan to compete with private insurers. The AMA had supported the goal of universal health care in 1921, but the AMA's policy stance had been to oppose vigorously every national health insurance bill since 1939.[31] The AMA's leaders (notwithstanding considerable dissent among the membership) held fast to the private insurance system as the only acceptable method of financing health care, which pitted the organization against any proposed government-sponsored health plan.

With the passage of Medicare, however, physicians became dependent on reimbursements from the program and lobbied hard to preserve rates they deemed acceptable. The AMA's support for the Obama administration's bill can be interpreted in part as a strategic move to retain the allegiance of key Democrats for the group's Medicare and other policy positions. Yet it was also a striking departure for the AMA's executive vice president, Michael D. Maves, to admit that "We do not believe that maintaining the status quo is an acceptable option for physicians or the patients we serve."

It remains to be seen how the law will be implemented, but the AMA committed its support for "achieving enactment of comprehensive health system reform legislation that improves access to affordable, high-quality care and reduces unnecessary costs."[32] As long ago as 1969 the group called adequate health care "a basic right of every citizen," and given time, the Affordable Care Act will move the country forward toward that goal.

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Chairman ISSA. Thank you. I couldn't disagree with you more, Doctor. First of all, I wasn't talking about NIH; it is a small part of the budget compared to the trillion dollars plus that Medicare and Medicaid consume. The ranking member, in his opening statement, talked about the buy-in rate of Social Security and Medicare. With all due respect, the buy-in rate is mandated by law, and the people who are not in it are in fact State employees and city employees who have the good fortune to be out of the system, in most cases to their benefit.

I am from California, which is the largest area of an alternative to the Social Security system, one in which the returns are three to four times greater than what Social Security does, which means for the same amount of dollars in California State employees, city, county, that participate receive far better benefits. But we are not here to talk about Social Security or the NIH.

What we are here, I believe, is to figure out some questions that Dr. Winston—and, Dr. Winston, Brookings is not a right-wing conservative bastion, is it? Not a trick question.

Mr. WINSTON. No.

Chairman ISSA. Okay.

Mr. WINSTON. It is not anything, to the best of my knowledge.

Chairman ISSA. Right. Usually when we look for people on the left, we often look to Brookings; when we look for people on the right, Mercatus, Cato, and so on often come in. We try to have a balance here.

You said some very important things and I am going to use my time specifically on areas that are more liberal for a moment. You mentioned monopolies, free rider, market distortions. Those are all good points and I think you made some points. And the Affordable Care Act, although I didn't vote for it, does recognize that the market is dysfunctional.

But, Dr. De Rugy, CMS underpays the prevailing rate, the cost of healthcare, don't they? So isn't Medicare and Medicaid, administered by CMS, already distorting the market by taking private sector doctors and hospitals and underpaying, compared to what the private sector has been paying, and cost-shifting then to private sector by statute?

Ms. DE RUGY. This is a very good question. I am not a healthcare expert, but one of the things that we know about government intervention is that it often distorts pretty widely the market it operates in. And as Dr. Thomas rightly mentioned, the healthcare market has been highly subsidized and Government has intervened quite widely. So yes, of course, we can expect that providers would be expected to provide a service at a lower rate than they would otherwise, which creates problems, and also force people to pay at a higher price than they could otherwise.

Chairman ISSA. Dr. Calabria, similar question. The fact is that Federal intervention, over a trillion dollars worth of money taken involuntarily by American workers that are spent on Medicare, Medicaid, do eligible, the poor, retirees, so on, it is over a trillion dollars. Is there any case to be made, not that the money hasn't done good, because people do have healthcare, but is there any case to be made that it has driven down the cost of delivery to the American people broadly?

Mr. CALABRIA. I think this is something we fundamentally see across a variety of areas, whether it is housing, whether it is education, whether it is healthcare. If you take something, and again I am going to apologize for making members think about their Econ 101 classes, but if you think about something where the supply is relatively fixed, if you give people more money to spend on that, you will largely run up prices. You have to make sure that you are actually doing something that increases supply in the process, and for the most part healthcare, like education, like housing, is relatively inelastic; that is, supply does not increase a lot in the interim. So we do need to make sure that it isn't simply captured by providers, but it actually flows through to the ultimate beneficiaries.

Chairman ISSA. One of the areas that I want to bring out today that is going on today, and it is a little off topic, but I think it is appropriate, CMS is reimbursing hospitals at a rate higher than clinics or doctors' offices. And, Dr. Thomas, you talked about this rugged individual doctor. I haven't met them, so they must have been before my time, because doctors, in fact, have joined hospitals, and even when they have clinic practices they are being bought out by hospitals because CMS has made a decision that the same procedure they will pay two to three times more if it is done in a hospital, even if not clinically necessary, than if it is done in a clinic or doctor's office.

Is there any question in your mind not that Affordable Care Act should be scrapped or not scrapped, any of that, is there any question in your mind that we need serious reform in how we deliver medicine so that the patient gets the best value?

Ms. THOMAS. Yes, and I agree that we do need reform, but leaving the market to act supposedly independently is not the way to achieve that.

Chairman ISSA. Right. And no one here is suggesting—and I will close with this, Mr. Ranking Member—no one is suggesting for a moment that we take Government out of healthcare. I was with former member Jim Marshall, a dear friend of mine, today and we were talking about the fact that we have taken the consumer out of the process. And nothing in the Affordable Care Act puts the consumer back into it. If anything, health savings accounts and other areas in which the consumer was making decisions about best value have been taken away.

So as much as we can rail for or against the Affordable Care Act, today is one of many hearings that I believe this committee will have on both how do we get good product for the Federal Government, like a website, if it is determined to be there, but also how do we deal with the fact that since Medicare enactment what we have done is we have inordinately driven up the cost of healthcare with cost-shifting from the Government whenever possible to the private sector. It is not sustainable as the Government becomes a bigger and bigger buyer.

And I think, Mr. Ranking Member, with the Affordable Care Act we are going to see that, which is we are telling insurance companies what is the cost, and we can't tell them to work for less, so when they give us the cost it is higher. And I think it is the first time, unlike Medicare, where we just find what we will pay, it is

the first time that we are dealing with the market force and finding out that we haven't driven down cost, and that is something that your constituents and my constituents demand that we figure out how to do.

With that, Mr. Ranking Member, Elijah, I recognize you.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. Mr. Chairman, I too want a good product for the Federal Government, and I do believe in effectiveness and efficiency. I also want to make sure that every single American has healthcare and that we save lives. So I want to thank our witnesses for being here today.

Dr. Thomas, the basic idea seems to be, in this hearing, that the Government is bad and the private sector is good; the Government should not intervene, it should not try to help people, it should not distort market forces. I certainly understand the logic behind free market principles, but I think we need to recognize that private corporations are not going to necessarily look out for the poorest, the sickest, and the least fortunate among us. We have seen people thrown off of their insurance policies over and over again. We see the preexisting condition situation, where women had minor ailments in the past and the next thing you know she doesn't have insurance because she didn't even know there was a preexisting condition.

So, Dr. Thomas, I want to ask you, as a historian, to take us back and describe for us what it was like for our Nation's seniors 100 years ago, before Social Security, before Medicare, before they had the social safety net that they have today. What was it like for poor, elderly Americans heading into their final years when they were unable to work or to rely on a family or friends?

Ms. THOMAS. Well, before Social Security and before Medicare and Medicaid, older Americans were the single most impoverished demographic group in American society and one of the problems with healthcare markets is that it is not profitable to provide many types of healthcare that are most needed. So care for long-term chronic disability, such as that caused by tuberculosis or cancer or many other diseases that afflict us in old age, is very expensive to provide, so that has traditionally been provided, in many cases, by either nonprofit charitable organizations or by Government hospitals. In those days, many poor people would end up in poor houses, and there were no separate health facilities to even care for them.

Mr. CUMMINGS. Is it safe to say that some of them died?

Ms. THOMAS. Absolutely. Yes.

Mr. CUMMINGS. So where did they go for healthcare services if they had no insurance?

Ms. THOMAS. Well, if they were lucky enough to belong to a fraternal order, they might go to their fellow members for help, but the resources there were so small and especially in the rural south and in poorer parts of the Country, even in the poorer areas of northern cities, the resources were simply not available, either individually or collectively, to pay for adequate medical care, and certainly not for preventive care. And I think one thing we haven't really talked about is the cost of not preventing disease is much greater than the cost of preventing it.

Mr. CUMMINGS. Ron Paul stated, during the debate in 2012, that when he started medicine, he said, "There was no Medicare or Medicaid and nobody was out in the streets." I don't know how old he is, but do you agree with that assessment?

Ms. THOMAS. I do not. In fact, there has been a very lively—in the 1930s and 1940s people were riding the rails; many people were in fact homeless during the Depression. I don't know how old he is, but certainly there were people on the streets at that time as well.

Mr. CUMMINGS. There is a New York Times article this morning that talks about 39 percent of the bank tellers in New York are getting some type of public assistance, and, of course, that probably means a lot of them don't have insurance; they need some assistance. What about that type of population? And this is in New York, now.

Ms. THOMAS. Right. Well, they can go to city, State, and federally-funded health clinics; they can end up in the emergency rooms of their local hospitals, who are required by law to care for them; and in some cases they may get inadequate care or get care too late, which can end up being even more costly in the long-run, or they may die.

Mr. CUMMINGS. And that doesn't necessarily include the follow-up.

Ms. THOMAS. Correct.

Mr. CUMMINGS. Right. They might get care right there, but then the question is what follow-up is there, is that right?

Ms. THOMAS. That is right. And if the services are not coordinated, and that is a function that government agencies often have, if the services are not coordinated, then it may be very difficult for individuals to navigate through the system and get care.

Mr. CUMMINGS. Just a last question. Dr. Thomas, The Washington Post cited a report issued in 1959 by the United States Department of Health and Education Welfare, finding that the elderly faced disproportionate risk of illnesses, yet had less ability to afford medical care, mostly because of fixed incomes. It also cited a report issued in 1963 by Social Security Administration which concluded "Many aged persons never recover from economic effects of a single hospital episode. Unfortunately, the heaviest burden is likely to fall on those with the least resources, and even for the insured there is no present guaranty against dependency in old age caused by catastrophic medical expenses."

Do you agree with that?

Ms. THOMAS. I do, and a major problem with the healthcare market is the people who are most likely to be able to participate in the private healthcare market are the least likely to need extensive and very expensive care. So if we do not broker a system where everyone is participating and everyone is covered, then there will be large populations that are not covered and that create major needs for care.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

I now ask unanimous consent that the pages from Wikipedia on Alexander Fleming be placed in the record. Without objection.

Chairman ISSA. Dr. Thomas, do you know who Dr. Fleming was?

Ms. THOMAS. Of course I do.

Chairman ISSA. So March 7th, 1929 is the date of the invention and naming of penicillin?

Ms. THOMAS. Yes.

Chairman ISSA. In Scotland?

Ms. THOMAS. Yes.

Chairman ISSA. Okay. I just wanted to make sure it was World War I that caused it to be invented. It was World War II that it was widely used in and had very little to do with the U.S. Federal Government except that we were a recipient of Scottish invention.

Mr. CONNOLLY. Mr. Chairman? Would you yield for a unanimous consent request?

Chairman ISSA. Of course.

Mr. CONNOLLY. I thank the chair.

While we are putting things in the record, I would ask unanimous consent that an article from The Washington Monthly called The Best Care Anywhere, by Phillip Longman, be entered into the record.

Chairman ISSA. Without objection, so ordered.

Mr. CONNOLLY. I thank the chair.

Chairman ISSA. Dr. Thomas, I put this in, but I went beyond it. Is there something you wanted to say? I didn't want to cut you off.

Ms. THOMAS. Just that we may have had penicillin before World War II, but we did not know in what dosage to use it or how to effectively treat disease with it until we conducted clinical trials during World War II that were coordinated by the Federal Government. That is what I meant.

Chairman ISSA. By the Department of War, yes.

We now go to the distinguished gentleman from Florida, Mr. Mica.

Mr. MICA. Thank you, Mr. Distinguished Chairman. Good to be with you this morning. Thanks for highlighting some of the issues that we face with the size and scope and reach of Government.

Probably some fundamental questions. Ever since the founding of the Republic, to get away from king's distant rule, taxation without representation, and then the size and scope of government and their interference in the colonies' affairs, shifting to the creation of our current government, founding fathers were always skeptical of government, and again probably for good reason. The longer I stay here, the longer I am convinced that government could screw up a two car funeral and, if given the opportunity, often does.

Big government programs—I saw some of your comments, Dr. Winston—sometimes are adopted because a need, a social need or public need, is not met or the public's private sector cannot meet that need. In looking at this whole mess, wouldn't it have been possible to—for example, I think there is pretty wide consensus we need to do something about preexisting conditions, about people who were in a lower economic scale, maybe not poverty scale, but couldn't afford healthcare, but these were some of the deficits that brought about the government and people stepping in, saying that government had to take a bigger role. But, honestly, the question I would pose is wouldn't it have been possible to take and tweak some existing things to establish a rules that these plans, and then

let the public sector put the plans out there, rather than creating the exchange, the bureaucracy?

I remember they came to me when I was chairman of transportation. We oversee public programs. They came and said we just came to tell you we need a building in Washington that will house 5,000 people. That is the administrative people required under the—I am not talking about enforcement people, just the—I was kind of stunned when they said, well, the bill mandates this, we just can do it, all we have to do is tell you. And then they came back later and I think they needed a building for 7,000. But couldn't it have been done by changing some of the requirements and then letting competition and the private sector, existing mechanism rather than big government take it over?

Dr. Winston, then others.

Mr. WINSTON. I am not an expert in healthcare, but, to be honest, I asked the same question. My thinking about this is we already have an existing insurance program in the Government; it is quite a large one.

Mr. MICA. Right. We have Medicare and we have Medicaid. Medicaid, in particular, might be a vehicle. But we could have also mandated that insurance plans cover some of these or——

Mr. WINSTON. Or allowed them into the Government's plan.

Mr. MICA. Exactly.

Mr. WINSTON. That was my sense.

Mr. MICA. Exactly.

Mr. WINSTON. I think what we are grappling with is, again, what really would be the "lowest cost solution."

Mr. MICA. Exactly.

Mr. WINSTON. To the extent we want to achieve this goal, how can we do it at least cost.

Now, my understanding from the experts I know is there is no magic bullet. No one has ever told me, look, we all know exactly what would be the least cost solution. I think that is one of the intellectual challenges in dealing with this. But, that said, it would have been nice to at least see a set of alternatives, including the one that you are talking about, one that intuitively, to me, made sense, and sort of get these head-to-head and see how we should go forward.

Now, maybe that was out there, but through political compromises that didn't work. But I think at least it would be good to separate out the economics and the politics.

Mr. MICA. We have something else.

You wanted to comment?

Ms. DE RUGY. Government intervention always creates distortion, so no matter what it would have done, so the question is how do you get the Government to do exactly that social goal at the least cost without introducing too much distortion. And it is worth noting that one of the goals of the ACA was to provide universal coverage, which, by the way, getting insurance is very different from getting improved health outcome. And when you look at the actual results, actually not everyone is going to get insurance.

So right there, when you try to measure success and failures, you see that there is a problem in the way the whole thing was designed. And, yes, targeting it better could have achieved it. It

would have introduced distortions, because it always does, but it would have been probably better and maybe even have achieved the stated goal of the ACA.

Chairman ISSA. You can go ahead and answer briefly.

Mr. CALABRIA. Again, what I will start out with, we know that the resources have costs, therefore we know that the market is not going to provide anything at zero cost. Or the fact that somebody cannot afford something when they have zero income is not a market failure. It is also important to keep in mind that somebody who has zero income can't pay taxes, and we don't consider that a government failure.

So my point is that we confuse, in my opinion, a number of programs in thinking that this is some market failure to provide a good, when the problem that we are facing is an issue of poverty. If rich people don't have this problem, then we know it is not a market failure. And essentially I think we would have a much better functioning Government if we gave people in poverty the dignity of let's cut you a check and make you non-poor, and let's let you make the decisions for what is important in your life for you to spend that money on, rather than us tying assistance to a whole basket of various different goods, of which, of course, the providers grab most of the subsidy anyhow.

Mr. MICA. Thank you.

Chairman ISSA. I thank you.

We now go to the gentlelady from New York, Mrs. Maloney.

Mrs. MALONEY. I want to thank the chairman and the ranking member for holding this important hearing and all of the panelists for their testimony, many of whom represent distinguished institutions of learning and think tanks. I would like to quote my own distinguished comedic think tank, the Borowitz Report. Now, Andy Borowitz has pointed out that many or some of my Republican colleagues have criticized President Obama and his team for having the audacity to support one of their own ideas, an idea that came out of The Heritage Foundation. And I would like to quote the conservative Heritage Foundation, which had praise for a plan that it described this way. And this was their report in 2006 on Romneycare, this statement. They said, "The cornerstone for this reform is a personal and responsibility principle. The plan establishes a health insurance exchange to enable individuals to purchase health insurance. The plan also focuses on restraining the growth in healthcare costs by empowering consumers and making healthcare service and cost information more readily available."

The distinguished report went on to criticize some of my Republican colleagues for plotting to make the Affordable Care Act work, or criticizing efforts by President Obama and his team to be flexible, to make adjustments in the plan. Some went on to criticize the President and his team for having a website that was far too slow. Then some turned around and criticizes the President's team for having a website that worked too fast.

So we have some difficulty in working together, but I do think you raise some important points in your testimony, Dr. Thomas, and I would like to quote the area where you talked about how healthcare, not only the improvement in quality of life and education, but the life expectancy has been improved by 37 years, and

some of this was because of public healthcare and public healthcare research and standards, and I want to thank you for pointing that out. But I have some further questions on healthcare.

I would like to ask you, Dr. Thomas, do you remember how many Americans were without healthcare insurance before the passage of the Affordable Care Act? How many Americans were there? There were many reports. Do you remember how many Americans did not have healthcare?

Ms. THOMAS. I have always gone with the figure of approximately 40 million.

Mrs. MALONEY. Some say 50.7 million in 2010.

Ms. THOMAS. Right.

Mrs. MALONEY. I also want to cite a very important study in 2009 by the Harvard School of Public Health. Now, this celebrated study, you may remember it, found that a large number of early deaths were associated with the lack of health insurance. And they further pointed out that 45,000 Americans died yearly, in their report they estimated, because they did not have health insurance.

Now, do you believe this report, Dr. Thomas, that came from the Harvard School of Public Health?

Ms. THOMAS. Yes, I do.

Mrs. MALONEY. You do believe that that many people were dying. And before the passage of the Affordable Health Care Act, do you recall the percentage of people without healthcare by States? There were a lot of reports that showed the percentage of people who did not have healthcare, and it varied dramatically, from 4 percent to 24 percent. The 24 percent was the State of Texas. And the 4 percent, guess what State it was? What State was it that had the highest number of people with health insurance? Only 4 percent of their population did not have it.

Ms. THOMAS. I am guessing Connecticut, but I——

Mrs. MALONEY. No, it was Massachusetts.

Ms. THOMAS. Right.

Mrs. MALONEY. Because of Romneycare.

Ms. THOMAS. Yes, of course. Yes. Yes.

Mrs. MALONEY. Romneycare. And I did my own survey; I called anyone I know in Massachusetts. They were very happy with their healthcare coverage.

Do you understand why there was a difference between the 4 percent and the 24 percent? What was the difference?

Ms. THOMAS. Because there was Romneycare in Massachusetts.

Mrs. MALONEY. Yeah, Romneycare, which President Obama gives full credit to the distinguished former governor for his work in supplying healthcare to the vast majority of the people who live there.

Are you also aware that in the three years since 2010, the real per capita annual growth rate of national health expenditure has been just 1.3 percent? And this responds to the concerns that I think are very legitimate of the chairman to contain costs. We all agree the costs were out of control, and the historic average growth rate was 4.5 percent. But now, because of the Affordable Care Act, we are at 1.3 percent growth in the cost of medical care.

So I would like to ask any of the panelists are you able to point to any prior three-year period that saw a lower growth rate in our national healthcare expenditures ever in history?

Chairman ISSA. The gentlelady's time has expired, but please answer.

Ms. DE RUGY. So, actually, the growth in the cost of healthcare has been going down since 2003, and, in fact, it has stopped to decline since 2009. So in some ways you could actually say that maybe the ACA has actually paused that decline in the cost. And, in fact, CMS has put out a report which actually one of my colleagues, a trustee for Social Security and Medicare, charged——

Mrs. MALONEY. Reclaiming my time. If you could get your response in writing, because I think it is very important, and it is absolutely different from the report that I have seen on the per capita growth rate that showed a 4.5 annual growth in expenditures. I think this is an important point and we should get this in the record.

Chairman ISSA. Without objection, that material could be placed in the record.

Ms. DE RUGY. Absolutely.

Chairman ISSA. Thank you.

We now go to the gentleman from South Carolina.

Mrs. MALONEY. And may I also place in the record my research on this from the National Institutes of Health on the growth rate during those periods.

Chairman ISSA. Anything from the National Institutes of Health will be welcome. Without objection.

Mrs. MALONEY. Thank you.

Chairman ISSA. Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman. The debate over the role of Government in our Republic is a fascinating one and probably outside the boundaries of a five-minute Q&A. What is not debatable is if Government is going to enter into something, we have a legitimate expectation that they do so competently and in a trustworthy fashion.

So, Dr. Thomas, let me start with you. What do you think the largest avoidable mistake was with respect to the rollout of the website? The largest avoidable mistake.

Ms. THOMAS. I am not qualified to speak to that. I am not knowledgeable about the technological aspects of the website.

Mr. GOWDY. Neither are the people who designed the website, apparently. You have no thoughts on what the largest avoidable mistake was with respect to the website?

Ms. THOMAS. I do not.

Mr. GOWDY. Dr. Calabria?

Mr. CALABRIA. I would preface with saying I am not an IT expert, I am not an expert on the website, so I certainly would say the sense you had to have it running by a certain date, rather than having made sure it was ready before I certainly think is a mistake, but I would emphasize what Dr. Thomas said, not an expert on the website.

Mr. GOWDY. Well, let me ask you this, then, if you are not an expert on the website. It strikes me that if there is a security issue with Amazon or eBay, the consumer has recourse; there are consequences for that. What are the consequences if there are security issues with a Government website? I mean, you could argue that there would be electoral consequences, but we had a several hour

hearing and I still can't tell you who is responsible for the website. I can tell you it is not the President, it is not Kathleen Sebelius, it is not any of the people that you would think would be responsible for this train wreck. So what does a consumer do when they are let down by a Government website?

Mr. CALABRIA. I think that is an important point, and both Veronique and myself talked about the role of incentives here, which is, A, there is often not clear chains of authority, I mean, the buck should stop somewhere with something; and there is never any penalty, there is never any punishment. Certainly not the website. Alone, we have all heard the stories of NSA spying and going through what we are all looking at on the web, but I haven't yet heard of any NSA employees being disciplined for that.

Mr. GOWDY. I have one even worse than that. How about the GSA? Do you remember the picture of the gentleman with the glass of wine in the hot tub?

Mr. CALABRIA. Oh, yes.

Mr. GOWDY. Do you know what consequences came from that?

Mr. CALABRIA. I believe they rehired him. Of course, I will also say, as somebody who follows financial services, you have probably heard of the very large number of SEC employees who spent the financial crisis looking at porn sites on their office. None of them were fired. So, again, where is the accountability? Where does the buck stop is an important part of this question.

Mr. GOWDY. Dr. Winston?

Mr. WINSTON. I mentioned in my testimony that story that I read about an IT supplier who offered to build this website at no cost. I can't remember exactly now the name of the firm, but they had a lot of experience doing it. I am sure we can find that out. But they were told they couldn't do it because of regulatory constraints, and then the Government went out and hired another firm. At the very least, one could have brought them on as a technical consultant or somebody who could provide guidance, because they certainly were confident enough and experienced enough to do it. So I think clearly an avoidable mistake was just the lack of ability to bring in the highest level of technical advice and competence, which apparently may have been able to prevent some of the problems that occurred.

Mr. GOWDY. Well, it just strikes me that you can debate the role of Government, but if Government is going to do something, you really should not debate whether it ought to be done competently and in a trustworthy fashion. And there are no consequences or, if there are, I haven't seen them to date.

With that, I would yield to the chairman.

Chairman ISSA. I thank you for yielding.

I just want to get two things in the record quickly. One of them is because there was the doubling of life expectancy, I just want to get into the record in 1960 we spent 5 percent of GDP on healthcare and we had a 69.7 combined life expectancy age. In 2006 we spent 16 percent, a more than threefold increase in the percentage of our growing GDP we had. We became very wealthy during this period, but we exceeded it by triple and we raised ourselves by eight years, to 77.7.

Dr. Calabria, quite frankly, isn't that what we should be talking about, is how we spend more than three times the growing wealth of our Nation on healthcare and, yes, we are getting an increase in life expectancy, but certainly not proportional and not when you look at our competitors around the world, where countries like Canada, to our north, spend a third to a half less than we do?

Mr. CALABRIA. I would very much agree. You could certainly that we are spending a lot of money on these things, but what are we getting? We are getting a bang for our buck and we could do a far better job of that and try to get more efficiencies out of that, which I think gets back particularly to Congressman Mica's point about having some consumer choice in this to me is an incredibly important part of it.

Chairman ISSA. Dr. Thomas, my colleague said something and I am taking something because he said it and he is rightfully so. He said universal healthcare. The debate that we are having today is on something that is not universal, it is an extension of Medicaid, effectively, it is a vast expansion of Medicaid both in literally who gets it and in the subsidy that is effectively a back-door Medicaid for the working less wealthy up to over $60,000. From the standpoint of your view of the good it is doing, it is predicted we will get to 20 percent to 21 percent of GDP as a result of the Affordable Care Act in total healthcare spending. Would you sit here today and say that our goal should be to deliver life expectancy beyond 78 years and do it for less than 21 percent of GDP?

Ms. THOMAS. I would respond to that by saying that our healthcare spending, we are living longer than ever before and much of our healthcare spending is to deal with the chronic diseases of old age that we used to not have to deal with because were dying earlier. So those life expectancies——

Chairman ISSA. Okay, well, my time has expired, so does anyone want to answer the question, which is should we have a goal to live long, live well, and do it at a rate below 21 percent and growing, or likely to be 21 percent and growing, percentage of GDP, when we are competing against nations that have 9 percent or less and have life expectancy as long as ours? Hearing none, I will recognize that my time has expired.

Mr. GOWDY. Mr. Chairman, could I correct one thing very, very briefly that my friend from Virginia—my friend from Virginia told me that there were consequences that arose from a hearing that we had with respect to GSA. If my friend from Virginia tells me that, I believe him and I will take it upon myself, Mr. Chairman, to find out the full panoply of the consequences and report back to you and to my friend from Virginia.

Chairman ISSA. I thank you. And I don't think there is anyone here that would fail to think there should be consequences in the case of GSA.

With that, we go to the gentlelady and my friend from the District of Columbia, Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman. Just to try to respond to your question about the correlation between the increase in life expectancy and what we spend, sure it is going to go down, because we have been spending—and I think Dr. Thomas gave one answer, but you know the Affordable Healthcare Act is going to help that

because we have been spending this money on sending these people, up until now, to the emergency room; we have been spending almost no money on preventative care; we have been spending disproportionate amounts of money on the very last years of life, when people are about to die anyway. You have a lot of factors. But I do want to——

Chairman ISSA. Would the gentlelady yield?

Ms. NORTON. If you don't take my time for me.

Chairman ISSA. I will stop the clock.

Are you saying that there is something in the Affordable Care Act that is actually going to drive down——

Ms. NORTON. I am. I am saying, for example, that the subsidies, which are a part of the Affordable Healthcare Act, means that people are going to get their own doctors, they are going to have preventative care, that you won't get to the point where the disease is costly, you have to have the most expensive procedure, you have to have your leg taken off.

Chairman ISSA. I hope to see it.

Ms. NORTON. I am saying that those things will, in time, show up. They are not going to show up in the first few weeks of the rollout.

And I do want to thank a very distinguished panel. One of them is one of my own constituents. Welcome, Mr. Calabria. But I want to thank all of you for your testimony.

I do note for the record that only Dr. Thomas is an expert in healthcare, and I think that must have been deliberate, because we are talking about the rollout of healthcare. And that is without casting any dispersion on the very distinguished witnesses we have here.

But what troubles me, Mr. Chairman——

Chairman ISSA. Would the gentlelady accept a friendly——

Ms. NORTON. Certainly.

Chairman ISSA. Dr. Thomas, according to our information, is a historian and communications associate at Johns Hopkins. We were unaware. It is the School of Public Health, so it is history of health. But I may be wrong. Perhaps she could tell us what her expertise is in health, because everyone today is a PhD. None of these are medical doctors.

Ms. NORTON. She is an expert on healthcare, Mr. Chairman. And if she is not, let her tell us.

Ms. THOMAS. I spent four years doing a post-doctoral fellowship in the history of medicine, largely concentrating on twentieth century health policy in public health at the Institute of the History of Medicine at Johns Hopkins University.

Ms. NORTON. I was simply drawing a contrast between some background in healthcare, and I did say, even though I respect all three of the other witnesses, Mr. Chairman, I hope that wasn't taken from my time.

But I do want to say that this is an amazing hearing that the Government of the people, by the people, and for the people should not provide healthcare for the people is essentially the theme of this hearing. It is a fundamentally anti-American message. Fortunately, it is false, and I think the chairman, with his rollout of the

many ways in which the Government has produced for the people, lays that to rest.

The Affordable Healthcare Act is not a Government program. Not even single payer. So I don't understand the concept here. This is a Republican idea which outsources to the private sector. This is why the insurers bought into the program and that is why they are so anxious that this website get up and get right. Yes, they are getting subsidies, but that is to save the American people money. Nobody is just throwing money at people.

Mr. Chairman talked about D.C. Health Link. Yes, there are errors there, but it was cited as one of the four successful rollouts throughout the United States, and I want to cite it because it is an example of why this is not a Government program. You go on D.C. Health Link; 267 options. And when they insisted that on D.C. Health Link they would put the costs up front out so anybody could see it, they drove competition and others came in and lowered their prices. This is a quintessentially private sector approach. The Government's only role is to say we are not even refereeing it, we are putting up a website. That is why we think that website has got to be gotten right.

The chairman talked about winners and losers. Here we have 267, or whatever the number is in your district. Nobody is picking anything except the people who go on that website.

Mr. Calabria talked about market feedback. I just cited to you, Mr. Calabria, what the market feedback was when competitors saw 267 prices on the link. They never could have seen it otherwise. The individual never could have gotten that information if it had not been for D.C. Health Link. My staff went on there and report, for example, several of them have reported to me that they have saved $100 already looking on the site, with comparable healthcare, $100 per month.

Dr. Winston talked about programs in the public sector, like ACA, do not necessarily drive down costs, and he may be right. Of course, I have cited an example where, precisely because the Government put this website out, costs are being driven down.

One thing that ACA does not have is a mechanism, a Government mechanism for driving down costs. They are depending upon this competition to do so.

I want to ask Dr. Thomas about—since what was supposed to have spurred this was the rollout—about the Medicare rollout. Now, we would have done Part D in a different way. The last thing we did, though, when it finally happened, we certainly didn't say we will just wipe it off the board. We didn't try to repeal it. Do you recall public and, for that matter, political sentiment at the time of the Medicare D rollout, whether there were large problems?

Chairman ISSA. The gentlelady's time has expired.

Ms. NORTON. My time was taken up, Mr. Chairman, by you, among others.

Chairman ISSA. No, we stopped the clock.

Ms. NORTON. You don't even want to let her answer the question?

Chairman ISSA. No, I was saying your time has expired, but the gentlelady certainly can answer.

Dr. THOMAS. At the time of the Part D rollout in 2005 and 2006, there is great concern about how complex the instructions were for enrollment and people were very concerned that their existing drug coverage would end and that they would not be picked up by the new law, and there were great difficulties in the initial implementation of the law that have since been fixed, and we now, I think, are in bipartisan agreement that Medicare Part D is working and is a good program.

Ms. NORTON. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

The gentleman from Tennessee, Mr. Duncan.

Mr. DUNCAN. Well, thank you, Mr. Chairman. I remember during my first term in Congress, in 1989, I went to a conference put on by the American Medical Association, and the man who was then the president of AMA was laughing in a presentation that he made about the fact that, as the ranking member mentioned, the AMA had opposed Medicare, because he said that he knew at the time it was started that the doctors would get their part, and they certainly have. Many doctors have gotten wealthy off of it. And I remember reading last year, I think it was in an Associated Press article, that six of the ten wealthiest counties in this Country are suburban counties to Washington, D.C.

What I am getting at is, as Dr. De Rugy has mentioned, all these Federal programs, they have wonderful motherhood and apple pie titles and they have good goals, but they end up benefitting primarily Government contractors, large corporations, and Government employees. You mentioned Goldman Sachs and some other companies, and the chairman mentioned that we have spent $640 million so far on the website. The Canadian company whose American subsidiary got the bulk of the money on the website, one of the top officers is a close friend to the President's family. And all of these Government contracts, when you go beneath the surface and you find out what is behind it, almost all these big Federal contracts are some sort of sweetheart or insider deal. I read several years ago about the revolving door at the Pentagon, because they hire all the retired admirals and generals, the defense contractors do.

And the same thing is going to happen, I am afraid, with Obamacare. It is going to end up benefitting some extremely big companies. I read just this morning an article that some of the health insurance companies are now working with the White House to try to implement the program because they see huge profits ahead.

And I think back to the mid-1990s, when I went to a reception in Tennessee, and the doctor who delivered me came and brought my records, and I asked him how much he charged back then. He said he charged $60 for nine months of care and the delivery, if they could afford it. Medical care used to be cheap and affordable, and doctors even made house calls; and then the Federal Government got into it. The same thing has happened. It shocked students at the University of Tennessee when I tell them that it was $90 a quarter when I went there, $270 a year. Until that program started, college tuition and fees went up at just the rate of inflation. Then when the Federal Government got into it, every year

since then it has gone up three or four or five times the rate of inflation.

It just seems that everything the Federal Government subsidizes, the costs just explode. And we talk now, already we are hearing that Obamacare is going to cost three or four times more than when it was passed. And I remember reading years ago that Medicare was predicted was going to cost $12 billion after the first 25 years; instead, it cost almost 10 times that much, and now it costs four times more than that. So all these Federal medical programs have been low-balled on the front end. And what I don't understand is how we are going to add many millions of people who were previously uninsured and now millions more receiving notices saying that their premiums are going out the window so much that they are not going to be able to afford those premiums, so we are going to add all those millions.

These costs, it seems to me, are inevitably going to explode. Dr. De Rugy, what do you say about that?

Ms. DE RUGY. I agree with you. A lot of these programs, independently of the social benefit that we assign them, are unsustainable, whether we like them or not. Medicare, Social Security, Medicaid, these are programs that are extremely expensive. And then you add on top of it the ACA. We already have a big debt problem, but it is going to explode.

And I wanted to add something about what you said. Yes, the private insurance industry was extremely supportive because they were going to benefit immensely from it. When you have a law that mandates that everyone buys insurance, that means millions more customers for the insurance industry. And I would bear to also say that in this instance, because of the way the law was drafted, the law did pick winners and losers. Because of the requirement by Obamacare, it meant that younger and healthier Americans were going to have to face much higher premiums.

Chairman ISSA. The gentleman's time has expired.

Dr. Winston, if you need to answer.

Mr. WINSTON. I just want to add one point just to round out what you were saying. I think it is important to keep in mind that a large source of the increase in medical expenditures is due to technological change and innovation. Obviously, we are not getting the same products that we once got. That is a good thing, and that is coming from the private sector, to a large extent. The challenge for Government is how is it that they intervene in ways that spur technological change in innovation without excessive increases in cost, as opposed to impeding technological change and innovation. That is really what we need to do.

Mr. DUNCAN. Well, I will close just by saying that we are having great difficulty funding the programs that we already have.

Thank you, Mr. Chairman.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

So, Dr. Calabria, I just want to note that you were here for a hearing on the rollout of healthcare government. Your own testimony says, "I am not an expert on healthcare," is that right?

Mr. CALABRIA. That is correct.

Mr. TIERNEY. Okay. And in your statement you also say, "Doing nothing should always be an option or, rather, leaving the problem to be solved by the voluntary private sector." Is that accurate as well?

Mr. CALABRIA. Absolutely. You can always make something worse.

Mr. TIERNEY. Thank you.

Dr. De Rugy, in your written testimony you focus mostly on the Department of Energy's loan guarantee program and then you say, "Government solutions are not only unlikely to solve most of our problems, they often make problems worse." Is that fair?

Ms. DE RUGY. It is fair.

Mr. TIERNEY. Okay.

Dr. Winston, you talked mostly about transportation and infrastructure programs. Let me quote from your testimony: "I am much less familiar with empirical assessments of Government services and programs to pursue social goals." Is that an accurate quote?

Mr. WINSTON. Yes.

Mr. TIERNEY. Thank you.

So, Dr. Thomas, you actually work in the public health field, you have the background that you just stated on that, so I want to focus a little bit on you and talk about this concept that the free market always works better. Before Horace Mann, how was the private sector doing on educating most students in this Country?

Ms. THOMAS. In some parts of the Country, literacy rates were high, but in many, many parts of the Country there is no education available to the vast majority of the population.

Mr. TIERNEY. And before Social Security and Medicare, what was the poverty rate among seniors?

Ms. THOMAS. I do not specifically know, but I know that it was significant and that health costs were a major part of that poverty.

Mr. TIERNEY. And how did Social Security and Medicare's enactment affect that?

Ms. THOMAS. We need to remember Medicare and Medicaid are parts of the Social Security Act. Together those things lifted many, many millions of Americans out of poverty. And I think it is important to add that minority groups, who had been hardest hit by poverty rates, were also dramatically helped by those programs.

Mr. TIERNEY. And I would assume that since the recession, the fact that 95 percent of all economic gains have gone to the top one percent is not what you would think is a great symbol of the private market working effectively for everybody?

Ms. THOMAS. No, I would not.

Mr. TIERNEY. Okay. So the premise by the Majority seems to be that Government's ability to effectively or inability to effectively design, implement, and administer large-scale projects and programs. Let me talk to you a second about the GI Bill. Is it your understanding that the GI Bill has been a success?

Ms. THOMAS. Absolutely. My own father went to Georgia Tech on the GI Bill.

Mr. TIERNEY. And, in fact, on November 8th of this year we had the one millionth recipient of the GI Bill that was passed after September 11th, 2001.

Ms. THOMAS. Yes.

Mr. TIERNEY. And basically I would think that the Government has been administering that program fairly well, in your opinion?

Ms. THOMAS. Yes.

Mr. TIERNEY. Some $30 billion in new GI Bill benefits have been awarded to Iraq and Afghanistan veterans since 2009, is that about right?

Ms. THOMAS. Yes.

Mr. TIERNEY. So you would think that the GI Bill has been worth the effort of the Federal Government in its expenditures?

Ms. THOMAS. Yes. And it helped the overall market to work better because it brought so many more skilled people into the workforce.

Mr. TIERNEY. Now, the intervention of Government in 1966 through Medicare, that saw some problems with the rollout of that program, similar to what we are hearing today?

Ms. THOMAS. Very similar.

Mr. TIERNEY. And in 1937 we could say the same about Social Security, correct? People were all sorts of critics about the program; it was going to cause too much swelling of bureaucracy, it was going to slow the economy?

Ms. THOMAS. Correct.

Mr. TIERNEY. And Part D, Medicare Part D talked about their being a marred rollout. Republicans, in fact, at that point in time, however, were saying, look, it is a marred rollout, but it has glitches; we should work closely with CMS to get the problems resolved on that.

Ms. THOMAS. Yes.

Mr. TIERNEY. All right. And I would protest that if we work closely with the glitches in the Affordable Care Act, we can get those resolved as well, would you agree?

Ms. THOMAS. I agree. I think the Affordable Care Act is very much in the tradition of these other programs that you have mentioned and that we are going to look back even a year from now and see that the Affordable Care Act is a good investment and is working.

Mr. TIERNEY. So, historically, are you familiar with any program that the Republicans proposed during this discussion of the Affordable Care Act that would cover the 40 million Americans that were otherwise uncovered?

Ms. THOMAS. I am not.

Mr. TIERNEY. Are you aware of any proposal that would have affordably allow people to stay on their parents' policy until they are 26 if they are not otherwise covered?

Ms. THOMAS. No.

Mr. TIERNEY. Are you aware of any Republican suggestions of how they would affordably make sure that insurance companies didn't shut off your health insurance with an annual or lifetime cap on coverage?

Ms. THOMAS. No. The insurance companies had done none of this on their own.

Mr. TIERNEY. And the same is true with preexisting conditions, is that correct?

Ms. THOMAS. Correct.

Mr. TIERNEY. I yield back. Thank you.

Chairman ISSA. I thank the gentleman.

I now ask unanimous consent that 15 letters sent to health insurance companies related to broken promises and when did they know that they were going to be canceling individuals under the Affordable Care Act be placed in the record. Without objection, so ordered.

Chairman ISSA. We now go to Mr. Meadows, who came back just in the nick of time.

Mr. MEADOWS. Thank you, Mr. Chairman.

Dr. Thomas, I know that my friend and colleague was asking you about Republican proposals, and hopefully this is not something—how many people do they estimate will still be uninsured under ACA, do you know?

Ms. THOMAS. I do not have an exact figure.

Mr. MEADOWS. Do you have an approximate figure? You are a historian.

Ms. THOMAS. Yes.

Mr. MEADOWS. So you don't know trends?

Ms. THOMAS. Well——

Mr. MEADOWS. So, under ACA, how many people will—you were able to quote how many were going to be covered, so I would assume that you would know how many are going to be left uncovered.

Ms. THOMAS. I think there will still be approximately 5 to 10 percent uncovered.

Mr. MEADOWS. Well, according to estimates, some 30 million people will still be left uninsured, is what the current estimates have. Some 30 million people would still be without insurance even under ACA.

Ms. THOMAS. And may I ask where those estimates are from?

Mr. MEADOWS. CBO. So if you look at the CBO, they are saying almost 30 million people will still not be covered. So this is not a solution that will have everybody covered.

Ms. THOMAS. Mm-hmm.

Mr. MEADOWS. So I want to ask—you have gone and you have had a number of options here as we have started to look at history. Can you speak to the fact that we have trends right now where, under current Medicaid and Medicare, that the reimbursements are not covering the costs? Would you agree with that? To provide those healthcare coverage. Does Medicaid cover all the costs of actually providing that service, reimbursement to physicians?

Ms. THOMAS. No, it does not.

Mr. MEADOWS. All right. So does that distort the market?

Ms. THOMAS. The rates of——

Mr. MEADOWS. Of reimbursement.

Ms. THOMAS. Well, I can speak from personal experience. When you get an explanation of benefits from a medical visit——

Mr. MEADOWS. All right, maybe let me change and rephrase the question. Do you ever hear complaints from physicians where they don't want to take new patients because the reimbursement is not adequate to cover their costs? That is an easier question.

Ms. THOMAS. Yes. However, in some cases, over time Medicare has reimbursed at higher rates than private insurance.

Mr. MEADOWS. Okay, but let's look at Medicaid. I am in a rural areas, so we get a lot of Medicaid patients, and what I am finding is a lot of physicians don't want to take Medicaid patients because the reimbursement doesn't even cover their costs, hospitals included. Would you agree with that?

Ms. THOMAS. I would, but I would also say that without the Medicaid program, there would be far more people who wouldn't get care at all.

Mr. MEADOWS. All right. Is there not a Federal law that says everyone has to get care?

Ms. THOMAS. There is a Federal law——

Mr. MEADOWS. Is there a Federal law, yes or no?

Ms. THOMAS. Care in the emergency room, yes.

Mr. MEADOWS. Right. So it is a matter of how we get that care to them in terms of the efficiency of that. Because right now there is a law, if I show up, regardless of my ability to pay, at an emergency room, I can get care, is that correct?

Ms. THOMAS. Yes.

Mr. MEADOWS. That is a Federal law. So what we are talking about is the efficiency, as Dr. Winston talked about earlier, is what is the most efficient way to deliver that healthcare, is that not correct?

Ms. THOMAS. Yes.

Mr. MEADOWS. All right. So in doing that, from a historical perspective, are there major inefficiencies in Government delivery of services, whether they be medical or anything else? Are there inefficiencies there?

Ms. THOMAS. Certainly.

Mr. MEADOWS. All right. So has the private sector historically done a more efficient job of providing services, whether they be medical or not? Have they historically done a better job of providing a more efficient delivery, historically speaking? You are under oath.

Ms. THOMAS. You are talking about all of the private sector in all parts of the economy?

Mr. MEADOWS. I am saying historically speaking—you are talking about trends. Historically speaking, is the private sector a more efficient mode of delivering goods and services, whether they be medical or not, historically speaking, have they been more efficient? You are a historian.

Ms. THOMAS. I don't think I can answer that question because it is so broad.

Mr. MEADOWS. Okay. Well, my time has expired. I yield back.

Thank you, Mr. Chairman.

Chairman ISSA. We now go to the gentleman from Virginia, Mr. Connolly.

Mr. CONNOLLY.

Mr. CONNOLLY. I thank the chairman. And I am delighted to hear my friend from North Carolina's concern about uncovered citizens. Hopefully, North Carolina and Virginia will both come to their senses and broaden Medicaid so that those people will have coverage.

By the way, let me follow up on my friend's last question to you, Dr. Thomas. Historically, since World War II, can you give us a

single industrialized country where the government has not intervened and provided healthcare to its citizens?

Ms. THOMAS. No. There are none.

Mr. CONNOLLY. There are none. So that efficient private sector somehow just didn't work in any industrialized country. The United States is actually laying way behind others in the industrialized world in the comprehensiveness of its coverage until the passage of the ACA. Would that be an accurate historical statement?

Ms. THOMAS. That is absolutely true.

Mr. CONNOLLY. And you are under oath, as my friend reminded you.

Ms. THOMAS. Yes.

Mr. CONNOLLY. Thank you.

Ms. THOMAS. That is absolutely true.

Mr. CONNOLLY. Dr. De Rugy, my friend the chairman characterized Brookings as a left-of-center organization in contradistinction to your center, the Mercatus Center, which he characterized as right-of-center. Would you accept that characterization?

Ms. DE RUGY. No. Actually, we are really independent.

Mr. CONNOLLY. Really independent.

Ms. DE RUGY. We spend a great amount of time criticizing both sides of the aisle.

Mr. CONNOLLY. And lots of donors like the Koch brothers, for example, is that correct?

Ms. DE RUGY. We have lots of individual donors.

Mr. CONNOLLY. Including the Koch brothers?

Ms. DE RUGY. Yes. It is well known.

Mr. CONNOLLY. Yes. You don't come here as a healthcare expert, you come here as an economist, is that correct?

Ms. DE RUGY. That is correct.

Mr. CONNOLLY. And your position is, a priori, that any Government involvement distorts the marketplace.

Ms. DE RUGY. It does.

Mr. CONNOLLY. It does. So you consider Medicare a distortion?

Ms. DE RUGY. It does, yes.

Mr. CONNOLLY. Medicaid?

Ms. DE RUGY. Medicaid.

Mr. CONNOLLY. Veterans Administration?

Ms. DE RUGY. We may be willing to put up with distortion to achieve some social goal.

Mr. CONNOLLY. No, I am not asking—don't jump ahead. I am asking the question here. So is TRICARE, medical TRICARE, military TRICARE healthcare a distortion in the marketplace, based on your philosophy?

Ms. DE RUGY. All Government intervention introduced distortions.

Mr. CONNOLLY. And that includes the Veterans Administration healthcare system.

Ms. DE RUGY. It does.

Mr. CONNOLLY. It does. And I see Dr. Calabria agreeing with you. Does the Centers for Disease Control, is that a distortion? It is a big Government program; monitors public health.

Ms. DE RUGY. It does, but again——

Mr. CONNOLLY. Again, ma'am, I am just trying to see is it consistent with your philosophy that it represents a distortion. We will hold off for a minute, normatively, whether it is good or bad.

Ms. DE RUGY. Government intervention introduced distortions.

Mr. CONNOLLY. And you would include the National Institutes of Health in that rubric?

Ms. DE RUGY. It does.

Mr. CONNOLLY. And the Federal Drug Administration.

Ms. DE RUGY. It does, certainly.

Mr. CONNOLLY. Now, all right, are some of those things necessary, despite their distortive effect?

Ms. DE RUGY. Yes.

Mr. CONNOLLY. Which ones do you think are unnecessary?

Ms. DE RUGY. So I think there are a lot. For instance, I don't think the Government should be involved in education; that is a State and private function. I mean, there are a lot of things.

Mr. CONNOLLY. No, no. I am talking about the healthcare system. Would you abolish the CDC and let the private sector monitor public health?

Ms. DE RUGY. I think there is an important role for the Government to try to prevent epidemics, true epidemics. But the CDC does a lot of things that actually it shouldn't be doing.

Mr. CONNOLLY. Okay. So there are some things—you would go granular and pick what functions you like and what you don't.

Ms. DE RUGY. Yes.

Mr. CONNOLLY. Even though anything you pick is distortive, by your definition.

Ms. DE RUGY. Yes. Government intervention——

Mr. CONNOLLY. Excuse me, but because of time. Is it your position that absent the Government, even in functions you might deign to approve of, the private sector could do it better, and should?

Ms. DE RUGY. Not necessarily.

Mr. CONNOLLY. Not necessarily.

Ms. DE RUGY. Because, as I said, there is some function that we may want the Government to do, even if it introduces some distortions. And as Dr. Calabria has said, the private sector doesn't do everything efficiently.

Mr. CONNOLLY. Right. By the way, there was a debate here earlier about the Government setting prices for Medicare. Do you actually know how the process is set for which are recommended and approved procedures? Who does that? Who recommends that to the Government, do you know?

Ms. DE RUGY. I don't know——

Mr. CONNOLLY. It is actually a committee.

Ms. DE RUGY. Actually, it is a committee made of doctors.

Mr. CONNOLLY. That is right.

Ms. DE RUGY. And I think I remember a report recently that actually highlighted the fact that a lot of what they were doing was boosting prices in area where the service could be delivered at a lower price.

Mr. CONNOLLY. That is the private sector doing that.

Ms. DE RUGY. But this is how one of the ways that the Government introduces distortion, is it gives incentive to the private sector to try to get as much as it can from the Government.

Chairman ISSA. I would ask unanimous consent the gentleman have an additional minute. Without objection.

Mr. CONNOLLY. I thank the chair.

Well, of course, philosophically, Dr. De Rugy, there is no end of that; that is a horse that left the barn a long time ago. Gosh, if we want to talk about economic distortions and the Government's role, let's talk about agriculture.

Ms. DE RUGY. I agree.

Mr. CONNOLLY. Let's talk about nuclear.

Ms. DE RUGY. I agree. I agree.

Mr. CONNOLLY. All nuclear power in the United States came from Federal research and dollars.

Now, is it your contention that this big Government distortive effect extends to pharmacological research? Because it is my understanding that, by and large, all basic research in the United States, and this is not new, is done by the Government. It is the commercialization of that basic research is when the pharmaceutical firms come in, but they do not fund basic research, nor are they going to.

Ms. DE RUGY. Some of the distortions that the Government introduces by actually picking and choosing which areas are going to be funded, which areas should be researched while others may not.

Mr. CONNOLLY. Yes, that is true.

Ms. DE RUGY. And the Government has a knowledge problem.

Mr. CONNOLLY. Excuse me. Pharmaceutical companies do that too, except their motivation is commercial value, as opposed to the health value.

Ms. DE RUGY. Actually, I actually think——

Chairman ISSA. This is a wonderful discussion, but I have a feeling it could go back and forth for a very long time.

Mr. CONNOLLY. Mr. Chairman, I want to thank you for extending my time. I just wanted to highlight that. I think this is a really important debate because it is a very fundamental one in the United States when people say why can't we all get along? Because we have fundamental differences philosophically about the role of Government. And while I respect Dr. De Rugy and I certainly love George Mason University, which is entirely within my district, I couldn't disagree with her more, fundamentally. Just as you pointed out you disagree with Dr. Thomas, I also disagree with Dr. De Rugy and her philosophy.

Thank you, Mr. Chairman.

Chairman ISSA. Thank you. If I can enter a colloquy quickly, I actually think that all of the panelists have said, in one way or the other, that Government is necessary. They all know it causes market distortion and they all have differing views at the level of Government intervention. It could be that you disagree with some of the levels. I am sure they disagree with some of the levels I would achieve.

Mr. CONNOLLY. Yes.

Chairman ISSA. By the way, one of my major constituents produces botox, which was a Government-funded orphan drug that if

not for the Government looking at a very rare disease, probably would not be the blockbuster success it is in other areas.

Mr. CONNOLLY. That is right.

Chairman ISSA. So I think we all know that basic research is important. Hopefully here today we are talking about the 16 to 18 to 20 percent of GDP is that is there a better way to allocate those resources.

Mr. CONNOLLY. Mr. Chairman, I couldn't agree with you more, and I actually commend you. I think we have actually put together a panel here that has been very stimulating. It highlights some of our differences, but it also asks some provocative questions that need to be asked, and I thank the chairman for putting it together.

Chairman ISSA. Thank you. And then we are going to get back to FITAR and real IT reform together. Thank you.

We now go to the gentleman from Michigan.

Oh, I am sorry.

Ms. THOMAS. I wanted, if I may, to add that it is not always just the Government that "distorts" the market, that sometimes private actors can also drive up prices. And in healthcare a very good example of that is competition among private hospitals, private for-profit hospitals for highly expensive and complex medical equipment that one hospital buys the million dollar piece of equipment and they are the only hospital in town with it until the hospital next door buys it also, and really there is only enough patients to justify one such purchase. So that is one way that private healthcare drives up prices sometimes.

Chairman ISSA. The allocation of resources in healthcare is so complex that, to a great extent, the theme of today is is it so complex that neither the public nor the private sector have been able to do it.

I apologize, Dr. Winston, but it have taken too much time of everyone's.

The gentleman from Michigan.

Mr. BENTIVOLIO. Thank you, Mr. Chairman, and thank you for holding an important hearing.

The founders of this Nation understood exactly what some of our witnesses have all expressed: Government makes decisions poorly because too often politicians and bureaucrats do not have the same incentives that the citizenry has.

I certainly don't wish to offend my colleagues here, but our Government is inherently made up of those with at least a little hubris. After all, it takes some hubris to believe that you should be the representative of the sovereign people of the United States. In fact, I have even heard of people campaigning for office simply to say that they are Congressman, rather from the hope of protecting people's rights. A hubristic style trumps substance in service of the people.

Unfortunately, Mr. Chairman, that hubris in our leaders sometimes gets out of control and leads to disaster. The President's healthcare reform is the only major reform ever passed by one party over a bipartisan opposition. And, boy, Obamacare is certainly turning into a disaster.

I thank the witnesses for their enlightening testimony.

Dr. De Rugy, you talk a lot about special interest groups and the lack of incentives for politicians to spend taxpayer money wisely, stemming from the average citizen not really feeling the pain from having the collective money of the Nation wasted. Could this come from taxpayers simply not realizing how much money is being spent on what departments in Government?

Ms. DE RUGY. That is one of the reasons. I mean, one of the ways the Government expands is by concentrating benefits of Government intervention and spreading the cost thin and wide. So that is one of the reasons why we don't always see that cost. We also don't necessarily see the distortions, or even when we feel them it is hard to track it back to a particular Government intervention. What is interesting about the ACA—and I am going to make a prediction and we will see whether I am correct—is even when the website is completed, it is possible that the Administration is not going to get the benefit and the hurray that people are going to feel because actually it is a program that is designed the opposite way, like the benefits are spread somewhat widely to an audience who may not actually be very vocal about how great it is, while the costs are highly concentrated and visible to some, which will continue to be vocal.

Mr. BENTIVOLIO. Thank you. Do you think that if every taxpayer received a receipt explaining where their tax money went would be useful in granting politicians here in Washington more incentive to act more wisely?

Ms. DE RUGY. More transparency, certainly would be necessary. For instance, I would be very happy to see which part of my taxes go to farm subsidies.

Mr. BENTIVOLIO. I couldn't agree with you more.

With that, thank you very much. I yield back.

Chairman ISSA. Would the gentleman yield?

Mr. BENTIVOLIO. Yes.

Chairman ISSA. We have had a lively discussion, and I am sure we are going to continue to, but, Dr. Winston, in your opening remarks you really did touch on the fact that—and I think it is something that Dr. Thomas also said—monopoly and monopolistic type behavior, distortions in the market not just by Government, but the inherent distortions that occur in both for-profit and not-for-profit hospitals. I happen to have two not-for-profit hospitals nine miles apart along its a State highway, but it is built like an interstate, and I can't get them to put one machine that is not emergency-related in one and share; they just don't do it. Isn't that part of the problem—and I will go to Dr. Winston and maybe back to Dr. Thomas—is that healthcare has built, with a system that has very little to do with market forces, meaning that market forces already didn't work well in healthcare before we started funding a system that didn't work well from a standpoint of supply and demand? In other words, cash is not king; the consumer is not educated to make a buy-in; prices are not transparent; cost-effectiveness is not easy to discover.

Dr. Winston?

Mr. WINSTON. Yes, that is right. There is not distortions, but there are wedges, if you will. It is not a simple market, you go to a store, you buy something. You are going through a doctor, you

are going through insurance, so on and so forth. So these wedges make efficient, smooth operations——

Chairman ISSA. I am going to ask a closing question for all of you. If this committee, the committee of transparency in Government spending, if we concentrated our efforts related to the Affordable Care Act on mandating transparency in healthcare so the consumer knew more and the public knew more, would we be well spent in then driving, through market awareness, better distribution of dollars and, thus, more efficiency? Any opinion?

Ms. THOMAS. Yes.

Chairman ISSA. That is Econ 101, so just go ahead.

Mr. CALABRIA. Certainly, transparency would help, but you have to get the incentives right, too.

Mr. WINSTON. Incentives are, I think, the critical thing. Information is one thing, but still people have to have incentives and firms have to be able to enter, so on and so forth.

Chairman ISSA. I know people want to buy the best healthcare. Hopefully we can also create incentives for them to buy it at the lowest possible price. Thank you.

We now go to the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. You know, I believe that a good way to measure the greatness of a society is by how well it treats its young, how well it treats its elderly, and how well after it looks after those who have some difficulty handling their affairs effectively themselves.

Dr. Thomas, as a historian at Johns Hopkins, I am certain that you have some insight into the question of whether or not the Federal Government, as I have heard questioned, is able to administer large-scale programs effectively.

Ms. THOMAS. Yes.

Mr. DAVIS. I have heard comparisons between the Federal or the Government and the private sector. So I would like to ask you about the Medicare program, which was signed into law by President Johnson in 1965.

Mr. Chairman, I ask unanimous consent to enter into the record an article that appeared in The Washington Post on May 17th of this year.

Chairman ISSA. Without objection, so ordered. I love The Washington Post.

Mr. DAVIS. Yes, it is a great paper.

Mr. DAVIS. The article is entitled, When Medicare launched, Nobody Had Any Clue Whether It Would Work. Dr. Thomas, I would like to read an excerpt from this article and then get your response. Here is what it says: "Medicare in these days, an incredibly popular program. Americans overwhelmingly oppose cutting it. No politician would consider repealing it. Most think providing health insurance to all Americans over 65 is worth both the trouble and the cost. That was not always true. Back in 1966, as Medicare was just about to launch, nobody knew whether the new program would provide benefits to millions or fail completely."

Dr. Thomas, based on this reporting, there was trepidation in 1966 with the rollout of the Medicare program. Is that correct?

Ms. THOMAS. That is absolutely correct.

Mr. DAVIS. Well, the article describes how the American Medical Association ran ads across the Country denouncing the program as the beginning of socialized medicine, and many people who were unfamiliar with the program were suspicious of it. Is that correct?

Ms. THOMAS. Certainly.

Mr. DAVIS. The article also describes the implementation effort. It says that the Government launched project Medicare Alert, with thousands of Federal workers charged with educating people and helping them enroll in the program. Is that correct?

Ms. THOMAS. Yes. They had to go door-to-door to try to reach people, of course, before the Internet, who might not know about the program and make sure they knew they were eligible.

Mr. DAVIS. Means they were serious. One of the biggest challenges of that era——

Ms. THOMAS. They even asked forest rangers to go out in the rural areas.

Mr. DAVIS.—was with hospitals in States that did not want to provide healthcare services to black Americans. I know that this has been a focus of some of your research and some of your writing. Can you tell us a little bit about how this problem was addressed?

Ms. THOMAS. Yes. I would say that one of the greatest moral failures of the private health system and, unfortunately, for a time of the public system as well was its segregation by race of patients and outright denial of care to many Americans in minority groups, so that death rates, disease rates, draft rejection rates, many measures were dramatically higher among African-Americans than among whites, and there is racial disparity in life expectancy and many other health measures that persist to this day.

Mr. DAVIS. And yet we have been able to overcome all of those objections and all of those difficulties where now Medicare is considered a very popular program. Everybody who can get it wants it, and I think it just takes a bit of time. It will take some time with the Affordable Care Act and ultimately I think that Americans are going to feel the same way about the Affordable Care Act that we now feel about Medicare.

Ms. THOMAS. I do——

Mr. DAVIS. And I yield back.

Chairman ISSA. I thank the gentleman.

The gentlelady may answer, if you were mid-sentence.

Ms. THOMAS. Just that it was the combination of the 1964 Civil Rights Act and the Medicare-Medicaid Act of 1965 that definitively integrated the American healthcare system, and it was much more successful in healthcare and has produced some very good results.

Chairman ISSA. I thank you.

I now ask unanimous consent that the New Yorker article entitled GOP Healthcare.gov Too Fast Now be placed in the record. Without objection, so ordered.

Chairman ISSA. We now go to the gentleman from Arizona, Dr. Gosar.

Mr. GOSAR. Thank you very, very much.

Dr. Thomas, just as a background, I am a dentist for 25 years, okay? This is going to be very important to kind of keep track of this. Is Medicare financially sustainable as is?

Ms. THOMAS. No.

Mr. GOSAR. Is Medicaid financially stable as is?
Ms. THOMAS. No.
Mr. GOSAR. Is Obamacare financially stable as is?
Ms. THOMAS. I can't answer that question.
Mr. GOSAR. It's a no. Is Romneycare financially viable as is? No.
Ms. THOMAS. I don't know.
Mr. GOSAR. No. I mean, you are a historian. You better know. You are very flippant with the statistics, and I am about details. And Romneycare isn't financially stable. The only reason it has lasted so long is it is from a rich State. That is it. So aren't they very close to go to a single payer?
Ms. THOMAS. I am sorry, is Romneycare close to a single payer?
Mr. GOSAR. Massachusetts.
Ms. THOMAS. Yes.
Mr. GOSAR. Yeah. That is what I thought. That is how they keep hinting in this way.
I am looking at three problem-solvers here, and that is what is key about this thing, is that when you have a problem, you always go to lowest common denominators to figure them out. Wouldn't you agree?
Ms. THOMAS. I am not sure what you mean by lowest common denominators.
Mr. GOSAR. Well, you figure out all the parts that are part of the problem, you go to the lowest basis and you come up with core principles and build upon simple simplicity. Wouldn't you agree?
Ms. THOMAS. Okay. Sure.
Mr. GOSAR. Would you agree, Dr. De Rugy?
Ms. DE RUGY. [Nonverbal response.]
Mr. GOSAR. Dr. Winston?
Mr. WINSTON. [Nonverbal response.]
Mr. GOSAR. Dr. Calabria?
Mr. CALABRIA. [Nonverbal response.]
Is it possible, the three of you, is that actually possible today in the Federal Government to do that? Quick answer.
Mr. WINSTON. No.
Ms. DE RUGY. No.
Mr. GOSAR. I want to agree with you, because we talked about monopolies, we talked about noncompetitive bids, we talked about all sorts of things. Is there tort reform in this bill, Dr. De Rugy?
Ms. DE RUGY. No.
Mr. GOSAR. Is it part of the problem?
Ms. DE RUGY. I guess part of it.
Mr. GOSAR. Dr. Winston?
Mr. WINSTON. Yes.
Mr. GOSAR. Dr. Calabria?
Mr. CALABRIA. [Nonverbal response.]
Mr. GOSAR. Hey, how about you, Dr. Thomas?
Ms. THOMAS. It is part of the problem, but politically——
Mr. GOSAR. No, I don't care about politically.
Ms. THOMAS. Okay.
Mr. GOSAR. Because you know what? It has to be part of the solution here, okay?

Number two is we brought up monopolies. Do you think that we have handled, Dr. Thomas, the monopolies of insurance industries properly in Obamacare? I'll give you a minute to catch that answer.

How about you, Dr. De Rugy?

Ms. DE RUGY. No, absolutely not.

Mr. GOSAR. Actually, the Federal Government is prohibited from interceding in insurance companies by McCarran-Ferguson, is it not?

Ms. DE RUGY. Yes.

Mr. GOSAR. Dr. Winston?

Mr. WINSTON. Yes.

Mr. GOSAR. So do you see a need for actuarial tables? I mean, 1945 I see actuarial tables being a necessity; we didn't have good computers back then. But today you have an algorithm, your own facts, a computer, you should be able to do it on your own, don't you think Dr. De Rugy?

Ms. DE RUGY. [Nonverbal response.]

Mr. GOSAR. Dr. Winston?

Mr. WINSTON. Times change.

Mr. GOSAR. Absolutely.

Dr. Calabria?

Mr. CALABRIA. Yes.

Mr. GOSAR. So, I mean, one of the key principles here is that we have a collusive environment, right?

Ms. DE RUGY. Yes.

Mr. GOSAR. Oh. Is any part of this bill talking about repealing McCarran-Ferguson?

Mr. WINSTON. No.

Mr. GOSAR. Let me ask you, Dr. De Rugy, because my colleague from Virginia asked a question. Government intervention would be great here, because in this aspect the Federal Government now intercedes and breaks up the monopoly, sends it back to the State, would it be, Dr. De Rugy?

Ms. DE RUGY. Yes, it would be.

Mr. GOSAR. Dr. Winston?

Mr. WINSTON. A quick point, if I could just say, is we are looking to Government to correct distortions. There is too much emphasis on the distortions it "creates," but its main job is to correct the distortions. That is the problem we are having.

Mr. GOSAR. That is exactly, redirect it. So I am getting to this.

Dr. Calabria, do you want to comment on that?

Mr. CALABRIA. I would absolutely agree with that. We need to allow competition, particularly across State lines, in terms of bringing competition to the insurance market.

Mr. GOSAR. Wow. I mean, I want to turn the insurance industry free because they are harnessed right now.

Ms. DE RUGY. Or create a level playing field.

Mr. GOSAR. What is that?

Ms. DE RUGY. Create also a level playing field between employer tax credit and individual market.

Mr. GOSAR. Thank you.

Dr. Thomas, can we treat out way out of this epidemic of healthcare?

Ms. THOMAS. Can we——

Mr. GOSAR. Can we treat our way?

Ms. THOMAS. Treat? No. You have to prevent.

Mr. GOSAR. Oh, absolutely. So what we have actually done is, what I have shown you right here through distortions is, we have actually priced primary care out of the marketplace. From 1965 on, what we started doing is taking the lowest common denominator, which is the private family doctor, and priced them out of the market so that you weren't making any money. And that my good friend highlighted about the committee that redresses CMS, but CMS redirects the reimbursement rate for medical.

There is a reason I brought up dentistry. Can you tell me about the inflationary aspects of dental costs over 30 years versus medical costs over 30 years? Inflationary. Which one is higher?

Ms. THOMAS. Dental costs have stayed much more in line with inflation.

Mr. GOSAR. That is right. And medical more than 20 times. What is the thing that is interesting about the two healthcare models, one has lots of government, almost entirely Federal Government, and one has very little Federal Government. Wouldn't you say that, Dr. Thomas?

Ms. THOMAS. Yes. But the nature of dental care is largely preventive and not anywhere near as expensive as the medical care system, so I don't think you can compare apples to oranges.

Mr. GOSAR. Oh, yes we can. Oh, absolutely. It is paradox that we do this, because in the dental model there is many more primary care physicians than there are specialists. Today, what we have done is reinversed the whole payment model to be a specialist, not a primary care doctor. That is key.

Mr. WINSTON. If I could just quickly add one additional point to what you are getting at. Dental schools and medical schools. Dental schools are closing, and there is less availability of dentists. That too is affecting the market. I would say a similar kind of restriction also exists in medical care in the sense that you still have an entry barrier and a license to provide service and I think the combination of those things are also increasing the costs, and there is another area where Government could intervene to reduce distortions.

Mr. GOSAR. Oh, absolutely.

Chairman ISSA. I thank the gentleman. Suffice to say that the Affordable Care Act does not have preventive dentistry in it, which perhaps was one of the mistakes.

With that, we go to the gentlelady from New Mexico.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman. I really appreciate this hearing. I think it is demonstrating on both sides of the aisle these principles: one, the healthcare system is incredibly complicated, so complicated, in fact, that, when each of us are identifying situations, historical facts, spending trends, it is very difficult to say whether that is a private market issue in and of itself or a Government issue. Some of the best programs that are most cost-effective are where the Government and the provider system, whether that is local or Federal, are effective, that partnership is effective. When it is not effective, you have all kinds of things that we can point to, and members have done this throughout the hearing, demonstrated that the private market, the insurance market on its own certainly hasn't solved any of these problems and has

gotten increasingly more expensive, so has the provider system. The Government systems we can talk about, they have had fluctuations in productive outcomes and not so productive. Some States have great public health outcomes, some States do not.

So, for me, I think that I sort of changed how I want to approach the panel. One, I agree with the chairman that we need to do much more in transparency, and being able to, apples to apples, talk about those effective investments, whether that is policy, regulatory, oversight, transparency, marketing, consumer protection; it is all of those.

I do want to point out that in the conversations that we have had about life expectancy, what we haven't talked about is what sort of investments public health has gotten at the same time. Because if you look at sustainable effective, that is both in terms of amounts and what they are directed at in public health, because States also make significant public health policy decisions, although the bulk of their money largely comes from the Federal Government because States haven't picked up that role because in the United States we don't put a lot of credence in public health, which is the largest effort we could take to do productive, low-cost preventative care. And while there are incentives to do that in public and community health in the Affordable Care Act, we will have to see whether it is, frankly, enough, because like in all of the things that we have done in the United States, we have seven, eight, nine, ten independent systems of care that we try to then roll into one and try to make sense out of it, and I don't think that you can. And where we go from here I think this committee and others are going to have to play a much more significant role in getting that addressed.

So maybe, given that I only have a couple minutes left, I just want to sort of re-ascertain a couple of things from the panel. One, that the private market, by itself, in all of those aspects that I identified, insurance companies, providers, hospitals, for-profit, not-for-profit, by itself has not been able, globally, to do any of the things that I just described; provide access, lower cost, improve outcomes, provide consumer protection, and affect policy in a way that would be meaningful from oversight to better regulatory reform. True? Not true?

Ms. THOMAS. True.

Mr. CALABRIA. I would say not true.

Ms. LUJAN GRISHAM. Okay.

Mr. WINSTON. Not true.

Ms. DE RUGY. I would say not true.

Ms. LUJAN GRISHAM. All right. And I believe that it is true, and I have 30 years. I don't have any of your expertise from your particular aspects, but I navigate healthcare even in this job every single day, and no matter what, it is getting increasingly more complicated. And I would submit that if any of you have—does anybody on the panel have a family member on Medicare or Medicaid?

Ms. THOMAS. Yes.

Mr. CALABRIA. Yes.

Ms. DE RUGY. My family members are in France.

Ms. LUJAN GRISHAM. So arguably better than Medicare. So the two that have family members on Medicare, if Medicare was gone,

would you be able to finance that family member's healthcare on your own?

Ms. THOMAS. Absolutely not. Both my parents died of cancer and their care was subsidized completely by Medicare, and they would not have been able to have that care without Medicare.

Mr. WINSTON. I don't think we know what the system would look like without Medicare. So you are asking me for an imaginary world that I don't have an option of really choosing.

Ms. LUJAN GRISHAM. Right. And I am almost out of time, but also the reality is, and that is my point, that we know that none of these systems are sustainable as they are. We know that without Medicare the private market rates would be much higher because we would have to figure out what we would do with all of those elderly sick people who would also be increasingly accessing emergency rooms and hospitals without any primary or preventative or routine care. And that is before you get to their acute care or chronic care issues that are covered by Medicare.

We have to start figuring out how all of those systems impact the private market, or the lack thereof. The sicker people are in the private market, the higher those costs are. The higher those costs are, limited access to providers. Rural and frontier States are a whole different issue.

So now that I am out of time, and I really appreciate the chairman's support, I would love to see this committee do lots more in transparency. I would love to talk about the models for dental care. There is in fact oral healthcare in the Affordable Care Act; it is pediatric. We are really going to have to talk about better integration for all of these models, and I would support the chairman and this committee spending much more time in healthcare issues such as this hearing than not. So thank you very much.

Mr. GOSAR. [Presiding.] You get no qualm from me at all.

I would like to acknowledge the gentleman from Oklahoma, Mr. Lankford.

Mr. LANKFORD. Thank you, Mr. Chairman.

Thank you all for the time and the conversation. Can we agree on a principle that is economic-wide, I guess, or economy-wide, and that is fair competition is better for the consumer than price controls?

Ms. THOMAS. Yes.

Ms. DE RUGY. Yes.

Mr. LANKFORD. Can that translate into healthcare?

Ms. THOMAS. Yes.

Ms. DE RUGY. Yes, it can.

Mr. LANKFORD. So then the challenge is how does that get managed. If the goal is the benefit to consumer, the patient at this point, and to provide fair competition and to provide multiple voices and as much transparency as you can have in it, there are some issues that are coming up currently right now with our system that get in the way of that. For instance, I know the chairman mentioned earlier this issue of testing reimbursement. If you do, right now, in our system, according to CMS, if you do a histology test, a test for skin cancer or whatever it may be, outside of a hospital, your reimbursement is 50 percent less than it is inside a hospital. So the incentive there is is to do all the testing for the hos-

pitals inside because their rates weren't cut, for the big hospitals; they were for every small lab all around the Country, by 50 percent. Does that promote fair competition?

Is it cheaper to do that test in a hospital or is it less expensive to do that test in an outside lab, typically? I would submit it is probably more expensive to do it in a hospital. I don't know that anyone would disagree with that. They are also reimbursed now 50 percent more. So there is this, again, leaning in to the larger hospitals.

In the Affordable Care Act, it caps the growth of physician-owned hospitals. It set a date for them and said however many rooms you have at this point, you have to remain at that. So physician-owned hospitals are at a permanent disadvantage to the hospital down the street forever. Is that fair competition? Does that benefit the consumer? Does that help us in price and cost and benefit consumers? I don't hear anyone saying that would benefit the consumers. No?

Ms. THOMAS. There have been some problems with physician-owned hospitals that are part of why that measure was passed, but I won't——

Mr. LANKFORD. Was the problem with the patient or—because seven of the ten top hospitals in the Country are physician-owned hospitals, even still right now. But all of them will be capped in the days ahead and refused to grow; they can't expand. So while patients may choose to do that, the Affordable Care Act steps in and says, no, I don't want more competition; I want less competition. To me, that doesn't benefit the consumer; that doesn't benefit, in this case, the taxpayer, even, who is now paying the bill on it, where we are going to pay a higher price at a hospital than we would in the lab. We are going to pay a higher price in this facility, this one. And I am not denigrating those, it just is a step into it to say we want less competition rather than more, and that doesn't seem to work anywhere else.

Durable medical equipment right now, there was a decision by CMS to have fewer companies provide durable medical equipment because it is easier to oversee fewer companies. A large central government can't oversee thousands of durable medical equipment companies, so you need to have fewer companies so the Federal Government can oversee that for fraud.

Right now, our payments out to companies where we can't verify, or individuals, not fraud, just inaccurate payments, we are topping $50 billion in inaccurate payments through Medicare and Medicaid at this point. Can you make that more efficient by putting the controls for that closer to the payment location, closer to those individuals? So that may be a State that oversees that, rather than the Federal Government, instead of having to track it from Washington, D.C. Does it make it more efficient to oversee those things from a State or local municipality, or to try to do it all from a central location?

Ms. DE RUGY. The State would make more sense.

Mr. LANKFORD. So if we are going to go after inaccurate payments, is it better to make those decisions closer, and check for fraud and check for inaccuracies closer, rather than a centralized location? It seems like everybody is onboard with that. These are some of the challenges that we have.

While we can talk about some of the healthcare issues, there is a basic principle of economics that we want fair competition and we want to increase competition, and the Affordable Care Act is reducing the number of opportunities out there, reducing the number of places, so we are actually reducing the amount of competition and we are saying, every area of the economy, free and fair competition works well except in healthcare, where we have to have more price controls, because that is "different."

In Oklahoma City right now we have two hospitals that have all of their prices online for their procedures. It started with one hospital that did it. And the push to get all your prices online has now pushed another hospital to say, okay, we will put all of our prices online as well, and be able to detail out. What was interesting, the first hospital that did it, I talked to the gentleman that runs the hospital, he said we were surprised when we put all of our prices online. Guess who came first? The Canadians. The Canadians came first to our hospital. We suddenly became a spot for medical tourism because they were tired of waiting six months in Canada for a procedure, so they would fly to Oklahoma City, have the procedure done there, when they knew exactly what the price was and to be able to fly home.

It is the same thing that is happening right now in our Veterans Administration. I have veterans call my office all the time. It takes six months for them to get a knee replacement or they could cross the street and go to a fantastic hospital, OU Medical Center, and get it done on Tuesday. But for some reason we have this concept that we have to do price controls and have to do central control because this is healthcare, when in everything else it seems to work well with free and fair competition. We have to find a way to do this.

Integris Hospital in Oklahoma City is one of the best transplant hospitals in the world; fantastic facility, incredibly well run. People come from all over the place to come to it because of the quality of the services and the openness of what they do. We have to be able to push back on some of this.

With that, I yield back.

Mr. GOSAR. I want to take off on that for a second. Could you explain to me, Dr. Thomas, why a procedure done out in a family doctor's procedure under Medicare is billed under Medicare Part A, but then the same procedure by a physician under a hospital is billed under Medicare Part B? You can't defend that. And that is what is happening. We are allowing, willy-nilly, these rules to be unequivocally violated right and left. It is the same procedure. Buildings, each office has their own space to have to look at in overhead. So there is no reason why you have to allow hospitals to get reimbursements that sometimes double the price of a Medicare Part A aspect.

One other thing that I wanted to highlight in your earlier testimony. It is not just about emergency rooms, is it, about access to care? I thought that was under federally qualified health centers, that your ability to pay could not stem you from not getting treatment. Is that true? Federally qualified health centers have a sliding fee scale in which they have to see you, but not based upon your ability to pay. It is. I mean, I served kitty-corner from one for

many, many years. So there are more opportunities out there than meets the eye.

The gentleman from California, Mr. Cardenas.

Mr. CARDENAS. Thank you very much, Mr. Chairman. I would like to thank the panel for availing yourselves to this committee so that we can hopefully improve on our understanding of what is going on with healthcare in our Country.

But there has been a lot of discussion today, and I guess rightfully so, because the hearing title is The Limitations of Big Government, the Rollout of Healthcare.gov. So a lot of discussion has been about Government and whether or not Government has a role. But earlier in a discussion, as a result of a question from one of my colleagues, the three non-healthcare expert panelists, all of you seemed to agree that private sector is more efficient than Government when it comes to providing services and/or systems to Americans. Is that consistent with what your answers are today?

Mr. WINSTON. When the goal is to provide an economically efficient product or service, yes. You have to be very clear on what you are trying to do. In other words, the market is not great at necessarily providing some specific targeted service to a particular individual who can't pay for it. The market may not do that. So, again, you have to be very clear on what your objective is. But generally, if you are talking more about the efficient production and provision of goods and services, yes, I think the evidence is overwhelming that the market is superior for Government. In fact, Government rarely corrects those problems.

Mr. CARDENAS. Any of the other panelists want to clarify?

Mr. CALABRIA. I would pretty much agree with that and clarify the point that certainly the market, I think, has proven itself to be of lower cost and have more innovation. I think it is incredibly important to parse out that a lot of times what we are talking about is an income problem. And again, as I said earlier, all resources have cost. If someone has zero income, that is not a market failure; they can't afford those goods. You could make the same thing about Government. If you had a group of people with zero income, obviously they can't pay taxes to support Government either. We don't call that a Government failure. So I do think we need to separate out the difference between are we talking about a problem that is purely of poverty? Are we talking about a failure of the healthcare system? And those are two separate issues and I think we combine them, quite frankly.

Ms. DE RUGY. I agree with what has been said, but I would like to add that Government very often, even when there is, let's say, we see a role like providing healthcare for low-income people who couldn't get it on their own, doesn't do that very well either. I mean, we have been talking about expanding Medicaid, but there has been no discussion about health outcome for people who are in Medicaid. And a lot of the things that I have read, whether it was the Oregon study, it is like it is not a desirable outcome, or it could be improved; and I think we need to also talk about outcomes versus just providing delivery.

Mr. CARDENAS. Well, I just wanted to clarify. Fortunately, all three of you do provide a service when it comes to the exercise of trying to understand where Government should or should not be

playing a role. However, the fundamental problem that we have in this Country with the private sector is that the private sector has the right to ignore who they serve and where they draw the line at how much they are going to charge or not serve at all. Yet, in our Government, in this Country, in many cases the Government has passed legislation and created laws that say we are not going to ignore. For example, an extreme case is when somebody shows up to an emergency room in this Country.

I don't know how they do it in other countries, it is a big world, but in this Country, if somebody shows up in the emergency room, that provider of service, private or public, is required to stop the bleeding, regardless of the cost and regardless of the ability to pay. And that is the fundamental difference that I have with having a discussion that tries to have a purity of discussion about how Government doesn't have a role in XYZ, yet at the same time the private sector would do a better job or perhaps would provide better. But the fundamental problem that we have is, especially when it comes to healthcare, the private sector has the right, insurance company A has the right to tell person B if they approach that company and say I would like to apply for insurance, they have the right to say, mm-mm, we checked all of what we provide, we cannot provide service for you, we are not going to insure you. They have the right to do that.

And fundamentally we have anywhere between 40 to 50-plus million people in this Country who, some of them, fall into that category that, no matter how hard they are going to try, the private industry is not going to provide for them; and that is where the Affordable Care Act is trying to thread that needle and saying is there a way in which, in this great Country, we can actually provide that to some of those 40 to 50 million people, and not all, to some of those 40 to 50 million people that on the natural, as the system is before the Affordable Care Act is in full bloom, that those private sector corporations have the legal right to say, sorry, we don't have a policy for you, go to the next place or do whatever you wish, but don't come here.

Dr. Thomas, is that an accurate portrayal of what one of our dilemmas is right now in this Country, that we are trying to tackle?

Ms. THOMAS. Yes.

Mr. CARDENAS. I am out of time, so, Mr. Chairman, they are welcome to answer.

Mr. GOSAR. The witnesses may answer if they would like to answer.

Mr. CARDENAS. Thank you very much.

Mr. WINSTON. What you are characterizing is something what we call in economics merit goods. That is, these are goods that American society believes, goods and services, that people are entitled to regardless of whether they can afford them or not.

I think what has changed over time is, yes, the Government can step in and say, given democratic outcomes, we support the provision of these goods or services. We are now discussing and thinking about, okay, given that that is the case, what is the least cost way of providing those goods and services? I think people might think it is through the Government. So the question about Medicare is saying if we didn't have Medicare, what would happen to people?

You have to construct what we call a counterfactual, that is, really construct what would have happened in the absence of the policy. So increasingly people are saying, Marty Feldstein is most notably, saying if we had private health accounts, that might be able to achieve the goals that Medicare is trying to achieve at lower cost. And I think the questions we are raising about ACA and I think the debate will follow, universal coverage, fine. What now is the least cost way of doing that?

Mr. CARDENAS. Mr. Chairman, if I may, I appreciate that accurate portrayal of arriving at ideal solutions, but unfortunately we live in a very dynamic, humanistic world where ideal solutions will perhaps never be attained.

Thank you. I yield back.

Mr. GOSAR. I thank the gentleman.

I would like to recognize the gentleman from Pennsylvania, Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Dr. Gosar. I want to thank the chairman and Ranking Member Cummings for putting together this fascinating panel and allowing this interesting philosophical discussion that we have been having. Also thank you to my colleague, Mr. Cardenas, for weighing in on that as well.

For my own part, I will say I think the Government of the United States of America has been responsible for some of the most innovative and successful programs the world has ever seen. When we talk about Social Security, we talk about a program that has lifted people out of poverty, as you have said, Dr. Thomas. When we talked about Medicare, same thing, a program that has enabled regular people to avoid medical bankruptcy, to qualify for treatment, as in the case of your parents, Dr. Thomas. And so many Americans depend on Social Security and Medicare. I will be an unceasing advocate for both of those programs, as well as other Federal programs.

Our interstate highway and rail system transports millions of people daily, safely. The Environmental Protection Agency ensures clean drinking water and breathable air for Americans. Our brave soldiers in the military put together a program that is the envy of the free world, our American military, our soldiers and sailors. The Consumer Product Safety Commission ensures that Americans feel secure in their purchases. The Federal grants, loans, and work study funds provided to our students enable higher education to become a reality for millions of Americans.

And then when we get to this ACA, absolutely it has been a rocky rollout and, in my view, we are going to have further work to do on it. We may well be tinkering with the ACA for years to come, but my view is and my prediction is that history will look kindly back on the Affordable Care Act as just another in a long line of examples of American greatness.

Dr. Thomas, I want to follow up with you. I would like to ask you about Social Security a little bit. You touched on it. The implementation of that program was hugely controversial at the time, in the 1930s, and not without its own challenges, but today, like Medicare, it is obviously an extremely admirable, successful, and popular program. I have an article here that was published on Oc-

tober 28, 2013, and it is entitled What About Social Security's Rollout.

Dr. Gosar, I ask unanimous consent that this article be inserted into the public record.

Mr. GOSAR. So ordered.

Mr. CARTWRIGHT. Dr. Thomas, this article describes many of the problems facing Social Security in its first several years, and it compares them to what we are seeing now in the ACA. For example, the article says this: "After the Nation's major social program finally became law, critics regularly blamed it for slowing the economy and a swelling of the Federal bureaucracy. Fierce congressional opposition led to the formation of a blue ribbon panel to overhaul Social Security. Obamacare, in 2013? Not quite. It was Social Security in 1937."

Dr. Thomas, it seems obvious, but would you agree that the implementation of a large-scale Federal Government program like Social Security takes time?

Ms. THOMAS. I would agree, and I would also add that anything that is ambitious that will actually enact real change is bound to encounter problems.

Mr. CARTWRIGHT. Well, I want to go on quoting the article. "Created in 1935, the Social Security program took 40 years just to include all working Americans in its basic coverage. When old-age insurance program launched in 1937, barely more than half of the labor force participated. A series of amendments to the Social Security Act gradually expanded the coverage and by 1979 it finally reached over 90 percent of American workers."

Dr. Thomas, the history of Social Security implementation seems to support the idea that the Government is in fact capable of effectively administering a large-scale program like this that helps millions and millions of Americans. Would you agree with that?

Ms. THOMAS. Yes. The administration of the program has evolved over time, but is certainly working smoothly at this point, and Social Security has evolved over a period of more than 70 years. For instance, the amendments to include domestic and agricultural workers, to make sure that they were covered, they weren't passed until, I believe, 1950 because there was such political opposition in the south previous to that, when the law was passed originally. So over time new priorities are brought into the law that improve its function.

Mr. CARTWRIGHT. And I say let's work together and improve the ACA and make it work for us over time.

With that, I yield back, Dr. Gosar.

Mr. GOSAR. Well, I want to let Dr. De Rugy answer a question. She wanted to answer one of your questions.

Ms. DE RUGY. What I wanted to say about Social Security was, and that is one of the problems with Government, is like sometimes Government creates a program because there is an actual need, and the problem is you then go back 60 years later and that need may not be there for a majority of the people it serves, but then the problem stays in place. And that is the case. Fifteen Federal agencies have run a state of seniors in America right now and you can see that their conditions have dramatically improved, and yet this program still serves everyone as if everyone is in poverty.

The other thing I would add is that if Democrats like Social Security so much, why not try to reform it? This is a system that is bankrupt. In 2035, and probably before, when the trust fund expires, the prediction is that benefits will have to be cut across the board by 25 percent. The people who will be hurt the most are the people, the seniors who, at the time, still actually are poor. So I want to say if we think it is a program that provides a valuable service to seniors who are poor, why not reform to make sure that when that time comes they will not be the ones hurt the most?

Mr. GOSAR. Dr. Winston, did you want to make a comment?

Mr. WINSTON. No.

Mr. GOSAR. How about you, Dr. Calabria?

Mr. CALABRIA. I was going to add. Veronique touched on this, but I do think we have talked about the benefits of Medicare, Social Security, and these programs, but again, as mentioned, I will echo something that the gentleman from Illinois, Representative Davis, said about the young and the elderly. Programs that leave trillions of dollars of debt for the young to pay off, programs that make promises to the elderly that cannot be kept, that is not compassion, in my view.

Mr. GOSAR. That is creating cripples.

I just want to ask you, Dr. Thomas—I have a few extra moments and the privilege of sitting in the chair—are we healthier as a Nation right now?

Ms. THOMAS. Healthier than when?

Mr. GOSAR. Oh, let's talk about the 1930s. Rising rates of diabetes? Was diabetes as high then as it is now?

Ms. THOMAS. We have dramatically improved life expectancy——

Mr. GOSAR. So let me ask you another question. Compared to other industrialized nations, how healthy are we? Let's compare diabetes.

Ms. THOMAS. Well, I can tell you off the top of my head that the infant mortality——

Mr. GOSAR. No, we are not comparing apples to apples here.

Ms. THOMAS. I am going to agree with you.

Mr. GOSAR. I want to talk to you about obesity.

Ms. THOMAS. Okay.

Mr. GOSAR. Let's talk about obesity. Let's not change the subject, let's go directly to apples-to-apples. Obesity.

Ms. THOMAS. Fortunately, the obesity epidemic has leveled off and is beginning to improve, but, yes, that is a major healthcare problem.

Mr. GOSAR. I would disagree on that. Diabetes?

Ms. THOMAS. Also a major healthcare problem.

Mr. GOSAR. Absolutely. So I want to bring you back to talking about——

Ms. THOMAS. They are diseases of affluence.

Mr. GOSAR. What is that?

Ms. THOMAS. They are diseases of affluence.

Mr. GOSAR. I don't know about that. You know, good eating policy, I am one of those guys. I am Celiac Sprue, by the way, so I am allergic to wheat and gluten, so that is why I am kind of the incredible shrinking guy. But we have to have patient accountability in this process. For example, for me, as Celiac Sprue, I have

a seven day greater chance of getting any type of lymphoma. Okay? So what we want to do is have prevention. So what I want to see is I want an insurance come to me and say, listen, Dr. Gosar, we know that early detection of lymphoma is the best way and the cheapest way, so we are going to give you some incentives to come and have a physical twice during three years, and if you do that we are going to give you a kickback for doing that. You reincentivize good behavior. It is like our eating, our snack program. I have some problems with our snack program. Don't you? All that sugary stuff on those? I mean, you are public health. Come on, now.

Ms. THOMAS. I would definitely like to improve that, yes.

Mr. GOSAR. Okay, so tell me what is on the WIC program that everybody shouldn't be on? Women, infants, and children; complex carbohydrates, complex proteins. Why shouldn't we be all on that?

Ms. THOMAS. Well, some of us can't eat that without getting sick.

Mr. GOSAR. Name one. Name one diet that you won't get sick on. I am cautioning you once again, this is my forte, so if it is good enough for women, infants, and children——

Ms. THOMAS. Give me some specific examples.

Mr. GOSAR. I am asking you for specific examples. You said——

Ms. THOMAS. I don't have the WIC formulary in my head, I am sorry.

Mr. GOSAR. Oh, it is complex proteins and complex carbohydrates, so there are no simple sugars, maybe outside of a few fruit choices. I think if you are on government assistance, we should be all on the WIC program. Don't you think? If it is good enough for women, infants, and children, I am just telling you, those are one of the groups that was highlighted today, one of the weakest groups here, that if it meets a criteria of meeting that formulation for——

Ms. THOMAS. But they have different nutritional needs than everybody else. I am not sure where you are going.

Mr. GOSAR. Not necessarily. No, not necessarily. Can you tell me the public health mantra, was it a success in Indian Health Services? I mean, you heard about the integration for African-Americans. Tell me about the Indian Americans. It was a disaster. It has not been great. In fact, part of the trust obligations from the Federal Government was to work in concert with the Tribes, not to dictate to them. Isn't it true that the Tribes have an option out of ACA because of self-determination, and they are taking it? They are actually building their own hospitals. They are doing their own thing because they want to breed the aspect of prevention and patient accountability.

Ms. THOMAS. And you say the Indian Health Service has not done that?

Mr. GOSAR. They haven't. I mean, I am from Indian country. I can tell you that right now. The Navaho Nation and the San Carlos Tribe, they are all privatizing, because Government came in and said these are the services we are going to give you, regardless of what you want, we are going to do this accordingly, and it was a failure.

Thirty percent of my patient base in my practice came to me to pay for my services because they valued them. Because they could

have got it free from the Federal Government and they refused. There is something to learn from that experience there, and I hope that you go back and look at your notes, because some of the things you are citing aren't exactly factual historically.

Last comments. Dr. De Rugy, from the standpoint of this hearing, is there anything that you would like to comment in regards?

Ms. DE RUGY. No. I mean, I think that we need to remember that even when the Government is well intentioned, a lot of the ways that it intervenes actually goes even against the goal that they have set of themselves, and we also need to remember that it always introduces distortion and that Government officials, unfortunately, have a great incentive to listen to interest groups.

Mr. GOSAR. So it is not about whether the Government is involved, it is a balance, wouldn't you say?

Ms. DE RUGY. Sorry?

Mr. GOSAR. Trying to find a balance of Government involvement.

Ms. DE RUGY. Well, I think one of the things that we have learned is that Government fails, and one of the best ways to prevent them is to actually limit the purview of Government intervention.

Mr. GOSAR. And maybe hold people accountable for things poorly done.

Ms. DE RUGY. Absolutely.

Mr. GOSAR. Dr. Winston, final comments.

Mr. WINSTON. My final comments are that an awful lot of the discussion has been looking backward; there has been reference to history, Medicare, Social Security, things done in the past. The world changes, and I think it is probably more important to start looking forward, the future, looking for new ways in which we want to try to do things, recognizing that, yes, maybe in a different time Government was effective in doing something, initiating, doing it, but things change. And if there are other ways in which we can try to achieve the goal we are trying to do it, particularly with the market, we should be experimenting and be more open-minded to the fact that we don't have to be wedded to the past and look for new ways of doing things.

Mr. GOSAR. I like that aspect. You always have to look at your past before you go forward, because you are doomed to repeat the past if you don't.

Dr. Calabria.

Mr. CALABRIA. I will end with maybe summarizing a few points. First of all, of course, I think sometimes there is a bit of a strawman aspect to the market not being perfect, the Government not being perfect. Of course, as we know, there are no perfect institutions; they all have their flaws, and I think we need to find the better that works out of any of those institutions.

I will reiterate a point I made a couple times before, which is I do think that there is a confusion between what is essentially a poverty problem and a failure of various markets. If you have zero income, you can't afford anything. That doesn't mean that all of those markets are failing. And, again, the way to address that is to try to address poverty directly, which I will say, as an aside, I think the overwhelming evidence across countries and across his-

tory is if you really, seriously want to reduce poverty, extending the market is the way to do it, and creating wealth in that regard.

Finally, we often sort of hear a moral argument made. I will be very clear that my preference oftentimes for markets is not simply an issue of efficiency. But I believe that markets are, by and large, based on consensus, where I believe it was the gentleman from Virginia made the point about us not getting along. Well, the part of us not getting along is you can use the Government to force me to do things I don't want to; whereas, in the marketplace, for me to sell you something, I have to come to a price in agreement and terms on which you agree. So my goal as a generality is how do we try to build society more on consensus and cooperation, rather than coercion.

Mr. GOSAR. And customer service.

Dr. Thomas, your last comments.

Ms. THOMAS. Well, I would agree with I believe it was Ms. Grisham who said that the health system works best when Government and nonprofits and for-profits all cooperate in the most efficient way, and that is what I am advocating. I also agree with Dr. Winston, who said times are changing, and even as a historian I don't think that we can do things exactly the way they did in 1935. But I think a sign that things really are changing is that the American Medical Association, which has opposed every national health insurance proposal since 1939, in 2010, supported the Affordable Care Act, and, in fact the AMA's executive vice president, Michael D. Maves, admitted that we don't believe that maintaining the status quo is an acceptable option for physicians or the patients we serve. I think that is a very important turning point that we are at.

Mr. GOSAR. I don't think anybody will disagree that what we have as status quo would work. I am here because of that. I just don't think the solution that we have on the table works, because we didn't get everything on the table put on the table. At that time, the AMA represented about 18 percent of all physicians across the Country, hardly a vote of acknowledgment. And I think they are actually rescinding that aspect now; they don't particularly care about that, if I am not mistaken. So statistics can be used a certain way.

The last thing I would like to say is that when we look at problems, problem-solvings, we have to look at where our costs are spent. You made a comment about we are spending a lot of money. In Medicaid and Medicare, the dual eligibles are the ones we are spending the most money on, and these are problem-solvings that we want the best of the best. And there are two pools, there are the seniors that are so poor with Medicaid and Medicare, and there are the youngers that have real chronic conditions like multiple sclerosis and that aspect. It is ingenuity that sets us free, and that is why I came back to McCarron-Ferguson, okay? I want to turn the insurance industry upside down. I want them to be revolutionized to compete for my dollars, because I want new incentive programs based on me, customer service. That is one of the things that we have to get back to. Not Government dictated, but good customer service; patient-centered, patient-friendly. When we put all the market factors working on behalf of people, not making

them cripples but to empower them to make health choices, they win.

Ms. THOMAS. But how can you turn that insurance industry upside down without an outside force?

Mr. GOSAR. That is why I said McCarron-Ferguson.

Ms. THOMAS. Okay.

Mr. GOSAR. I want choice. My choices are very different, as I elaborated, versus somebody else's. So breaking up the common denominator, if all of us are physicians here, we can't collude on prices. Okay? But insurance companies do. Okay? So what I want to do is I want to see the innovation within the insurance industry and show me what I don't even know. They are the experts in that. I am an expert in dentistry. I want them to show me what is possible, because I haven't dreamed it yet. Neither have you; neither has anybody here.

What I see at this panel is the people that bring the building blocks of what you can envision as success, and we haven't got it. And what I think we saw from this panel is Government can't do that. When you talk about monopolies, noncompetitive bidding practices, Davis-Bacon, it goes on and on and on. I mean, look at the bid process of this website. There was no competitive bid. Tell me that a Davis-Bacon job is different than a private sector job. It isn't. But it is 22 percent, on average, higher. It doesn't make any sense today. So we should be big people today and ask that all the pieces be put on the table. It is not a Republican, it is not a Democratic issue; it is an American issue, putting it out there and having a transparent discussion. We haven't that. And until we do, we are not going to get a solution.

Thank you very much for this panel and we stand adjourned.

[Whereupon, at 12:26 p.m., the committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Opening Statement
Ranking Member Elijah E. Cummings

Hearing on "The Roll Out of HealthCare.gov: The Limitations of Big Government"

December 4, 2013

Thank you, Mr. Chairman, and welcome to our witnesses here today. I look forward to an informative and spirited discussion.

According to the Chairman's invitation letters, today the Committee will examine "the institutional limitations on the efficacy of government action." And our case study will be the rollout of the HealthCare.gov website. The fundamental presumption underlying this hearing is that the federal government is somehow incapable of successfully administering large-scale programs. In fact, the Republican staff briefing memo challenges "government's ability to effectively design, implement, and administer large scale projects and programs."

The problem with this presumption is that it does not take into account the many extremely successful government programs that have helped millions of Americans throughout our history.

In 1935, President Roosevelt signed into law the Social Security Act—the centerpiece of our social safety net. When it first launched, critics panned its confusing procedures, and less than half of the labor force participated. Over time, however, it has reached 90% of American workers and has been expanded to cover the self-employed, to include dependent and survivor benefits, and to provide for cost of living adjustments.

Thirty years later, in 1965, President Johnson signed Medicare into law. Like the Social Security rollout, there were challenges initially, and the American Medical Association called it "the beginning of socialized medicine." The federal government had to negotiate with hospitals, nursing homes, and insurance companies, and it had to coordinate with all 50 states. Eventually, 93% of eligible seniors enrolled in Medicare, and the program has been expanded and improved several times since then.

Forty years after that, in 2005, President Bush signed into law the prescription drug program under Part D of the Medicare law. Like Social Security and Medicare before it, this drug program also experienced challenges in its rollout. Newspaper headlines were dire, stating "Confusion Reigns Over Drug Plans," "Not Ready for Prime Time," and "Prescription-Drug Plan Part D Gets an Early 'F.'"

In all of these cases, early setbacks were resolved, critics were proved incorrect, and these programs are now immensely popular with the American people. But more importantly, they prevented our nation's seniors from dying penniless and homeless. They provide a basic level of security to the American people where the private sector failed to do so.

The same is true of the Affordable Care Act. The private insurance market discriminated for decades against people with preexisting conditions. Insurance companies threw people off existing plans when they discovered evidence of previous illnesses that patients themselves did not know about. But now, thanks to the ACA, millions of Americans who could not get health insurance in the private market now have access to it.

In terms of today's hearing, I think everyone understands what is going on. The Republicans want to use the initial challenges with the HealthCare.gov website to make a broader argument that the federal government cannot administer large-scale programs effectively and that we are all better off leaving things to the private sector. But we have tried that, and it simply does not work.

I believe the premise for today's hearing is fundamentally flawed. Our country's experience with Social Security in 1935, Medicare in 1965, and the prescription drug program in 2005 demonstrates that our government is fully capable of overcoming initial problems with the implementation of programs that help millions of people in their daily lives.

This premise becomes even more absurd when you look at our nation's broader history. In the 1940s, we mobilized our entire country—our people, our industry, and our workers—to defeat the Nazis and the Japanese in World War II. In the 1960s, we tapped the best and brightest minds in government and the private sector to build a space program that put a man on the moon for the first time in human history. Our government does not always work as well as it should, but it is certainly capable of great things when there is a strong commitment to the underlying goals we all share.

In the case of the ACA, we all know that one component of the rollout—the HealthCare.gov website—did not work as it should have. But we also know from testimony before this Committee that another component—the complicated interagency data hub that most experts worried about—worked much more smoothly. And that is a testament to the strong work of the agencies and contractors involved.

As we go forward, I hope we can all work together to solve any problems that arise in order to improve the program so it works effectively and efficiently. In that way, we can honor the commitment we made in the Affordable Care Act to help people who could not get health insurance to obtain it now. I look forward to hearing from today's witnesses.

Contact: Jennifer Hoffman, Communications Director, (202) 226-5181.

Alexander Fleming

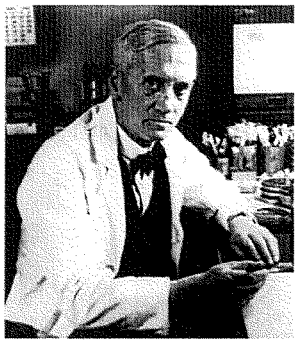
From Wikipedia, the free encyclopedia

For other uses, see Alexander Fleming (disambiguation).

Sir Alexander Fleming, FRSE, FRS,FRCS(Eng) (6 August 1881 – 11 March 1955) was a Scottish biologist, pharmacologist andbotanist. He wrote many articles on bacteriology, immunology, and chemotherapy. His best-known discoveries are the enzymelysozyme in 1923 and the antibiotic substancepenicillin from the mould *Penicillium notatum*in 1928, for which he shared the Nobel Prize in Physiology or Medicine in 1945 with Howard Florey and Ernst Boris Chain.[1]

Contents [hide]

Sir Alexander Fleming
FRSE, FRS, FRCS(Eng)



Born	6 August 1881 Lochfield, Ayrshire, Scotland
Died	11 March 1955 (aged 73) London, England
Citizenship	United Kingdom
Nationality	Scottish
Fields	Bacteriology, immunology
Alma mater	Royal Polytechnic Institution St Mary's Hospital Medical School Imperial College London
Known for	Discovery of penicillin
Notable awards	Nobel Prize in Physiology or Medicine (1945)

Signature

Biography [edit]

Early life and education [edit]

Fleming was born on 6 August 1881 at Lochfield farm near Darvel, in Ayrshire, Scotland. He was the third of the four children of farmer Hugh Fleming (1816–1888) from his second marriage to Grace Stirling Morton (1848–1928), the daughter of a neighbouring farmer. Hugh Fleming had four surviving children from his first marriage. He was 59 at the time of his second marriage, and died when Alexander (known as Alec) was seven.

Fleming went to Loudoun Moor School and Darvel School, and earned a two-year scholarship to Kilmamock Academy before moving to London, where he attended the Royal Polytechnic Institution.[2] After working in a shipping office for four years, the twenty-year-old Fleming inherited some money from an uncle, John Fleming. His elder brother, Tom, was already a

physician and suggested to his younger sibling that he follow the same career. and so in 1903, the younger Alexander enrolled at St Mary's Hospital Medical School in Paddington; he qualified with an MBBS degree from the school with distinction in 1906.

Fleming had been a private in the London Scottish Regiment of the Volunteer Force since 1900,[1] and had been a member of the rifle club at the medical school. The captain of the club, wishing to retain Fleming in the team suggested that he join the research department at St Mary's, where he became assistant bacteriologist to Sir Almroth Wright, a pioneer invaccine therapy and immunology. In 1908, he gained a BSc degree with Gold Medal inBactericlogy, and became a lecturer at St Mary's until 1914. On 23 December 1915, Fleming married a trained nurse, Sarah Marion McElroy of Killala, County Mayo, Ireland.

Fleming served throughout World War I as a captain in the Royal Army Medical Corps, and was Mentioned in Dispatches. He and many of his colleagues worked in battlefield hospitals at the Western Front in France. In 1918 he returned to St Mary's Hospital, where he was elected Professor of Bacteriology of the University of London in 1928.

Research [edit]

Work before penicillin [edit]

Following World War I, Fleming actively searched for anti-bacterial agents, having witnessed the death of many soldiers from sepsis resulting from infected wounds. Antiseptics killed the patients' immunological defences more effectively than they killed the invading bacteria. In an article he submitted for the medical journal *The Lancet* during World War I, Fleming described an ingenious experiment, which he was able to conduct as a result of his own glass blowing skills, in which he explained why antiseptics were killing more soldiers than infection itself during World War I. Antiseptics worked well on the surface, but deep wounds tended to shelter anaerobic bacteria from the antiseptic agent, and antiseptics seemed to remove beneficial agents produced that protected the patients in these cases at least as well as they removed bacteria, and did nothing to remove the bacteria that were out of reach. SirAlmroth Wright strongly supported Fleming's findings, but despite this, most army physicians over the course of the war continued to use antiseptics even in cases where this worsened the condition of the patients.

Accidental discovery [edit]

Main article: History of penicillin

Miracle cure.

"When I woke up just after dawn on September 28, 1928, I certainly didn't plan to revolutionise all medicine by discovering the world's first antibiotic, or bacteria killer," Fleming would later say, "But I suppose that was exactly what I did."[3]

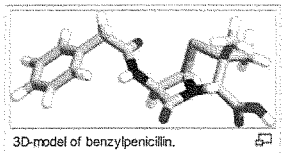
By 1927, Fleming was investigating the properties of staphylococci. He was already well-known from his earlier work, and had developed a reputation as a brilliant researcher, but his laboratory was often untidy. On 3 September 1928, Fleming returned to his laboratory having spent August on holiday with his family. Before leaving, he had stacked all his cultures of staphylococci on a

bench in a corner of his laboratory. On returning, Fleming noticed that one culture was contaminated with a fungus, and that the colonies of staphylococci that had immediately surrounded it had been destroyed, whereas other colonies farther away were normal. Fleming showed the contaminated culture to his former assistant Merlin Price, who reminded him, *"That's how you discovered lysozyme."*[4] Fleming grew the mould in a pure culture and found that it produced a substance that killed a number of disease-causing bacteria. He identified the mould as being from the *Penicillium* genus, and, after some months of calling it *"mould juice"*, named the substance it released *penicillin* on 7 March 1929.[5] The laboratory in which Fleming discovered and tested penicillin is preserved as the Alexander Fleming Laboratory Museum in St. Mary's Hospital, Paddington.

He investigated its positive anti-bacterial effect on many organisms, and noticed that it affected bacteria such as staphylococci and many other Gram-positive pathogens that causescarlet fever, pneumonia, meningitis and diphtheria, but not typhoid fever or paratyphoid fever, which are caused by Gram-negative bacteria, for which he was seeking a cure at the time. It also affected *Neisseria gonorrhoeae*, which causes gonorrhoea although this bacterium is Gram-negative.

Fleming published his discovery in 1929, in the British *Journal of Experimental Pathology*,[6]but little attention was paid to his article. Fleming continued his investigations, but found that cultivating *penicillium* was quite difficult, and that after having grown the mould, it was even more difficult to isolate the antibiotic agent. Fleming's impression was that because of the problem of producing it in quantity, and because its action appeared to be rather slow, penicillin would not be important in treating infection. Fleming also became convinced that penicillin would not last long enough in the human body (*in vivo*) to kill bacteria effectively. Many clinical tests were inconclusive, probably because it had been used as a surface antiseptic. In the 1930s, Fleming's trials occasionally showed more promise,[7] and he continued, until 1940, to try to interest a chemist skilled enough to further refine usable penicillin. Fleming finally abandoned penicillin, and not long after he did, Howard Florey andErnst Boris Chain at the Radcliffe Infirmary in Oxford took up researching and mass-producing it, with funds from the U.S. and British governments. They started mass production after the bombing of Pearl Harbor. By D-Day in 1944, enough penicillin had been produced to treat all the wounded in the Allied forces.

Purification and stabilisation [edit]



3D-model of benzylpenicillin.

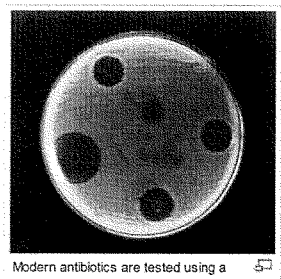
In Oxford, Ernst Boris Chain and Edward Abraham discovered how to isolate and concentrate penicillin. Abraham was the first to propose the correct structure of penicillin.[8][9]Shortly after the team published its first results in 1940, Fleming telephoned Howard Florey, Chain's head of department, to say that he would be visiting within the next few days. When Chain heard that he was coming, he remarked *"Good God! I thought he was dead."*

Norman Heatley suggested transferring the active ingredient of penicillin back into water by changing its acidity. This produced enough of the drug to begin testing on animals. There were many more people involved in the Oxford team, and at one point the entire Dunn School was involved in its production.

After the team had developed a method of purifying penicillin to an effective first stable form in 1940, several clinical trials ensued, and their amazing success inspired the team to develop methods for mass production and mass distribution in 1945.

Fleming was modest about his part in the development of penicillin, describing his fame as the *"Fleming Myth"* and he praised Florey and Chain for transforming the laboratory curiosity into a practical drug. Fleming was the first to discover the properties of the active substance, giving him the privilege of naming it: penicillin. He also kept, grew, and distributed the original mould for twelve years, and continued until 1940 to try to get help from any chemist who had enough skill to make penicillin. But Sir Henry Harris said in 1998: *"Without Fleming, no Chain; without Chain, no Florey; without Florey, no Heatley; without Heatley, no penicillin."*[10]

Antibiotics [edit]



Modern antibiotics are tested using a method similar to Fleming's discovery

Fleming's accidental discovery and isolation of penicillin in September 1928 marks the start of modern antibiotics. Before that, several scientists had published or pointed out that mould or*penicillium sp.* were able to inhibit bacterial growth, and even to cure bacterial infections in animal (Ernest Duchesne in 1897 in his thesis "Contribution to the study of vital competition in micro-organisms: antagonism between moulds and microbes",[11] or also Clodomiro Picado Twight whose work at Institut Pasteur in 1923 on the inhibiting action of fungi of the "Penicillin sp" genre in the growth of staphylococci drew little interest from the direction of the Institut at the time). Fleming was the first to push these studies further by isolating the penicillin, and by being motivated enough to promote his discovery at a larger scale. Fleming also discovered very early that bacteria developed antibiotic resistance whenever too little penicillin was used or when it was used for too short a period.Almroth Wright had predicted antibiotic resistance even before it was noticed during experiments. Fleming cautioned about the use of penicillin in his many speeches around the world. He cautioned not to use penicillin unless there was a properly diagnosed reason for it to be used, and that if it were used, never to use too little, or for too short a period, since these are the circumstances under which bacterial resistance to antibiotics develops.

Personal life [edit]

The popular story[12] of Winston Churchill's father paying for Fleming's education after Fleming's father saved young Winston from death is false. According to the biography,*Penicillin Man: Alexander Fleming and the Antibiotic Revolution* by Kevin Brown, Alexander Fleming, in a letter[13] to his friend and colleague Andre Gratia,[14] described this as *"A wondrous fable."* Nor did he save Winston Churchill himself during World War II. Churchill was saved by Lord Moran, using sulphonamides, since he had no experience with penicillin, when Churchill fell ill in Carthage in Tunisia in 1943. The *Daily Telegraph* and the *Morning Post* on 21 December 1943 wrote that he had been saved by penicillin. He was saved by the new sulphonamide drug, Sulphapyridine, known at the time under the research code M&B 693, discovered and produced by May & Baker Ltd, Dagenham, Essex – a

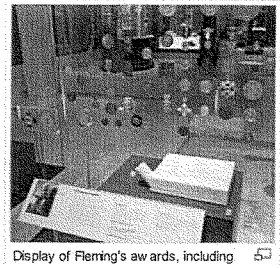
subsidiary of the French group Rhône-Poulenc. In a subsequent radio broadcast, Churchill referred to the new drug as "*This admirable M&B.*".[15] It is highly probable that the correct information about thesulphonamide did not reach the newspapers because, since the original sulphonamide antibacterial, Prontosil, had been a discovery by the German laboratory Bayer, and as Britain was at war with Germany at the time, it was thought better to raise British morale by associating Churchill's cure with the British discovery, penicillin.

Fleming's first wife, Sarah, died in 1949. Their only child, Robert Fleming, became a general medical practitioner. After Sarah's death, Fleming married Dr. Amalia Koutsouri-Vouvekas, aGreek colleague at St. Mary's, on 9 April 1953; she died in 1986.[16]

Death [edit]

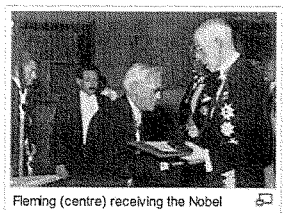
In 1955, Fleming died at his home in London of a heart attack. He was buried in St Paul's Cathedral.[17]

Honours, awards and achievements [edit]

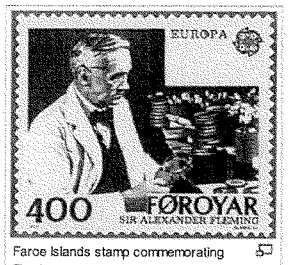


Display of Fleming's awards, including his Nobel Prize. Also shows a sample of penicillin and an example of an early apparatus for preparing penicillin.

His discovery of penicillin had changed the world of modern medicine by introducing the age of usefulantibiotics; penicillin has saved, and is still saving, millions of people around the world.[18]



Fleming (centre) receiving the Nobel prize from King Gustaf V of Sweden (right) in 1945



Faroe Islands stamp commemorating Fleming

The laboratory at St Mary's Hospital where Fleming discovered penicillin is home to theFleming Museum, a popular London attraction. His alma mater, St Mary's Hospital Medical School, merged with Imperial College London in 1988. The Sir Alexander Fleming Building on theSouth Kensington campus was opened in 1998 and is now one of the main preclinical teaching sites of the Imperial College School of Medicine.

His other alma mater, the Royal Polytechnic Institution (now the University of Westminster) has named one of its student halls of residence *Alexander Fleming House*, which is near toOld Street.

- Fleming, Florey and Chain jointly received the Nobel Prize in Medicine in 1945. According to the rules of the Nobel committee a maximum of three people may share the prize. Fleming's Nobel Prize medal was acquired by the National Museums of Scotland in 1989 and is on display after the museum re-opened in 2011.[19]
- Fleming was a member of the Pontifical Academy of Sciences.[1]
- Fleming was awarded the Hunterian Professorship by the Royal College of Surgeons of England.
- Fleming was knighted, as a Knight Bachelor, by king George VI in 1944.[20]
- He was made a Knight Grand Cross of the Order of Alfonso X the Wise in 1948.
- In 1999, *Time* magazine named Fleming one of the 100 Most Important People of the 20th century, stating:

> “It was a discovery that would change the course of history. The active ingredient in that mould, which Fleming named penicillin, turned out to be an infection-fighting agent of enormous potency. When it was finally recognized for what it was, the most efficacious life-saving drug in the world, penicillin would alter forever the treatment of bacterial infections. By the middle of the century, Fleming's discovery had spawned a hugepharmaceutical industry, churning out synthetic penicillins that would conquer some of mankind's most ancient scourges, including syphilis,gangrene and tuberculosis.[21]”

- When 2000 was approaching, at least three large Swedish magazines ranked penicillin as the most important discovery of the millennium.
- In 2002, Fleming was named in the BBC's list of the 100 Greatest Britons following a nationwide vote.[22]
- A statue of Alexander Fleming stands outside the main bullring in Madrid, Plaza de Toros de Las Ventas.[23] It was erected by subscription from grateful matadors, as penicillin greatly reduced the number of deaths in the bullring.[23]
- Flemingovo náměstí is a square named after Fleming in the university area of the Dejvicecommunity in Prague.
- A secondary school is named after him in Sofia, Bulgaria.
- In mid-2009, Fleming was commemorated on a new series of banknotes issued by theClydesdale Bank; his image appears on the new issue of £5 notes.[24]
- 91006 Fleming, an asteroid in the Asteroid Belt, is named after Fleming.

Washington Monthly

Donated for the veteran display

The Best Care Anywhere

Ten years ago, veterans hospitals were dangerous, dirty, and scandal-ridden. Today, they're producing the highest quality care in the country. Their turnaround points the way toward solving America's health-care crisis.

By Phillip Longman

Phillip Longman discusses his book, *Best Care Anywhere*, with Paul Glastris, Editor in Chief of the *Washington Monthly*. Longman's book was based on this January/February 2005 *Washington Monthly* Article.

Quick. When you read "veterans hospital," what comes to mind? Maybe you recall the headlines from a dozen years ago about the three decomposed bodies found near a veterans medical center in Salem, Va. Two turned out to be the remains of patients who had wandered months before. The other body had been resting in place for more than 15 years. The Veterans Health Administration (VHA) admitted that its search for the missing patients had been "cursory."

Or maybe you recall images from movies like *Born on the Fourth of July*, in which Tom Cruise plays a wounded Vietnam vet who becomes radicalized by his shabby treatment in a crumbling, rat-infested veterans hospital in the Bronx. Sample dialogue: "This place is a fuckin' slum!"

By the mid-1990s, the reputation of veterans hospitals had sunk so low that conservatives routinely used their example as a kind of reductio ad absurdum critique of any move toward "socialized medicine." Here, for instance, is Jarret B. Wollstein, a right-wing activist/author, railing against the Clinton health-care plan in 1994: "To see the future of health care in America for you and your children under Clinton's plan," Wollstein warned, "just visit any Veterans Administration hospital. You'll find filthy conditions, shortages of everything, and treatment bordering on barbarism."

And so it goes today. If the debate is over health-care reform, it won't be long before some free-market conservative will jump up and say that the sorry shape of the nation's veterans hospitals just proves what happens when government gets into the health-care business. And if he's a true believer, he'll then probably go on to suggest, quoting William Safire and other free marketers, that the government should just shut down the whole miserable system and provide veterans with health-care vouchers.

Yet here's a curious fact that few conservatives or liberals know. Who do you think receives higher-quality health care. Medicare patients who are free to pick their own doctors and specialists? Or aging veterans stuck in those presumably filthy VA hospitals with their antiquated equipment, uncaring administrators, and incompetent staff? An answer came in 2003, when the prestigious *New England Journal of Medicine* published a study that compared

veterans health facilities on 11 measures of quality with fee-for-service Medicare. On all 11 measures, the quality of care in veterans facilities proved to be "significantly better."

Here's another curious fact. The *Annals of Internal Medicine* recently published a study that compared veterans health facilities with commercial managed-care systems in their treatment of diabetes patients. In seven out of seven measures of quality, the VA provided better care.

It gets stranger. Pushed by large employers who are eager to know what they are buying when they purchase health care for their employees, an outfit called the National Committee for Quality Assurance today ranks health-care plans on 17 different performance measures. These include how well the plans manage high blood pressure or how precisely they adhere to standard protocols of evidence-based medicine such as prescribing beta blockers for patients recovering from a heart attack. Winning NCQA's seal of approval is the gold standard in the health-care industry. And who do you suppose this year's winner is: Johns Hopkins? Mayo Clinic? Massachusetts General? Nope. In every single category, the VHA system outperforms the highest rated non-VHA hospitals.

Not convinced? Consider what vets themselves think. Sure, it's not hard to find vets who complain about difficulties in establishing eligibility. Many are outraged that the Bush administration has decided to deny previously promised health-care benefits to veterans who don't have service-related illnesses or who can't meet a strict means test. Yet these grievances are about access to the system, not about the quality of care received by those who get in. Veterans groups tenaciously defend the VHA and applaud its turnaround. "The quality of care is outstanding," says Peter Gayton, deputy director for veterans affairs and rehabilitation at the American Legion. In the latest independent survey, 81 percent of VHA hospital patients express satisfaction with the care they receive, compared to 77 percent of Medicare and Medicaid patients.

Outside experts agree that the VHA has become an industry leader in its safety and quality measures. Dr. Donald M. Berwick, president of the Institute for Health Care Improvement and one of the nation's top health-care quality experts, praises the VHA's information technology as "spectacular." The venerable Institute of Medicine notes that the VHA's "integrated health information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation."

If this gives you cognitive dissonance, it should. The story of how and why the VHA became the benchmark for quality medicine in the United States suggests that much of what we think we know about health care and medical economics is just wrong. It's natural to believe that more competition and consumer choice in health care would lead to greater quality and lower costs, because in almost every other realm, it does. That's why the Bush administration—which has been promoting greater use of information technology and other quality improvement in health care—also wants to give individuals new tax-free "health savings accounts" and high-deductible insurance plans. Together, these measures are supposed to encourage patients to do more comparison shopping and haggling with their doctors; therefore, they create more market discipline in the system.

But when it comes to health care, it's a government bureaucracy that's setting the standard for maintaining best practices while reducing costs, and it's the private sector that's lagging in quality. That unexpected reality needs examining if we're to have any hope of understanding what's wrong with America's health-care system and how to fix it. It turns out that precisely because the VHA is a big, government-run system that has nearly a lifetime relationship with its patients, it has incentives for investing in quality and keeping its patients well—incentives that are lacking in for-profit medicine.

Hitting bottom

By the mid-1990s, the veterans health-care system was in deep crisis. A quarter of its hospital beds were empty. Government audits showed that many VHA surgeons had gone a year without picking up a scalpel. The population of veterans was falling sharply, as aging World War II and Korean War vets began to pass away. At the same time, a mass migration of veterans from the Snowbelt to the Sunbelt overwhelmed hospitals in places such as Tampa with new patients, while those in places such as Pittsburgh had wards of empty beds.

Serious voices called for simply dismantling the VA system. Richard Cogan, a senior fellow at the Center on Budget and Policy Priorities in Washington, told *The New York Times* in 1994: "The real question is whether there should be a veterans health care system at all." At a time when the other health-care systems were expanding outpatient clinics, the VHA still required hospital stays for routine operations like cataract surgery. A patient couldn't even receive a pair of crutches without checking in. Its management system was so ossified and top-down that permission for such trivial expenditures as $9.82 for a computer cable had to be approved in Washington at the highest levels of the bureaucracy.

Yet few politicians dared to go up against the powerful veterans lobby, or against the many unions that represented much of the VHA's workforce. Instead, members of Congress fought to have new veterans hospitals built in their districts, or to keep old ones from being shuttered. Three weeks before the 1996 presidential election, in part to keep pace with Bob Dole's promises to veterans, President Clinton signed a bill that planned, as he put it, to "furnish comprehensive medical services to all veterans," regardless of their income or whether they had service-related disabilities.

So, it may have been politics as usual that kept the floundering veterans health-care system going. Yet behind the scenes, a few key players within the VHA had begun to look at ways in which the system might heal itself. Chief among them was Kenneth W. Kizer, who in 1994 had become VHA's undersecretary for health, or, in effect, the system's CEO.

A physician trained in emergency medicine and public health, Kizer was an outsider who immediately started upending the VHA's entrenched bureaucracy. He oversaw a radical downsizing and decentralization of management power, implemented pay-for-performance contracts with top executives, and won the right to fire incompetent doctors. He and his team also began to transform the VHA from an acute care, hospital-based system into one that put far more resources into primary care and outpatient services for the growing number of aging veterans beset by chronic conditions.

By 1998, Kizer's shake-up of the VHA's operating system was already earning him management guru status in an era in which management gurus were practically demigods. His story appeared that year in a book titled *Straight from the CEO: The World's Top Business Leaders Reveal Ideas That Every Manager Can Use* published by Price Waterhouse and Simon & Schuster. Yet the most dramatic transformation of the VHA didn't just involve such trendy, 1990s ideas as downsizing and reengineering. It also involved an obsession with systematically improving quality and safety that to this day is still largely lacking throughout the rest of the private health-care system.

Amercia's worst hospitals

To understand the larger lessons of the VHA's turnaround, it's necessary to pause for a moment to think about what comprises quality health care. The first criterion likely to come to mind is the presence of doctors who are highly trained, committed professionals. They should know a lot about biochemistry, anatomy, cellular and molecular immunology, and other details about how the human body works—and have the academic credentials to prove it. As it happens, the VHA has long had many doctors who answer to that description. Indeed, most VHA doctors have faculty appointments with academic hospitals.

But when you get seriously sick, it's not just one doctor who will be involved in your care. These days, chances are you'll see many doctors, including different specialists. Therefore, how well these doctors communicate with one another and work as a team matters a lot. "Forgetfulness is such a constant problem in the system," says Berwick of the Institute for Health Care Improvement. "It doesn't remember you. Doesn't remember that you were here and here and then there. It doesn't remember your story."

Are all your doctors working from the same medical record and making entries that are clearly legible? Do they have a reliable system to ensure that no doctor will prescribe drugs that will interact harmfully with medications prescribed by another doctor? Is any one of them going to take responsibility for coordinating your care so that, for example, you don't leave the hospital without the right follow-up medication or knowing how and when to take it? Just about anyone who's had a serious illness, or tried to be an advocate for a sick loved one, knows that all too often the answer is no.

Doctors aren't the only ones who define the quality of your health care. There are also many other people involved—nurses, pharmacists, lab technicians, orderlies, even custodians. Any one of these people could kill you if they were to do their jobs wrong. Even a job as lowly as changing a bedpan, if not done right, can spread a deadly infection throughout a hospital. Each of these people is part of an overall system of care, and if the system lacks cohesion and quality control, many people will be injured and many will die.

Just how many? In 1999, the Institute of Medicine issued a groundbreaking study, titled *To Err is Human*, that still haunts health care professionals. It found that up to 98,000 people die of medical errors in American hospitals each year. This means that as many as 4 percent of all deaths in the United States are caused by such lapses as improperly filled or administered

prescription drugs—a death toll that exceeds that of AIDS, breast cancer, or even motor vehicle accidents.

Since then, a cavalcade of studies have documented how a lack of systematic attention not only to medical errors but to appropriate treatment has made putting yourself into a doctor's or hospital's care extraordinarily risky. The practice of medicine in the United States, it turns out, is only loosely based on any scientifically driven standards. The most recent and persuasive evidence came from study by Dartmouth Medical School published last October in *Health Affairs*. It found that even among the "best hospitals," as rated by *U.S. News & World Report*, Medicare patients with the same conditions receive strikingly different patterns and intensities of care from one another, with no measurable difference in their wellbeing.

For example, among patients facing their last six months of life, those who are checked into New York's renowned Mount Sinai Medical Center will receive an average of 53.9 visits from physicians, while those who are checked into Duke University Medical Center will receive only 20.9. Yet all those extra doctors' visits at Mount Sinai bring no gain in life expectancy, just more medical bills. By that measure of quality, many of the country's most highly rated hospitals are actually its shoddiest.

Worse, even when strong scientific consensus emerges about appropriate protocols and treatments, the health-care industry is extremely slow to implement them. For example, there is little controversy over the best way to treat diabetes; it starts with keeping close track of a patient's blood sugar levels. Yet if you have diabetes, your chances are only one-out-four that your health care system will actually monitor your blood sugar levels or teach you how to do it. According to a recent RAND Corp. study, this oversight causes an estimated 2,600 diabetics to go blind every year, and anther 29,000 to experience kidney failure.

All told, according to the same RAND study, Americans receive appropriate care from their doctors only about half of the time. The results are deadly. On top of the 98,000 killed by medical errors, another 126,000 die from their doctor's failure to observe evidence-based protocols for just four common conditions: hypertension, heart attacks, pneumonia, and colorectal cancer.

Now, you might ask, what's so hard about preventing these kinds of fatal lapses in health care? The airline industry, after all, also requires lots of complicated teamwork and potentially dangerous technology, but it doesn't wind up killing hundreds of thousands of its customers each year. Indeed, airlines, even when in bankruptcy, continuously improve their safety records. By contrast, the death toll from medical errors alone is equivalent to a fully loaded jumbo-jet crashing each day.

Laptop medicine

Why doesn't this change? Well, much of it has changed in the veterans health-care system, where advanced information technology today serves not only to deeply reduce medical errors, but also to improve diagnoses and implement coordinated, evidence-based care. Or at least so I kept reading in the professional literature on health-care quality in the United States. I arranged to

visit the VA Medical Center in Washington, D.C. to see what all these experts were so excited about.

The complex' main building is a sprawling, imposing structure located three miles north of the Capitol building. When it was built in 1972, it was in the heart of Washington's ghetto, a neighborhood dangerous enough though one nurse I spoke with remembered having to lock her car doors and drive as fast as she could down Irving Street when she went home at night.

Today, the surrounding area is rapidly gentrifying. And the medical center has evolved, too. Certain sights, to be sure, remind you of how alive the past still is here. In its nursing home facility, there are still a few veterans of World War I. Standing outside of the hospital's main entrance, I was moved by the sight of two elderly gentlemen, both standing at near attention, and sporting neatly pressed Veterans of Foreign Wars dress caps with MIA/POW insignias. One turned out to be a survivor of the Bataan Death March.

But while history is everywhere in this hospital, it is also among the most advanced, modern health-care facilities in the globe—a place that hosts an average of four visiting foreign delegations a week. The hospital has a spacious generic lobby with a food court, ATM machines, and a gift shop. But once you are in the wards, you notice something very different: doctors and nurses wheeling bed tables with wireless laptops attached down the corridors. How does this change the practice of medicine? Opening up his laptop, Dr. Ross Fletcher, an avuncular, white-haired cardiologist who led the hospital's adoption of information technology, begins a demonstration.

With a key stroke, Dr. Fletcher pulls up the medical records for one of his current patients—an 87-year-old veteran living in Montgomery County, Md. Normally, sharing such records with a reporter or anyone else would, of course, be highly unethical and illegal, but the patient, Dr. Fletcher explains, has given him permission.

Soon it becomes obvious why this patient feels that getting the word out about the VHA's information technology is important. Up pops a chart showing a daily record of his weight as it has fluctuated over a several-month period. The data for this chart, Dr. Fletcher explains, flows automatically from a special scale the patient uses in his home that sends a wireless signal to a modem.

Why is the chart important? Because it played a key role, Fletcher explains, in helping him to make a difficult diagnosis. While recovering from Lyme Disease and a hip fracture, the patient began periodically complaining of shortness of breath. Chest X-rays were ambiguous and confusing. They showed something amiss in one lung, but not the other, suggesting possible lung cancer. But Dr. Fletcher says he avoided having to chase down that possibility when he noticed a pattern jumping out of the graph generated from the patient's scale at home.

The chart clearly showed that the patient gained weight around the time he experienced shortness of breath. This pattern, along with the record of the hip fracture, helped Dr. Fletcher to form a hypothesis that turned out to be accurate. A buildup of fluid in the patient's lung was causing him to gain weight. The fluid gathered only in one lung because the patient was consistently sleeping

on one side to cope with the pain from his hip fracture. The fluid in the lung indicated that the patient was in immediate need of treatment for congestive heart failure, and, fortunately, he received it in time.

The same software program, known as VistA, also plays a key role in preventing medical errors. Kay J. Craddock, who spent most of her 28 years with the VHA as a nurse, and who today coordinates the use of the information systems at the VA Medical Center, explains how. In the old days, pharmacists did their best to decipher doctors' handwritten prescription orders, while nurses, she says, did their best to keep track of which patients should receive which medicines by shuffling 3-by-5 cards.

Today, by contrast, doctors enter their orders into their laptops. The computer system immediately checks any order against the patient's records. If the doctors working with a patient have prescribed an inappropriate combination of medicines or overlooked the patient's previous allergic reaction to a drug, the computer sends up a red flag. Later, when hospital pharmacists fill those prescriptions, the computer system generates a bar code that goes on the bottle or intravenous bag and registers what the medicine is, who it is for, when it should be administered, in what dose, and by whom.

Each patient also has an ID bracelet with its own bar code, and so does each nurse. Before administering any drug, a nurse must first scan the patient's ID bracelet, then her own, and then the barcode on the medicine. If she has the wrong patient or the wrong medicine, the computer will tell her. The computer will also create a report if she's late in administering a dose, "and saying you were just too busy is not an excuse," says Craddock.

Craddock cracks a smile when she recalls how nurses reacted when they first were ordered to use the system. "One nurse tried to get the computer to accept her giving an IV, and when it wouldn't let her, she said, 'you see, I told you this thing is never going to work.' Then she looked down at the bag." She had mixed it up with another, and the computer had saved her from a career-ending mistake. Today, says Craddock, some nurses still insist on getting paper printouts of their orders, but nearly all applaud the computer system and its protocols. "It keeps them from having to run back and forth to the nursing station to get the information they need, and, by keeping them from making mistakes, it helps them to protect their license." The VHA has now virtually eliminated dispensing errors.

In speaking with several of the young residents at the VA Medical Center, I realized that the computer system is also a great aid to efficiency. At the university hospitals where they had also trained, said the residents, they constantly had to run around trying to retrieve records—first upstairs to get X-rays from the radiology department, then downstairs to pick up lab results. By contrast, when making their rounds at the VA Medical Center, they just flip open their laptops when they enter a patient's room. In an instant, they can see not only all of the patient's latest data, but also a complete medical record going back as far as the mid-1980s, including records of care performed in any other VHA hospital or clinic.

Along with the obvious benefits this brings in making diagnoses, it also means that residents don't face impossibly long hours dealing with paperwork. "It lets these twentysomethings go

home in time to do the things twentysomethings like to do," says Craddock. One neurologist practicing at both Georgetown University Hospital and the VA Medical Center reports that he can see as many patients in a few hours at the veterans hospital as he can all day at Georgetown.

By this summer, anyone enrolled in the VHA will be able to access his or her own complete medical records from a home computer, or give permission for others to do so. "Think what this means," says Dr. Robert M. Kolodner, acting chief health informatics officer for the VHA. "Say you're living on the West Coast, and you call up your aging dad back East. You ask him to tell you what his doctor said during his last visit and he mumbles something about taking a blue pill and white one. Starting this summer, you'll be able to monitor his medical record, and know exactly what pills he is supposed to be taking."

The same system reminds doctors to prescribe appropriate care for patients when they leave the hospital, such as beta blockers for heart attack victims, or eye exams for diabetics. It also keeps track of which vets are due for a flu shot, a breast cancer screen, or other follow-up care—a task virtually impossible to pull off using paper records. Another benefit of electronic records became apparent last September when the drug-maker Merck announced a recall of its popular arthritis medication, Vioxx. The VHA was able to identify which of its patients were on the drug within minutes, and to switch them to less dangerous substitutes within days.

Similarly, in the midst of a nationwide shortage of flu vaccine, the system has also allowed the VHA to identify, almost instantly, those veterans who are in greatest need of a flu shot and to make sure those patients have priority. One aging relative of mine—a man who has had cancer and had been in and out of nursing homes—wryly reports that he beat out 5,000 other veterans in the New London, Conn., area for a flu shot. He's happy that his local veterans hospital called him up to tell him he qualified, but somewhat alarmed by what this implies about his health.

The VistA system also helps to put more science into the practice of medicine. For example, electronic medical records collectively form a powerful database that enables researchers to look back and see which procedures work best without having to assemble and rifle through innumerable paper records. This database also makes it possible to discover emerging disease vectors quickly and effectively. For example, when a veterans hospital in Kansas City noticed an outbreak of a rare form of pneumonia among its patients, its computer system quickly spotted the problem: All the patients had been treated with what turned out to be the same bad batch of nasal spray.

Developed at taxpayer expense, the VistA program is available for free to anyone who cares to download it off the Internet. The link is to a demo, but the complete software is nonetheless available. You can try it out yourself by going to http://www1.va.gov/CPRSdemo/. Not surprisingly, it is currently being used by public health care systems in Finland, Germany, and Nigeria. There is even an Arabic language version up and running in Egypt. Yet VHA officials say they are unaware of any private health care system in the United States that uses the software. Instead, most systems are still drowning in paper, or else just starting to experiment with far more primitive information technologies.

Worse, some are even tearing out their electronic information systems. That's what happened at Cedars-Sinai Medical Center in Los Angeles, which in 2003 turned off its brand-new, computerized physician order entry system after doctors objected that it was too cumbersome. At least six other hospitals have done the same in recent years. Another example of the resistance to information technology among private practice doctors comes from the Hawaii Independent Physicians Association, which recently cancelled a program that offered its members $3,000 if they would adopt electronic medical records. In nine months, there were only two takers out of its 728 member doctors.

In July, Connecting for Health—a public-private cooperative of hospitals, health plans, employers and government agencies—found that persuading doctors in small- to medium-sized practices to adopt electronic medical records required offering bonuses of up to 10 percent of the doctors' annual income. This may partly be due to simple techno-phobia or resistance to change. But the broader reason, as we shall see, is that most individual doctors and managed care providers in the private sector often lack a financial incentive to invest for investing in electronic medical records and other improvements to the quality of the care they offer.

This is true even when it comes to implementing low-tech, easy-to-implement safety procedures. For example, you've probably heard about surgeons who operate on the wrong organ or limb. So-called "wrong site" surgery happens in about one out of 15,000 operations, with those performing foot and hand surgeries particularly likely to make the mistake. Most hospitals try to minimize this risk by having someone use a magic marker to show the surgeon where to cut. But about a third of time, the VHA has found, the root problem isn't that someone mixed up left with right; it's that the surgeon is not operating on the patient he thinks he is. How do you prevent that?

Obviously, in the VHA system, scanning the patient's ID bracelet and the surgical orders helps, but even that isn't foolproof. Drawing on his previous experience as a NASA astronaut and accident investigator, the VHA's safety director, Dr. James Bagian, has developed a five-step process that VHA surgical teams now use to verify both the identity of the patient and where they are supposed to operate. Though it's similar to the check lists astronauts go through before blast off, it is hardly rocket science. The most effective part of the drill, says Bagian, is simply to ask the patient, in language he can understand, who he is and what he's in for. Yet the efficacy of this and other simple quality-control measures adopted by the VHA makes one wonder all the more why the rest of the health-care system is so slow to follow.

Why care about quality?

Here's one big reason. As Lawrence P. Casalino, a professor of public health at the University of Chicago, puts it, "The U.S. medical market as presently constituted simply does not provide a strong business case for quality."

Casalino writes from his own experience as a solo practitioner, and on the basis of over 800 interviews he has since conducted with health-care leaders and corporate health care purchasers. While practicing medicine on his own in Half Moon Bay, Calif, Casalino had an idealistic commitment to following emerging best practices in medicine. That meant spending lots of time

teaching patients about their diseases, arranging for careful monitoring and follow-up care, and trying to keep track of what prescriptions and procedures various specialists might be ordering.

Yet Casalino quickly found out that he couldn't sustain this commitment to quality, given the rules under which he was operating. Nobody paid him for the extra time he spent with his patients. He might have eased his burden by hiring a nurse to help with all the routine patient education and follow-up care that was keeping him at the office too late. Or he might have teamed up with other providers in the area to invest in computer technology that would allow them to offer the same coordinated care available in veterans hospitals and clinics today. Either step would have improved patient safety and added to the quality of care he was providing. But even had he managed to pull them off, he stood virtually no chance of seeing any financial return on his investment. As a private practice physician, he got paid for treating patients, not for keeping them well or helping them recover faster.

The same problem exists across all health-care markets, and its one main reason in explaining why the VHA has a quality performance record that exceeds that of private-sector providers. Suppose a private managed-care plan follows the VHA example and invests in a computer program to identify diabetics and keep track of whether they are getting appropriate follow-up care. The costs are all upfront, but the benefits may take 20 years to materialize. And by then, unlike in the VHA system, the patient will likely have moved on to some new health-care plan. As the chief financial officer of one health plan told Casalino: "Why should I spend our money to save money for our competitors?"

Or suppose an HMO decides to invest in improving the quality of its diabetic care anyway. Then not only will it risk seeing the return on that investment go to a competitor, but it will also face another danger as well. What happens if word gets out that this HMO is the best place to go if you have diabetes? Then more and more costly diabetic patients will enroll there, requiring more premium increases, while its competitors enjoy a comparatively large supply of low-cost, healthier patients. That's why, Casalino says, you never see a billboard with an HMO advertising how good it is at treating one disease or another. Instead, HMO advertisements generally show only healthy families.

In many realms of health care, no investment in quality goes unpunished. A telling example comes from semi-rural Whatcom County, Wash. There, idealistic health-care providers banded together and worked to bring down rates of heart disease and diabetes in the country. Following best practices from around the country, they organized multi-disciplinary care teams to provide patients with counseling, education, and navigation through the health-care system. The providers developed disease protocols derived from evidence-based medicine. They used information technology to allow specialists to share medical records and to support disease management.

But a problem has emerged. Who will pay for the initiative? It is already greatly improving public health and promises to bring much more business to local pharmacies, as more people are prescribed medications to manage their chronic conditions and will also save Medicare lots of money. But projections show that, between 2001 and 2008, the initiative will cost the local hospital $7.7 million in lost revenue, and reduce the income of the county's medical specialists

by $1.6 million. An idealistic commitment to best practices in medicine doesn't pay the bills. Today, the initiative survives only by attracting philanthropic support, and, more recently, a $500,000 grant from Congress.

For health-care providers outside the VHA system, improving quality rarely makes financial sense. Yes, a hospital may have a business case for purchasing the latest, most expensive imaging devices. The machines will help attract lots of highly-credentialed doctors to the hospital who will bring lots of patients with them. The machines will also induce lots of new demand for hospital services by picking up all sorts of so-called "pseudo-diseases." These are obscure, symptomless conditions, like tiny, slow-growing cancers, that patients would never have otherwise become aware of because they would have long since died of something else. If you're a fee-for-service health-care provider, investing in technology that leads to more treatment of pseudo-disease is a financial no-brainer.

But investing in any technology that ultimately serves to reduce hospital admissions, like an electronic medical record system that enables more effective disease management and reduces medical errors, is likely to take money straight from the bottom line. "The business case for safety...remains inadequate...[for] the task," concludes Robert Wachter, M.D., in a recent study for Health Affairs in which he surveyed quality control efforts across the U.S. health-care system.

If health care was like a more pure market, in which customers know the value of what they are buying, a business case for quality might exist more often. But purchasers of health care usually don't know, and often don't care about its quality, and so private health-care providers can't increase their incomes by offering it. To begin with, most people don't buy their own health care; their employers do. Consortiums of large employers may have the staff and the market power necessary to evaluate the quality of health-care plans and to bargain for greater commitments to patient safety and evidence-based medicine. And a few actually do so. But most employers are not equipped for this. Moreover, in these days of rapid turnover and vanishing post-retirement health-care benefits, few employers have any significant financial interest in their workers' long-term health.

That's why you don't see many employers buying insurance that covers smoking cessation programs or the various expensive drugs that can help people to quit the habit. If they did, they'd be being buying more years of healthy life per dollar than just about any other way they could use their money. But most of the savings resulting from reduced lung cancer, stroke, and heart attacks would go to future employers of their workers, and so such a move makes little financial sense.

Meanwhile, what employees value most in health care is maximum choice at minimal cost. They don't want the boss man telling them they must use this hospital or that one because it has the best demonstrated quality of care. They'll be their own judge of quality, thank-you, and they'll usually base their choice on criteria like: "My best friend recommended this hospital," or "This doctor agrees with my diagnosis and refills the prescriptions I want," or "I like this doctor's bedside manner." If more people knew how dangerous it can be to work with even a good doctor

in a poorly run hospital or uncoordinated provider network, the premium on doctor choice would be much less decisive, but for now it still is.

And so we get results like what happened in Cleveland during the 1990s. There, a well-publicized initiative sponsored by local businesses, hospitals and physicians identified several hospitals as having significantly higher than expected mortality rates, longer than expected hospital stays, and worse patient satisfaction. Yet, not one of these hospitals ever lost a contract because of their poor performance. To the employers buying health care in the community, and presumably their employees as well, cost and choice counted for more than quality. Developing more and better quality measures in health care is a noble cause, but it's not clear that putting more information into health-care markets will change these hard truths.

Health for service

So what's left? Consider why, ultimately, the veterans health system is such an outlier in its commitment to quality. Partly it's because of timely, charismatic leadership. A quasi-military culture may also facilitate acceptance of new technologies and protocols. But there are also other important, underlying factors.

First, unlike virtually all other health-care systems in the United States, VHA has a near lifetime relationship with its patients. Its customers don't jump from one health plan to the next every few years. They start a relationship with the VHA as early as their teens, and it endures. That means that the VHA actually has an incentive to invest in prevention and more effective disease management. When it does so, it isn't just saving money for somebody else. It's maximizing its own resources.

The system's doctors are salaried, which also makes a difference. Most could make more money doing something else, so their commitment to their profession most often derives from a higher-than-usual dose of idealism. Moreover, because they are not profit maximizers, they have no need to be fearful of new technologies or new protocols that keep people well. Nor do they have an incentive to clamor for high-tech devices that don't improve the system's quality or effectiveness of care.

And, because it is a well-defined system, the VHA can act like one. It can systematically attack patient safety issues. It can systematically manage information using standard platforms and interfaces. It can systematically develop and implement evidence-based standards of care. It can systematically discover where its care needs improvement and take corrective measures. In short, it can do what the rest of the health-care sector can't seem to, which is to pursue quality systematically without threatening its own financial viability.

Hmm. That gives me an idea. No one knows how we're ever going to provide health care for all these aging baby boomers. Meanwhile, in the absence of any near-term major wars, the population of veterans in the United States will fall dramatically in the next decade. Instead of shuttering under-utilized VHA facilities, maybe we should build more. What if we expanded the veterans health-care system and allowed anyone who is either already a vet or who agrees to perform two years of community service a chance to buy in? Indeed, what if we said to young

and middle-aged people, if you serve your community and your country, you can make your parents or other loved ones eligible for care in an expanded VHA system?

The system runs circles around Medicare in both cost and quality. Unlike Medicare, it's allowed by law to negotiate for deep drug discounts, and does. Unlike Medicare, it provides long-term nursing home care. And it demonstrably delivers some of the best, if not the best, quality health care in the United States with amazing efficiency. Between 1999 and 2003, the number of patients enrolled in the VHA system increased by 70 percent, yet funding (not adjusted for inflation) increased by only 41 percent. So the VHA has not only become the health care industry's best quality performer, it has done so while spending less and less on each patient. Decreasing cost and improving quality go hand and hand in industries like autos and computers—but in health care, such a relationship virtually unheard of. The more people we can get into the VHA, the more efficient and effective the American health-care system will be.

We could start with demonstration projects using VHA facilities that are currently under-utilized or slated to close. Last May, the VHA announced it was closing hospitals in Pittsburgh; Gulfport, Miss.; and Brecksville, Ohio. Even after the closures, the VHA will still have more than 4 million square feet of vacant or obsolete real estate. Beyond this, there are empty facilities available from bankrupt HMOs and public hospitals, such as the defunct D.C. General. Let the VHA take over these facilities, and apply its state-of-the-art information systems, safety systems, and protocols of evidence-based medicine.

Once fully implemented, the plan would allow Americans to avoid skipping from one health-care plan to the next over their lifetimes, with all the discontinuities in care and record keeping and disincentives to preventative care that this entails. No matter where you moved in the country, or how often you changed jobs, or where you might happen to come down with an illness, there would be a VHA facility nearby where your complete medical records would be available and the same evidence-based protocols of medicine would be practiced.

You might decide that such a plan is not for you. But, as with mass transit, an expanded VHA would offer you a benefit even if you didn't choose to use it. Just as more people riding commuter trains means fewer cars in your way, more people using the VHA would mean less crowding in your own, private doctor's waiting room, as well as more pressure on your private health-care network to match the VHA's performance on cost and quality.

Why make public service a requirement for receiving VHA care? Because it's in the spirit of what the veterans health-care system is all about. It's not an entitlement; it's recognition for those who serve. America may not need as many soldiers as in the past, but it has more need than ever for people who will volunteer to better their communities.

Would such a system stand in danger of becoming woefully under-funded, just as the current VHA system is today? Veterans comprise a declining share of the population, and the number of Americans who have personal contact with military life continues to shrink. It is therefore not surprising that veterans health-care issues barely register on the national agenda, even in times of war. But, as with any government benefit, the broader the eligibility, the more political support it is likely to receive. Many veterans will object to the idea of sharing their health care system with

non-vets; indeed, many already have issues with the VHA treating vets who do not have combat-related disabilities. But in the long run, extending eligibility to non-vets may be the only way to ensure that more veterans get the care they were promised and deserve.

Does this plan seem too radical? Well, perhaps it does for now. We'll have to let the ranks of the uninsured further swell, let health-care costs consume larger and larger portions of payrolls and household budgets, let more and more Americans die from medical errors and mismanaged care, before any true reform of the health-care system becomes possible. But it is time that our debates over health care took the example of the veterans health-care system into account and tried to learn some lessons from it.

Today, the Bush administration is pushing hard, and so far without much success, to get health-care providers to adopt information technology. Bush's National Coordinator for Health Care Information Technology, Dr. David Brailer, estimates that if the U.S. health-care system as a whole would adopt electronic medical records and computerized prescription orders, it would save as much as 2 percent of GDP and also dramatically improve quality of care. Yet the VHA's extraordinary ability to outperform the private sector on both cost and quality suggests that the rest of the Bush administration's agenda on health care is in conflict with this goal.

The administration wants to move American health care from the current employer-based model, where companies chose health-care plans for their workers, to an "ownership" model, where individuals use much more of their own money to purchase their own health care. But shifting more costs on to patients, and encouraging them to bargain and haggle for the "best deal" will result in even more jumping from provider to provider. This, in turn, will give private sector providers even fewer incentives to invest in quality measures that pay off only over time. The Bush administration is right to question all the tax subsidies going to prop up employer-provided health insurance. But it is wrong to suppose that more choice and more competition will solve the quality problem in American health care.

VHA's success shows that Americans clearly could have higher-quality health care at lower cost. But if we presume—and it is safe to do so—that Americans are not going to accept the idea of government-run health care any time soon, it's still worth thinking about how the private health-care industry might be restructured to allow it to do what the VHA has done. For any private health-care plan to have enough incentive to match the VHA's performance on quality, it would have to be nearly as big as the VHA. It would have to have facilities and significant market share in nearly every market so that it could, like the VHA, stand a good chance of holding on to customers no matter where they moved.

It would also have to be big enough to achieve the VHA's economies of scale in information management and to create the volumes of patients needed to keep specialists current in performing specific operations and procedures. Not surprisingly, the next best performers on quality after the VHA are big national or near-national networks like Kaiser Permanente. Perhaps if every American had to join one such plan and had to pay a financial penalty for switching plans (as, in effect, do most customers of the VHA), then a business case for quality might exist more often in the private health-care market. Simply mandating that all health-care providers adopt electronic medical records and other quality protocols pioneered by the VHA might seem

like a good idea. But in the absence of any other changes, it would likely lead to more hospital closings and bankrupt health-care plans.

As the health-care crisis worsens, and as more become aware of how dangerous and unscientific most of the U.S. health-care system is, maybe we will find a way to get our minds around these strange truths. Many Americans still believe that the U.S. health-care system is the best in the world, and that its only major problems are that it costs too much and leaves too many people uninsured. But the fact remains that Americans live shorter lives, with mohttp://www.washingtonmonthly.com/features/2007/0710.longman.htmlre disabilities, than people in countries that spend barely half as much per person on health care. Pouring more money into the current system won't change that. Nor will making the current system even more fragmented and driven by short-term profit motives. But learning from the lesson offered by the veterans health system could point the way to an all-American solution.

http://www.washingtonmonthly.com/features/2005/0501.longman.html

2013-11-29 DEI to Health Insurers - Obamacare broken promises due 12-13 (15 letters) sent to:

Mr. William Winkenwerder, Jr.
Highmark, Inc.

Mr. J. Bradley Wilson
BlueCross BlueShield of North Carolina, Inc.

Mr. Bernard Tyson
Kaiser Permanente

Mr. Joseph Swedish
WellPoint, Inc.

Mr. J. Mario Molina
Molina Healthcare, Inc.

Mr. Daniel Hilferty
Independence Blue Cross

Mr. Stephen Hemsley
UnitedHealth Group Inc.

Ms. Patricia Hemingway Hall
Health Care Service Corporation

Mr. Patrick Geraghty
Blue Cross and Blue Shield of Florida, Inc.

Mr. Jay Gellert
Health Net, Inc.

Mr. David Cordani
Cigna Corporation

Mr. Chet Burrell
CareFirst BlueCross BlueShield, Inc.

Mr. Bruce Broussard
Humana, Inc.

Mr. Bruce Bodaken
Blue Shield of California

Mr. Mark Bertolini
Aetna, Inc.

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

MAJORITY (202) 225-5074
FACSIMILE (202) 225-3974
MINORITY (202) 225-5051
http://oversight.house.gov

November 29, 2013

Mr. Mark Bertolini
Chairman, President, and CEO
Aetna, Inc.
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Bertolini:

The Committee on Oversight and Government Reform is continuing its oversight of the implementation of the Affordable Care Act, also known as ObamaCare. The President sold his health care reform plan to the American people on two fundamental promises:

> "[N]o matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period."[1]

After millions of Americans received notices that their plans were being cancelled, the President was forced to acknowledge just how misleading his assurances were.[2] The President has since offered an "administrative fix" that may allow certain individuals to keep their current plans for up to one year.[3] Serious questions remain as to the proposal's feasibility and legality.

Now, there is mounting evidence that the President's *second* promise is similarly untrue. Even among the individuals fortunate enough to keep their plans, many Americans are finding that access to their preferred doctor(s) is being abruptly terminated. On November 16, 2013, the *Wall Street Journal* reported that UnitedHealth Group, the nation's largest provider of privately-managed Medicare Advantage plans, has dropped thousands of doctors from its network in recent weeks.[4] Termination letters sent to doctors in at least 10 states cited "significant changes and pressures in the health-care environment."[5] When pressed for an explanation, the president

[1] President Barack Obama, Remarks by the President at the Annual Conference of the American Medical Association (June 15, 2009).
[2] Interview by Chuck Todd, NBC News, with President Barack Obama, in the White House (Nov. 7, 2013).
[3] Carol E. Lee and Louise Radnofsky, *White House to Allow Insurers to Continue Canceled Health Plans*, WALL ST. J., Nov. 14, 2013,
[4] Melinda Beck, *UnitedHealth Culls Doctors From Medicare Advantage Plans*, WALL ST. J., Nov. 16, 2013.
[5] *Id.*

of UnitedHealth's network explained "It's no secret we are under substantial funding pressure from the federal government."[6]

Some health insurers have acknowledged that they are slashing provider payment rates for plans offered on ObamaCare exchanges.[7] State medical associations are concerned this will create a "two-tiered system in which fewer doctors participate, potentially making it harder for consumers to get the care they need."[8] Dr. Richard E. Thorp, an internist and president of the California Medical Association, noted that one plan sold on that exchange "was going to pay us significantly less for doing that business. And we are already very busy."[9] This has prompted concern among experts: if providers are paid less, enrollees will confront significant difficulty even getting physicians to accept them as patients.[10] According to a comprehensive report of insurers offering coverage in the new health insurance exchanges, "the exchange market will essentially offer Medicaid managed care for the middle class."[11] Medicaid managed care plans often feature narrow networks of providers, which result in many Medicaid enrollees overusing emergency rooms for basic health care needs.[12]

It appears that this "access shock" was an entirely predictable consequence of the core operative mechanisms of the law.[13] In an op-ed in the *Concord Monitor*, the president and CEO of Concord Hospital explained why his hospital network would not be participating in the plans offered by the *sole* insurer in New Hampshire's ObamaCare exchange, Anthem New Hampshire:

> Our decision to not participate in this exchange at this time was not a political statement. We are not opposed to the tenets of the Affordable Care Act or exchanges. However, Anthem was unwilling to negotiate sustainable contract terms, and the reimbursement rates that they offered would ultimately result in us being paid less than what it costs us to provide care. **Anthem has indicated that it intends to convert all of its individual policies to the exchange product in 2014, which means that those patients may not be able to access care through Concord Hospital in the future.**[14] [emphasis added]

The predictability of these impacts raises serious questions as to the origin and nature of the President's assurances. When pressed for an explanation, officials in the

---

[6] *Id.*
[7] Roni Caryn Rabin, *Doctors Complain They Will Be Paid Less By Exchange Plans*, KAISER HEALTH NEWS, Nov. 19, 2013.
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Edmund F. Haislmaier, *Health Insurers' Decisions on Exchange Participation: ObamaCare's Leading Indicators*, Heritage Foundation, Nov. 12, 2013, *available at* http://www.heritage.org/research/reports/2013/11/health-insurers-decisions-on-exchange-participation-obamacares-leading-indicators.
[12] Brian Blase, *Medicaid Provides Poor Quality Care: What the Research Shows*, Heritage Foundation, May 5, 2011, *available at* http://www.heritage.org/research/reports/2011/05/medicaid-provides-poor-quality-care-what-the-research-shows
[13] *See, e.g.*, Alex Altman, *'You Can Keep Your Doctor': Obamacare's Next Broken Promise?*, TIME, Nov. 19, 2013.
[14] Michael B. Green, *Here's why Concord Hospital opted out*, CONCORD MONITOR, Sept. 11, 2013.

White House offered tortured redefinitions and obfuscations. In a press briefing on November 19, 2013, the White House Press Secretary asserted that what the President *meant* by "if you like your doctor, you will be able to keep your doctor, period," was that "if you want coverage from your doctor, a doctor that you've seen in the past and want that, you can look and see if there's a plan in which that doctor participates."[15] Such a gloss must ring especially hollow to the patients of Concord Hospital, who stand to lose access to their long-time doctors.

Tellingly, in stark contrast to the White House Press Secretary's revision and qualification, the White House website continues to unequivocally affirm the President's original promise. A page answering "Frequently Asked Questions" on ObamaCare includes the following exchange:

> Q: Will I be able to keep my doctor?
>
> A: Yes, you will. Health insurance reform will not affect the choice of doctors you have today **and it won't affect your relationship with your doctor.**[16] [emphasis added]

The Annenberg Public Policy Center of the University of Pennsylvania has labeled the President's claim "misleading," noting that "the president simply can't make this promise to everyone."[17] The glaring inconsistencies in the Administration's narrative, coupled with the dispositive evidence that millions of Americans are unable to "keep their doctor, period," demand rigorous examination. To enable the Committee to better understand the nature of ObamaCare's impact on provider access, we respectfully request your assistance. Please provide responses to the following requests for information

1. Provide all documents that identify when employees or agents of Aetna first learned that the Administration would publically advocate for its health care reform initiatives on the premise that individuals would be able to keep their current plans or current providers.

2. Provide all documents showing whether employees or agents of Aetna informed Administration officials that the Administration's health care reform initiatives would cause Aetna to reevaluate its provider networks or provider payment rates.

3. Provide all documents showing any objection by employees or agents of Aetna, whether internally or to external parties, to the Administration's characterization that if one "likes their doctor, they can keep their doctor."

---

[15] Press Release, Office of the Press Secretary, The White House, Briefing by Press Secretary Jay Carney (Nov. 19, 2013).
[16] *Putting Americans in Control of Their Health Care, Frequently Asked Questions*, the White House, *available at* http://www.whitehouse.gov/health-care-meeting/questions/medicare-2.
[17] *Obamacare Myths*, FactCheck.org, Annenberg Public Policy Center, the University of Pennsylvania, Sept. 16, 2013, *available at* http://www.factcheck.org/2013/09/obamacare-myths/.

4. Provide all documents identifying the number of plan cancellation notices sent by Aetna, since January 1, 2013, in which the cancellation was attributable in any way to provisions of the Patient Protection and Affordable Care Act.

5. Provide all documents identifying the number of providers terminated from Aetna provider networks since January 1, 2013, in which the termination was attributable in any way to provisions of the Patient Protection and Affordable Care Act.

6. Provide all documents and communications, including meeting notes, since March 23, 2010, between employees or agents of Aetna and any employee of the Executive Office of the President.

7. Provide all documents and communications since March 23, 2010, between employees or agents of Aetna referring or relating to the accuracy of statements to the effect that if one "likes their doctor, they can keep their doctor."

The Committee on Oversight and Government Reform is the principal oversight committee of the House of Representatives and may at "any time" investigate "any matter" as set forth in House Rule X. An attachment to this letter provides additional information about responding to the Committee's request.

Please provide all such responses as soon as possible, but no later than 5:00 p.m. on December 13, 2013. When producing documents to the Committee, please deliver production sets to the Majority Staff in Room 2157 of the Rayburn House Office Building and the Minority Staff in Room 2471 of the Rayburn House Office Building. The Committee prefers to receive all documents **in electronic format.**

Sincerely,

Darrell Issa
Chairman

Enclosure

cc: The Honorable Elijah E. Cummings, Ranking Minority Member

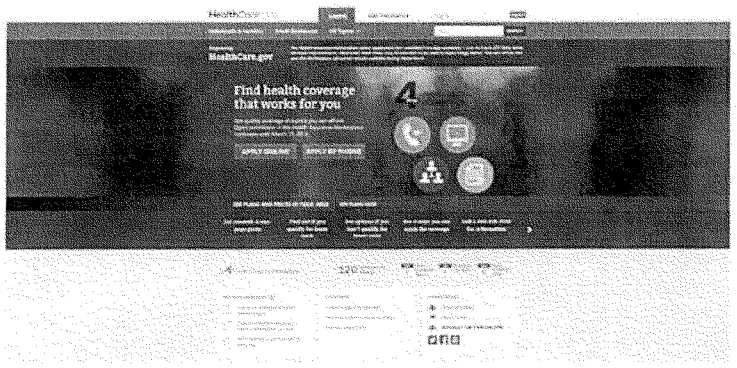
THE NEW YORKER

« Iran's Supreme Leader Hopes Nuke Deal Distracts Attention from Obamacare
Main

December 1, 2013

G.O.P.: Healthcare.gov Too Fast Now

Posted by *Andy Borowitz*



WASHINGTON (The Borowitz Report)—Republican critics of Obamacare rose up in anger today, claiming that, after two months of fixes, the healthcare.gov Web site is now "unacceptably fast."

Leading the howls of protest was the House Committee on Oversight and Government Reform chairman Darrell Issa (R-Calif.), who accused President Obama of designing a Web site that operates at a "blistering, breakneck speed."

"With pages loading in milliseconds, this Web site is insuring people before they know what hit them," Rep. Issa charged. "Clearly, this is what the President and his team had in mind."

Additionally, Rep. Issa said, at such high speeds "it is questionable whether this Web site is even safe for consumers to use, particularly the elderly."

The California Republican said he would call for hearings this week to investigate the dangerous new velocity of healthcare.gov, telling reporters, "If anyone can slow this thing down, it's me."

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Nov 16

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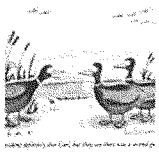
BY AMY DAVIDSON



The Humor in the J.F.K. Conspiracy
BY IAN CROUCH

Did a Director Push Too Far?
BY EMILY GREENHOUSE

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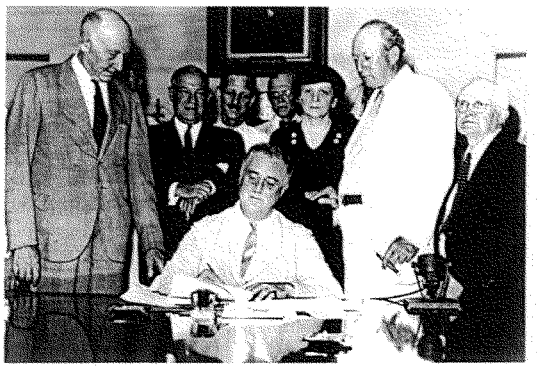
BY BEN GREENMAN

undefined

What about Social Security's rollout?

October 28, 2013 @ 10:34 pm

By Bruce J. Schulman



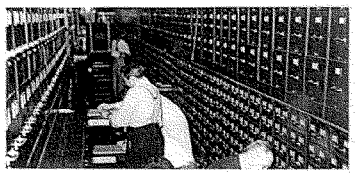
[1]

After the nation's major social program finally became law, critics regularly blamed it for a slowing economy and a swelling federal bureaucracy. Fierce congressional opposition led to the formation of a blue-ribbon panel to overhaul the measure. Obamacare in 2013? Not quite. It was Social Security in 1937.

Meanwhile, after enrollment began for the far-reaching health insurance initiative, administrators wrestled with myriad, unexpected problems. Implementation, according to the man who oversaw the introduction of Medicare in 1965, "took the form of a whole year of consultation with literally hundreds of people in identified areas of concern."

The tortuous, often controversial implementation of both Medicare and Social Security serves as an early template for the current controversies over the Obamacare rollout. The ultimate success of those social programs ought to calm the overheated atmosphere surrounding the first days of enrollment for the Affordable Care Act.

[2]Obamacare is but a few weeks old, and partisan opponents like Senator Ted Cruz (R-Texas) have already denounced supporters of the fledgling program — comparing them to Neville Chamberlain and other appeasers [3] of Adolf Hitler and Nazi Germany. Even thoughtful critics like former George W. Bush speechwriter Michael Gerson [4] are depicting the healthcare



insurance program it as an "intellectual crisis for modern liberalism."

Meanwhile, voices on the political left [5] have called the launch a "failure." [6] Or they have leapt on the website glitches as evidence of the need for a simpler, universal single payer system.

To be sure, Americans might one day regard the Affordable Care Act as the foundation of a successful national health insurance system — an untouchable entitlement like Social Security. Or Obamacare might enter the annals as an ignominious failure. But if history is any guide, nobody will be able to decide authoritatively for years, maybe even decades — certainly not until after the program evolves significantly from its original conception.

Implementation of massive public programs on a national scale takes time — especially in the United States, when responsibility for administering them is divided not only among local, state and national governments, but between public agencies and private actors like insurance companies, hospitals and doctors.

Social Security, that now beloved centerpiece of the nation's social safety net, offers a case in point. Created in 1935, the program took 40 years just to include all working Americans in its basic coverage. When the old-age insurance program launched in 1937, barely more than half the labor force participated.

[7] A series of amendments to the Social Security Act gradually expanded coverage. By 1979 it finally reached 90 percent of American workers. Over the decades, Congress repeatedly retrofitted Social Security [8]: adding dependent and survivor benefits; balancing payments between early participants and later retirees; including farm workers, domestic laborers and the self-employed, and introducing annual cost-of-living adjustments.

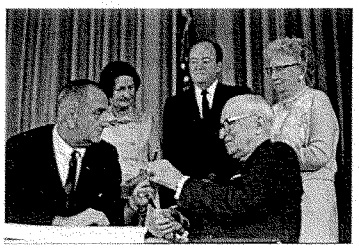
Social Security's first baby steps proved especially uncertain. Of course, opponents denounced the pension plan as the leading wedge of a socialist revolution. One senator warned that the nationalization of wheat fields would soon follow. Former President Herbert Hoover [9] suggested the law would reduce once-hearty Americans to servile passivity. "Our people are not ready to be turned into a national zoo," Hoover warned, "our citizens classified, labeled and directed by self-approved keepers."

But it was not just dissident conservatives who issued ideological censure. Even friendly critics disparaged the program for its incompetent personnel, confusing procedures and widespread abuses. One watchdog group particularly disapproved the rapid hiring of thousands of untrained, ill-qualified workers to staff the program.

In response, the fledgling Social Security administration launched a massive PR campaign to educate Americans about the intricacies of the program and broaden support for it. This effort included a widely distributed booklet, "Why Social Security [10]?" with whimsical illustrations by a popular author of children's books.

Worse yet, it quickly became clear that the new payroll taxes that financed the program and reserve accounts that squirreled away millions of dollars made poor economic sense in the middle of the Great Depression. Leading congressional Republicans like Senator Arthur Vandenberg (R-Mich.) and mainstream opinion makers like the syndicated columnist Walter Lippmann blamed Social Security for the "Roosevelt Recession" of 1937-38. Not surprisingly then, the Roosevelt administration revised the act in 1939 to reform its financing scheme and pay out larger sums in

benefits.

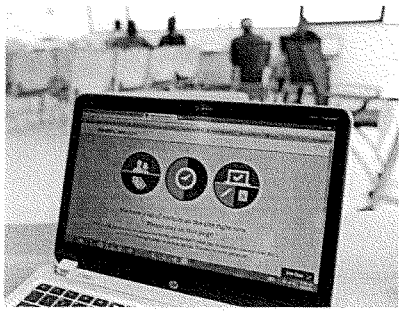


[11]Similar uncertainty marred the introduction of Medicare. When the health insurance program went on the books in 1965, the federal government already possessed a Social Security administration to run it with three decades of experience in the business of social insurance.

Still, the complexity of the new program made its rollout a lengthy, contentious process [12]. Federal officials had to negotiate with a wide variety of providers (nursing homes, hospitals, insurance companies), deal with a largely uncooperative American Medical Association, and coordinate with 50 state governments.

Unforeseen problems stymied implementation: How would Medicare respond to segregated facilities in the South? How would the program accommodate group health plans like Kaiser, which did not use traditional fee-for-service systems?

As sign-up day approached, President Lyndon B. Johnson put the Veterans Administration and army hospitals on alert to insure that nobody was denied care, particularly African-Americans in the South. LBJ also readied a fleet of helicopters to transport patients in case newly insured seniors overwhelmed their local hospitals on "M Day."



[13]Some of the most difficult challenges revolved around recruiting elderly Americans to enroll in the program by the March 31, 1966 sign-up date. Deploying resources across the federal government, including enlisting the Forest Service to track down senior citizens in isolated rural locations, "Project Medicare Alert" hired 5,000 new, part-time workers to sign up often reluctant elderly Americans. Newspapers reported concerns about the costs of the new program, widespread confusion over the available coverag [14]e and people slamming their doors shut on government employees.

Much like the history of Social Security, Medicare has also experienced repeated tweaks, expansions and improvements [15], ranging from new coverage for catastrophic care and prescription drugs to changing eligibility rules and financing formulas.

Implementing large-scale social programs, as the history of Medicare and Social Security demonstrate, rarely run smoothly. A large swath of the American public seems to understand this.

Despite the recent orgy of criticism, polls [16] show that majority of Americans still support the law or believe it doesn't go far enough.

For better or worse, today's retirement plan infrastructure, with its complex mixture of Social Security benefits, privately-run but publicly-regulated pension plans, and tax supported 401k and 403b savings schemes, took decades to build. So did Medicare.

A comparable effective national healthcare system could never emerge overnight.

PHOTO (Top): President Franklin D. Roosevelt signing the Social Security Act, August 14, 1935, Labor Secretary Frances Perkins stands behind him. Courtesy of FRANKLIN D. ROOSEVELT PRESIDENTIAL LIBRARY

PHOTO (Insert 1): Filing workers' applications for Social Security account numbers: Considered at the time part of the biggest book-keeping job in the world. Courtesy of FRANKLIN D. ROOSEVELT PRESIDENTIAL LIBRARY

PHOTO (Insert 2): Unemployed insured workers registering for jobs and filing benefit claims at a state employment office. Courtesy of FRANKLIN D. ROOSEVELT PRESIDENTIAL LIBRARY

PHOTO (Insert 3): President Lyndon B. Johnson hands President Harry S. Truman a pen as Lady Bird Johnson, Vice President Hubert Humphrey, and Bess Truman look on at the signing of the Medicare Bill at the Harry S. Truman Library in Independence, Missouri, July 30. 1965. Courtesy of LBJ PRESIDENTIAL LIBRARY

PHOTO (Insert 4): A busy screen on the laptop of a certified application counselor as he attempted to enroll an interested person for Affordable Care Act insurance at the Borinquen Medical Center in Miami, Florida, October 2, 2013. REUTERS/Joe Skipper

[1] Image: **http://blogs.reuters.com/great-debate/files/2013/10/fdr-signing-social-security1.jpg**
[2] Image: **http://blogs.reuters.com/great-debate/files/2013/10/SS-clerks.gif**
[3] Neville Chamberlain and other appeasers: **http://www.slate.com/blogs/weigel/2013/09/24/ted_cruz_funding_obamacare_is_basically_like_appeasing_hitler.html**
[4] Michael Gerson: **http://www.washingtonpost.com/opinions/michael-gerson-ailing-obamacare-could-become-a-crisis-for-liberalism/2013/10/21/00bbc938-3a82-11e3-a94f-b58017bfee6c_story.html**
[5] voices on the political left: **http://www.washingtonmonthly.com/political-animal-a/2013_10/malfunctioning_exchanges_show047419.php**
[6] called the launch a "failure.": **http://www.washingtonpost.com/blogs/wonkblog/wp/2013/10/14/five-thoughts-on-the-obamacare-disaster/**
[7] Image: **http://blogs.reuters.com/great-debate/files/2013/10/SS-benefits2.gif**
[8] retrofitted Social Security: **http://www.ssa.gov/policy/docs/ssb/v66n1/v66n1p1.html**
[9] Herbert Hoover: **http://news.google.com/newspapers?nid=1928&dat=19350506&id=79MgAAAAIBAJ&sjid=6WoFAAAAIBAJ&pg=1522,2944240**
[10] Why Social Security: **http://www.ssa.gov/history/whybook.html**
[11] Image: **http://blogs.reuters.com/great-debate/files/2013/10/medicare-signing-better3.jpg**
[12] Still, the complexity of the new program made its rollout a lengthy, contentious process: **http://www.nasi.org/usr_doc/med_report_reflections.pdf**
[13] Image: **http://blogs.reuters.com/great-debate/files/2013/10/obamacare-comp.-screen1.jpg**
[14] Newspapers reported concerns about the costs of the new program, widespread confusion over the available coverag: **http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/17/when-medicare-launched-nobody-had-any-clue-whether-it-would-work/**
[15] tweaks, expansions and improvements: **http://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/history/**
[16] polls: **http://www.washingtonpost.com/blogs/plum-line/wp/2013/10/21/the-morning-plum-dont-squander-your-shutdown-gains-dems/**

Questions for Dr. Calabria
Director of Financial Regulation Studies
Cato Institute

Questions from Representative Collins
Committee on Oversight and Government Reform

Hearing on:
"The Roll Out of HealthCare.gov: The Limitations of Big Government"

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1. The debacle that has been the rollout of Healthcare.gov has illustrated a point that has been clear to me and the people of Northeast Georgia for a long time: the President has been far more interested in campaigning, and far less interested in governing. Let's look at his 2012 campaign for example, universally lauded as the most technologically advanced campaign in history. Then a year later, with the same man in charge of both projects, we get Heathcare.gov. One website crashes constantly and is unable to relay accurate information; the other has an enormous capacity and is fully integrated for quality and reliability of information. I think that this raises a broader question, which is why is it acceptable, even to the President, to produce a subpar product as long as the federal government is footing the bill? Is this inherent in the nature of government, or is it reflective of this administration?

   Calabria: The short answer is: Both. There were certainly mistakes made in the roll-out of HealthCare.gov that were likely under any administration. As GAO has made clear in countless reports on a variety of federal programs, information technology in the federal government falls far below private sector standards and often displays costs far in excess of the private sector. So some of the problems of HealthCare.gov go beyond this administration.

   That said, given the known problems with federal IT, HealthCare.gov was clearly rushed. If you know something is likely to encounter problems, then you plan for problems, even if the exact details are not known ahead of time. The roll-out of HealthCare.gov appears more driven by political considerations than by practical ones. Of course failure is an inherent part of any learning process. The difference is that markets generally correct their failures, whereas political systems generally deny and continue their failures. While I believe that people inherent spent their own money more carefully than they spent other people's money, this administration does appear to have taken that disregard to a new level.

2. You've done a great deal of research on GSEs (government-sponsored enterprises), and in specific Fannie Mae and Freddie Mac. You've been very open about how needless and wasteful you believe that Fannie and Freddie are. They perform the same action as the private sector, they just do it worse. Do you think that it would be fair to expect similar results from Obamacare that we've seen from Fannie and Freddie? Repeated failure and needing additional large infusions of cash in order to remain in place?

Calabria: I do believe there are numerous examples from our mortgage finance policies that shed light on our health care policies. The nature of government insurance programs displays similarities across the risks being insured. Both moral hazard and adverse selection characterize any insurance system, both private and public. The temptation to use insurance as a means of wealth redistribution, rather than simply pooling risk, is strong and certainly characterizes our mortgage finance system. The temptation to also use insurance mechanism to create off-budget contingent liabilities is also particularly great. Recall we were told for years that Fannie Mae and Freddie Mac would never cost the taxpayers a dime. A basic knowledge of economics and insurance would have revealed that to be false. Unfortunately it took a crisis to demonstrate that fact.

Housing, education, and health care policies also demonstrate another commonality: when subsidize demand in the face of relatively fixed supply, you largely run up prices. We've seen that in housing, where Fannie Mae and Freddie Mac did not result in any long run increase in homeownership but did result in a run-up in housing prices, contributing to a boom and bust in housing. Subsidies for higher education have also resulted in dramatic price increases that have largely been captured by the universities. There is every reason to believe that Obamacare will continue to drive up health care costs as it does not address the inherent lack of competition in health care. Cato scholars have written regularly on the topic of health care reform. I would point you to the work of my colleagues Michael Tanner and Michael Cannon. My decades of long study of mortgage finance policy suggests to me that Obamacare will be very costly but with very little actual benefit for health care consumers as a whole. As with mortgage finance, the best solution would be to remove pre-existing distortions and barriers to competition.

Questions for Dr. de Rugy
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Questions from Representative Collins
Committee on Oversight and Government Reform

Hearing on:
"The Roll Out of HealthCare.gov: The Limitations of Big Government"

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2. We have heard about the repeated crashes of Healthcare.gov over the past two months. The Obama administration is now claiming that the website is working, however we are continuing to hear reports of more issues. According to Robert Zirkelbach from America's Health Insurance Plans, "insurers are still receiving enrollment files that are duplicative or include missing or inaccurate information. In some cases they aren't receiving those enrollment files at all." Now this law has mandated that people have insurance, it has provided them a broken system through which to attain it, and once they claim that it is fixed, it is not transmitting the information to the companies who will be providing said insurance. It sounds to me like the government poking their nose in and messing the whole process up. Dr. de Rugy, you have written about the failures of big government, no matter how much money is spent. We know that this law is ill conceived and poorly implemented, but what do you see as the next failure of this law?

1. President Obama's two very different experiences in overseeing broad technological projects suggest that the failure of the Affordable Care Act (ACA) is fundamentally rooted in government failure. The striking differences between the private sector and the government's ability to successfully deliver goods and services were apparent during the rollout of the healthcare.gov website. The technological outcomes of the Obama presidential campaign were worlds away from the technological capabilities of the Obama administration's overseeing an unprecedented expansion of the federal bureaucracy. It has been well documented that one of the reasons the healthcare.gov experience was so disastrous is that government officials faced the same constraints from excessive regulations as the private sector.

In fact, President Obama himself acknowledged that fact a few months ago during one of his appearances discussing the ACA's troubled rollout. In an interview with Chuck Todd, the president said, "You know, one of the lessons—learned from this whole process on the website — is that probably the biggest gap between the private sector and the federal government is when it comes to I.T. Well, the reason is that when it comes to my campaign, I'm not constrained by a bunch of federal procurement rules, right?" President Obama should apply this same principle to the other unsuccessful areas of government involvement he oversees.

In addition to the negative impact of excessive regulations on the government's ability to successfully build things and deliver goods and services, the way government actors make decisions is an important explanatory factor of government failure. This persistent failure is not due to the personality flaws of any one politician or party, but is a predictable result of the incentives and constraints that necessarily permeate political systems. As the work of public choice economists such as James Buchanan, Gordon Tullock, Bill Niskanen, and many others show, government decisions are all too often driven by politics, special interests and misguided aims—regardless of the party in power. Typical proposals for "more accountability," "more funding," or "more transparency" simply will not obviate the realities of political decision-making. Rather, we should, as our Founders so presciently articulated, restrict the domain of government intervention to limit the toxic influences of political pressures.

Unfortunately, far from learning the lesson from the healthcare.gov fiasco that government isn't very good at building things or that government gets in the way of private business, the president appears to remain determined to further expand the government's sphere of intervention. This will make the problem much worse for many years to come.

2. The technical troubles of the widely maligned healthcare.gov website are now infamous. The website rollout, however, should have been one of the easiest components of the health care law to implement. The design and functionality of the healthcare.gov website are qualities that were well within the control of program administrators. Executive administrators were presented with clear deadlines, ample time, and considerable funding to launch the website, which would provide Americans with their first salient impression of the ACA. The implementation of the substance of the legislation, on the other hand, is critically dependent upon broad American participation, understanding, and support. A host of carrots and sticks—such as mandates, subsidies, and minimum insurance plan requirements—were included in the ACA to incentivize citizens to behave in the way that planners intended. Not only have many of these provisions proven to be wildly unpopular, the Obama administration itself has consistently delayed or

quietly ignored the critical incentives that legislative designers included to ensure the proper functioning of the law, creating more confusion and further diminishing Americans' faith in its purported benefits. More important to policymakers, the growing number of these ad hoc, de facto line-item vetoes progressively undermine the objectives that ACA supporters originally sought.

It is *because* the law was, "ill-conceived and poorly implemented," that it is therefore difficult to speak of any one next "failure" that we can expect. We know from the recent Congressional Budget Office report that the ACA will have a chilling effect on the number of hours worked in the nation over the next decade. We know from a recent Harvard study that Medicaid expansion in Oregon led to increased emergency room visits, which suggests that the intended purpose of Medicaid expansion in the ACA is not likely to be achieved. We know from the paltry enrollment figures the Department of Health and Human Services has finally provided the public that 68 percent of enrollees have been in the relatively less healthy (and more expensive to treat) 35-64 year old range as of February 1, 2014. We know that many individuals' previous insurance plans have seen dramatic premium increases and that too many Americans have tragically lost access to the doctors and even critical care that they desire or need during this awkward transition.

Indeed, the ACA is dying a death of a thousand paper cuts. Each little dent to the ACA's reputation is inconvenient and inefficient, but appears relatively minor on its own. When considered together, however, the ACA—already a mess of contradictory and uncertain incentives and provisions—is gradually collapsing under its own weight with each delay and ad hoc waiver. It will not, as ACA supporters claimed, boost job growth, decrease emergency room visits, adequately manage insurance risk pools, or lower premiums while increasing quality. From this perspective, perhaps the worst "failure" that could come would be if the federal government continued to delay provisions and ignore these growing problems in an effort to save ACA simply for the sake of saving it.

Response from Dr. Thomas
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External Affairs

Question from Representative Collins
Committee on Oversight and Government Reform

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Representative Collins, your question specifically deals with the reasons for the failure of Healthcare.gov in contrast to the technological savvy of President Obama's successful 2012 re-election campaign. My first response is the obvious one: The re-election campaign was far better funded, with far fewer obstacles and constraints, than HealthCare.gov, which was charged with the herculean task of linking multiple federal agency databases that were completely siloed from one another, and orchestrating them all to smoothly populate the HealthCare.gov insurance sign-up page. No computer interface to date, public or private, had been asked to do a similarly complicated task, with so many moving parts that could cause problems at any number of points along the way.

I turn to history for my rebuttal: in 1942, Paul V. McNutt, chairman of the War Manpower Commission during World War II, said this about the federal government's performance during the Great Depression and World War II: "Your Government has turned out some of the biggest and best-run jobs in history during this last 10 years. Unlike private business, Government business lives in a 'goldfish bowl.' . . . Government business is the object of vast public attention before it ever begins to operate at all. . . . The cause of victory will not be served by hasty, half-cocked or misinformed action. The War Manpower Commission has been set up to minimize dislocation--not to create it." I submit to you, Representative Collins, that HealthCare.gov has,

like the War Manpower Commission, been in a fish bowl of scrutiny since before it ever got off the ground, and that its very valuable cause, to extend health coverage to a larger portion of Americans, will not be served by the kind of hasty, half-cocked or misinformed action that the Republican majority in Congress has thrown against HealthCare.gov during its very short lifespan.

You noted, quite correctly, that President Obama was re-elected in 2012—by a four-point margin, more than two years after he signed the Affordable Care Act into law on March 23, 2010. His reelection signified the American public's overall satisfaction with the principles enacted in ACA—principles that House Republicans and Governor Romney himself had significant influence in shaping.

Even in the short amount of time that has passed since I received your question on January 7, HealthCare.gov has made major strides and has, as I and others predicted during the December 4, 2013 hearing, resolved many of the problems that have plagued it since October.

Finally, Representative Collins, I am from northwest Florida, which is not so very far, geographically or culturally, from your district in Northeast Georgia. Much of my work as a historian has focused on the reasons why the South was the focus of early national health policy during the 1930s, 1940s, and 1950s. During World War II, fully half of Southern recruits were rejected for the draft, versus one third of non-Southerners, which points to the severe health deficiencies then existing throughout the country, but especially in the rural, impoverished South. Federal programs such as the public health titles of the 1935 Social Security Act, the Bolton Nurse Training Act, the Wartime Emergency and Maternity Care program (which subsidized hospitalized births for 1 in 6 American babies born in 1944), and the 1946 Hill-Burton Hospital Survey and Construction Act all channeled federal resources to uplift Southern health, and they were incredibly successful at doing so. Between 1930 and 1950, malaria was eradicated from the South, maternal and infant mortality dropped dramatically, federal funding for education and training programs trained thousands of doctors, dentists, nurses, and public health workers, and the rate of typhoid, a deadly waterborne disease, was cut by 90 percent, largely due to federally funded water and sewer construction projects. And what's more, these programs were largely conceived and passed into law by forward-thinking Southern members of Congress such as Sen. Claude Pepper of Florida, Sen. Lister Hill of Alabama, and Sen. Allen Ellender of Louisiana, with the help of private sector reformers such as the famous surgeon and Georgian Louis T. Wright, who chaired the NAACP and led its fight for equity in federal health programs.

I urge you, Rep. Collins, to consider the example of your family member who was a physician during those days, about which you spoke during the hearing. You said that he and other country doctors took care of everyone without the federal government needing to interfere, but I submit to you that the South had far more federal help in providing health care and public health services than any other region. In fact, your home state of Georgia established 181 public

maternity clinics under the Social Security Act, more than any other state, and these clinics saved the lives of thousands of mothers and babies who would otherwise have had no prenatal or postnatal care whatsoever.

You see, my grandfather was a doctor too, and my great grandfather, and my great-great grandfather—all were Georgia doctors who worked hard and cared deeply about their patients. And sadly, they often had to watch them die—as my grandfather often told me, in the days before penicillin, infectious diseases like measles, diphtheria, and polio killed or crippled children on a regular basis. I'm deeply thankful that, thanks to the private-public partnerships that resulted in developing and testing penicillin, polio vaccine, and many other medical miracles, I and my children are protected against those scourges. And I'm also thankful that now, the Centers for Disease Control and Prevention, based in your home state of Georgia because its predecessor, the wartime Malaria Control in War Areas program, was also based in Atlanta, is tracking disease outbreaks and protecting our whole nation from epidemics.

In conclusion, HealthCare.gov is not a "subpar product," as your question states, and therefore it is most certainly not inherent in the nature of government, nor is it reflective of President Obama's administration, for the federal government to produce an inferior product. Based on my knowledge of history, and my own personal experience as a Southerner and an American, I believe that the passage of time will demonstrate the value of the Affordable Care Act to the American people, including those of Northeast Georgia.

My response:

I believe that the President is not as engaged with the private commercial sector as much as he should be. He is fully engaged with private sector campaign services, where he successfully used a very sophisticated polling and campaigning apparatus to help his election and re-election. However, he does not seem to trust the private sector to produce innovations and technological advance that could benefit millions of Americans.

Clearly, the private sector could have been used much more effectively to develop and monitor a successful Healthcare.gov website. Indeed, it was my understanding that the CEO of Salesforce.com reportedly offered to build the website for no charge when it was clear that the administration was encountering problems. This firm was experienced and capable of getting the job done, but they were told that "regulations" prevented them from being used. Instead, it was my understanding that the firm that was used, CGI, had problems in the past and had not set up an effective monitoring process. It is difficult for me to believe that the administration could not have used a well-regarded firm in the Cambridge, Massachusetts area, relying on MIT graduates, or in Silicon Valley, relying on Stanford graduates, to build an effective website.

I do not think that the President intended to produce a subpar product. As noted, I just do not think he is as thoughtful about the private sector and its capabilities as he should be. I also do not think this problem is reflective of only the current administration. I believe that there is an anti-market sentiment generally in the United States. I am often amazed about how much unregulated activity there is in this country given the bias against markets.

Part of the problem is that there is not systematic knowledge among policymakers about government and market performance. I tried to point that out with reference to my book, GOVERNMENT FAILURE VERSUS MARKET FAILURE, which Chairman Issa noted at the beginning of the session. The book provides empirical evidence that government efforts to correct alleged market failures have done more harm than good. This does not imply that markets are perfect, but I do believe that they are more capable than government of learning from and correcting mistakes. Unfortunately, I doubt that this administration and succeeding administrations will learn from the website debacle. My hope is that we allow the private sector to solve as many social problems as possible without counterproductive government interference.

Sincerely, Clifford Winston

Questions for Dr. Winston
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