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FULL COMMITTEE HEARING ON STATE STRATEGIES TO EXPAND HEALTH INSURANCE FOR SMALL BUSINESSES

COMMITTEE ON SMALL BUSINESS UNITED STATES HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 26, 2008

Serial Number 110-72

Printed for the use of the Committee on Small Business

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

40–362 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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FULL COMMITTEE HEARING ON STATE STRATEGIES TO EXPAND HEALTH INSURANCE COVERAGE FOR SMALL BUSINESSES

Tuesday, February 26, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 2360 Rayburn House Office Building, Hon. Nydia Velázquez [chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Shuler, González, Altmire, Clarke, Ellsworth, Sestak, Chabot, Bartlett, Akin, Fortenberry, Westmoreland, Davis, Fallin, and Buchanan.

OPENING STATEMENT OF CHAIRWOMAN VELÁZQUEZ

Chairwoman VELÁZQUEZ. This hearing on state strategies to expand health insurance coverage for small businesses is now called to order.

The Committee is honored to have before us today Governor Tim Pawlenty of Minnesota and Governor Edward Rendell of Pennsylvania. These leaders have been at the forefront of the health care debate that has implications for the entire nation. While I understand their approaches to reform may be very different, we hope to gain insight on how their proposals can improve health coverage for the citizens of their states.

This is the fifth hearing that the Small Business Committee has held on the issue of access to health insurance for small businesses. It is a problem that threatens to undermine our entire health care system. It is for that reason we are continuing to work with the small business community and stakeholders to identify ways that Congress can address this crisis. While major change may be a year away, the Committee is attempting to identify consensus reforms that can either be enacted this year or as part of any health care reforms made in the future.

The Governors here today are fully away of the obstacles that meaningful health care reform presents. With any efforts to increase coverage that impacts our nation's health system, it will invariably create some form of opposition. Governor Pawlenty and Governor Rendell are responding to the harsh reality of rising health care costs and declining coverage in their states.

This Committee is particularly interested in the steps that Minnesota and Pennsylvania are considering to ensure small firms have access to affordable health insurance coverage.

More than a year ago, Governor Pawlenty laid out his Health Connections platform that has set the stage for reforming his State. Governor Rendell is also in the midst of a major debate on comprehensive changes to the health care system in Pennsylvania. He is now working with the legislature to advance his prescription for a Pennsylvania plan.

Both of these plans make small businesses a critical component of expanding coverage. I believe it is becoming increasingly clear that addressing the problem of the uninsured requires a focus on encouraging small businesses to offer health insurance coverage.

Today's discussion will hopefully allow the Committee to gain new perspective on approaches to improving health care choices for small businesses. In the past year, this Committee has examined how competition among insurers and risk are cost drivers for small businesses seeking health insurance. These are problems that I believe can and must be addressed by changes at both the State and federal level.

While demographics and localized issues may shape the solutions that you are proposing, it is clear that you both agree that the current system needs to change. The matter of affordable coverage for small businesses is something that every state is facing across this nation. Given the challenges, it comes as no surprise that 6 out of 10 uninsured Americans, including more than 10 million children, are in households headed by self-employed workers or small business employers.

I look forward to today's testimony, and again thank you for being here to discuss this important issue. I will now yield to the Ranking Member, Mr. Chabot, for his opening statement.

OPENING STATEMENT OF MR. CHABOT

Mr. CHABOT. Thank you, Madam Chairwoman, and good morning. Thank you for holding this hearing on state initiatives to expand health insurance. And special thanks to our distinguished witnesses who are taking time from their National Governors Association winter meeting here in Washington to be with us today.

Governors Pawlenty and Rendell, we really do appreciate your participation here this morning. We will stop talking shortly, so we can get to you.

Forty-seven million Americans are uninsured, and for those who are uninsured, and for those who are insured, costs continue to skyrocket. For small businesses, health care is continually ranked as one of the top concerns. And as we have heard expressed by witnesses throughout this Committee's 10 health hearings so far this Congress, it continues to be a problem in this country.

With premiums escalating, small companies face limited choices of health insurance providers. Many operate within margins so thin that they cannot provide health insurance for themselves or their employees. According to the Government Accountability Office, health care spending is a chief culprit of our national debt. The structural debt, at the current rate of growth and spending in federal entitlements, is $53 trillion—$53 trillion with a T—assuming

future promise and funded benefits of Medicare, Social Security, veterans health care, and other programs are kept.

These figures are nothing short of astonishing, not to mention disturbing. The cost of health care has outstripped inflation by two percentage points per year each year for the past 40 years, and costs are expected to continue to rise. Health care costs for individuals and small businesses must be addressed at present, and they must be curtailed for our children and grandchildren.

These are tough problems with many facets and no easy answers. Clearly, entitlement spending must be addressed, and I believe there are important steps Congress can take to bring down the cost of health care and make it more accessible. For example, I introduced the Health Insurance Affordability Act, which would allow every American to deduct 100 percent of the cost of their health insurance premiums when calculating their federal income tax.

It is also important to eliminate frivolous lawsuits, which drive up health care costs. To that end, many of us support The Health Act, which would cap non-economic damages and ensure that only those with legitimate claims can proceed to a lawsuit. And many of us also support legislation that would allow small businesses to join together with national associations to purchase health insurance for their employees.

The increased purchasing power and lower premium costs would encourage small companies to offer health insurance to their employees if they don't already. The House has passed this legislation many times in previous Congresses only to be stalled in the Senate. Because Congress has not addressed these issues, many states have become incubators of health care reform proposals. Some have proposed innovative programs to expand health insurance coverage.

The Governors who are with us today have been at the forefront in offering imaginative health insurance solutions in their states. We are eager to hear your ideas for reform.

Madam Chairwoman, thank you again for holding this important hearing, and I think we all look forward to both Governors' testimony here this morning.

And thank you for being here, Governors.

Chairwoman VELÁZQUEZ. Thank you.

It gives me great pleasure to welcome Governor Tim Pawlenty, who was elected to his first term as Governor in 2002, and was reelected in 2006. He is the 39th Governor of Minnesota, and currently serves as Chair of the National Governors Association. The State of Minnesota has one of the lowest uninsured rates in the country.

In 2005, Governor Pawlenty signed into law a health care reform bill that creates small employer flexible benefit plans which are designed to assist small entrepreneurs purchase health insurance. He is continuing to work on health care reforms to improve access to coverage.

Governor, we always allow for a five-minute presentation. We will give you more latitude, but we would love to be able to ask some questions.

STATEMENT OF THE HONORABLE TIM PAWLENTY, GOVERNOR OF MINNESOTA, ST. PAUL, MINNESOTA

Governor PAWLENTY. Madam Chair and members, thank you so much for the opportunity to be here. We sincerely apologize. We were expecting only a brief meeting with the Speaker and the leader, and they were very generous with their time. So we are sorry for our lateness in arriving here today.

We recognize—Governor Rendell and all Governors—the importance of small businesses. It is the main engine of our economy in Minnesota and across the nation. Seventy percent or so of all of the new jobs created in the country are created by these small and early stage companies. It is vital to our future economic picture and health in this country to make sure our small business sector is healthy, and a key variable, as you well know, Madam Chair and members, is the ability to contain health care costs for small businesses, not only as a way to help them provide health insurance coverage to their employees, but to allow them to even remain viable.

I am the Governor of one of the I think best states from a health standpoint in the country. We had the healthiest State in the nation seven years in a row. Vermont just beat us out this last year, so we are second this year. But we are going to get them back next year, Madam Chair. But for seven years in a row, the healthiest State in the nation by a number of wide measurements on health.

And we have the second longest rate of living or longevity in the country, second only to Hawaii. I think they have us beat out on tropical fruit digestion and eating there, but that helps them.

We have one of the lowest health care costs in the country. And as you mentioned, we have the lowest rate of uninsured in the country at about 7 percent. It fluctuates up and down a little bit. Many states define full insurance—in fact, Massachusetts I think is defining universal coverage at 95 percent. We are already at 93 percent, and we still have a ways to go with respect to our reforms.

The reason I share all of that with you is not to brag about Minnesota, but to tell you that even with all of that nation-leading status, home of the Mayo Clinic, home of the University of Minnesota, even with all of that, we can't make the current system work and have it be affordable and accessible and high quality, the way it is currently configured. And so that is how high the bar has become for our citizens and for our small business leaders and job providers across the country.

The costs of this health care system are killing us economically. The current system is not sustainable for individuals, for families, for small businesses, for local units of governments, for school districts, for counties, for state governments, for the Federal Government. It is the thing that is driving us further towards insolvency, financially and economically, and we hope that you will join us—and I know you will—in trying to find ways to make it more affordable and available.

We have seen in Minnesota, as the nation has seen, an erosion of employer-sponsored/employer-provided health care coverage that is very concerning. As that displacement occurs, those individuals either are on their own or they fall through the cracks or look in-

creasingly to government programs. And that has its own limitations and concerns associated with it as well.

As to my comments that the current system is flawed and what we could do about it, Madam Chair, right now we have a system where what we pay for is not aligned with the outcomes that we desire. And we have a system where we pay for procedures, volumes of procedures, and as largely disassociated with whether those procedures are leading in an efficient and impactful manner to better health, or whether the health care being provided is of a high quality. And the pricing around that is quite mysterious to most consumers, and even to some third-party payers of those bills.

In short, and in oversimplified terms, we have a health care system where all of us get to go to a health care provider as consumers, consume goods and services, being largely ignorant of price or quality, and then we send the bill to a third-party payer, namely an insurance company, an HMO, or a government, and they pay the bill.

There is no system that I am aware of where that is going to work. It defies what we know about human nature. It defies what we know about markets, and all of the flaws and warts of that are now being visited upon us in terms of what we see and the deficiencies in this system.

Madam Chair and members, if we invited you to go purchase a television—and I hope you would purchase it at one of our great Minnesota companies like Target or Best Buy that are headquartered in Minnesota—and we said, "No consideration about price or quality, just go pick out a television," I doubt that many members or citizens would go pick out a, you know, 12-inch television. I think probably most of the people would go get the big flat screen.

And so we need to connect consumers and payers and providers as it relates to how we pay for the desired outcomes that we have. With that in mind, we note that even in Minnesota, with all of our nation-leading health care quality and delivery systems, until recently only 1 in 10 people were getting optimal care in diabetes.

We know what optimal care in diabetes is. We can define it at Mayo Clinic levels. We can define it at world-class leading levels. And 1 in 10 people were getting that kind of care. And if you don't get optimal care in diabetes, it leads to very expensive, worsening, problematic, chronic conditions that get even more expensive.

So paying for providers, as one example of many, to move their patient loads towards optimal care, and putting benchmarks around that and pain premiums, pain incentives for that, seems to me like it makes a lot of sense. And you know most of the money goes into the five big chronic conditions. It is diabetes, obesity, heart disease, cardiac care, end of life issues.

And, you know, setting best of class expectations on quality and pain for that, rather than paying for volumes of procedures, seems like a movement that we need to take with respect to our payment systems.

I also think there is a lot of back room costs that can be taken out, and we are requiring in Minnesota in our public health programs, if you want to be paid by the State government and be a participating provider in our State programs, you have got to e-pre-

scribe. Now, there is some legacy problems with that in terms of small providers and rural providers who can't make the pivot. We are going to try to give them some financial help.

But at a time certain in the next couple of years, if you want to be part of a provider in our State program, you have got to e-prescribe. We have a non-profit that has been assembled of our health care providers in Minnesota that will share medical records electronically. That is not a government central storage of data. It is the ability for providers to mutually go into databases with proper security in place and pull out medical records. So if you are in Duluth, you can get the record from Minneapolis that you may need, even though you had two different providers.

From an employer standpoint, Madam Chair and members, 125 plans are low-hanging fruit, you know, and they are not costly to set up for employers. It is a relatively modest and easy thing to do. But if they do that, whether the employer actually pays for the insurance, or an individual comes to the marketplace and can declare the benefits of a 125 plan, it is a significant savings either for the employer and/or the employee. So I would encourage that type of approach as well.

But if I—and there are many, many other things, but if I were to leave you with one thought that I think is just critical, is we have to reform the payment system. Some would argue that the way to do that is to move to a single payer system. For me, I don't think that is the correct approach. I don't think it is realistic. I don't think it will work.

For me, I think the idea is to get transparency around quality and price, and be very aggressive about that. And the new reform that we have in Minnesota is to try to put to the side the third-party payers, the insurers, the health plans, and have them become vendors of the providers, but have the providers come forward and be the bidders of the price.

They can name whatever price they want. But once they name it, it is good for a certain period of time, and it has to be available to the whole market, whether it is an individual, whether it is a small business, whether it is the government.

When we go to Minute Clinic, which was started in Minnesota, there is no mystery about what stuff costs. You know, go to the CVS up on the wall when you walk in. If you want the flu shot, there is the price. You know, if you want the strep test, there is the price. It is simple. So we need to have price transparency and ways that average Americans, average Minnesotans, average citizens of Governor Rendell's State, can see in a user-friendly, simple format, and then I think we also have to align payments, whether they are coming from individuals or third-party payers, to quality, and not defined just by the volumes of the procedures.

If you pay providers by how many procedures they perform, you are going to get more procedures. If you pay people to keep people healthy, and define what that means, either in terms of initially optimal care, but ultimately outcomes, I think that is a better use of our money and a brighter future.

So that is the direction we are headed in Minnesota. I would say it is mission critical for our country. This issue, as one measure—and you know this—the rate that these programs are growing at

the state level, and, candidly, at the federal level, this will usurp the vast majority of our State's budget within 20 years, probably within 15 years.

It has enormous implications for our ability to do almost everything else—K-12, higher ed, roads and bridges. It is the big vacuum in the room. And if we don't find a way to deal with this, it is not only going to be a very severe challenge to small businesses, but the rest of what we are trying to do as well.

Thank you for listening. I would be happy to answer your questions after Governor Rendell.

Madam Chair, I have—Governor Rendell is being very kind and is offering me to take questions now, because I am going to try to catch a plane, and then he is willing to suspend his comments, if that is okay with you, Madam Chair.

[The prepared statement of Governor Pawlenty may be found in the Appendix on page 38.]

Chairwoman VELÁZQUEZ. Thank you. Sure. All right. Without objection.

Okay. Let me address my first question, of course, to you, Governor. And I would like maybe—if Governor Rendell wants to comment on this—

Governor RENDELL. Sure.

Chairwoman VELÁZQUEZ. —very first question. We all know that small businesses across the country are struggling with the rising costs of health care. And one of the main problems in many states if the lack of competition in the health insurance market.

This was reiterated yesterday by the Nevada merger between United Health and Sierra that was approved by the Department of Justice. Governor Pawlenty, while I appreciate that Minnesota-based United Health employs many citizens of your State, I was hoping that you can talk about whether this increase in consolidation concerns or presents any concerns about competition.

Governor PAWLENTY. Well, I will give you one other—Madam Chair, thank you, and members. United Health is a large company located in Minnesota, but oddly it is not allowed to do business in Minnesota. We have an old law in Minnesota that prohibits for-profit health companies from providing health services in our State. I think we are the only State in the nation that does that. So what we have is three non-profit providers, three health plans that control 85 percent of the market.

In the early '90s, we did a reform where we were going to try to—we were the first in, and heaviest in, in the HMO. I wasn't there then, but that is what we tried to do. And what happened is initially there was some progress as to cost containment. They took the low-hanging fruit. But I would suggest to you that in Minnesota our market is not robust from a competitive standpoint. We have three non-profits that compete.

What they do from year to year is cannibalize each other's market share, so when one comes in as the low-cost provider one year for these big employee groups, they get selected. The losers come back and underbid them next year. And so they just trade relative market share from year to year.

The quality of services and offerings don't vary significantly, other than on marketing labels. And we could stand for much more robust competition in my State. I think the semi-monopolization of our health care market in Minnesota, and the vertical integration of it, has not served us well. Now, that is not a comment about what is going on in other states or United. It is a comment about the fact that we have allowed, and encouraged in some ways through public policy, the vertical integration of the health care delivery system in Minnesota. And it has not served us well.

Chairwoman VELÁZQUEZ. Okay. Thank you.

And let me go—Governor?

Governor RENDELL. I want to add very quickly on that. Ironically, we are trying to get United to come into Pennsylvania to spread competition.

[Laughter.]

But there are things you can do. The reason that there is no competition is when you have two or three or one dominant carrier in an area, they are allowed to negotiate with hospitals and doctors clauses that make it impossible for competition to come in.

And I would recommend that Congress take a look at those type of clauses, sort of the most favored nation clauses, and outlaw them—plain and simply outlaw them, make it impossible for them to negotiate those, because providers—a hospital—if you are 80 percent of the market, you are the HMO, and you want that type of clause, the hospital is in deep trouble if they don't do that. So they are forced to take an abusive regulation that stifles competition.

That is something I would urge you to take a look at, and something I think you could legislate.

Chairwoman VELÁZQUEZ. Thank you.

Governor Pawlenty, we have been here in this Committee, and throughout the Congress, trying to enact legislation that will allow for small businesses to be able to purchase health coverage. And one of the bills that we passed was the creation of the association health plans.

I supported that legislation, which would allow for small firms to pool together for purchasing health insurance. And despite passage of the bill in the House numerous times, wide support from the small business community, and the backing of Minority Leader Boehner, and the President, the proposal was unable to get through the Senate.

And during the debate some states expressed concerns about allowing firms to buy coverage across the state line, and the National Governors Association actively oppose AHPs. As a Governor, do you have reservations about allowing small businesses to band together, if the plans were regulated by the Federal Government, as opposed to the state?

Governor PAWLENTY. Madam Chair and members, I would even take it one step further, and say, first and foremost, we need to make sure that consumer protections are in place. These policies and rules and regulations are complex, and to have typical consumers try to sort through that without some guardrails and protections in place is something that we need to be very careful about.

Assuming that those are in place at a state level or a federal level, in the world of the internet, in the world of the iPod, in the world of global markets, in a world where regional and state boundaries are, you know, melding, why is it that in Minnesota I can't buy a California insurance plan? Or why is it that I can't bind together with similarly-situated people?

I am speaking for myself now, not NGA, but it seems outdated and parochial to limit these offerings to the state that you happen to live in when this is largely a transaction involving the exchange of data and the exchange of information. So my personal view, not the NGA's view, is that association health plans—and assuming consumer protection is robust, consumer protections are in place, people should be able to buy insurance wherever they want, and in whatever form they want. It is a free country, and you shouldn't be bound by your own state's boundaries in that regard.

Chairwoman VELÁZQUEZ. Thank you.

Governor RENDELL. I would differ just slightly. I certainly agree with the sentiments Governor Pawlenty offered. But one of the things I am fighting for—and in my testimony I will mention it—is for the State Insurance Commissioner to get the right to regulate health insurance rates. He regulates car insurance, homeowners insurance, but doesn't regulate health insurance.

And if we get that right—and I think it is very important consumer protection, so no one can be denied coverage because they have a prior existing condition, which is a yeast infection, for example, we need the Insurance Commissioner to have that right. How does our Insurance Commissioner regulate a product that is being offered in California?

But if you go to—and I believe Congress should—some form of national health insurance, maybe a form that relies on a working arrangement with the states, but if you go to that, then I think it makes sense.

Chairwoman VELÁZQUEZ. I now recognize Mr. Chabot. And I will ask the members to please address the question to Governor Pawlenty, because—given the time constraint, and then we will have Governor Rendell make his presentation, and we will have an opportunity to ask questions to the Governor.

Mr. CHABOT. Thank you very much, Madam Chair.

And, Governor Pawlenty, you proposed a path to universal coverage rather than universal coverage. Could you elaborate on why, in your State, you decided a more incremental approach?

Governor PAWLENTY. Yes. You know, we are pretty far along the continuum, as I mentioned already, at 7 percent uninsured, 93 percent insured. And so as we looked at the various models that have been proposed, either academically or on the ground around the country, we think we can make very substantial progress, beyond even 95 percent, with the types of payment reforms that I have suggested in my earlier comments. And then, we are going to harvest part of the savings from those payment reforms and plow it back into an existing or style of program that we have in Minnesota, provide more access to the uninsured.

We hope that most of the savings—in my view, about two-thirds of it—will go into holding down premiums, and then more for access. In my opinion, and you have got to be careful about a man-

date where you say everybody has to be insured—and then, if you—the health care that you have available in your marketplace isn't affordable, you end up criminalizing poor people, or penalizing poor people.

So I think a better approach—and we think we can get there without such a mandate—would be due to the payment reform and provide the ability for individuals to go into the marketplace and purchase it themselves, or through their employer or association.

Mr. CHABOT. Thank you. And in your written testimony, you had emphasized that states should continue to have the flexibility to try new approaches. Could you discuss why that is so important?

Governor PAWLENTY. Well, we celebrate this year the 100th anniversary of the National Governors Association. And one of the roles that we think we can play is to be laboratories of democracy, that we can go out, try new things. We are a little smaller. We are little more nimble. We can do things a little quicker. The good news is, if we can show that it works, you could perhaps take some comfort as a Congress before you took it national, without having to take on all the risk.

On the other hand, if we do things that don't work, and they turn out to be stupid, then you could prevent that from being visited upon the whole country before we road test it a little bit in the states. So having flexibility, first of all, respects federalism, respects state rights, and that is the tradition of our country.

But second of all, it preserves this role as a laboratory of democracy where we can be experimenters and hopefully deliver results that might be appealing to you.

Mr. CHABOT. Thank you. And, finally, in your written testimony also you referred to making consumers meaningful partners in their health care. Could you discuss why that is so important?

Governor PAWLENTY. Well, it has been my experience, sir—and I am sure it has been yours—where when people have some skin in the game—I don't mean that medically, I mean that financially—

[Laughter.]

—the tend to behave differently. And, you know, if we—I go out in the hallway here and have a cardiac arrest, I don't have the time to look up, you know, who the best local provider is in terms of a quality web site and look up price transparency. But for those things that are schedulable, predictable, preventable, and repetitive, it seems to me having consumers' interests financially aligned with best price/best quality is a good thing to do.

And the good news there is, in our research, in most instances the highest quality providers in many cases are also lower cost providers. Not in all cases, but in many cases. And so this investment of consumers changes their behaviors in ways that I think will serve the financial systems well, but, more importantly, will also drive them to better health care.

Mr. CHABOT. Thank you very much, Governor.

I yield back the balance of my time, Madam Chair.

Chairwoman VELÁZQUEZ. Sure. Mr. González.

Mr. GONZÁLEZ. Thank you very much, Madam Chairwoman, and, of course, welcome.

The first and most burning question—and I apologize if someone asked it. I was outside actually meeting with a bunch of physicians from the State of Texas in the city. I mentioned Governor Rendell's suggestion on the most favored nation type provisions, and actually the Texas legislature is going to be looking into that. I asked them—they ought to come in here, if there was some room.

But the most pressing question, and I don't think anyone has asked it yet, but I know it is on everybody's minds, given where we are in the primaries. I would ask both Governors: if nominated, would you accept? If elected, would you serve?

[Laughter.]

You can answer that some other time, instead of putting you in the hot seat.

Governor Pawlenty, I really wanted—there are a couple of things—the most interesting things we have been discussing about pay-for-performance and such. But, first, just protocols. And you were talking about the optimum care and such. How do you establish those benchmarks? I think you made reference to diabetes treatment, and you said that is easily identifiable, what you should do, what are the basics, what is the proper care, best practices, and such.

But if you are talking about treatment across the board, whether it is a particular disease or regular treatment or whatever for other—or just checkups or whatever, how do you ever get to that bottom line, first of all, as to what would be the minimum of best care, best practices? How do you establish that?

And then, secondly, I guess it is, how do you establish pay-for-performance criteria? Because we have asked Governor Leavitt, Secretary, HHS, and he hasn't been able to give us an answer to that, at least the last few hearings that I have attended. So those are the two questions.

Governor PAWLENTY. Thank you, Congressman González. I can tell you in Minnesota that we envision this in two steps. We are not ready yet, nor are the databases ready yet, nor is the delivery system ready yet, to pay purely for health care outcomes. The systems aren't robust enough. The culture—medical culture is not yet advanced enough.

But conceptually, we see that, and there is acceptance of it. In the meantime, as a proxy for outcomes, we want to pay for adherence to world-class standards, which gets to your point. Again, this is not the destination, but it is the pathway to the destination.

We have a hometown advantage in Minnesota, because we have the Mayo Clinic. And so we have the Mayo Clinic and others who have sponsored something called ICSE standards. I forget what it stands for, but it is ICSE, and it is basically a depiction of world-class standards in many courses of treatment. And so when doctors come and say—did say, "You know, why do I want to practice medicine by a cookbook? You know, I have got my own standards," and, like, you really want to take issue with the Mayo Clinic as being, you know, low quality?

And so we are not saying you have to do that, but we are saying we will pay you more if you do do it. So in the case of diabetes, we have this program called Bridges to Excellence, where we say, all right, we have got about 6 or 8 percent of our current diabetics

in Minnesota on these optimal care treatment regimes, we want to get that to 80 percent over the next 10 years. So we are saying to our providers, "We will pay you more if you can get your patient load to 10 percent next year, and then, after that 15 percent, and after that," so it is a bonus system based on these ICSE standards.

But I will acknowledge to you that is not the endpoint. Those treatment protocols or standards are proxy for better health, better health care outcomes. They are not the outcomes themselves.

So we had some resistance in Minnesota, and still do to some extent, but the medical community has come around these ICSE standards mostly. There is still some dissent, but they have mostly come around it, and most because of the credibility of the Mayo Clinic and the people who stand behind the standards.

Mr. GONZÁLEZ. Thanks very much, Governor.

Governor RENDELL. Congressman—

Mr. GONZÁLEZ. Government Rendell?

Governor RENDELL. —I will take a quick shot at that. Number one, obviously, standards are always debatable. But we know that there are certain things that we shouldn't pay for, and our Medicaid program has informed providers that we are not going to pay for medical errors anymore. We are not going to pay for obvious medical—preventable medical errors.

You know, right now in the current system, you go in for the amputation of your right arm, the hospital by mistake amputates your left arm, your provider pays for that. Then, for the remediation of the left arm, including the placing of a prosthesis, your provider pays for that. And then, they get around to amputating the correct arm, and your provider pays for that—a third time. No one business, no other field of endeavor in the United States of America, would business people put up with that, paying for that type of performance.

And we are not in our Medicaid program anymore. We have notified them. We have worked on it with our hospitals, and our hospitals have agreed that this is a fair system. We are not going to pay for obvious preventable medical errors. That is a standard that should be applied across the board.

Secondly, we do know—the industry, the science of health care, knows what works and what doesn't work. There are 10 states—and I think Minnesota is one of them—that allow for the—what is called the Taylor model, named after the doctor who formulated it, for treating chronic care diseases like diabetes.

Right now, in Pennsylvania, if you have diabetes, the only thing we will pay for is the time you spend with your primary care physician. Most primary care physicians are swamped. They tell you you have diabetes, they will give you a pamphlet on diet, they will give you a quick run-through of how you test yourself, you are out of the office. And the next time they see you may be when you are going into the hospital for amputation.

The Taylor model—the health care system pays for a nutritionist who works almost on a weekly or every two week basis with that patient, saying, "How are you doing? Is your diet too restrictive? If it is, I can make substitutions." The Taylor model pays for a physician's assistant who will tell that person how to test themselves, or, if it is too painful, will suggest an alternate method, and make

sure that the patient is living up to those procedures on a weekly basis.

The Taylor model pays for the pharmacist's time as well. You manage the disease. You don't just treat it; you manage it. We can show you, in the 10 states that have the Taylor model, the hospitalization rate for diabetes compared to Pennsylvania. And we estimate we will save $2.1 billion if we can get down to the hospitalization rate of the 10 states who manage chronic care diseases. So it is doable.

Mr. GONZÁLEZ. Thank you very much.

Chairwoman VELÁZQUEZ. Time is expired.

Mr. GONZÁLEZ. I yield back.

Chairwoman VELÁZQUEZ. Governor, at what time do you need to leave the room?

Governor PAWLENTY. Madam Chair, just in a few moments.

Chairwoman VELÁZQUEZ. Okay. So I now recognize Mr. Fortenberry. Is he here? No. Who is next here? Mr. Westmoreland. No? Mr. Akin, okay.

Mr. AKIN. Thank you, Madam Chair.

I have just a real quick question. Are you assuming—and in your State is the health insurance policies, are they portable, or is that not the case?

Governor PAWLENTY. Generally, no.

Mr. AKIN. And do you support that idea, or have you looked at that? Or what is your position on that?

Governor PAWLENTY. Yes.

Governor RENDELL. Same answer.

Mr. AKIN. That is all I had. Thank you, Madam Chair.

Chairwoman VELÁZQUEZ. Mr. Altmire.

Mr. ALTMIRE. Governor Pawlenty, thank you for being so generous with your time with your flight on the other end. I spent my professional career before being elected in health care policies. This is something I have thought about and worked a lot. And I talk about pay-for-performance all the time, and I want to commend you for your testimony—and I will commend Governor Rendell after his testimony—but for what you have done to take a leading role in pushing that.

And I agree with everything you said about the incentives that exist, and it is almost as though the incentive of the provider is for the patient to get sick. They make more money the more often they come to see them, and you have taken steps to address that.

So, quickly, my question is: given the impact that pay-for-performance will have on health care providers, and particularly solo and small group providers, practitioners, what steps have you taken in your state to make sure that they are fairly considered with their interests?

Governor PAWLENTY. Thank you, Congressman Altmire. It is a great question. And I also want to say in the interest of full disclosure, what we have done in Minnesota is early stage. I think I would be misleading this Committee if anybody said we have got a full-blown pay-for-performance program, it is embedded in the culture, deeply embedded in the payment system. We are at the very beginnings of paying at the margins for diabetes, obesity, and

a few other things. So it is a start. We think we know where we need to end up, but it is just beginning.

As to your question about rural or smaller providers, in Minnesota we are trying to address that, and one way is through health information technology. That if you are in an area of greater Minnesota, and you need access to this type of information on standards, practice protocols, or the like, that you have the capabilities to access that. And we also don't make the system mandatory.

You know, in the end, if we are going to pay for outcomes, we should be agnostic as to how they get there, you know, making sure there is consumer protection and it is legal and ethical and appropriate. But we have got this intermediate step where we are paying for procedures now, and now we are going to go to best practices, and hopefully to outcomes.

But we could say to small and rural providers, "Here is the outcomes we expect. How you get there, you know, is part of the art of medicine. And we will see you on the results side of this." But we are not there yet with the system we have. But to answer your question, we are trying to provide some support to transition them, to make sure they have access through technology to the same information everybody else has got.

Mr. CHABOT. Would the gentleman yield? I thank the gentleman for yielding.

Madam Chair, if I could make a suggestion. Since the Governor has to leave literally very soon, in moments, perhaps, because a lot of members have been here, if each member could maybe ask one question so we get to as many as possible.

Chairwoman VELÁZQUEZ. Without objection, yes.

Mr. CHABOT. Thank you.

Chairwoman VELÁZQUEZ. Mr. Westmoreland. And we will come back a second round.

Mr. WESTMORELAND. Thank you, Madam Chair.

And, Governor, thank you for being here, too. I wanted to ask you about the flexible benefits program that you allowed small business—or I guess insurers to offer small business. It says that—I was just reading a statement—that the plan must be offered on a guaranteed basis to all small firms.

So are you saying that there is—that each small business cannot come up with their own menu of plans that they would want based on the employees getting together and saying, "We need this, we don't need this," but they would all have to be offered the same plan?

Governor PAWLENTY. Within a range of—Congressman Westmoreland, within a range of benefit options they can design. But once the plan is offered, it has to be available in the market broadly.

I will also tell you this program has not been particularly successful. Not because I don't think it is well designed and well intentioned, but it has been woefully under-marketed. And in my view, the health plans do not have a large incentive to sell this particular product. It is a low-profit, low-margin, high administration product, and I would say to you the impact of this in Minnesota so far has been very modest.

And so I would not bring this up yet as a success, and I think more flexibility perhaps would be—but the heart of the matter is the health plans have very little incentive to aggressively market that plan. And they are marketing, frankly, more revenue-robust plans.

Mr. WESTMORELAND. Do you think it would be better if they were able to offer different plans to different businesses?

Chairwoman VELÁZQUEZ. Remember, one question.

Governor PAWLENTY. Yes. Congressman Westmoreland, yes, but within a base of consumer protection. You know, again, this is an area where consumers can get really exploited if we are not careful. These plans and policies are very complex.

I used to be a lawyer. I try to read this stuff. I can't understand my benefits and rights, and so you have got to—within a range, you have got to protect the consumers.

Chairwoman VELÁZQUEZ. Mr. Sestak.

Mr. SESTAK. Thank you. Governor, you made a response to a question earlier—I think the response had something to do with, you know, an individual having skin in the game, you know, changes the behavior because they have to pay a part of it. Why can't you extend that skin in the game analogy that you want to change behavior by having a mandate, so that people are involved in it? And isn't that the same philosophy that, therefore, their behavior might change if they are involved in a particular sense? If they are not, you then have to wait until they go to the emergency room. Isn't it the same analogy?

Governor PAWLENTY. Madam Chair—I am sorry, Congressman, I can't see your name plate there, but—Sestak—you are speaking to an individual mandate for coverage. We have an individual mandate for automobile insurance in Minnesota with the threat of a criminal penalty, and the non-compliance rate is well north of 10 percent. And the reason for that is, in part, some people just aren't responsible, but a large part of it is people can't afford the insurance. And so there is a reality there that lies underneath that.

The other thing is, at least in Minnesota, we are so close to what many would define as, you know, reasonable universal coverage that we don't think it is necessary. We are already at 93 percent, you know, and we think we can get to the Massachusetts standard without that.

And the other thing I would be careful about, the Massachusetts approach is a work in progress. And I would suggest to you that there are some unique circumstances there that may not be—that you can't replicate. Specifically, they cut a deal with the Federal Government where they have got a big bunch of transition money that is available for a couple of years and then it sunsets. And that was part of a deal they cut on some Medicaid negotiation issues that sunsets.

Number two, they promised affordability, and it—the jury is still out yet on whether over time that is going to be an affordable plan. You know, originally, they had hoped to do it under $200 a month. I think it is north of $300, and maybe in many people's minds, if the legislature keeps putting stuff in there, it could be a $400 or $500 a month plan.

Now, they have added some people to the rolls. No question about that. But I don't think that mandating something through government is the best way to go, particularly when the main barrier is you have got people who can't afford it. And so I think a smarter way to go is to try to make it affordable and help them through the marketplace, if need be give them some financial assistance. But saying, "Poor people, you know, get this or you are going to be a criminal," seems to me not the wisest path.

Chairwoman VELÁZQUEZ. Mr. Fortenberry.

Mr. FORTENBERRY. Thank you, Governors, for joining us today. I am in your neighborhood. I am from Nebraska. And I really appreciated your opening comment. I think the major challenge before us all is: how do we improve outcomes and reduce costs? And to that end, I think you identified three absolute critical factors, one being both transparency in terms of quality of care as well as price, and in addition to that the use of health information technology to increase efficiency, but also encouraging/incenting healthy behaviors.

In that regard, I want a clearer understanding, though, as to what level of subsidy the State is providing to the various components of the health care plans that you have talked about, and whether or not health savings accounts are an important component of that, because the health savings account, in my view, particularly when you can—again, allowing someone to use the price mechanism for their own care, in partnership with their health care provider to improve an outcome, but also save a little money, is a very important way in which we can, again, achieve, again, a better outcome and reduce costs.

So I am curious as to the level of State subsidy and whether health savings accounts are an important part of that.

Governor PAWLENTY. Well, thank you. And if I could just jump back to the other Congressman's question. The other aspect of a mandate is if you mandate it, and people can't afford it, then you have just either made them criminals or you have sent the government the bill. And you guys are broke, we are going broke, so it is—where does that lead?

As to your question, Congressman Fortenberry, HSAs philosophically for me, are a right direction, a right option to present. I will say their impact in the market so far has been modest. A cousin of HSAs, as it relates to consumer empowerment, consumer responsibility, is what you do with financial alignment of—you can go wherever you want—my attitude is, go wherever you want, but if you pick a high-cost, low-quality place, we are not going to pay as much of that as we would if you went to a high-quality efficient place.

And, you know, that is oversimplified, but within the deductibles, co-pays, those types of mechanisms, I think you want to align those mechanisms to high-quality efficient places. And those are powerful incentives.

I will tell you one quick, true story. A guy's daughter got injured in Michigan. He is a Minnesotan, a Minnesota health plan, so he is out of network with a Michigan provider. She has a knee injury. It is not life-threatening, and they wanted something like $1,600 or $1,800 for the MRI in Michigan.

He gets a friend to drive her home. In the meantime, he is in an HSA, so he gets on the phone to Minnesota MRI providers. He gets quoted a $1,200 price, a $900 price, an $800 price. Finally, he finds a place that, if he pays cash up front, cash discount, he got it done for like $600.

So now not everybody is going to jump on the phone and do that, but he was a motivated, involved, engaged consumer, and got the price of that procedure down from $1,600 to $600. That is the power of having people say, "Hmm, if I have got to pay something, maybe I had better think about what the price is and what the quality is." I am sorry?

Mr. FORTENBERRY. The mechanism by which the State sets it up.

Governor PAWLENTY. Oh, yes. We have endless numbers of State programs in health care, and we are going broke over them. But one of our flagship programs is called Minnesota Care. You know that if you are—oversimplify it, if you are a senior citizen or older, you get Medicare, which is a good program. If you are disabled or poor, you get Medicaid, which is a good program. If your employer-based coverage, you get your coverage from your employer, the people who are falling through the cracks of course are the working poor who don't make enough to, you know, buy their own, or don't get their insurance from their employer, but make too much to qualify for the public program.

So the in-betweeners in Minnesota might qualify for something called Minnesota Care. It is a sliding scale subsidy program for you to go out and buy insurance, or we buy it for you, in the private market. And that is the way we deal with the in-betweeners, the working poor that fall through the cracks. And it is a big program, and the amount of subsidy varies depending on income level, and then it falls off completely. And it is a good program, but it is an expensive program.

Chairwoman VELÁZQUEZ. Ms. Clarke.

Governor PAWLENTY. Madam Chair, I am afraid I am going to have to go. But if I could thank you for your understanding, and I also want to particularly thank Governor Rendell for his patience. And I owe him one now.

[Laughter.]

And owing Governor Rendell is not a good thing.

[Laughter.]

Chairwoman VELÁZQUEZ. Thank you, Governor. Thank you so very much, Governor.

Okay. Well, I now recognize Mr. Sestak for the purpose of introducing our next witness properly.

Mr. SESTAK. Thanks, Chairwoman Velázquez and Ranking Member Chabot.

I am very pleased to introduce Governor Rendell. When I got out of the Navy two years ago this month and entered politics, and I asked somebody what to do, he said, "Do what Ed does." Everybody, you know, calls him Ed. You can go to every train station in the morning at 6:00, every hoagie shop during the day, and every restaurant early evening, and every bar late at night.

[Laughter.]

And then, finally, they said, "Make sure you do what he did as—make sure Wawa names a sandwich after you," because we have

up there the Rendelli Wrap, which is chicken strips with buffalo blue cheese. I haven't gotten the last one, but I followed everything else and I am here.

He certainly is a man of the people. After he took over in 2003, even though I watched from a distant way at sea, he basically took very strategic investments and revitalized communities of people, enhanced their education, an really began to expand health care, starting with those who were disenfranchised at the time, the young children, all the way to mental health and drug addiction.

I am really pleased that we are addressing this today with him, because it is a real brain-drain on small businesses at times. They do create 70 percent of all jobs, but they don't—aren't as able to provide health care, so, therefore, those kids, those entrepreneurs, those startup types, are being potentially more attracted to large businesses rather than small.

And so what we will hear from him is a prescription for Pennsylvania that has several components to it—cover all children, cover all Pennsylvanians, but also to address costs by—what I am most taken by is the impact that we are going to address this issue of health-caused infections, all the way down to chronic disease management.

In short, his approach is exactly who he is. It is everybody contributes, everybody benefits in a common-sense, comprehensive approach to health care. And at the end, just before I introduce him, on a personal note, as every new politician does early in their career, they get into trouble.

[Laughter.]

They make some decision to speak somewhere potentially, as in my case, and where segments of a certain community were either blogging me to death, or whatever, and I decided to stay the course. There was one politician who decided to show up that evening uninvited to stand beside me at a pretty trying time, and so I very much thank you, Governor. You really are not just a great politician, but, without question, a selfless individual who is truly, in my opinion, a profile of courage.

Thank you.

STATEMENT OF THE HONORABLE EDWARD G. RENDELL, GOVERNOR OF PENNSYLVANIA, HARRISBURG, PENNSYLVANIA

Governor RENDELL. Thank you, Congressman.

Chairwoman VELÁZQUEZ. Welcome, Governor.

Governor RENDELL. Thank you, Madam Chair.

Let me just give you, first, a quick look at a thumbnail sketch of where we stand in Pennsylvania, our situation, not quite as rosy as Minnesota.

In the last seven years, from 2000 through 2006, health care inflation has risen in Pennsylvania by 75 percent. Regular inflation—health care premiums have risen by 75 percent. Regular inflation, 17 percent; median income has grown by 14 percent. So you can see just how far, how fast, small business or all business employers have fallen behind the health care premium rate of growth, and how the employees who contribute have fallen behind. Their buying power is much, much less than it was seven years ago.

I would submit to you that if we fast-forwarded to 2013, the next seven years, and those statistics continue, health care as we know it in Pennsylvania, and my guess is in almost all of the states represented by this panel, will be over. There will be no employer-based health care in the United States of America. I think that is unsatisfactory and wouldn't be a good result for us.

In Pennsylvania, we have—the good news is we have about 92 percent of our people covered. The bad news is it is 800,000 adults without coverage—a little less than 150,000 children. Of those who are uncovered, 74 percent of them work, and the vast majority of them work for small businesses. And I am using the federal definition of small businesses—50 employees or less.

Twenty-seven percent of them have been uninsured for at least five years. Premiums for employer-based health care rose in 2005 by 9.2 percent. It was the fifth straight year that premiums increased by at least 9 percent.

In less than 10 years, the average cost for premiums for family coverage in Pennsylvania through employer-sponsored health care has gone from $4,800 in 1996 to $11,400 in 2005. During that same period, if you were just trying to insure your employee, coverage went from $2,000 to $4,600. Stunning increases.

And the most stunning fact of all—Pennsylvania is second only to California in the number of citizens who, between 2000 and 2007, have lost employer-based health care; 491,000, effectively one-half million Pennsylvanians, have lost employer-based health care in the last seven years, second only to California, as I said.

Now, what can we do about it? I think what we have to do is take strong and decisive action, do it quickly, do it smartly, and I believe the answer is a combined federal and state program.

But let me tell you a little bit about what we have tried to do in Pennsylvania. You have heard Congressman Sestak said, and the Chairwoman said, we have a plan called Prescription Pennsylvania. It has three components, all equally important. The first component is to contain and drive down costs. If we don't do that, nothing else we are designing here will matter, because—Governor Pawlenty used the vacuum analogy—because everything will be swept away unless we can contain and reduce certain costs. We believe we can do that.

The second component of our plan is to cover all Pennsylvanians. But if you did that, the average premium for a small business or a large business would drop by 6.2 percent. If we covered all Pennsylvanians, it would save the health care delivery system $1.2 billion in Pennsylvania—a 6.2 percent reduction in that small businesses' premiums. And I want you to keep those percentages in mind.

The second thing we want to attack is medical errors, and we are attacking them in a number of ways. As I said, in our Medicare and Medicaid program, we are stopping paying for obvious and preventable medical errors. We want big businesses to join us in doing that. Preventable medical errors cost $2.1 billion, about 10 percent reduction in premiums if you get rid of all them, and I know you can't.

Hospital-acquired infections—I think Congressman Sestak made reference to that. We require our hospitals to report the level of

both medical errors and hospital-acquired infections. Last year, there were $4 billion of hospital-acquired infections. You know what that is. I come in for an appendectomy, I am otherwise perfectly healthy, but I get infected by something that occurred inside the hospital. It is stunning.

The average cost of hospitalization in Pennsylvania is $32,000. If you get a hospital-acquired infection, the average cost is $180,000. Are hospital-acquired infections—and you have all now heard about MRSA—are they preventable? Yes, they are. And Scandinavian countries have pretty much zeroed them out. They are preventable.

Some good work is being done here. The Pittsburgh VA, Congressman Altmire, is the leading Veterans Administration hospital in controlling hospital-acquired infections. They have an interesting protocol, which I don't have time to tell you about, but over the course of the average stay that protocol costs $377. It is masks and gowns and hats for everyone who comes within a certain amount of the patient. It costs $377, so you pay me now $377 per patient, or you pay me later $150,000 per patient.

We passed in Pennsylvania the first comprehensive hospital-acquired infection bill in the State. We make hospitals file an HAI control plan. We make them adhere to best practices. We reward them, give them monetary rewards, for incremental reductions in hospital-acquired infections, and we punish them.

I have said, and my Health Commissioner stands ready, if a rate of hospital-acquired infection does not come down or grows over a certain period, we will take away the license of that hospital. And I don't care if it is the most blue chip hospital in Pennsylvania, if they are not going to take it seriously, we will take away their accreditation.

The next thing we do is to free up our non-medical providers to do more in the health care delivery system. We passed comprehensive legislation to do that. And as a result, nurse-run clinics are cropping up all over Pennsylvania—in big box drug stores, in food stores, in supermarkets—and they give treatment in off-hours.

So we have stopped the flow of people going to emergency rooms for non-emergency treatment, because they can go to these nurse-run clinics. It increases accessibility, particularly in rural areas, in hard-served urban areas, and at the same time it cut costs, because instead of a primary care physician, you are getting a certified nurse practitioner delivering the same treatment. Instead of a dentist, you are getting a dental hygienist, delivering the same treatment at significantly less cost.

Chronic care I alluded to, and so did Governor Pawlenty. We believe we can cut out most of those $2 billion of unnecessary hospitalizations that come from an improper method of treating chronic care diseases. Just take hospital-acquired infections—if we could eliminate half of the $4 billion that is being spent now by the health care delivery system, that would be another 12 percent reduction in the cost of premiums.

So can we constrain health care costs? Is it useless? Of course not. Of course not.

In our State Employee Benefit Program, it employs 58,000 employees. Rather than all of those increases that I have told you, in

the last three years we have had zero increases. Why? Because we went to generic prescription drugs for everyone. You can't get a name brand. You cannot get a name brand.

We have wellness programs where we give employees financial incentives for meeting wellness standards, and those things have caused us to be able to hold down our plan. So anyone who tells you that we can't constrain costs in the health care delivery system is not telling you the truth.

The second part of our plan is cover all Pennsylvanians. That doesn't relate directly to small business.

The third part of our plan is how we attack insurance reform, and insurance reform is very, very important. Small businesses in many states get killed by the rating system. If you have got 10 employees, and two of your employees—let us say they are 28-year old men—leave, and you hired or replaced them with two 25-year old women, your rates, unless they are controlled, will spike through the roof. Why? Because they are child-bearing years, and there are potential risks.

Many states still allow—and Pennsylvania is one of them—still allow that type of demographic rating. We want to change that. We want to go to only age, location, and geography, as things that can cause differential in prices. We want to make sure the highest price that an insurance company can charge per employee is only twice the level of the lowest price that they charge. That is crucially important to small businesses.

We want to pass a law that says 85 percent of the premium dollar goes to providing health care, not to advertising, not to salaries, not to overhead, but to health care—a crucially important aspect of this. And as I said, we want to give the Insurance Commissioner the right to set rates and to adjust some things that are clearly unfair practices.

Cover all Pennsylvanians—we offer a good—stripped down but good basic health care product—hospitalization, prevention, unlimited doctors' visits, generic prescription drug coverage, mental health and substance abuse coverage. We subsidize it using some federal funds, 33 percent federal funds, about 30 percent State funds. We subsidize it by asking the employer to pay $130 a month. The employee pays either $40 or $60 in contribution per month, depending on their overall family income.

It is a good, stripped down, affordable plan, and we believe it will cover virtually everyone who works for small businesses. This is only available to small businesses, 50 employees or under. And it is only available to low wage businesses. Low wage businesses are defined as businesses that have a median income—their average payroll is less than the median income, which in Pennsylvania is $42,000 times, let us say, 10 employees. If their payroll is lower than that, they qualify for the product. But we are requiring all insurers in Pennsylvania to offer this product without the subsidy.

We also offer it to people who are self-employed. We offer it to people who don't have coverage in any other way. We even offer it to people who make more than 300 percent of poverty, but they come in and buy it at our cost. Our cost is $240 a month that we pay to subsidize. So it is a good, workable plan. It will cover most of the people in small businesses.

And at the same time, insurance reform is crucial, it is absolutely crucial—small businesses get hit more by insurance company practices than anything else—and containing costs. Those are the things that I believe can give us a workable, affordable, accessible health care system in both Pennsylvania and across the country.

[The prepared statement of Governor Rendell may be found in the Appendix on page 45.]

Chairwoman VELÁZQUEZ. Thank you, Governor.

And I am going to ask unanimous consent that the Chair and the Ranking and all the members will have an opportunity to ask just one question. Without objection.

Governor, if I may, I would like to talk to you about the funding vehicles for the CAP program. And I know that has been the center of the debate in the Pennsylvania legislature. And under your original proposal, the fair share assessment would have required businesses pay into a fund if they do not offer health coverage.

And this plan was similar to the Massachusetts reform, but I understand that it was opposed by some lawmakers. Can you talk to us about the original plan and why you believe there was some resistance to it, and how are you funding this initiative now?

Governor RENDELL. Well, real quickly, we had three sources of funding—one, to increase our cigarette tax by 10 cents a pack, still keep us far lower than New York and New Jersey; two, to tax smokeless tobacco products. Unbelievably, Pennsylvania is the only State in the union that doesn't tax cigars and smokeless tobacco products. When I came in, I said that can't be right. North Carolina, Kentucky, Virginia—no, we are the only ones. So those were the two sources.

And the third source was the fair share assessment that got at the free riders. And I believe, conceptually and in every way, that there shouldn't be free riders. Whether you are a small business or whether you are a 1,000-employee business, if you don't provide health care, you are driving up the cost of everybody else.

If you have got 1,000 employees and you don't provide health care, everybody's premium—every small business in the State who does provide health care is paying over 6 percent additional to their premium because of you. So we proposed a 3 percent payroll assessment, payroll tax, whatever you want to call it.

Because it would have impacted on small businesses, it got very little support in the legislature, including by my own Democrats. Even though we phased it in for five years for small businesses, we had a lot of small business protections, but it still became—you know, eventually you get the message you are not going to get it through.

I still think it is the best way to go. There should not be free riders in the system. Why should one machine shop with 10 employees offer health insurance to its employees and the other, who is competing with it—you know, two miles down the road—get away without offering health insurance, and those 10 employees get picked up in ways that we all eventually pay for—ratepayers and the State and eventually pays for.

So as a substitute, it is really too complicated and not worth spending the time. But we have an abatement fund for our doctors

from their medical malpractice insurance liability that they pay to the State in Pennsylvania—you pay private premiums, and you pay to the State for the catastrophic fund. We abated that fund; especially for specialists, we abated it when we were in the middle of the medical malpractice crisis.

We have kept that abatement on, and it has worked very successfully to stabilize the practice of medicine in Pennsylvania. but it is racking up big surpluses, so we are tapping into the surplus to pay for—to cover all Pennsylvanians.

Chairwoman VELÁZQUEZ. Thank you, Governor.

Mr. Chabot.

Mr. CHABOT. Thank you. First of all, I represent Cincinnati, Ohio, Governor, and I would appreciate it if your Steelers would quit beating up on my Bengals. So—

Governor RENDELL. Next year.

Mr. CHABOT. All right. We will see. Hopefully, we will do better next year.

But my question is that there are some uninsured individuals, especially young people, who could afford health insurance who just choose not to be covered. What would you do, what do you do, about individuals in that situation?

Governor RENDELL. Well, interestingly, I favor mandating so those people aren't free riders either. I favor mandating. But, again, it was one that I knew—we have, as Representative Altmire and Representative Sestak will tell you, a little bit of a conservative legislature. And I have dragged them kicking and screaming into the 21st century.

But there were certain things that I knew I couldn't accomplish, and what we said in Pennsylvania—we will try it without the mandate for five years, and then see if the free riders are hurting the system. Do you know who wants those 28-year olds in the system? The HMOs, and with good reason—because if we are going to force them to cover—and in Pennsylvania we intend to force them to cover cancer patients, everybody—they should have the right to have the healthy 28-year olds in the system.

In fact, they are called by the health care profession "the invincibles." They are 28-year old males, they never think they are going to get old, they have never seen a doctor, they don't think they have any need for a doctor. In fact, I was an invincible once. I was playing basketball and I took a pass on one of my fingers. And I didn't go to the doctor for three days because I thought I could heal it myself. As a result, I have a crooked finger for the rest of my life.

The invincibles are the ones that everybody wants. In Pennsylvania, we have designed a bizarre system. If you have cancer, and you are not covered, you can't get health care coverage. If you are a 28-year old, and you are perfectly healthy, everybody wants to cover you. It is you-know-what backwards. It makes no sense at all.

[Laughter.]

You know, it makes no sense at all. And to make the system work, to be fair, if we are going to keep the system of insurance companies delivering the basic product—and I think we should—I think you need to get the invincibles into the system for the benefit of the insurance companies.

Mr. CHABOT. Thank you, Governor. I yield back.

Chairwoman VELÁZQUEZ. Mr. Ellsworth.

Mr. ELLSWORTH. Thank you, Madam Chair.

Governor, thanks for being here. Governor Pawlenty talked a lot about the performance pay or time payment to quality. Could you tell—in your studies, you have obviously studied this a lot. Can you tell me your views on that and some of the pitfalls you see and/or the challenges? I know you said it was in the infancy stage, but just what your experience has been or how you view that.

Governor RENDELL. You know, we have a wonderful medical profession in this country, wonderful hospitals, wonderful doctors, the best in the world. And Pennsylvania really, in teaching hospitals, leads the way. But you have got to motivate the system to change.

Think about it for a second. Why are there $4 billion worth of hospital-acquired infections? Why are there? Don't the hospitals care about the quality of care that they deliver? Aren't they worried about what happens? By the way, that $4 billion, also 2,500 deaths a year; 22,000 cases of hospital-acquired infection, 2,500 deaths.

And the interesting thing, all the cost containment stuff I talked about, better way of handling chronic care, hospital-acquired infections, medical errors, all of those things improve the quality of the system. Normally, when we save money—I know when you try to save money in Washington people say, "Oh, you are hurting people." Here, we are saving money and helping the quality of the delivery of the system.

So preventable medical errors are step 1, and we are doing it in the Medicaid program. We intend to do it for everyone in our system, for our seniors, for our employees. I mean, we are the 800-pound gorilla. The State of Pennsylvania actually insures 24 percent of the people who get health insurance in the Commonwealth of Pennsylvania. So we intend to do it, and I am talking to employer groups about doing it.

Why? Because it will motivate cost-saving and quality-inducing changes that we can't seem to motivate anyway. When I visited the Pittsburgh Veterans Administration Hospital—and if you all have time, go there and see what they have done—the protocol is neat and it makes sense, but the thing that is so important is everybody has bought in—the doctors, the nurses, the janitors, the maintenance men. We had a janitor who showed us, with great pride, his storage room, and he said, "Governor, I don't leave work until I make sure there are enough caps and gowns and masks in here so nobody can use as an excuse that they didn't have available caps and masks and gowns." Everybody has bought in.

And right now, the medical profession isn't thinking about cost savings. A some of our great teaching hospitals, I have had people tell me that surgeons look at hospital-acquired infections as a cost of doing business. Well, we have got to motivate them to start thinking about quality of care and about cost reductions.

Mr. ELLSWORTH. Thank you. I would yield back.

Chairwoman VELÁZQUEZ. Ms. Fallin.

Ms. FALLIN. Thank you, Governor, for coming today. I was just slipping out to another meeting, but they told me I was next to ask a question, so I am going to stay for just a second.

Governor RENDELL. Well, thanks for staying.

Ms. FALLIN. I was interested in your comment about the two men and the two women, and the two men left and the two women were hired, and the insurance premiums went up for the small business, if I remember the story right. And you were talking about how the women were of child-bearing age, and so the rates went up because they were rated differently, and how are we going to resolve the difference on ratings in various stages.

And, you know, as I was sitting here thinking about that, Mr. Chairman, I was thinking about how women are kind of discriminated against with the ratings on health care and health care costs for insurance, and how, you know, I could see where employers might rather hire a man than a woman if their insurance premiums are going to go up because a woman is of child-bearing age.

So I just thought that comment was kind of interesting. I hadn't really thought about that in the past.

Governor RENDELL. It is devastating. The smaller number of employees you have, the smaller your pool is. Demographic rating allows them to rate just your pool of employees. Community rating is you rate all of the people in that HMO in the entire state or in the entire nation. We should basically have community rating with a few nods—obviously, age would be one, the geography would be one, because in certain part of the country—in Philadelphia it is more expensive to have health care than it is in Tioga County in the northern tier of Pennsylvania.

So some limited number of factors in which they can spike rates. But, again, we want to reduce the spike to no more than two to one. Right now, some rates spike seven, eight, to one. Heaven forbid you have got five employees, and you just—you want to hire this brilliant woman who has got a brilliant resume, she is 29—sorry, she is 39 years of age and in her mid-30s she successfully fought breast cancer. Wait until you see—in states that have demographic rating, wait until you see what happens to that small business' overall premium because they have hired somebody, even though the breast cancer is in remission, who has had breast cancer.

So, yes, I think there is a lot of discrimination in the system, as long as you allow demographic rating.

Ms. FALLIN. I appreciate your comments. Thank you.

Chairwoman VELÁZQUEZ. Ms. Clarke.

Ms. CLARKE. Thank you, Madam Chair.

And thank you, Governor. Why do you think that only certain small businesses get access to the subsidized health plans under the CAP program? And why not all small businesses?

Governor RENDELL. Well, because let us say you are a hedge fund, and you have 20 employees, and the non-administrative employees—let us say the 12 professional employees are making—oh, on an average, the hedge fund these days—$3 million each. We don't think the state should be subsidizing them.

But we do say—we do offer—by regulation, we would make the HMOs offer the same plan to them at cost—you know, at cost. It wouldn't be subsidized, but they could get it if they wanted it, for $240 a month per employee. They probably wouldn't want it, because they would probably want a few things like, for example,

only dental emergencies or cover all Pennsylvanians. Now, a hedge fund is not going to want that plan, obviously, but that is why we did it—just to make sure that those firms who really can't afford to do a non-subsidized plan take it.

Chairwoman VELÁZQUEZ. Mr. Buchanan.

Mr. BUCHANAN. Thank you, Governor, for coming in. I am in Florida, Sarasota, Florida. I want to thank you for your leadership. One of the things I would just say, with all of this discussion about national health care programs, I am glad that governors like you are leading in this, because I am scared to death to let the Federal Government deal with this. If we can find the best practices within a given state, and then take that, because as you mentioned it could break the country. I mean, we are already tight on federal dollars. I know you are tight on dollars in Pennsylvania. So that is just a statement.

I have been in business for 30 years myself, and I have seen this cost go up. You know, we had, two or three years ago, 1,200 employees, so we have dealt with this. We use a lot of different insurance companies. And you mentioned a lot of different things.

One thing you didn't mention that does come up a lot—and I would just get your opinion, and I know this is a little bit political, but I think there is a lot of blame to go around for a lot of things—hospitals, doctors, and, of course, insurance companies. But one of the things I do hear a lot of our doctors—and we don't have a lot of doctors coming to Florida, and I am concerned about that—is this whole concept of defensive medicine. What is that costing us?

You know, it is not about the trial lawyers. It is about you looking—putting everything on the table. But when you look at defensive medicine, you look at a lot of the doctors 20, 30 years in practice, specialties, that deal with surgery, have put all of their assets into asset protection, their wife's name. Then, you have the cost of MedMal; many times that gets passed through. Or, in our State, I have got to tell you, a lot of doctors don't even take it, can't afford it. texas has come up with their cap where it is $250,000, and that seems to lower premiums.

But I will tell you last week I was with a neurosurgeon. We had our week in the District, and he said to me, he said, "Vern," he said, "I give out 10 times more in CAT scans than I used to. I shouldn't, but I do because a guy comes in or a gal comes in, has a headache. I have got to have them run down all these tests because of that chance—1 in 10,000—that it is more than what I think it is. I have got to run all of these tests. They are expensive tests, and, you know, that just—that gets passed on to, you know, Medicare in our case."

And so I don't—what is your whole thought on that aspect? And, again, I just want to make it clear, I am not just pointing out one area, because—

Governor RENDELL. No, no, no.

Mr. BUCHANAN. —there is a lot of blame to go around, and I am—I share—

Governor RENDELL. And you are absolutely right. And when I came in, we did things to, first, stabilize the medical malpractice crisis, because we were right up there with Florida in the level of our premiums. And premiums were increasing 50, 80 percent. I am

glad to tell you that, because of the things we did, we have had three years where—two years where premiums stayed zero, and this year the two major companies dropped them by 7 and 11 percent.

There are too many junk cases in the system, too many outrageous verdicts. There are ways you can do reasonable tort reform that don't throw the baby out with the bath water. The case I gave you about the never event, the amputation of the wrong arm, is there anybody here who would not want some compensation for somebody who goes into a hospital and loses an arm that there was never anything wrong with? Of course not. You are not suggesting that either. There has to be some reasonable compensation.

I think the long-range plan that we have adopted in Pennsylvania by rule of criminal—of civil procedure, excuse me—we have adopted a mediation program. The one that Chicago, Rush Hospital, it is a very famous program—the mediation program, within a month, if there is a claim, the claimant comes in—they can bring a lawyer—the hospital and the doctor are there. There is a mediator. They hear both sides. The mediator makes a suggestion.

He says, "Mrs. Rose, you know, this is a very close case. I am not sure there was error here. I am not sure you would convince a jury. But, you know, you do have some injuries. It wasn't your fault. We are going to give you $80,000, I recommend." She can take it, or then reject it and go on to court. She is not waiving any rights.

It is amazing—in Russia, I think it is 73 percent of the cases are settled within one month in the mediation program. And what that does is knocks out most of the legal costs. Most of—it is not—the big verdicts are the ones that get the attention. But if you talk to an insurance company, what it really is is the junk lawsuits that are thrown in where someone is hoping that they will settle for $35- or $50,000. It eliminates most of those junk lawsuits.

And it eliminates the insurance company, the hospital's legal bills, because if it is a junk lawsuit, even if they win it, often they run up $100,000 in depositions and pre-trial stuff and all of that.

So, yes, I think we should have reasonable tort reform. I don't agree with a $250,000 cap, because I could sit here and give you examples, and I don't think any one of you would think that $250,000 were compensation. Someone goes in for—a 25-year old sheet metal worker goes in for a herniated disc operation. Through undisputed malpractice, he gets—he comes out of that operation a quadraparaplegic—never hold his child, never have relations his wife, never walk again, never bathe himself again. $250,000 above medical costs for—he will probably live another 50, 60 years? I don't think that is fair.

But having said that, we can certainly do something—and you are right, we should do something—because there is too much defensive medicine being practiced, and we have got to get a hold on rates, and we have got to have a balanced approach.

I would love it if the Congress could get together with the next administration and do something reasonable on tort reform that doesn't take away rights in the most extreme and brutal cases, but at the same time doesn't make the medical system do all of these things.

Remember, $2.1 billion of avoidable medical errors, and that is the assessment of the Patient Safety Authority in Pennsylvania that is made up of mostly either former doctors or practicing doctors or academicians, not the assessment of trial lawyers. So we want to reduce those, too, because it is patient safety.

We focus on the monetary aspect of the tort system, but it is also patient safety, too. A physician told me about hospital-acquired infections—he said, "If my wife had to go in for surgery, let us say on her elbow," he said, "I would have someone do it in my office before I would put her in the hospital."

Chairwoman VELÁZQUEZ. Okay. Time is expired.

Mr. Altmire.

Mr. ALTMIRE. Governor, Congressman Heath Shuler sits next to me here in the Committee, and he wanted me to pass on to you that, in preparation for you coming in, he went back and reviewed your comments from the Philadelphia Eagles game where you used to do—

[Laughter.]

—against the Redskins, the media and television worker.

Governor RENDELL. Absolutely.

Mr. ALTMIRE. He was very much looking forward to cross examining you.

Governor RENDELL. Sorry I missed it.

[Laughter.]

Mr. ALTMIRE. But he did want to pass on his regrets that he was unable to be here.

The purpose of this Committee is to study national policy as it relates to small businesses that are struggling with affording health care. And you have done great work in Pennsylvania, and you have made small businesses the staple of your reform policy. So I was wondering if you could explain, to the degree you could extrapolate, how we might look at this from a national perspective, what you have done in Pennsylvania.

Governor RENDELL. Yes, that is a good question. And can I say to the Committee, when you talk about state plans, when Massachusetts pounds its chest and says, "We have a State plan," and California and Pennsylvania are going down that road, it is a state-federal plan. Your plan—under my plan, the Federal Government would pay 33 percent of the cost. So it is not fair to say it is a state plan. It is somewhat similar to how we deal with Medicaid; we share the costs.

And, again, no disrespect to Senator Obama, Senator Clinton, or Senator McCain, but I think one thing you should possibly examine is, do we promote states going down this road? And do we reserve for the Federal Government a couple of key things that the Federal Government can do that nobody else can do?

Governor Pawlenty talked about bringing technology into the system, and we desperately need it, and it will save tens and tens and tens of billions of dollars a year across the nation. Well, right now, we are going down that road a little bit, but I don't believe we will ever have a truly interoperable health care technology system without the Federal Government stepping up and at least putting matching dollars into the fray.

And when I say "matching dollars," not necessarily for the states—maybe—but also for the institutions, because they will benefit by it. We should have a card that you can take out of your wallet like a credit card, and that card should be—it should be the type of card that if I am visiting friends in Seattle, and for some reason I fall unconscious, while they are bringing me into the emergency room, somebody should take that card, stick it into a computer, it should give you my entire medical history, my blood type, what I am allergic to, etcetera, etcetera, and at the same time read out tests.

I may have had an EKG just a week before in my doctor's office in Philadelphia. That will save us so much money, and, again, improve the delivery of health care services. How many episodes—they are called ADEs—when someone gets the wrong prescription, and they get grievously sick because they get the wrong prescription. If you had that card that went from provider to provider, pharmacy to pharmacy, and you could stick it in the computer, we would eliminate all ADEs.

And so I think the Federal Government is the only vehicle who can up-front that money. But it is a particularly important role.

Stop loss-if you had three corporate executives here—big business, medium business, small business—they would tell you that what kills them the most and drives up their premiums is the one or two percent of their employees who have significant illnesses, chronic care, heart disease, cancer, brain tumor, etcetera.

Well, stop loss—I thought it was the best idea that came out of Senator Kerry's campaign. The Federal Government pays 75 percent of the costs above the first $50,000. They pay 75 percent of the cost. If the Federal Government did those two things, maybe we have a system where the state government provides the coverage, federal money matches it, maybe we have a system that works there without, you know, doing a massive program, just two basic things.

Now, there is a cost involved for this. You all know—and I know you are all smart enough to know this, and you have been here—that we are not going to get a program that will improve health care, constrain costs, give everybody access to health care, without some upfront cost.

But the option of doing nothing is the most costly of all. If we do nothing, those 75 percent increases in premiums in the last seven years in Pennsylvania will continue. And I would submit to everyone that that is not an option. Right now, doing nothing is not an option for our health care system delivery problems.

Chairwoman VELÁZQUEZ. Mr. Davis.

Mr. DAVIS. Thank you, Madam Chair.

Thank you, Governor, for being here today. I come from the State of Tennessee, and you have probably followed TenCare down through the years.

Governor RENDELL. Sure.

Mr. DAVIS. TenCare was such a good program that it went broke, and the current Governor had to pretty much dismantle TenCare. How does your State's program parallel TenCare?

Governor RENDELL. Well, it is different, because we have a sliding scale of subsidies, number one. We make the employer and the

employee contribute. That is crucially important. It is crucially important. And we believe we have done the actuarials and all of those things well enough that we have got revenue streams that will control the—it is always easy to do the first year of these programs. It is easy to do the first three or four years.

What you should judge these programs by is: what is the funding going to be? Are you going to be okay 10 to 15 years down the road? And I think we have worked very, very hard with actuaries and everybody else to try to make sure that adequate funding exists for the program down the road. It does no good to design a health care program and then have it go bust seven, eight years later. It just increases people's frustration.

So I think it is very important that what we do we do—we study it, we do it well, and we do it practically. And it is not worth doing if we are going to try to do it on the cheap. And, again, in the long run, I believe we will save a tremendous amount of money, but it is not worth doing if we do it on the cheap.

And putting technology into the medical system is a good example. There is going to be significant upfront costs—significant—and maybe it is the Federal Government, the state, and the providers that share the burden. But there will be tremendous cost savings down the road—tremendous cost savings down the road.

So, but you are right—I mean, we have tried to plan—I gave the people who are working on Prescription for Pennsylvania—I said I want to know where we are going to be 15 years from now. And I think that is the crucial part of it.

Mr. DAVIS. And if you look at health care now, I think health care needs to be patient-centered. Patients need to—really, not even government, not business owners. We need to have patient-centered health care.

Governor RENDELL. No question.

Mr. DAVIS. And I think that is where we get off base sometimes when we are looking at health care, and if we could get it back down to the patient—actually, I had a health care conference last week in my district, and I brought in U.S. Chamber of Commerce, I brought in National Federation of Independent Business, I brought in American College of Physicians, I brought in hospitals, I brought in large insurance companies, I brought in consumers.

And I think it is vitally important that we have the stakeholders sit together and talk about the issues that are important and what we can afford, what we can't afford, what we need to do. One of the things that came out of the hearings last week in my district is we need more primary care physicians. There are so many physicians that are actually being trained, and then they can't afford to pay their loans off by being a primary care physician, they have to be a brain surgeon or a cardiac surgeon or—

Governor RENDELL. That is an incredibly relevant point. To address that in Pennsylvania, we have actually increased our Medicaid reimbursements to primary care physicians as part of this. But interestingly—my staff always tells me I am not allowed to give the exact percentage—but there is a New England Journal of Medicine study that says certified nurse practitioners can do X percentage—and it is pretty high—of what a primary care physician can do for 40, 45 percent of the cost.

We need to unleash nurse practitioners and RNs. We need to unleash them to do the things that they are trained to do. Most of those nurse practitioners, many of them have Ph.D.s, and so you can set in rural parts of Tennessee and rural parts of Pennsylvania—you can have those nurse practitioner-driven clinics that do an awful lot of good in providing basic health care to citizens. You don't need to go to a doctor for a flu shot, right? I mean, there is no reason to go to a doctor for a flu shot.

One of the cost-saving devices we have—and this is—this question reminds me of it—we are requiring every hospital in Pennsylvania that has an emergency room to have a 24/7 non-emergent care facility staffed by nurse practitioners and physician assistants, because we designed a health care system in this country that is open from 8:00 in the morning until 5:00 at night, Monday through Friday. Heaven forbid you get sick on the weekends or you get sick at night. You have to go to the emergency room for non-emergent care.

Your dog bites you, just you are rolling around having fun with your dog, he gets too playful and bites you at 9:00 at night, where do you go? You go to an emergency room. You go to the emergency room, the attending physician gives you a gauze pad, says, "Put pressure on it," and then he utters the most dreaded words known to mankind, "We will get to you as soon as we can." Four and a half hours later, they bring you into a room, the doctor looks at it, gives you—wipes it with an antibiotic, and gives you two stitches.

What we want is, when that admitting physician looks at you, says, "No, go down to Room 101. You don't have to be here." You go into Room 101, a nurse practitioner or physician's assistant looks at it, puts the antibiotic on, stitches you up, you are out in a half hour, 45 percent of the cost to the system. Forty-five percent of the cost to the system.

But you couldn't be more right; patient-centered is crucial, and we have got to find a way to do these things. And communication is important. You know, I asked the hospital execs, I said, "Why don't you do something about hospital-acquired infections?" If it was impossible to do something about it, I could understand. Then, it would be a cost of doing business. But Scandinavia has done it, and certain hospitals in the U.S. have done it. And they said, "Well, it is hard to get the doctors to buy into it."

Chairwoman VELÁZQUEZ. Time has expired.

Governor RENDELL. You are not a good administrator if you can't get the doctors to buy into it.

Chairwoman VELÁZQUEZ. Mr. Sestak.

Mr. DAVIS. Thank you.

Mr. SESTAK. Thanks, Madam Chair.

Governor, I wanted to follow up with a question I had asked Governor Pawlenty, but I didn't get a chance to kind of follow up with him. The reason I am—I am curious about this mandate question, because the theory—and I understand how Massachusetts is unique and all. I don't think anyone was asking to criminalize anyone.

Governor RENDELL. No.

Mr. SESTAK. Criminalize with—

Governor RENDELL. Not at all.

Mr. SESTAK. —insurance. But my question stems from so many kind of comments that were made here—if you have managed care, if you can prevent the diabetes from getting worse, the cost of going to the emergency room when it is acute for those who don't have insurance, the fact that millions of the 47 million uninsured can afford insurance, the youth that are living on Wall Street and doing well.

So the concept has been that the mandate has the healthy as well as the unhealthy in the pools, and then you theoretically have the premiums go down, because the healthy are mandated to be in it. The benefit also is less go to the emergency room.

Governor RENDELL. Absolutely.

Mr. SESTAK. Because you have managed that care. So my question is: I know you have touched upon this, I think in your plans thinking of the 300 percent and above, because you would have subsidies, obviously, who—those can't afford it, you know, so that you could do it. So could you give me your opinion on this concept of mandate?

Governor RENDELL. Well, I will—you know, this business, and then, you know, this issue has reared its head in the political campaign. It is ludicrous to suggest that the poor are going to be criminalized or in any way punished or be in violation, because they won't be able to afford it. For example, on Cover All Pennsylvanians, if you are 150 percent below the poverty level, if your family is, you get into the CAP program without paying a dime, without paying a dime.

And as you go above 150 percent, the premiums—monthly premiums rise for you. But if you are 150 percent and below, you get in without paying a dime. It is as plain and simple as that. And Massachusetts was much like that, etcetera, etcetera, etcetera.

Nobody is going to keep a poor person out because they can't pay. What the mandate was designed for is—ironically, is to help everyone and to help the insurance companies, because every one of those 28-year olds—and there are plenty of them, there are plenty of them—if I was a—I was an assistant DA working for the city of Philadelphia, but if I had—when I went to private practice, I had my own little practice, I didn't have health care. I was 29 years old.

But if something happened to me, I would be treated in an emergency room. And that cost gets paid—passed back to the taxpayer and to the ratepayer. "No free riders" ought to be the rule. It is absolutely basic. And, you know, as I said, we do it—and Governor Pawlenty is right, there are a lot of people who avoid insurance. But most of them don't avoid it because—some of them avoid it because they can't pay, but in this case no one is going to have to worry about not being able to pay for it. So I think it is a fair system.

And if you had an insurance company—the Congressman made a good suggestion to have not just political people at one time, get a panel of one person representing everything. The insurance company guy would be waving his hand frantically and saying, "Well, if you are going to make us take someone with a pre-existing cancer, then you have got to give us the 28-year old." And that is right.

Unless we want to go to single payer, and, you know, there are pluses and minuses to single payer—unless we want to go single payer, we have to do something that is fair and balanced for the insurance companies as well.

Mr. SESTAK. Governor, one other question that I am intrigued by in watching Massachusetts. And sometimes it is not just the theory; it is how they executive it. So the quasi-government connector that is permitted to take all of these small businesses and pool them together to where to some degree you can Wal-Mart it, then, through competition, having mandated that the healthy are in as well as the unhealthy, again, the question was asked here, and I understood his answer is—I think what his answer was, "I wouldn't prescribe anything." But yet, do you see value in pursuing that?

Governor RENDELL. Sure. Absolutely. And by the way, I know the Congressman asked a question about the health savings account. It isn't here. If you are a small business, and you offer health savings accounts to your employees, that counts. You don't have to go into Cover All Pennsylvanians. That counts, even though I think when you get to lower income working people health savings accounts are not very realistic—not very realistic, but, still, we allow that to count.

And certainly, allowing—I mean, there are a lot of ways to skin the cat here, and allowing small businesses to group together are important, except the insurance company guy who is not here, he would be howling. He would be howling, because he would by—and, by the way, one of the things—and I think this is important for both Democrats and Republicans in the Congress-we are not going to get this, a good system of affordable, accessible health care, without stepping on the toes of the insurance companies.

They are going to be forced to take some things they don't like—they don't like. But they should understand that this plan, what you are looking at, will step on their toes. Single payer is the death penalty for them, and they ought to accept the fact that everybody is going to have sacrifice a little to make this work.

I don't know if any of you saw this, and maybe it was just in—I thought I saw it on Washington TV, so maybe you did see it—but it is this woman who works for one of the insurance companies that has gotten a series of bonuses because she has been tremendously successful in denying claims. She has been their single most successful person in denying claims. Again, sometimes you should deny claims—I am not saying that—but the system is all out of whack.

You know, you can't do that, any more than—what would you as a Congress say to Mary Smith, 35 years old, self-employed, she had a little health plan, she got cancer, the health plan coverage period ran out, she can't get coverage now. She was clearing $26,000 a year in her small business. She has no way of fighting for her life.

I mean, what do we say to her? The richest country in the world, the only country that doesn't have some form of—the only developed nation that doesn't have some form of guaranteed health insurance. What do we say to that lady? Sorry, you are out of luck? It would be too tough for the insurance companies to pick it up? There is no catastrophic fund?

The little State of Delaware has an interesting plan. They will—and this is impractical for the big states—they will cover 100 percent of the expenses in fighting cancer for any Delawarean citizen who gets cancer and doesn't have health coverage and can't afford health coverage. I asked Governor Minner how many it was, and it was like 732 people. You know, would that we could do that in Pennsylvania. You know, I would do it tomorrow.

I mean, how do we explain that to people? You know, you have great coverage. I have great coverage, you know. How do we explain it? I just don't think we can.

So I would, again, urge the Congress—and I appreciate Madam Chair and everyone on this Committee taking this issue seriously. It is—I think it is the seminal issue of the next 10, 15 years in America. And you have got to solve it, and we will work with you in every way we can. I don't think we want to just absolve ourself of any fiscal responsibility for the delivery of health care. We will work with you on any reasonable system that is set up, but let us get this done.

Chairwoman VELÁZQUEZ. Thank you so very much, Governor, for your generous time that you spent with us, and also for all of the efforts that you are putting together in Pennsylvania to expand health coverage for the uninsured.

And particularly, for this Committee, it is the Small Business Committee, there is no way that we address the lack of health coverage in our country without addressing the issue of the lack of coverage for small businesses. And in today's Wall Street Journal, they report on the federal—a new federal study that says that federal spending on health care will reach $2 trillion by the year 2017.

So this is our biggest challenge, and we cannot wait, and this is why for us to have you here has been not only a great honor but a great service to the work that we do in this Committee in trying to reach consensus to see what kind of legislation we can move forward, and not to wait until the next administration is in place in the White House. Too many people are suffering in this country, and these are working people.

Governor RENDELL. And remember, we can contain costs. It is an achievable goal. I know that from our own experience, but I believe it with all my heart. We just need the will to do it.

Chairwoman VELÁZQUEZ. Thank you. I ask unanimous consent that members will have five days to submit a statement and supporting materials for the record. Without objection, so ordered.

This hearing is now adjourned. Thank you.

[Whereupon, at 12:32 p.m., the Committee was adjourned.]

NYDIA M. VELAZQUEZ, NEW YORK
CHAIRWOMAN

STEVE CHABOT, OHIO

Congress of the United States
U.S. House of Representatives
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515-6315

STATEMENT
of the
Honorable Nydia M. Velázquez, Chairwoman
House Committee on Small Business
"State Strategies to Expand Health Insurance Coverage: The Road to Reform"
February 26, 2007

The committee is honored to have before us today — Governor Tim Pawlenty of Minnesota and Governor Edward Rendell of Pennsylvania. These leaders have been at the forefront of the health care debate that has implications for the entire nation.

While I understand their approaches to reform may be very different, we hope to gain insight on how their proposals can improve health coverage for the citizens of their states.

It is for that reason we are continuing to work with the small business community and stakeholders to identify ways that Congress can address this crisis. While major change may be a year away, the Committee is attempting to identify consensus reforms that can either be enacted this year or as part of any health care reforms made in the future.

The Governors here today are fully aware of the obstacles that meaningful health care reform presents. With any efforts to increase coverage that impacts our nation's health system, it will invariably create some form of opposition.

Governor Pawlenty and Governor Rendell are responding to the harsh reality of rising health care costs and declining coverage in their states. This Committee is particularly interested in the steps that Minnesota and Pennsylvania are considering to ensure small firms have access to affordable health insurance coverage.

More than a year ago, Governor Pawlenty laid out his Healthy Connections platform that has set the stage for reform in his state. Governor Rendell is also in the midst of a major debate on comprehensive changes to the health care system in Pennsylvania. He is now working with the legislature to advance his Prescription for Pennsylvania plan.

Both of these plans make small businesses a critical component of expanding coverage. I believe it is becoming increasingly clear that addressing the problem of the uninsured requires a focus on encouraging small businesses to offer health insurance.

Today's discussion will hopefully allow the Committee to gain new perspectives on approaches to improving health care choices for small businesses. In the past year, this Committee has examined how competition among insurers and risk are cost drivers for small businesses seeking health insurance. These are problems that I believe can and must be addressed by changes at both the state and federal level.

While demographics and localized issues may shape the solutions that you are proposing, it is clear that you both agree that the current system needs to change.

The matter of affordable coverage for small businesses is something that every state is facing across this nation. Given these challenges, it comes as no surprise that six out of ten uninsured Americans—including more than 10 million children—are in households headed by self-employed workers or small business employers.

I look forward to today's testimony and again thank you for being to be here today to discuss this important issue.

U.S. House of Representatives

SMALL BUSINESS COMMITTEE

Tuesday, February 28, 2006

Representative Steve Chabot, Republican Leader

Opening Statement of Ranking Member Steve Chabot

State Strategies to Expand Health Insurance Coverage for Small Businesses

Good morning. Madam Chairwoman, thank you for holding this hearing on state initiatives to expand health insurance. And special thanks to our distinguished witnesses, who are taking time from their National Governors Association winter meeting here in Washington to be with us today. We appreciate your participation.

Forty-seven million Americans are uninsured, and for those who are insured, costs continue to skyrocket. For small businesses, health care is continually ranked as one of the top concerns, as we have heard expressed by witnesses throughout this Committee's ten health care hearings. With premiums escalating, small companies face limited choices of health insurance providers. Many operate with margins so thin that they cannot provide health insurance for themselves or their employees.

According to the Government Accountability Office, health care spending is a chief culprit of our national debt. The structural debt at the current rate of growth and spending in federal entitlements is *$53 trillion*, assuming future promised and funded benefits of Medicare, Social Security, veterans' health care, and other programs are kept. These figures are nothing short of astonishing.

The cost of health care has outpaced inflation by 2 percentage points per year each year for the past 40 years, and costs are expected to continue to rise. Health care costs for individuals and small businesses must be addressed at present, and they must be curtailed for our children and grandchildren.

These are tough problems, with many facets and no easy answers. Clearly, entitlement spending must be addressed. And I believe there are important steps Congress can take to bring down the cost of health care and make it more accessible.

For example, I introduced the Health Affordability Act, which would allow every American to deduct 100 percent of the cost of their health insurance premiums when calculating their federal income tax. It's also important to eliminate frivolous lawsuits, which drive up health care costs. To that end, I am a supporter of the HEALTH Act, which would cap non-economic damages and ensure that only those with legitimate claims can proceed.

And I'm also a supporter of legislation that would allow small businesses to join together with national associations to purchase health insurance for their employees. The increased purchasing power and lower premium cost would encourage more small companies to offer health insurance. The House has passed this legislation many times in previous Congresses, only to be stalled in the Senate.

Because Congress has not addressed these issues, many states have become incubators of health care reform proposals. Some have proposed innovative programs to expand health insurance coverage. The governors who are with us today have been at the forefront in offering imaginative health insurance solutions in their states. We are eager to hear your ideas for reform.

Madam Chairwoman, thank you for holding this important hearing. I look forward to the governors' testimonies.

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Governor Tim Pawlenty

State of Minnesota

Testimony before the U.S. House of Representatives
Committee on Small Business

Tuesday, February 26, 2008

Chairwoman Velazquez and members of the committee, thank you for inviting me here today to discuss state efforts on health care reform and, in particular, one of the most important issues facing our state and nation: rising health care costs.

The Challenge of Rising Health Care Costs

Although small businesses have unique challenges affording health care coverage for their employees, businesses of all sizes will be facing a major financial crisis if we do not change the current health care delivery and financing system.

The Congressional Budget Office (CBO) projects that total health care spending will rise from 16 percent of GDP in 2007 to 25 percent in 2025. These increases are burdening our economy, causing hardships for millions of Americans, and are clearly unsustainable.

Government is facing the same crisis. At the state level, rising Medicaid budgets continue to consume more and more of our state budgets – a result of increases in public program enrollment and higher costs per enrollee. We anticipate that the share of our state budget devoted to health care will increase from 18 percent in 1998 to 27 percent by 2011. Spending more state dollars on health care means less funding available for education, infrastructure, and economic development – significant issues for the state's business climate and competitiveness.

In Minnesota we are working hard to address these issues and we are fortunate to have the lowest rate of uninsured, some of the lowest medical care costs, and some of the highest quality health care in the country. Yet, even with these advantages, we are challenged.

Minnesota's historically high rate of employer-based coverage has been primarily responsible for its low rate of uninsurance. However, between 2001 and 2007, the percentage of Minnesotans with health insurance through an employer fell from 68.0% to 62.5%.[1] Although enrollment in our public insurance programs helped offset some of the decline in employer-sponsored insurance, our uninsured population, while still lowest in the nation, has grown.

This recent erosion of employer-based health insurance is of special concern to policymakers in our state. Most of the decline in our employer health insurance has been

[1] Minnesota Department of Health, Minnesota Health Insurance and Access Survey, 2001 and 2007.

the result of declining access: fewer Minnesotans have a connection to an employer that offers coverage, and those who do are less likely to be eligible to sign up for coverage.

The problem is especially pronounced for small businesses facing unique challenges in attracting and retaining their workforce, operating with minimal administrative resources, and operating on thinner margins. They often face even tougher challenges in dealing with the health care system and are especially vulnerable to health care cost increases.

Rising health care costs force hard choices between discontinuing coverage for employees and keeping businesses operating. Smaller employers are less likely to offer health insurance, and each year the percent of small businesses no longer offering health coverage is steadily growing.[2] In the end, spiraling health care inflation makes small business less competitive in the marketplace, and as a result, our overall economy is less competitive in an increasingly global market.

As you know, this is a particular concern because of the critical role of small business nationally, and in every state. In Minnesota, small businesses are a huge driver of the state's economy and account for roughly 97 percent of all businesses.[3] They play an integral role in adding new jobs, innovation, and increasing the overall vibrancy of our economy. We need to preserve the vitality of small business for our economy to thrive.

We can begin by working to reign in runaway health care costs. Accomplishing this goal is possible, but it will require fundamental, lasting changes in how health care is delivered and financed.

The current health care system is fundamentally flawed and will never provide both the quality and efficiency we need until it is transformed. Today, we pay primarily on a fee for service basis, meaning we pay for the volume of services delivered, rather than the value – the quality or the outcomes – of the services provided. This often leads to excessive, repetitive or even unsafe care.

One widely cited study reported that, on average, patients receive the recommended care they should be getting only 55 percent of the time.[4] In Minnesota, only one in ten persons with diabetes is receiving optimal levels of care for their health condition.

If business owners only shipped the correct product fifty percent of the time, or if manufacturers could only meet specs in one of every ten cases, they probably wouldn't be in business long. So why is a lackluster level of performance tolerated in health care? It shouldn't be and it needs to change.

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[2] Employer Health Benefits, 2007 Summary of Findings, Exhibit D. The Kaiser Family Foundation and Health Research and Educational Trust at http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf

[3] Minnesota Department of Employment and Economic Development 2006 census data. Small employer defined as those with 100 or fewer employees.

[4] Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003).

Minnesota's current health care reform efforts

It has often been noted that "What is measured improves" and that "What is measured and rewarded, gets done." These are true in health care as in any other endeavor.

Over the past six years of my administration, we have taken a number of important steps to align efforts and incentives for greater transparency of health care quality and costs, and for more accountability for performance and outcomes.

For example, I created a Governor's Health Cabinet to bring together the heads of state agencies with responsibilities for health care purchasing, regulation and delivery, including especially our agencies that administer Medicaid and the state employee health benefits plan, to work together in implementing more common, reinforcing health care purchasing and measurement strategies. This is not a government takeover of the health care market, or the creation of huge single health care mega-state agency, but rather it is about reaching agreement on standard messages to send to the market and using common ways of measuring and reporting health care performance.

In addition, in late 2006 I issued an executive order creating QCare – Quality Care and Rewarding Excellence. QCare was developed with assistance of a group of health care providers, payers, and state government leaders in association with the National Governor's Association "Center for Best Practices." It sets stretch goals for health care improvement in four key care areas: diabetes; heart disease; preventive care; and hospital safety. The QCare executive order also instructs the heads of our state Medicaid program and the agency that is responsible for the state employee health benefits plan to add provisions to their contracts with health plans and other vendors to help meet the goals.

The Governor's Health Cabinet concept was expanded to include the private sector and other employers of all sizes with the establishment of the "Smart Buy Alliance"[5], representing together nearly 3/5 of the Minnesota market. The Alliance was named the "smart buy" because the goal is not to simply gang up and drive discounted prices for some that ultimately shift costs to others. The goal is to buy smarter by collectively sending similar signals to the market, especially in seeking out and rewarding "best in class" health care providers; adopting and utilizing uniform measures of quality and results; providing easy access to information for consumers and purchasers; and promoting use of health information technology.

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[5] For further information about the Smart Buy Alliance, see reports by the Commonwealth Foundation, including *Minnesota's Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care* at: http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=278285 and *Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance* at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515815

I also signed into law this past legislative session the creation of a multi- Health Care Transformation Task Force to further explore and develop ways to bring about needed change, and to reduce the rate of health care cost increases for all Minnesotans, including small business.

As a result of these efforts, Minnesota's Medicaid program, the state employee health benefits program, and nine private sector employers have instituted one of the largest state-based health care pay-for-performance efforts in the nation through a program known as Bridges to Excellence. Together they represent one-seventh of all Minnesotans. Under this program, health care providers who demonstrate superior outcomes with patients with certain chronic diseases receive special recognition and financial bonuses.

Greater alignment of appropriate incentives and practices is also needed to dramatically improve the use of health information technology. Unlike the financial, transportation, and other sectors of the economy, health care has lagged far behind in its use of IT solutions to improve patient care and to reduce the logjam of millions of routine health care administrative transactions each year. The result is poorer, more costly care for patients with everyone paying the bill, not to mention the continued hassle factor and waste in just administering the system.

To help move health care into the twenty-first century, I signed legislation last spring that requires all health care providers to implement electronic health records by 2015. I also signed legislation requiring all providers and payers to exchange routine administrative transactions electronically, in a single standard format, by 2009. In September 2007, we announced the Minnesota Health Information Exchange - a public-private nonprofit, including our state Medicaid program, and other large health plans and health care providers, to connect doctors, hospitals and clinics across health care systems so they can quickly access medical records needed for patient treatment during a medical emergency or for delivering routine care.

These efforts to increase the use of health IT are being undertaken to ensure better patient care and outcomes, in order that more of each dollar spent will be devoted to quality patient care, and to produce significant savings across the health care system.

These and other health care reform efforts and accomplishments are important, necessary first steps to help lower the cost of health care, engage consumers in a meaningful partnership in their care, and make our health care markets operate more effectively. However, they are not sufficient to fully transform the health care system and additional steps are needed.

Next steps toward reform

First, we have to improve the health of our population. This is a long term strategy, but one that has the largest potential payoff. We need to have a concerted and coordinated effort to reduce health risks causing needless loss of life and productivity. We need to reverse the obesity epidemic, lower smoking rates, increase physical activity and reduce

levels of alcohol consumption. If current trends continue, more and more Minnesotans will be at risk of preventable chronic diseases. If we want to control costs, we need to stop adding more people with preventable chronic diseases to the health care system.

Second, we need to continue and expand our efforts to make information more transparent and meaningful to health care providers, purchasers, and individuals. This means we must come to a consensus on what constitutes high quality care and encourage competition among providers to achieve the highest possible quality at the lowest cost. To do this, we need to expand quality measurement and price reporting while making this information even more available and understandable to consumers.

Third, we need to make it easier for small employers and their employees to be able to purchase and afford insurance coverage. We need to make sure everyone has access to advantages of paying for health insurance with pre-tax dollars. We can do this by encouraging the use of Section 125 plans and developing an easy one-stop-shop insurance exchange to help employers and employees obtain information about coverage options and to facilitate paying for and purchasing coverage.

Finally, and most importantly, we need to continue and strengthen efforts to fundamentally reform how we pay for health care. Our system too often rewards simply doing more, regardless of quality. Commonsense ideas and innovations by providers are stymied by the archaic way we pay for health care and we must move to a system that explicitly rewards value rather than quantity.

For example, a large Minnesota multi-specialty provider group, Park Nicollet Health System, achieved significant improvement in patient health, avoided heart damage and individual suffering for many, and averted 625 hospital admissions per year through a special congestive heart failure program. However, the hospital faces a projected loss of around $5 million/year because the current payment system does not provide for a rate of return on investments such as this, despite the demonstrated savings.

We need to move to a payment system that more completely and explicitly rewards quality. In Minnesota we are proposing a payment reform policy that will better coordinate and facilitate effective care, especially for people with chronic disease. We will align the incentives for providers to be lower cost, higher quality providers of care, and for individuals to choose and use providers who achieve the best outcomes at the lowest cost.

This policy reforms our payment system to provide choices, to more clearly reveal prices and quality, and to encourage more effective, stronger competition in the market. We envision a market where health care providers will establish a uniform price regardless of who is paying the bill. It will not encourage continued consolidation among health plans and providers, as our current system does but will encourage new levels of competition. It will reward innovative providers, who find ways to achieve better health outcomes at lower costs, rather than punishing them. It will give providers the flexibility to deliver the care that is right for their patients, at the right time, in the right place and setting. In

return, our payment system will reward value, and ensure that providers are responsible for delivering lower cost and higher quality care. In this new approach, consumers will be empowered with tools and information to choose among health care delivery choices and options, but will also be expected to share in the costs of those decisions.

Aligning with the federal government

States such as Minnesota are actively working to innovate and explore new approaches to solve fundamental problems in health care. It will be important is to allow states the flexibility to continue to innovate and try new ways, whether with the state's single largest health care cost item, the federal-state Medicaid program, or other programs and initiatives. I encourage Congress to continue to allow options under Medicaid for states to find creative means of covering their uninsured populations.

The availability of IRS Section 125 plans makes health care insurance more affordable by allowing employers and employees to purchase health benefits on a pre-tax basis. However, many employers and their employees have not established the Section 125 plans and are paying for health benefits with after-tax dollars, effectively increasing their cost.

In addition, as employers plan for the future, they may take desire to take advantage of opportunities to move from what is known as a "defined benefit" health benefits plan to one known as a "defined contribution", in ways that minimize perceived downsides of the transition for the employer and employees.

Oftentimes small employers are now faced with a difficult "all-or-nothing" choice – continue to offer an expensive health benefits when they can really no longer afford them, or stop offering them all together in order to stay in business. However, employers' flexibility to move to a defined contribution approach is currently limited by federal requirements such as provisions in the Health Insurance Portability and Accountability Act (HIPAA) that are in conflict with individual health insurance market issuance laws in Minnesota and many other states.

States need all the tools that they can get in their efforts to support small employers that want to continue to contribute to health insurance benefits, and we would ask Congress to examine ways it can support states and private employers in these efforts.

Conclusion

Thank you, Madame Chair, for this opportunity to present today. I commend you and this committee for taking on this tough issue. I have tried to convey the need for fundamental changes and reforms that are needed to control rising health care costs for small businesses and government. I also hope that you consider further opportunities for change. In Minnesota, we have a very strong history of public-private collaboration. I encourage employers of all sizes, including small employers, to join in this effort. I

would ask the federal government to partner with states to help restructure the payment system to ensure all Americans receive the best care for the best cost.

Again, thank you for this opportunity to present to the committee today.

Written Testimony
Submitted by
Pennsylvania Governor Edward G. Rendell
Before the
U.S. House of Representatives Committee on Small Business
Hearing on
"State Strategies to Expand Health Insurance Coverage for Small Businesses"
Washington, DC
February 26, 2008

In the United States, we rely on businesses to provide health insurance coverage to 160 million workers and their dependents – which is nearly two-thirds of the population under the age of 65.

Most employees who receive employer-based coverage are happy with that system – and employers who offer health benefits are committed to continuing to serve as the backbone of our insurance system, according to a Summer 2007 Commonwealth Fund survey.

However, our current system also fosters spiraling supply costs, variable and inadequate quality, and little or no access for millions of Americans and these problems are building to a crisis for our health care system.

America now spends $2.1 trillion per year or $5.3 billion per day MORE on health care than we spend on food.

Despite the huge amount of money we are spending on heath care, a study in the New England Journal of Medicine found that participants received only about 55 percent of the recommended medical care for their acute and chronic conditions. And, there are 46 million Americans without insurance.

According to the Institute of Medicine, the cost of lost productivity of these uninsured due to their inability to get medical care ranges as high as $205 billion annually. The Commonwealth Fund did a similar study and found that common ailments alone – for which the uninsured do not receive treatment – such as headaches, back pain, arthritis or muscle and joint pain cost the nation's employers $62.1 billion dollars annually in lost workplace productivity and absenteeism.

Equally troubling is that our country ranks high in medical errors.

The United States loses more American lives to patient safety incidents every six months than it did in the entire Vietnam War. If medical errors were recognized as a cause of death by the CDC in its annual vital statistics report, it would be ranked as the 6th leading cause of death – outranking diabetes, influenza and pneumonia.

Nationally, hospital acquired infections are the fourth leading cause of death, affecting 2.2 million people every year and causing 100,000 deaths. And most hospital acquired infections can be avoided.

A recent Institute of Medicine study reported that racial and ethnic minorities tend to receive lower-quality heath care than whites, even when insurance coverage, income, age and severity of conditions was comparable.

I firmly believe the health care crisis is a national problem and the best solution is a national solution. But, in the absence of such a plan, Governor's like Tim Pawlenty and me have had to come up with plans that will meet the needs of our states' residents.

As we started crafting our plan, which is called Prescription for Pennsylvania, we faced these Pennsylvania-specific statistics:

Since 2000, the rate of inflation has increased 17 percent while wages only increased by 13 percent. The increase in health insurance premiums for individual workers has increased by nearly 76 percent.

Growing heath care costs are projected to almost double between now and 2014. Health care costs will become unsustainable for the state government, our employers and our residents at the present growth rate.

In Pennsylvania, we have 133,000 children and 767,000 adults who are uninsured. Of those, 71 percent are employed, 77 percent earn less than 300 percent of the federal poverty level, which in our state is $29,400 for an individual and about $60,000 for a family of four. And 27 percent of our uninsured have been without insurance for at least five years.

The overwhelming majority of the uninsured are employees in low-wage jobs.
Small employers, employers with a majority of low-wage employees, and employers with older employees are less likely to be able to afford health care coverage for their employees.

Premiums for employer-based health insurance rose 9.2 percent in 2005, the 5th consecutive year of increases over 9 percent.

The smaller the business, the less likely employees will have employer-based coverage. In 2006, only 44.4 percent of employees in businesses with less than 10 employees have employer-based health care coverage. However, 77.5 percent of employers with 10-24 employees offer employer-based coverage.

The cost of providing for the uninsured is a burden borne by everyone. An estimated 6.5 percent of the cost of premiums for our insured residents goes toward the cost of care for the uninsured. That means that every Pennsylvania business that offers insurance ends up paying for those without.

Prescription for Pennsylvania is a set of integrated, practical strategies for improving health care and containing costs for all Pennsylvanians. The core components are affordability, accessibility and quality.

Our plan is centered on improving quality and access by delivering the right care, right, the first time and promoting wellness – strategies which that will save money while they improve lives

We have already begun the process of implementing portions of Prescription for Pennsylvania which deal with matters of quality and access to health care as well as reducing the impact of major health care cost drivers, which will help all of us including our small businesses.

In July of 2007, I signed a series of bills which expand the scope of practice for non-physician health care providers to ensure they may practice the fullest extent of their education and training. These bills – which will help to expand access to care and reduce the cost of care – are now in the regulatory process and we expect that they will be in full effect in mid-2008.

I also signed cutting-edge legislation to address health facility acquired infections, or HAIs, making Pennsylvania the national leader in the effort to improve quality outcomes and eliminate these types of medical errors. The HAI initiative provides guidelines for health care facilities to use in long-term infection control planning as well as in surveillance activities to allow for better implementation of infection control protocols.

Charged with reducing the human and economic cost of chronic diseases, the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission, established by Executive Order in the spring of 2007, recently presented an extensive implementation plan which we believe will help to revolutionize chronic care management in the Commonwealth. We know that about $.80 of every dollar spent on health care in Pennsylvania is spent on those with chronic diseases. Our plan focuses on better management of chronic disease through a team-based health care approach which will help to eliminate avoidable hospitalizations by ensuring that individuals with chronic disease are given the appropriate preventative care in the community.

In addition, the Commonwealth has already taken the lead on implementing a program to provide incentives for wellness among its employees through our "Get Healthy" program. Prescription for Pennsylvania includes programs to educate businesses on how they can encourage healthy behaviors in their employees to help reduce health care costs and boost productivity. For every dollar invested in worksite health promotion programs, a business or organization may realize a savings of $3.50 through reduced absenteeism and health care costs.

So, we've made a good start, but we still have more to do.

On November 1, 2007, the Economic Policy Institute, a non-profit, non-partisan think tank released a report on the erosion of employer based health coverage using Census Bureau Current Household Surveys for 2000-2007.

Pennsylvania was reported as having the second highest loss of employer-based health care coverage for those under 65, with 491,392 fewer Pennsylvanians being covered through their employer in 2007 than in 2000.

Pennsylvania also had the second highest loss of coverage for children through employer-based coverage in the country, with 198,683 fewer Pennsylvania children receiving health care coverage through their parents' employers in 2007 than in 2000.

Despite these losses, employer-based coverage is still the most prevalent way Pennsylvanians receive health care, so it is critical that we try to stem this erosion of coverage as quickly as possible.

The findings in this report underscore the urgency to pass the remaining pieces of Prescription for Pennsylvania which focus on the people and small businesses that need the most help in paying for health care insurance.

Over the past year, I have heard from small business owners across the state about the dire circumstances they are facing as they struggle to provide health insurance for their employees.

People like Tim Wilkins, who is the president of PA Insulating Glass in Lewistown. His company has 16 employees, and he told us that he can only afford to provide an insurance plan for its few management team members; he cannot afford health insurance for his hourly workers. Even with paying premiums for just the management team, health costs are one of the company's largest expenses at more than $20,000 annually. Tim said he is very worried about losing valued employees who go elsewhere to work just for the insurance. His small company simply cannot compete with larger companies who can offer health insurance.

I also heard from Patrick S. Au, the owner and CEO of Pittsburgh Engineering Consultants. Mr. Au's firm has 12 employees and he told us that his medical costs are second only to payroll in his overhead costs. He laments that his small group lacks the abilities that larger companies have to bargain over price. And, he believes his group is "discriminated against" because of the medical and age profile of the employees. He told us that even health savings accounts were priced too high for his group. Patrick's company is in danger of becoming another statistic in the EPI study of employers dropping their coverage.

While I was traveling across Pennsylvania talking about the need for the Prescription for Pennsylvania, I met Roberta Ayers from the Erie area. She and her husband own an auto body shop and they cannot afford insurance. She told us they had insurance 10 years ago, but it cost them $500 a month with a $5,000 deductible and they couldn't afford it. She

said she can't imagine what it would cost today. She said they don't go to the doctor, don't have yearly physicals, can't afford medical test and "live on needles and pins hoping everything is okay." Prescription drugs are not an option. Because they are uninsured they "try to live healthy, but the older you get the more you think about it." These are just three stories, but there are thousands more like them in Pennsylvania alone. And they are the reasons we created Cover All Pennsylvanians (CAP), our plan to make affordable basic health insurance available to eligible small businesses that do not presently offer health insurance to their employees and to the uninsured. This coverage will be offered through the private insurance market.

Small business employers can participate if they have 50 or fewer employees who earn less than the state average wage. Employers who choose to join CAP will pay approximately $130 per employee per month, and each employee will pay a premium of $10 to $70 per month depending on family income.

All uninsured Pennsylvanians, no matter what size company they work for, will be able to purchase affordable health insurance through CAP. A family of four who earns up to $61,000 a year will receive help from the state paying their premiums.

The premiums paid by the employee for their coverage under CAP would be $0 for individuals with a household income up to 150 percent of the federal poverty level, $40 for 150-200 percent FPL, and $60 for 201-300 percent FPL. In addition, all uninsured adults who earn more than that amount – 301 percent of the federal poverty level and higher – could participate in Cover All Pennsylvanians by paying the full cost of the premium.

CAP would also allow businesses that already provide insurance to enroll individuals who may have previously declined to enter the pool because they could not afford the employee contribution. The Commonwealth would provide the same amount of funding toward that premium as it would otherwise have done if the individual enrolled in the CAP program. This will allow small businesses who do offer insurance to increase their pool which usually results in lower, more stable rates.

The CAP program would be funded through redirected existing funds; a new 10-cent-per-pack increase in the cigarette tax; a first ever tax on cigars and smokeless tobacco; federal matching funds; and funds from a surplus in an account which helped physicians pay for their medical malpractice premiums.

Originally, I proposed a 3 percent Fair Share Assessment on businesses that did not offer health insurance to their employees. I proposed the assessment because I believe that it is, in fact, fair. Businesses who currently pay to cover their employees are already shouldering the burden for those who do not through increases in their premiums which go toward covering the cost of uncompensated care. In addition, Pennsylvania provided hospital subsidies totaling $400 million to cover uncompensated care for the uninsured in 2006.

I pulled the Fair Share Assessment as a funding source when I was told that the state legislature would not act on CAP if it included anything that might be considered a business tax. This is despite the fact that according the Commonwealth Fund survey of employers in 2007; "Two-thirds of employers—including those who provide health benefits and those who do not—agree that all employers should share in the cost of health insurance for employees, either by covering their own workers or by contributing to a fund to cover the uninsured."

This basic commitment is also at the heart of state reform efforts in Massachusetts and California, and it is what I believe is right for Pennsylvania. Never-the-less, I have proposed another other option to replace the Fair Share Assessment with surplus funds in the Health Care Provider Retention Account.

The Health Care Provider Retention Account is supported by funds from a 25-cent cigarette tax. This fund helps physicians and other health care providers pay for their medical malpractice premiums. Due to the improvements in our medical malpractice climate in Pennsylvania, there is a surplus in that fund. I have proposed using a portion of that to fund CAP, while dedicating the rest to a long-term commitment to medical malpractice relief for Pennsylvania's physicians.

In order to fully address the problems in health insurance affordability for small businesses, Prescription for Pennsylvania also includes a series of insurance reforms to help regulate and stabilize premiums for small business. The growth and volatility in the premium costs in Pennsylvania for small employers is a driving factor and primary reason for the erosion of employer-based coverage in Pennsylvania.

In less than 10 years, the average cost for premiums for family coverage in Pennsylvania through employer sponsored health care has gone from $4,859 in 1996 to $11,416 in 2005. During the same period, the average premium per enrolled employee of a small business in Pennsylvania more than doubled from $2,036 to $4,625.

If current trends continue, in five years the cost to insure a family of four would be more than $20,000 a year, representing as much as 30 percent of the median household income for that family.

That's why the insurance reforms contained in Prescription for Pennsylvania that are currently being debated in the Pennsylvania General Assembly are so critical. They will ensure that small businesses and other consumers are not faced with skyrocketing costs for their health care coverage.

These reforms are especially critical to our small businesses because 72.4 percent of all private businesses in Pennsylvania and 26.8 percent of all Pennsylvania-based employees work for businesses with fewer than 50 employees and employers with fewer than 10 employees make up 56.4 percent of all businesses in the Commonwealth.

Under our current system, small employers can't spread their risks over a large number of employees the way large employers can. Large employers have leverage for getting preferred rates because of their size and the number of employees-enrollees. When community rating prevailed in Pennsylvania, small businesses were rated as part of a larger pool where risks were shared and insurance was more affordable for more people.

Over the years, more and more insurance companies moved to a demographic form of rating and rates were determined based on the characteristics of the small group. So if a small business had some older employees, and/or women of child bearing age, and/or an employee with a chronic condition, these individual and combined factors spiked the premium rates for employers and employees alike making health care coverage unaffordable.

In addition, no limit on rating factors causes large volatility in rates. A business with nine employees can face a huge premium increase if an employee is hospitalized the previous year, or if a 25-year-old employee is replaced by a 45-year-old employee or a male employee is replaced by a woman of child-bearing age.

Pennsylvania is now one of only two states in the country that does not limit the rating factors insurance companies can use to determine rates in the small group and individual group market.

We would change that. We would only allow insurance companies to use age, location and family size to determine rates. We would also limit the most expensive premium rate to no more than twice as costly as the lowest rate for small and individual group coverage, so risks can be shared more broadly and so insurance can be affordable for more people.

The also believe it is important that small employers are getting good value for their premium dollar. That is why we are proposing that 85 percent of every premium dollar must pay for health care and, if not, the Insurance Commissioner can require insurers to rebate premiums to employers.

Also, small employers have told us about how hard it is to determine which health plans are the best deal for their premium dollars. They find it almost impossible to be able to compare one plan with another because of plan variation.

We would require insurers writing health insurance in the small employer and individual market to offer the same basic health care plan, so employers can compare apples to apples in choosing health care coverage. This will foster price competition in the small group and individual market.

We've heard the objection from the insurance industry that our proposal will hurt competition in the small group market in our state. Evidence from our surrounding states does not bear that out.

The other initiatives in the of Prescription for Pennsylvania that I mentioned earlier will generate significant health care cost reductions by eliminating additional costs due to avoidable health care acquired infections, avoidable hospitalizations due to lack of community care for chronic conditions, and avoidable errors.

To ensure that these savings are translated into reduced premiums for employers and individuals, Rx for PA would give additional rate approval authority to the Insurance Commissioner, tying cost control in health care delivery to cost control of health care insurance.

These programs are not arbitrary. We have studied national and international data on private and public health care systems, insurance programs, the effects of insurance on employee productivity, the relative costs of health care and economic growth, and best-practice models in various other states and communities to determine what blueprint would be the best fit for Pennsylvania – a public-private partnership to improve the quality, accessibility and affordability of health care.

We currently have a strong private industry employer-based health care insurance system supported by the strength of our businesses. Yet, as our research has shown, few American business owners would be satisfied with the performance of the health care system if it were their business. Spiraling supply costs, inefficiencies which drive up overhead, poor quality outcomes which endanger customers, and little or no access for millions of Americans - these are not the markers of a successful business model. Rather, these are the markers of a business in crisis.

As the largest collective purchasers of health insurance, employers can and should drive the fundamental health system reform our country needs and Americans want. But in order for them to do so, we must be sure that we are giving our small businesses the tools they need to keep their employees healthy ensuring their productivity continues to rise so that they can succeed in an increasingly global marketplace.

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