

**MAKING HEALTHCARE WORK FOR AMERICAN
FAMILIES: ENSURING AFFORDABLE COVERAGE**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS

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CONTENTS

	Page
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	1
Prepared statement	3
Hon. Nathan Deal, a Representative in Congress from the State of Georgia, opening statement	5
Hon. Anna G. Eshoo, a Representative in Congress from the State of California, opening statement	5
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	6
Hon. Lois Capps, a Representative in Congress from the State of California, opening statement	7
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, opening statement	8
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	9
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	10
Hon. Marsha Blackburn, a Representative in Congress from the State of Tennessee, opening statement	11
Hon. Phil Gingrey, a Representative in Congress from the State of Georgia, opening statement	11
Hon. Kathy Castor, a Representative in Congress from the State of Florida, opening statement	12
Hon. Betty Sutton, a Representative in Congress from the State of Ohio, opening statement	12
Hon. Tammy Baldwin, a Representative in Congress from the State of Wisconsin, opening statement	13
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	13
Hon. Jim Matheson, a Representative in Congress from the State of Utah, opening statement	14
Hon. Joe Barton, a Representative in Congress from the State of Texas, prepared statement	153
Hon. Roy Blunt, a Representative in Congress from the State of Missouri, prepared statement	158
Hon. Henry A. Waxman, a Representative in Congress from the State of California, prepared statement	160

WITNESSES

Uwe Reinhardt, Ph.D., Professor of Political Economy, Economics and Public Affairs, Princeton University	15
Prepared statement	18
Sally C. Pipes, B.A., President and Chief Executive Officer, Pacific Research Institute	31
Prepared statement	33
Judy Feder, Ph.D., Senior Fellow, Center for American Progress Action Fund	36
Prepared statement	38
Mila Kofman, J.D., Superintendent of Insurance, State of Maine Bureau of Insurance	92
Prepared statement	95
Jon Kingsdale, Ph.D., Executive Director, Commonwealth Health Insurance Connector Authority	100
Prepared statement	103

VI

	Page
Karen Pollitz, M.P.P., Research Professor, Georgetown University Health Policy Institute	107
Prepared statement	109
Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health	116
Prepared statement	119
Edmund F. Haislmaier, B.A., Senior Research Fellow, Center for Health Policy Studies with the Heritage Foundation	128
Prepared statement	130

MAKING HEALTHCARE WORK FOR AMERICAN FAMILIES: ENSURING AFFORDABLE COV- ERAGE

TUESDAY, MARCH 17, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Dingell, Eshoo, Green, DeGette, Capps, Schakowsky, Baldwin, Weiner, Matheson, Harman, Gonzalez, Barrow, Christensen, Castor, Murphy, Sutton, Braley, Waxman (ex officio), Deal, Whitfield, Shimkus, Shadegg, Blunt, Pitts, Rogers, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff present: Phil Barnett, Staff Director; Karen Nelson, Deputy Staff Director for Health; Karen Lightfoot, Communications Director; Purvee Kempf, Counsel; Tim Gronniger, Professional Staff Member; Bobby Clark, Senior Political Analyst; Jon Donenberg, Health Fellow; Virgil Miller, Legislative Assistant; Caren Auchman, Communications Associate; Alli Corr, Special Assistant; Alvin Banks, Special Assistant; Caitlin Sanders, Staff Assistant; Brandon Clark, Professional Staff; Marie Fishpaw, Professional Staff; Clay Alspach, Counsel; Chad Grant, Legislative Analyst; and Aarti Shah, Counsel.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REP- RESENTATIVE IN CONGRESS FROM THE STATE OF NEW JER- SEY

Mr. PALLONE. The subcommittee hearing is called to order. Good morning and welcome to our witnesses on the first panel. This is a second in our series of hearings on health reform. Today the subcommittee will examine issues surrounding the affordability of health coverage.

Now more than ever securing quality health care coverage at an affordable price is not possible for millions of American families. First and foremost, health insurance has become too expensive. As health insurance premiums continue to outpace wages every year, people can no longer expect to pay a reasonable price for health coverage.

And as we talk about health care reform, we have to ask ourselves what should we expect to pay for health care coverage and what should that coverage include. Cheap plans that offer little protection, such as high deductible plans, are not a solution in my opinion. We need real reform that makes quality health care coverage affordable to every American, and in order to do that, we need to change the rules which govern the way people obtain health care coverage, particularly within the individual market.

I am particularly interested to hear from our witnesses today about new ideas like a health exchange or connector, similar to the one in Massachusetts, a public plan option, and an individual mandate that can help provide individual's access to affordable options for meaningful coverage.

I also think it is important that, as we talk about making coverage on the individual market more affordable, we don't do anything to disrupt the affordability of coverage in other sectors. There was talk last week and in the media about eliminating or cutting back on the tax exclusion for health benefits offered by employers. This was an idea promoted by former President George Bush and was a key component of Senator McCain's health care proposal during his presidential campaign, but obviously this is controversial as well.

The employer market is already declining. It is becoming increasingly difficult for both employers and employees to afford health care coverage, and eliminating those tax incentives may further exacerbate the affordability problems we already face with employer-sponsored insurance and not necessarily do anything to improve the affordability of coverage in the individual market.

Again these are all issues that I think we need to discuss. Looking at places like Massachusetts, public plan options, individual mandates, and the tax exclusion for health benefits. Not that I am taking a position on any of those right now, but I think these are important things that we have to look at.

I want to thank our witnesses again for being here today. I know we have a very distinguished panel.

[The prepared statement of Mr. Pallone follows:]



News from
Frank Pallone, Jr.
New Jersey Congressman, Sixth District



FOR IMMEDIATE RELEASE
 March 17, 2009

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**PALLONE STATEMENT AT HEALTH REFORM
 HEARING ON ENSURING AFFORDABLE COVERAGE**

Washington, D.C. --- U.S. Rep. Frank Pallone, Jr. (D-N.J), Chairman of the House Energy and Commerce Subcommittee on Health, gave the following opening statement this morning at the second of a series of hearings focused on making health care work for American families. Today's hearing addresses the need to make health care coverage more affordable.

"Good morning and welcome to our witnesses. This is the second in our series of hearings on health reform. Today, the Subcommittee will examine issues surrounding the affordability of health coverage.

"Now more than ever, securing quality health care coverage at an affordable price is not possible for millions of American families.

"First and foremost, health insurance has become too expensive. As health insurance premiums continue to outpace wages every year, people can no longer expect to pay a reasonable price for health coverage.

"As we talk about health care reform, we have to ask ourselves, what should we expect to pay for health care coverage and what should that coverage include?

"Cheap plans that offer little protection, such as high deductible plans, are not the solution. We need real reform that makes quality health care coverage affordable to every American.

"In order to do that, we need to change the rules which govern the way people obtain health care coverage, particularly within the individual market. I am particularly interested to hear from our witnesses today how new ideas like a health exchange or connector, (similar to the one in Massachusetts); a public plan option; and an individual mandate can help provide individuals access to affordable options for meaningful coverage.

"I also think it's important that as we talk about making coverage on the individual market more affordable, we don't do anything to disrupt the affordability of coverage in other sectors.

"There is a lot of talk lately about eliminating the tax exclusion for health benefits offered by employers. This was an idea promoted by former President George W. Bush and was a key component of Senator McCain's health care proposal during his presidential campaign.

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Page 2 / Health Hearing

"I think that this is a dangerous road to go down. The employer market is already declining. It's becoming increasingly difficult for both employers and employees to afford health care coverage. Eliminating those tax incentives will further exacerbate the affordability problems we already face with employer sponsored insurance and will do nothing to improve the affordability of coverage in the individual market.

"I want to thank our witnesses again for being here today and I look forward to hearing their testimony. I now recognize our ranking member, Mr. Deal for three minutes for the purpose of making an opening statement. Thank you."

Mr. PALLONE. And I will now call on Mr. Deal for opening statements, and then we will have opening statements from other members, both Democrat and Republican. Thank you.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. Thank you for holding the hearing today, and thanks to the witnesses for being here, and I believe we have two panels of them. So we are going to be here a while, I suppose.

Obviously as we broach this subject of how to reform the health delivery system in this country, it is a difficult task and one that has many facets to it. Dr. Reinhardt, I was interested in reading your article that appeared back in January in the "New York Times" on the question of pricing.

As you probably know, this is an issue that has been important to me in the area of transparency of pricing. It is probably one of the most difficult issues to understand and try to get a handle on. We have so much difference in pricing of health care of services in this country that it is, in fact, I think, one of those issues we have to begin to wrestle with if we are going to decide how we are going to approach the delivery of health care because pricing obviously has a lot to do with it.

I look forward to the testimony of the witnesses. There are a lot of issues that we have not talked about in previous hearings, and I am sure that these two panels today will broach some of those subjects that we have yet to explore. And thank you for being here, and I look forward to your testimony. I yield back.

Mr. PALLONE. Thank you, Mr. Deal. The gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman, for holding not only today's hearing but the series that you have planned as we work to bring health care to every American.

One of the biggest problems in health coverage is including those who are left out of group coverage and must purchase insurance in the private market. These very same people not only face tougher access and higher cost issues, but they are also taxed on these plans.

Any individual who receives coverage through their employer gets their plan tax-free. I think it is very important that everyone has the option to buy into a group plan that would mitigate costs and not discriminate based on pre-existing conditions. We don't want to upset the health insurance for people who have it and who like it. We want to expand affordable comprehensive health care options to those who don't or those who want better coverage.

So I look forward to our very distinguished panel's testimony today, and I hope we are able to discuss the tax treatment of health insurance and how we might address that as well. Thank you.

Mr. PALLONE. Ranking member of the full committee, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. I have an excellent statement that my staff has prepared. I am going to submit it for the record, but in the interest of time, I am going to just submit it.

The main thing that is in the statement that I think we need to put before yourself and the members of the committee is that the Republicans do want to work in a bipartisan fashion this year. We are willing to work with you and the full committee chairman and other members on the majority side to enact comprehensive health care reform if it really is reform.

So this is not an issue where we are going to try to rope-a-dope the committee. We are prepared to work if it is something that is in the middle and can be done and maintain the private health care plans of Americans.

[The prepared statement of Mr. Barton appears on page 153.]

Mr. PALLONE. Thank you, Mr. Barton. I appreciate what you said, and I think it is crucial that we work in a bipartisan fashion. And that is certainly our intention. Thank you. The gentleman from Texas, Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. I want to thank you for holding this second hearing on health care reform. Our state of Texas has the unfortunate distinction of having the largest number of uninsured in the United States, nearly 5.4 million Texans or 25 percent of the population in Texas without health insurance coverage, and nearly 1.4 million children are uninsured. Of that 1.4 million, 900,000 children in Texas are S-CHIP eligible.

We need a national system designed so that every American should be covered, either employer-based plan, an individual plan, or a public plan no matter what state they live. The largest rate of growth in the uninsured and underinsured are middle class families who make too much to qualify for public plans but don't make enough money to pay costly premiums under the private plans, and those who work in low-wage jobs without employer-based insurance.

Ultimately, the large number of uninsured Americans create a vicious cycle by driving up health care costs which increases the number of people who can't afford insurance.

Mr. Chairman, I ask unanimous consent to have the remainder of my statement be placed in the record.

Mr. PALLONE. Without objection, so ordered, and thank you. The gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Thank you, Chairman Pallone, and I am going to waive an opening statement.

Mr. PALLONE. Next is the gentlewoman from Colorado, our full committee vice chair, Ms. DeGette. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I too am excited about getting into this debate, basically how do we make sure we get insurance for those who have no insurance. So my focus has always been affordable, portable, and access. I do believe that the market-

based system, which encourages price transparency and shopping around is the best method. I do fear a government backstop plan of action which the government controls, and I am deadily in opposition to a one-payer system, which I hope we don't segue into when this fight really gets going. I do not want bureaucrats picking health care decisions in the end.

So having said that, it is great to be back on this committee. As I said, Mr. Chairman, I look forward to working with you. I yield back.

Mr. PALLONE. Thank you. Our subcommittee vice chair, Ms. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. CAPPS. Thank you, Chairman Pallone. Since today's hearing is about ensuring affordable coverage, I want to quickly set the stage with a story about my constituent, Terry Terpin. Her story was featured in the Ventura County Star yesterday, and I would like unanimous consent to enter the article for the record.

She, like so many others, recently lost her job when her employer filed for bankruptcy. Unfortunately, Terry had just been diagnosed with a relapse of cancer only a month earlier. COBRA would have cost her well over \$500 a month, so she applied for coverage in the individual market but never heard back because of her pre-existing condition.

Luckily, Ventura County has a wonderful public health system where she was able to get access to oncology treatment. Not everybody lives in a community that provides that backup. At the bottom line is that patients shouldn't have to switch providers in the middle of treatment because they lose their job.

So I look forward to discussing today how we can improve access to affordable coverage for everyone. I yield back.

Mr. PALLONE. Gentleman from Missouri, Mr. Blunt.

Mr. BLUNT. Thank you, Mr. Chairman. I have a statement for the record. I do look forward to working with you and with Mr. Deal and the subcommittee to find a solution to this question of affordability.

I think we can find common sense solutions. In fact, the Medicare Part D program that has been in place now for several years is an example of a program where, for the first time, the government organized a private, competitive-driven system rather than try to operate a system. The cost is lower. Satisfaction is higher. Seniors have more options. In fact, competition works, and it puts patients and health care providers in control.

There is no government-run program offered under Medicare Part D, and in fact, there is no government run plan offered for members of Congress or any other federal employee. And I think there is a good reason for that. People want choices, and choices bring greater satisfaction. I look forward to the testimony today, Mr. Chairman.

[The prepared statement of Mr. Blunt appears on page 158.]

Mr. PALLONE. Thank you. The chairman emeritus, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Thank you for your courtesy. I commend you for this hearing. First of all, this is an important hearing on affordable coverage. Addressing affordability is a crucial piece of health care reform debate. This hearing will help guide us in our future deliberations.

The amount that workers pay for health insurance has greatly outpaced the rate of inflation and certainly has risen faster than stagnant wages and incomes. The statistics are frightening. The share of family income spent on health insurance increased from 7.3 percent in 1987 to 16.8 percent in 2006. In 2006, one-fifth of the nation spent more than 10 percent of their income on out-of-pocket medical expenses.

In 2007, 69 percent of the people who went without medical care or delayed needed medical care cited worries about cost, a 3.8 percentage increase from 2003. The average cost of employer-based family insurance policy in 2008 was \$12,680, an amount almost equal to the annual earnings of a full-time minimum wage job.

It is not just the uninsured population that suffers from the high cost of health care. More than 42 million people with health insurance report having problems paying medical bills. Of those who face medical bankruptcies, almost three-quarters had health insurance at the time of the illness that left them financially unstable.

Without any action, the expected cost of full family employer health insurance will increase to more than \$24,000 in 2016, and the average deductible will reach nearly \$2,700. This means that in only seven years, almost half of American households will spend more than one-third of their income on health insurance.

It comes as no surprise to anyone that families are literally going bankrupt. The high cost of health care causes a bankruptcy every 30 seconds. At the end of the year, it will cost 1.5 millions the homes which they cherish. Furthermore, as health care costs dominate budgets, families will have less to spend on food, education, and necessities.

As we continue the debate, we must ensure that every American has coverage, but we can't stop there. Increasing costs alone will get us nowhere if we don't find ways to reduce the cost of health insurance and health care delivery as a whole.

Access to health insurance does not mean that individuals can utilize available services. They are also kept out of the circle of care due to high premiums, deductibles, and other out-of-pocket costs. I look forward to working with my colleagues and working with the leadership here and the administration. There are a number of worthy options being debated. I think public option is something that should be seriously considered as we move forward on health reform. While we have not decided the specifics of what a public option should look like, I believe that such option must be affordable, and it must have suitable benefits. And it must provide healthy competition in the marketplace.

Insurance market has a nasty habit of gaming the system, of building barriers to affordable coverage, of excluding coverage all together, or coverage for pre-existing conditions, and charging high-

er premiums for certain individuals, cherry picking, and other games that make insurance unavailable to our people.

I am confident if we weigh our options with an eye towards the end goal of providing quality coverage for Americans, we can pass a reform that benefits all of our Americans. We must do so because the consequences of not doing so are terrifying. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Dingell. Next is the gentleman from Pennsylvania, Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Mr. Chairman, for convening this hearing. Recently the Pennsylvania Insurance Department released a survey of Pennsylvania health insurance. Let me just share a couple of results. Overall in 2008, 15.3 percent of Pennsylvanians did not get some type of needed medical care during the past 12 months due to its cost. This represents about 1.9 million residents. Currently 8.2 percent of Pennsylvania residents are uninsured. That is about a little over one million residents.

According to the survey, the cost of health insurance remains the primary barrier to coverage. I believe any health reform plan must contain several key principles to empower the consumer. Among them, in-tax policies that discriminate against an individual who purchases private health insurance on their own rather than through their employers make it easier to de-couple health insurance from employers. Those who own their coverage should be able to take their plan with them with they change jobs or quit working and one they can take to another state. They should be able to buy from another state. Also risk-pooling within a state or across state plans. People should be able to choose the plan and doctors and services they want. And insurance and providers are accountable to them, not their employer or government bureaucrats.

The bottom line is privately owned health insurance will lead to competition among plans, lower costs, higher quality, more choices, and more transparency. I thank all the witnesses for testifying, look forward to hearing their thoughts, and yield back my time.

Mr. PALLONE. Thank you. The gentlewoman from Chicago, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I will put my entire statement in the record, but I wanted to make a couple of points. One, this debate about cost should not be about providing access to health insurance. It must be about providing access to health care. Too many insured Americans find that having an insurance policy is no guarantee that they or a loved one will be able to afford care when they need it.

And finally I want to point to a new report by the Illinois Main Street Alliance in which 56 percent of small business owners in the state support a choice between a public insurance option and a private option. Those are the small businesses in our state.

And finally, Mr. Chairman, I would like to submit for the record a report from the Institute for America's Future, Massachusetts Health Reform, Near Universal Coverage but No Cost Controls or

Guarantee of Quality Affordable Health Care For All, if I may submit it for the record.

Mr. PALLONE. Without objection, so ordered.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Mr. PALLONE. Next is the gentleman from Texas, Mr. Burgess.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. I was astonished a couple weeks ago to be invited to the White House to a forum. I still haven't figured that out, but I was grateful to be there, and I heard the President observe that he just wants to figure out what works. And I am certainly prepared to help him.

Now, I always get a little bit discouraged on these panels and discussions. We end up talking a lot about cost and coverage. After all, as a physician, I can tell you it is about taking care of people in the final analysis.

One of the things the President also told us was that the status quo is not an option. I would also observe that very little is static in the field of medicine, and in fact, in the 15 years since the last major attempt at reform was undertaken, medicine has changed drastically.

Now, the President wants to figure out what works. We are going to hear a lot of about former Governor Romney's proposal in Massachusetts that has now had a couple of years to go through a couple of iterations. It is a bold experiment. It deals with a connector. It deals with mandates. But maybe we should also look at Wal-Mart, which in the past four years now, covers without mandates 95 percent of its employees with affordable coverage. If we want to learn from what works, maybe we ought to include that in our broad-based discussion.

You know you look at the cost increases. It was referenced by former Chairman Dingell, the cost for indemnity insurance, PPO. In fact Medicare and Medicaid all are going up in excess of 7 percent a year.

Look at consumer-directed health plans though, and they are rising at a rate of a little over 2 percent a year. It seems to me it would make sense that if we are going to deal with issues of cost and coverage, we would give a close look to those things that are working particularly how Wal-Mart has provided affordable coverage to its employees and how consumer-directed health plans have held the line on cost increases. I will yield back the balance of my time.

Mr. PALLONE. Thank you. Gentlewoman from California, Ms. Harman.

Ms. HARMAN. Thank you, Mr. Chairman. Health care reform can't wait. It is an integral part of any economic recovery strategy, and I think it is very good news that both the Obama Administration, this Congress, and this committee know that.

Let me just make three brief points. First I am new to this subcommittee but not new to this issue, and I welcome the opportunity to be a player at some level as we craft legislation.

Second, I urge that all of the expertise on this committee, starting with our chairman emeritus, but including every other member

of the committee, Democrat and Republican, be tapped as we draft a bill.

Third, of special interest to me is the lack of surge capacity in our health care system. Should we have another major terrorist attack or near simultaneous attacks, I would bet that all of our trauma centers will be full to capacity even before the latest victims get there.

And finally, let me say that both wellness and preventive care are the cheapest options for health care, and I hope we feature both as we craft a bill. Thank you very much.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee, Ms. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Ms. BLACKBURN. Thank you, Mr. Chairman. Thank you for the hearing, and welcome to our guests today. You know there is a saying nothing in life is free, and in Tennessee we have figured this out with our Tenn Care system. It has become proof of that. We have learned that comprehensive health care packages for all cannot be affordable. Government's resources to provide care are fixed, and as we learned, intervention can exacerbate rather than control the growing cost of health care. And Tenn Care has been very problematic for our state.

Tenn Care kept a blind eye to rising costs and over generosity. It imposed no limits on days in the hospital or number of prescriptions that were allowed each month, and in the mid '90s, each Tenn Care enrollee received an average of 30 prescripts per year. However, health outcomes in the state did not improve.

So to control costs and expand care, we must look to market forces, not look past them. And while the private sector is in need of reform, it is more effective than the proposed government-run options being floated to bring about more efficient, higher quality, and more effective health care.

This hearing is entitled "Ensuring Affordable Coverage." I believe it should be entitled "Ensuring Access to Affordable Health Care Options," and I say that because of the experience we have had in our state. The nation will achieve high quality care at a lower cost when Americans are empowered to make choices and become prudent health care consumers.

Thank you, Mr. Chairman, and I yield back my time.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Gonzalez. Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you. Ensuring affordable quality health care for all Americans is a worthy goal indeed, a necessary goal. We should work to ensure that low-income families, those with disabilities or chronic diseases, and all who purchase health care on their own, have the same opportunity to access health care as their neighbors.

But access to an insurance card, no matter if that card is for a family health plan or a government program, it does not guarantee access to quality health care. In my state of Georgia, the number of general physicians has declined over 15 percent in the past 10 years. Unfortunately Georgia is not an isolated case.

Mr. Chairman, access to quality health care should mean that all Americans are able to see a qualified medical professional and receive a life-saving treatment or drug when they need it. Going forward, Mr. Chairman, it is my hope that this subcommittee will not lose sight of the fact that we will destroy, not improve, but destroy health care if we take actions to reform the system that drive doctors out of the practice. Thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Ms. Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman. I waive my opening statement.

Mr. PALLONE. Gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Thank you, Chairman Pallone. Our neighbors and folks all across this country are depending on us to tackle this health care reform effort and help make health care more affordable for their families. So we need your expert testimony now more than ever. The stakes are very high in my home state of Florida that has the second highest rate of uninsured.

In fact, I was going through the comment cards in my office last night, and health care is the number one issue. They know that it is not just their well-being. It is their economic well-being in a very difficult time.

One constituent shared a story. I guess they felt so compelled. They were so offended by the fact they were waiting in line at the pharmacy behind a woman who was picking up insulin for a relative, and the pharmacist had to say I am sorry. Your private HMO has declined coverage. We cannot provide the insulin. And they said there is no other option? No, there is no other option for this expensive insulin. We cannot provide it to you. So that person, that neighbor waiting behind felt so compelled to write to their member of Congress to say this just is not acceptable in our country.

The proof of dysfunction is legion. Now, what we need are the solutions. So I look forward to your testimony very much, and I know that this committee will act expeditiously this year on health care reform. Thank you.

Mr. PALLONE. Thank you. The gentlewoman from Ohio, Ms. Sutton.

OPENING STATEMENT OF HON. BETTY SUTTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. SUTTON. Thank you, Mr. Chairman, for holding this important hearing. I am particularly interested in today's topic of making health care affordable for working families. Unfortunately our current system is far from affordable, and every day we wait, there are consequences.

Ask Tammy Whit from Ohio. She was diagnosed with stage three breast cancer in April of 2006 and had to undergo a mastectomy and nine months of radiation. Tammy was receiving what she thought was comprehensive health insurance from her job, but Tammy's low annual insurance benefit caps left her with unaffordable medical debt that eventually caused her to declare bankruptcy.

Like Tammy, far too many Americans have to worry about facing bankruptcy when they become ill because of the cost of health care. We can do better, Mr. Chairman, by Tammy and families across this country. We have to do what we can to rein in costs and make health care more accessible and affordable. And I look forward to hearing from our panelists today.

Mr. PALLONE. Gentleman from Iowa, Mr. Braley. Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. I hear from my constituents every single day about the high cost of health care, whether they are insured or not. Brenda, a constituent of mine, was self-employed as a children's book author. Her small income disqualified her from being eligible for Wisconsin's public health insurance program, and she couldn't afford to purchase health care in the individual market.

Last year, Brenda got a small kidney stone, but because she was uninsured and could not afford health care, she delayed getting it treated to the point that she had to be hospitalized with severe infections and internal bleeding. She is no longer able to work and receives insurance from the public health insurance program now.

We absolutely must tackle this issue if our reform is to succeed at all, and we must ensure that individuals like Brenda are able to access the care they need when they need it.

In my last couple of seconds, Mr. Chairman, I just wanted to respond to some of the comments we have heard about having public sector options along with private sector options. Medicare Part D is used as an example frequently. I would note that in the state of Wisconsin, I think we are the only state that has a public sector option in the Medicare Part D program. It is very, very successful, and I hope that we will be able to study it further as we have this debate about whether there should be both public and private sector options available to our constituents.

Mr. PALLONE. Thank you. Gentleman from Connecticut, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY OF CONNECTICUT. Thank you, Mr. Chairman. I hope that we spend some time this morning talking about the fact that just because you have health care insurance doesn't necessarily mean you have health care. This is an important distinction that needs to be at the center of this debate.

For instance, in Connecticut, we have a very generous Medicaid program, but because it doesn't pay doctors enough to be part of it, we have Medicaid recipients that can't find a psychiatrist or can't find an orthopedic surgeon no matter where they go. Before I came here, we had to pass a law in Connecticut that cracked down on private insurers that were charging \$200 copays for MRIs, basically putting the entire burden of that procedure on the consumer.

Universal health care insurance and universal health care are potentially very different things, and I hope that this hearing will push Congress towards passing a health care reform bill that guarantees that every American gets quality health care that they can afford, not just a claim of coverage or phantom access. I thank the panel for being here, and I look forward to hearing from you today.

Mr. PALLONE. Thank you. Gentleman from Utah, Mr. Matheson.

**OPENING STATEMENT OF HON. JIM MATHESON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH**

Mr. MATHESON. Thank you, Mr. Chairman. Cost is the issue, and today we are talking about affordability for families. We should be talking about affordability for everyone, the American families, businesses, the effect on small business. There is a lot of talk about access and making sure everyone has access to health care. If we give access to everyone under our current system and don't take steps to create reform in our system and make it more efficient, we are going to drive off the financial cliff even more quickly than we are headed right now.

So I encourage this committee to continue to look at ways to make this system better. The good news is there is tremendous opportunity to make it better without spending more money. The current system is inefficient. It is not productive. It has perverse incentives built throughout its structure. It has a bloated administrative component that I can't believe we have put up with as a country. So I think there are great opportunities for this committee to act in the best traditions of the Energy and Commerce Committee in a bipartisan way to be substantive, to look at multiple variables that really need to be addressed if we want to reform our health care system.

That is what this committee ought to do, and I look forward to this hearing and additional hearings in the future. Thanks, Mr. Chairman.

Mr. PALLONE. Thank you, and I want to thank all of our members for their opening statements, and now we will turn to our witnesses and welcome to all of you. We have a very distinguished panel with us today, and I am going to introduce them from left to right. And then we will have five-minute statements from each of you.

First again to my left is Dr. Uwe Reinhardt, who is a professor of political economy, economics and public affairs at Princeton University in home state. Thank you very being here today. We have Ms. Sally Pipes who is president and chief executive officer of the Pacific Research Institute, and then we have Dr. Judy Feder, who is senior fellow of the Center for American Progress Action Fund.

She also has been before our committee many times in the past, our subcommittee.

So thank you all, and if we could start with Dr. Reinhardt. Is your mike on? I am not sure. You pressed the button?

Mr. REINHARDT. High tech.

Mr. PALLONE. That is good.

STATEMENTS OF UWE REINHARDT, PH.D., PROFESSOR OF POLITICAL ECONOMY, ECONOMICS AND PUBLIC AFFAIRS, PRINCETON UNIVERSITY; SALLY C. PIPES, B.A., PRESIDENT AND CHIEF EXECUTIVE OFFICER, PACIFIC RESEARCH INSTITUTE; AND JUDY FEDER, PH.D., SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS ACTION FUND

STATEMENT OF UWE REINHARDT

Mr. REINHARDT. I am from rural New Jersey, as you know, and I have to learn these things.

I have submitted a statement to the committee. It falls into three parts, and the first one I briefly visit the issue of cost, just to remind Americans how expensive our system is. The second one, I look at what this cost does to American families, looking sort of at the median American family. And then in the final, I have some perspectives on proposals before the nation to fix this problem.

Now, it is well known that we spend on a per capita basis in purchasing power parity a lot more than other nations, 56 percent more than Switzerland, which is viewed as a very high quality health care system, and 83 percent more than Canadians do. And yet if you look at health statistics, you will not find that much different. In fact, I find it an intellectual breakthrough of major proportions that the business roundtable, which used to be the staunch defender of our system as the best in the world, now comes out with a report just last week talking about a 20 percent value gap, saying relative to other nations, Americans get 20 percent less value for their health care dollar than other nations. That is a very important recognition by these important people.

I also remind people of what we call the Winberg variations, for example, that under Medicare, it costs more than twice as much per elderly in Miami than it does in San Francisco, which is an issue, I believe, that Congress should begin to look into, fund research to say why should it cost twice as much in one part of the country than in others. But it is not just in Medicare. You will find the same in private insurance as well.

So I believe cost effectiveness analysis, which is a dirty word yet on the Hill, at some point does have to be embraced. It is just called operations research. There is no other industry that wouldn't look at cost per unit of output. Health care is really the only one.

But I also would urge Congress not to say let us do cost control first and then universal coverage because we have said this for 30 years. We have never done the former, and I don't think you can fool God that long with the excuse that we cannot afford it. We have said this now for 30 years. It is time to go to universal coverage.

In the second section, I look at the American family. I use for this not health insurance premiums, which is a very misleading in-

indicator. I use the Milliman medical index, which includes the premium for health insurance for the family plus their out-of-pocket spending. But you can always make premiums go down or slower just by cutting the benefit package, raising deductibles, and so on.

So you really should look at the Milliman medical index. Last year, on average, for a family of four, it costs \$15,600 for health care in America. It would be now \$16,500. Now, compare that to the median household income in America in 2007 was \$51,000. So if one had the view that people should be responsible for their own health care, you would be saying for a median American family that they should spend \$16,000 out of their \$51,000. That is an awful heavy burden. Now, for lower income families, as your statement correctly says, 30 percent of available discretionary income goes for health care.

So what I predict that in the next decade—I have a little table here. I use a family here with a wage base of \$50,000 and say if that wage base grows at 3 percent and health care spending per capita by 8 percent, which is what it has been, for the next decade, then half that family's wage base would be chewed up by health care 10 years from now, half.

Even if you make very optimistic assumption that health spending grows only 4 percent and wages 5 percent—it is even unthinkable given what we are facing right now. But even if you make that, 30 percent of that family's wage base would be chewed up. So we are sailing into a perfect storm, and the Congress at some point faces the following question. Either taxes have to be raised on those of us fortunate to be in the upper part of the income distribution, myself included, or—and then you could have a roughly egalitarian health system. Or you seriously have to redesign the system to ration health care by income class, which is, of course, what we have been doing already. And this is a sort of mischievous piece of mythology that government run systems like Canada's ration health care and private markets don't.

If you have a specialty drug that costs \$100,000 a year and you ask somebody to pay a 30 percent co-insurance for getting that drug, you are rationing that person out of that specialty drug if their income is \$50,000. I mean it is just—every textbook in economics will tell you that prices ration. It is just one other form of rationing. So this is what the Congress faces.

And then look in the last section at the individual market and presents several models. I don't have time to go into it, but there is the issue of the public health plan. Given what the American people have witnessed, they have seen great American companies, AIG, GM, CitiGroup, go under. Given the shock they have received, one could imagine that Americans would yearn for an option that is government because I believe in the end it is the government Americans trust because that is where they always run to when they get in trouble, whether they are big bankers, or whether it is FEMA or whoever it is. When the going gets tough, the tough run to the government. That is the slogan, and I have observed it for 40 years in this country.

So therefore I believe that people say we shouldn't have a public option have a tall order to explain to the American people why they should be deprived of a choice that they may yearn to have. And

I then go through later on how one could make that a level playing field. It is after all only a choice. You don't have to choose it. You can go private. But it should be, in my view, I as a citizen would love to have that option, and I might even take it. Thank you very much.

[The prepared statement of Mr. Reinhardt follows:]

Testimony of

**Uwe E. Reinhardt, Ph. D.
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Woodrow Wilson School of Public and International Affairs
and
Department of Economics
Princeton University
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e-mail: reinhard@princeton.edu**

**Before the
U.S. House of Representatives
Committee on Energy and Commerce Subcommittee on Health**

**Hearing on
*“Making Health Care Work for American Families:
Ensuring Affordable Coverage”***

March 17, 2009

My name is Uwe E. Reinhardt. I am a Professor of Economics and Public Affairs at Princeton University and have been engaged in research on health economics and health policies for several decades.

I would like to thank you, Mr. Chairman, for convening this hearing on an issue that is now uppermost in the mind of the American people. It is an honor to be invited to present a statement to your Committee.

My statement has three sections. In the first I present some data on the extraordinary and increasingly indefensible high cost of American health care. In the section I shall illustrate how these high and relentlessly growing costs are inexorably pricing American families in the lower half of the nation's income distribution out of health insurance and timely, efficient health care. The third section then offers some perspectives on how the nation might address this growing problem.

A. The High Cost of American Health Care

Over the past four decades the United States has constructed for itself a health system that is now the most expensive such system in the world.

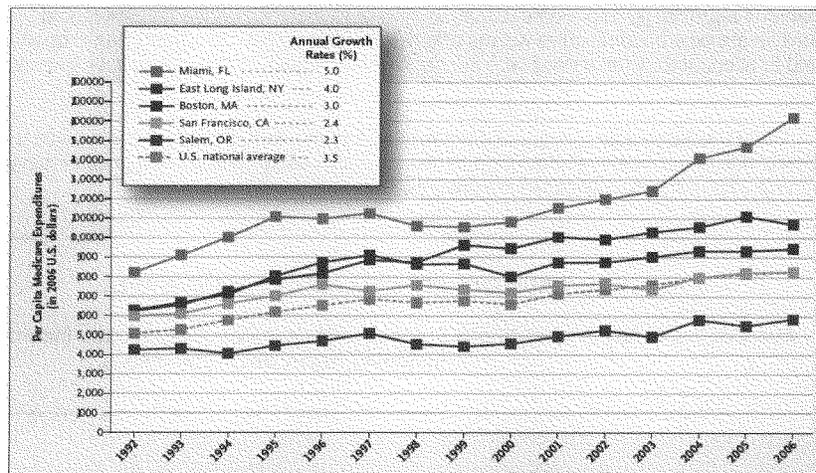
In 2006, the last year for which such data are available from the Organization of Economic Cooperation and Development (OECD), the U.S. spent 56% more per capita in Purchasing Power Parity Dollars (PPP\$) than did the second most expensive health system, Switzerland's, which is widely regarded as a well-endowed, high-quality with remarkably good health-status statistics. The U.S. spent 83% more per capita in PPP\$ than does neighboring Canada, whose health statistics also are as good and sometimes better than comparable American statistics although, unlike the Swiss or, say, Germans, Canadians do have to queue up from time to time for elective surgery and certain high-tech procedures, such as imaging.

For decades, Americans have viewed these sizeable cost differentials in health care with equanimity, on the unquestioned premise that the American health system is the best in the world. A growing volume of research in the past decade, however, has cast serious doubt on that premise. While at its best American health care undoubtedly has few, if any, rivals, on average the system does not appear to rank at the top of nations, and certainly not as high as its high health spending would seem to warrant.

Only last week, for example, the *Business Roundtable*, traditionally a staunch defender of this country's approach to health care, delivered itself of a doleful report which concludes that, in terms of value received per dollar spent on health care, the American health system exhibits a "23 percent value gap relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France."¹ Coming from that quarter, this is a quite remarkable statement.

¹ The Business Roundtable, *Health Care Value Comparability Study, Executive Summary*, available at <http://www.businessroundtable.org/sites/default/files/BRT%20exec%20sum%20FINAL%20FOR%20PRINT.pdf>

But one need not look across national boundaries to question what value Americans actually receive for their enormous health spending. Several weeks ago, researchers of the Dartmouth Medical School published in *The New England Journal of Medicine* their latest report in a long series of similar reports published in the literature and formally presented to the U.S. Congress during the past two decades.² The graph below, taken directly from the report, indicates that in 1992, Medicare spent about 33% more per Medicare beneficiary in Miami, Florida than it did for statistically similar beneficiaries in San Francisco, and close to twice as much than was spent on Salem, Oregon. By 2006, this spending gap had widened. In that year, Medicare spent twice as much per Medicare beneficiary in Miami than for similar beneficiaries in San Francisco and 2.7 times as much as it spent for Medicare beneficiaries in Salem Oregon. While Medicare spending over the period 1992-2006 per beneficiary rose at an annual compound rate of 5% in Miami, it rose by only 2.4% per year in San Francisco and only 2.3% per year in Salem Oregon.



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992-2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

I mention these international and intra-US variations in per capita health spending not to deflect us from the topic before this hearing, but to register an important point:

Sooner or later those who write most of the checks for health care in America – employers, Congress and state governments – must embrace the idea that, like any other sector, health care should be subjected to the rigorous cost-effectiveness analysis known elsewhere in the economy as “operations research.”

² Elliott S. Fisher et al., “Slowing the Growth of Health Care Costs – Lessons from Regional Variation,” *The New England Journal of Medicine* vol. 360, No. 9 (February 26, 2009): 849 - 52.

To the detached observer, for example, it seems incredible that, having been apprised for over two decades now of the huge geographic variations in Medicare spending per beneficiary, the U.S. Congress has never funded research to inquire whether the high spending levels in the high-cost states are really necessary.

The same, of course, can be said of private employers, who have done very little over the years to reign in the growth of health spending in this country and to extract greater cost-effectiveness and accountability from the supply-side of the health system.

Unfortunately, the term “**cost-effectiveness analysis**” remains as yet anathema in the halls of Congress, as we saw only recently in connection with the Economic Stimulus Bill. That is unfortunate, because more and more American taxpayers and families are now becoming the victims of a health system that has never been properly held to account for what it does with the enormous real and financial resources entrusted to it.

At the same time, of course, I am fully aware also that any attempt to wrestle the supply-side of our health sector down on the issue of **cost-effectiveness** is constrained by what I have facetiously called in earlier work

ALFRED E. NEUMAN'S COSMIC LAW OF HEALTH CARE

Every dollar of health spending = Someone else's dollar of health care income, including fraud, waste and abuse.

As the members of this Committee know only too well, much economic and political power resides on the right-hand side of this equation. Indeed, even the legendary General David Petraeus might find daunting the legion of K-Street insurgents enlisted by that side.

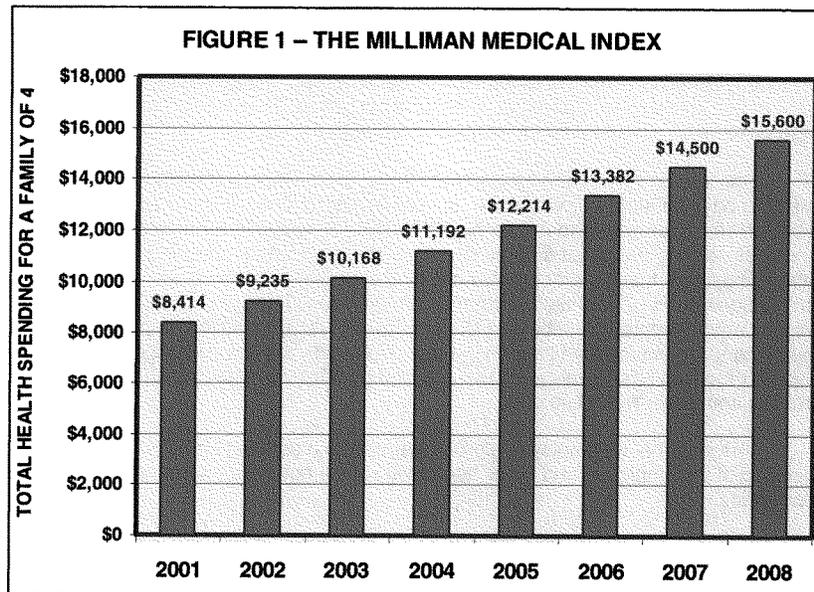
For that reason, I would never advocate a frequently proposed policy of controlling health care cost first, before helping Americans currently priced out of the health system to gain access to timely, good-quality health care, without pushing them to the brink of personal bankruptcy. Eliminating the value gap of which the Business Roundtable speaks will take decades of concerted effort by an alliance of payers and health-services researchers. Congress must ask itself whether America's growing number of families without health insurance should be made to wait that long.

A. Pricing Americans out of Health Care

During the past four decades, real (inflation-adjusted) health spending in the United States has, on average, grown 2½ percentage points faster than the rest of real GDP. This differential was not constant year by year and is not true for every component of national health spending. But, over the longer run and for total national health spending, it has been remarkably stable over the decades.

If this differential persisted for another four decades, then health care would absorb close to 40% of the GDP by 2050.³ It would severely stress the budgets of governments, of employers and of households across the United States, most of all those of families in the lower half of the nation's income distribution.

Household spending on health care: Figure 1 below shows data from the Milliman Medical Index published annually by Milliman, Inc., a benefits consulting firm. The index shows the average annual health spending for a privately insured hypothetical American family of four, averaged over a very large, nationwide data base of families covered by a private Preferred Provider health insurance plan (PPO).⁴



³ See, for example, Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November, 2007; Figure 4, p. 13.

⁴ Milliman, Inc., *2008 Milliman Medical Index*, <http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2008.pdf>

The virtue of the Milliman Medical index is that it includes not only the premium for the family's employment-based health insurance, but also the family's out-of-pocket spending for health care. Many other surveys capture only the premium component, which can be treacherous when benefit packages change over time and deductibles and coinsurance as well as exclusions rise over time.

It is seen that over the past 7 years the average total outlay on health care for a family – from all sources – nearly doubled. The overall average annual compound growth rate in the series is 8.9%, although on a year-to-year basis that growth rate had declined from 10% in the earlier years to 7.6% in between 2007 and 2008.

To put the data in Figure 1 in perspective, it may be noted that according to the U.S. Bureau of the Census, median household income in the United States in 2007 was about \$51,000⁵. The word "median" means that 50% of American families had a smaller income. That figure is not likely to grow much in the near future – it is apt to fall -- and it may grow only sluggishly over the next decade. For the 50% of households falling below this median, then, it will be increasing difficult to finance the household's health insurance premiums and out-of-pocket spending with its own resources.

Household spending on health care and the wage base: An important point to note in connection with Figure 1 is that the total spending on health by or on behalf of a non-elderly American family must be supported by what one may call the "gross wage base" of this family's income earner or earners combined. This conception of the "gross wage base" is so important that it merits some further explanation.

One should think of the "gross wage base" of an employee as the total price an employer pays for labor per employee. In accounting parlance, it is the sum of all of the debits an employer makes to the account PAYROLL EXPENSE for an employee. Thus, it includes not only the gross amount shown on the employee's paycheck, prior to withholdings from that sum for taxes owed by the employee or the employee's contributions to his or her health insurance and pension. The gross wage base also includes any mandated contributions the employer must make to the employee's Social Security and Unemployment Insurance Fund, along with the voluntary contributions the employer makes to the employee's pension and health insurance plans, the cost of vacation and sick pay, and so on.

The idea that an employee's gross wage base must support all of the health spending of the employee and his or her family seems not well understood among non-economists.

For example, it tends to confuse people – many corporate executives and union leaders among them -- who believe that the employer's contribution to an employee's health insurance is paid by shareholders and not the employee or himself in the form of lower take-home pay. That myth that has long bedeviled the role of employment-based health insurance in health policy. Most economists are convinced, by dint of their and empirical research, that over the longer run, employers are able to shift the cost of

⁵ U.S. Census Bureau, Quick facts from the U.S. census Bureau, <http://quickfacts.census.gov/qfd/states/00000.html>.

their contributions to the employee's fringe benefits back to employees by lowering take-home pay. An implication of this insight is that the cost of employment based health insurance should not make American business uncompetitive in the global market.

The fact that the employee's gross wage base must support all of a family's health spending, including its out-of-pocket spending, also confuses the many people who argue that reducing the premiums for health insurance through higher deductible and coinsurance – an idea frequently offered under the label Consumer Directed Health Care -- solves the health-care cost problem for American families. It certainly does not. For the most part, high-deductible health insurance merely shifts spending out of the insurer's accounts into the family's accounts. It must still be borne by the family's gross wage base and, therefore, is not a solution to the American health-care cost problem. Indeed, the whole idea of measuring the cost of American health care by the premiums for employment-based health insurance is faulty.

Health spending as a percentage of the gross wage base: Consider a family supported by a gross wage base, as defined above, of \$50,000. It could be a family with one or two breadwinners. Suppose that wage base grew at an annual rate of about 3%, the long-run average growth rate of average weekly earnings during the past two decades.⁶ It would then be \$67,200 by 2018. Suppose next that the total annual health spending of the family grew at an annual compound growth rate of 8% during the next decade, from \$15,600 in 2008 to \$33,700 by 2018.

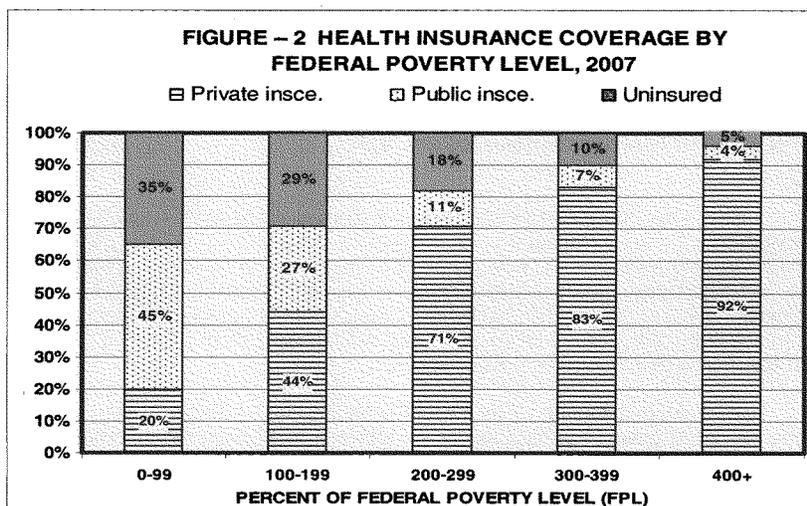
It follows that the family's total health spending in 2018, which must be supported by its gross wage base as defined above, would absorb half that wage base before it could support any other of the family's spending, including its tax obligations. Table 1 repeats this calculation for other combinations of growth in the wage base and in health spending. It is seen that even if health spending grew only at 4% per year and wages by 5% -- both highly optimistic assumptions -- 29% of the wage base in 2018 would be chewed up by health care.

TABLE 1 -- RATIO OF FAMILY'S HEALTH SPENDING TO ITS WAGE BASE, 2018

Annual Growth in Wage Base	- Assumed Annual Growth in Family Health Spending -				
	4%	6%	8%	10%	12%
1%	42%	51%	62%	74%	89%
2%	38%	46%	56%	67%	81%
3%	35%	42%	51%	61%	73%
4%	32%	38%	46%	55%	66%
5%	29%	35%	42%	50%	60%

⁶ See Economic Report of the President to the Congress 2008, Table B47, <http://www.gpoaccess.gov/eop/2008/B47.xls>.

Figure 2 shows that being uninsured is strongly related to income levels. If the average health spending from all sources for American continues to grow in the next decade as it has in the past, an increasing number of families with incomes 200% of the Federal Poverty level and above will find themselves among the uninsured and unable to finance their health care with their own resources.



SOURCE: Kaiser Family Foundation, The Uninsured: A Primer, October, 2008; Figure 3.

This circumstance will confront American voters and their representatives in the political arena with the following choice:

Either the households in the top half of the income distribution must pay higher taxes to help subsidize the health care of households in the lower half of the income distribution,

or

The American health-insurance and health-care systems will gradually be restructured into a two- or multi-tiered system that rations health care by income class, perhaps by means of reference pricing.

By "reference pricing" is meant an insurance system that covers patients fully or near fully only at low cost hospitals and medical practices and for low-cost medical devices and pharmaceutical products – e.g., generics -- forcing the patient to pay out of pocket the whole difference between the cost of the low-cost facility or product and a higher priced

option. We see this form of pricing already in drug therapy. Quite possibly it will be extended in the next decade to other segments of the health care sector.

C. Providing American Families with Secure Health Insurance

In formulating their thoughts on the goals for reforming the nation's health system, American might begin their contemplating by thinking about the following questions:

1. Do you want to live in a society were a family, already financially stricken when one or both of the family's breadwinners lose their jobs, the family also loses the financial security of health insurance?
2. Do you want to live in a society views getting sick pretty much as the same as having a poor driving record, that is, that views illness as basically the sick person's own fault, rather than a matter mainly of genetic inheritance, or an unhealthy workplace, or unhealthy living conditions, or just plain bad luck all around, so that it is perfectly fair that chronically sick individuals should be charged higher health-insurance premiums than chronically healthy people?
3. Do you want to live in a society in which access to health care is rationed by income class, through price and the household's ability to pay?
4. Do you want to live in a society in which your offspring, who may be starting their work-life in a small business firm -- perhaps one of their own creation -- or many other self-employed entrepreneurs cannot get health insurance because the insurance industry does not serve small business firms well?
5. Do you want to live in a society in families are can easily face bankruptcy when one of its members is stricken by serious illness?

If the answer to these questions were "Yes" in every case, you will find the present health insurance system perfectly adequate. If the answers were "No," then this list furnishes the minimal benchmarks a sound health-reform program ought to achieve.

Most citizens in the industrialized world have long enjoyed the mental and financial security of permanent, life-cycle health insurance that is portable from job to job and from employment into the status of unemployment or retirement. Furthermore, most citizens in other industrialized countries still view illness as mainly bad luck, often driven by genetic make-up that amplifies or mitigates the effects of unhealthy life styles.

In the United States, the state of security in health care enjoyed by citizens elsewhere is enjoyed only by Medicare beneficiaries, who do have permanent, portable, life-cycle insurance for life starting at age 65. The rest of society could be said to be more "**uninsured**" than "**insured**," because insurance coverage can be lost for a number of reasons, job loss most prominent among them.

To the outsider, the question is why Americans have been content with this inherently brittle health insurance system for so long and for how long they wish to continue it.

The employment-based health insurance system: It can be doubted that any health-policy analyst, given the luxury of starting from scratch, would ever think of making the current American employment-based health insurance system a major corner stone of the American health system. Not only is that form of coverage ephemeral and, thus, brittle, but it also entails huge administrative costs all around.⁷

In the eyes of many, however, a major advantage of employment-based health insurance within the American health system is it is based on usually wide risk pools that are not segregated by risk class. In fact, as already noted, these systems can be viewed as a form of private social health insurance.

It can be predicted that the fraction of the American population covered by employment-based system – now still over 60% of the non-elderly population – will shrink gradually in the decade ahead, especially among smaller enterprises, unless employers are directly subsidized publicly for continuing that form of coverage. The reasons for that erosion were explored in the previous section of this Statement.

Therefore, this is a propitious time to develop soon a robust, alternative track to the employment-based system, based either on a reformed market for individually purchased health insurance or a public insurance program for the non-elderly or both.

A strengthened market for individual health insurance: Volumes have been written on the merits and shortcomings of the market for individually purchased health insurance and how to strengthen that market. There are two options.

One extreme option would be to permit this market to segregate itself by risk classes through medical underwriting and then to subsidize individual families buying coverage in this market so that their total annual outlay on health care, plus health insurance, does not exceed a legislated fraction of discretionary income (i.e., income after covering basic necessities such as food, utilities, housing, etc).

In theory, economists find this the most attractive model, as it permits efficient competition among private insurers without having to worry about the problem of creating broad risk pools for individually purchased health insurance. In practice, of course, this approach would require a whole new bureaucracy to determine and pay out the customized public subsidies to individual families in this market.

At the other extreme are arrangements such as the German statutory health insurance system under which private, non-profit sickness funds compete for enrollees, but subject to guaranteed issue, community-rating for each insurer and even uniform fee schedules for paying the providers of health care.

⁷ In this connection, see U E Reinhardt, "Employer-based health insurance: a balance sheet," *Health Affairs*, November/December 1999; 18(6): 124-132.

In between these extremes are countless alternative arrangements leaning to one or the other of the extremes. One can find a good sampling of such arrangements on *eHealthInsurance.com*.

These arrangements always come with several problems.

First, there is the well-known problem that a major instrument of competition in these markets will be judicious cherry picking among insured risks – especially if insurers are subject to community rating. The question then is whether that behavior should be discouraged by public policy and, if so, how.

Second, if insurer's competing in the individual health insurance market are subject to guaranteed issue and community-rated premiums, but households are free to insure or not to insure, there will be adverse risk selection on the part of consumers. Many of them will go without insurance when they are healthy, but then have the privilege of throwing themselves on the mercy of community-rated premiums when they fall ill. It is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance. The State of New Jersey, which introduced this arrangement some years ago, furnishes a clear example of this tendency.⁸ Thus, the question is whether having health insurance should be made mandatory upon the individual in such a system.

Third, there is the expectation that insurers will compete in part on their ability to pay the providers low prices for health care. It is not at all clear, however, that the price discrimination on the part of providers this competition engenders works to the advantage of society. As William Porter and Elizabeth Olmsted Teisberg remark on this issue in their *Redefining Health Care*, correctly in my view:

The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts.⁹

Fourth, it is not clear to me how the market for individual health insurance, any more than employment-based insurance, can offer Americans what citizens in any other nation take for granted: stable, permanent, life-cycle insurance, if that is what some or many Americans actually would like to have. In Germany, private commercial insurers must offer permanent, life-cycle insurance policies; but that is achieved only with very heavy handed federal regulation. To create such policies in American private insurance would require similarly heavy regulation of insurers.

A public health insurance program for the non-elderly: It seems clear that a well functioning market for individually purchased health insurance ought to be based on some form of farmer's market for insurance that brings order to the transactions and makes sure that they are reliable.

⁸ See, for example, Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "Community Rating And Sustainable Individual Health Insurance Markets In New Jersey," *Health Affairs*, July/August 2004; 23(4): 167-175.

⁹ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006: 66.

Electronic farmers markets such as *eHealthInsurance.com* go a long way of providing such a farmers market, but they are mainly passive organizers of listings of different insurance products. They lack regulatory power.

A more powerful alternative would be the *National Insurance Exchange* proposed by President Obama and also by Senator Max Baucus¹⁰, which, at the blueprint stage, seems to be a compound of the *Massachusetts Insurance Connector* and the *Federal Employee Health Benefit (FEHB)* system. In the 1990s, these organizations went by the name of "*Health Insurance Purchasing Cooperatives*" or "*Health Insurance Alliances*."

Whatever their name, these types of more powerful farmers markets for health insurance would have to be endowed with regulatory powers to supervise and enforce the reputability of the products being offered on these markets and perhaps even to develop standard contracts whose fine print does not have to be studied every time an insured buys insurance. Policymakers might also look to these farmers markets to organize larger risk pools and to limit, if not altogether eliminate, cherry picking on the part of insurers and adverse risk selection on the part of the insured.

Whatever the eventual shape of such an organized market would be, it would presumably offer consumers a menu of choices among different health insurance products. The question then arises whether among these products should be a public insurance program for the non-elderly as well.

In his presidential campaign, President Obama promised to provide Americans such a public, Medicare-like health insurance plan, which American desirous to enroll in such a plan could chose, if they preferred it to rival private insurance offerings. A similar provision is included in Senator Baucus white paper *Call to Action: Health Reform 2009*.¹¹

On its face, this idea should not appear controversial to anyone who believes that *choice* among insurance products and carriers should be a hallmark of a reformed American health insurance system. Remarkably, however, this idea now seems to have become the proverbial third rail in the current health reform debate. Opponents of a public health plan for non-elderly Americans want Congress to deprive American citizens of the choice of such a plan; but taking choice away from citizens is a tall idea calling, at a minimum, for a strong and persuasive defense.

The arguments against offering non-elderly American citizens the choice of a public plan, enrollment in which would be entirely voluntary, is that such a plan

¹⁰ <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>

¹¹ <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>

would have an “unfair” advantage over private insurers.¹² That argument requires careful and convincing explication in what way such a plan would be “unfair.”

After all, it may well be that, after having seen their private savings eroded in the private market, after having seen promised retiree health benefits disappear, and after seeing hallowed American business firms such as GM, AIG, Lehman Brothers, Citigroup sliding into bankruptcy or hanging on to life only on life support from the taxpayer, many American citizens might well look upon a government-run health insurance program as a more stable option that could, in principle, offer the insured permanent, fully portable, life-cycle financial protection against the financial inroads of illness. In the present economic turmoil, and after the truly disappointing performance of so many executives in the private sector, that feature of a public plan could become a decided advantage in the market for health insurance; but I am not sure that one could call it an “unfair” advantage.

Another candidate for an “unfair” advantage might be the ability of a public insurance plan to obtain exceptionally low prices from providers by virtue of its market power. For example, if the new public plan simply piggy-backed itself onto the existing Medicare payment system and paid the same rates, which are unilaterally set (albeit after some indirect negotiation with providers in the political arena), then the public plan would have a comparative advantage *vis a vis* private insurers in the market for health insurance that could be called “unfair.”

On the other hand, if the new public plan had to negotiate its own prices, then it would not have a competitive advantage any more “unfair” than is the ability of large insurers – such as Aetna or Wellpoint – to negotiate lower prices with hospitals and physicians than these providers charge smaller insurers. For some reason, not one has ever called this form of price discrimination “unfair,” although, as Porter and Teisberg have pointed out¹³, it is difficult to defend it on grounds of economic efficiency.

It will be fascinating to see whether, in the coming months, how the debate over the proposed public health plan will evolve – whether in the end it will be debated and decided upon on the basis purely of its economic merit, or whether it will be disposed of as part of political horse trading.

¹² It is more than a bit ironic that commentators who make this argument so no “unfair” advantage in having taxpayers by private insurers an average of 14% more per Medicare beneficiary choosing a private insurance option than that beneficiary would have cost taxpayers in traditional Medicare.

¹³ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006: 66.

Mr. PALLONE. Thank you, Dr. Reinhardt. I want to make sure I got this quote. When the going gets tough, the tough run to the government?

Mr. REINHARDT. Yes.

Mr. PALLONE. OK.

Mr. REINHARDT. That is the marching order of the rugged individualist.

Mr. PALLONE. Thank you. Ms. Pipes.

STATEMENT OF SALLY C. PIPES

Ms. PIPES. And that is probably me. Thank you very much for the opportunity to testify. I think we would all agree that all Americans want affordable, accessible quality health care. The question is how do we achieve that goal? And there are two competing visions for reforming health care and achieving universal coverage in this country.

One focuses on patient-centered solutions, empowering doctors and patients, and encouraging innovation in new pharmaceuticals and medical devices. The other vision is focusing on increasing the role of government in our health care through higher taxes, mandates, and subsidies. This vision for greater government involvement is on the rise today, and I think we need to focus on the fact 47 percent of health care in this country today is in the hands of government through Medicare, Medicaid, S-CHIP, and the VA system.

The long-term goal of the new administration and many Democrats in Congress is Medicaid for all. As has been pointed out, the U.S. today spends 16 percent of GDP on health care, about \$2.3 trillion, and many people say that that is too much. And if we are going to get that percentage down and achieve universal coverage, how do we reduce the number of uninsured from the 46 million Americans?

Canada, my country of birth and where I spent most of my career working as an economist, spends 10 percent of GDP on health care and does have universal coverage. If Canada has universal coverage and only spends 10 percent of GDP, why can we not duplicate that model? The Canadian government took over the Canadian health care system in 1974 and banned any private health care for procedures provided under the Canada Health Act.

Of course, the demand for health care was much greater than could be provided by government. As a result, Canadians suffer from long waiting lists for care, rationed care, and a lack of access to the latest technological equipment.

A few statistics: 750,000 Canadians are on a waiting list, waiting for procedures; 3.2 million Canadians, out of a population of 32 million, are waiting to get a primary care doctor. The average wait today from seeing a primary care doctor to getting treatment by a specialist is 17.3 weeks. That is over four months. Canada ranks 14th out of 25 countries within the OECD on MRI machines and 19th out of 26 countries in CT scanners.

When the government is the monopoly provider of health care, people wait and wait. When they get tired of waiting or are too sick to wait further, they flee if they can, and many come to the United States for treatment.

Belinda Stronick, former member of Parliament in Canada, opposed opening up the Canadian health care system to any private side, but when she was diagnosed with breast cancer in June 2007, she came to UCLA and had her breast cancer surgery done and paid for it out of pocket.

A woman in Calgary, Alberta, expecting quadruplets last year, there was not a single neonatal unit in Calgary, in Alberta, or in Canada where she could deliver her quads. She was air lifted to Great Falls, Montana, a city of 55,000, and her quads were successfully delivered.

I have many, many stories of people in my family. My mother couldn't get a colonoscopy at her age and died within two weeks when she was hemorrhaging in the emergency room. Dr. Brian Day, orthopedic surgeon and former president of the Canadian Medical Association, told the "New York Times" "Canada is a country where a pet—a dog can get a hip replacement within two weeks. A Canadian citizen has to wait two to three years."

In June 2005, the Canadian Supreme Court ruled on a case for the province of Quebec that the ban on private health care and private insurance is illegal because of the long wait times. Madame Chief Justice Beverly McLaughlin said access to a waiting list is not access to health care. Canada is opening up its system while the U.S., it seems to me, is moving more towards a government-administered system.

President Obama has said that employers would have to provide coverage or pay a payroll tax so that employees can get coverage within a new government-run insurance plan, which would be part of a newly created national insurance exchange.

The exchange would also include private insurers. I think the government insurance and the private plans would have to have guaranteed issue, community rating, and many mandates which will make them even more expensive.

My view is that the government plan will be priced lower than the private plans. I see ultimately crowding out of private plans and taking American down a fateful road to Medicaid for all. We would then have universal coverage. We would not have universal access. Care will be rationed. Taxes will increase significantly, and the entrepreneurial spirit of this country will be weakened.

When we get totally socialized health care in America, where are we going to go? We can change the tax code, as has been mentioned, by removing the tax advantage to those who get their insurance through their employer. We could offer, as McCain suggested, a refundable tax credit for everyone. We want to empower patients. We want to reduce state mandates, which add between 20 and 50 percent to the cost of an insurance plan.

I think people should be able to purchase insurance across state lines. We need med now reform, and if we do all that, we can reduce costs and significantly reform and reduce the number of uninsured in this country. Universal choice will lead to universal coverage for all Americans, and then we will have affordable, accessible quality health care for all.

As P.J. O'Rourke, my friend, says if you think health care is expensive now, just wait until it is free. Thank you.

[The prepared statement of Ms. Pipes follows:]

Testimony to the U.S. Committee on Energy and Commerce, Subcommittee on Health

By Sally C. Pipes, President & CEO, Pacific Research Institute, Tuesday, March 17, 2009

2322 Rayburn Building, Washington, D.C.

I would like to thank the members of the Subcommittee for inviting me to testify on “Making Health Care Work for American Families: Ensuring Affordable Coverage”.

I think that everyone would agree that the goal for all Americans is affordable, accessible, quality health care.

The question is: how do we achieve that goal?

There are two competing visions when it comes to health care reform and achieving universal coverage.

One focuses on patient-centered solutions: empowering doctors and patients and encouraging innovation for new pharmaceuticals, biologics, and medical devices.

The other vision is increasing the role of government in our health care system through higher taxes, mandates, and subsidies.

This vision of a greater role for government is on the rise. In America today, government controls 47% of health care through Medicaid, Medicare, S-CHIP, and the VA system.

The long-term goal of the new Administration and the Democrats in Congress is “Medicaid for All.”

The U.S. spends about 16% of GDP on health care (\$2.3 trillion) and it is considered too high. Politicians say we need to get that percentage down if we are going to achieve universal coverage and reduce the number of uninsured from the 46 million Americans without health insurance.

Canada, my country of birth and where I spent a major part of my career as an economist, spends about 10% of its GDP on health care and has universal coverage. If Canada has universal coverage and only spends 10%, why can't we duplicate their model?

The Canadian government took over the health care system in 1974 and banned any private health care for procedures provided under the Canada Health Act. The government mandates that the share of spending on health care not exceed 10%.

Of course, the demand for health care is much greater and as a result, Canadians suffer long waiting lists, rationed care, and a lack of access to the latest technology.

I would like to provide some statistics that are not generally known to most Americans:

750,000 Canadians are waiting for procedures.
3.2 million out of a population of 32 million are waiting to get a primary care doctor.
Average wait from seeing a primary care doctor to getting treatment by a specialist in 2008 was 17.3 weeks.
Canada ranks 14th out of 25 OECD countries in MRI machines and 19th out of 26 countries in CT scanners.

When the government is the monopoly provider of health care, people wait and wait. When they get tired of waiting, or are too sick to wait further, they flee—if they can—to the United States for treatment.

Examples: Lindsey McCreith from Ontario had brain surgery in the U.S., former Canadian MP Belinda Stronach who had her breast cancer treated in LA, the Calgary quadruplets delivered in Great Falls, MT because no neo-natal units in Canada were available.

Dr. Brian Day, orthopaedic surgeon who is the immediate past president of the Canadian Medical Association and who runs the illegal Cambie Clinic in Vancouver told the New York Times, “Canada is a country where dogs can get a hip replacement in less than a week and where humans have to wait two to three years.”

In June 2005, the Canadian Supreme Court ruled on a case from Quebec: “the ban on private health care and private insurance is illegal because of the long wait times.”

Madame Chief Justice Beverly McLachlin said, “access to a waiting list is not access to health care.” Madame Justice Marie DesChamps reported, “the idea of a single payer system without waiting lists is an oxymoron.”

Canada is opening up its government-run health care system to private alternatives while the U.S. is moving, under the current Administration, to a system where government has more control in order to provide universal coverage at affordable prices.

President Obama has said that employers would have to provide coverage or pay a payroll tax so employees can get coverage in a new government-run insurance program that would be part of a newly-created National Insurance Exchange.

The National Insurance Exchange would also include private insurance companies in addition to the government insurance plan.

The government insurance and private plans would have to include guaranteed issue, community rating, and many mandates.

My view is that the government plan will be priced lower than the private plans. The result will be “crowding out” of the private plans and a fateful turn down the road to a Canadian style “Medicaid for All” program. We may have universal coverage but not universal access. Taxes will increase significantly and weaken the entrepreneurial spirit in this country.

Many Canadians and others from around the world come to the U.S. and pay out of pocket for the best health care procedures and treatments.

When we get totally socialized health care, where will “we” go?

If we could change the tax code to level the playing field by removing the tax advantage from those who get their insurance through their employer, reduce state mandates that add between 20-50% to the cost of a premium, allow the purchase of insurance across state lines, and have medical malpractice reform, we could reduce costs and significantly reduce the number of uninsured in this country.

Universal “choice” will lead to universal coverage for all Americans. And, we will have affordable, accessible, quality health care for all.

As P.J. O’Rourke says, “if you think health care is expensive now, just wait until it is free.”

Thank you for the opportunity to provide my perspective on health care reform in America.

Mr. PALLONE. Thank you. Dr. Feder.

STATEMENT OF JUDY FEDER

Ms. FEDER. Thank you, Chairman Pallone and Congressman Deal and members of the committee. It is a pleasure to be with you today to talk about the critical need for affordable health care for all Americans.

As I listened to Ms. Pipes, I wonder whether she is truly following the plight of Americans who can't afford health care and whether she is following the kind of American health reform that we are really talking about. You mentioned President Obama's campaign plan. He has talked about his commitment of the choice of health plan, of quality care, and affordability for all Americans. So I would like to get our attention back to the problems Americans are facing as 14,000 Americans are estimated every day to be losing their health insurance as they lose their jobs and as benefits are shrinking even for those Americans who have health insurance.

The problem of unaffordability is most apparent for the now probably more than 47 million Americans who lack health insurance, most of whom have incomes below twice the federal poverty level, about \$44,000 per family of four. And if they don't get health insurance through their employers, as most of them don't until most of them are working, they simply can't afford the \$13,000 roughly 2008 cost of a comprehensive health insurance policy.

But affordability, as you have noted, is increasingly a problem even for people who have health insurance. In 2007, for example, the Commonwealth Fund identified 25 million people under-insured or economically threatened due to high out-of-pocket costs up from 15 million. So that is 15 up to 25 million in only four years.

Similarly, the number of Americans who report problems facing paying medical bills has risen. It has jumped from one in seven Americans under age 65 in 2003 to one in five Americans by 2007. Not surprisingly, low income families face the greatest problems, and sadly, our valuable Medicaid and CHIP programs do not necessarily prevent these problems. No matter how low their incomes, working aged adult who are not parents of dependent children or are not disabled aren't eligible for Medicaid in most states. And even the populations they do cover, Medicaid and CHIP have been modified in recent years to give less protection in terms of out-of-pocket costs to low-income families.

Finally, not really surprisingly but ironically, affordability problems are the biggest problem for people when they get sick. In particular, individuals who are older, have an activity limitation, a chronic condition like diabetes or heart disease are most likely to be underinsured. And if they don't get coverage through an employer-sponsored health plan or if they lose this coverage, they are going to have one heck of a time getting it from a non-group market that systematically denies coverage, limits benefits, or charges excessive premiums to individuals with pre-existing conditions or whom insurers believe are likely to need health care.

Now, I have been talking here about money problems, but we all know that affordable health care is a problem of your money and your life. There is lots of evidence and the Institute of Medicine has come out with a new report documenting once again that people

without health insurance are more likely than people who have health insurance to delay care, to get less care, and actually to die when they get sick.

Sadly, evidence suggests that increasingly people who are underinsured are facing similar problems. One report shows that they are postponing care, skipping recommended medical visit or treatment, not filling prescriptions, and skipping doses or cutting pills. The underinsured not only struggle medically to survive, their medical struggle, as we have heard from some of you and you hearing from your constituents is forcing them into bankruptcy and increasingly into foreclosure.

Even people with insurance just can't afford to get sick. But we are gathered here today to address these problems, and, Mr. Chairman, we are counting on you in the coming months to do exactly that. So let me give you four principles to keep your eye on as the committee and the Congress moves forward.

First, keep your eye on families' total health spending, as Dr. Reinhardt said, not just premium contributions but also on deductibles, cost sharing, and spending for other service. You have to watch out for a desire to keep those premiums low by keeping the cost sharing high. The result is going to be insurance that doesn't work when you get sick.

Second and related, remember that benefits matter. Health insurance worthy of the name has to work for people when they are sick. So despite claims that I have heard and I am sure you have heard that any insurance is better than no insurance, insurance that leaves people without the ability to buy the services that their doctors and practitioners prescribe is just not good enough. Like members of Congress, all Americans need adequate benefit packages with a defined set of services. It is a critical linchpin for affordability.

Third, affordability clearly depends on income, and low-income families need special protections.

And finally, insurance must stop discriminating against sick people. As long as insurers can deny coverage, limit benefits, or charge higher rates based on people's age or health status, insurance is going to remain unaffordable for people who need health care.

Meaningful health reform cannot fail to ensure that health insurance is affordable for people who have been or whom insurers believe are likely to become sick.

We know that enacting health reform is a challenging task, but now is the time. I commend you for your efforts and look forward to working with you to get affordable coverage for every American this year. Thanks.

[The prepared statement of Ms. Feder follows:]

38

Statement of Judy Feder, Ph.D.
Senior Fellow
Center for American Progress Action Fund

before the

Energy and Commerce Committee
Subcommittee on Health
United States House of Representatives

March 17, 2009

Chairman Pallone, Congressman Deal and Members of the Committee, I am honored to be here today to testify on the importance of assuring affordable health care for all Americans. As you well know, health reform is critical to restoring prosperity for our nation's families. Reform means reducing the crushing burden of rising health care costs on America's families, businesses and governments at all levels. Achieving that goal requires streamlining Medicare and refocusing our health care delivery system on prevention, primary care and treatments that work. But it also requires that everyone, all the time, have affordable health insurance—regardless of where they work, their income, their age, or their health status. Affordable health insurance is the key to a productive work force, small business innovation, and the economic as well as health security of our nation's families. My focus today is on those families: how lack of affordable health insurance undermines their health and economic security and how health reform can and must assure affordability in order to restore families'—and the nation's—well-being.

The Evidence on Affordability

As health care costs continue to grow faster than the economy as a whole – not to mention faster than family incomes – individuals and families have felt the pinch of escalating health spending. People feel that pinch not only in insurance premiums, but also in the payments they make toward services their insurance covers (through deductibles, copayment, and other cost-sharing arrangements) and in payments they make for services that are not covered by their health insurance policies. Affordability—or unaffordability -- has to look at all three.

The problem of unaffordability is most apparent for the nearly 47 million Americans who lack health insurance. Roughly two thirds of Americans without health insurance have incomes below 200 percent of the federal poverty level—or approximately \$44,000 for a family of four. Most people without health insurance are workers or live in families with a worker, but do not have health coverage through an employer.ⁱ With the annual average cost of employer-sponsored health insurance nearing \$13,000 in 2008, health insurance is clearly unaffordable for families who must purchase it on their own.ⁱⁱ

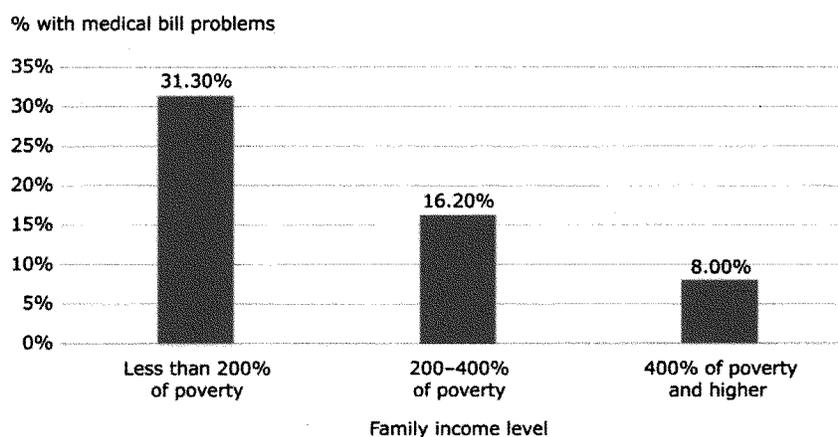
Sadly, even people who actually have health insurance increasingly face affordability problems when it comes to paying for health care. Research documents that a growing number of Americans with health insurance face affordability problems for health insurance and for health care. Researchers define affordability in a number of ways. One set focuses on medical spending as a share of income, characterizing families that exceed specified thresholds as economically threatened or underinsured. For example, a recent analysis by the Commonwealth Fund identified families as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or, for low-income adults (defined as 200 percent of the federal poverty level), at least 5 percent of family income; or if they faced deductibles of at least 5 percent of family income. Using these tests, the study identified 25 million adults who had health coverage as underinsured in 2007 – a 60 percent increase from the 15.6 million Americans who were underinsured in 2003.ⁱⁱⁱ

Similarly, AHRQ researchers Jessica Banthin and Didem Bernard found that while 15.8 percent of adults spent more than 10 percent of their family income on health care services in 1996, by 2003 the proportion of adults bearing what has historically been considered catastrophic financial burdens had increased to 19.2 percent of the population, or 48.8 million individuals.^{iv} An additional analysis by Jessica Banthin, Peter Cunningham and Didem Bernard also determined that by 2004, financial burdens had increased to the point that, for low-income families, private coverage no longer provided adequate financial protection.^v

Another approach has examined affordability problems directly—exploring families’ actual problems paying medical bills. According to the Center for Studying Health System Change, one in seven Americans under age 65 reported problems paying medical bills in 2003 – a figure that jumped to one in five Americans by 2007. This analysis indicates that even moderate levels of out-of-pocket spending relative to family income – that is, spending that is well below the 5 or 10-percent of family income considered to be underinsured by the studies just cited – created medical bill problems. For example, two-thirds of the individuals who reported trouble paying medical bills spent 5 percent or less of their family income on health care.^{vi} As author Peter Cunningham noted, many families have little wiggle room within their family budgets for large or unexpected out-of-pocket health care expenses. And even a relatively low level

of health care spending compared to family income can create financial stress for low-income families. (See chart below.)

Burden of medical bills for families spending 2.5% or less of family income



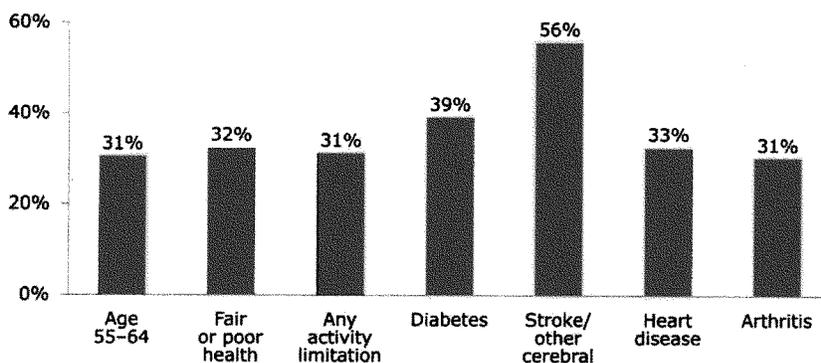
Medicaid and CHIP, established to provide special protection for low-income and modest income families, do not necessarily prevent these problems. First, no matter how low their incomes, working aged adults who are not parents of dependent children (or are not disabled) are not eligible for Medicaid (except in states with waivers), and, in many states, parents earning the minimum wage have too much income to qualify for Medicaid protection.

For populations they do cover, Medicaid and CHIP have been modified to give less recognition to low-income families' limited ability to absorb significant out-of-pocket health care spending. The traditional Medicaid program limits cost-sharing responsibilities to nominal deductibles and copayments for most services, and exempts children, pregnant women and other vulnerable groups from service-related cost-sharing. The Deficit Reduction Act of 2005 made some important changes to Medicaid's traditional limitations on cost-sharing, thus exposing even some low-income children to cost-sharing that can equal 5 percent of family income. The CHIP program, which typically serves children with somewhat higher – although still modest – incomes also utilizes a 5 percent of income cap on aggregate cost-sharing.

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income but also by health status. Health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care. In particular, individuals who are older, have an activity limitation, have a chronic condition such as diabetes, heart disease, or arthritis, or have experienced stroke, are more likely to spend a high proportion of their income on health expenses. (See chart next page.) If these individuals are not covered by an employer-sponsored health plan, or lose this coverage, their ability to purchase coverage in the non-group market is limited at best. Far from serving as a safety-net, the non-group market systematically denies coverage, limits benefits or charges excessive premiums to individuals with pre-existing conditions or whom they perceive as likely to need care. Ironically, then, underinsurance or financial

problems is most likely to arise for people who get sick—the very population that insurance is supposed to protect.

Groups at high risk of having high financial burden for health care, 2003



Note: High Financial Burden defined as families spending more than 10% of their after-tax income on health care, including premiums and out-of-pocket health costs.

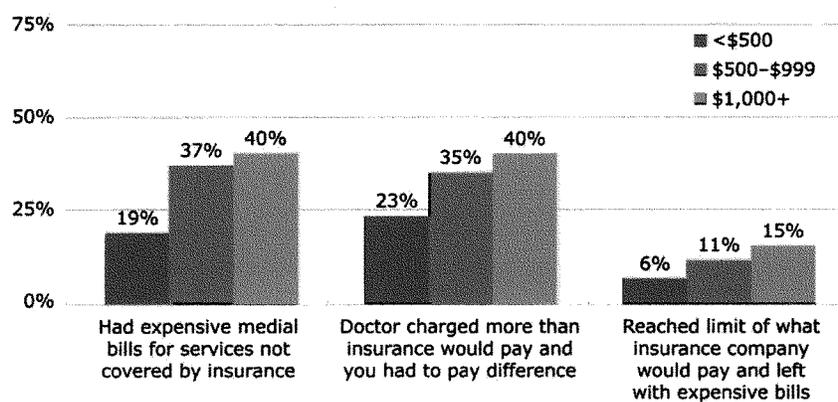
Source: Kaiser Family Foundation, based on Banthin, JS and DM Bernard. "Changes in Financial Burdens for Health Care," JAMA 296(22), December 2006.

As stated at the outset, affordability problems do not reflect a single feature of insurance—its presence or absence, its premiums or its benefits. Rather they result from the interplay among various aspects of insurance design: premiums, deductibles, co-insurance and other cost-sharing, and spending on services that are not covered by health insurance. This means that insurance design that aim to make premiums more affordable by imposing substantial deductibles or low annual lifetime benefit limits offer a false promise: they place individuals and families at substantial financial risk of facing unaffordable health care costs when they get sick. Similarly, benefit packages that constrain covered services—by excluding, for example, prescription drug or mental

health benefits, placing arbitrary day or visit limits on specific benefits, or steeply tiering prescription drug cost-sharing—leave families at risk of being unable to afford necessary but un-covered services—again, undermining the very purpose for having insurance in the first place.

Problems with health insurance plan, by deductible

Percent of adults ages 19-64 insured all year with private insurance



Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

The Consequences of Affordability Problems

A strong and growing body of literature demonstrates that unaffordability of health insurance makes health care unaffordable and unavailable. As the Institute of Medicine recently noted, there is a chasm between the health care needs of people without health insurance and access to effective health care services. People without health insurance are more likely to delay care, to get less care, and to die when they get sick.^{vii}

Evidence suggests that people who are underinsured can experience very similar problems getting needed care. According to the Commonwealth Fund, underinsured individuals are two to three times as likely as insured individuals to forgo various needed medical services because of cost.^{viii} Of sicker underinsured adults, a full two-thirds went without needed care due to cost, including half of individuals with a chronic condition forgoing necessary medications.^{ix} In a recent Kaiser Family Foundation survey, concerns about affording needed medical care led insured individuals to cut back on care due to cost. Responses included postponing care (34%), skipping a recommended medical visit or treatment (30%), not filling prescriptions (27%), and skipping doses or cutting pills (21%).^x

People who are under-insured not only face the medical problems of inadequate treatment; they also face financial problems from the treatment they actually get. High in the list is bankruptcy. Nearly half of all bankruptcies in the United States are related, at least in part, to health care expenses. And of those facing medical bankruptcies, roughly three-quarters had health insurance at the onset of their bankrupting illness.^{xi} Of sicker underinsured adults, three-fifths reported having been contacted by a collections agency. In a 2007 survey, respondents reported making difficult choices between using up a lifetime of savings, running up credit card debt, skipping the purchase of other necessities, or trying to take out a mortgage.^{xii}

Home mortgage foreclosure, another personal financial catastrophe, is also related to health care expenses. Seven out of ten respondents in a recent survey of borrowers in foreclosure self-reported unmanageable medical bills as an underlying cause of their foreclosure, or had experienced other medical disruptions to their income, such as lost work due to illness or using home equity to pay medical bills.^{xiii}

Insurance that makes care unaffordable can be a problem for anyone facing serious illness, no matter what its cause. But an examination of the problems facing patients with cancer makes clear how people are dealing with overwhelming financial problems at the very point they are coping with overwhelming medical conditions. A recent report prepared by the Kaiser Family Foundation and the American Cancer Society illustrates how much people are actually “Spending to Survive.”^{xiv} Some patients who actually have insurance can pay more than \$100,000 for their treatment because of high deductibles, high cost-sharing, and limited lifetime spending caps that shift the financial risk of care to the individual. And health insurance underwriting and rating practices leave many individuals whose cancer has been treated – like many others with significant health events or chronic illnesses – unable to obtain insurance against future illness.

Principles for Assuring Affordable Health Insurance

Assuring all Americans affordable health insurance is, in my view, the most fundamental goal of health reform. Families cannot be economically secure as long as they face financial catastrophe when illness strikes. And people cannot lead healthy and

productive lives as long as they cannot afford the care they need when they get sick. Enacting health reform is a challenging task. But the concepts of affordability are straightforward. It's not enough just to make health insurance affordable; affordable health insurance has to make health care affordable.

As you move forward with reform legislation, I therefore urge you to consider four basic principles:

First, keep your eye on total spending. Affordability depends not just on individual and family premium contributions, but also on deductibles, cost-sharing obligations and other health care spending. Beware of a desire to keep premiums low by making cost-sharing high. If only some components of family health care spending "count" towards a consideration of what individuals and families can contribute towards their health care costs, some Americans – most likely those with ongoing, chronic illnesses – will continue to grapple with unmanageable and unaffordable health care expenses.

Second, benefits matter. Health insurance worthy of the name has to work for people when they are sick. Despite claims, which I'm sure you've heard, that "any insurance is better than none," insurance that leaves people without necessary protections is simply not good enough. Adequate benefit packages with a defined set of services are another critical lynch-pin to health care affordability. If a health insurance policy doesn't

cover the services people need when they get sick, it doesn't provide the financial protection Americans need and legitimately expect from health insurance coverage.

Third, affordability depends on income. Low-income families should be expected to contribute a lower proportion of family income towards their health care expenses, in recognition of their more limited ability to absorb unpredictable health care costs.

Finally, insurance must stop discriminating against sick people. Because premium prices will have a substantial effect on overall healthcare affordability, by extension so will insurance market rules that determine whether rates can vary based on people's "pre-existing conditions" or other health-related characteristics. As long as insurers can deny coverage, limit benefits or charge higher rates based on people's age or health status, insurance will remain unaffordable for people who know in advance they need its protections. Meaningful health reform cannot fail to assure that health insurance is affordable for people who have been (or whom insurers believe are likely to become) sick.

Enacting health reform is a challenging task. But achieving affordable health care for all Americans will be worth the effort. I applaud your commitment to achieving that goal and I look forward to working with you to achieve it.

ⁱ Kaiser Family Foundation, *The Uninsured: A Primer*, October 2008, available at: <http://www.kff.org/uninsured/upload/7451-04.pdf>.

ⁱⁱ Kaiser Family Foundation/Health Research and Education Trust, "Employer Health Benefits 2008 Annual Survey," available at: <http://ehbs.kff.org/?page=charts&id=1&sn=6&p=1>.

ⁱⁱⁱ C. Schoen, S. Collins, J. Kriss and M. Doty, "How Many are Underinsured? Trends Among U.S. adults, 2003 and 2007," *Health Affairs* 27 no. 4 (2008):w298-2309.

- ^{iv} J. Banthin and D. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," *JAMA*. 2006;296(22):2712-2719.
- ^v J. Banthin, P. Cunningham and D. Bernard, "Financial Burden of Health Care, 2001-2004," *Health Affairs* 27, no. 1 (2008):188-195.
- ^{vi} P. Cunningham, C. Miller and A. Cassil, "Living on the Edge: Health Care Expenses Strain Family Budgets," *Research Brief*, Center for Studying Health System Change, No. 10, December 2008.
- ^{vii} Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care," *Report Brief*, February 2009, available at: <http://www.iom.edu/Object.File/Master/63/122/America%27s%20Uninsured%206%20pager%20FINAL%20for%20web.pdf>
- ^{viii} C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1.
- ^{ix} C. Schoen, "Insured But Not Protected," *Health Affairs* 2005: hlthaff.w5.289v1.
- ^x D. Rowland, "The Adequacy of Health Insurance," Testimony before the Senate Health, Education, Labor and Pensions Committee, February 24, 2009, available at: <http://www.kff.org/uninsured/upload/7870.pdf>.
- ^{xi} D. Himmelstein, E. Warren, D. Thorne, S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, 2005, w5-63:w5-73.
- ^{xii} Schoen, Cathy, "Insurance Design Matters," Commonwealth Fund, February 24, 2009.
- ^{xiii} C.T. Robertson, R. Egelhof, and M. Hoke, "Get Sick, Get Out: The Medical Causes of Home Foreclosures," *Health Matrix*, 18 (2008): 65-105, available at: http://works.bepress.com/christopher_robertson/2
- ^{xiv} Karyn Schwartz et al, "Spending to Survive," Kaiser Family Foundation and American Cancer Society, February 2009. http://www.cancer.org/downloads/accesstocare/Spending_to_Survive.pdf

Mr. PALLONE. Thank you, Dr. Feder, and thank all of you really for your statements. Now, the way we work it, we have questioning now from members of the committee, and I will start by recognizing myself for 5 minutes.

And my question really is to both Dr. Reinhardt and Dr. Feder. I would like to get your thoughts on the addition of a new public plan, which you actually did discuss a new public plan to a menu of health care tools available for expanding coverage.

Obviously we want to build on existing programs like S-CHIP and Medicare and Medicaid. But the fact remains that with 46 million uninsured people in this country, we will need to build significant new capacity in our insurance system.

Now, you know, we have talked about having the government do a health care marketplace. Massachusetts is sometimes cited as an example where the government would go out to private plans and, you know, see what their benefits are, their premiums perhaps, negotiate both those standards and premiums and offer group plans to people as an alternative to the individual market.

But in the context of that is this possibility of an option to enroll in a new quality affordable public plan. And the goal of that would be to create healthy competition with private insurers, lowering overall costs and at the same time expanding access across the health care system. So I wanted to start with Dr. Feder and ask what you think about creating a new public plan, and is that a good idea in the context of some kind of health marketplace, national health marketplace?

Ms. FEDER. Mr. Chairman, I think you posed the question exactly right. It is very important to remember that what you put forward and what is being talked about is a choice for Americans and in choice of private and public plans, not characterized as a public takeover or Medicaid for all. That is completely incorrect. We are talking about choice.

And the importance of that choice is actually to set a model, and insurance companies are no model for running this system efficiently, private insurance companies. And they are not getting us good deals and getting us adequate protection. So establishing a public plan that is a choice and that operates on a level playing field with private insurers can actually serve as a push to get more competition. I think competition is a goal that all of us have, effective competition, to get efficiency in the health care system.

Mr. PALLONE. OK, thank you. Dr. Reinhardt, do the experiences of other countries that have successfully built universal health care systems suggest that a new public plan could be helpful to America, to the U.S.?

Mr. REINHARDT. I think certainly it could. Not a lot of countries actually have this sort of mixture. The only one that comes close is Germany. They don't really have a public plan, but they have privately managed sickness funds, nonprofit, that work a little bit like Medicaid managed care where the government collects the taxes essentially but lets private competing health plan purchase the health care but under unbelievably tight regulation. So it almost is like a government plan.

I too share the view that if choice is the mantra, and many Americans really do like choice, then having a public plan that peo-

ple might like seems to be something that should be done because by what rights would one deprive the American people of a choice they might favor? Now, where would I get this idea that they might favor a government plan?

Well, two. The first one is we do have Medicare, and the elderly do have a choice to go into private health plans or to stay in the government-run plan. And I don't know what the—I think 75 percent still choose the government plan in spite of the fact that the private health plans get—the taxpayer pays them 14 percent more to be able to offer a benefit. To me, that suggests there is a strong latent demand among the American people for a private health plan.

And then people say well, that is socialized medicine, and I would urge the committee not to use that term anymore. And the reason I do is I will tell a little vignette. People will tell me socialized medicine is just terrible, and it is awful. And then I will say OK, I will accept it. Why do you not like my son? And then they look. What have you got to say—my son? I say my son is a veteran, a decorated U.S. Marine Corps veteran with a purple heart, and yet you give him socialized medicine called the VA.

So why do Americans run down this concept? We are not even talking socialized medicine—we are talking about social insurance—run it down and yet give the very contract to the veterans, and I am a father of one.

And I would like sometime if somebody in this room write to me and explain this paradox to an immigrant like me why do you give veterans socialized medicine when it is so bad.

Mr. PALLONE. Thank you. Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman. As I indicated in my opening statement, transparency of pricing is important to me, and I have introduced a bill. And I would like to give you some of the components of that and see what your reaction to it would be.

First of all, the bill would allow uninsured patients and other patients who pay out of pocket for certain health care costs to be able to go to an HHS Web site, enter their families income and the health care services they need, and find out the prices they will be charged for these services by all the health care providers in their area.

Second, it would allow doctors and hospitals to use the same Web site to find out what a particular insurance company will pay them for a particular item or service before it is delivered, and it will allow these providers to find out what their patients' copays will be.

Third it would allow the insured patients to make better informed decisions by allowing them to use the same Web site to find out what their copayments would be for particular health care services in their area, depending on who the health care provider was.

And finally, it would require HHS to publicly disclose all of their Medicaid data in a way that protects individual's privacy but allows the public to join in the fight against Medicaid fraud and allow patient advocates to make sure that Medicaid patients, for example, are getting the care that they need. It would allow citizens to know whether or not young children who are enrolled in

their state's Medicaid program are getting their well child check-ups, and whether older patients are getting their annual cancer screenings.

Would a piece of legislation like that be something that each of you might support? And I will just ask you individually. Dr. Reinhardt?

Mr. REINHARDT. As a general principle, price transparency is essential if you ever want to have models based on choice and competition. And, of course, the health system has been uniquely opaque in this regard. Now, there is a problem with posting prices. Hospital charge masters has close to 20,000 items, and a physician fee schedule has 7,000 items in it. So prices would have to be reconfigured to be for complete procedures.

I had in a paper proposed, in Health Affairs, that maybe the way to go is to say let us use the DRG system for all patients, no matter who the insurer is, because it is a relative value scale. But each hospital has the right to set its own conversion factor to monetize the thing, and they have to advertise that. And only one number would give you the prices of a hospital.

Or one could have research that bundles all the services that go into a treatment like a coronary bypass graft or a hip replacement and then give you the price per procedure with everything bundled in.

But I think the idea of transparency is one I would wholeheartedly support.

Mr. DEAL. Thank you. Ms. Pipes.

Ms. PIPES. Yes, and I too support price transparency. We have price transparency in most aspects of our life, whether it is what service we use or what bank we use. I would be against government mandating price transparency. I think, you know, in consumer patient-centered health care, we have seen—we will see, if we encourage that and support it, I think we will see price transparency because when you put doctors and patients in charge of your health care, prices will be negotiated.

I think if we change the tax code, as I mentioned, so that individuals can by health insurance, as Ms. Eshoo said, on the same level playing field that those who get the tax benefit through their employer-based coverage. I think we will see much more competition. We will see new entrance into the insurance market, and when we have more competition, we will see prices being negotiated.

I think even in Medicare, you know, we could open up to empowering Medicare patients and doctors, and we will see people negotiating. And we will get price transparency as we have in all other aspects of American life.

Mr. DEAL. I take that as a qualified yes?

Ms. PIPES. Yes.

Mr. DEAL. Dr. Feder.

Ms. FEDER. I think that your proposal, Congressman Deal, makes a great deal of sense. I haven't seen it in all its details, but transparency in what—getting inside the black box of insurance is critical as a customer, as a taxpayer, every other way. And so I applaud your efforts, and I am happy to be of what help I can.

Mr. DEAL. Thank you. Let me explore very briefly because my time is running out. If we go to a government option proposal that

would be offered as part of a package, would you anticipate that that government option would also have to take into account state mandates on what must be offered, which vary obviously from state to state, and would it also therefore take into account community pricing? And if it does all of that, don't we wind up with a system where a public plan would cost significantly more depending on where you lived? And how do we deal with that inequity in terms of explaining that to the public? Or would it simply be a uniform premium that you would anticipate that public plan would offer?

Ms. PIPES. So I pointed that out in my testimony that things like guaranteed issue, community rating, and a lot of mandates add significantly, 20 to 50 percent, to the cost of a premium. And if, within this national insurance exchange, there is going to be a public plan and all of those things are going to be added onto it, you are right. We are going to see the cost of insurance go up rather than going down. And that is going to crowd more people out of getting covered and reducing that number of uninsured.

So under the health saving account patient-based health care, it is not for everyone, but we have seen prices come down as Mr., I think, Burgess mentioned. We have also seen that people who have HSAs are 30 percent more likely to get an annual checkup and be engaged in prevention because they don't want to be facing significant cost once they have a degree. And that work was done by McKinsey and Company.

So I think we have to be very careful. I am very worried. New Jersey, New York, Massachusetts have community rating, guaranteed issue. Their insurance is very expensive, and if we do this plan, it is going to crowd out private insurers, and that is my main concern.

Mr. DEAL. I am sorry I can't have any time. I have already exceeded my time, and I am afraid I can't let the rest of you answer. But maybe we can get to it later. Thank you.

Mr. PALLONE. Thank you, Mr. Deal. Ms. Eshoo.

Ms. ESHOO. Well, I want to thank the witnesses, each one coming from their own place and stating their case really forthrightly. I enjoyed your testimony, and I think that, while I might not agree with everything that I have heard, I like the way you have framed it and presented it to us.

Since today is St. Patrick's Day and the one day where we are all Irish, Ms. Pipes—is it, yes, Pipes. You quote P.J. O'Rourke. And you say if you think health care is expensive now, just wait until it is free. Where, in anything, is anyone talking about free?

Ms. PIPES. Well, Michael Moore—

Ms. ESHOO. I mean where does this come from?

Ms. PIPES. Well, because people, as Michael Moore said in his movie "Sicko"—

Ms. ESHOO. We are not talking about movies. We are talking about reality.

Ms. PIPES. Right.

Ms. ESHOO. So when you say in congressional testimony if you think health care is expensive now, wait until it is free, who has suggested that health care is free? We are faced with 12 and 14 percent increases every year. It simply is unsustainable. We know that people are left out. We know that it is a system that is frac-

tured. We know that we are spending too much as a nation and not getting back for people what they should have. And so I really think that the notion to say just wait until it is free is—it really doesn't belong here. I just—I feel strongly about that. I don't know if—you might not regret having said it, but I don't think it is really part of this.

I mean you can defend it, but do you have a defense for it?

Ms. PIPES. Yes.

Ms. ESHOO. Yes.

Ms. PIPES. So thank you for that comment. What it means is when government takes over the total supply of health care, people think it is free because—

Ms. ESHOO. Well, we can get into a real debate here. This is not a discussion about the government taking it over. This is about the government rewriting the rules of this because so much of it is not working, and we know that it is not. Insurers say that. Families say that, and so there is consensus on that.

So now, let me move on and just ask a few questions. I really want to kind of drill down on this whole issue of tax treatment. And while this is not the Weighs and Means Committee, you are all experts, and I really would like to hear your views on this and what your opinions are on the tax treatment of employer-sponsored insurance plans.

As you know, those who get their insurance through work pay no tax, while those that purchase insurance without a group plan do. Do you think that all plans should be taxed? Do you think they should be taxed in part for certain services? What is your view on all of this? It is not a subject matter that is often discussed, and I am curious about it. So Dr. Feder, do you want to start?

Ms. FEDER. Sure. You raised it in your opening remarks—

Ms. ESHOO. Right.

Ms. FEDER [continuing]. That it is concerning to you. And our employer-sponsored health insurance has grown up as the development preceded the special tax treatment, but that has strengthened it. And there is a concern about inequities because better off people get a better break than low income and certainly than low insured because it varies with your tax bracket. And so there are concerns about that.

But I am very concerned about doing anything that undermines the employer-sponsored health insurance system because although it has significant limitations, it does create the groups, and you talked about ensuring access to group insurance. It creates those groups that enables us to pool risk rather than having everybody on his own, which we see in the non-group market.

So I think that there are concerns about it. I think as we develop a system, we want it to be fair and share responsibility, whether it is through the tax system or other mechanisms for everybody. But I am very concerned about proposals to eliminate the tax break because it essentially does undermine the insurance system, the employer-sponsored. And also anything that would shift, that would make it come apart and throw everybody into the non-group market.

Ms. ESHOO. Um-hum, thank you. Dr. Reinhardt.

Mr. REINHARDT. Well—

Ms. ESHOO. Well, you posed a question about socialized. It is a political phrase to scare people.

Mr. REINHARDT. Yes.

Ms. ESHOO. That is what it is.

Mr. REINHARDT. Yes, but it is——

Ms. ESHOO. It is a bumper sticker.

Mr. REINHARDT. It is really peculiar when you——

Ms. ESHOO. It is peculiar.

Mr. REINHARDT [continuing]. Are the father of a veteran to have that——

Ms. ESHOO. Well, how about members of Congress receiving Social Security?

Mr. REINHARDT. Yes, or a——

Ms. ESHOO. Right.

Mr. REINHARDT. Who are on Social Security as you know.

Ms. ESHOO. Right.

Mr. REINHARDT. No, the issue of taxing employer-provided benefits, most economists in theory would be for that, but there is always the concern, and I have written a paper on the balance sheet for employment-based insurance. At the moment, it is the only really functioning risk pooling mechanism in the private sector and actually, for all its flaws, has worked and served Americans reasonably well.

So an alternative might be to go and say well, self-employed people should have the same tax privileges, anything tax-wise that would cost that much money. And that seems fair to do, but there still is an issue of giving people in high income brackets a bigger tax break than in low income brackets, which you really sense with the flexible spending account, where when I get a tool drilled it costs me half, and the gas station attendant pays 85 cents on the dollar.

So there are ways to deal with it. For example, one could say harvest some of the money. I am a full professor at an Ivy League university. I really don't need this tax break to get health insurance. I could be asked to pay taxes on it, and I think I would. So you could say if you are making less than \$75,000, you won't be taxed on it. If you make between \$75,000 and maybe \$150,000, we will take half what the employer pays and add it to your W-4. And if it is over \$150,000 or over \$200,000 the whole thing is taxed. Then you say you are punishing the rich. Well, I don't consider that punishment. I consider asking me, who is so lucky to have a tenured job at Princeton, to pay for my own health care, I don't call that an imposition. I don't really need that subsidy from the gas station attendant, which I now have.

So that is one way you could harvest some of the money without hurting the rank and file.

Ms. ESHOO. Thank you very much to each one.

Mr. PALLONE. Gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Thank you very much, and thank you all so much for your testimony today. We appreciate it very much. When we think about Medicare, Medicaid, the VA, S-CHIP, we know that that represents about 48 or 49 percent of the total health care delivery system in the U.S.

And I think most people view those as government programs, which is providing a valuable service, but we also know that those programs are contributing greatly to the escalating costs in health care. Every time you visit with the Concord or a lot of groups, they say with Medicare increasing costs every year and Medicaid increasing costs every year and Social Security increasing costs every year, that we are going to have a financial disaster 22, 23, 24 years down the road on top of our already economic crisis that we face today.

So when we talk about reforming health care, I think many of us on this side of the aisle view it as the government taking it over. I mean and the government already runs Medicare, Medicaid, SCHIP, the Veterans' health care system. And I know, Dr. Reinhardt, you mentioned that we—I had to leave during your testimony, but I think you said we need universal health coverage.

And, Dr. Feder, I don't know that you said that, but I believe you set out certain principles that you had to consider to—

Ms. FEDER. And I do favor universal coverage.

Mr. WHITFIELD. Yes, so if the government plan that is in operation today, I mean the ones that I mentioned, the costs are escalating every year. We can't control those costs. If we allow government to be basically responsible for the other 50 percent, why are we encouraged that the government could control those costs better than the way we are controlling costs today?

Ms. FEDER. Well, Congressman, I don't think we are proposing having government take over those other costs, and I actually think, as you look at the share the government is spending, some talk about it as a shifting from the private sector to the public sector because our public programs are taking care of older Americans, disable Americans. And Medicaid, the bulk of the spending in Medicaid is for people with disabilities and older people and long-term care. So they have particular responsibilities and have left the healthiest population to the private sector.

And when you talk about the overall cost growth, we have lots of evidence—and I know that former CBO director Peter Orzack presented that to you as CBO director, and now as OMB director, he makes the same point. And that is that our public health insurance programs are not growing faster than the cost of health care in general. Everybody is buying in the same market; although, Medicaid really buys on the cheap.

Mr. WHITFIELD. Yes.

Ms. FEDER. But the costs are growing in general so that the only way to get a handle on the growing costs, which you rightly recognize, of Medicare, Medicaid, Veterans, any health insurance program that we have, is to pursue slower cost growth through investment in primary care and prevention and a host of other mechanisms—

Mr. WHITFIELD. Right.

Ms. FEDER [continuing]. That affect the entire system and to make sure that everybody has coverage all the time so that we can promote prevention and better treatment.

Mr. WHITFIELD. Now, you know, as you were talking—and, Dr. Reinhardt, I will give you an opportunity to reply also. But as you were talking, another government program that I think has worked

very well is the community health centers. I mean I think the community health centers addressing the primary health care issue have worked very well. And basically they are paid for by the federal government working with local entities. And I always thought that community health centers and a partnership in the private sector with gigantic employers might be a way to expand accessibility too.

Ms. FEDER. Well, I share your view of the excellent performance and the value of community health centers, and they certainly are a part of the system in making sure that, as many have said, people don't just have access to health insurance, they have access to care.

Mr. WHITFIELD. Right.

Ms. FEDER. But the community health centers, when less people have insurance coverage, they face tremendous problems once anybody gets beyond primary care.

Mr. WHITFIELD. Right.

Ms. FEDER. They can't find specialists.

Mr. WHITFIELD. Right.

Ms. FEDER. People need insurance coverage.

Mr. WHITFIELD. Now, Dr. Reinhardt, if you will take about 30 seconds to reply, if you can, then I want to make one other comment.

Mr. REINHARDT. The first point I want to support, if you look in November '07, Peter Orzack published a beautiful report on health care cost growth. And it is figure four. You can actually really see how each sector, public, private, is growing. And in fact, on a per capita basis, Medicare has grown less rapidly than the private sector. On the community health center—

Mr. WHITFIELD. On the cost of it?

Mr. REINHARDT. On the cost. You have to do it per beneficiary, and Marilyn Moon has done a lot of research.

Mr. WHITFIELD. OK.

Mr. REINHARDT. And that is well understood. On the community health center, I think they are an important part of the landscape in American health care because they are so accessible, and they do a great job for the money they have used. But we had a commission on rationalizing New Jersey health care and looked at these centers, and this theme that they are great in primary care, but then they are not multi-specialty. Getting access to specialists was the Achilles heel. So yes, I think we should have them. It should stay, and the Congress might worry about how to have a larger range of services provided.

Mr. WHITFIELD. Fine. Mr. Chairman, I would just make one other comment. Another thing that bothers a lot of people though when you talk about universal health coverage and you think about the Canada system and the Great Britain system and so forth, and Ms. Pipes went over this in her testimony. Maybe you all can address it later. But if it is true 750,000 Canadians are waiting for procedures and 3.2 million out of the population are waiting to get a primary care doctor and Canada, the average wait for seeing a primary care doctor for getting treatment by a specialist was 17.3 weeks and the rationalization of health care, that is a real concern to a lot of people.

And you can't respond to it now, but later on I am sure we will have an opportunity to address that in more detail. Thank you.

Mr. PALLONE. Thank you. Gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and following up on my colleague from Kentucky, I have a district, a very urban district in Houston. It is an under, underserved district. We have actually four community based health centers, and they are in financial trouble right now because so much of that we depend on is foundation funding. And foundation funding, because of the economy, is cratering. So we need more of them, but we also need to look at, you know, our authorization levels, that we upped the authorization to five-year authorization last time. Even with the stimulus money that was in there, in the Houston area, fourth largest city in the country, it helped two of our FQHCs. So, you know, we need to be better on the community based health centers. And hopefully whatever plan we have will make them where the rubber meets the road literally for the uninsured and the underserved. I mean it is a great program. It has been around for almost 50 years now, I guess, since President Johnson.

And I would like to ask the panel how do you see these FQHCs because of the—my problem is the disparity of the location. Great example, Chicago is fortunate to have 81 community health centers, and in Houston, Harris County, we have 10. And we are trying to create more even though we are the fourth largest city and may pass Chicago in the census.

But we have a disparity in where these centers are located because of the local networks.

Ms. FEDER. It seems to me, Mr. Green, and I would have to look into it further as to what the problem is under the circumstances, but the best way that you can promote those delivery systems is to get everybody health insurance because then every patient who comes into a community health center is carrying money. They are not dependent on the federal grants. So the bottom line is that we need health insurance in order to enable the delivery systems to prosper.

Mr. GREEN. Well, the problem FQHCs have is just like the problems of hospitals and doctors. You have a lot of uncompensated care.

Ms. FEDER. Exactly.

Mr. GREEN. Even though people have to pay something, they don't pay enough that covers the cost of the service.

Ms. FEDER. Right, and valuable as they are, and as Mr. Whitfield said, is that even expanding community health centers is not a substitute for getting people insurance. They are a valuable part of the delivery system and should be supported by everyone having health insurance coverage.

Ms. PIPES. I would just like to add that I support community hospitals, and Michelle Obama, during the campaign, you know, said being at the University of Chicago, people shouldn't be turning up at the University of Chicago emergency rooms for very, very expensive care. She supported the community hospitals. So that was a very good point.

Just a point on the hidden tax. People keep saying that the uninsured are adding a tremendous burden to the cost of those who

have private insurance. The work done by Dan Kessler at Stanford, he shows that the uninsured are adding about 1 percent to the cost of premium for those who have private insurance.

The 10 percent cost addition to private payers' premiums comes from Medicare and Medicaid from the lower reimbursement rates paid by the government. So I think that we really need to focus on, you know, how, you know, if we are going to go down to the path to more Medicare, more Medicaid expanding these programs, reimbursement rates are low and as we see now, one in three new Medicare eligible patients is having trouble finding a primary care doc.

Because in systems like Canada, when the government took over the health care, people talked about there would be a lot of increase in primary care, but in fact, med students didn't go into primary care because when the government determines how much you are paid, they would rather go into specialties. So that is why we have a tremendous shortage in Canada of primary care docs.

Mr. GREEN. Well, I will give you an example of the FQHC doctors can't make a decent living there. You know, you can get \$135,000 or a family practice in a community based health center. The problem is that it is not, you know, not the specialties. And we know how high the specialties are. Dr. Reinhardt?

Mr. REINHARDT. I would want to stress Dr. Feder's point. The important thing is to endow people with purchasing power to get health care because the trouble with institutional grants is you can have community health centers that are angelic. They have the budget. And you have others that are not, and to get performance is measured is not easy. But when customers can walk, competition will actually take care of it. That is why in general community health centers, as a delivery device are good. But I think it would be good that if their clients brought their own purchasing power with them.

On this issue of cost shift, this is actually an interesting thing. People who believe in markets should not believe in my view that just because Medicaid or Medicare pays hospitals too little, private payers have to pay more. That is not true in a hotel. If somebody gets a discount, they don't call you up in the middle of the night and say hey, Smith just registered. We gave him a discount. We are going to raise your rate. So if you actually believe the private market works, why are private insurers not following Nancy Reagan's advice, just say no—

Mr. GREEN. Well—

Mr. REINHARDT [continuing]. We are not going to take it. So I don't believe this cost shift story of private payers picking up what Medicare doesn't pay. I don't believe in that story.

Mr. GREEN. Well, Mr. Chairman, I know we have a situation in our country, Medicare pays so much. Medicare actually pays less, but in some cases, if you have a military base, got to see Champus and TriCare, don't even pay what Medicare makes in reimbursement. And we have run into that problem in a very urban area with our number of activations. So you are right. We need to look at the reimbursement rate to make sure they actually do fit the cost of the service. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Let me just ask a question. I hate to do this because it is beyond the scope of this panel. But Mr. Green brought up in his opening statement that Texas has 25 percent uninsured. When Massachusetts did their program several years ago, they made a decision that they were not going to factor in or they were not going to include in their factoring any cost for people who were in the country without the benefit of a Social Security number. Of the uninsured in Texas, there are a significant number. We could never ignore that number of people who are in the country without the benefit of a Social Security number.

So we failed on several attempts since my short tenure in Congress to deal with this issue. Can we really get to the point where we are talking about the type of reform that you three are discussing if we don't deal, in some way, with the problem we have with immigration and people who are in the country again without the benefit of citizenship?

Mr. REINHARDT. Well, I served on the board of a Texas-based hospital company, and we had this very problem. On the front lines, you cannot tell when people come in bleeding or pregnant about to deliver. You cannot send them away. So we served them one way or the other.

Mr. BURGESS. And, in fact, you are required to under federal law under IMTALLA.

Mr. REINHARDT. IMTALLA, yes. And in New Jersey, it is even more. The whole thing has to be delivered. So most of the immigrants are actually working or have families where somebody works. And it seems to me we have let employers in this country off the hook much too easily. They should pay for the social services that the immigrants and their families consume, whether it is schooling or—they should be made to pay Social Security. And that includes even people who do shrubbery as they do in Princeton. One ought to be required by law to pay a prorated contribution to these people's social services. But we have never actually done that. Quite a few people who employ undocumented aliens pay nothing into Social Security and get away with it. They have them as a subcontract, and God knows. So yes, I think you cannot not give health care to these families, particularly the children because, whether you like it or not, these children will one day be Americans.

Mr. BURGESS. Well, many of them in fact are by virtue of the fact of the—

Mr. REINHARDT. That they were born here.

Mr. BURGESS [continuing]. They were born here. Again I am not seeing from congressional leadership or from the White House any serious attempt at dealing with this issue. And I just think it is—I stipulate the points you made, Dr. Reinhardt, are accurate. But it is just going to be very, very difficult for us to deal with us this issue when we have that larger looming problem in Texas, New Mexico, Arizona, and California where it is just going to be very, very difficult to overcome.

Mr. REINHARDT. Well, there is a moral problem. If you make this great American health care available to people, people will flock here ever more.

Mr. BURGESS. And that was the argument.

Mr. REINHARDT. That is why the Congress sometimes says let us not do this because we are creating a magnet. But—

Mr. BURGESS. But we did that in S-CHIP. We essentially said that we are going to remove some of the barriers. And we have turned off the jobs magnet to some degree, but we have to be careful not to turn on the benefits magnet.

Mr. REINHARDT. In the end, there is a doctor and a nurse and a hospital looking at this human being, and they cannot say no.

Mr. BURGESS. Dr. Reinhardt, I will just stipulate that that is correct, and practically every night of my practice life, I was called to do just a delivery because IMTALLA said I would have a \$50,000 fine and some serious questions to answer if I did not respond within 30 minutes, and yet at the same time that same federal government failed to secure the borders. And the consequence, we in the hospitals are left on the front line.

I didn't mean to get so far down into that. I did want to ask a couple of questions about the federally qualified health center issues that Mr. Green brought up because the distributional issues are significant. While he has four or what did he say? How many did he have in Houston? It was way too many, whatever he said. We only have four in Dallas County, one in Tarrant County, none in Denton County where I represent significant numbers of people. The infant mortality rate in Tarrant County in some of the zip codes is phenomenally high, and we only have one federally qualified health center, not in the neighborhoods with those zip codes. So there it is not a question of access. We have a good county hospital in Tarrant County. The question is utilization. We have not put the clinics where the people are so that they will use them, and that is one of the great inequities.

I have often wondered why we reimburse at a higher rate for Medicaid reimbursement for a federally qualified health center, and we won't do the same thing for a physician in practice in the community to keep that physician involved and in practice. So, Dr. Reinhardt, you almost went there with the money should follow the individual. Can you expound upon that just a little bit?

Mr. REINHARDT. Yes, I think in general, certainly in my profession, economics, we believe in competition. And therefore whether it is—scholarships should never be given to a medical school or a university. It should travel with the client, and that is why ideally people should have the same insurance. A doctor should get paid the same, no matter where they work. You are reimbursing a professional service, and it shouldn't really depend on what location you do that. And so I sympathize very much with your thought.

Mr. BURGESS. And what are the mechanisms—

Mr. PALLONE. We—

Mr. BURGESS [continuing]. That money could follow the individual?

Mr. PALLONE. Mr. Burgess, we—

Mr. REINHARDT. Universal—

Mr. PALLONE. You are over. This will be the last question.

Mr. REINHARDT. Universal insurance is, in fact, the mechanism. That is why some of us are so much for it. That if people have purchasing power, like a Canadian has a credit card, and with the credit card, every doctor gets paid the same, whether it is a poor child or a rich child. While in New Jersey, we have Medicaid \$30 for a pediatric visit, and for the commercial, \$120. Canadians don't do this. This is why I think the Canadian story is not really relevant to us at this time. They have a different social ethic. They look at life differently than we do.

If you did a survey now in Canada, Canadians are not stupid. They are highly educated. They watch American TV. They have a democracy, and yet if you had a referendum whether they would want our system or keep theirs, overwhelmingly, I would bet a lot of AIG stock on that, overwhelmingly, you would find—well, it is still worth something.

Mr. BURGESS. We will see to that actually. We will stipulate to that.

Mr. REINHARDT. I will put real money on it, real New Jersey money. The Canadians would vote for their system. There are, of course, some who are not happy, and they can come here and do research. But by and large, when I go up—I am a Canadian too. When I go up there, by and large, people are very proud of their system. And I invite you to do it. Go to the airport. Talk to anyone.

Mr. BURGESS. Yes, my father was a refugee from Canada so I understand.

Mr. PALLONE. All right, we have to move on here. Next is Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. Dr. Feder, I was wondering if you wanted to respond very briefly to this issue of the undocumented immigrants coming in and taking advantage of our system.

Ms. FEDER. Thank you, Ms. DeGette. You saw me chomping at the bit.

Ms. DEGETTE. I did.

Ms. FEDER. I will be brief. I just wanted to make very clear that, although immigration is a very serious problem that does create serious problems for health providers, particularly in some areas, that the problem that we are talking about is we should not ever think that the bulk of people without health insurance coverage or the bulk of people who are facing affordability problems are immigrants, whether they are here legally or not legally.

And I also believe that when we are talking about—we asked universal coverage or were talking about universal coverage, we are talking about universal coverage for people who are Americans and are here legally. And I just didn't want that issue to get confused.

Ms. DEGETTE. So if you were structuring the universal health care program, you wouldn't necessarily structure it so that we were inviting people to come in and enroll.

Ms. FEDER. I think that is absolutely true, and we have seen that people, as Dr. Reinhardt said, people are coming here as long as employers want to hire them and we don't enforce our rules.

Ms. DEGETTE. Right.

Ms. FEDER. And with the decline in the economy, they are not coming in those numbers anymore.

Ms. DEGETTE. Right.

Ms. FEDER. Although it is a very serious problem that I wouldn't minimize and faces some institutions in particular ways, it would be a mistake to hold the whole health care system and all Americans hostage to that problem.

Ms. DEGETTE. Thank you. What I really want to talk to this panel about is this issue of a public plan alternative because I think that frankly as we move forward with drafting legislation in this committee, that is going to be one of the top issues of discussion and debate. And some people say well, we shouldn't have a public alternative, I guess, because it leads us down a slippery slope towards socialized medicine or single payer or so on.

But we actually do have one of our largest public health care systems right now has a public option and a private option. That is Medicare, and the Medicare fee-for-service option is the most popular option, and people like that. But more importantly, I think, if we didn't retain the fee-for-service option when we did Medicare Advantage, we would have never realized that we weren't getting more efficiencies in the private option that we had adopted. And frankly I was here when we did Medicare Advantage, and I thought that when we did the private alternative that it would save us money and it would cause us to revamp our fee-for-service program to get more efficiencies in that program.

We all know now that, of course, it has not been the case, and that we are spending far more in the private alternative than we would have in the public. And so I guess maybe, Dr. Feder, I will start with you. I would like your comments on why you think it is important to have a public option if we are going to maintain the private competition that we have.

Ms. FEDER. Yes, I think you nailed it, Congresswoman DeGette, when you said that essentially the public system can keep the private system honest. But we have evidence that private insurers are not negotiating effectively in terms of getting affordable health care. And if we have a public health insurance option, and remember because I think it gets misrepresented, as a choice, then we, you, the public can hold that plan accountable for bargaining effectively with providers, for delivering quality care, for being transparent, for all the things that we need insurance to be. And essentially it puts some pressure and makes a market that claims to be competitive but is not, it can make it work.

Ms. DEGETTE. And just to follow up on something, Ms. Pipes. I never try to misconstrue what people who I disagree with say, but what I had heard Ms. Pipes saying is part of the way in Medicare and part of the way it would happen in this system that you would get the efficiencies is by ratcheting down reimbursement for medical services, and doctors wouldn't want to provide those services. What would your response be to that, Doctor?

Ms. FEDER. Well, I find these claims fascinating at a time when the Congress is responding to concerns about physicians in the Medicare program and responding to access problems by raising physician fee. And in Medicare, we make an extra effort to make

certain that we are paying appropriately, but that when access problems arise, that we, essentially you, enact higher rates.

And we are talking about then a responsiveness to—people need access to care, and your constituents hold you responsible for that. So I don't think this concern that somehow it is going to go to nothing or Medicare for all is—I don't know where this is coming from.

Ms. DEGETTE. Dr. Reinhardt.

Mr. REINHARDT. Yes, I agree. I served on the physician payment review commission, your commission, and we every year did a survey of the elderly and asked do you have access to health care—and that is still part of what Med Pac does—and monitored it very, very closely. And we have rules of thumb; when we saw access becoming even a small problem, we would recommend to the Congress to raise rates. So that, in the Medicare program has, I think, been pretty well modulated.

But there is another thing that really I find puzzling around the business roundtable. On the one hand, they complain that we are spending too much on health care, and then on the other hand though they are saying the public sector isn't spending enough on health care, and then they also come out that government should stay small. And I sometimes in my simple mind try to put that all together. They say they want small government, but they want to pay more for Medicare so that their rates are somehow viewed the correct rate. Who is to say that private insurers aren't overpaying?

They say, I have so little bargaining power. In some places, say California, even a large company like Well Point cannot face down a hospital system. And who is to say the private sector isn't overpaying? You know, you could make that case.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Mr. Chairman, I will defer to whoever is next on this side if I may since I just want to listen.

Mr. PALLONE. Thank you. Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. Ms. DeGette was just referencing in Medicare that we have a—

Ms. DEGETTE. Would the gentleman yield? It is DeGette, and everybody including the President has been saying it wrong. So I would just like to—

Mr. GINGREY. Ms. DeGette.

Ms. DEGETTE. Thank you very much.

Mr. GINGREY. And it is Diana and not Deana. Is that correct?

Ms. DEGETTE. You got it.

Mr. GINGREY. Thank you. I will remember that. But Ms. DeGette was talking about the public and private plan that we have within the Medicare system and that the private plan turned out to be so much more costly. The reason I bring that up, because, Dr. Reinhardt, in your presentation, you talked about the importance of rigorous cost effectiveness analysis. And I have concern that our way of scoring things in a static environment rather than a dynamic way of doing it.

Medicare Advantage—and the President, of course, has certainly taken a swipe at Medicare Advantage and is going to cut that significantly to the chagrin, I think, of 10 million people who get their care through Medicare Advantage.

If it is true that end-of-life cost is the biggest cost of Medicare, the last month of life, then I think we might be judging that cost of Medicare Advantage prematurely. Now, I am not saying that it should be 115 percent compared to Medicare fee-for-service. Maybe it is a little too high, but in the final analysis, it seems to me that if we looked at this in a dynamic way, follow it all the way to the end of life, then it may turn out that Medical Advantage, the private versus the public, would be much more cost effective.

And I worry in regard to what you were saying, Dr. Reinhardt, in rigorous cost effective analysis in regard to medications, in regard to biologicals, in regard to durable medical equipment or devices. That maybe in fact these would, by some rigorous cost effective analysis, almost like a Federal Reserve Board for health care, that these decisions would be made too early. And if we had an opportunity to wait and see in combination with other things, whether it was a cancer drug or a new surgical procedure, that in fact, in the long run, it would be cost effective. So I would like for you to respond to that for us.

Mr. REINHARDT. Well, I mean first of all your point of ideally we would like to have a dynamic view is correct. I agree with this. Ideally what you would really like to have is a natural experiment where some people went into Medicare Advantage, some stayed with the traditional program, and you could follow them until they die and say what were the life cycle costs adjusting for illness and so on. That would be ideal obviously, and maybe you are right. It could be cheaper if they manage somehow the last month of life more efficiently. I am not sure there is any evidence—

Mr. GINGREY. Well, I would say this. It is very likely that those were managed efficiently over a number of years in regard to wellness and taking care of themselves and taking care of their medications. When it comes to be their final day on earth, it might be a catastrophic event like a heart attack or a stroke but not in an intensive care unit for months suffering from multiple horrendoplasties, as we used to say in medical parlance.

Mr. REINHARDT. No, it is possible, I mean, and it is researchable. One could research it even now. You could give the ARC some money—and I speak here with a conflict of interest. I am a health services researcher, but we could research this.

Mr. GINGREY. Yes, I think you could, and let me ask you one last question, Dr. Reinhardt, before my time runs out completely. You had an article published March 13 of this year in the “New York Times.” You pointed to two groups who comprised the “opposition to cost effectiveness analysis.” And you said one of those groups were manufacturers of pharmaceuticals and biotechnology products or of medical devices. But the second group, and this is what I want to address my question to. You said the second group are individuals who sincerely believe that health and life are priceless, and you went on and you said in describing this second group, you state that for them cost should never be allowed to enter clinical decisions. “It is an utterly romantic notion, and if I may so say, also an utterly silly one. No society could ever act consistently on such a credo.” That is the end of your quote.

Dr. Reinhardt, do you believe that we, as individuals, in America should have the ability to value our own lives, or is this something

we should ask the government to do for us, i.e., ration that care when you get to be 90 years old and you need a hip replacement, do you just let them fall and break the hip and die of pneumonia? Or do they get the opportunity, if they value that, to get that hip replaced?

Mr. REINHARDT. I cannot even tell you, Congressman Gingrey, how much I hoped someone would ask me this question because this is how I would think about it. Every American should have the right to value their own life any way they wish. But then the question is at whose expense. If it is at their own expense, by all means. But if you are dealing with a collective insurance fund, then those who preside over those funds do have, at some point, to ask themselves at what price do I buy additional life years, quality adjusted—we call them quallies—or additional health? And to say we don't make airports as safe as they could be. Our air traffic control system is reckless, I think, from what you read, and what often near misses. And why don't we do it? Over money. We may calculate our some fault in an unarmored Humvee. That was a calculated decision to say well, it would cost so much to have armored vehicles. We are going to take a chance of some Marines, and that is what the Congress does.

So what I listed there is a paper that shows the value of human life legislators and people routinely put on their own life, and they are rather low numbers in many ways. And I raise the question why should health care be the only area in an economy in society where I have the right to say spend the limit, spend \$5 million on me and let the taxpayer pick up the tab. I think that notion, to my mind, is romantic and, in fact, silly.

Mr. PALLONE. We are——

Mr. GINGREY. Like a German philosopher of yesterday.

Mr. PALLONE. We have to move on, Mr. Gingrey. I am sorry, but we just have a lot of people, and we got another panel. Next is Ms. Capps.

Ms. CAPPS. Thank you, Mr. Chairman, and I want to use my time really well with a great panel. And I have a question for each of you, starting with Ms. Pipes. In your testimony, you talked a lot about rationing care and waiting lists, and Canada does have bad wait times, but so does the United States. Twenty-three percent of adults reported having to wait over six days to get an appointment to see a doctor the last time they needed one. In the U.K., which also has a single payer system, it was only 15 percent.

In addition, 34 percent of sick adults in America who had medical problems skipped important doctor visits because of cost. That is way more than the 4 percent in the U.K. and the 7 percent in Canada.

Not to belabor that, because we are talking about American system that we want to try to reform, is there any data you can present to this committee showing that a new optional public health plan will create rationing times or wait times worse than what we are seeing right now?

Ms. PIPES. Well, I haven't done the exact research on that particular issue, but I think——

Ms. CAPPS. So there is no documentation that you know of?

Ms. PIPES. Not that I know of, but I can look into it and find that out because I think——

Ms. CAPPS. That would be great. If you can find it, I would love to have it for our——

Ms. PIPES. Because I think, you know, Canada does have long waits, and people that have money come to the United States and pay out of pocket.

Ms. CAPPS. You said that in your testimony.

Ms. PIPES. So it is very important that we improve the U.S. system so that people can get better access.

Ms. CAPPS. Exactly.

Ms. PIPES. And that is why I support universal choice because a young man of 30, you know, wants to get a high deductible——

Ms. CAPPS. Thank you.

Ms. PIPES [continuing]. Insurance plan. Why should he have to pay \$12,000 to \$15,000 to cover my in vitro fertilization? You know what I mean?

Ms. CAPPS. Thank you very much, and if you can find that information for us, I think it would help us to make some good decisions. Dr. Feder, I mentioned the story in my opening minute about a constituent of mine who lost her job and had a reoccurrence of her cancer. She did well in the country that I represent because they have a particular public access program that worked for her.

But I want you to be able to elaborate briefly but for our value what you were saying about how when someone loses employer coverage, their ability to purchase coverage in the non-group market is limited at best.

Ms. FEDER. Yes, well it is. You are absolutely right, but in your community she had an option. She had what is called a pre-existing condition. She was sick, and you are going to hear on the next panel from my Georgetown colleague, Karen Pollitz, who can give you examples, a tremendous number of examples of this kind. That people in the non-group market essentially does not—either denies people who have conditions, rules out coverage for the body parts that have been damaged, limits the benefits, or charges higher rates.

The market simply does not work for people. It is not any kind of safety net, and the evidence on the non-group market is that rather than people falling into that system and getting picked up, it ends up people are healthier in that market than in the employer-sponsored system.

So this woman, without your plan, when she most needed care, would have lost any means to get access to it. And we know looking at the evidence in general on the uninsured that people are actually dying in that circumstance.

Ms. CAPPS. Thank you very much, and I——

Ms. PIPES. I mean because people get their insurance through their employer and it is not portable if they lose their job, this is the reasons why changing the tax code so that people can go into the individual market. And also I think we will see more competition and new insurance companies that will deal with specific people.

Ms. CAPPS. Well, we will see about that.

Ms. FEDER. They don't compete for sick people.

Ms. CAPPS. That is right. If there is anybody who can show a plan where they compete for sick people, we would love to hear about that too.

There is another topic that is very dear to my heart, Dr. Reinhardt, I saved for you. In the United States, we spend nearly \$7,500 per person on health care. It is the most expensive system in the world, if I am not mistaken. Yet in terms of maternal mortality, women dying in childbirth, we rank 41st out of 171 countries. So there is a disparity there. How can we now as we want to reform our system—what are some proposals specifically that would improve issues like maternal health, a classic indicator, according to the millennium challenge, for the overall health of a nation while striving for lower costs?

Mr. REINHARDT. Well, obviously part of the reason why women die has to do with issues outside of the health system, and every health services researcher would recognize this. But when you come to infant mortality or maternal death, the health system does have a contribution to make. And I think we are falling short. It is because people often do not have insurance particularly when you are just slightly over the Medicaid limit or live in a state with a low threshold.

And I must say as a European and ex-Canadian, I am stunned at this. I believe the children are the treasure of a nation. They are the future generation. And I always have said to me, mothers are on par with soldiers. They do a patriotic service because they bring us the next generation. We should give them medals rather than the way we treat them.

And I remember I once gave a speech called “Motherhood and Apple Pie” where I said I do buy the idea that Americans love apple pie, but I am not so sure about motherhood. I don’t think in this country we respect mothers enough. And people who know me know that is a big deal with me. We do not respect mothers enough.

Mr. PALLONE. We—

Ms. PIPES. It would be worthwhile you looking at some of the work that June O’Neill has done on infant mortality rates because other countries—we have the best neonatal procedures and clinics and facilities in this country. And often in other countries, people are not counted as live births. And so look at the work that June O’Neill has done because you have to compare apples with apples.

Ms. CAPPS. I was talking about maternal mortality.

Ms. PIPES. Right.

Ms. CAPPS. But our infant mortality rate is not so hot either.

Ms. PIPES. Well, but I think you have to compare on an equal playing field how other countries treat—what they count as infant mortality rate versus this country because we keep a lot of babies alive that wouldn’t even be counted as live births in other countries. So it is very important, look at June O’Neill’s work on this issue.

Mr. PALLONE. Thank you. Next is the gentleman from Arizona, Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. Ms. Pipes, I would like to begin with you. I think I have heard you describe what you favor as universal choice. Are you familiar with plans that have been in-

roduced that would provide every American with a stipend? That is either a tax credit or a refundable advancible tax credit that is cash to go buy a health care plan for every single person. Are you familiar with those? And would you describe that as universal choice?

Ms. PIPES. Yes, I would, and Mr. McCain during the campaign was sort of hit by Mr. Obama saying—Mr. Obama said Mr. McCain would like to tax your health care. In fact, the plan would be—

Mr. SHADEGG. Well, I don't want to talk about his plan. I want to talk about some quick questions, and I have a long list.

Ms. PIPES. So but I think it—

Mr. SHADEGG. Would you say we have a patient choice driven system now?

Ms. PIPES. No, I would not. I would say 47 percent of health care is in the hands of government today, and we have a small sector 7 million people have patient-centered health care.

Mr. SHADEGG. Would you include in that patient centered health care plans that are picked by your doctor? Don't we really have a third-party control system in America today where your health insurance plan is picked by your employer, and then plan then picks your doctor, and you have virtually no choice?

Ms. PIPES. Absolutely. And that is why if we can move away from employer-based care and move up the individual market, new competition will come in. New insurance plans will be available, and people will be able to choose the type of plan that fits their individual—

Mr. SHADEGG. What if we let them choose from the private market or choose their employer's plan, but put the choice with them?

Ms. PIPES. That is an excellent idea, yes.

Mr. SHADEGG. Would you say that we have a healthy market in health insurance in America today?

Ms. PIPES. No, I would not.

Mr. SHADEGG. This represents the northern Virginia residential phone book. All of the people in that book get to buy auto insurance if they have an auto, right?

Ms. PIPES. Right.

Mr. SHADEGG. If I put up here the northern Virginia phone book, it would be a fraction of this size, would it not?

Ms. PIPES. Yes.

Mr. SHADEGG. Maybe a fifth or less. Perhaps that kind of a graphic of the health insurance market versus the auto insurance market today. That is only employers get to buy health insurance, and they make the decision for their employees. Whereas in auto insurance, everybody gets to make their own choice and gets to pick a plan, and we have a much healthier market. Wouldn't you agree?

Ms. PIPES. Absolutely, and, you know, the average employer spends \$12,000 per year on an employee's health plan, maybe even \$15,000. But the thing is that not all employees need that much health care, and there would be more competition if people could choose, like in the auto insurance, the type of insurance that fits their needs. And some will be a lot cheaper.

Mr. SHADEGG. So you would favor a system where they get to make their own choices?

Ms. PIPES. Absolutely.

Mr. SHADEGG. And moving away from a system where there is a third-party control?

Ms. PIPES. Right.

Mr. SHADEGG. I take it then you would not agree for moving from a system that is third-party controlled by your employer to third-party controlled by the government? Is that going to solve the problem in your view?

Ms. PIPES. I think that if the government takes over the health care system, and including this public plan within the National Insurance Exchange, it is going to reduce people's choices, cost are going to go up, and ultimately care will have to be rationed as it is in countries like Canada and the U.K.

Mr. SHADEGG. Dr. Feder said, and I agree with her, that affordability is the real key here. We are worried about expense. We are worried about how expensive health care has become.

Ms. PIPES. Right.

Mr. SHADEGG. And how expensive health insurance has become. Do you think it is a coincidence that we are experiencing a huge spiraling costs in health care costs where it is all third-party control and the market doesn't include all these people, it just includes this little business phone, that we are only experiencing that spiraling cost in the one place in America where there is genuinely no market? Is that a coincidence?

Ms. PIPES. Well, as you have said, I mean we don't have a free market in health care. We have a lot of government in health care. We have the third party payer system, and people are not in charge of their health care. We don't get our life insurance, our long-term care insurance through our employer.

Mr. SHADEGG. We have pretty well divorced the consumer of health care services from the payer of health care services.

Ms. PIPES. Right, exactly. Absolutely.

Mr. SHADEGG. And once divorcing them, costs have gone up dramatically once we have divorced the consumer from the payer.

Ms. PIPES. Because we have in this country what you call first dollar coverage. When people they pay nothing—if employees don't pay anything for their premium or they pay a little bit, or they pay no copay or a small copay, first dollar coverage means when people think something is cheap or free, they demand a lot more but—

Mr. SHADEGG. And they think it is cheaper right now because their employer is paying for it.

Ms. PIPES. Yes, and then—

Mr. SHADEGG. Wait, let me switch topics. A lot of discussion here today about a public plan. If we institute a public plan, won't politicians have a tendency to increase the subsidy of that public plan year after year after year as they have done with other public offerings?

Ms. PIPES. Well, I think if you look at Canada, when the government took over the health care system in 1974, they were completely taken aback by how much demand there was for a program that people think of as virtually free because they don't know how much they are paying through the tax system. And it went up and up, and then government has to put a cap to say we can't—

Mr. SHADEGG. I am almost out of time, but if we let the government create a public plan and increase its subsidy year after year—I really have two questions. One, how will the private sector stay in competition with that if the government sector's subsidy goes up year after year? And second, if the government both offers a plan and also sets the rules for its plan and the private plan, aren't we allowing the government to be both a player in the game and a referee in the same game?

Ms. PIPES. Right, and that was what I mentioned in my testimony. If you have guaranteed issue, community rating, and a lot of mandates, that is going to push up the costs of the plans. And if the government prices their plan slightly cheaper, you are going to crowd out the private insurers and leave us with a taxpayer funded plan, which ultimately will be too expensive and end up with rationed care.

Mr. SHADEGG. You—

Ms. PIPES. It is not going to help the American people get the finest health care available.

Mr. SHADEGG. You would rather give them cash and let them make a choice?

Ms. PIPES. Right, absolutely.

Mr. SHADEGG. Thank you.

Mr. PALLONE. All right, thank you. Gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you. If I could just ask each of you. Do you think that health care is a right?

Ms. FEDER. Yes.

Ms. PIPES. No.

Mr. REINHARDT. Health care is too big a label. Some kind of health care is absolutely a right viewed in this country. It is not in the Constitution. However, think of someone lying in the street. A car hit them. They are bleeding. Does anyone in this room think you don't have a right to be picked up and brought to the nearest hospital? Does any American think that right does not exist? So yes, some health care, a lot of it, is a right, and some of it like plastic surgery is not.

Ms. SCHAKOWSKY. Well, that is not necessary health care.

Mr. REINHARDT. Cosmetic surgery.

Ms. PIPES. And we do have, as someone mentioned earlier, IMTALLA. I think it was—that we have IMTALLA, which is a law that says no one can be denied access to emergency room—

Ms. SCHAKOWSKY. I know. I am just asking if you think it is a right. You said no.

Ms. PIPES. No, because how do you determine how open-ended that right is and what it will cost? And so I think that we are entitled to life, liberty, and the pursuit of happiness.

Ms. SCHAKOWSKY. Yes, I want—

Ms. PIPES. You mean access—

Ms. SCHAKOWSKY. It is my time, and I reclaim it. What would you say, Ms. Pipes though, that 87 percent of Canadians view the elimination of public health care as a negative? This is according to McGill professor Stuart Sirroca, author of the study. It was the highest ranking opinion in the entire survey, that they would not want to eliminate their public health care system?

Ms. PIPES. Well, there are poll numbers that have come out of Decima that the majority of Canadians, 47 percent versus 41 percent, are dissatisfied with the Canadian health care system.

Ms. SCHAKOWSKY. Well, you spend about 10 percent of GDP, you said, on health care—

Ms. PIPES. Right.

Ms. SCHAKOWSKY [continuing]. On health care in Canada. What do we spend, Ms. Feder, in—

Ms. PIPES. Sixteen percent here.

Ms. SCHAKOWSKY. OK.

Mr. REINHARDT. More than that.

Ms. PIPES. But it is going up, yes.

Ms. SCHAKOWSKY. Yes, so in other words, perhaps if more were spent on the Canadian health care system, it could serve more people. But I am not looking for a comment now.

I am concerned about this notion, and you referred to it earlier, Dr. Reinhardt, and I would appreciate if you or Dr. Feder would want to comment on that. The United States, it seems to me, does in fact ration health care. That the dollar bill is essentially that ration card and that when you have more than half of Americans who say that they haven't gotten health care, they have postponed or have completely eliminated health care that they need, that clearly this health care is being rationed. That people—we don't count the people not in line because they can't afford it. And I think this is really an important point about comparing our system with a Canadian system where they actually count people that wait in line. Either one of you or both.

Ms. FEDER. Yes, I appreciate the question, Congresswoman Schakowsky. And the first point I would make is, as you were making earlier, is that we are not talking about turning the American system into the Canadian system. We are talking about slowing the growth and making sure—of health care costs, and making sure everybody has affordable insurance and affordable care.

And as Dr. Reinhardt said earlier, that when people can't afford care, when they don't have insurance coverage or there are holes in their insurance coverage, care is being rationed. And I find very interesting not just people who aren't showing up because they know they can't afford it, but how much do you hear from your constituents about the runaround they get from their insurance companies, the denials, the submitting the claims over and over again, the not being able to get service?

Ms. SCHAKOWSKY. All the time.

Ms. FEDER. Exactly, so what is it? We think the system works? It is being compared to a straw man. What we need to do is to fix our system, get better value for the dollar and make sure that everybody gets access to care when they need it.

Ms. SCHAKOWSKY. And prescriptions left in the drawer because they can't afford to fill them. Dr.—

Ms. FEDER. Exactly. We have the evidence of it.

Mr. REINHARDT. It so happens I have written three papers on this rationing issues. One, in fact, entitled "Styles of Rationing: Canada Versus the U.S." And there is no question they do ration with a queue for some procedures up there, and there is no question we ration through price and ability to pay. And to deny that

defies anything any freshman is ever taught if they have a good economic professor. I could show you textbook after textbook from people who are actually conservative politically who says the role of prices is to ration. And we use price as a rationing device.

There was a recent study out—Judy, you may know it—that showed for low income people, they actually consume less health care because they very often are uninsured. But if we compare people who do not have insurance with those who have insurance, Jack Hadley's numbers, the uninsured get 43 percent of the care that similarly situated insured get. And to deny that that is rationing borders on the mischievous. I think that is rationing, and we are discussing styles of rationing. Canadians have a different view about what is equitable than what apparently we have.

Ms. SCHAKOWSKY. Thank you. Bottom line, we want to do an American system that works for everyone. Thank you.

Mr. PALLONE. Thank you. Gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman, and I did, by listening appreciate a lot of the comments, and I won't be long. Following up on John Shadegg's comments about buying power, just two quick questions. There is a debate for those who propose about it being a mandatory or voluntary system. If you use the automobile insurance debate, if you drive in states, you have to have insurance.

I am of the point of view that if you went to a private option, what is called the public choice, however we are going to define that, that it would be—everyone would have to cover—I mean you would not have a choice to be out. Everyone would have to have something. You would also have to force then the insurers to have the wide breadth of everyone involved. I mean you couldn't allow them to cherry pick is kind of the terminology I use. And it is a mandatory system.

And the final thing is there would have to be the basic package would have to be a catastrophic package. I mean the cost shifting, what goes on in a hospital, and what everybody is worried about is catastrophic care. And maybe you could allow people through health savings accounts or just their own dollars to do the preventative care, to go to the doctor for the cold and flu and all that other stuff.

What do you think about that premise? And, Dr. Reinhardt, if you would just then mention, and Ms. Pipes and Dr. Feder? And that would be the only question I—that is what has been bubbling around in my thought process, how do you get to the 44 million or 47 uninsured Americans? They have to have insurance. They have to have a catastrophic package. What would you say to those comments?

Mr. REINHARDT. Well, ultimately, when you discuss universal coverage and when do you know how have you reached this fairly. The only metric that really makes sense to me would be to say what fraction of a family's discretionary income, after food, housing, and shelter, should a family in America be required to contribute towards it own health care. And presumably that percentage would be small for a waitress or a cab driver, and it would be higher for a full professor at Princeton. You could easily ask me to contribute 10, 12 percent of our household budget towards health care,

and you would not ask a waitress to do that. So that is the first thing.

Now with respect to the choice market for private insurance, if you put community rating on, say you must charge everyone the same, sick or healthy, and guaranteed issue, if you don't couple that with mandatory insurance, you will get a death spiral of private insurance, which we actually see in New Jersey happening. So those two go together.

The alternative model would be that you say oK, we let the private insurers medically underwrite. So if somebody is sick, they pay a huge premium. Somebody has AIDS, they pay \$80,000 a year. And someone who is very healthy gets it very cheap. But then you would have to have a bureaucracy that could give subsidies to the chronically ill for the huge premiums that they are charged and subsidize them to the tune that ultimately you are happy with that percentage. And this is really something. I think my colleague Mark Polly at UPenn, and who is the co-author—had a very lovely paper on this. How do you know that you are equitable? And he proposes this metric. Adam Wagstaff at the World Bank had the same thing for the International—

Mr. SHIMKUS. Yes, sir, and I don't want to cut you off, but I do want Ms. Pipes and Dr. Feder, briefly. I only have a minute left. If you could kind of summarize that quickly. Sorry, Dr. Reinhardt.

Ms. PIPES. And you mentioned mandatory car insurance, but 15 percent of drivers in this country, even though all states but two have mandatory care insurance, are driving around without car insurance. And we have seen the experiment in Massachusetts where now after—it will be three years old in April—that still 2.5 percent of people are uninsured.

And about 60 percent of the people who are people signed up for the Commonwealth Care, the subsidized thing. So it is very hard to take the American mind set and ensure and make them do—I mean Hillary Clinton said the only way you could enforce a mandate was to garnish the wages. I don't think that is the American way. And so I think it is very hard. But if we have, you know, universal choice, and people can choose the system that best suits them, I think we will get a lot of those 45.7 million Americans going into the insurance market. There is nothing wrong with having a high risk pool for people who are falling between the cracks.

Mr. SHIMKUS. Thank you. Dr. Feder with the chairman's permission.

Ms. FEDER. Yes, is it okay?

Mr. PALLONE. Yes, sure.

Ms. FEDER. I will be quick. I was interested in what you said about making rules for insurance because as I listen to Mr. Shadegg, no matter how big that phone book gets of insurance companies, if 20 percent of the people account for 80 percent of the spending we spend on health care when we get sick, insurers always win if they insure us when we are healthy and avoid us when we are sick. So you have to have rules. It has to be group insurance. That is the only way it can work.

I am less concerned about mandates than I am concerned about making sure that everybody has the wherewithal to buy insurance so that means subsidies, making those adequate. And also I think

facilitating enrollment in many ways can get everybody into the system so that we fix it not only—people don't walk around with a U for uninsured on their foreheads. There is a problem in the whole system, and we need to make it work for everybody.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. First just a couple of observations. Trying to use the car insurance as an analogy is a terrible mistake because if it operated like health care providers what would happen is your first accident or speeding ticket, the insurer would drop you. Then you would go to the next insurance company, and they would say you had a pre-existing condition and wouldn't offer you any insurance.

The other observation is anybody that doesn't believe that our health care system is broken would be those individuals that presently have coverage, number one, but even out of those, you would have to say it be those that are healthy and haven't attempted to use the coverage.

I am going to quote from a paper from 2004. I get these all the time from a physician friend of mine. Every time we have a hearing, he will send me an email and refer me to articles, but I am going to agree with this article. And I think it is going to embrace some of the concepts that have been advocated by members on the other side of the aisle here in the committee.

And this is by Michael Porter and Elizabeth Ulmstead-Teasburg. "We believe that competition is the root of the problem with U.S. health care performance, but this does not mean we advocate a state-controlled system or a single payer system." Of course what we have here is we are talking about a public option, which is separate because those approaches would make things only worse. "On the contrary, competition is also the solution, but the nature of the competition in health care must change. Our research shows that competition in the health care system occurs at the wrong level over the wrong things in the wrong geographic markets and at the wrong time. Competition has actually been all but eliminated just where and when it is most important. The health care system can achieve stunning gains in quality and efficiency, and employers, the major purchasers, of health care services, could lead the transformation."

This paper was written 2004. Jury was out. Jury has come in. Employers have not been able to do it. Someone has suggested that a well-educated consumer will be able to do it as long as we give vouchers or some—and we know that we don't have that level of competency out there, through no fault of the consumer, of course.

I would like comments from Dr. Reinhardt and Dr. Feder as to the way I view this without trying to be married to any kind of ideology to the point of a faith or religion that doesn't allow us to discuss this thing rationally and in good faith.

I believe that what we are espousing here and hopefully will have a bill which is going to be a public option will be the vehicle that will allow us to bring into the marketplace those wonderful ideas of competition, consumer choice, education, quality, efficiency, and get our biggest benefit out of every dollar. Is this what we see here today? That is what I really think we are discussing. Because

we are really talking about concept at this point. And we may bring into immigration and other things, but those are issues that we will have for another day.

But overall, conceptually speaking, is that what this will bring to this debate as far as a public option? Dr. Reinhardt.

Mr. REINHARDT. Well, this paper was in the "Harvard Business Review" by them and then followed by a huge tome that they wrote, and a number of us reviewed it in "Health Affairs." My view is their vision is correct but very utopian because somehow they pretend that you can slice all ill health into episodes that begin and end and that you can get physicians and hospitals and convalescent centers to build little groups that specialize, little focus factories as Reggie Hertslinger calls them, that specialize in this, and then advertise their price for the whole bundle and have a quality rating. And they don't even say who would do that, who would rate the quality.

So as a concept it is good, and I think we are gingerly moving that way. But it will take at least 20 years before you would have realized that. But it is true. A public health plan does have the advantage of being able to experiment with that just like a private plan.

I would urge you to think—they always say Medicare wasn't an innovator. Who developed the DRGs? It was Medicare, copied now around the world. Who developed the resource-based relative value scale for physicians? It was Medicare now copied by every private insurance plan. So I believe the vision they had is good, and competition is a good thing. And none of us are against competition.

But in the meantime, we have American families in dire need. We cannot wait for Utopia, and we have to make sure one of the principles—the President said American families should not go broke over health care. I think on either side of the aisle—

Mr. GONZALEZ. Dr. Reinhardt, I do want to give Dr. Feder an opportunity, and I only have a minute left. I apologize.

Ms. FEDER. I am for affordability, to finish Dr. Reinhardt's sentence, but I—and I would say that what we are talking about in terms of paying more effectively for medical care is what we are talking about. So whether it is episode-based or better rewards for primary care or refining what we do in the existing system where we are overpaying within some DRGs, we have a lot of room for improvement. And what you have put forward is that a public health insurance option can be a leader, not only in payment reform but also in managing chronic illness and promoting prevention. And we focus so heavily on fees because that is, I think, another straw man. What we need to focus on is leadership and accountability to us as an option in the health insurance system.

Mr. PALLONE. Thank you. The gentlewoman from the Virgin Islands, Ms. Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman, and I want to also thank the panelists this morning. I think the discussion will hopefully guide us through the minefield that we face trying to get to universal coverage and hopefully help us to shape a bill that we can get passed here and in the Senate and signed by the President.

My first question is to Dr. Reinhardt and to Dr. Feder. I have a little bit of discomfort around the public plan, which both of you

support as well as many others because—help me understand. Is this the same as Medicaid or different than Medicaid? Are you going to have Medicaid for the poor, and would there be a public health plan for everybody else? Wouldn't that be continuing the same kind of two-tiered system that we are trying to get away from? And shouldn't it just be one public plan that Medicaid patients would have paid for them and others pay in according to their income? Or is that what you envision anyway?

Mr. REINHARDT. Well, as a practical matter, you would probably have to go with a separate plan because Medicaid involves the state, and that system, to fuse that with a public plan, which I think would be ideal, would be very difficult because the states might object to that. And then there would be an issue of the fiscal transfers to make that possible.

Ms. FEDER. Yes, I would just say to think of a public health insurance plan not as Medicaid, but think of it as a publicly owned, publicly accountable insurance option that you would be able to choose along side private insurance options, with everyone having a guaranteed standardized set of benefits. So they would compete on their ability to deliver care efficiently. Couldn't discriminate based on health status.

And I would distinguish that from the importance of retaining Medicaid. Not only do we have statutory law that provides statutes that protect very low-income people that we should extend, I think, to all people below poverty.

But the whole body of law defined through litigation, that actually protects very low-income people. And I think to disrupt that would be a mistake.

Ms. CHRISTENSEN. It is not that I want to disrupt it. It is just that Medicaid has not been really providing the kind of outcomes that we want to see.

Ms. FEDER. Your concern—

Ms. CHRISTENSEN. But, you know, we can fix that as well.

Ms. FEDER. Your concern is well taken, and that gets to whether we are paying providers adequately to serve people. So we want to keep the protections, which, if we have it as a public health insurance plan among choices, is not going to have as generous benefits as Medicaid has.

Ms. CHRISTENSEN. And, Dr. Reinhardt, one of our people on the other panel, Dr.—Professor Baiker, I guess, spends a considerable part of her written testimony on the problem of the sick and the uninsured, which is a population group that I am particularly concerned about. We spend a lot of our time and focus on eliminating health disparities in poor racial and ethnic minorities, rural individuals, and they would be sicker and prominently among the uninsured.

And because they are sicker, bringing them into the system, Professor Baiker would say would drive up the cost of care. It drives up the cost of care now, affects the quality of care for the uninsured. So how do we insure that their high cost—because they are bringing them to make sure that they have access to care. How do we work the system so that it doesn't drive up—so that we keep insurance affordable and still provide that high level of service at

the outlet? Or should we just make the investment and not worry, you know, know that it is going to pay off in the long run?

Mr. REINHARDT. Well, I wouldn't say make the investment and not worry about it. I would say make the investment and then worry about a long-term strategy to take costs into our gun sights and really start looking at how much, for example, do we spend on administration that buys no health care that could be reduced, these Winberg variations I talked about in Medicare, and you have them in the private sector as well.

So I think cost control, we ought to be able to do this more cheaply than we are in America. Even the business roundtable says that, but you can't wait. These American families are hard pressed. They are facing a deep recession. There will be ever more of them, and to say if there is somebody who is poor and sick and now we serve them, and that will drive up cost, I would say yes, it will. But that is why you are doing it.

Ms. CHRISTENSEN. And this does not eliminate the need for focusing more on prevention or other programs to eliminate health disparities. It is part of the testimony in the other panel, and I wanted to get a response on that.

Ms. Pipes, despite your data that shows that the Canadian system may not be working as well as many purport it to be, how do you explain the 20 or 23 percent value gap? Our country is running 20 or 23 percent behind yours on the value we get for health care? How do you reconcile those two things?

Ms. PIPES. Well, I think that, you know, Canadians, a lot of Canadians come to the United States and get health care when they are on waiting lists. So I think it is very hard, when the government runs the health care system, to actually measure, you know, actual comparisons between a totally government-run system and a system that is a hybrid of a number of different types. So I think, you know, I don't know where your number comes from. But, you know, I haven't analyzed that number, and I would be interested in it.

But I will say that 250 Canadian doctors leave Canada every year to come and practice in the United States, not just for the money because they can make more money, but because they can practice the type of medicine that they are trained to practice because doctors in Canada are basically union members.

I mean Dr. Reinhardt mentioned that when you work in a province, whether you work in British Columbia, your medical association negotiates your fee with the provincial government. My cousin is a corneal transplant specialist. He hasn't had an increase in four years because the government is in a deficit situation. And so doctors, you know, it doesn't matter whether you are the best cardiac surgeon or the worst, everyone gets paid the same. And it destroys the incentive to attract the best people into health care and into medicine.

And so, you know, we want to continue to have—America has the best. People come from all over the world to get health care here. Whether it is Silvio Berlusconi coming from Italy to get a pace-maker. We need to make some changes to build on the system we have and not break it down and have a public health plan that I think will crowd out the private insurers because when you are

adding tremendous cost with guaranteed issue, community rating, and these mandates.

So I just think that universal choice will lead us to universal coverage because young people—17 million Americans earning over \$50,000 a year, two-thirds of them are young people. And they don't need every single aspect. They want insurance to be insurance for catastrophes.

Ms. CHRISTENSEN. Well—

Mr. PALLONE. Your time is over. Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman, and thanks to the panel. I would like to go back to what is driving these huge increases over the past decade in the cost of health care and recall that health insurance premiums have outpaced wage growth. From '99 to 2008, premiums grew at three times the rate of wages, and, Dr. Reinhardt, in your testimony, you said that we had seen that just over the past seven years, the average total outlay on health care for a family from all sources has nearly doubled.

And folks back home, they want to know why. It is just out of control. One easy answer has been when I go to the hospitals, that is an easy case because they say the uncompensated care, the folks that come into the ER that do not have health insurance and have chronic disease or something. That translates to them. They get that, and they understand we are—if you have private insurance, they are subsidizing part of that uncompensated care.

The hospitals in my area, in turn, have developed a clinic system with very low administrative costs. It is a partnership with the private doctors, private hospitals, and nonprofits. And it is saving everyone money. But what else is driving these astronomical increases? Lessons that we can learn moving forward as we develop this public choice option?

Mr. REINHARDT. Well, the American system is expensive because we have structured it to make the demand side weak and the supply side strong. And all the other nations that are cheaper have a strong demand side or a stronger demand side and a weaker supply side. And it is really how you apportion the market power. I mentioned that even in a large insurer like Well Point had real trouble negotiating with the Sutter Health System in California. Because it is a big system, you cannot run a health insurance plan without having that in your network. And therefore they had all the market power.

So I think it is quite clear. It is part of the reason why we have a very luxurious system overstocked. You read Med Pac. We have too many MRI machines. Canada may have too few, but everyone agrees we have too many. It is because we essentially turned over a disproportionate amount of power to the supply side of the system.

Ms. FEDER. To answer in a slightly different way, I think your constituents will have had the experience of being bumped from doctor to doctor, having tests duplicated, finding it impossible to get—being stuck in a hospital, not able to get out, seeing attempts at treatment that seem to be, not to work.

What we are lacking and what we are talking about with comparative effectiveness research is to provide an information base, real evidence. So that you don't go to what Uwe is talking about,

the supply side. You don't go to the pharmaceutical companies to find out which medication you need. You have an actual evidence base that enables you to know, enables doctors and patients to decide together on what works and what doesn't.

And we can refine our repayment mechanism so that we are actually able to encourage and reward the provision of services that work and the discouragement of services that don't. There is no mechanism for that now, and we are talking about developing that, not in a punitive way, not in an arbitrary way. In a way that enables physicians and patients to choose.

Ms. CASTOR. You know, let me ask you all this. I am starting to hear much greater concern as folks realize the astronomical salaries in the corporate sector in health care, and the HMOs are not immune to this. And I wonder if you see any analogy in what is going on in the financial system to health care. This is again a segment where the government—the taxpayers are subsidizing private HMOs, and CEOs are making a multi, multi-million dollar, we are talking about \$25 million, \$50 million per year. Is this also a factor in the high costs? Shouldn't some of this be plowed back into people's health and not paid out in these astronomical salaries?

Mr. REINHARDT. Well, if you think of the United—former United CEO who had \$1.6 billion, the bulk of that income actually came from stock options, which is taken away from shareholders and customers. So one has to be somewhat careful of how that salary is composed. If \$50 million were a salary booked into payroll expense and added to the premiums, then, of course it would be driving health care costs. But if it comes out of stock options, then it is another story, and he got \$1.6 billion simply because during his reign, the stock went up and up.

What is much more troublesome to me with private insurance is that, as an industry, I think they have not done enough to reduce the administrative cost of health care, that the amount of money they need to run the business is higher than I think it would be if they were all electronic, had a common nomenclature, common claim forms, et cetera.

The president of Johns Hopkins mentioned in a speech not long ago, he deals with 700 distinct managed care contracts, each with different terms. And so if you were to look at a Canadian—there was just a program. They were looking at a Canadian hospital and American hospitals in terms of the billing clerks. You would be shocked at the difference. That is where the real money is, not so much CEO salaries.

Ms. PIPES. Well, also I think that Dr. Ben Zyker of the Pacific Research Institute did a study comparing administrative costs of government programs versus the private sector, and there are a lot of things that aren't included in the government Medicare and Medicaid. So I think you should take a look at the study.

Ms. CASTOR. Well, that is interesting because the example of my local community that is a collaboration of the hospitals and doctors and our county government, our administrative costs are way, way low. And that has been proven out for a number—

Ms. PIPES. Well, I urge you to look—

Mr. PALLONE. We are going to have to end on this one. Sorry. Mr. Braley from Iowa.

Mr. BRALEY. Thank you, Mr. Chairman. Ms. Pipes, you have certainly been a prolific commentator on health care issues. Do you hold yourself out at this hearing as a health care policy expert?

Ms. PIPES. Yes, I am an economist by training. Grew up in Vancouver, went to college there, and was an economist at the Fraser Institute in Vancouver, and then came to the U.S. in '91.

Mr. BRALEY. One of the things that has been difficult for me to do is ascertain the extent of your educational background. Do you have any advanced degrees in economics?

Ms. PIPES. I have an honors degree in economics from the University of British Columbia, and then I joined the Fraser Institute working under Dr. Michael Walker and, you know, started out as an econometrician. I won the Canadian Crystal Ball award.

Mr. BRALEY. So the answer to my question would be no, correct?

Ms. PIPES. No, I have an honors BA in economics but have worked in the economic research field for—

Mr. BRALEY. And you don't have a masters or Ph.D. in health care policy?

Ms. PIPES. No, I don't.

Mr. BRALEY. Or in public policy as a general concept?

Ms. PIPES. No, but I have worked in the field.

Mr. BRALEY. All right, on the Web site for the Pacific Research Institute, you are identified in your individual bio as a scholar. Are you aware of that?

Ms. PIPES. Yes, I am a scholar. I write a lot on health care. I write books—

Mr. BRALEY. Have you published any scholarly treatises in a peer-reviewed journal of economics on health care policy?

Ms. PIPES. Yes.

Mr. BRALEY. And can you give us some examples?

Ms. PIPES. I have done some things in "Health Affairs" over the past, and in—

Mr. BRALEY. But can you just identify the scholarly journal that is a peer review journal of that kind?

Ms. PIPES. Right, well "Health Affairs" is, I think. I don't know whether you would say it is but—

Mr. REINHARDT. It is peer reviewed.

Mr. BRALEY. All right, and do you have a CV or resume that you use for your official purposes?

Ms. PIPES. Well, I use what we have on our Web site. I don't—I mean I have one in my desk from when I got my job in 1991. I don't keep it up to date, but I could—

Mr. BRALEY. I mean do you have a listing of your publications, a listing of your appearances? Some people do this as a way to—

Ms. PIPES. Right, and if you—

Mr. BRALEY [continuing]. Let people that they are speaking before know what the content of their background and expertise is. Do you have such a listing—

Ms. PIPES. Yes, and if—

Mr. BRALEY [continuing]. That you could provide to the committee?

Ms. PIPES. You will see that I write for the "Wall Street Journal" and the—

Mr. BRALEY. Just please answer my question. I don't have much time.

Ms. PIPES. Sure.

Mr. BRALEY. Could you provide that to the committee?

Ms. PIPES. Of course, yes. So you can—

Mr. BRALEY. OK. Now, one of the things you asked about or you raised in the conclusion of your opening remarks was the need for medical malpractice reform. Do you remember that?

Ms. PIPES. Yes.

Mr. BRALEY. I am sure you are aware that the Institutes of Medicine has done a series of three important studies dealing with the issue of preventable medical errors and the cost that they contribute to the overall health care economy of this country. The seminal work was the first work in 2000 "To Err is Human," and in that report, the Institutes of Medicine concluded that "preventable adverse events are a leading cause of death in the United States. The results of the study imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors. Deaths due to preventable adverse events exceeds the death attributable to motor vehicle accidents, breast cancer, or AIDS."

That was then followed by another seminal study "Patient Safety" also from the IOM, and in that study, they included the finding that the committee strongly believes that patient safety is indistinguishable from the delivery of quality care. A new delivery system must be built to achieve substantial improvement in patient safety. A system that is capable of preventing errors from occurring in the first place while at the same time incorporating lessons learned from any errors that do occur.

And then we had the important 2006 study from the Institutes of Medicine "Preventing Medication Errors" which concluded that medication errors are surprisingly common and costly to the nation. The committee concludes there are at least 1.5 million preventable adverse drug events that occur in the United States each year. The true number may be much higher. And they issued a conservative estimate that these adverse drug events cost our economy, at minimum, \$3.5 billion a year.

So what I am wondering is why when we talk about reforming our health care system don't people who come from your point of view come to the committee and talk about constructive ways we are going to reduce preventable medical errors, which we all know are the most dramatic way that we can reduce the cost of medical malpractice in this country?

Ms. PIPES. Well, I think you should look at some of the work done by Dr. Betsy McCoy, who has done work on infectious diseases and shows that more people die in hospitals from infectious diseases by a major part compared to medical errors. So I think that is important.

Mr. BRALEY. Well, let us talk about that though because are you familiar with the Joint Commission on Accreditation of Health Care Associations?

Ms. PIPES. Yes.

Mr. BRALEY. And are you familiar with their Sentinel Event Program?

Ms. PIPES. Right.

Mr. BRALEY. Do you know that in the first 10 years the Sentinel Event Program was in place over a 10-year period, only 3,000 sentinel event reports were filed with JACO, which is astonishing considering the incidents of preventable medical errors that resulted in deaths only, not serious injuries, when those numbers would suggest that they should have been receiving 44,000 to 98,000 reports at a minimum. So isn't it clear that the system of accountability that we currently use is completely failing American health consumers in making a more safe system?

Ms. PIPES. Well, I think all doctors are interested in people living longer and healthier lives. And, as I say, more people are dying from infectious diseases in hospitals than from medical errors. Unfortunately—

Mr. BRALEY. Well, I would disagree with that characterization because most people would tell you, who study this issue, that one of the most preventable forms of an adverse event in a hospital setting is nosocomial infection. And in fact, there has been a lot of research that indicates that, despite overwhelming evidence from medical economists, hospitals are reluctant to move to a business model that will allow them to reduce the incidents of nosocomial infections. So I disagree with your characterization that a nosocomial infection is not a preventable medical error.

Ms. PIPES. No, I—

Mr. PALLONE. All right, I am going to let you—

Ms. PIPES. I see that you—

Mr. PALLONE. Ms. Peeps—Pipes. Sorry. I would like you to respond, and then we have to end because we are over a minute.

Ms. PIPES. Right. No, I agree with you. We want to get infectious diseases in hospitals down because they are a tremendous problem and hardship. And on the medical malpractice reform, when they capped the noneconomic damage awards in Texas at \$250,000, a lot of docs who had left, OB/GYNs and neurosurgeons are now coming back into Texas because there is an environment there where doctors want to practice medicine.

We have seen in states like Pennsylvania and Nevada where a lot of OB/GYNs and neurosurgeons have left the practice of medicine because the cost of their med now is so expensive that it is not profitable for them to practice medicine.

Mr. PALLONE. Thank you. Next is Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. Professor Reinhardt, I enjoyed some of the points made in the end of your written testimony that you weren't able to make in your more abbreviated oral testimony. One of the things that I am interested in is the role—well, first your comment. You call it the electronic farmers' market. I think we are used to calling it the exchange or connector. But that that entity would have to be empowered with regulatory powers to supervise and enforce the reputability of the products being offered.

We have also had a lot of comments about having the inclusion of a public option, and, in fact, Dr. Feder said a public system—I think I am quoting accurately—a public system can keep the private system honest. So I would like to hear your take on the interplay between the regulatory powers that are going to be necessary

and having a public sector option sort of perhaps substituting for that or at least enhancing it.

Mr. REINHARDT. Well, if you want to have any market, no matter what it is, it has to be regulated. And we now find out, to our great dismay, that the market-for-credit default swaps also should have been regulated. So you need that, and in health care, with the insurance industry, it is still the Wild West in many ways when you come to the individual market. That is not true for the employment-based system.

So you do need to be sure that these policies don't have fine print that ultimately leave you uninsured rather than insured. So you need regulation there.

You then have to make a decision if you want community rating or not. If you say we allow medical underwriting, then the subsidies you give people have to be tailored to the health status, which is difficult to do. So I think such a body would, by nature have to be regulatory, endowed with the power to regulate, or it goes back to government.

Ms. BALDWIN. Dr. Feder, you address as, I think, your fourth point that you gave as take-home points that we have to stop discriminating against sick people in coverage. I want to hear your take on whether the high-risk pools that have been available as a tool to cover sicker populations, have then been a success story, a failure, somewhere in between? What is your take on that?

Ms. FEDER. Congressman Baldwin, my colleague Karen Pollitz, will be testifying on the next panel, and I will be drawing insufficiently on her expertise in answering the question. I think high-risk pools are problematic. One, they pull off people from the rest of the system, and I think we would be better pooling risk everybody together.

Second, they have been completely inadequately funded. Charge the people who are high risk high rates so that many people who are sick can't get into the high risk pool.

Third, as I understand it, they impose pre-existing condition exclusions on people who are sick or high risk, which I am laughing because that boggles the mind. So it is possibly true that adequately funded with good rules may all come together, and I urge you to ask Karen to tell you that. But as it has been treated, it is not a substitute for a well-regulated insurance market that everybody gets to choose a plan regardless of health status.

Ms. PIPES. In some states, the high-risk pools work better than in others depending on funding.

Ms. BALDWIN. Mr. Chairman, I yield back the remainder of time.

Mr. PALLONE. Thank you. The gentleman from Connecticut, Mr. Murphy.

Mr. MURPHY OF CONNECTICUT. Thank you very much, Mr. Chairman. Ms. Pipes, I want to go back to this issue of wait times for a moment. I think we spent a little too much time obsessing over one system, the Canadian system, given the number of other examples.

But one of the statistics that is often used is wait times for specific surgeries like hip replacements and knee replacements. And there certainly are longer waiting times in Canada for those procedures. For knee replacements, I think it is about three weeks. In

Canada—about eight weeks in Canada, about three weeks in the United States.

But what gets lost is that the payer for those surgeries in the United States is the government most often. 71, 70 years old is the average age for a knee replacement surgery. And in the United States, Medicare seems to do a pretty decent job at moving those people through the system and getting care at a more expedient rate than Canada does.

And so I guess it is a way of asking this question. You sort of in your remarks seemed to suggest that just an inherent flaw of a government system is longer wait time. But it seems that our experience with Medicare is that if you put the money behind the program, if you make the choice to get people care faster, then a public system or a public plan could work just as well as a private plan could.

So do you think that it is inherent in a public versus private dichotomy, or do you think that if you choose to spend the money and get the provider network and get the wait times down that you could get wait times down in a public plan?

Ms. PIPES. Well, in Canada, you could reduce the waiting times by putting more and more taxpayer dollars into the health care system. The problem is that Canadians are taxed at a much higher rate than Americans, and the government feels that where they are now they are taxed enough.

And, you know, I did work at the Fraser Institute in my early years called Tax Facts where we developed a Canadian consumer tax index and compared the levels of tax in Canada versus the United States. And work, on average, two months longer because we have a lot more government in our lives in Canada.

So, you know, in the case of my mother who needed a hip replacement, and she was a senior, she waited two years to get a knee replacement. And when they replaced it, they replaced it with a plastic knee because they said their actuarial records showed that at her age she would only live for five years and therefore the plastic knee was more efficient and more cost efficient—cost effective. But, you know, she lived eight years longer, and she was in severe pain.

So, you know, this is how Canada, you know, controls costs, and people don't have access to Pap smears on a regular basis or PSA tests and things. We have a lot of prevention in this country, but these things are more expensive. But we have to decide in this country, you know, if you want a lot more government in your health care, you are probably going to end up rationing care because as we have seen in Massachusetts, the cost of being a lot more than what the original estimates were.

Mr. MURPHY OF CONNECTICUT. You know I think we both use anecdotes on both sides of this debate, but I would say that your testimony has been peppered with stories about Canadian health care experience. And I am just looking at the data on knee replacement surgeries that just don't back up that type of timeframe. And I do agree with you that it is a matter of choosing to invest in the system. I mean no one is talking about a United States health care reform proposal ratcheting down the percentage of GDP to what Canada spends today.

You know, we would love to control costs, but we are not going to spend as much as Canada does, and we are going to hopefully get a little bit more than they do, which brings me to a question for Dr. Reinhardt.

In your testimony, one of the things you talked about was the relative ineffectiveness of the private insurance system to get a handle on the cost of care in this country. And that has been a vexing question for me for years. The private sector health care system has obviously immediate incentives to bring down the cost of care because it increases value for the company for its shareholders and doesn't have the burden that some government systems does of having to go through a regulatory process to try to change behavior. And yet we don't have private insurers investing in simple, preventative procedures and costs that could bring down care.

Why do you think that our private health care insurance system in this country isn't doing as good a job as it could controlling costs and investing in prevention?

Mr. REINHARDT. I think that is an extremely interesting question because in the '80s, a lot of us, myself, thought the HMOs actually could do exactly what you said. And there were proposals to make Medicare into a defined contribution plan because there was talk that an HMO, well-run private plan, could do the same thing Medicare does much cheaper. Sometimes even people said 25 percent.

So then we gave them 95 percent of the average actuarial per capita cost and said that is very generous. They should be able to shoot fish in a barrel, given Medicare is so inefficient as everyone said. But they couldn't. As you know, in the '90s, they all pulled out, and the only way they seem to have made it work is to get that 14 percent extra.

I find that very disappointing as an economist that the private market that I usually believe in somehow failed us here. Why are there not more efficient? Why, for example, given Florida is a lot more expensive for Medicare than, say, Iowa would be, why wouldn't HMOs thrive in Florida managing care? I don't think they have proven yet that they can do it.

I hope some day they can, but so far they have not, and it is a very intriguing question why they have not been able to reduce costs. And in the early decade, you know, premiums went up 14, 15 percent, and I always said it is stunning. Medicare has nothing like these increases, and yet the private sector came with these increases.

Mr. PALLONE. We have to move on.

Mr. MURPHY of Connecticut. Thank you, Mr. Chairman.

Mr. PALLONE. Gentleman from New York, Mr. Weiner.

Mr. WEINER. Thank you, Mr. Chairman. I think to some degree this discussion about public versus private plans I think might be too—I mean it is too binary a way to look at it. What does Congress have? I mean it has a private plan, right. But we aggregate our many employees. We offer a phone book not dissimilar to the size of Mr. Shadegg's visual aide there of different options, of different prices, of different types of service. What does the panel think Congress has in the language of this discussion?

Ms. FEDER. You can argue that what Congress is an example of a connector in the federal employees health benefit plan, and for

purposes of disclosure, I am the wife of a federal retiree. So I have it too. And we choose, from those of us who have it, from a set of private health insurance plans. So what is being talked about is talking about adding a public health insurance plan to that menu.

Mr. WEINER. And, Ms. Pipes, would you too characterize what Congress has as a private model in the way you have described it?

Ms. PIPES. Well, the federal employees health benefit plan, of course, is part of the government, but they have private plans within that. And my understanding is that the Blue Cross sort of traditional plan still costs members of Congress about \$400 a month because I think the plan is about \$1,200 a month. And it—

Mr. WEINER. Right, but—forgive me for interrupting. But mightn't there be—I mean, look, I think we have a political imperative, and as we try to work this out is to try to take that large percentage of American citizens who have health insurance that they are satisfied with that would like to pay less would keep them invested in this discussion. It is important that they be involved.

But I also think that this notion that government involvement, the moment it touches this, creates a problem. And letting everyone go out and deal with this problem on their own, as Mr. Shadegg and you have suggested, goes too far in the other extreme.

For example, you know, what if you aggregated a whole bunch of businesses that were on their own not able to shop very competitively for health insurance plans, but you as the government, we as the government said you know what? We are going to take 100,000 employees of small businesses in New York City, and we are going to go out and we are going to put a book together of different insurance plans who now knowing they are getting 100,000 customers.

And we are also going to do a couple of other things. We are going to say you can't exclude people because they have pre-existing conditions. There are certain minimum standards you need to have and the like. You are then kind of taking a little bit of the private model, a little bit of the public model, a little from column A and column B. Would you find that offensive to your notion that the government should not be involved in this?

Ms. PIPES. Well, you know I was a very big support of association health plans, which would have allowed, under a lot of smaller businesses to group together and then go into the market and negotiate better rates. So I am a big fan of, you know, small business needs, you know—

Mr. WEINER. So you would be fine with government putting its finger on the scale, having standards, having regulations, requiring certain coverage and the like, so long as the people writing the checks to the doctors were private insurance companies rather than government?

Ms. PIPES. Right, and I think we have seen, you know, New York has community rating, guaranteed issue. New York and New Jersey have some of the most expensive insurance plans because of those. I would prefer to see some of the mandates and things like that removed.

I mean if you want to get a plan that has community—

Mr. WEINER. Yes, I understand that. I just have a moment more. Dr. Reinhardt, can I ask you a question that touched on what Mr.

Murphy concluded with? Do you think that insurance companies in the present model intentionally do things to make money on the float? Do you think the reason there are six major insurance companies that have six different forms, for example, is an example of them trying to build in inefficiencies that benefit their bottom line but make reimbursement slower, make it more difficult for doctors, more difficult for patients to navigate? Do you think they are trying to find ways—I mean are they not incentivized by a different set of impairments than perhaps Medicaid is? Maybe that is why the inefficiencies remain.

I mean you go into a hospital administrator's office or a—and you sit literally inboxes and outboxes for all the different insurance companies because, despite the fact that they are asking for the same information, they intentionally keep that inefficiency in the system because they make money on it?

Mr. REINHARDT. Well, I think if interest rates, short-term rates were 8, 9 percent, I think you have a point there. In fact, I teach a course in financial management, and that was one of my lecture notes, how much you could make off the float by just dragging out payment.

But with low interest rates such as we have had, I think it would be unprofitable—

Mr. WEINER. No, I was thinking more of the structure, the way the industry has structured itself to have these inefficiencies, not just for the moment. Do you think that is why it evolved to be so inefficient and so lumbering very often is because they make money on that? When you were giving that class in 2003 or '04, what were you—well, maybe that was too early. 2005, what were you saying?

Mr. REINHARDT. Well, I mean there was definitely—I took a health plan in New York and showed that basically they made most of their money on the float, which is, of course, not necessarily dishonest. That is part of an insurance industry's source of income is to make money on the float.

What was questionable is did they deliberately drag out payment so that they could make more money on the float? And that is easily fixed by saying if you don't pay within 30 days, you will pay an interest rate. Just like in any trade credit in business, you could say you pay within 30 days, that is fine. If you drag it out longer, you have to pay the hospital one percent per month you drag it out. That would solve the problem, which is, in fact, what my class and I concluded could be done.

Mr. WEINER. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Waxman.

Mr. WAXMAN. Well, thank you very much, Mr. Chairman. I have been listening to the discussion. I had to miss some of the earlier presentations, but I think this has been an excellent panel.

Dr. Reinhardt, you have indicated you think that whatever we do, employer-sponsored insurance is shrinking, and it will continue to shrink. And that this may be a good time for us to develop an alternative for people, an alternative based on a reformed individual market, a public insurance program, or both. That has been the basis of a lot of the discussion and debate.

But I want to ask you what should a health reform bill do to make sure that health care coverage is affordable for those who no longer have access to employer-sponsored coverage? Should we look at the amount of money that people pay out of their income for health? Should we try to say that—not just look at the premium but all the out-of-pocket costs and then say that people shouldn't have to pay more than 10 percent, 7 percent plus or more of their income?

Mr. REINHARDT. I think, Chairman Waxman, that would be the way to go. You have to focus on total health spending, not just premium, and then relate it to the ability of the family to pay for that. And that, in some way, is an ethical political decision where you put those numbers. If you were to say somebody making less than \$25,000, what should that percentage be? I personally feel 5 percent would stretch them already. While, as I said earlier, if it were someone like me, if you set that at 12 percent, I wouldn't cheer, but I think I could eat it. I could manage that, and it would be fine.

In the short run, bringing more people under insurance will cost money because they are consuming less than half what insured people get. So we would have to top it off, and the estimates are—some are \$120 billion to \$150 billion a year if you want really full coverage.

But in the longer run, I do believe we can make health care in America a lot cheaper by doing the kind of cost containment candidates from both sides of the aisle had. Senator McCain also had ideas about cost containment, but they take longer to do.

Mr. WAXMAN. Would you put a limit on the out-of-pocket expenses at let us say for low-income people, 5 percent of income? Would that make sense given the cost of food, rent, transportation? Would you try to figure out some kind of limit for those who have insurance and how much they will to pay out of pocket?

Mr. REINHARDT. I would absolutely try to figure out a limit. Now, I am shooting off the hip. I said 5 percent might even stretch people. I always wonder, as someone on the upper strata of the income distribution, I wonder how people on \$25,000 family income make it. You know, I used to be there. I grew up poor, but I forgot. So I think it is quite conceivable that 3 percent would stretch them. One would really have to budget this out, and that may be a good research project for Judy Feder to figure out. That is what you do.

Ms. FEDER. Why, thank you.

Mr. WAXMAN. Right, in her spare time.

Mr. REINHARDT. I mean obviously you can list what families need to spend on the basics.

Mr. WAXMAN. Ms. Pipes, what do you think about that? Do you think there ought to be some limit on how much people have to pay for their health care?

Ms. PIPES. Well, you know, we have—people at \$25,000 are obviously on Medicaid. And we have now an expanded state children's health insurance plan. So we have a lot of government. I would like to see, as I have said, open up the market and, you know, change the employer-based system. Allow it to still be there, but if you tax the employer benefits and then provide a refundable tax credit for those who go—for those people. And also then I think we would see

then individual market expand, and we would see new competition, new insurers. And we would—

Mr. WAXMAN. Well, let us say we don't get what we want and people still, to get adequate insurance coverage for their health needs, have to pay so much out of pocket. Should we just assume that they just made a deal that didn't work out for them and let it go?

Ms. PIPES. Well, if you look at Massachusetts, which had the individual employer mandate in their Romney care plan in 2006, I mean even after, you know, the Commonwealth Care and the subsidized and free plans, you still saw that 20 percent of the people in the first year that should have bought insurance were excluded because the premiums were still too expensive. So it is very difficult for me. I don't know what the ideal number is, but—

Mr. WAXMAN. With the few seconds I have, I did want to ask you one other question.

What would you think of the idea—and Mr. Weiner was sort of hinting at this—that people go to a connector and buy a private insurance policy, but the connector would be like the federal employees' benefit package where you have, in effect, a lot of private choices that are group plans so you eliminate the discrimination and all of that.

What would you think of that kind of a connector to private plans—

Ms. PIPES. Well, I would—

Mr. WAXMAN [continuing]. Private insurance plans.

Ms. PIPES. Yes, I would support a connector if it was totally private, but when you have government politicians or government bureaucrats determining, you know, what has to be on the insurance plan in the connector, then often I see price going up. And it becomes more difficult. So I would support a totally private connector, but I am not in support of a national insurance exchange such as President Obama has been talking about because I see the controls that would be set by government being—causing—

Mr. WAXMAN. So you don't see that working? Dr. Feder, if we had that ability for people to go a connector and buy a private insurance plan, do you think it could work like the federal employees? And do you think you need a public option to provide some tension to keep the private insurance plans affordable and all of that?

Ms. FEDER. I think the combination is ideal. I think what we are looking for is we can think of it as a public choice plan. That essentially we create a place, as you say, where people are able to buy group insurance without discrimination based on health status. But to do that alone without a public health insurance option, we have not seen great competition, whether in the federal health employees' plan or any other. So that having the public health insurance option, as I said earlier, can make the whole market work more effectively because we can hold it accountable for delivering good benefits, delivering good care, and essentially working to negotiate good rates with providers.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Waxman. And I think all of our members have asked questions, so I really want to thank you.

This was a great panel. It was really thought provoking in terms of our efforts to draft legislation and address the whole issue of health care reform. So thank you very much. We appreciate it.

Ms. PIPES. Thank you.

Ms. FEDER. Thank you.

Mr. PALLONE. And I would ask the next panel to come forward. Thank you all for being here. And let me introduce each of you starting on the left, and I hope I get the names right. First, is it Mila Kofman? Mila Kofman who is superintendent of insurance for the State of Maine Bureau of Insurance. Then we have Dr. Jon Kingsdale, who is executive director of the Commonwealth Health Insurance Connector Authority. And then we have Karen Pollitz who two Ls, not three. Your name tag has three Ls. Karen Pollitz, who is research professor at Georgetown University Health Policy Institute. And then we have Dr. Katherine Baicker, who is professor of health economics at the Harvard School of Public Health. And finally Edmund Haislmaier.

Mr. HAISLMAIER. Haislmaier.

Mr. PALLONE. Haislmaier.

Mr. HAISLMAIER. Thank you.

Mr. PALLONE. Who is senior research fellow at the Center for Health Policy Studies with the Heritage Foundation. Thank you all for being here. I know some of you have actually been here since the beginning, which is, I am sure, been difficult.

But in any case, we will have statements from each of you, about 5 minutes each, starting with Ms. Kofman.

STATEMENTS OF MILA KOFMAN, J.D., SUPERINTENDENT OF INSURANCE, STATE OF MAINE BUREAU OF INSURANCE; JON KINGSDALE, PH.D., EXECUTIVE DIRECTOR, COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY; KAREN POLLITZ, M.P.P., RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE; KATHERINE BAICKER, PH.D., PROFESSOR OF HEALTH ECONOMICS, HARVARD SCHOOL OF PUBLIC HEALTH; AND EDMUND F. HAISLMAIER, B.A., SENIOR RESEARCH FELLOW, CENTER FOR HEALTH POLICY STUDIES WITH THE HERITAGE FOUNDATION

STATEMENT OF MILA KOFMAN

Ms. KOFMAN. Good afternoon, Mr. Chairman. I thank you and the committee for your leadership and willingness to address the health care crisis in America. It is both an honor and a privilege to be here before you to testify on this matter. I did submit a written statement, and I ask that the full written statement be admitted as part of the record.

Mr. PALLONE. And that will be the case for each of you. We will enter your full written statement in the record.

Ms. KOFMAN. Thank you. My name is Mila Kofman. I am the superintendent of insurance in Maine. My agency serves and protects the public through regulation and oversight of the insurance industry. It is my job to ensure that insurance companies keep their promises. My views about reforms and the private market have also been informed by my experience as a federal regulator and

through my research on private health insurance as an associate professor at Georgetown.

I believe it would be optimal for us to address the health care crisis in America in its entirety and for the federal government to ensure that all Americans have access to affordable, adequate and secure health coverage.

We live in the wealthiest nation in the world, yet we allow 18,000 Americans to die preventable deaths each year on our soil, not overseas but here. The uninsured problem is estimated to cost our economy as much as \$130 billion annually.

Maine has been at the forefront of reforms, developing innovative initiatives to help finance medical care. Governor Baldacci has been a leader in establishing meaningful new health coverage options for individuals and small businesses, coverage that actually works for people when they are sick.

Today I will discuss the types of problems I am not seeing because of the insurance reforms we have in Maine. First, it is important to remember that the private market is not a free market where purchasers have meaningful options. A free market assumes that everyone who wants to buy a product can choose among sellers competing for their business.

Insurance companies do not compete to insure sick people. Insurance companies do not compete to insure sick people. An insurance company's success depends on its ability to minimize its risk. This provides incentives to cherry pick healthy people and limit the number of unhealthy. It creates a private market from which many Americans are shut out. Even minor conditions like an allergy could be the basis for not selling you a policy.

Also in most states, insurers are allowed to charge higher rates for people with medical needs. This includes charging small businesses with sicker workers higher rates than small businesses with healthy workers.

Maine is one of five states, in addition to New Jersey, Massachusetts, New York, and Vermont, that prohibits discrimination against individuals. We do this through guaranteed issue and adjusted community rating laws. Guarantee issue laws prohibit insurers from turning you down because of your health. Adjusted community rating laws prohibit insurers from charging sicker people higher rates.

In addition to allowing people with medical needs to access private coverage, the combination of guaranteed issue and adjusted community rating laws has protected Maine consumers from some of the problems experienced by consumers and small businesses in other states.

For example, we do not have rescissions, the problem that Chairman Waxman examined extensively as chairman of the oversight committee last year. This is a problem of having your policy retroactively cancelled and being responsible for all the claims paid while you had the policy. Rescissions leave people on the hook for their medical bills and uninsurable, completely shut out of the private market.

In Maine, a consumer does not fear losing his or her insurance because he or she may have completed the application for insurance incorrectly by mistake. In other states, consumers reported

having their policies cancelled retroactively for forgetting to report seeing a marriage counselor years before. In Maine, because insurers are not allowed to consider current or past medical needs in the first place when selling or pricing a policy, we have not had a problem with rescissions.

We do have a problem, however, with affordability. The health care crisis is like a slow disease slowly killing off the middle class. It is a huge burden on employers of all sizes, on workers, and families. Health insurance premiums are expensive because medical care is expensive. The private health care financing system has not effectively switched its focus and incentives from paying for sick care to promoting wellness. The current system rewards inefficiency. Carriers have not been able to negotiate effectively enough with providers to keep costs contained.

Many factors contribute to the price of coverage. That includes the cost of medical care, administrative costs, and profits. Since 2002, our state's largest insurer has declared nearly \$152 million in dividends.

As far as next steps, there is a strong and appropriate role for federal policy makers. Americans need and demand meaningful health insurance coverage options to access and pay for necessary, and in many cases, life-saving medical care and services. Working together, the federal government and the states, we can address the health care crisis facing our nation's employers, workers, and families.

I encourage you to build upon the foundation that you established in 1996 through HIPAA, a federal floor of protections, recognizing that states have and should be allowed to create and enforce higher levels of consumer protections as their populations need.

In addition to improving and having strong protections, it is equally important to have strong regulators to enforce the law. State regulators have a long history of effectively protecting insurance consumers. I encourage you not to duplicate or replace the existing effective state-based insurance oversight system. Thank you, and I look forward to assisting you as you move forward in addressing the health crisis.

[The prepared statement of Ms. Kofman follows:]

**Testimony of Mila Kofman, J.D.
Superintendent of Insurance
State of Maine**

**Before the
U.S. House of Representatives
Committee on Energy and Commerce Subcommittee on Health
March 17, 2009**

Good morning. My name is Mila Kofman and I am the Superintendent of Insurance for the State of Maine. Mr. Chairman, I thank you and the Committee for your leadership and willingness to examine the private health insurance market. It is both an honor and a privilege to testify before you on this matter.

By way of background, I lead the State of Maine agency which serves and protects the public through regulation and oversight of the insurance industry. My views about reforms and the private market have also been informed by my experience as a federal regulator at the U.S. Department of Labor (EBSA - ERISA health plans) and through my research on private health insurance as an associate professor at Georgetown University.

I believe it would be optimal for us to address the health care crisis in America in its entirety and for the federal government to ensure that every American has the same basic rights and protections related to health care no matter where one lives or works. Maine and other states have been at the forefront of health care reform, developing innovative new initiatives to help finance medical care, and to restructure the private and public insurance programs to cover more people. In Maine, Governor Baldacci has been a leader in establishing meaningful new health coverage options for small groups and individuals – coverage that actually works for people when they are sick.

Maine's Dirigo Health Reform Act of 2003 was intended to deal with systemwide issues of cost, access and quality. The DirigoChoice insurance product – a public/private partnership between the State of Maine and a private insurance company – was designed to be a bridge for people who are not eligible for Medicaid and who cannot afford private insurance coverage, and it is for both individuals and small businesses.

Despite such efforts by Maine and other states, 47 million Americans have no health coverage and millions more have inadequate coverage. The leading cause of personal bankruptcies in the United States is illness (the majority of those filing for bankruptcy were insured).¹

Moreover, the uninsured problem and the way we finance medical care handicaps American businesses in a global economy. The widespread lack of adequate health coverage is estimated to cost our economy \$60 billion to \$130 billion annually.² Even though our spending on health care is higher than Germany, Canada, France, Australia, and the United Kingdom (UK), both per person and as a percentage of GDP, we have worse health outcomes: Americans report more problems with access to care than in the UK and Canada; in terms of life expectancy we rank lower than Japan, France, Australia, Canada, Germany, New Zealand, the Netherlands, and the UK.³

A great deal of national attention has been focused on our current health insurance system in this time of economic crisis. This morning, I will discuss the types of problems I am not seeing because of the insurance reforms we have in Maine. I will also describe one of the biggest problems I am seeing with the private health insurance market – affordability.

Guaranteed Issue and Adjusted Community Rating

The reality of the health insurance market is that a carrier's success depends on its ability to minimize its risk. This means that each company is better off if it only insures people who will not need medical care. This provides incentives to cherry-pick healthy people, and limit the number of unhealthy people covered. An estimated 20% of people account for 80% of health care spending.⁴ Avoiding even a small number of high cost individuals can substantially reduce an insurer's losses.⁵ While the desire of insurance companies to reduce risk is rational from a free market perspective, it creates a market which many Americans cannot access. No one competes to insure sick people.

In the private health insurance market, insurers adopt practices that seek to minimize their risk of loss, including denying coverage for applicants who have health conditions or a history of health problems. People have had insurance applications rejected for such commonplace ailments as hay fever.⁶ In most states, insurers are allowed to charge higher rates for individual market policies based on one's health.⁷ Even if a person with less-than-perfect health passes medical underwriting and can afford being surcharged for having past or current medical needs, their conditions may not be covered (e.g., permanently excluded through a rider or temporarily excluded through a pre-existing condition exclusion period).

Furthermore, although state and federal laws give individuals the right to renew coverage once they have bought it, guaranteed renewability provides no protection against rate increases – people who want to go out and shop other companies need to go through the full underwriting process all over again. In the group insurance market, state and federal laws require coverage to be available to all small businesses, but in many states, insurers are allowed to charge higher rates to small businesses whose workers have medical needs.

Since 1993, Maine has prohibited these practices. Insurers are required to sell coverage to any individual or small business that wants to purchase it. Called "guaranteed issue," this consumer protection law prohibits insurers from denying coverage because a person has a medical condition, now or in the past.

In Maine we also have adjusted community rating.⁸ Adjusted community rating is the requirement that insurers set prices for policies based on the collective claims experience of everyone with such a policy. In other words, insurers are not allowed to discriminate against individuals with past or current medical needs. They are not allowed to charge sicker people higher rates. Rate variations are allowed for such factors as age and geography within limits. These protections also apply to small groups. Businesses with sicker workers are not penalized by higher rates because they employ workers with health needs.

In addition to allowing people with medical needs into the private health insurance market, the combination of guaranteed access and adjusted community rating laws has protected Maine consumers from some of the problems experienced by consumers and small businesses in other

states. For instance, we do not have “rescissions” – the problem Chairman Waxman examined extensively as Chairman of the Oversight Committee. In Maine a consumer does not fear losing his or her insurance because he or she may have accidentally completed the application form improperly. People in other states have reported losing their insurance as a result of failing to remember and to indicate on the application such events as: seeing a marriage counselor years before, having been prescribed anti-depression medications after having a child, and for misinterpreting the question “have you had a headache” as meaning having serious on-going headaches. In Maine, because insurers are not allowed to consider this information in the first place when selling or pricing a policy, we have not had this problem.

Affordability

Premiums in both the individual and group markets have escalated rapidly, far outpacing increases in wages. Many individuals and businesses can no longer afford the prices charged. Those with insurance choose higher deductible policies in order to keep their premiums lower. As of 2006, approximately 72% of policies in Maine’s individual market had deductibles of \$5,000 or higher and the average deductible was approximately \$7,000.⁹ The annual family premium for a major medical plan in the individual market with a \$5,000 deductible is \$9,919.32.¹⁰

Health insurance premiums are expensive because medical care is expensive. The private health care financing system has not effectively switched its focus and incentives from paying for sick-care to promoting wellness. The current system rewards inefficiency. Carriers have not been able to negotiate effectively enough with providers to keep costs contained.

Many factors contribute to the price of coverage. The price for private health insurance generally reflects the cost of medical care, administrative costs, and profits.

- In Maine, between 1997 and 2007, medical expenses paid by HMOs each month increased from \$125 per member to over \$300; nearly \$250 of the 2007 cost is for hospital/medical care.¹¹ Anthem Health Plans of Maine, the state’s largest health carrier, saw its non-HMO per member per month medical expenses increase from \$160 in 2001 (the earliest year that data is available) to \$221 in 2007.¹²
- Administrative expenses among Maine’s HMOs increased from approximately \$22 per member per month in 1997 to \$26 in 2007.¹³ Anthem’s non-HMO administrative expenses rose from \$8 per member per month in 2001 to \$20 in 2007.
- Since 2006, Anthem has declared nearly \$152 million in dividends (reflecting profits for all its business in Maine -- individual, small group, and large group markets).¹⁴

Next Steps

There is a strong and appropriate role for federal policymakers. Americans need and demand meaningful health insurance coverage options to access and pay for necessary -- in many cases lifesaving -- medical care and services. Working with the states, together we can address the health care crisis facing our nation’s employers, workers, and families.

I encourage you to build upon the foundation that you established in 1996 through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA established a floor of consumer protections including guaranteed access requirements for small business, nondiscrimination protections and portability for workers and their families. Those same consumer protections should be extended to the individual market. All Americans deserve the same rights and

protections, whether they have health insurance coverage through their employers or buy it themselves in the individual market. Federal reforms should be modeled on HIPAA – a federal floor recognizing that states have and should be allowed to create and enforce higher levels of consumer protections as their populations demand. The federal government could:

- Prohibit discrimination against people with medical needs. Guaranteed access and adjusted community rating must be basic consumer protections for all Americans, no matter where they live. Rate protections should also be extended to small group coverage.
- Establish standards for individual “health insurance” – the label of “health insurance” is applied to policies that cover little and leave people exposed to significant financial out of pocket expenses, as well as limited or no access to needed medical care.
- Help people pay for meaningful health insurance coverage.
- Make a federal financial commitment to states to help fund expansion programs and develop strategies for system-wide changes to address medical cost drivers.

It is equally important to have watchdogs in place to ensure that consumer protections are being enforced. State regulators already have the people and infrastructure to serve as effective watchdogs. States routinely police insurance companies through market conduct exams and rate and form filing reviews. State insurance investigators provide critical intelligence, identifying areas in which carriers are not complying with the law. I encourage you not to duplicate or replace the existing, effective state-based insurance oversight.

Thank you for your consideration of this important issue. I look forward to assisting you as you look for ways to address the health care crisis, the ever growing problem faced by millions of Americans without adequate coverage, and the rising costs. I hope that you will create new meaningful options to provide access to affordable, adequate and secure health insurance coverage for all Americans.

¹ David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, “Illness and Injury as Contributors to Bankruptcy” Health Affairs Web Exclusive February 2005. Many insured debtors blamed high copayments and deductibles for their financial ruin.

² Press Release, January 14, 2004, “IOM Report Calls for Universal Health Coverage by 2010: Offers Principles to Judge, Compare Proposed Solutions,” available at www.nationalacademies.org/opinews/newsitem.aspx?RecordID=10874.

³ Commonwealth Fund charts, “Spending on Health, 1980-2004” (Data source: OECD Health Data 2005 and 2006) and “Access Problems Because of Care in Five Countries, 2004”, available at www.cmf.org.

⁴ Marc Berk and Alan Monheit, “The Concentration of Health Care Expenditures, Revisited,” Health Affairs, Vol. 20, No. 2, March/April 2001.

⁵ The private health insurance market is largely for-profit, with some of the largest companies publicly traded on Wall Street. These companies have an obligation to their shareholders to operate in ways that maximize profits, which means avoiding the risk of loss. Not-for-profit insurers must also avoid losses, since: (1) they cannot insure only sick people and stay in business absent government subsidies and; (2) they must compete with for-profit companies for “good” risks.

⁶ A Georgetown University study on the individual market in eight locations around the country found that applicants were rejected 37% of the time, and when offered coverage, 85% of the time the coverage had benefit restrictions, 20% of the time it had premium surcharges, and nearly 20% of the time had both. This does not take into account the people who were discouraged from applying, so the number of people squeezed out of the private market is likely to be much greater, absent guaranteed access requirements. See Karen Pollitz, Richard Soriano, and Kathy Thomas, “How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?” a report for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2001.

⁷ A GAO study on HIPAA implementation found that carrier pricing of HIPAA guaranteed access products could result in substantially higher rates, ranging from 140 to 600 percent of the standard rate. See U.S. GAO, “Health

Insurance Standards: New Federal Law Created Challenges for Consumers, Insurers, Regulators”, Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, February 1998, GAO/HEHS-98-67.

⁸ Maine’s small group rating rules: no rate variation allowed based on gender, health status or claims experience; variations based on age, industry, and geography are limited to no more than 20% above or below the community rate; additional variation allowed for smoking status, group size, family structure, and participation in wellness programs. Maine’s individual rating rules: same as the small group rules, except that variation for industry, group size, and wellness programs do not apply.

⁹ Bela Gorman, Don Gorman, Elizabeth Kilbreth, Taryn Bowe, Gino Nalli, Richard Diamond, “Reform Options for Maine’s Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance”, May 30, 2007.

¹⁰ Maine Bureau of Insurance, “Consumer Guide to Individual Health Insurance”, last updated: September 2, 2008.

¹¹ Maine Bureau of Insurance, “Maine HMO Aggregate Data – 2008 Quarter 2”, last updated: September 12, 2008.

¹² Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

¹³ Maine Bureau of Insurance, “Maine HMO Aggregate Data – 2008 Quarter 2”, last updated: September 12, 2008. Anthem Health Plans of Maine for 2004 through 2007.

¹⁴ Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

Mr. PALLONE. Thank you. Dr. Kingsdale.

STATEMENT OF JON KINGSDALE

Mr. KINGSDALE. Thank you, Mr. Chairman and members of the committee for this opportunity and more importantly for tackling this tough subject. I am executive director of the Commonwealth Health Insurance Connector Authority, which is one of the principle agencies of health reform in Massachusetts, and I want to share with you a couple lessons learned.

First of all, I would note we do have 97.4 percent of our residents covered with insurance. Before I heard that characterized in the former panel, I actually thought that was good. It is, by far, the highest insurance level in the United States, which sadly is below 85 percent nationally and declining as we speak.

Two years ago, after beginning implementation, we reached the principle goal of Massachusetts Chapter 58 of the Acts of 2006, near universal coverage. As a result, financial barriers to obtaining care have fallen markedly. An Urban Institutes survey conducted midway through implementation, and I emphasize midway, found that Massachusetts rates of deferring needed care, because of financial barriers, were between one-half and one-third of the national average. And I think it is reasonable to assume, as enrollment continued to grow, the financial barriers continued to fall.

Importantly, Massachusetts has been able to achieve near universal coverage without a surge in medical inflation. In Commonwealth Care, a program run by the Health Connector for lower income adults without access to employer sponsored or other public coverages, annual premium increases average under 5 percent, and that is better than the national experience, in fact, most private experience in Massachusetts.

Last week, we actually completed bidding and plan selection for the next fiscal year, starting this July, which has produced the following rather extraordinary results: choice of health plans and access to new primary care physicians will increase, and both the government spending per enrollee and what our 165,000 enrollees contribute monthly will decrease. And I have been in the insurance business for 35 years, and I don't usually use premium and decrease in the same sentence.

The connector runs actually two distinct programs. So its second program, Commonwealth Choice, unsubsidized enrollees enjoy a broad array of commercial health plans. They can compare 37 private options that we offer, confident that these plans have received the commonwealth seal of approval for quality and value. On the day we initiate Commonwealth Choice and the individual mandate, July 1, 2007, purchasers of non-group plans experienced a huge gain. Their choice of plans increased suddenly. Their average premiums dropped markedly, and shopping for a plan became far easier.

The result has been a resuscitation of the non-group market in Massachusetts. Prior to reform, non-group enrollment had been falling and premiums rising. A year later, the number of Massachusetts residents buying insurance directly on their own had doubled, and the premiums for standard coverage in the largest non-group plans had declined by 25 percent.

Although we only offer 37 of the 180 options now available to individuals in Massachusetts and they are priced the same in the connector or if purchased outside the connector, our growth has accounted for 50 percent of the growth in non-group coverage in Massachusetts.

Health care reform in the state is a shared responsibility. One-third of the some 440,000 newly insured residents in the commonwealth are in employer-sponsored plans. Near universal coverage is the product of shared responsibility among employers, taxpayers, and those directly involved in providing and reimbursing care. Our governor and legislative leaders are committed to maintaining coverage and sustaining access.

Now, let me just say a couple things about the two connector programs that I briefly described. The Connector organizes a market to provide meaningful choice. Like any retailer, we ask our customers what they want. What they tell us is they want quality, meaning insurance options they can trust, they want value, meaning that we compare and showcase those plans which offer the best benefits for prices charged, and they want to be able to compare and shop online as opposed to calling each carrier, asking a bunch of questions, being put on hold, and then trying to compare notes at the end of the day.

In both Commonwealth Care and Choice, we set standards for covered benefits. We rigorously evaluate the products before offering them, and we organize the choice of plans so that members can readily compare them. At enrollment and afterwards, we work with members and health plans to resolve member issues.

With Commonwealth Care, since we are spending public monies for coverage, the Connector specifies a set of benefits and conducts a highly competitive bidding process. But enrollees choose the plan. They choose the provider network, and if they choose a more expensive plan and they earn above 100 percent of FPL, they pay the additional cost.

With Commonwealth Choice, which is the unsubsidized plan, our members are making a major buying decision. They are spending somewhere between \$1,500 and \$15,000 a year on insurance, depending on family size, age, zip code, et cetera, and the plan they choose. The Connector sets four very different levels of benefits from which customers can choose and offers at least six different carriers on each of these benefit tiers. Our customers can shop by entering three pieces of information: age, household size, and zip code.

We do offer customer telephone service, but 80 percent of the buying is online, typically in 20 to 30 minutes, spend somewhere between \$1,500 and \$15,000 a year. And whichever plan they buy, enrollment is guaranteed as is the next year's renewal regardless of any change in members' medical condition.

And believe it or not, after spending all that money, our members consistently thank you, even though we all know this is outrageously expensive. Frankly this is—and I have been in the insurance business for over 30 years—the most consumer friendly, consumer-driven offering that I have encountered. Thank you for your time and interest, and I will be happy to do my best to answer questions.

[The prepared statement of Mr. Kingsdale follows:]

Statement of Jon Kingsdale, Ph.D.

Executive Director, Commonwealth Health Insurance
Connector Authority

Before the

Subcommittee on Health

Committee on Energy and Commerce
U.S. House of Representatives

March 17, 2009

My name is Jon Kingsdale. I am Executive Director of the Commonwealth Health Insurance Connector Authority. This is one of the principal agencies of healthcare reform in the Commonwealth of Massachusetts. Thank you for this opportunity to share with the Subcommittee some of the lessons we have learned while developing the Connector.

97.4% of Massachusetts' residents now enjoy the security of health insurance coverage. This is by far the highest insurance level in the United States—which, sadly, is below 85% nationally, and dropping even as we speak. Two years after beginning implementation, we reached the principal goal of Massachusetts' Chapter 58 of the Acts of 2006--near-universal coverage.

As a result, financial barriers to obtaining care have fallen markedly. An Urban Institute survey, conducted midway through implementation, found that just one year after reform, financial barriers to care had fallen markedly. In 2007, the first full year of reform, Massachusetts rates of deferring needed care because of

financial barriers were between one-half and one-third of the national average. And it is reasonable to expect that financial barriers continued to decline in the second year of reform, as the number of newly enrolled continued to grow.

Importantly, Massachusetts has been able to achieve near-universal coverage without a surge in medical inflation. In Commonwealth Care, a new program run by the Health Connector for lower-income adults without access to employer-sponsored or other public coverage programs, annual premium increases average under 5%. Last week, we completed bidding and plan selection for the fiscal year starting this July, as a result of which:

(a) choice of health plans and access to new primary care physicians will increase; and

(b) both government's spending per enrollee and what our 165,000 enrollees contribute toward premiums will decrease.

In the Connectors' second program, Commonwealth Choice, unsubsidized enrollees enjoy a broad array of commercial health plans. They can compare the 37 private options that we offer, confident that these plans have received the Commonwealth's Seal of Approval for quality and value. On the day we initiated Commonwealth Choice, July 1, 2007, purchasers of non-group plans experienced a huge gain: their choice of plans suddenly increased, average premiums dropped, and shopping for a plan became much easier.

The result has been a resuscitation of the non-group market in Massachusetts. In 2006, before reform began, non-group enrollment was falling and premiums rising; by 2008, the number of Massachusetts residents buying insurance directly on their own had doubled and the premiums for standard coverage in the largest non-group plans had declined by more than 25%. Although we

offer only 37 of the 180 non-group policies available in Massachusetts and although our 37 policies are priced the same, in or outside the Connector, half the total growth in non-group insurance has come through the Connector. And this value has held, with modest premium increases, since CommChoice began.

At roughly 5% average annual trend for both Commonwealth Care and Choice, the rate of health insurance premium inflation is well below the broader experience in Massachusetts and the nation.

Health care reform in Massachusetts is a shared responsibility and goes far beyond these two programs. One-third of some 440,000 newly insured residents of the Commonwealth are in employer-sponsored plans. Near-universal coverage is the product of shared responsibility among employers, taxpayers, and those directly involved in providing and reimbursing medical care. Governor Deval Patrick and our legislative leaders are committed to maintaining coverage and to sustaining access by controlling costs.

The two connector programs that I briefly described do differ substantially. But they share some common advantages, which suggest the role that connectors might play in national healthcare reform.

The Connector organizes a market to provide meaningful choice. Like any retailer, we ask our customers what they want. They want quality, meaning insurance options they can trust. They want value, meaning that we compare and showcase those plans which offer the best benefits for the prices charged. And they want to be able to compare and shop online, as opposed to calling each carrier to compare offerings.

In both Commonwealth Care and Choice, we set standards for covered benefits. We rigorously evaluate the products before offering them. And we organize the choice of plans so that

members can readily compare them. At enrollment and afterwards, we work with members and health plans to resolve member issues.

With Commonwealth Care, since we are spending public monies for coverage, the Connector specifies a set of plan benefits and conducts highly competitive bidding, but enrollees choose the plan, the provider network, and (for those with incomes above the federal poverty level) they pay any extra for choosing a more costly plan.

With Commonwealth Choice, our members are making a major buying decision with their own money--anywhere from \$1,500 to over \$15,000 a year, depending on their age, family size and plan preference. The Connector sets four very different levels of benefits from which customers can choose, and offers at least six different health plans on each of these four benefit tiers. Our customers can shop by entering just three pieces of information: the subscriber's age, household size and zip code. We do offer telephone customer service, but 80% of buying is done online, typically in just 20-30 minutes. Whichever plan the individual picks, enrollment is guaranteed, as is next year's renewal, regardless of any change in the member's medical conditions.

And our members consistently thank us, even though we all recognize that the cost of health care in America is a serious financial drain. Frankly, this is the most consumer-friendly, consumer-driven offering that I have encountered in my nearly three decades of professional experience with commercial insurance.

Thank you for your time and interest. I will do my best to answer your questions.

Mr. PALLONE. Thank you. Ms. Pollitz with two Ls, not three.

STATEMENT OF KAREN POLLITZ

Ms. POLLITZ. Like Mr. Pallone. Thank you, Mr. Chairman, members of the subcommittee. Health reform presents you with an opportunity to provide for more health insurance markets through a connector, as Dr. Kingsdale discussed, or an exchange. You can organize markets around explicit outcomes that you want to achieve from health insurance.

I would like to briefly review five key goals. The first is to promote risk spreading and stability in health insurance. We have already talked today about how a small minority of people accounts for most health care spending, and this creates an overwhelming financial incentive for insurance companies to avoid risk. So we need rules to make that stop.

I have testified before about medical underwriting practices that make it harder for consumers to get coverage, but other marketing practices make it difficult for consumers to keep affordable coverage. Age rating raises your premium steadily, and when you reach your 50s and 60s, when the incidents of most health conditions starts to increase, health insurance becomes very unaffordable.

Carriers also use durational ratings to actually apply a surcharge to premiums based on how long you have held your policy. The idea is to encourage people who can still pass underwriting to not renew, but to go out and buy a new policy, go through underwriting again to get a good rate. But the people who can't do that get stranded in policies and see their premiums spiral.

Health reform can help by changing the rules of health insurance marketplaces, require guarantee issue, community rating, no pre-ex, so that we stop competition on the basis of risk avoidance.

The second goal must be to assure adequate coverage. Today we have 57 million Americans struggling with medical debt, and three-quarters of them are insured. Some are underinsured because their policy doesn't cover key benefits, but increasingly the problem lies with high deductibles and high cost sharing.

We have accepted higher cost sharing year after year in an effort to try to hold premiums down, but as soon as we get sick, we realize what a failed strategy this is. Especially for patients with chronic conditions, high deductibles hit relentlessly year after year. Even modest copays will mount quickly, and as a result, people have difficulty affording basic care management for chronic conditions like asthma and diabetes. And as a result, avoidable and expensive medical complications arise.

In short, underinsurance is becoming a threat to the public health. It also drives up bad debt and collections costs for doctors and hospitals. The industry experts tell us that the collections rate for low deductible plans is about 87 percent, but for high deductible plans is only 43 percent. So it adds to that administrative cost and hassle for providers as well.

Reform can help by setting comprehensive standards for what health insurance covers and make sure that in the marketplace only good choices are available.

A third choice is to assure affordability. In the interest of time, I won't belabor this point. I think the other panel talked very convincingly about the need for subsidies for both premiums and for cost sharing to make health care and health coverage affordable.

The fourth goal is cost containment. Most private health insurance markets today are dominated by a few, large carriers, and yet these dominant carriers have not used their market clout to control costs. Instead, they have passed out health care costs to consumers while increasing profitability at the same time. Reform can help by organizing health insurance markets to generate new forms of competition and more effective cost containment strategies.

You have a number of options to consider. As is the case in Massachusetts, the exchange can have the option of not including all carriers as participants but instead selecting those that are the most effective and the most efficient. As also was discussed earlier at great length, a public health insurance plan option can and should be offered to heighten competition.

And finally, Mr. Chairman, transparency and accountability are critical to a well-functioning health insurance market. Mr. Deal spoke earlier this morning about price transparency and the importance of that, and I completely agree. But we need transparency throughout our health insurance system and market. Health insurance policies themselves need to be transparent and understandable. Policies are so complex today they leave most consumers confused and frustrated. A recent industry survey found that most people would prefer to do anything, including working on their taxes, rather than trying to read through their insurance policy to figure out what it covers.

And we need transparency of market behavior as well. Too many market practices are hidden from view. It is very difficult to track who is enrolled, who is disenrolling, when claims are paid, when they are pended, when they are denied. These questions are important, and they are answerable if only we will insist on the data.

In an organized insurance market we can do that. In the past few months, as financial markets in the economy have struggled, how many times have you heard or you yourselves made the call for greater transparency and accountability? These themes must allow apply to health insurance and guide your efforts on health care reform. Thank you.

[The prepared statement of Ms. Pollitz follows:]



GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE

Statement of

**Karen Pollitz, Research Professor
Georgetown University Health Policy Institute**

**Committee on Energy and Commerce
Subcommittee on Health**

March 17, 2009

Mr. Chairman and Members of the Subcommittee,

Thank you for inviting me to testify on opportunities to strengthen health insurance markets in health care reform. My name is Karen Pollitz. I direct the study of private health insurance and its regulation at Georgetown University's Health Policy Institute.

In our present health care system, and particularly private health insurance markets, several key shortcomings must be addressed as part of an overall effort to assure universal coverage. These include:

1. Discrimination based on health status and risk selection
2. Inadequate coverage
3. Affordability challenges for low- and middle-income people
4. Rising costs
5. Lack of transparency and accountability

Part of the solution to these problems will lie in strengthening and reorganizing private health insurance markets to produce the coverage results we seek. A health insurance Exchange – sometimes referred to by other names, such as “Connector” – can be established to pursue the goals of reform and to hold markets accountable for progress toward those goals.

Promote risk spreading and stability

It has long been true that approximately 20 percent of the population accounts for 80 percent of health spending. The sickest one percent account for nearly one-quarter of health expenditures. We rely on health insurance to spread costs more evenly across the population and protect all of us from the risk that we may find ourselves in need of expensive care in any given year. Unfortunately the distribution of medical care needs creates a powerful economic incentive to avoid risk, not spread it. Discrimination based on health status is a problem for all health insurance purchasers, although most pronounced in the individual market today. Even consumers with mild conditions may be turned down, charged more, or offered a policy with permanent coverage exclusions. More expensive health conditions such as cancer, diabetes, pregnancy, will always render a person uninsurable in medically underwritten individual markets.

Risk avoidance practices continue even after coverage is issued. Last summer, the House Committee on Oversight and Government Reform studied problems relating to post-claims underwriting and rescission. Individual market policyholders who make claims in the first year of coverage may be investigated for evidence their health condition was pre-existing or not fully disclosed during the initial medical underwriting process. Claims may be denied or coverage cancelled or rescinded as a result. Although these practices are intended to protect against fraud, abuses have also been documented.¹

Stability and long term affordability of coverage is also highly problematic in the individual market today. Typically people remain enrolled in policies for less than two years.² High rates of turnover result from several factors. In general, the individual market today is a residual market and unsubsidized, so participants tend to leave as soon as they regain eligibility for subsidized job-based or public coverage. However, for those who must remain longer, various market practices encourage churning or make it increasingly unaffordable to remain covered.

Age rating makes it difficult to afford coverage over time. Insurers typically charge people in their early sixties three to five times the premium for people in their early twenties. The slope of this age climb varies, but often age adjustments are modest for young adults, becoming more pronounced for people in their fifties and early sixties, not coincidentally, when the incidence of many high cost medical conditions also increases.

Durational rating is used by many insurers to increase premiums based on the tenure of the policyholder. The predictive power of medical underwriting wears off over time; policyholders who were young and healthy when they first applied for coverage tend not to remain that way. By applying tenure surcharges, insurers encourage those enrollees who are still healthy to apply for new coverage, and resubmit to medical underwriting, in order to hold premiums down. This practice has the effect of segregating policyholders who have gotten sick, forcing their premiums even higher.

In a related practice, insurers may introduce new policies into the marketplace every few years, leaving older policies in force but no longer actively marketed. With freshly underwritten applicants diverted to new policies, the claims experience of the “closed” policies deteriorates, driving up premiums. People healthy enough to leave the closed block will do so, further escalating premiums for those with health problems who are stranded.³

A recent health insurance survey of family farm and ranch operators, who rely disproportionately on the individual health insurance market, found high rates of financial burden due to these kinds of market practices.⁴

How reform can help – Congress can and must change the rules of the health insurance marketplace so that insurers no longer compete on the basis of risk selection, but instead, on the basis of efficiency and customer service. All policies should be sold on a guaranteed issue basis. Premiums should be determined based on community rating. Pre-existing condition exclusions should end. Federal minimum standards for health insurance should be strengthened so that these protections apply to all types of health coverage. Vigorous oversight to ensure compliance is also essential.

Assure coverage adequacy

Under-insurance is a serious and growing problem. In 2007, 57 million Americans lived in families struggling with medical debt – a 33 percent increase since 2003 – and 75 percent of them had health insurance.⁵ Policies that fail to cover key benefits, such as prescription drugs, maternity care, and mental health care, can leave people under-insured. Likewise, caps on covered benefits leave patients at risk for catastrophic medical expenses. High deductibles, co-pays, and other cost sharing are also problematic.

In an effort to offset rising premiums and stem coverage loss, the content of coverage under many health insurance plans and policies has eroded steadily. However, this strategy has proven to be ineffective. Coverage erosion leaves the under-insured in circumstances very similar to the uninsured – they forego or delay needed medical care due to costs, experience poorer quality care, and suffer financial burdens.⁶

Coverage adequacy is particularly important for patients with chronic conditions. Even modest co-pays for services can accumulate to burdensome levels for patients who need medical care

and prescriptions on a regular basis. For example, a study of the effect of doubling prescription drug co-pays – from \$6 to \$12 for generic drugs and from \$12 to \$25 for brand name drugs – found that patients with diabetes, hypertension, and depression reduced use of their respective medications by nearly one-quarter.⁷ Failure to properly manage chronic conditions often leads to the development of more serious and expensive medical complications. Under-insurance among the chronically ill should be viewed as a threat to public health. There is also evidence high cost sharing is exacerbating collections problems and fueling bad debt for hospitals and doctors.⁸

How reform can help - A key goal of health reform must be to ensure that all people have adequate coverage. Minimum standards for what health insurance covers must be developed and explicitly take into account what insured patients will be left to pay out of pocket when they need medical care. Research finds that when out-of-pocket spending for health care services exceeds just 2.5 percent of family income, financial pressures on families from medical bills increase dramatically. Financial burdens arise for low-income families at even lower levels of out-of-pocket spending.⁹ Accordingly, the design of all health insurance plans and policies must consider the care needs of patients with cancer, diabetes, heart disease and other serious medical conditions. Coverage for care needs of people when they are healthy – primary and preventive care services and maternity care – must also be included. Cost sharing must be held to modest levels and further subsidized for low-income individuals.

A condition of insurer participation in a health insurance Exchange must be the offering of policies that meet minimum coverage standards. The elimination of substandard coverage options will not only address the problem of under-insurance, it will reinforce risk spreading. When all policies provide adequate coverage, people will not sort themselves by risk status into plans that offer widely varying levels of insurance protection.

Assure affordability

Overwhelmingly, the uninsured lack coverage today because they cannot afford it. Most uninsured have incomes below twice the federal poverty level. Significant assistance is needed to make coverage affordable. As just discussed, artificially depressing premiums by offering substandard policies will not help.

Affordability must be measured against the cost of comprehensive coverage. Job-based group health plans offered by large employers today suggest one benchmark for the likely cost of adequate coverage. Such plans currently cost approximately \$4,800 per year for self-only coverage and \$13,000 for family coverage.¹⁰

How reform can help - Subsidies are essential to make coverage affordable for millions of uninsured Americans. Defining affordability will certainly entail some subjective judgments. However, economic studies of consumer spending suggest health insurance may be affordable for middle income families as long as premiums do not exceed 4 to 8 percent of household income, with lower affordability thresholds for lower income families.¹¹ A similar standard has been adopted by the state of Massachusetts in determining its premium subsidies and affordability index, and as a result, subsidies for both premiums and cost sharing are available for individuals and families with income to 300 percent of the poverty. Residents with even higher incomes are ineligible for subsidies but may receive a waiver of the requirement to buy health insurance on grounds of affordability.

Cost containment

Since 1999, employer-sponsored insurance premiums have more than doubled, well outpacing inflation and the rise in earnings.¹² In 2007 total national health expenditures reached \$2.2 trillion, or more than \$7,400 per capita and more than 16 percent of GDP.¹³ All indications are that unless we take action through health care reform, health spending will continue to rise at levels beyond what families, employers, and taxpayers can afford.¹⁴

In today's private health insurance markets, competition between carriers does not help control costs. Quite the opposite, data show there is a high degree of concentration among insurers, with just a handful of carriers accounting for the majority market share in most states. Insurers have not used their market power to negotiate favorable provider rates or otherwise control costs as might be expected; rather, they've passed on health care costs to consumers while increasing profitability at the same time.¹⁵

How reform can help - Health insurance markets can be better organized to generate new forms of competition and more effective cost containment strategies. First and foremost, once all policies meet standards for comprehensive coverage, it will be easier for consumers to shop on the basis of price prompting insurers to behave more cost effectively.

As is the case in Massachusetts, the Exchange could also be given authority to negotiate with health insurers over premiums and to exclude the least efficient and effective carriers from participation. The Exchange might also adopt minimum loss ratio targets, adopt standards for broker commissions, and institute other expectations of efficiency to lower health insurance administrative costs.

Importantly, a public health insurance plan option should also be offered to heighten competitive pressures to contain costs. A public health insurance plan can substantially influence market innovation by investing in new approaches to disease management or more effective use of information technology. Such innovations should be freely shared with other insurers so they could adopt them at lower cost. A public health insurance plan also could induce other insurers to be tougher price negotiators with providers.

The issue of a public health insurance plan option has prompted concern that it would constitute unfair competition with private insurance companies, and might even result in the elimination of private insurers over time. However, experts suggest a different outcome seems as or more likely because a public health insurance plan will face other unique constraints. In particular, health care providers have been formidable in their exercise of political pressure to oppose payment rate cuts under Medicare, as evidenced by Congress' vote to prohibit Medicare from negotiating prescription drug price discounts under the Part D program. While a public health insurance plan will likely enjoy some cost advantages over private insurers, political constraints will prevent it from exploiting those advantages.¹⁶

In addition, it is important to remember how private insurers have benefited from public programs by shifting costs to them. Thanks to Medicare, the private market no longer finances most medical care for the elderly and disabled, nor for patients with ESRD and ALS. Medicaid eligibility categories now include women with breast and cervical cancer who are under-insured for this care. Three-fourths of states have opened high-risk pools for uninsurable residents whom private insurers refuse to cover. In 2000, Minnesota's attorney general found private health insurers were shifting to taxpayers the cost of mental health care it contracted to provide its beneficiaries by forcing policyholders, through claims delays and denials, to turn to public

programs for mental health care.¹⁷ Offering a public health insurance plan option also ensures that the sickest patients will always have a source of affordable, adequate health coverage in the event that some private insurance companies do not immediately cease cost avoidance activities.

Transparency and accountability

Finally, transparency of information is critical in a competitive market where consumers have choices. Lack of transparency promotes inefficiency and bias in consumer choices.¹⁸ Health insurance policies are complex and confusing for consumers, who often do not understand what type of coverage they have or how it works.¹⁹ One industry survey found that less than one-fourth of consumers understand the terminology in their health insurance contracts; and rather than try to read their policy, most would prefer to prepare their income taxes or go to the gym.²⁰

Greater transparency in market behaviors will also be needed to ensure accountability. Compliance with market rules must be closely monitored and enforced if we want insurers to cease competition on the basis of risk selection.

How reform can help - In an organized marketplace, there can be rules to ensure that insurance products are understandable and marketing practices are transparent and above board. One important task of an Exchange must be to provide more and better information about health insurance than most consumers have today. The Commonwealth Connector, for example, designates types of health insurance plans as gold, silver, and bronze to make it easier for consumers to compare across option. In addition, the Connector makes available plan comparison tools that highlight differences in key plan features such as deductibles, co-pays, and benefit limits.²¹

The Exchange should also collect and make available information about how different plans perform on measures such as prompt payment of claims, customer service, breadth and quality of plan provider networks, outcomes of grievance and appeals processes, and others. In Washington state, for example, the Office of the Insurance Commissioner (OIC) makes available a Health Carrier Information Comparison tool with information about carrier loss ratios, profit margins and other characteristics to help consumers see how much of their premium dollars are spent on medical claims vs. administrative costs.²²

In a reformed market, insurers must disclose and the Exchange must collect data necessary to track the goals of reform. This includes data on consumer enrollment in and disenrollment from health plans, as well as insurer marketing and rating practices and detailed data on loss ratios. Accountability and transparency have become watchwords as we strive to address problems in our financial markets and the economy generally. These themes must also apply to health insurance and guide your efforts on health care reform.

Notes

- ¹ See Committee hearing transcript at <http://oversight.house.gov/story.asp?ID=2089>. See also Girion, L., "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, November 9, 2007.
- ² "Individual Health Insurance: An Update" Henry J. Kaiser Family Foundation, August 2004. <http://www.kff.org/insurance/7133.cfm>
- ³ "On their own," *Consumer Reports*, January 2008. Available at <http://www.consumerreports.org/health/insurance/health-care-on-your-own-1-08/overview/health-care-on-your-own-ov.htm>.
- ⁴ "2007 Health Insurance Survey of Farm and Ranch Operators" Issue Brief No. 3, The Access Project, September 2008. Available at http://accessproject.org/adobe/issue_brief_no_3.pdf
- ⁵ Cunningham, P., "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007" Center for Studying Health System Change, Tracking Report No. 21, September 2008.
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- ⁷ Goldman, D, et al, "Pharmacy Benefits and Use of Drugs by the Chronically Ill," *Journal of the American Medical Association*, Volume 291, No. 19, May 19, 2004.
- ⁸ See for example, "Hospital Strategies for Addressing Out of Pocket Expense," Healthcare Financial Management Association Roundtable, October 1, 2008. Available at <http://www.allbusiness.com/company-activities-management/operations/11664702-1.html> See also Cash, Cheryl, "Adding up the cost of high-deductible health care plans: Quality care, billing and collection challenges face many pediatricians as more families switch to consumer-driven health insurance," *AAP News*, Vol. 28, No. 1, January 1, 2007.
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- ¹¹ Blumberg, L., et al, "Setting a Standard of Affordability for Health Insurance Coverage" *Health Affairs* Web Exclusive, June 4, 2007.
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- ¹⁴ <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf>
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- ²¹ See <http://www.mahealthconnector.org>
- ²² See <https://fortress.wa.gov/oic/hcis/public/comparisonhome.aspx>

Mr. PALLONE. Thank you. Dr. Baicker.

STATEMENT OF KATHERINE BAICKER

Ms. BAICKER. Thank you very much for the opportunity to be here. I would like to draw a couple of key distinctions at the beginning. First, health is very different from health care, and second health care is very different from health insurance. I know we have all hit on these points already, so I will be brief. But we know many things affect health outcomes besides the health care system.

By the time someone shows up at the hospital in critical condition, it is already too late in some senses. That means that comprehensive reform should address investment in all sorts of things that promote health including health behaviors, access to nutritious foods, exercise, et cetera. It also makes international comparisons of health systems particularly different because when we look at the value our health care system is producing, the health outcomes are the product not just of that health care system but of all those other factors that may be different across countries as well.

The second distinction I wanted to draw was between health care and health insurance, and that sounds obvious, but it is often conflated in the debate. And this goes to the point that Representative Christensen raised earlier about what our responsibility and what our goals should be for helping sick people who are uninsured.

People need health insurance because health care is uncertain because the risks are uncertain, not because health care is expensive. There are lots of things that are expensive that we might want to redistribute resources for to low-income people but not through the form of insurance because those expenses aren't so variable, so unknown. Whereas health insurance exists to protect people against the risk of needing a lot of resources to pay for an expensive health care condition when those resources could save their life.

So what do uninsured sick people need? They need health care, but they don't necessarily need health insurance. And we might want to design a reform to help those people that gets them access to care that doesn't necessarily build on an insurance system designed to help the majority of people who get insured when they are healthy, some of whom then fall sick and some of whom don't.

The problem that sick people who are insured have is one of insuring the affordability of that care going forward. People want protection not just against high expenses today, but against the risk of high expenses next year. And that means having an insurance policy that you can count on if you or a family member get sick. Your premiums shouldn't go up. You shouldn't lose your insurance. You have done what you needed to do to get insurance when you were healthy. We need to ensure that that insurance stays around to protect people should they fall ill.

A second principle I would like to bring up is the idea that covering the uninsured doesn't pay for itself. It would be wonderful if we could recoup the investment that we make in covering the uninsured through less spending on emergency departments and ineffi-

cient care that we know the insured differently from the uninsured right now.

Unfortunately, I don't think we can count on saving money by covering the uninsured, but that doesn't mean that it wouldn't be money extremely well spent. If we invest money in covering the uninsured, they will gain enormous health benefits from it. So the money is worthwhile, but it is not free. And it doesn't save money on net to extend insurance coverage because we know the uninsured are consuming too little health care today. So extending coverage to them would give them access to more care that would cost more money. So we need to design reforms that can pay for that.

A corollary to that idea is that preventive care doesn't pay for itself by and large either. There are a few exceptions. Flu shots for toddlers more than pay for themselves. Most preventive care again is a good investment in health. It promotes health in the long run, and it is worth spending money on, but it doesn't reduce costs. Most preventive care buys quality adjusted life years at a pretty good price, and we should invest in that. Some preventive care is very expensive for the health that we buy and is in fact less cost effective than care that wouldn't be characterized as preventive. So we shouldn't think of preventive care as a uniform cure-all either. It is a mix of highly cost effective and highly non-cost effective care as well.

Another principle that I would like to bring to the debate is that insurance alone doesn't guarantee access to high quality care. We hit on that, the questions discussed that a fair amount in the first panel, so I won't spend a lot of time on it here. But there is ample evidence, largely derived from the Dartmouth data on variations in health care within Medicaid, that high spending on health doesn't guarantee high-quality care. And even people in the same insurance program, Medicare fee-for-service, get wildly different health care benefits in different parts of the country.

Next I would like to raise the idea that employees bear the burden of employer-provided health insurance. This means that if we want to foster the employer system, if we want to put employer-based policies on a level playing field with non-group markets, the reasons to think about doing that involve risk pooling and economies of scale in large purchasing, not the idea that employers somehow bear the burden of health costs through profits.

In the long run, when health care costs go up for employer provided plans, employees bear that cost in the form of lower wages. That is part of the reason we have seen slower wage growth over the last decade. It is because an increasing share of compensation that workers get has come in the form of health insurance rather than wages. In some cases, when wages can't accommodate that increase in health care costs, that results in unemployment. So ultimately workers bear the burden either through lower wages or in some cases through losing their jobs.

The last point that I would like to make is that high deductible health plans can introduce cost sharing that promotes efficiency, but they aren't the magic bullet. There is no reason to think that the high deductible health policies that we see today are the perfect structure. What I think the tax system should aim to do is promote innovative insurance coverage that fosters high value care.

That might mean higher deductible for some kinds of care and subsidizing other kinds of care. Maybe we should pay people to go get flu shots because those are particularly cost effective. It should have a negative copayment associated with it.

Any reform design should promote that kind of high value insurance structure that I think is unlikely to be generated by a monolithic single public payer plan but is unlikely to be generated by a prescribed particular form of deductible.

So in conclusion, I think we should address the issues of coverage and cost together, not because they are equally important necessarily, although I think both are very important, but because each goal is more likely achieved when the two are considered together. It is very difficult to design a system to cover the uninsured that we can afford tomorrow if we don't take health care costs into account. And if we don't get costs under control, more people will find themselves falling into that uninsured bucket as their employer provided plan or the non-group market plans become less and less affordable.

[The prepared statement of Ms. Baicker follows:]



HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

March 17, 2009

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Congressman Pallone, Congressman Deal, and the Members of the Committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of making our health care system work better for American families. This testimony is derived in large part from recent academic work with my colleague Amitabh Chandra that appeared in the journal *Health Affairs*. I summarize that work here.

This morning I would like to discuss several general principles about the nature of health insurance. Misunderstandings about these principles have the potential to impede the development of a much-needed consensus on how to engineer reform. Uncovering the kernels of truth that underlie these misperceptions can help focus reform efforts on the critical challenges facing our health system.

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

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

THE PROBLEM OF THE SICK AND UNINSURED

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

Medicare for those over 65. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the confusion between health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health *care*, not health *insurance*. Insurance is about reducing uncertainty in spending. It is impossible to “insure” against an adverse event that has already happened, for there is no longer any uncertainty. Try purchasing insurance to cover your recent destruction of your neighbor’s Porsche: the premium will be the cost of a new Porsche. You wouldn’t need car insurance – you’d need a car. Similarly, uninsured people with known high health costs do not need health insurance – they need health care. Private health insurers can no more charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care – and ideally, as discussed below, to minimize the number of people in this situation.

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

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

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

spawned additional myths that suggest that the costs of expanded insurance are lower and the benefits higher than the data suggest.

THE COST OF COVERING THE UNINSURED

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

Why does insurance cause greater consumption of health care? Insurance, particularly insurance with low cost-sharing, means that patients don't bear the full cost of the health resources they use. This is a good thing – having just made the case for the importance of the financial protections that insurance provides – but comes with the side-effect of promoting greater consumption of health resources, even when their health benefit is low. This well-documented phenomenon is known as “moral hazard,” even though there is nothing moral or immoral about it. The RAND Health Insurance Experiment (HIE), one of the largest and most famous experiments in social science, measured people's responsiveness to the price of health care. Contrary to the view of many non-economists that consuming health care is unpleasant and thus not likely to be responsive to prices, the HIE found otherwise: people who paid nothing for health care consumed 30 percent more care than those with high deductibles.⁴ This is not done in bad faith: patients and their physicians evaluate whether the care is of sufficient value to the patient to be worth the out-of-pocket costs. The increase in care that individual patients use because of insurance has even greater system-wide ramifications. R&D in new medical technologies responds to the changes in aggregate incentives driven by health insurance. While these technologies may improve welfare, they also raise premiums because of larger armamentarium of treatments available to the sick. There is evidence of these system-wide effects: when Medicare was introduced in 1965, providers made spectacular investments in high-tech care, and hospital spending surged over 25 percent in 5 years.⁵

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

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

GETTING HIGH-VALUE CARE

Having insurance may increase the quantity of care patients receive, but it is no guarantee that they will receive high quality care. A recent study found that Americans received less than 60 percent of recommended care, including preventive, acute, and chronic care, and including such low-cost interventions as flu vaccines and antibiotics for surgical patients.⁸ Beginning with the work of John Wennberg at Dartmouth, an immense literature in medicine and economics has found that even among Medicare enrollees, there are enormous differences in the quality of care received: in fact, in areas where the *most* is spent on Medicare beneficiaries, they are the *least* likely to get high quality care. Mammograms, flu-shots, the use of beta-blockers and aspirin for heart-attack patients, rapid antibiotics for pneumonia patients, and the use of simple laboratory tests to evaluate the management of diabetes are all lower in higher-spending areas.⁹ Higher spending is not even associated with lower mortality, which suggests that more generous insurance provision does not necessarily translate to better care or outcomes.

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

What, then, do patients in high-spending areas get? Evidence suggests that this higher intensity is driven by greater use of procedures with questionable clinical value – that may even be associated with underuse of high value, less-intensive care. Patients in high-spending areas are no more likely to receive surgery, but see more specialists more frequently, have more diagnostic and imaging services, and get more intensive care in the end of the life - none of which has been shown through clinical trials to improve health.¹⁰ “Coordination failures” in delivery may both raise costs and lower quality, even among the insured.

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

THE ROLE OF EMPLOYERS

Employees ultimately pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company. The view that we can get employers to shoulder the cost of providing health insurance stems from the misconception that employers pay for benefits out of a reservoir of profits. Regardless of a firm's profits, valued benefits are paid primarily out of workers wages.¹¹ While workers may not even be aware of how much their total health premium is, employers make hiring and salary decisions based on the total cost of employment, including both wages and benefits such as health insurance, maternity leave, disability and retirement benefits.¹² They provide health insurance not out of generosity of spirit, but as a way to attract workers – just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers bearing the cost of their benefits in the form of lower wages.¹³

The uncomfortable arithmetic of this wage-fringe offset is seen in other contexts – for example, workers bear the costs of workers compensation, and mandated maternity benefits primarily reduce the wages of women of child-bearing age.¹⁴ When it is not possible to reduce wages, employers may respond in other ways: employment can be reduced for workers whose wages can't be lowered, outsourcing and a reliance on temp-agencies may increase, and workers can be moved into part-time jobs where mandates do not apply. These adjustments are neither instantaneous nor one-for-one for every person (depending, for example, on wage rigidities, how much individuals value the insurance benefit, and how heterogeneous the employees' income and health are) – a fact that obscures the underlying connection. This also means that the claimed connection between health care costs and the “international competitiveness” of U.S. industry is murky at best: higher health costs primarily lower current workers' non-health compensation, rather than firms' profitability (although the same trade-off cannot operate in retiree health benefits, making their effects more complicated).¹⁵

Why, then, do we have a private health insurance system based primarily on policies offered through employers? There is a preference in the tax code for premiums paid by employers relative to premiums paid by individuals or direct payments for health care. This tax preference drives both the predominance of employment-based policies and the prevalence of policies with low cost-sharing, because care paid for in the form of higher employer premiums comes at a lower after-tax price than care paid for out-of-pocket. Of course, this tie between employment and insurance comes at a well-known cost: workers who leave or lose a job risk losing their insurance or facing much higher premiums, sometimes forcing them to stay in a job to retain health insurance.¹⁶

This is not to say that there are not important advantages to getting insurance through an employer instead of on the individual non-group insurance market (especially given the current state of individual market), including better pricing and risk pooling. The employer market is the primary mechanism for maintaining cross-subsidization from low-risk populations to high-risk ones, with tax subsidies adding an element of social insurance (albeit one that is not particularly progressive).¹⁷ It is these benefits that are the main advantages of access to employer policies, not the fact that employers nominally pay part of the premium.

EFFICIENT INSURANCE

Greater patient cost-sharing could help improve the efficiency of health care spending, but it is not a cure-all. It is certainly true that first-dollar insurance coverage (that is, insurance coverage for the first dollar of health care expenditures or insurance with very low cost-sharing more broadly) encourages use of care with very low marginal benefit and that greater cost-sharing would help reduce the use of discretionary care of questionable value. But there is also evidence that patients under-utilize drugs with very high value when confronted with greater cost-sharing (whether because they lack resources or information). Worse, there is evidence that even \$5 - \$10 increases in copayments for outpatient care can result in some patients getting hospitalized as a result of cutting back too much on valuable care, offsetting the reduced spending.¹⁸ Capping total insurance benefits is also short-sighted and imprudent: not only does evidence suggest that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs, but the presence of caps means that patients are not insured against catastrophic costs – exactly what insurance is supposed to protect against the most.

There is no reason to think that the optimal insurance structure would look like the typical high-deductible plan. Rather, it might subsidize high-value care such as treatments to manage diabetes or asthma, while imposing greater cost-sharing on care of lower value, such as elective surgeries with limited health benefits. People would choose the insurance plans that offered them the best benefit mix – trading off higher premiums for plans that covered care of diminishing marginal value. Of course, what may be valuable to one patient could be wasteful for another, and the key challenge for ‘value based insurance design’ policies is to differentiate these cases. Many firms are experimenting with these plans.¹⁹ We believe that focusing exclusively on high-deductible plans that rely on a blunt structure of patient cost-sharing and perfectly forward-looking patients may forestall the development of even more innovative plans.

This does not mean that competition and cost-sharing have no role in driving higher value spending, however. Competition between insurers to offer plans that have the mix of benefits enrollees find most valuable could drive the kind of innovative plans described above. Increased cost-sharing such as that promoted by high deductible policies coupled with health savings accounts can also be an important tool for improving the value of care. As the evidence from the RAND HIE discussed above shows, the low-cost sharing plans fostered by the current tax treatment of health insurance (which look more like pre-paid health care than true insurance) promote the use of care that is of limited health benefit. While most spending is indeed done by people with very high total costs, well-designed cost-sharing programs could still have substantial effects on spending decisions. Most spending is not done in emergency settings, and even limited cost-sharing can have an effect on a substantial share of total spending.²⁰ This suggests that carefully designed incentives could have a big effect on improving the value of care delivered.

CONCLUSION

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

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

How one balances these trade-offs is likely driven as much by philosophy as economics, and any reform will involve tough choices between competing values. Serious reforms would focus not exclusively on lowering costs, but on increasing the value that we get from health insurance and health care.²¹ Reforms that promoted higher-value insurance could both extend coverage so that more people benefit from the protections that insurance affords and ensure that those protections are secure for those who fall ill. These reforms would not be enough to achieve uniformly high-quality care, however. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. That many nations, including both the U.S. and Canada, struggle with these challenges suggests that reforms of the payment system alone are unlikely to solve all of these problems. A comprehensive reform proposal that aimed both to extend insurance protections to those who lack them and to improve the value of care received by those who are insured would be more likely to succeed at each goal than proposals that focused on just one.

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

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Mr. PALLONE. Thank you, Doctor. Mr. Haislmaier.

STATEMENT OF EDMUND F. HAISLMAIER

Mr. HAISLMAIER. Thank you, Mr. Chairman and members of the committee for inviting me here today to testify. I have submitted prepared remarks which I will summarize briefly. Let me just make a couple of points, and I would particularly like to follow on what Dr. Baicker just said about silver bullets.

In 20 years of doing health care policy, it has been my observation that too often too many of us, regardless of where we are on the political spectrum, are tempted to try to latch onto something as a small silver bullet solution to health care. I have come to the conclusion that while each and every one of those things has some value, none of them are a magic silver bullet to fix the problem. Rather you have to take them in a context, and you have to look at them as pieces of the puzzle.

We also have a tendency to run towards fads. That is the silver bullet, if you will, that is most popular at the given moment. Again this can be on either side of the aisle. We have seen it with HMOs, HSAs, public plan, this, that, and the other. Again I would encourage you to refrain from that.

In looking at the situation we have today, what strikes me, not only based on my experience over 20 years, but actually based on the last five years of working with about 18 different states. Literally I was in the period of seven days testifying in Anchorage and Tallahassee. So it is across the country, in very different circumstances. How diverse the situation is on the ground in your different states and also how much more amendable it is to solution at the state level.

I have also at a policy then intrigued by the few things that are really needed in my view to make measurable progress, and let me summarize them as I do in my testimony. I think the Massachusetts Connector, which is the first example, and now Utah—unfortunately Representative Matheson isn't here—last week enacted something very similar—is the first couple of examples of what I think needs to be done in one area, which is to create an individualized solution for employers and their workers.

This is not the same as the traditional individual insurance market, as Mr. Kingsdale points out. This functions just like an employer market. You are guaranteed the coverage. You have a right to pick an open season. In fact, it works like FEHBP, which was discussed earlier.

In fact, they are doing the things you would have to do if you were to say we are going to take FEHBP and instead of having it be one employer, the federal government, we are going to have a state do it for any employer in the state to participate in. That is what the unsubsidized Commonwealth Connector reforms that they are rolling out right now are designed to do and what other states are looking at doing. Any state can do that today, and we have shown them how they can do it working as Massachusetts and now Utah are doing within federal law.

Point two is if you want to apply guaranteed issue to the individual market, that can be done. It can be done at the state level. Some states have done it, as Ms. Kofman pointed out. It could be

required at the federal level. The important thing is to do it right. It should not be an unlimited pick-it-up-drop-it-anytime-you-want kind of guaranteed issue, but rather as the federal government set forth in HIPAA, a set of standards for guaranteed issue in the group market for individuals when it is reasonable for people to do that.

The other two points in my testimony are that the way to make those reforms work in an optimal fashion is to support them with risk adjustment mechanisms. And I noted in my testimony that in my discussions with folks in Massachusetts and in my observations, I think if I was to go back and say what did they leave out that they should have included. And that was they didn't include a risk-adjustment mechanism for making sure that nobody was disadvantaged as an insurer getting more of the sick cases than somebody else.

Interestingly enough, learning from that lesson, that is the first order of business in the Utah reforms is to set that piece of it up.

And then finally if you are going to move to guaranteed issue in the individual market, and you are going to give people the right to buy coverage, then for that to work economically and socially, people have to take of the obligation to take advantage of that right when they are healthy and pay into the system and not simply avoid it until they need it and then want to take out of the system.

Finally what strikes me about all of this is that any of this stuff and all of this stuff can be done by states now. It is not necessary for the federal government to do it for them. The federal government, however, could do things to aid and encourage them. And I will be happy to discuss that later.

And then finally to Representative Deal's question, again I think price and transparency is essential to making this work even better down the road. But again I think this is something, given that states regulate insurance and the practice of medicine, that states are looking at doing themselves to one degree or another and is certainly something I would encourage there to support it. Thank you.

[The prepared statement of Mr. Haislmaier follows:]



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CONGRESSIONAL TESTIMONY

**Issues in Health Insurance Market
Reform**

**Testimony before
Subcommittee on Health of the Energy and
Commerce Committee
United States House of Representatives**

March 17, 2009

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My name is Edmund F. Haislmaier. I am Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Mr. Chairman, Representative Neal, and members of the committee, thank you for inviting me to testify before you today on some of the key issues involved in health insurance market reform.

There is currently considerable interest in both Congress and a number of states in health insurance market reforms as part of broader designs for health system reform. In that regard, I will focus my testimony today on four key issues:

- 1) Reforms to create greater choice and portability in the employer-sponsored coverage market.
- 2) The application of guaranteed issue rules to the individual health insurance market.
- 3) Risk adjustment mechanisms to accompany these first two reforms.
- 4) The role of "automatic enrollment" and "personal responsibility" provisions.

1) Creating choice and portability in employer-sponsored coverage.

Whatever advantages the long-standing model of employer group coverage may offer, it still has several major weaknesses. First, because coverage is attached to the employer, and not the worker, it isn't portable and changes in employment often create gaps in coverage. Second, because employers make the coverage decisions, and in most cases offer only a single one-size-fits-all group plan, workers are frequently unable to obtain the coverage that best suits their personal needs and preferences. Third, insurers face distorted incentives because their real customers are the employers, not the individual workers. This skews insurer behavior towards limiting costs in consumer-unfriendly ways, such as by restricting coverage, denying claims, or limiting access to providers -- instead of giving insurers incentives to compete on the basis of providing individual patients with the best value (price, quality, provider access) for their health insurance dollars.

The solution being pursued in Massachusetts, and now in Utah as well -- and under active consideration in a number of additional states -- is for a state to exercise its authority to regulate health insurance to create a new option of "individualized" employer-sponsored coverage. The design works as follows:

Rather than offering a traditional group plan, the employer could elect to provide its workers a menu of different plans, offered by different insurers. Each worker would

be able, at first enrollment and during an annual open season, to choose the plan the best suits him or her and to maintain that coverage if they left their employer. The insurance products would all be subject to state regulation and would also comply with all federal ERISA, HIPAA and COBRA standards for employer-sponsored coverage. Among other things, that means that coverage would be guaranteed issue to enrollees and all employer and employee premium payments would be on a pre-tax basis.

The state would support this arrangement by creating or authorizing some type of administrative mechanism to coordinate the offering of plans, the election by employers to participate, the selection of coverage by participating workers, and the collection and transmittal of premium payments from multiple sources. While "health insurance exchange" is the generic name I have given such administrative mechanisms, the design can take a number of different forms and be given a different name. For example, Massachusetts created its health insurance "Connector" as an independent body to perform these, as well as a number of other tasks.¹ In contrast, the recently enacted Utah legislation envisions the creation of a more decentralized, internet "Portal" to perform the same basic functions.²

If this idea sounds somewhat familiar, it is because it is modeled on the very successful Federal Employee Health Benefits Program (FEHBP). While conceptually similar to FEHBP, this basic design is adapted to serve multiple employers on a statewide basis.

2) Applying guaranteed issue rules to the individual health insurance market.

A related issue is the interest at both the state and federal level to applying guaranteed issue to the individual market. While it is possible for lawmakers to institute such a reform, they will need to be careful to do it in a way that does not destabilize insurance markets. The key difference between the employer-sponsored market and the individual market is that it is easier in the employer-sponsored market to prevent the destabilizing behavior of individuals opting to go without coverage until they are sick. I will discuss further in my fourth point some other mechanisms that can be used to control such undesirable "selection" effects.

For now, my main point is that when discussing guaranteed issue it is important to focus on the conditions to be applied to individuals exercising such a right. Properly designed, the rules governing guaranteed issue offer conditional -- not unrestricted -- rights to individual enrollees.

For example, under current federal law if an employer sponsors health insurance coverage, an eligible worker has a right to obtain that coverage on a guaranteed issue basis under the same terms as other, similarly situated, employees of the same firm. However, there are limits to that right. Namely, guaranteed issue applies only when the worker first becomes eligible for coverage, at any subsequent open season, or upon the

¹ The Massachusetts legislation is Chapter 58 of the Acts of 2006.

² The Utah legislation is H.B. 188 of the 2009 session.

occurrence of one of the "change of status" events specified in law. In other words, the worker does not have an unrestricted right to obtain and drop coverage any time he or she chooses -- which would be destabilizing to both the employer's plan and the insurance market as a whole.

If guaranteed issue is applied to the individual market it will need to be structured to include the same limitations on individuals exercising that right to avoid damaging the market. Furthermore, I would argue that, given the greater propensity for adverse selection behavior in the individual market, the application of guaranteed issue to individuals should also be on an "earned-right" basis.

My recommendation is to stipulate that individuals can obtain coverage on a guaranteed issue basis only during an annual open season, and that they are charged standard rates for their coverage only if they can give evidence of 18 months or more of prior creditable coverage. In cases where the individual has less than 18 months of prior creditable coverage, they could still obtain coverage on a guaranteed issue basis, but insurers would be permitted to impose pre-existing condition exclusions and rating surcharges to the maximum extent and duration allowed by HIPAA -- namely, pre-existing condition exclusions for up to 12 months, reduced by the number of months of prior creditable coverage, and rating surcharges of up to 150 percent of standard rates for up to two years.

Thus, while the coverage would be guaranteed issue to all, the right to obtain that coverage at standard rates and without the imposition of any pre-existing condition exclusions must be "earned" by the individual obtaining and maintaining continuous coverage. Such a policy rewards those who do the right thing -- getting and keeping coverage -- while appropriately discouraging any who are tempted to decline available coverage so long as they are in good health.

3) Risk adjustment mechanisms.

Guaranteed issue and the creation of the option to offer portable, "individualized" employer-sponsored coverage are necessary preconditions for realigning insurer incentives away from avoiding risks and toward maximizing value for patients. However, those steps alone are not sufficient. What is also required are risk adjustment mechanisms to ensure that the market works smoothly and fairly for all insurers and policyholders.

This involves both a "front-end" and a "back-end" component. On the "front-end," lawmakers will need to reach agreement with insurers on the specifics of the parameters that insurers will use to price their products so that consumers can effectively comparison shop. For example, to account for some of the variation in health risks and health status, will the premiums vary by age, and if so by how much? On the "back-end," lawmakers will need to authorize market-wide health risk pooling mechanisms that enable insurers to fairly share the costs of expensive cases so that no insurer is

disadvantaged relative to its competitors and all insurers have incentives to compete, on a level playing field, in offering the best value to subscribers.

For a further discussion of these concepts, I would refer you to two papers I have published on the topic.³ However, for purposes of today's discussion I would simply note that the absence of such a mechanism in the Massachusetts reform design has in some degree limited the Connector's options and contributed to the delays that they have experienced in implementing their private market reforms. In contrast, the Utah legislation sets up tackling both the "front-end" and a "back-end" components of risk adjustment as one of the first orders of business in implementing their private market reforms.

4) The role of "automatic enrollment" and "personal responsibility" provisions.

Finally, there is the consideration of other, accompanying changes that lawmakers can make to ensure the success of reform efforts. The issue is identifying other provisions to further prevent the market destabilization that would occur if individuals with the ability to pay for coverage chose to decline coverage until they need it.

My first suggestion is to include an "automatic enrollment" feature to accompany employer participation in a health insurance exchange. In other words, rather than leaving with individual workers the initiative to accept the offered coverage, the employer would instead pick one of the plans on the menu and the exchange would automatically enroll the employer's workers in that plan, but then give each of them the option to choose different coverage, or to decline coverage if they can show that they have coverage from another source, such as a spouse's plan or a public program.

Second, if the conditional guaranteed issue provisions I described above are to be extended to the non-group market, lawmakers will want to consider also adding "personal responsibility" provisions to the reforms. In Massachusetts, that took the form of the legislature requiring all residents to obtain health insurance coverage, and unless otherwise exempted from that requirement, pay a fine if they fail to do so. While such an individual mandate to buy coverage has raised philosophical objections, as well as some practical difficulties in defining and enforcing it, I would note that it is not the only option available to lawmakers. Indeed, then Governor Romney's original proposal would have allowed individuals to fulfill their "personal responsibility" requirement in other ways, such as by setting aside money to pay for their own medical care.

Regardless of the mechanism the basic principle is the same, and it is a sound one. Namely, if lawmakers are going to reform health insurance markets to make coverage

³ See: Edmund F. Haislmaier, "State Health Care Reform: The Benefits and Limits of "Reinsurance," Heritage Foundation *WebMemo* No. 1568, July 26, 2007, at www.heritage.org/Research/HealthCare/wm1568.cfm, and; Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Background* No. 2166, July 28, 2008, at www.heritage.org/Research/HealthCare/bg2166.cfm

portable and accessible for all, further provide all individuals with a wide choice of coverage options, and finally, ensure that those with lower incomes have sufficient financial help to buy coverage, than citizens have no excuses left for not obtaining coverage, or otherwise paying for the medical treatments that they and their dependents receive.

Mr. Chairman, this concludes my prepared remarks. I will be glad to answer any questions you or the other committee members may have. Thank you.

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Mr. PALLONE. Thank you, and I want to thank all the panelists. We are going to have questions now. Each member gets 5 minutes, as you probably know, and I will start out with myself. And I wanted to ask Mr. Kingsdale. You have achieved remarkable results in Massachusetts with your two connectors. Our national rate of uninsurance is 17 percent. In Massachusetts, just 2.6 percent are uninsured. But to achieve this result, you have in place a requirement that all residents must have health insurance coverage that meets minimum standards for adequacy, and I just want to ask a few questions about this individual mandate and how you ensure that the coverage people are required to buy is affordable.

I have four questions. I am going to try to go quickly here. What type of coverage does Massachusetts require its residents to have, and how is that individual mandate enforced? Of course, I heard about this during the presidential campaign, but I want your opinion.

Mr. KINGSDALE. Thanks for the question. If you require insurance or anything, you have to set a minimum standard. Obviously a dollar of coverage per year does not constitute real insurance. And that has been one of the two thorniest problems, which the legislature in its wisdom as the board of the connector to resolve rather than to do in legislation.

And we have used a couple principles to develop what I would call minimum credible coverage. One is that, like any insurance, it ought to protect people from catastrophic costs so there are some maximum cost sharing elements to it. And the second is that because this is health care, which does differ in some important respects from other kinds of insurance, we actually require coverage up front of preventive care before a deductible and coverage with or without a deductible of a broad array of services, such as you would expect from coverage in your own health plan.

Mr. PALLONE. And how about the enforcement of the individual mandates? How do you do that?

Mr. KINGSDALE. The enforcement is through the tax code. The enforcement has been on the principle that it is good to have insurance and we want to help you get there, not got you. So the actual requirement went into effect July 1 of 2007. As long as you had insurance by December 31 of 2007, you did not pay a penalty. And if you did not have it, the penalty was pretty modest, \$219. That penalty goes up and becomes month by month as we move into 2008 and 2009.

We have exceptions for religious beliefs, a much bigger exception for affordability. Of course, we have significant subsidies to low-income people who are not eligible for employer-sponsored insurance to help them afford it. And then we have a robust and generous appeals process for individual cases. So we bend over backwards to try to get you there rather than penalize you for it.

Mr. PALLONE. Let me see if I can get to these other three questions. How did the state decide what combination of premiums, deductibles, coinsurance, other out-of-pocket payments were affordable for individual and families?

Mr. KINGSDALE. That is the other very tricky question. Again the legislature asked the connector board to do that. And we kind of did a bookends approach. So at the bottom of the income scale, zero

is affordable. And we defined that as 150 percent of federal poverty level. That is a fairly arbitrary decision but a gut check. And at median income—and ours is a wealthy state, so that's about 550 percent of federal poverty—we said you have to have insurance. There is no exception for affordability.

And in between, we basically do a scaled progressive schedule, but the principle underlying that is that by the time you get to 200 to 300 percent of federal poverty, so that would be an individual making \$21,000 to \$32,000 a year, where 80 percent of our citizens who get their insurance through employer-sponsored insurance, pay something like about \$100 on average per individual per month toward that. We thought that was a reasonable affordability basis. It had political equity. It would reduce or avoid crowd-out, and it seemed sort of gut check fair.

Mr. PALLONE. Now what about, have any studies been done to determine if rates of medical debts or bankruptcy have declined since Massachusetts achieved this near universal coverage?

Mr. KINGSDALE. That is a great question. I actually have asked several times to have such a study done. It is on somebody's project list, and I keep looking for outside research to do it. I am hopeful that the answer would be medical bankruptcies would go way down if you compare '08 to '06, but we have not done the study.

Mr. PALLONE. Let me just ask Ms. Pollitz, this issue again with the individual bankruptcy or debt. There was a study published by the Senate for Studying Health Systems Change that showed that 75 percent of those with medical debt in 2007 were actually insured. They had health care coverage, but they still had debt. Can you explain that? I mean this whole issue of people who actually have coverage going bankrupt or going seriously into debt.

Ms. POLLITZ. It can be a number of different factors. It could be that their policy doesn't cover all of the services that they need. May not have a prescription drug benefit, for example. If you have HIV and you don't have a prescription drug benefit or MS or something that has very expensive pharmaceutical need, then you could run up very high medical bills because those services aren't covered by your insurance.

There may be caps on what is covered. You see policies that, you know, only pay so many mental health visits a year, and then, you know, a kid gets an eating disorder. Or a policy that, you know, caps total benefits at \$10,000 a year, and then you have a heart attack that costs \$100,000. So that can happen.

Typically the literature on medical bankruptcy suggests though that it is not six-figure medical debt that is sinking families. On average, it is less than \$12,000 or \$15,000 in medical debt that will run a family over the limit and leave them to declare bankruptcy. And so we need to also look at cost sharing, and cost sharing that we might think of even as modest.

One study that I cited in my testimony looked at medical copays in the range of \$6 to \$25, and what those meant for people with chronic conditions, asthma and diabetes and so forth. If you are needing to, you know, take medication several times a day every day for your entire life and you are always refilling these prescriptions, those little copays add up and become thousands of dollars.

And if you add on to that, deductibles, copays for other medical care that you need, it really adds up remarkably quickly.

Mr. PALLONE. OK, thank you. Mr. Deal.

Mr. DEAL. Thank you. I want to get my transparency question out of the way real quickly. I think most of you were in the audience and heard my description of the proposed legislation. And I will just go down the list. Do you generally believe that pricing transparency is something that we need to enhance in our system regardless of what that system may ultimately turn out to be? Ms. Kofman, start with you, and we will go down.

Ms. KOFMAN. Thank you. I think it is critical when you have a private market to have transparency to provide consumers with useful information they can understand and use in making decisions. Right now, if you were shopping around, you couldn't get your policy ahead of time, the full contract. You can get a benefits description which may or may not be accurate.

So transparency in my view includes everything, from how your contract, how your insurance will work when you need it, to choosing your provider and to making more informed choices from start to finish. Right now, that just does not exist in the private market.

Mr. DEAL. Dr. Kingsdale.

Mr. KINGSDALE. I would strongly endorse the idea of making prices and benefits and everything else transparent. In fact, in our programs, that is exactly what we do. I have been in the insurance business for over 25 years before becoming a bureaucrat. And so I am pretty realistic about how much is achievable. Price is absolutely—and other information—requisite to a functioning market, but so is competition.

In Ms. Kofman's state and in most towns in my state, you don't have but one hospital, period. So you can know all you want about their prices. You really don't have a choice, and so it doesn't do you much good. So I am realistic about what you can do with it.

Mr. DEAL. But even in those situations where there is one hospital, who you are and who is paying the bill will determine what the price from that one hospital is because you have negotiated prices by government agencies. You have negotiated prices by private insurers, and generally, the ones that wind up in the bankruptcy court are the ones that don't have anything, and they are generally charged the highest price of all. Ms. Pollitz.

Ms. POLLITZ. I agree it is very important, and I commend you for your legislation. And I would just agree also that looking at all of the dimensions where transparency is necessary is important to do, and I hope that will be part of this effort as well.

Mr. DEAL. Thank you. Dr. Baicker.

Ms. BAICKER. Agreed. Transparency is a prerequisite for a well-functioning market, and the prices that we could publish now would be very useful. And even more useful would be building together bundles of prices that would really let people choose how much does it cost to have this condition taken care of by this group, not line by line. It is harder for them to aggregate, but you have to start with what is available.

Mr. DEAL. Mr. Haislmaier.

Mr. HAISLMAIER. Yes, Congressman, as I mentioned in my remarks, I do agree with you on that. I would simply, as I mentioned

in my remarks, encourage everyone to recognize that this is one very important piece of the puzzle, but it is not the only thing.

To follow up on what Mr. Kingsdale was saying, the first question is what does it cost. The next question is what am I getting for my money. And that is where you start comparing the data on quality and outcome. So you always have to ask that first question before the second question gets asked. That is true.

There are ways where you can do that not only in insurance but also in the provider side, which is really important. And I would also encourage folks to think not about the consumer versus the provider interaction but creating a common data set that all the insurers can use to act as the agents, as the experts, on behalf of the consumers in these decisions. And so a number of states are looking to do that.

And I think the regrettable thing about it, if Massachusetts's mistake in the beginning was not to have a risk adjuster, their mistake in implementation was that the governor and this administration recently cut back the cost and quality commission that was designed to do that in the legislation.

Mr. DEAL. Could I follow up with less than three-quarters of a minute? Would you contrast the Utah situation with the Massachusetts? What improvements do you think they made that were important? What other changes, if any, would you suggest the state look into?

Mr. HAISLMAIER. Well, I think the most striking thing about this—and you all as members of Congress will probably think of the very different politics of those states—but I would encourage you to realize that the most striking thing to me about this is when you rank the 50 states by the per capita cost of health care, Massachusetts is the single most expensive, and Utah is the absolutely cheapest. So those are vastly different in their health care systems.

That said, Massachusetts had a large amount of money that it was giving to hospitals, public dollars, to pay for the uninsured, which is now being converted into buying those people insurance. Utah is on the other end. They have almost no public money going to insurance. So what they are doing is, while Massachusetts focused on expanding coverage by subsidizing low-income individuals with the dollars they already had and is only now rolling out the reforms to allow employers and unsubsidized workers to have a choice of coverage.

Utah is going about it the opposite way. They are starting in the private market and then working towards the public side. That is my point is states are very different. Each can use the same things, but they have to find their own way and their own order for doing it that suits them.

Mr. DEAL. Thank you.

Mr. PALLONE. Thank you, Mr. Deal. Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. I apologize to the witnesses. There are so many conflicting appointments today and another hearing of the judiciary. So I missed the testimony of the witnesses, except for the first witness, and I apologize. I may go over something that you all covered, and again do understand though that you have written statements in here. We have memos that are prepared by staff. We are going to have many hearings.

Much of what you say here today, if not listened by individual members of the committee, believe me, these statements will be reviewed and may well serve as the basis for some of the memos in the future as we take on different panels.

I will start with pronunciation. Is it Dr. Baicker? How would you pronounce that?

Ms. BAICKER. Baicker.

Mr. GONZALEZ. Baicker, OK.

Ms. BAICKER. Just spelled funny.

Mr. GONZALEZ. No, it is spelled in a very interesting way. But you were here for the witnesses statements by the previous panel, were you not?

Ms. BAICKER. Yes.

Mr. GONZALEZ. OK, and in your own statement, and I couldn't agree with you more, and I am sure everyone that is here—in your statement, you indicate while there are many open questions in the design of the ideal system, with millions uninsured and rising costs threatening to swamp public and private budgets alike, we cannot afford to wait to act.

Obviously this committee is going to move forward. This administration is going to move forward, but I think you highlight the biggest obstacle. And that is something I referred to earlier when I was quoting from the two authors from the “Harvard Business Review” in the article No Doubt, but we still face the same problem.

How one balances these tradeoffs is likely driven as much by philosophy as economics. And any reform will involve tough choices between competing values, and I think that is the biggest problem. If we can just stick on the economics, the efficiency of what we do, we are well served. But you have already heard words like socialism, the Big Brother, and such. We need to get past that.

So the question is do we move forward now? And we do so, we are not talking about a single payer. Is that correct? Now, there are many here that would like that, but I am just saying is it going to be a public option. That is the way I like to think of it. And as we move forward again, leaving back ideologies, we have always said that we probably could form the most efficient system if the employer, which is the greatest purchaser of insurance, could lead that fight. That is what I had in the “Harvard Review” article, but that hasn't transpired in the past few years.

So employers haven't been able to identify a better system. The consumer is ill equipped. Ms. Pollitz, thank you very much for your comment. It was very sad in that “Time” article about someone from San Antonio who had an insurance policy that was totally worthless when his kidneys failed. So you can't say that the consumer is equipped to deal with this. The health care providers aren't doing it, not the medical professions. As a matter of fact, we have the specialties that compete with one another depending on what is going to be covered and when and how much.

So wouldn't it be appropriate for the federal government—and I know someone has suggested let every state do it individually. But what are your views today about where we are going and what we are going to be proposing as far as the federal government coming in and playing a major role? Yes, Dr. Baicker.

Ms. BAICKER. Thank you for the question. I think you have hit on so many important issues. One of the things I would like to pick up on is that there are things that we cannot expect a private market to do. Private markets are great at pooling risks, and there are regulatory requirements to ensure that they do so fairly and effectively. But we can't expect private markets to redistribute money from rich to poor or from people with low health risks, the healthy, to people with high health risks, the sick. That kind of redistribution of resources is fundamentally social insurance not private insurance. Social insurance need not be socialized. It could be done through the form of risk-adjusted vouchers where people with high health risks take extra money that they are given. Maybe particularly low income people get more generous risk-adjusted vouchers to ensure that they have access to the care that they need.

That kind of redistribution happens a little bit now because of the way that we subsidize employer-provided health insurance. The way that we subsidize it encourages some risk-pooling in the employer market by encouraging high-risk people and low-risk people to stay in the same pool, whereas otherwise low-risk people might flee.

Now, is that the most efficient way to do that kind of subsidization of high-risk people? There are probably other ways that we could accomplish that goal that might have better distributional implications while preserving what is good about the risk pooling that is occurring right now.

Any reform going forward that is going to take care of our most vulnerable citizens is going to have a component of social insurance, and that is the way we should be thinking about that function, not trying to impose that on private markets that are ill equipped to do redistribution.

Mr. GONZALEZ. Thank you very much. I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Dr. Baicker, if we could just continue on that line for a moment. One of the things that was talked about in the fall campaign was using the best practices of the states that had high-risk pools and trying to construct or constructing rather a mechanism for dealing with individuals who had conditions of medical fragility that would apply to their unique situation without changing the landscape for everyone else. Is that still a realistic possibility in the environment that we find ourselves today, taking the best practices from the states that have high-risk pools?

Ms. BAICKER. I think we certainly want to learn from the diversity of state experiences, and some states have high-risk pools that are functioning much better than others. And there are some general principles we can draw from that, more broadly subsidizing the high-risk pools rather than trying to subsidize them from narrow tax bases, for example, seems to be a more productive way of subsidizing them. Again that is falling under the role of social insurance where you are explicitly trying to redistribute some money to high-risk people who are otherwise uninsured.

I would think the first goal of a reform would be to get people insured as early as possible while they are healthy so they can in-

vest in their health so they get the most efficient they can. And a system that is designed to minimize the number of people in that condition in the first place could spread dollars a lot further. Then I think it would be great to learn from best practices at the state level to deal with people who fall through the cracks and to ensure that there is a broad enough subsidization that it doesn't drive a cycle that leads to more health people being uninsured for example.

Mr. BURGESS. All right, thank you. Dr. Kingsdale, on the Massachusetts experience, do you have a figure on the number of people who are paying the fine rather than buying the insurance?

Mr. KINGSDALE. We have a lagging indicator because you file in April, of course, for the year before, and some people get extensions. So we have it only for 2007, and that was about 100,000 people—

Mr. BURGESS. And so you will—

Mr. KINGSDALE [continuing]. About 1.5 percent of our population.

Mr. BURGESS. And then you will have comparable data that you will generate this—in your file period, April 15, like the federal income tax?

Mr. KINGSDALE. Right, although 10 percent extend until October, but we will have pretty good data.

Mr. BURGESS. Yes, I do that too.

Mr. KINGSDALE. Got to try that.

Mr. BURGESS. Mr. Haislmaier, if I could ask you on the—you pointed out that a lot of things are being done by the states now, that they have a great deal of flexibility. In fact, I think we gave them a great deal of flexibility in the Deficit Reduction Act in 2005. Ezekiel Emmanuel writing with John Lyndon in the "Journal of American Medical Association" in October of this past year alluded to that and said the one thing the states cannot do is to alter the federal tax code, that it is not within their power to do that. So could you speak to that?

Mr. HAISLMAIER. Sure.

Mr. BURGESS. We heard a lot about taxing health benefits during the fall campaign. It appeared to me at the time to be something that was disfavored by the parties that won, but now it seems to be coming back in vogue. And I wonder if you might just address that.

Mr. HAISLMAIER. Well, I think it all depends on what you do with the money once you have taxed them. Most of the proposals I am familiar with, and I worked on about eight different ones over the years from everybody from Mr. Army to Mr. McDermott on changing the tax treatment in Congress, would redistribute the money in the form of new tax credits to address some of the equity issues that were addressed earlier.

The illustration would be the unsubsidized commonwealth choice plans that are now being rolled out in the Connector in Massachusetts and is envisioned in other states whereby an employer would say look, instead of offering you a group plan, I am going to take you down to the Connector and you will each, as employees, have a choice of that menu of plans that they have on offer. And you pick what is best for you. It is all guaranteed issue. If you leave me, you are still in the system. You still have your insurance. You take it with you, et cetera.

That is structured in a way that under federal employee benefit law, it qualifies as employer-sponsored insurance and therefore qualifies for favorable tax treatment. The problem becomes that that favorable tax treatment is essentially the deduction against income and payroll tax. So if you are a lower wage worker who pays no income tax, that is worth 15 cents on the dollar to you. That is your payroll tax. If you pay the employer/employee share 15 cent at payroll plus you are in the 15 percent income bracket, it is now 30 cents on the dollar up to like 50 cents on the dollar for somebody who is maybe making \$100,000 in the 28 percent bracket, et cetera, or the 31 percent.

So the idea of tax reform is to change that to redistribute the money more equitably. The state can only maximize their citizens' access to those federal benefits. They can't change the federal benefits. There are other places in federal law where you could make changes that would aid the states.

Mr. BURGESS. Just one quick question. As I understand it right now, there is not a public option plan in the federal employee health—

Mr. HAISLMAIER. No, there is no public option.

Mr. BURGESS. Would there be an advantage to putting a public option plan on the—

Mr. HAISLMAIER. Well, my approach to the public option plan is I—you know, it strikes me as one of these fad and silver bullet things that go around as I talked about earlier. I look at it this way. No matter how you cut it, the government always sets the rules.

Now, you in Congress have a set of issues because some of the rules are set at the federal level like this federal employee benefit law, Inirisa, HIPAA, COBRA, tax treatment of health care, the Medicare/Medicaid program. OK, but then other rules like licensure of providers, regulation of insurance is done at the state level. So your issue is which one is going to set which set of rules.

But beyond that, you then have this issue, whether it is federal or state is, you know, if competition is going to work, everybody competing has to be on the same set of rules, right? OK, now you get to point three, which is oK, can the entity that is inherently the rule setter field the team in the competition and have that fair? I mean, you know, is the public plan going to have to meet the solvency requirements their a private insurer would have to meet in Ms. Kofman's regulations? Are they going to have to have prompt pay laws? Are they going to have to have, you know, can you sue them, or is sovereign immunity going to prevent you from suing them? When they deal with doctors, is it purely on a contractual basis, or is it like Medicare where if the doctor does something you don't like, you can say it is criminal because it is fraud.

These are all questions you have to work out, and depending on how you answer them will depend on whether it will work well.

Mr. PALLONE. We have to move on here. Thank you.

Mr. BURGESS. To coin a phrase.

Mr. PALLONE. Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman, and thank you to the panel. Your testimony has been very thoughtful, and I was glad that you raised the value of the premium dollar for individual

health coverage because I am very skeptical in the individual market that consumers are getting the value of the health benefits they need. And I have read testimony and understand a lot of that dollar that consumers pay is going for other purposes other than the health of that individual.

And Ms. Kofman testified that in Maine, insurer administrative expenses have more than doubled in the past eight years. This is at the same time when all across the health care spectrum, the premiums are going way up, and what you receive, what a family receives, just isn't what it used to be.

And you also noted that in the past three years, the state's largest insurance carrier has declared \$152 million in dividends. So as regulators and experts in the individual health care market, tell me, on average, how much of the individual health insurance premium dollar is spent on covered medical benefits, and how much is spent on marketing and administration including high executive compensation and profit? And then how does this percentage or medical loss ratio compare to the medical loss ratio in employer group health insurance products? And what explains that difference? And what do you recommend? How can families and consumers get a better deal? Why don't you start?

Ms. KOFMAN. Thank you very much for your question. I apologize for my voice. I am trying to get over a cold. In Maine we have, excuse me, 65 percent medical loss ratio requirements. We have two companies in the individual market. One was not meeting the 65 percent loss ratio. They paid out, I think, 50 some cents on every dollar they took in for medical. And so exercising my authority as a state regulator, I ended up requiring them to refund the extra premiums they collected, and I also fined them \$1 million for violating the state law.

The other major carrier, which is the majority of our market, they pretty much pay out over 90 cents on the dollar that they take in in medical. Now, there has been a whole lot of discussion about the cost of guaranteed issue and adjusted community rating requirements, those protections that allow sick people to access the private market. What that means is a lot of what the carriers take in, they do pay out in medical claims, but they also achieve healthy profits from being in the private market.

Earlier, you heard that the private insurance market isn't really set up in a way where carriers can assume too much risk. I would say if you are going to have a private market where insurance companies are allowed to profit, it is equitable and fair for them to take on risk, and we shouldn't expect taxpayers to pay for the sick while insurance companies are very profitable and make millions and billions of dollars in the industry. So if you are going to have a private system, the carriers have to assume the risks, and the taxpayers should not bear the burden.

Mr. KINGSDALE. If I could add to that, I think it is—to your question about how much administrative costs in a non-group market. It is highly variable with the rules that are set up. So in Commonwealth Care, our subsidized program, this is really kind of individual insurance. Individuals sign up. Their administrative costs run about 8 percent. In the non-group market more broadly in

Massachusetts, they probably run twice that, maybe 12 percent, something like that, maybe not twice.

In California, I am told, brokers earn 10 percent just for their services. So it depends very much market by market what the market rules are. And, of course, one of the great things, potentials, about the connector—remember my 20 to 30-minute shopping. It is all on web—is we can take the distribution costs of non-group insurance because they are very, very high even without large commissions. In an unorganized market, they are just very high. There are no scale economies. It is a one-on-one, hand-to-hand combat kind of situation to sell a policy and explain it. We can take those way down. And if you add scale economies with, on a national level, millions of people buying this way, you are talking about a couple of percentage rather than 10, 15 percent. But it does depend on the rules and how you have structured the market.

Mr. HAISLMAIER. Ms. Castor, could I comment on that as well, or do you—

Mr. PALLONE. I am sorry. You can comment. Sure, go ahead.

Mr. HAISLMAIER. I am sorry. This question comes up at the state level a fair amount, and I just would want to make the observation I have suggested to states that what they can do, and, in fact, Jon might be able to do this in connector too, is to simply publish, apropos of the transparency, the loss ratios. And you publish what last year each company for each plan paid out in claims and what they retained for administration, profit, et cetera with the proviso that you let them buy it down. So in other words, the dollar premium that was either paid out in claims or refunded to the policyholders.

Now, in that kind of a world, imagine you have two plans that are pretty much the same and cover the same benefits, et cetera, but one does a better job of managing care than the other, oK. And the one that does the better job of managing care costs \$4,000 instead of \$5,000, but to get that care managed, their loss ratio is 70 percent not 80 percent because they had to spend more in administration. Which would you buy? Would you buy the one that spent more in administration but produced the \$4,000 premium because they did a better job working with providers to manage care? Would you buy the plan that was \$5,000 but paid 80 percent out in benefits? If you put the information out, people can make those decisions would be my suggestion.

Mr. PALLONE. Thank you. Mr. Gingrey.

Mr. GINGREY. Thank you, Mr. Chairman. Dr. Kingsdale, in regard to the Commonwealth health insurance connector, I was curious to know in comparing the Commonwealth Care versus the Commonwealth Choice, what has been the experience in regard to what consumers are choosing? Maybe that was in your written testimony. I did read it, but it was the wee hours this morning. But what is the breakdown at this point?

Mr. KINGSDALE. Yes, there are two very distinct programs so it is going to be hard for me to, I think, answer your question in a way that is going to satisfy probably the intent. So the four health plans that are available—and now we just could open that up to competition because they had restrictions in the original legislation. So we are adding a fifth, the first new entrant, major new entrant into the insurance business in Massachusetts in decades. But

those four/soon five all basically serve Medicaid and lower income folks. And while two of them also participate in the unsubsidized program that has—

Mr. GINGREY. So your Commonwealth Care is the subsidized program?

Mr. KINGSDALE. Right, and the Commonwealth Choice is unsubsidized. That is dominated by commercial insurers who are not in the low-income Medicare—

Mr. GINGREY. So they really don't—

Mr. KINGSDALE. They are really very separate.

Mr. GINGREY. The patients or the consumers don't have a choice. It depends on their income status.

Mr. KINGSDALE. Right.

Mr. GINGREY. If they need a subsidy, then their choice is care.

Mr. KINGSDALE. Right.

Mr. GINGREY. If they don't need a subsidy, then their choice is choice.

Mr. KINGSDALE. I will take a stab at one thing that might be helpful, which is because the transparency and because the price differential, the premium differential is 100 percent borne by the individual making the choice, there is disproportionately large purchase of lower-priced plans even though the lower-priced plans may have by far much less brand name recognition than the higher priced plan offering the same.

Mr. GINGREY. Well, let me ask you this follow-up. In regard to that, in the Care plan, the subsidized plan, I guess physician fees, reimbursement rates for provider care is set. And are you finding that the many physicians, the acceptable rate of the Care plan in the commonwealth is pretty high?

Mr. KINGSDALE. Well, yes, and that is—

Mr. GINGREY. Are you running into problems with that?

Mr. KINGSDALE. Not really, and that is part of an ethos of shared responsibility. There is tremendous support for this program among physicians, hospitals, insurers, employers, et cetera. You know, all but 2 legislators, all but 2 of 190 voted for the thing.

But Medicaid MCOs that serve that lower income population, Commonwealth Care, while the fees are not set, so they can get negotiated up, kind of the reference point, the starting point that people have in mind when they start those negotiations are Medicaid fees. And they say you are going to pay us 10 percent more than that. As opposed to the commercial side where they might say we are starting at 150 percent of Medicare.

Mr. GINGREY. Right.

Mr. KINGSDALE. So it is a bifurcated set of negotiations.

Mr. GINGREY. Well, the reason I asked that question, of course, as we go forward and we are looking at all the options and hearing from all the experts in regard to, you know, the federal exchange connector, if you will, and the public option plan. And I just wonder if physicians are not forced, if they take any patients within the exchange that they would also have to take the public option.

But if not and those fees are set so low, then you are going to have a lot of resistance, a lot of push back. And again what we are saying is what good is that card if there is no doctor that is going

to accept the public option. So that is a concern of mine, other than the additional concern of the crowd out.

Let me shift real quickly to—is it—

Mr. HAISLMAIER. Haislmaier.

Mr. GINGREY. I have already messed up once today on pronouncing one of my colleague's name. Doctor, I wanted to ask you on page three of your testimony, you speak at some length about market reforms that would "realign insurer incentives away from avoiding risk and toward maximizing value" and you cite in your testimony the need for risk-adjusted mechanisms to ensure the market works smoothly and fairly for all insurers and policy holders.

It would seem to me that these market reforms that you talk about in your written testimony might address some of the major breakdowns in health care today without requiring government-controlled care. And I would like in the 15 seconds left, could you elaborate on these risk-adjusted mechanisms a little bit more if the chairman would bear with me?

Mr. HAISLMAIER. Yes, sir. Very simply—and I reference two papers in the footnotes in this testimony that are on our Web site that I wrote on the subject if you want to go into it in more length.

But essentially in a market that is underwritten where the insurer could turn you away, OK, what we have created is a high-risk pool that says well, you can be guaranteed issue into there. OK, so the person who is sick gets sent over there, all right. If you have a market where the insurers can't turn you away, as we are talking about in the employer group market when you go to the connector or if you would expand guaranteed issue to the individuals, then you can't send the sick person off there.

So what you do is you create essentially the same mechanism. It is just the insurers get in the room together and they put in the pot all their claims. I have five diabetics, you have three cancer patients, and we are going to sort it out and do it in a fair way.

Now there are many different ways to do that, but that is essentially the concept behind it. And my point is for the market to work well so that the insurer can say hey, you know, I do a good job of treating diabetes. I can help coordinate your care so you get better results at a lower price, and then they get all the diabetics and somebody else gets all the cancer patients. Well, they can work it out in the back room on their own. That is what a risk-adjustor pool does OK, and it spreads the cost among everybody else. As opposed to saying well, you are sick, go there, and then we are going to spread that cost over everybody else.

So it is the same concept. It just depends on the market you have. Again the papers discuss it in more length.

Mr. PALLONE. Thank you. I am going to have to stop you because they are telling us we are going to have votes, and I want to get the last two members in here. Ms. Capps.

Ms. CAPPS. I am sorry. Thank you very much, and I just got a tip, but I also have some questions I want to ask. This has been a very interesting panel, and I appreciate your contributions, each one of you. I will single out two people because five minutes goes very quickly. But I understand, Ms. Pollitz, before I ask you my

question, which I am very interested in your response to, that you never got to weigh in on the risk adjustment or risk insurance.

Ms. POLLITZ. Well, I didn't think I was asked but—

Ms. CAPPS. No, that is why I am giving you a chance to if you could briefly do it.

Ms. POLLITZ. Sure, I think reinsurance is a mechanism that has been tried on a voluntary basis in a lot of insurance markets. And public reinsurance has been tried in a few states as well. It is simply another way to subsidize health insurance at the end of the day if it is public reinsurance. Instead of subsidizing the premiums, which come regularly on the first of every month, you need to sort of reach in and find somehow the high-cost claims or the high-cost patients.

So it, I think, can achieve the same thing. It is more complicated. There are many more transactions involved, and at the end of the day, you need to make sure that if the end result is to subsidize the premiums, if that is what you want, to have the premiums reduced, then you need to have very, very good transparency to make sure that all of those savings from the reinsurance actually find their way back into reducing the premiums. Otherwise, you know, kind of like we are having with AIG now.

Ms. CAPPS. I hear you.

Ms. POLLITZ. You are putting a bailout in, and you are not getting the result that you want.

Ms. CAPPS. OK, thank you. Now, could I ask you the question that I had intended? And you will understand why when I tell you where I am coming from. I am hesitant about proposals that suggest that people should just purchase insurance in the individual market, whichever state they are from or wherever they are, because there are states like California that offer much stronger minimum protection for insurance.

For example, California mandates screening for osteoporosis while most other states do not. That happens to be a topic I am personally very interested in. California also requires private insurers to cover treatment for eating disorders. More than half of the states do not. So that would make a huge difference to Californians if they got their insurance in another state that then refused to cover—and they came to California and refused to cover that. Wouldn't a public option be able to account for variances in state protections and be more consumer friendly? Also couldn't a public plan be formulated in a way that protects the strongest minimum coverage provided to individuals so that you would get the benefit from living in a state where these things were mandated?

Ms. POLLITZ. It is absolutely up to the Congress to determine whether you want to set these standards at the lowest or the highest common denominator or somewhere in between. So you absolutely could create a public program that provides for comprehensive coverage so that people get the care they need everywhere. And I would defer to Mila on the other issues about selling coverage.

Ms. CAPPS. Right.

Ms. POLLITZ. In addition to the concerns about not being able to access benefits, I think there are real questions about—and I have enormous respect for Mila—but whether she has the resources to

enforce against a plan in California. Or a resident of her state who would buy 3,000 miles away and then get into trouble——

Ms. CAPPS. Right.

Ms. POLLITZ [continuing]. I think would be very difficult.

Ms. CAPPS. And some of us in states like California are worried about the opposite, but I could see it going both ways. For example, people who worked so hard in California to do the things like what I have just mentioned. This would be a huge step backward if we would be forced into what we would consider a step backward.

And I am going to need a little extra time, Mr. Chairman, because I kind of did something else too. But because, Ms. Kofman, I am really interested. You can speak to this one issue if you would like to. But I wanted to learn more about programs that you have been able to create, which bridge the gap between Medicaid-covered individuals and those who are uninsured but don't quite qualify for Medicaid.

For example, I will tell you where I am coming from in my district. In fact, in each of the three counties I represent, we have seen some very innovative proposals such as county-organized health systems which better capture all Medicaid eligible individuals in using a sort of managed care model, non-profit, but a locally organized one.

And also then there is another program in Ventura County, which refers to the person I acknowledged this morning in my opening statement. Because she lived in Ventura County, those who are uninsured but don't qualify for MediCal or Medicaid in Ventura County have access to another program. And they have seen such a dramatic decline in emergency room visits for non-urgent care as a result. And that is the kind of outcomes we should strive for because they can put that money back into the system and help extend it to more individuals.

The reason it works—and this is what I would like you to verify or add to—is because it is public-public partnership whereby the local government can provide the innovation and creativity in creating a system that works best for their particular population.

Can you talk—I know it is briefly now—about how have you done this? How have you managed to tailor a plan that Maine really benefits from?

Ms. KOFMAN. We have a slightly different partnership, public-private partnership which I call a bridge program. It is called Deargo Choice. Right now, due to funding challenges, it is not open for new enrollment. But essentially the state helps to pay for the premiums. There is a private insurance company that provides the coverage, but it is a Deargo agency that negotiates the benefits, the price, and people who really can't afford the private coverage but are working and make too much money to qualify for the public insurance program, that is the place where they can get coverage where there is a private payer that pays their medical bills. And the state helps them with the premiums.

The program has served over 23,000 people, both small business workers, their families, as well as individuals. Unfortunately because of funding challenges, it hasn't been open for new enrollment. And as premiums have gone up even slightly in that pro-

gram last year—I believe it was 11 percent, which in our market is slight.

I can tell you that the major carrier recently came in with a premium increase of 40 percent, and actually that was for their consumer-driven product higher than the other products they sell. So 11 percent premium increase for the Deargo Choice is not as high as the rest of the market is asking for. But that forced some people to leave that program because they just couldn't afford even the 11 percent due to limited incomes. Their wages have not gone up, and everything else has gone up, the price of food, gas, energy. So it has been really different absent a strong and real financing mechanism.

There has been a lot of talk here that states could do this. If we were able to address—

Mr. PALLONE. We are going to have to—I am going to have to cut you short because we have one more member, and we have three votes so—

Ms. CAPPS. Well, could she finish her sentence? I just wanted to hear—

Mr. PALLONE. Sure, go ahead.

Ms. KOFMAN. States need help. If we were able to tackle the health care crisis, we would have done it. We want to do it. We cannot do it alone despite Ed's comments earlier. We need help, and we want to be your partners in tackling the health care crisis.

Mr. PALLONE. OK.

Ms. CAPPS. Well, to make this work, there are times when the federal government should really shift the balance a little bit more when states are having a hard time. Or that is one of the ways that it could survive. Thank you.

Mr. PALLONE. Thank you. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. Ms. Kofman, I just want to make sure. Did I hear you earlier say that there are only two carriers in the individual market in Maine?

Ms. KOFMAN. Actively selling. That is correct.

Mr. SHADEGG. Tragically I think that is the situation in most states where people forced into the individual market have almost no choice whatsoever. A public plan which they could buy as an individual would be another option for them that would give them at least one other choice? Is that what you understand?

Ms. KOFMAN. Yes, people want real choices. To the extent that the public plan offers good coverage, adequate coverage that pays for you when you are sick, that is a real new option that people would benefit from. I talk to providers and individuals alike, and people are losing faith in the private market.

There is this perception out there because the profits have been so high that claims decisions are not made in the best interest of the insured person. And I can tell you they are, but the perception there is not the reality, and I think many people would choose the public option because of those reasons. And I think the public option would give—

Mr. SHADEGG. I understand that.

Ms. KOFMAN [continuing]. Real competition for the private plans out there.

Mr. SHADEGG. Well, I believe that there have been instances where benefits have not been paid in the interest of the beneficiaries. Indeed, I conducted a long campaign against HMOs who I think were denying care to try to make profit. But we have people forced into the individual market often because of the tax treatment. Some people can get health care inexpensively through their employer on taxpayer favored basis. But if you go buy it in the individual market, you pay with after-tax dollars, making it much more expensive.

Would you then favor mechanisms that would create other group purchasing options so that people could pool through a mechanism other than their employer?

Ms. KOFMAN. I think we need a more equitable way to help people buy coverage, and people shouldn't be disadvantaged because their employer doesn't offer—

Mr. SHADEGG. I couldn't agree more.

Ms. KOFMAN [continuing]. In the individual market. I think in terms of pooling, the price of pooling—pooling in itself doesn't get you anything unless there are real protections and oversight around pooling. So I would be very supportive of increasing and incentivizing more pooling as long as there are real protections for people who want to be in those pools.

Mr. SHADEGG. Mr. Haislmaier, high-risk pools. As I understand it, you just tried to explain or discussed with Dr. Burgess the issue—or maybe it was with Dr. Gingrey—people who are high cost can either be put in a high-risk pool or kept within the existing pool of insurers in a given state. Is that what the paper you discussed addressed?

Mr. HAISLMAIER. Basically what you are doing is you have a—both of them, a high-risk pool or a risk-transfer pool are mechanisms for pooling on a market-wide basis. So you start at the individual insurer level where they say well, I get some sick people and some healthy people, and there is a cross-subsidization of the sick by the healthy.

The next step is to say well, we are going to take all the insurers in the market, and we are going to do this same sort of cross-subsidization for the whole market, defined however you want, a region, a state, whatever. But for purposes of this probably a state.

Now, at that point, you have a decision. If the insurance is provided to the individual on the basis of underwriting where the insurer—a seller-driven market where the insurer can refuse to offer coverage, then what you do is you send that sick individual over to a high-risk pool. The excess cost is then passed back onto all those people you did—

Mr. SHADEGG. I wrote the state high-risk pool.

Mr. HAISLMAIER. Right.

Mr. SHADEGG. What is encouraging—

Mr. HAISLMAIER. So all I am saying is a risk-transfer pool is simply the same mechanism, but it is for a market where it is guaranteed issue and you can't send the individual off. You take the individual, you send the claim off.

Mr. SHADEGG. Let me change topics. Ms. Capps just talked about the fact that she loved the California mandates. She likes certain things that are mandated under California law for coverage. You

mentioned earlier one of your concerns about a so-called public plan—and I think you are right. It is the current system in vogue or the idea in vogue—would be well, what does it cover, what doesn't it cover. I think you also touched upon a point that I think I touched upon in my questioning earlier. And that is if the government offers a public plan and the government also sets the rules for that plan and for all the other plans, isn't the government both a player in the game and the referee of the game? And I would like to see if you do agree with that point and if you would expand upon it.

Mr. HAISLMAIER. Well, very simply, the last point, the government will always be the rule setter. So in a state, any state right now, they could set up a public plan in competition. I mean Massachusetts could do it with the connector if they wanted to, OK. You will always have that question of do they play by exactly the same rules because what we know is that when you have different rules, then you will have market segmentation.

We have seen this in Maryland. We have seen this—I mean I have just been dealing with Washington state where they allowed association plans one set of rules for the small group market and commercial insurers another set of rules, and it has created all sorts of problems. So the first rule, whether it is a public or private plan or two groups of private plans, is, is everybody playing on the same rules.

So that is one level of questions that you would confront regardless at any state. Now, if you are at the federal level, you have all those questions, but now you have an additional set of questions, and the additional set of questions is, will the 50 states have different standards. As Representative Capps pointed out, whose standards are we going to apply nationally? OK, so you have all the same set of questions you have to deal with, plus you have another set.

Mr. PALLONE. We are going to have to—

Mr. SHADEGG. Well, just, Dr. Kingsdale, you said there are 100,000 people who have not joined or not paid in, they are simply unenrolled. In the first year, right. That was going back to '07. What does the system do for or about them? How do they get care?

Mr. PALLONE. Quickly because we have to vote.

Mr. KINGSDALE. OK, well if they are low income, they wouldn't be subject to that penalty. So they would basically be self-pay. They are part of the 2.5 percent that we haven't insured.

Mr. SHADEGG. OK, and—

Mr. PALLONE. All right. Well, we are going to run out of time if we want to vote. Thank you all. Again this has been very helpful in our efforts to try to put together legislation. And you may get some additional questions from members that you can respond to in writing. The clerk will notify you of that. But without objection, this meeting of the subcommittee is adjourned. Thank you.

[Whereupon, at 2:48 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Opening Statement of the Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce**

**Subcommittee on Health Hearing
*Making Health Care Work for American Families:
Ensuring Affordable Coverage*
March 17, 2009**

Thank you, Chairman Pallone.

As my colleagues are aware, today's hearing is the second in a series that will help this Committee as we attempt to provide needed reform to the health care delivery system in our country. I am particularly interested in the conversation that we will have on the need for comprehensive medical liability reform during the hearing scheduled for March 24th and how medical liability reform and other reform ideas will help improve the physician workforce in this country. I also look forward to the hearing on April 2nd that will focus on Subcommittee on Health Ranking Member Deal's *Health Care Transparency Act* and how providing patients with the right to know the prices of health care

services in advance will help the market function more effectively.

On behalf of the Republican Members of this Committee, Mr. Chairman, I want to thank you again for scheduling these important hearings. I also want you to know that we look forward to working with you in a constructive and bipartisan manner as try to make health care affordable and available to everyone.

You'd think from listening to some people that America is the worst place in the world to be sick, instead of the place where the world's sick come to get well. Our country has the best doctors and hospitals on the planet. But nearly everybody agrees that changes are needed if Americans are going to continue getting the care they deserve. The Republicans on this Committee stand for innovation, efficiency, and accountability in health care.

I got some attention the other day for saying that I was proud that I helped kill what we all used to call

Hillarycare. That's because Washington-controlled, bureaucrat-run health care is not a reform, at least not the kind that most Americans want. A system where you have to see a bureaucrat before you can see a doctor wasn't what Americans wanted then, and they don't want it now.

We all agree that insurance needs to be affordable, and that the system has to deliver better value as well as better care. Health care costs \$2.3 trillion per year or approximately 17 percent of the American economy. So as we consider reform, we'll have to fix the root problems and misaligned incentives that drive up the cost of care, reduce access, and generally make life rough for doctors, hospitals and patients.

To eliminate the tens of billions of dollars that are wasted each year by doctors being forced to practice defensive medicine instead of focusing on what is best for the patient, we'll need to face up to the medical liability crisis and junk lawsuits. Doctors shouldn't have to see their lawyers before they see their patients.

To help families make the health care decisions that best fit their unique situations, we need to empower patients with good information on the price and the quality of their options. We must also eliminate the unnecessary 15 to 20 percent of health insurance premium caused by providers overcharging everyone else in an attempt to make up for underpayments from the Medicare, Medicaid, and SCHIP programs. And, while we improve our system's shortcomings, we must keep doing what our nation does right – including equipping our nation's brilliant researchers to create innovative new treatments and breakthrough cures.

It seems to me that bipartisanship is both possible and necessary. Any successful reform will include the work of both Republicans and Democrats, and it must be subject to the full scrutiny of both the Senate and House of Representatives and the American people. Therefore, I am thankful for the chance to participate in this hearing today.

I thank you, Mr. Chairman, for your commitment to raising these important issues in a constructive manner. It indicates a break from the unfortunate beginning of the 111th Congress, which put us on the wrong track to address health reform – through piecemeal reforms in the stimulus legislation that was marked by an increasingly partisan and closed process. Despite this unfortunate start, I'm ready to work with you to pass a bill this year. The American people expect an open and vigorous debate on one of the most difficult challenges facing our nation. And they deserve a beneficial result from that debate.

Thank you, Mr. Chairman, and I yield back the balance of my time.

BLUNT STATEMENT FOR E&C SUBCOMMITTEE ON HEALTH

MARCH 17, 2009

Mr. Chairman,

Thank you for holding this hearing on the affordability of health care. It's essential that we work together to examine the issues that have caused health care costs to rise so significantly over the years. I think we can all agree at this point that the increases are simply unsustainable. We need to work together to find solutions that will give all Americans access to affordable coverage and quality care.

There is no question that Americans are concerned with the cost of their health care. In a recent survey conducted by HHS, 55 percent of the respondents listed cost as their primary concern – 31 percent are concerned with the cost of health insurance, while the remaining 24 percent are worried about the cost of health care services. Health care costs are among people's top three economic concerns. I believe that competition is going to be a key element of any health care system that is affordable and ultimately sustainable over a number of years. I do not believe that a government-run plan is going to offer cost savings or patient and doctor satisfaction in the long run. With a government-run plan, the private insurers will eventually

be forced out of business. The government is not a fair competitor, because it doesn't take into account the same real-world factors as private business.

We can find common-sense solutions. The Medicare Part D prescription drug program is an example. For the first time, the government organized a private, competition-driven system rather than operating the system. Cost is lower; satisfaction is higher; seniors have more options – competition works and it puts patients and doctors in the driver's seat. In fact, there is not a government-run plan offered under Medicare Part D and there is no government run plan offered to members of Congress and other federal employees.

I'm hopeful this subcommittee can find ideas and solutions to help bring down health care costs, which will allow more people to obtain the quality care they need. I look forward to working with you Mr. Chairman, with Mr. Deal and the subcommittee, as well as my colleagues in the full committee to achieve good policy in a bipartisan way.

**Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
Making Health Care Work for American Families:
Ensuring Affordable Coverage
Subcommittee on Health
March 17, 2009**

I want to thank Chairman Pallone for holding this hearing.

The challenge before our Committee is to enact comprehensive health reform consistent with the President's eight principles.

To achieve this goal, we need to ensure that health coverage is affordable. That is the issue that today's witnesses will help us solve.

We cannot — and I am determined that we will not — ask Americans to purchase health care coverage that they are unable to afford.

When we ask what individuals and families are able to afford, we need to look not just at the premium costs, not just at the deductibles and copayments, but also at whether the services they are likely to need are covered at all.

Similarly, we cannot — and I am determined that we will not — ask Americans to purchase health care coverage that is not worth paying for.

We must make sure that Americans have access to health insurance products that pay out most of the premium dollars they receive to providers for high-quality services that consumers need.

I look forward to today's testimony.