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# INSURED BUT NOT COVERED: THE PROBLEM OF UNDERINSURANCE

## HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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# INSURED BUT NOT COVERED: THE PROBLEM OF UNDERINSURANCE

**THURSDAY, OCTOBER 15, 2009**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

The subcommittee met, pursuant to call, at 1:40 p.m., in Room 2123, Rayburn House Office Building, Hon. Bart Stupak [chairman of the subcommittee] presiding.

Present: Representatives Stupak, Braley, Markey, Doyle, Schakowsky, Christensen, Welch, Green, Sutton, Dingell, Waxman (ex officio), Walden, Burgess, Blackburn, Gingrey and Barton (ex officio).

Staff Present: Phil Barnett, Staff Director; Bruce Wolpe, Senior Advisor; Mike Gordon, Chief Investigative Counsel; Dave Leviss, Chief Oversight Counsel; Stacia Cardille, Counsel; Molly Gaston, Counsel; Erika Smith, Professional Staff Member; Scott Schloegel, Investigator; Ali Golden, Professional Staff Member; Jennifer Owens, Investigator; Ali Neubauer, Special Assistant; Ken Marty, HHS–OIG Detailee; Sean Hayes, Minority Counsel; and Alan Slobodin, Minority Chief Counsel, Oversight and Investigations.

## OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This hearing will come to order.

Today we have a hearing entitled Insured But Not Covered: The Problem of Underinsurance. The Chairman, the Ranking Member and Chairman Emeritus will be recognized for a 5-minute opening statement. Other members of the subcommittee will be recognized for 3-minute opening statements. I will begin.

A few months ago our subcommittee held hearings on the health industry practice of terminating coverage after a policyholder becomes sick and files a claim. In our investigation we learned that if your insurance company believes you have an illness that may be costly, it will go back and reexamine your application for health insurance to find any excuse to cancel your coverage. As health insurance industry executives brazenly told us, this practice, called rescission, will continue until there is a national health care coverage for all Americans.

Today we continue our investigation of the private health insurance market focusing on the underinsured. An underinsured person is one who has health insurance coverage, but the policy does not adequately cover the health care costs or high medical expenses.

Underinsured individuals traditionally have high out-of-pocket expenses because of high deductibles and copays. In some instances people are uninsured because they can only afford a basic policy. In other instances policyholders believe that they have adequate coverage, only to find that there are limits buried within the policy, such as annual caps on the amount the insurance will cover or limits on the number of times the policyholder can receive certain services or treatments.

Regardless of how you define this financially fragile group, the sad consequences of being uninsured can be devastating; lead to financial ruin, bankruptcy and making medical decisions based on cost rather than care.

As the cost of health insurance skyrockets, more and more Americans are finding they can only afford bare-bone policies, leaving them one illness, one accident away from bankruptcy. According to the American Medical Association study in 2007, 62 percent of all bankruptcies filed in the United States were related to medical costs, and 78 of these filers had insurance. Many of these now bankrupt individuals were well educated, owned homes and had middle-class occupations. Unfortunately they were underinsured, and their health insurance did not cover their medical costs, forcing them to declare bankruptcy due to mountains of medical debt.

Still health insurance continue their unconscionable increase in premiums. Between 2000 and 2007, the annual family health insurance premium in Michigan rose 78 percent, while wages rose just 4.6 percent. I am currently receiving e-mails and letters from constituents reporting 22 to 40 percent premium increases in their individual health insurance policies. The average family health insurance policy now costs $13,125, which is, by the way, 34 percent of the median household income in my congressional district. The Commonwealth Fund, which will testify today, recently reported that, as a result, more families are experiencing medical problems or cost delays in getting needed medical care. In 2007, nearly two-thirds of U.S. adults, 116 million people, struggled to pay their medical bills, went without needed care because of the cost, were uninsured for a time or were underinsured.

Our first panel of witnesses will put a face on the frightening statistics found in the Commonwealth Fund report. Catherine Howard was diagnosed with breast cancer at the early age of 29 and survived to tell her story. Being young and healthy with a limited income, Catherine chose a low-premium, high-copay health insurance that left her in financial shambles after her breast cancer. At the time of her illness, she was earning just $20,000 a year, but her outstanding medical bills were $40,000. And Catherine was unable to work through her surgery, chemotherapy and radiation. To her credit, Catherine did not declare bankruptcy and is paying $1,800 per month on her outstanding medical obligations.

David Null will speak of his family and his daughter Tatem, who, at the age of 7, was diagnosed with liver failure. David bought health insurance for his family to cover emergency situations, not a policy to cover head colds. Still, when Tatem was on life support and needed a lifesaving $560,000 kidney transplant, David learned his emergency policy would only cover between $30,000 and $40,000, and the hospital was demanding a $200,000 deposit before

they would proceed with the transplant. Being underinsured left Tatem fighting for her life and David without a hope or a prayer.

Children's Hospital officials helped the Nulls qualify for a government-run, government-sponsored Medicaid health care program, and the entire hospital bill was retroactively covered. The catch is the Nulls could not earn more than $1,614 a month or they would lose their Medicaid coverage, which paid for Tatem's medication to prevent organ rejection, which can cost thousands of dollars each month.

Nathan Wilkes will tell us about his employer-provided health insurance with a $1 million limit for each family member. Unfortunately $1 million does not go very far when his son was diagnosed as severe hemophilia. Even though the Wilkes have paid up to $25,000 in a single year for out-of-pocket costs, Mr. Wilkes is unable to get a policy that will adequately cover his son's medical expenses. Now on his third insurance policy, Mr. Wilkes does not know how they will be able to afford his son's lifesaving medical treatments.

Each of these individuals and families did everything right; worked hard, purchased health insurance, paid their premiums, but were still left in financial ruin.

We will also hear, as I said, from Sara Collins of the Commonwealth Fund. She will discuss their study on how a number of uninsured have dramatically increased over the last few years and how now two-thirds, 116 million, of U.S. Adults struggle to pay their medical bills, like the Nulls, the Wilkes and Ms. Howard.

Stan Brock is the director of the Remote Area Medical Foundation based in Nashville, Tennessee. He has spent his lifetime coordinating with physicians, dentists, nurses and other health providers to provide free health care services to the uninsured and underinsured Americans. Mr. Brock will provide his insight and experience on how more and more Americans are showing up at his foundation seeking basic health care because their insurance policies will no longer cover their health care needs.

Each of us know a family member, a relative, a friend who did not go to a doctor when sick, who skipped a dose of medication or failed to fill a prescription, intentionally missed a medical test or a follow-up appointment, or did not see a specialist when needed because they could not afford the service, the medication or the test. I would hope every American will now take time to look at their policy and really understand what medical conditions does my policy cover or not, what is your copay, what is your potential for out-of-pocket expenses, do you have a lifetime cap of dollars or services with your insurance company.

The U.S. House will soon vote on H.R. 3200, America's Affordable Health Choices Act of 2009. H.R. 3200 does not allow insurance companies to rescind your policies when you are sick, it does not have a lifetime cap, and it will cover all Americans. Only the passage of meaningful health care reform, then and only then, will two-thirds of all adults not have to worry about how to obtain medical care for their families while remaining financially secure.

I next turn to the Ranking Member of this committee Mr. Walden of Oregon for an opening statement.

**OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON**

Mr. WALDEN. Thank you, Mr. Stupak, for convening this hearing.

As the Congress continues to debate ways to reform the health care system, the subject of this hearing should remain a top priority. As we will hear today, insurance does not always cover the complete cost of an illness or injury. This nagging question, if I get sick, will I be able to afford treatment, worries many Americans. Today, as we have heard from the Chairman, we will hear from several people who thought their insurance would be there when they needed it, and it was not.

David Null faced every parent's nightmare. His daughter fell into a coma as a result of a liver failure and needed a transplant within days. He thought his insurance would cover everything, but instead the policy only covered $25,000 of a $561,000 surgery. In order to pay for the transplant, Mr. Null had to turn away work in order to qualify for Medicaid.

Catherine Howard thought she had quality insurance. She had been happy with the coverage she had under a previous employer, so she purchased an individual policy for herself when she started working on her own. After being diagnosed with breast cancer, Ms. Howard learned that she would be paying approximately 30 percent of the treatment cost. Eventually she would end up $100,000 in debt.

And Nathan Wilkes also thought he had great insurance through his employer, yet his newborn son's illness required a substantial amount of care, and Mr. Wilkes soon learned that his health care policy had a cap, and that cap would eventually cut off care for his son. Meanwhile the premiums for his health care were beginning to rise substantially. The increased cost of care for his son was also driving up the cost of premiums for his employer.

I want to thank our three witnesses on this panel today for testifying and making your stories known. Their experiences, yours, are incredibly personal, and I want to commend you for agreeing to testify before this committee.

We will also hear from Sara Collins of the Commonwealth Fund and Stan Brock from the Remote Area Medical. And I thank them for their testimony as well.

Beyond the astronomical costs the underinsured face, this committee will also hear about other problems in the industry affecting our witnesses. Mr. Null will testify that he was misled by the company salesperson when he purchased the policy for his family. He considered himself a savvy purchaser of insurance, and he would research plans, purchase the ones that had offered him the best rate and coverage, and switched to a new insurer if a better deal came along. He told the insurance salesperson that he was looking for a policy that would cover "the big oh no." Instead he was sold a policy that capped hospital stays at $25,000, which in his daughter's case turned out to be only a few days.

Whether the salesperson's claims about Mr. Null's policy were fraudulent or mere sales puffery does not matter, because we can all agree that when selling something as important as health insurance, the American consumer needs to be protected from both fraudulent statements and over-the-top representations.

Two of the witnesses today are here to discuss the health care problems affecting their children. While these children are covered under family plans today, in the future their preexisting condition could limit the ability to obtain insurance themselves. Preexisting conditions affect many Americans, and I believe this committee and Congress need to work to make sure access to quality and affordable health care remains our top priority. We cannot ignore these problems, especially in light of rapidly increasing health care costs in the United States.

Over the last decade employer-sponsored health insurance premiums have increased 131 percent. Recent studies have found that in 1 year as many as 62 percent of all bankruptcies were linked to medical expenses, and 1–1/2 million families lost their homes due to these costs.

I again thank our witnesses for joining us, and I thank you for holding this hearing, Mr. Chairman.

On a personal note I would say that my wife and I were parents to a son who was diagnosed with hypoplastic left heart syndrome. We faced many of the challenges you faced when it came to trying to deal with the transplant that he needed. Tragically he passed away before he could have that transplant, but we faced many of the same issues that you faced and dealt with them as a parent, so I am deeply sympathetic to what you are encountering.

Mr. Chairman, I would like to remind this committee that on June 25th of this year, Ranking Member Barton and myself sent a letter to both you and Chairman Waxman requesting additional investigation hearings to follow up on our June 12, 2009, hearing on GM and Chrysler dealership closures. Interest in the subject was intense, as you know, at the time, and I hope this committee will not shy away from its oversight obligations on this matter, especially considering how the American taxpayer is now substantially invested in these companies. And I again urge you to hold additional hearings, including inviting the auto czar to testify and making sure that those who did testify provide us with the documents and e-mails that they said they would when they testified. So I have got another copy of that letter, Mr. Chairman, for both of you, and I hope you will take a look at it and afford us that opportunity to do the oversight that this committee has so proudly done in the past.

Mr. STUPAK. Thank you Mr. Walden.

[The prepared statement of Mr. Walden follows:]

Mr. STUPAK. Mr. Waxman, Chairman of the full committee, opening statement, please.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Thank you very much, Mr. Chairman. I want to commend you for holding this hearing.

The primary purpose that people have in buying health insurance is to protect them when they get sick and not to have catastrophic costs of health care drive them into bankruptcy. You should not have to go broke because you get sick, so people buy insurance to protect themselves. Yet we are finding out in the inves-

tigation this committee is doing on private insurance for health care that there are a lot of schemes that the insurance companies have not to pay.

We had a hearing earlier this year on how there is a thing called rescissions. Now, we all have heard that insurance companies don't want to cover you if you have preexisting medical conditions, and that means a lot of people can't get insurance even if they could afford to pay for it. But what some of the insurance companies have been doing is that when you get sick, they go back and look for some error on the application and then decide that they are going to rescind the agreement and leave you just high and dry without the coverage.

Today we are looking into another topic as we examine insurance company schemes, and this one is of underinsurance that people don't realize that they may face when they get sick. In recent years we have been looking at a lot of different problems, but we looked at rescissions. Now we are looking at underinsurance. But as we examine insurance practices, our committee has been looking into business practices in the small group market. And I am looking forward to the hearing on this topic next week where we will learn more about the challenges facing small businesses that seek to cover their employees. And they want to get quality, affordable health insurance for their employees, but the insurance companies will not cooperate and keep that insurance available to them.

But today's topic is underinsurance, and in recent years health policies have been costing more and covering less. The average cost of a family's premium has risen 131 percent in the last decade, while average wages have risen less than a third of that amount. Meanwhile benefits are declining, and employers are asking workers to shoulder more of the burden by paying higher premiums or other out-of-pocket costs.

Well, insurance companies ask you to pay more, but then there are a number of other ways they come up short. They can have caps or limits of the amount an insurer will pay for an individual's care over a lifetime or in a single year or for a particular service. And other plans exclude coverage for certain preexisting conditions or limit coverage in other ways. So in other words, what we are seeing are insurers increasingly shifting the risk to the individuals through greater cost sharing, such as higher deductibles, copayments or coinsurance. The risk should be borne by the insurance companies. That is why we are buying insurance in the first place.

So with skyrocketing health costs and skimpier coverage, we now see the ranks of the underinsured growing. In 2007, there were 25 million underinsured Americans, a 60 percent increase from just 2003. This is in addition to the 50 million people who are completely uninsured. Underinsurance is on the rise among both low- and middle-income Americans, and it often leads to medical debt that empties saving accounts and ruins credit scores. For many the medical debt is simply too much to bear. And a recent study found that 62 percent of all personal bankruptcies are related to illness or medical bills.

Underinsurance has grave consequences for a family's physical as well as financial well-being. I look forward to our hearing today from witnesses who have struggled with steep medical expenses de-

spite the fact that they paid for health insurance. And I want to thank Ms. Howard, Mr. Null and Mr. Wilkes for agreeing to share their stories with this committee. And I also look forward to hearing from Sara Collins of the Commonwealth Fund and Stan Brock of the Remote Area Medical Volunteer Corps about the growing problems of underinsurance.

This hearing comes at a time when Congress is struggling for health care reform. One clear reform has to be insurance reform to stop these medical insurance practices from going on. People shouldn't be fooled into thinking they are covered and then find out when they need their health insurance coverage the most that they are, in fact, underinsured.

This is one of an ongoing series of hearings from this committee. I think it is important that we have these hearings in order to drive forward legislation to stop these kinds of practices from going on in the future.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Barton, opening statement, please.

Mr. BARTON. Thank you, Mr. Chairman. Thank you, Ranking Member Walden, for holding this hearing. I am going to put my official statement in the record and just speak extemporaneously.

We obviously, on both sides of the aisle, believe that it is time to reform our health care system, and it is just as obvious that a part of that reform should be insurance reform. Myself, Mr. Green and Mr. Stupak and others offered an amendment at the additional day of markup several weeks ago where we put a transparency amendment in for the health care system, which would include insurance companies. And in underinsurance there is nothing more important than providing transparency so that individuals know what coverage they are really getting and the companies are up front about what coverage they are providing and what those caps are before the fact. It is terrible to find out after the fact, like Mr. Null found out that his what he thought was a catastrophic policy really wasn't, or it wasn't in such a way that it covered his daughter. So I think this is a good hearing. It is a part of the record that needs to be made.

I do want to say in response to what Chairman Waxman said that in the overall effort for health care reform, I do not believe a solution is a mandatory coverage requirement for individuals, because some individuals will be impacted in a very negative way by being mandated that they have to carry it. If we can get transparency and get competition and get reform across the board, then if you are not covered at work, and you want a private plan, and we set up with some of these pools, you will be able to choose from plans and know what you are getting.

But I have nothing but respect for the witnesses today that are going to give their case histories, because they are very moving. And I hope that a good thing will come out of this that will create a bipartisan consensus on some of the things that need to be done to reform the disingenuity in the private insurance market for plans like these folks have had to bear.

Thank you, Mr. Stupak.

Mr. STUPAK. Thank you.

For 3 minutes now we hear from the gentleman from Massachusetts Mr. Markey for an opening statement.

**OPENING STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS**

Mr. MARKEY. Thank you, Mr. Chairman, and thank you so much for having this very important hearing.

As we consider the urgency of expanding health care coverage and transforming our sick care system into a health care system in our country, this question of the underinsured is right at the heart of the matter, because there is an estimated 25 million Americans who are insured, but they are underinsured at the same time. And let us just focus in on this problem.

Medical bills are the leading cause of personal bankruptcy in the United States today. Sixty percent of all bankruptcies are because of medical bills, 60 percent. And of the 80 percent of people who went bankrupt because of their medical bills, 80 percent of them had insurance, and they still went bankrupt. Insured but not covered.

Now, I recently received a letter from a constituent in my district. He returned home from open-heart surgery and found a bill from the hospital informing him that his insurance company had denied coverage for the anesthesia used during the operation. They deemed the anesthesia, quote, "medically unnecessary," and demanded $10,000 for the anesthesia. Now, he asked me, did the insurance company expect him to take a swig of whiskey and bite a bullet while they cut open his chest? Well, unbelievable, but they did, and they sent him the bill for $10,000. Insured but not covered.

This is how we get 60 percent of all bankruptcies in America related to medical bills that people receive. It is unacceptable that patients must fight their health insurance companies for coverage while fighting disease at the same time as they are insured. It is unacceptable that parents have to help a child overcome a crippling illness while struggling to overcome crippling medical debt by postponing necessary treatment, skimping on food and even exhausting their savings so that they can qualify for Medicaid. It is wrong for health insurance companies to deny coverage for critical treatment when families need it the most. And I am pleased that the health reform bills that we are considering will make tremendous progress in this area.

The plight of the underinsured and the steady creep of the underinsured into the ranks of the middle class shows that health care affects each and every one of us, and now is the time for us to fix this sick care system and turn it into a health care system for all Americans.

Thank you, Mr. Chairman, very much.

Mr. STUPAK. Thank you, Mr. Markey.

Mrs. Blackburn for an opening statement, please, 3 minutes.

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

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to welcome all the witnesses and thank them so much for giving their time and for being here to share their experiences. And I especially want to welcome these two beautiful young girls that are sitting on that front row. We are thrilled that they have taken the time out—I bet it is a day out of school—and we hope that they see this as a learning experience.

Mr. Chairman, I do thank you for the hearing today. We are all concerned about coverage for preexisting chronic conditions. We are so concerned about the rescission issue. I think that where you are going to see some differences is how we approach the badly needed insurance market reforms that are out there. I am one of those that wants to keep things patient-centered, patients first, free-market-oriented. And I would like to see more competition in the marketplace as we seek to address this, allowing purchase of insurance policies from across State lines so that families have more options and more choices.

Now, in Tennessee, where I am from, health savings accounts are very popular. We would love to see the contribution and allowance limits there enhanced and to see incentives for individuals with healthy lifestyles.

Liability reform has already been mentioned this morning. The practice of defensive medicine does drive up costs, but it also plays in sometimes to that rescission issue, and we are aware of this and seek to address that and to address it in good faith.

I want to give a special welcome to Mr. Brock who is here. You are going to love hearing from him, and I commend him to my colleagues. The RAM program is one that we are very pleased with in Tennessee. Quoting from page 2, the second paragraph of his testimony, I want to highlight one thing: The greatest impediment to the RAM program is regulation in 49 States preventing willing practitioners from crossing State lines to provide free care. Now, in Tennessee we have addressed this issue; Dr. Burgess has talked about that issue, it came to light after Katrina. I am looking forward to hearing from him and to welcoming them today, and I yield back the balance of my time.

Mr. STUPAK. Mr. Welch, opening statement, please.

**OPENING STATEMENT OF HON. PETER WELCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT**

Mr. WELCH. Thank you, Mr. Chairman and Ranking Member Walden.

And the stories that each of you told really summarize, I think, what can only be described as the failure of the American health insurance industry. The health insurance industry, in fact, has served its own interests very well, but it has failed the American families and consumers, it has failed the small businesses that pay the premiums, it has failed our taxpayers, it has failed our doctors and our nurses and the health care providers.

What it has done is served its own interests very well: the CEOs, some of whom make $24 million in a year; Wall Street analysts

who cheer every time the medical loss ratio goes down, meaning that each of every premium dollar has less spent on health care and more spent on dividends, on CEO salaries. It has served—because it served its own interest very well, because essentially it is based on a model that you have heard described here, and that model says that if you are healthy, and you are wealthy, and you are unlikely to need it, we will insure you, and we will keep increasing your rates. But if you are sick or likely to get sick, if you are older, we won't ensure you; or if we do, we will make a policy so confusing and laden with so many loopholes that you won't get much benefit for the insurance that you thought you had. As Mr. Markey said, you are insured, but you are not covered.

And just another example to add to the laundry list here of horrors, this is much smaller and much more mundane, but it shows just the Alice in Wonderland world that the insurance companies operate in. We have a woman from Milton, Vermont, Cheryl, who had a policy that she thought had covered wellness screening. And she got a colonoscopy and was told that it would be covered, but lo and behold, a colonoscopy, in fact, diagnosed diverticulitis, and the insurance company said that procedure was no longer about wellness, it was diagnostic, and that was not covered, and they made her pay the $1,000 bill.

I mean, those days we have to put behind us because the insurance company has had its chance, and it has failed. And when a person buys insurance, when a small business pays a premium to cover its workers, those folks should have assurance that they are getting something real, health care insurance and coverage, when they need it.

Thank you, Mr. Chairman, for this very important hearing, and I yield back.

[The prepared statement of Mr. Welch follows:]******** COMMITTEE INSERT ********

Mr. STUPAK. Mr. Burgess for an opening statement, please, 3 minutes.

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

Dr. BURGESS. Thank you, Mr. Chairman. I will abbreviate my statement and submit it in its entirety for the record.

I do want to thank you for holding the hearing today. I really believe this is a twofold problem. On the one hand we have hardworking Americans who do the right thing day in and day out. They go to work, they buy health insurance, and then when they get sick, their medical insurance does not cover their bills. If they work harder, make tough choices in other areas of their life, they still struggle to pay their medical debt.

So I did my town halls this summer, as many of us did. One thing I heard over and over again, people are genuinely frightened of what Congress is going to do to health care in this country, and they are probably justified in that skepticism. But the one thing that everyone seems to agree on is the issue of excluding someone from insurance coverage because they have had a tough medical diagnosis, or the issue of excluding someone or the insurance rescission when a tough medical diagnosis is rendered for someone who

is already insured. Those are the processes that have to stop. Nothing infuriates people more than thinking that somebody has played by the rules, paid their dues, and then when they actually need the service, they find it is withdrawn from them. People who are responsible and do what it takes to provide for themselves or their loved ones are, in fact, to be commended and are not to be put in positions that are just absolutely untenable.

And we do have the issue of insurance as a whole. You do want to protect people from those contingencies in life from which no one can anticipate, and no one can reasonably be expected to save the amount of money that would be required to pay for some very, very tough diagnoses. The cost of care has gone up significantly. There is no question there is the advancing complexity of what we are able to do. When I think of some of the saves that I saw during my medical career that—late in my medical career you have never seen in the beginning of my medical career, those things are very important. And we certainly don't want to—in our zeal to cap costs, we don't want to cap innovation or remove the innovation that has really set American medicine apart from medicine that is practiced in almost any other country.

Mr. Barton referenced transparency. Three Congresses ago I was charged by the Speaker of the House, who was then a Republican, to work on the issue of transparency, and I introduced legislation that year. It finally did find a place in H.R. 3200 as it left the committee this year in September. I don't know if it will survive the cutting room floor over in the Speaker's Office, but I am hopeful that it will, because transparency is important.

Another provision that was in the bill that I partnered with Mr. Dingell on was the issue of internal and external review boards. When you have a—whether it be a public option or a private insurance company, if they deny the coverage, a patient ought to have the right of appeal; they ought to be able to appeal to not just the internal review board within the insurance company, but an external review board as well. And that is true whether it is Aetna, Signa, United or a new robust public option that is instituted by the United States Congress. If care is denied for whatever reason, patients ought to have the right of appeal. It doesn't mean that we need to be spelling out everything that is involved in someone's health care.

And I told the Chairman I would abbreviate my statement and submit the balance for the record, and that is what I will do. I do thank the witnesses for being here today. It is an important part of the process. I will just say I think we would have done the American people a service if we had concentrated on more how do you get around these nettlesome problems with preexisting conditions and rescissions without resorting to mandates, which really have no place in a free society and only ultimately enrich the insurance companies.

I will yield back the balance of my nonexistent time.

Mr. STUPAK. Nonexistent? Your summary was longer than your statement.

[The prepared statement of Mr. Burgess follows:]******** COMMITTEE INSERT ********

Mr. STUPAK. Let's go to Mrs. Christensen, please.

## OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Chairman Stupak, and thank you, Ranking Member Walden, for holding this hearing, both of you.

It is important to highlight why health care reform and providing affordable, secure insurance coverage without caps to everyone is so critical; not just the physical, but also the economic well-being of our families and our country.

I also want to welcome the witnesses and their families for being here this afternoon and to share those very personal, very painful stories and provide more insight on the need for affordable, adequate insurance coverage.

Underinsured Americans far too closely resemble the uninsured, but they are often the forgotten faces of the health care debate. Currently 25 million Americans, as we have heard, cannot afford to pay the gap left by weakened insurance coverage and large medical bills. And I was surprised to learn recently that even end-stage renal disease patients may find themselves uninsured even though they are covered by Medicare.

Underinsurance is also a contributor to health disparities. Despite the presence of full-time workers, in the vast majority of their households, racial and ethnic minorities are disproportionately underinsured or lack coverage altogether and, therefore, less likely to receive quality health care. It causes a vicious cycle, as we will hear, in our health care system that forces far too often people to forego medical treatments and prescriptions after they have already paid for insurance, resulting in poor outcomes.

Even more dramatic is the fact that people don't realize they are underinsured until they are already sick and facing those mounting health care bills. As we will hear, the average working family can faithfully pay their insurance premiums for years, but still go into medical debt or face bankruptcy when they get sick.

A study released this summer by the American Journal of Medicine found that in 2007 a family filed for bankruptcy every 90 seconds due to excessive medical bills. If that is not shocking enough, 75 percent of those Americans already had health insurance. These are hardworking Americans that did not choose to wake up one morning with an injury or an illness that would not only deplete their productivity, but also deplete their bank accounts.

The insurance companies have profited millions by ensuring that their policies are structured to defy the very purpose, as Chairman Waxman said, of having health insurance. So uninsurance and underinsurance is unacceptable, period. I look forward to passing and having the President sign a health care reform bill that ends it once and for all.

And I thank you and yield back the balance of my time.

Mr. STUPAK. Thank you.

Mr. Gingrey, opening statement, please.

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

Dr. GINGREY. Thank you, Chairman Stupak.

First, I want to thank all the witnesses who joined us today, and I certainly look forward to hearing your testimony.

As a physician who practiced medicine for over 30 years, one of the most important lessons I ever learned was that a medical solution for one of my patients was not necessarily the best solution for another patient. Each and every one was unique, but their needs, of course, were the same ultimately, to get better. So as this Congress debates the nuances of health insurance reform and what type of insurance American patients should have, I believe that we must frame the debate in terms of what is best for the patient.

With respect to the debate, H.R. 3200 and every other iteration of the Democratic Majority reform proposals purports to create access to affordable health care, certainly a worthy goal which I agree with. However, they do so by requiring that all health insurance products meet a one-size-fits-all mode through various Federal mandates, and, yes, cost-sharing limits. Unfortunately studies have shown that these same mandates and limits on cost sharing will drive up the cost of all health insurance products by as much as $4,000 a year for a family of four.

In their plan my Democratic colleagues, they seek to combat these cost increases with affordability credits. Unfortunately, in H.R. 3200, it does nothing to curb the cost of health care in this country. In fact, the CBO recognized that H.R. 3200 would actually increase the cost of health care in this country. So these affordability credits they give patients today will be worth less tomorrow, while the overall price of health insurance will continue to climb, as it has done so for decades, as has already been pointed out, only now at a much greater rate. One doesn't have to have a medical license to figure out that my colleagues are setting up a framework of an unsustainable system.

Where does this leave American patients? If we were to use the State of Massachusetts as an example, we would find patients losing their health care benefits to offset increased cost of care. Just this past June, 92,000 low-income patients lost their dental insurance because the State needed to trim the cost; 92,000 lost their dental insurance. Now, using the definition of underinsurance—I couldn't find it in the dictionary, by the way—would those 92,000 low-income individuals who lost their dental benefits qualify as underinsured? If so, I might suggest that mirroring a health reform plan after the Massachusetts model could end up hurting those patients who truly need help in the long run.

Mr. Chairman, while we do need reform to increase access to care for patients like those before us here today, we cannot simply slap the term "reform" on just any bill and assume that it will improve the quality of health care. In fact, the wrong kind of reform creates a system where these testimonies are the rule and not the exception.

And I yield back.

Mr. STUPAK. Mr. Doyle, opening statement, please.

**OPENING STATEMENT OF HON. MICHAEL F. DOYLE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA**

Mr. DOYLE. Thank you, Mr. Chairman. Thank you for holding this hearing on the issue of underinsurance at such a relevant time.

For the last few months, Congress and the country have been engaged in a debate largely focusing on the 45 million uninsured Americans, and often leaving out of the conversation the 25 million Americans that are underinsured. I look forward to our witnesses' testimony that will shine light on the problem of underinsurance in our country, a problem that unfortunately is growing at an alarming rate. In just six years, from 2003 to 2007, the number of uninsured Americans rose 60 percent. This is a problem that must be highlighted and will be addressed in the health care reform legislation that will go before the House soon.

Underinsurance is when a policyholder believes they have adequate health care coverage, and then, when it is too late, they are proven wrong. When individuals buy insurance or are provided with plan options from an employer, the small print of their contracts is often overlooked, text which contains vital information about their coverage. This is exactly where people need to be paying the most attention because it is here that often information on lifetime or even annual limits, copayment requirements, treatment exclusions and other limits on coverage is hiding.

We all know we are supposed to read the fine print, but we also know that people don't always do it, which brings us back to the big picture. People don't know what they need to know until it is too late. I believe if you buy an insurance policy, you should know what you are getting and not have to hire a lawyer to understand it. Hidden traps, fine print and, at times, misleading marketing ploys prevent the consumer from making an educated decision about their health coverage, and this is precisely why it is so important that we pass meaningful health care reform this year that will require insurers to provide a minimum set of benefits that will take care of patients' needs, limit out-of-pocket expenses and prohibit insurers from imposing annual or lifetime caps on coverage.

I look forward to hearing from our witnesses.

Mr. Chairman, I want to thank you for this hearing today, and I want to thank the committee for highlighting this very serious problem.

I yield back.

Mr. STUPAK. Thank you, Mr. Doyle.

Chairman Emeritus of the committee Mr. Dingell for an opening statement, please.

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

Mr. DINGELL. Mr. Chairman, thank you. And I commend you for holding this very important hearing on an issue of great importance in our consideration of health reform benefits and health reform efforts. I want to commend you for the hearing, and I want

to thank our panel of witnesses for being here today. We are grateful for your assistance, and I thank you.

In our fight for health care reform, we focus on the 46 million Americans without health insurance. That is very important, but as has been observed already, underinsurance is an all too common problem that must also be addressed. In fact, by some estimates 25 million Americans were underinsured in 2007. These 25 million people are paying at least 10 percent of their income for medical expenses in addition to the cost of the premiums. In more simple terms, there are far too many Americans paying for insurance policies that do not cover the medical care they need, some of which policies are sold by practices close to fraud.

Now, whether the underinsurance is caused by annual or lifetime caps or excessive cost sharing, or whether the policy doesn't cover the needs of the policyholder, the result is the same: Underinsurance creates an undue financial burden on far too many American families. In 2007, 28 percent of American adults reported carrying medical debt. Of the underinsured, 46 percent reported using all of their savings toward their medical debt. With statistics like these, it should come as no surprise that over 60 percent of personal bankruptcies are due to health care expenses.

These numbers are staggering, but the personal stories are even more moving. Just this week the Detroit Free Press ran a story about uninsured and underinsured Michiganders in my home State. One of the families profiled was the Hurleys of Canton, Michigan. The Hurleys have employer-sponsored insurance, but are forced to buy extra policies to cover the needs of their children, one a 7-year old with severe asthma, and another a 10-year old with skeletal disorder. Without the extra insurance policy, they could not afford the $50,000 spine surgery their son needs every 4 months.

I am particularly grateful for our first panel and to them for having joined us today to tell their story of hardships due to underinsurance. I want them to know that their testimony is going to remind us and others of why it is so critical and so crucial that we pass comprehensive health reform legislation this year.

Finally, I would be remiss if I did not mention the aggressive steps we take in H.R. 3200 to make underinsurance a thing of the past. This bill would, one, remove all annual and lifetime caps; two, limit the out-of-pocket expenses for everyone; three, provide affordability credits for low- and moderate-income people to assist them with premiums and cost sharing; and lastly, it would enable all to know that all insurance policies provide a minimum level of health benefits to all Americans. And, of course, we would see nasty little things like rescission of policies and preexisting conditions. So I am—we would see them end. So I hope today's hearings will serve as a call to action and remind us of the importance of the task before us.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you.

We have two votes on the floor. I would love to get all the opening statements in before we break if we could. So next, Mr. Green, please, for opening. Mr. Green.

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

Mr. GREEN. Thank you, Mr. Chairman. I ask unanimous consent for my full statement be placed into the record.

Underinsurance is when an individual actually has insurance, but their policy does not adequately cover their health-related expenses. That is such an important topic that I am glad we are having this hearing. And last month when our committee worked on or has been continuing to work on the health care reform bills, we addressed a great deal of that in H.R. 3200.

As our dean—Chairman Emeritus and dean of the House said, insurance premiums have risen steadily over the years, 131 percent over the past decade, and individuals are uninsured are paying at least 10 percent of their—underinsured—10 percent of their income, out-of-pocket expenses on top of their premiums. And according to the Commonwealth Fund, who we will hear with the second panel, 25 million Americans are underinsured in 2007, which is a 60 percent increase over 2003.

All of us have constituents who call us and assist them with their insurance company policy problems, whether it is very low caps—in some cases in our district it was $25,000—and either that or they do not provide coverage for certain services, such as experimental cancer treatments, certain prescription drugs, and those who have been denied coverage for a condition that is deemed preexisting. That is why I am so glad to have our first panel here today to talk about real-life experiences.

But again, our committee has made a great step on H.R. 3200, and hopefully we will get the vote on that sooner than later. And we can solve a lot of these problems not only with the uninsured 47 million, but the millions of underinsured we have in our country.

And, Mr. Chairman, like I said, I will put my full statement in the record. Thank you.

Mr. STUPAK. Thank you, Mr. Green.

Ms. Schakowsky for an opening statement, please.

**OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

First let me thank the witnesses. I read all your testimony, and I read it shaking my head. I have heard these stories before, but yet to hear the particulars are so disturbing. And I really look forward to you telling those stories yourself.

Here is one that was on the front page of the Washington Times yesterday. It says, Ian Pearl has fought for his life every day of his 37 years. Confined to a wheelchair and hooked to a breathing tube, the muscular dystrophy victim refuses to give up, but his insurance company already has. Legally barred from discriminating against individuals who submit large claims, the New York-based insurer simply cancelled lines of coverage altogether in entire States to avoid paying high-cost claims like Mr. Pearl's.

In an e-mail, one Guardian Life Insurance Company executive called high-cost patients such as Mr. Pearl "dogs" that the company

could get, quote, "rid of," unquote. By the way, in the meantime his parents are paying $3,700 and have been a month for his care. These are the kinds of horror stories that people face every single day in our country.

And, Mr. Null, you asked in your testimony, is that American? And I want to say that I hope at the end of 2009 you will be able to look at the kind of health care we provide Americans and your daughter Tatem and say, yes, this is American. And the kinds of things that we are going to do, I hope, are going to resolve the problems of all three of you and millions more in our country.

We address the problem of high deductibles and cost sharing by giving individuals access to group rates through the exchange, with annual out-of-pocket limits of $5,000 for individuals and $10,000 for families. We assure that coverage is adequate, eliminating preexisting condition exclusions and establishing a basic benefit package. We require that plans meet network adequacy requirements so that consumers, especially those with disabilities or ongoing health care needs, have access to the providers they need. Four, we eliminate annual and lifetime limits that leave health care consumers with huge medical bills when their coverage runs out, but their health needs continue.

I believe that your testimony today will contribute to getting these kinds of reforms. I thank you, and I yield back.

Mr. STUPAK. Thank you, Ms. Schakowsky.

Mr. Braley for an opening statement, please.

**OPENING STATEMENT OF HON. BRUCE L. BRALEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Mr. BRALEY. Mr. Chairman, I want to thank you and Ranking Member Walden for holding this important hearing. I think all of us have learned that when health care policy is abstract, the American people run away.

And the reason why your appearance here today is so important to us and the entire country is because until health care policy becomes personal, people don't realize how broken our health care delivery system is in this country.

This little boy that you see up here on the screen is the face of health care for me and my family. This is Tucker Wright. He lives in Malcom, Iowa. He father, Brett, is my nephew. When Tucker was 18 months old, he was diagnosed with liver cancer. He had two-thirds of his liver removed. He was lucky that he survived, but every day he has an ongoing lifetime medical challenge of survival.

He continues to accumulate exorbitant medical costs, many of which are not covered by his insurance policy. His family has already incurred tens of thousands of dollars of uninsured medical costs. They hold fund-raisers to try to raise the money that is not covered by their insurance policy. And his parents are both employed full time and had what they thought was good health insurance.

By the age of 20, he is 90 percent likely to have another form of cancer. He goes to Des Moines, Iowa, every month to have expensive diagnostic imaging studies to monitor his health condition. And until we start looking at health care as this type of face and the faces that you present to us today, we are never going to get

the American people to rally behind the need for comprehensive health care reform.

Your voices here today, Tucker's face and the people in this country just like him and just like you are going to be the unifying forces we need to transform health care delivery and the way we pay for it and the way we insure it in this country; and that is why I am personally so grateful that you took time out of your busy lives to help us put a human face on health care reform.

I yield back the balance of my time.

Mr. STUPAK. Thank you, Mr. Braley.

[The prepared statement of Mr. Braley follows:]******** COMMITTEE INSERT ********

Mr. STUPAK. Ms. Sutton from Ohio, opening statement, please.

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

Ms. SUTTON. Thank you, Mr. Chairman. And I too want to thank the witnesses for coming forward to tell us your stories because, with your voices, you speak for so many Americans who are facing similar situations. That is why we are so intent in this committee and in this Congress to make health care work for you and the people that you love, and all of those out there who aren't in this committee room, but whose voices you bring by your presence.

During the August district work period I held many meetings with constituents and I heard their views about health care reform. Among those whom I met with were Dash and Kathy Sokol in Lorain, Ohio. Dash just turned 56 and his wife Kathy is 53.

In February of 2007, Dash was diagnosed with prostate cancer, and as he fought that cancer and was fighting back, later that year Kathy was diagnosed with breast cancer. The Sokols had health insurance coverage through Dash's job at the steel mill.

However, with Dash and Kathy both receiving treatment for cancer, the costs began to add up. Their out-of-pocket spending became overwhelming, and the Sokols are now using their pension funds to pay for their medical bills instead of saving those funds for retirement.

Kathy told me that she felt guilty about having their family pay out of pocket for her cancer treatments in spite of the fact that they have insurance coverage. I want to repeat that: She felt guilty because their insurance plan did not provide adequate coverage.

Many insurance plans out there today are far from adequate, and when the Sokols came to my office, they brought with them stacks and stacks of insurance invoices. They had bills, explanations of benefits and records of what they had paid for, in addition to explanations about why most of their treatments were not adequately covered. Dash showed me that aside from being sick, aside from emptying their savings, they also were keeping full-time records to make sure that they kept up with their payments as best they could. Dash has been working on arrangements with providers to pay what he can when he can. He tells them, "I am willing to pay, but it will take time."

He continues to work to make sure that they keep the inadequate coverage that they have. And in these uncertain economic times, he is concerned about whether his job will be there tomor-

row. He told me that he would like to retire, but is fearful of doing so before the couple becomes eligible for Medicare. And if the job does go away, they worry, they live in fear about what will happen because they won't be able to get insurance having had cancer. He could not imagine, he explained, what individuals who get sick without coverage do and how they cope.

The Sokols came to my office to offer their story and to offer their help, just like you here today. They want to do all they can to make sure that meaningful, comprehensive health care gets passed.

Dash told me—when I asked about using his story to convey what they were experiencing, he said, "Absolutely. I am willing to do whatever it takes." Well, I don't think that we in Congress should offer any less than what Dash is willing to offer: whatever it takes to pass meaningful health care reform.

We have to do what it takes to make sure that American families are not spending their retirement funds just to stay alive. That is what far too many insured and uninsured Americans are facing. We have to do what it takes to hold insurers accountable for the benefits they promise us and, in many cases, that people pay for. We have to do what it takes to pass health care reform this year.

I yield back.

Mr. STUPAK. Thank you. That concludes the opening statements by all the members of the subcommittee.

We are going to stand in recess. We have 3 minutes remaining on this vote, and then we have another vote. Let's try to be back by 2:50, 2:55.

[Recess.]

Mr. STUPAK. The committee will come to order. We will now hear from our first panel of witnesses. Our first panel of witnesses, we have Ms. Catherine Howard, who is a policyholder from San Francisco, California.

Welcome.

Mr. David Null is a policyholder from Garland, Texas, and his daughter, Tatum, has joined him at the table.

Thank you for being here.

And Mr. Nathan Wilkes is a policyholder from Englewood, Colorado.

Thanks for being here.

## STATEMENTS OF CATHERINE HOWARD, POLICYHOLDER, SAN FRANCISCO, CALIFORNIA; DAVID NULL, POLICYHOLDER, GARLAND, TEXAS; AND NATHAN WILKES, POLICYHOLDER, ENGLEWOOD, COLORADO

Mr. STUPAK. It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under rules of the House to be advised by counsel. Do you wish to be represented by counsel?

Everyone is shaking their heads "no," so I will take it as a "no." Therefore, I am going to ask you to rise and raise your right hand to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative.

You are now under oath. We will begin with opening statements. Ms. Howard, if you don't mind, we will start with you. You may submit a longer statement for inclusion in the hearing record.

Ms. Howard, if you would start. Your light is on, I take it. Five minutes, please. And thank you again for being here.

**STATEMENT OF CATHERINE HOWARD**

Ms. HOWARD. Thank you, Mr. Chairman, members of the subcommittee. Thank you for inviting me to testify today.

My name is Catherine Howard, and I am from San Francisco. Five years ago, I was working as a documentary film producer. I wasn't making a lot of money, but I knew that maintaining my health coverage was a big priority.

My employer didn't offer coverage, so I went out and I bought myself a private plan; and this plan seemed perfect for a young, healthy person. And it was affordable, only $140 a month, but I had no idea what it would really cost me. I was afraid that I would get hurt in some minor way, take a fall snowboarding, need a couple of stitches, not living with a life-threatening illness like cancer.

After my breast cancer diagnosis in August of 2004, I thought I was covered. You know, I thought, I am so glad I have insurance. But, boy, was I wrong. I discovered that the health plan that I was paying for didn't cover a large part of the cancer care that I needed, and I was on the hook for tens of thousands of dollars in uncovered expenses.

I had chosen one of those low-premium but high-deductible plans, and I had to pay for 30 percent of all my treatments in the hospital. And it didn't even cover all the services that I needed. I remember staring at this one shot, Neulasta; it cost $2,100 per shot, and the insurance company said, well, that is 30 percent for you. So right there in that needle is $600.

I endured surgery, grueling chemotherapy, and radiation regimes that left me too weak to work full time. I was told all along that the key to my recovery was to minimize the stress in my life. And, tell me, how do you minimize stress when you owe the hospital more than you have earned in the past year?

As the expenses piled up, I was able to pay for some of them. My family helped me. Other things, I just put them on my credit card and I thought, if I don't die, I will just deal with this later.

Well, I didn't die, and this is later. So I find myself almost $100,000 in debt between the medical expenses and living expenses for while I was sick and couldn't work. By the end of my treatments, I owed $40,000 in medical expenses alone, and I have been paying this off over time slowly, using payment plans, paying down on those credit cards. But rather than saving money to put a down payment on a house, buy a car, or even have a savings account, I spend $1,800 a month, essentially all the money I have after the basics, to pay towards my debt. I live like a pauper because—to pay for the privilege of surviving cancer.

People have asked me why I don't just declare medical bankruptcy and wash my hands of all of this. But bankruptcy to me really seemed like a cop-out, and I don't cop out on my commitments.

I have made recovering from cancer my mission for the last 5 years. And as I look ahead to the next 5, I would like to see myself out of debt, and I would also like to make sure that this doesn't happen to anyone else.

In my work as an innovator at Jump Associates, I know that things can be different. I am fortunate that my employer offers comprehensive coverage, because if they didn't, if I was back on the private market, I would be totally uninsurable because of my preexisting condition. I couldn't even afford to buy the same crummy coverage that left me in this financial devastation.

The kind of health reforms in the House proposal would have kept me out of this devastating debt and the financial circumstances I am in now despite my best efforts. Limiting annual out-of-pocket costs and prohibiting junk policies will save other young people from facing the same circumstances I am in now.

Thank you.

Mr. STUPAK. Thank you.

[The prepared statement of Ms. Howard follows:]******** INSERT 2–1 ********

Mr. STUPAK. Mr. Null, if you would like to pull that mike up and hit the light, we would like to take your opening statement. Again, a longer one will be submitted for the record.

If you would, please. We look forward to your testimony.

**STATEMENT OF DAVID NULL**

Mr. NULL. Thank you. Good afternoon, Chairman Stupak. We appreciate the invitation here. It is quite an honor, and we thank the entire subcommittee for taking the time to hear our story.

Our story actually begins in 1999, when I became self-employed. We had a company. We employed 12 people, we had group insurance, and then 9/11 hit. And, like many Americans, that time hit us very difficult. Within about 6 months we had to drop our company-sponsored insurance, and I had to enter into the world of individual insurance.

In January 2005, we had been without insurance for about three months. We had a short lapse, and a quick trip to the ER for an $800 liquid bandage for my daughter's chin was a costly but excellent reminder of the value of insurance, so we began looking for a policy.

Sherry and I spoke at length to an insurance agent at our dining room table, and I explained, I don't mind paying for the hospital or the doctor visits; it is the big catastrophic hospital visits that we need. I told him, quote-unquote, "I need coverage for the big, 'Oh, no'"; and he looked at me in the eye and told me that I am a very savvy shopper and that this was the policy for us. By the time, he said, that we factor in our negotiated rates and what the policy pays out, "You will hardly have to pay anything." The way he explained it, we felt like we were getting what we asked for, and we were relieved to be protected again.

Three months later, Tatum was seven. It was the first night of our family vacation and Tatum's touch of stomach flu seemed to worsen and so we headed home. Hours later, she slipped into a coma. Before the sun set the next day we were told she would re-

quire a liver transplant within days to save her life if they could keep her alive that long.

While Tatum was clinging to life in the ICU, the transplant department administrator came to me and said, We need to talk about insurance, and he walked me to a counsel room. As we walked, I thought to myself, I wonder what he wants to talk about; aren't I glad that we picked up this policy when we did.

We reached the counsel room, and he proceeded to explain that my insurance had capped out at $25,000. That was basically the night before. From that point forward, Tatum no longer had any sort of insurance, and it was hospital policy to collect a $200,000 deposit for them to proceed with the liver transplant.

I honestly couldn't believe this was happening. Could this be true? Surely it is a mistake, because this is the big "Oh, no" that I was buying protection from. Suddenly, not only were we facing the possible death of our child, but now the financial death of our family. How could this be happening to us? We have insurance for this.

A donor was located, and Tatum received her transplant with probably less than 48 hours less to live. Once she stabilized, the hospital helped me apply for Medicaid, and we were narrowly approved. The coverage was retroactive, and they covered the entire transplant, well over $500,000. Our so-called hospitalization policy covered less than one-tenth of that cost. Even with insurance, we were left with a balance we could never bear to pay back.

Tatum and our finances both had near-death experiences. Although we didn't know at the time what going on Medicaid was going to mean to our family, we were grateful for it. But our daughter had been on life support for a week, and now our finances were going to be going on life support for the next 2 years.

Post-transplant is very medically expensive. We never knew what each day would bring, but we knew we couldn't afford even 1 day without insurance. We began to look for insurance that would help cover post-transplant expenses so we could get off of Medicaid. Then I was told by insurance agents not to waste the time, paper, or ink filling out the applications with Tatum's name on it because they would refuse to even accept it. We now had nowhere to turn, and we were somehow now stuck on Medicaid.

It was simply that the insurance industry would not make a policy available to us in the individual market. So in order to keep receiving health care for Tatum, we had to voluntarily drop our income to near poverty to satisfy the Medicaid requirements. The allowed monthly income on Medicaid was a shocking $1,630 for a family of four. This barely allowed us to cover our mortgage, most utilities, and some of our food bills. This meant that I would frequently had to pass on work, and it was even suggested that maybe Sherry and I should get a divorce for financial reasons. These were tough times, and we found ourselves in the red every month.

Interestingly, though, with Medicaid we never incurred any costs for health care. We actually owe nothing due to medical debt at this time. The cost of staying on Medicaid is on the back side, trying to survive on $20,000 a year. We took tremendous debt on,

eliminated our savings and retirement, and put our growth on hold trying to survive while she got the health care that she needed.

After 2 years, she began to reclaim her new life. There were now more good days than bad days, and so her mother returned to teaching and group health coverage, an entirely different insurance experience.

I found it interesting, when we transitioned to group coverage Tatum was accepted with open arms and without question. It would appear as though individual policies and group policies exist in completely different universes.

Her mother and I are thankful that Tatum's physical recovery is quicker than our finances. She is growing, thriving, and giving back. She regularly appears on behalf of Children's Medical Center, the Southwest Transplant Alliance, and her favorite charity, Make a Wish. Her life has been a joy and an inspiration to many. We would do it all again for her sake. And we are thankful Medicaid was there for us. We are thankful to be off of Medicaid.

We do hope our testimony illustrates how the hospitalization policy in question today was obviously worthless. We have learned that the language of policies can be confusing. In spite of both being college educated, we didn't understand at the time the $25,000 maximum for miscellaneous hospital expenses basically meant all hospital expenses.

Even today we find the wording still a little bit counterintuitive and misleading. But I asked for in very clear language, I thought, a policy that would protect us from the big "Oh, no," and we ended up with a policy that would do no such thing.

While our testimony should be labeled "Grossly Underinsured," we have since learned that even traditional million dollar policies, which would seem like a safe bet, are no challenge for long-term, life-threatening illnesses. I got the call on Tuesday that the hospital had added up Tatum's cost at Children's Medical Center, and as of right now her cost is $1,284,335. And that does not include any of the doctors' bills. They are billed separately.

But, most importantly, we have learned that being underinsured really is the same as being uninsured. They both lead to the same end.

Underinsurance certainly impacted our lives. God carried us through, and we trust that he will continue to do so, and we are glad. We have learned from this experience, and we are trying to move on.

It seems like the story ends here, but it is actually just the beginning for Tatum, as you already know. Underinsurance probably isn't the biggest tragedy of our story, if you ask me. Her story encompasses other shortcomings that you need to do something about.

What continues to sadden her mother and I is this issue of blacklisting because of her preexisting. Tatum is going to grow up, and one of these days she is going to need insurance. And we are lucky because Sherry's dream has always been to teach, and that gives us access to group coverage and the benefits that come with that, but that may not necessarily be everybody's dream; and I don't think that is really fair, and I don't really think that that is American.

I ask you to consider this. When Tatum was just 4, she went to New York City and stood transfixed on Lady Liberty. They told her then that Lady Liberty stands and invites the world to come to the land of opportunity where anyone can follow their dreams. And yet Tatum, a born-and-bred American citizen, might not be able to share in this dream through no fault of her own simply because the insurance industry has developed a system that won't allow it.

Our Tatum has so much potential, but for now she doesn't have full access to Lady Liberty's promise. She can't pursue little-girl dreams to be an artist or have a dress shop or restaurant or be self-employed in any fashion that requires individual coverage.

When she asks me what she should be when she grows up, I can't tell her the same thing that you probably tell your kids. I can't tell her she can be anything she wants; and you guys need to fix that for me. Do I tell her that the government before her today—a government for the people, by the people—refuses to take the steps to also protect her rights to life, liberty, and the pursuit of happiness? What do we tell her?

In closing, while my purpose today is to testify and answer your questions as an American citizen, I also come to pose just one question to the very distinguished committee as a father: Which of you will commit yourself today to be able to look Tatum in the eye and tell her that you will be helping lead the way, and you will see to it that when she grows up she will have affordable access to adequate health care regardless of her occupation; and that today she too can start pursuing all of her Americans dreams?

We sincerely pray that God will bless you and guide you. And God bless America. Thank you.

And please be an organ donor.

Mr. STUPAK. Thank you.

[The prepared statement of Mr. Null follows:]******** INSERT 2–2 ********

Mr. STUPAK. Mr. Wilkes, your testimony, please.

**STATEMENT OF NATHAN WILKES**

Mr. WILKES. Mr. Chairman and members of the subcommittee, my name is Nathan Wilkes. Thank you for the opportunity to talk to you today about the difficulty my family has had in maintaining health insurance due to the high cost of the treatment for my son, Thomas, the treatment he needs to live a healthy and productive life.

Although we have always been insured, always insured by group coverage, our family has come up against the issue of lifetime caps—not once, but twice before he was 4 years old. I have been able to maintain insurance coverage, but it has been a constant struggle and a worry for me. I am going to tell you a little bit about what we have had to deal with and how I have dealt with it, and ask your help in immediately eliminating the practice of lifetime caps as part of health legislation.

My son, Thomas, was born in 2003 and diagnosed with severe hemophilia, a genetic blood-clotting disorder, treatment for which means he has to get replacement clotting factor on a regular basis. It is easily manageable if he can get it, but it is very costly and very expensive to treat. If he does have a bleed, it has to be treated

quickly or else irreversible damage or death could occur. Bleeding into the joints, bleeding into the head or brain or abdomen could cause significant long-term damage.

On the day Thomas was diagnosed, a local hematologist came to us to help us with what we were facing. Her first question was, do you have good insurance? I said, Absolutely. I work for a company who made it a mission that we had the best, gold-plated, Cadillac—whatever you want to call it—plan we could have; and they had struggled to maintain that.

In 2004, he began—we had to start treating him. The cost of the treatment that year was roughly half a million dollars. The result of that was that in 2005 the insurance company forced us to accept a high-deductible plan, where we had been on a PPO that had covered everything before. They had shopped around all the other insurance companies, all of whom refused to cover my company that I worked for previously because of the high cost of claims.

In 2005 and 2006, claims rose to about three-quarters of a million dollars a year. These were treatments that were necessary for my son's well-being, and today, he is a very healthy and productive 6-year-old.

But one of the things they tacked on was a $1 million lifetime cap. When they did so, my wife cried for days. I worked with my HR director and the broker that they worked with to try to get around it, get an exclusion, get rid of it, do whatever it meant. But it couldn't be undone. We knew the hourglass had been turned over; it was running out on us. We knew we had maybe a year, maybe a little more before we had to find some other solution. We discovered that we had choices. We had six choices, and I have documented them here in the testimony. And as I go through them, I think you will understand that we really didn't have any choices at all.

I could have quit my job and gone to work for a larger company, somebody with a larger pool where I could hide in the shadows or hopefully lurk and not let them know that my son has a serious illness, or face possible termination.

I could go to work for the government, but frankly, it doesn't pay enough.

I could have my wife go to work. She had already made the decision to stay home to take care of our son, who had a chronic illness. That would mean putting kids into day care, and we just couldn't afford that, either, and that was just shifting the problem to another company.

We tried to turn to Medicaid. Now, Colorado is a difficult State to get on Medicaid, and we earn too much money. We didn't want to impoverish ourselves and go down that road. We had already been racking up significant medical debt as a result of this.

Several social workers told us we could get divorced. Just get a paper divorce, then the kids could qualify for Medicaid under my wife if she didn't work. But that would both put my wife at risk, because it turns out she is a carrier as well, and we didn't want to do that; that just wasn't in our family values.

We could put Thomas on the State high-risk pool. That too has a $1 million cap. That is something that once he did cap out in 2007, we put him in the high-risk pool; he lasted on that a year.

That was the second million dollar cap. That is known as insurance of last resort, but it didn't last for us.

And finally, the option was to start my own business, quit my job, take a pay cut, try to get myself—since you can only get insured as an individual if you are healthy and have no issues, or by the government if you are Medicare-eligible, or impoverished and have a disability for Medicaid, or you have to get insured through an employer. I decided to become an employer.

The struggle that we faced—all the while we were insured there were years where we were paying roughly $25,000 a year in premiums and deductibles and out-of-pocket and ancillary medical expenses. This hardship left us fighting to keep up with bills, forced us to rely on credit and home equity to stay afloat. The more credit we used, the worse our credit rating got. The worse our credit rating got, the more we ended up paying for everything as our interest rates climbed. Harassing collections agencies began calling us. We struggled to get providers paid for everything from the day he was born.

It took us over a year to set up our own business, so in May 2008, when my son nearly exhausted his $1 million cap on CoverColorado, I would be able to pull him into our own company. I had to quit my job even though my employer tried to do everything they could to keep me on board. They were fine with paying the rising premiums. Other companies weren't willing to take me on as that kind of employee, but they did everything they could to work with me. Ultimately, I had to quit my job and take a pay cut and start this business.

Now we are covered by another high-deductible health plan, a $6 million cap this time. Another hourglass. There has a little more sand in there this time, but it won't be long before we run out of that as well.

This thing about where we were now is one single event. We are hanging by a thread—death, injury, anything that stops the income through my business, or a serious illness that puts him in the hospital for a significant length of time means we are out.

I have included with my testimony and chart that shows the year-over-year changes to our premiums which I think you will find pretty interesting. When we started the claims, our premiums, our cost of care, went up 35 percent the next year.

The other point I want to make very quickly is the impact of the high cost of his care was not just felt by my family, but everyone I worked with. There were only 150 employees with the firm at the time, but moving into the high-deductible plan meant that everybody was now paying for medical care out of their own pocket.

Just a couple of quick examples: I had a coworker who got his leg cut, didn't have the money to go to the ER to cover it, so had a friend stitch up his leg on the kitchen table. Minor case.

Another case, a coworker, a young coworker, his wife was pregnant, had to have a C-section. And because of the deductible at the time, they were faced with putting over $9,000 on their credit cards just to deliver the baby.

So you have heard today maintaining health insurance has been a struggle, but it has allowed me to provide my son with the life-saving treatment that he needs. He is 6 and very healthy. But

without reforming the existing private insurance system in this country, this struggle will continue for me and many more.

It is critically important to me that the individuals and families that face health care costs due to chronic conditions see reform happen. I am pleased to see that several discriminatory practices such as preexisting conditions and annual lifetime caps are part of the plan, but I am concerned that for those of us currently insured that these changes won't take effect until 2013 or even later. Some of the plans we see have grandfathered in the caps, or they don't take effect until 2018.

I tell people that, in the individual market, rescissions are how insurance companies weed out the sick. What happened to us, we have always been in the group market. High-deductible health plans and caps have been how they have weeded us out and how they weeded other out people in the group market; and that has to stop and that has to change.

Our country needs health insurance reform. My family needs health insurance reform. And my family is thankful for the congressional efforts to eliminate lifetime caps on benefits and health reform. Thank you.

Mr. STUPAK. Thank you.

[The prepared statement of Mr. Wilkes follows:]******** INSERT 2–3 ********

Mr. STUPAK. And thank you all for your testimony.

As many members have said in their opening statements, you really help us put a face on what is going on in America with health care—those folks who are unfortunate enough to have medical problems we do not anticipate, and even when we have insurance, we cannot afford to deviate from the norm.

I am going to ask the chairman, Mr. Waxman, if he would like to go first. I know you have some meetings. And if you would like to begin questioning, we will have questioning for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I appreciate your courtesy to me.

I want to say to all of you, what happened to you is wrong. It is wrong in this country that people should be forced into bankruptcy, that Tatum should face a future where she may not get insurance under the way things operate now, that bankruptcy becomes the only way to wash your hands of these debts. And you all had insurance.

Tatum, I am going to assure you that if we enact the legislation that President Obama is supporting, your future will be very bright. It is not going to be hindered by your inability to get insurance, yours or anybody else's, in this country.

Insurance should be that we spread the costs over a broad population, and then those who need the care will have it available to them. But the insurance companies look at it differently; they want to avoid having to pay money, so they don't want to cover people who might be a risk. They exclude you if you have a preexisting condition. They put lifetime caps. They have annual limits on the out-of-pocket costs—annual limits on the costs that they will pay. There are so many things they do to avoid living up to what you expected you bought when you paid for your insurance coverage.

Now, Ms. Howard, you thought you were buying insurance coverage that would protect you. You knew it was going to require that you would have to pay a lot of money up front; but then, after that, if it was a huge amount, you would be covered. Isn't that what your thinking was?

Ms. HOWARD. That is what I thought. But that was wrong.

Mr. WAXMAN. Well, your policy said that if your costs exceeded $5,000, then the insurance company would pay for all of it. Isn't that right?

Ms. HOWARD. It did say that.

Mr. WAXMAN. So what happened with you was you spent far more than $5,000, because under your Anthem policy, every time you got a treatment, they didn't count that toward your out-of-pocket limits for the $5,000. They disqualified costs of out-of-network treatments and the portion you paid for prescription drugs. Isn't that the situation?

Ms. HOWARD. Yes. And that amounted to roughly $10,000 per year for each of those years.

Mr. WAXMAN. $10,000 each year for the——

Ms. HOWARD. Each of those years while I was under active treatment.

Mr. WAXMAN. So even though you exceeded the $5,000, they didn't step up to pay the rest. They just said what you paid doesn't count toward the $5,000, and kept on—it is almost like a goal they kept on moving away further and further from you.

When you tried to stay within network, because they said you have to stay within network—if you go out of network, they are not going to count those costs—how difficult was it to find somebody within their network?

Ms. HOWARD. There were some services that were not available in San Francisco.

Mr. WAXMAN. So you would have to go somewhere else other than San Francisco.

Ms. HOWARD. Yes.

Mr. WAXMAN. San Francisco is a pretty big city. So I would assume that you are talking about hundreds and hundreds of miles to get the care.

Ms. HOWARD. I made the choice to get the care that I needed regardless of cost. And that is why I feel like I am alive today.

Mr. WAXMAN. And each time you had a prescription filled, you had to pay a coinsurance fee of 30 percent of the cost; is that right?

Ms. HOWARD. Yes.

Mr. WAXMAN. And how much out of pocket did you actually spend while you had insurance coverage?

Ms. HOWARD. It was over $40,000 between 2004 and 2008.

Mr. WAXMAN. So for the years you were protected, presumably, for expenses no more than $5,000, you ended up spending $40,000 over that time?

Mr. Wilkes, your policy had a cap on out-of-pocket expenses as well, but they also had various limitations and exclusions.

Can you estimate the total out-of-pocket costs that your insurance did not cover?

Mr. WILKES. In the 6 years total that we have had, direct and indirect costs, I would say, well over $50,000, if not $100,000.

There were some claims that—at the very beginning and at the very end that they said they either did not cover because it was out of network or did not cover because it exceeded the cap; and those two individual claims were $50,000 and $80,000 each.

Mr. WAXMAN. Well, we started the hearing today—we had opening statements, and some of my colleagues on the side of the aisle who opposed health insurance reform said, We don't want one size to fit all, we want competition in the system.

Well, there is no competition when one insurance company can sell you a plan that doesn't pay over a certain amount, if it doesn't pay within the cap or it is not a one-size—in other words, what they are saying is competition—is competition to exclude payments.

And what we need is legislation that would ban the lifetime and annual caps, would have no limits on out-of-pocket costs, no more discriminatory insurance practices. And what we would like is a defined benefit package, so then you can shop around between different insurance claims; and you will know that you are buying a plan that will cover your needs. And you are going to choose between them, based on the price or based on the quality, but not based on what they will cover and what they will not cover when you find out that you really need that coverage to pay for your medical expenses.

I hope we will get that bill passed. And I thank the chairman for allowing me to proceed with these questions.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Walden for questions, please.

Mr. WALDEN. Thank you very much, Mr. Chairman.

I just want to make clear that there are many of us this side of the aisle who have also supported health care reform and insurance reform during my days in the Oregon legislature and here in Congress, and I will continue to. And I support dealing with the preexisting condition issue, dealing with the caps issue, dealing with the competition issue. I think insurance should be available across State lines.

I was on a hospital board for 5 years in a small community, and we looked at the uncompensated care we wrote off every month and dealt with the regulators and dealt with the companies and dealt with everybody involved.

I was a small employer, like you were, where we had 15 employees. We had virtually no option on where to go for insurance—maybe one, two companies. And I never could throw the dart high enough on the budget board each year to figure out what my premium increases were going to be. So I am sympathetic.

And you heard my own personal story as a parent.

Ms. Howard, I am curious, doesn't the State of California regulate the insurance policies like the one that you have or had? You don't still have that?

Ms. HOWARD. Fortunately, I don't have that policy anymore.

Mr. WALDEN. But would that policy have fallen under the regulatory scheme of the State of California?

Ms. HOWARD. Well, when I realized that expenses were mounting in a way that I had not foreseen, I called and I said, How is this possible? And they pointed to my signature on the contract and said, You signed up for this.

Mr. WALDEN. And so what good is the regulatory scheme in the State of California then to make sure that—don't they determine anything to do with the policies?

Ms. HOWARD. At the time that I was facing all of this, I was so ill that I had no strength to learn all of those things, and it is really only in retrospect that I have attempted to piece together the story.

Anthem, in fact, refused to hand over my records to me. I understand that they handed them over to the subcommittee, but——

Mr. WALDEN. They wouldn't give you your own records?

Ms. HOWARD. No. Because I don't have that policy any longer.

Mr. WALDEN. That is amazing.

Ms. HOWARD. I don't know what they could have to hide.

Mr. WALDEN. But I assume we subpoenaed them or requested them?

Mr. STUPAK. Requested them, and we have them: And she has access to them.

Ms. HOWARD. Maybe I could look at them.

Mr. STUPAK. Yes, you can. Right after, come on up and we will give you a complete copy.

Mr. WALDEN. These are the sorts of reforms that there needs to be a change here. There is no doubt about it. I am sorry for what you have gone through.

And I guess that is one of the things. You know, we hear that we have to have this regulatory scheme State by State; and yet I hear your story and think, well, that didn't exactly protect you as a consumer.

And I am sure that—I don't know. When we shop for health insurance, trying to read through those policies and figure out what is covered and what is not is a challenge. I leave that up to my wife, and she makes pretty good decisions on that front, but it is still a challenge.

And yet I want to make sure that you aren't tied to a job or have to go broke in order to have insurance for your kids. And while I am not convinced the bill before us, the one passed out of here, is the best way to achieve that, I do believe there are ways to get there.

And so I don't have any further questions, and I know we are going to have votes in another 15 minutes, so I yield back the balance of my time.

Mr. STUPAK. Thanks. And I have got to compliment you, because you have helped us get Ms. Howard's records.

But the hearing we are having Tuesday on small businesses, that has been adjourned a couple times because even though the small businesses have agreed that we can look at their insurance polices, the insurance companies have refused to give us the records because of the HIPAA requirements. And you and your side have been most helpful in having that hearing Tuesday.

We finally got some records, but it is a hassle. Whether you are the patient or the policy holder yourself, they do not want to give up those records.

Mr. WALDEN. Maybe we can have an oversight hearing on HIPAA, too. There are lots of issues associated with that law.

Mr. STUPAK. I will take my turn for questions.

The stories we have heard here from this panel are heartbreaking, but unfortunately, are not unique. If I could go to slide No. 1 there, The Commonwealth Fund health survey provides some remarkable data, if you take a look at—right here. This slide comes, as I said, from The Commonwealth Fund report. We will hear from Ms. Collins next.

I would like to highlight the comment labeled Underinsured and Used Up All Savings, like this panel. According to the report, there were 25.2 million underinsured Americans in 2007. This table shows 46 percent of the underinsured burned through their savings in order to pay for medical bills. That is 11.6 million Americans with health insurance who still spent all of their savings on medical expenses.

The table also notes—and you can see the arrows there—that 33 percent of those underinsured took on credit card debt as a result of medical bills. That is another 8.3 million people relying on credit cards, often with high interest rates, to cover medical expenses just leads to greater financial burden.

I guess—as the chart shows, I think we are just all—the underinsured are just one step away of being uninsured, in financial ruin.

Mr. Wilkes, let me ask you this. In your testimony, you state your family relied on credit card and home equity to stay afloat. Is that correct?

Mr. WILKES. That is correct.

Mr. STUPAK. Roughly, how much medical debt did you finance through credit, whether home or credit cards?

Mr. WILKES. It was spread over several years. I am not sure. I even had to cash in a life insurance policy, spend down our savings—got no savings left. So many bills. I mean, we literally get stacks and stacks of statements and bills from the hospital, from the insurance company, from everybody. So it is impossible to keep track.

Just to tell you how impossible it is to keep track, even the insurance companies couldn't track.

Mr. STUPAK. Right. You were telling me you requested one time, it is in your testimony, one of those nice charts you made.

Mr. WILKES. In 2006, when we were near the cap, we said tell us where we are. Give us a line item list of the bills. We got that 22 months later, a year and a half after.

Mr. STUPAK. So what would have happened if you would have gone over that waiting for this information, to see if you are near that million-dollar cap, you go over the million-dollar cap, not knowing.

If it takes them 22 months after requesting to give you the information, all that would have been out of your pocket then?

Mr. WILKES. Like I said, we had $80,000 over the cap that we were responsible for. Had we waited another week or two, it would have been well over a quarter million dollars.

Mr. STUPAK. Could I put up the chart by Mr. Wilkes? Because I want you to try to explain this one. You had it to your testimony.

I had a little trouble. I am in July, 2002 there. The green line on the bottom. It is about—just your total annual premium, right?

Mr. WILKES. The green line on the bottom is basically employee contributions. Just the portion—not the premiums that——

Mr. STUPAK. The employer paid?

Mr. WILKES. The minor portion of the premium that comes out of your paycheck.

Mr. STUPAK. The blue one there that starts at $7,000 in 2002, is that employee and employer contribution?

Mr. WILKES. Yes, that is basically the full premium.

Mr. STUPAK. And then—so over 5 years you went from $7,000 to over $17,000, the employee and employer contributions, if you follow that top line?

Mr. WILKES. When we were under the high-deductible plan, it was basically a $12,000-a-year premium. By the time we left, it was $10,000 out of pocket on top of that.

So you are—it was well over $22,000. And that includes—you know, plus funding the HSA that we had for those of us that could afford it.

Mr. STUPAK. So it was basically $17,000 for a premium, but you had a $10,000 deductible, first, you had to meet?

Mr. WILKES. Right.

There is another chart there, $6,000 deductible, $10,000 out of pocket with some coinsurance. The numbers get a little funny, but ultimately we had to lose a lot of money out of our pocket.

Mr. STUPAK. So with that coverage, even with the $10,000 deductible, you indicated some of your fellow employees, who shared that pain with you, financial pain, had to pay for a C-section for the birth of a child, sewed up a leg on a kitchen table——

Mr. WILKES. Everybody in the company now—we were the bomb that went off, but they were all casualties, all around us. They were all paying this $12,000 premium per family. But every time they had to go take their kid in to the doctor or go to the hospital, then they were paying 100 percent because they hadn't even come close to their deductible yet.

Mr. STUPAK. Well, I know you mentioned—and Mr. Null also mentioned—that one way to get around it is to file divorce, have one spouse get no income, go on Medicaid to pay for these expenses. I am pleased to see neither one of you chose that route, but I sure financially you look at it, it makes you think at least once or twice. Fair to say?

Mr. Null, let me ask you this. You had to reduce your annual income you said to, what, $16,013——

Mr. NULL. That is correct.

Mr. STUPAK. —in order to qualify? Or you had to be below $20,000.

Mr. NULL. You had to maintain below that level; it is 16,014. You can handle it yourself.

Mr. STUPAK. So at—16,013 is the magic number. I am sure you had to divest your assets, get rid of a savings account if you had anything left by then.

Mr. NULL. Absolutely. They do a complete asset search, and you have to liquidate all of that.

Mr. STUPAK. How long were you on Medicaid then to pay for Tatum?

Mr. NULL. We were on Medicaid for about 2 years.

Mr. STUPAK. I think you said you had to avoid work or did not take on work because you were afraid to go over that cap?

Mr. NULL. That is correct.

Mr. STUPAK. What would have happened? You would be without the insurance?

Mr. NULL. Yes. They would drop us effective immediately.

Mr. STUPAK. During this time, did you look for other insurance companies to see if you could get off Medicaid and try to get some coverage for Tatum?

Mr. NULL. Yes, sir, we did; and no insurance companies would write us because of the preexisting. They, quote-unquote, said they would not even accept our policy for review, or request or accept our application for review.

Mr. STUPAK. So it was only when you went from a private individual plan to a group plan you were able to get insurance for Tatum?

Mr. NULL. Correct.

Mr. STUPAK. You indicated Tatum is blacklisted from insurance. Can you explain that a little further?

Mr. NULL. It is because of her preexisting. As I mentioned, we could not find any insurance companies that would accept our application with Tatum's name on it.

Mr. STUPAK. What if you—I guess if you didn't put your name on it, when a claim was submitted—if you didn't put Tatum's name on it, when a claim was submitted it would be rejected because she is not covered underneath the policy, right? There is no way to get around it.

Mr. NULL. There is no way around it. No, sir.

Mr. STUPAK. Ms. Howard, we all want to compliment you for the struggles you have been through, but still trying to pay it and to not file for bankruptcy. I think you said you didn't want to go down that road. Could you just explain a little bit?

Ms. HOWARD. Oh, I didn't want to go bankrupt.

Mr. STUPAK. Why didn't you want to go through bankruptcy? That was one way to clean your debt, right?

You are single. You could clear off your debt. In 7 years, you could probably get your credit reestablished.

Ms. HOWARD. I figure in the next 7 years I might be able to pay this off. I would like to be able to say that I have stood up on my own throughout all of this.

Mr. STUPAK. Well, I think you have got the respect of everybody on this committee for trying to do what is right. Not that the 62 percent of the Americans who play by the rules, had insurance—78 percent of those 62 percent had insurance, but they had to file because they just couldn't do it.

So we compliment you for trying.

Mr. Gingrey, questions, please.

Dr. GINGREY. Mr. Chairman, thank you.

First of all, I certainly want to thank all of you for sharing your stories and the courage that you have exhibited in trying to deal with the very difficult situation that all three of you have experienced. And I wanted to direct my first comments to Ms. Howard.

Again, I want to commend you on the steadfastness with which you have taken responsibility for your own medical debt. Could you please comment on how that has affected you personally?

And, specifically, did you ever consider Medicaid? You may have mentioned that, but if you don't mind talking about that again. And were you able to obtain medical care from any other group or organization? Was there anybody out there to help you other than just that insurance policy that you had?

Ms. HOWARD. Yes. For part of 2005, I qualified for a State of California MediCal program, specifically for low-income breast cancer patients. They offered me some help, but in the long term it was just a drop in the bucket.

I am lucky that now, through my employer, I am covered by excellent group coverage. But I know that if I were back on the individual market, no one would cover me.

Dr. GINGREY. In California, Ms. Howard—I know in the State of Georgia, my State, and unfortunately, it is underfunded, but they have something called State Aid for cancer patients, low-income cancer patients.

Did you indicate that they have something similar to that in California?

Ms. HOWARD. They do. Specifically it is for breast cancer and for which I qualified, but the outcome was really minimal. I was grateful for the aid at the time, but it was really insufficient, given the extent of my debt.

Dr. GINGREY. It was a minimal help; some help, but minimal.

How about the providers in the State of California, the physicians? Did you run into any difficulty with regard to them accepting State aid for cancer reimbursement for their services?

Ms. HOWARD. You know, it is all somewhat of a blur, looking back on 5 years ago. But I fortunately had an excellent oncologist and group that was caring for me that—they just said, Hey, we will figure this out together.

What we really figured out is that I have owed them a lot of money for a long time, and I am still paying on it.

Dr. GINGREY. God bless you.

Mr. Wilkes, I wanted to ask you, too. The chairman of the committee, Mr. Waxman, commented in his remarks that many on this side of the aisle don't feel that we need to have health insurance reform. And maybe my opening remarks led him to believe that, that maybe I personally didn't feel that we should have or needed to have health insurance reform or health care reform.

But, clearly, I personally believe that we need health insurance reform, and I think most members on this side of the aisle believe that—firmly believe it. Your testimony today certainly well supports the need for reform of the health insurance industry. We just believe we can do that without—we use the expression sometimes—throwing the baby out with the bathwater.

And Mr. Walden mentioned a number of things that we are supportive of in regard to reforming the health insurance industry and some of the egregious things that you have described, like rescission of coverage after the fact and denying the ability for people with preexisting conditions to get coverage. Maybe they can get it,

but if it is five times standard rates, then they essentially can't get it.

So, Mr. Wilkes, I wanted to ask you in particular. I think you had mentioned that you were under group coverage for a time, and then when you had to get into the individual or small group market, because of the preexisting condition of your son with hemophilia, it was just virtually impossible.

And I want to ask you your opinion of a suggestion that I made in regard to reform to say that anybody that, say, a young healthy person like yourself with a young family, lots of expenses, and you are working and you really can hardly afford to get on the company's group policy. But you do it anyway. And you do it, you make that sacrifice every month and you pinch pennies, and maybe for 15 years or maybe 2 or 3 years even, you have done that and then all of a sudden something like this happens.

Don't you think that a company, an insurance company should be obligated because you have had this credible coverage, if something happens to you after the fact through no fault of your own—or one of your family members—that they should continue to cover you and your family at those essentially standard rates for until you are eligible for Medicare, or maybe even for the rest of your life? Because you have bought into that system and they have made a nice profit probably on covering you until you finally did have those claims.

Tell us what you are thinking about that.

Mr. WILKES. That speaks to a point I talked to other people about. Because of the way the group market works, insurance functions best as a large pool. And the way we have divided—the employers are all these little, tiny pools, so depending on the size of your company, if one person gets sick, it could be very damaging to the company.

That is what happened to my previous employer. We had the high cost; they paid the price. So what you are talking about then speaks to community rating.

We were blessed. In Colorado, in 2008, the State enacted a law creating modified community rating. We are one of a handful of States that does that for the small-group market now. That is the only reason that I can afford small-group coverage today is because we have modified community rating in the State of Colorado.

And I just want to speak very briefly to something Mr. Walden said about selling insurance across State lines.

The way I see it, we are talking about underinsurance today. I think that is a very bad idea, because that invites underinsurance. The average number of things that are required to be covered in the State—there are about 45 or so things that have to be covered under insurance plans. In Colorado we have 51—things like chiropractors, certain types of nurses, colorectal cancer screening, breast cancer screening—whereas over in Idaho they only have about 16 of these things that have to be covered by their plans.

And I think if you invite selling across State lines that way, then the same—the United Health Care in Colorado will now have the United Health Care in Idaho come try to sell a low-cost plan in Colorado that doesn't cover those things. And then you run—you create more of the problems that we are having with finding that,

Oh, the breast cancer is not covered anymore, or the liver cancer is not covered anymore.

So it is just—I hope that answers.

Dr. GINGREY. Mr. Wilkes, thank you.

Mr. Null, I don't have time. Maybe in a second round. But, again, thank you so much. And your daughter looks great and healthy, and thank God for that. I appreciate you.

Mr. STUPAK. Mr. Dingell for questions, please.

Mr. DINGELL. Thank you, Mr. Chairman. Again, to the panel, thank you for your presence and your help.

First question here is, some premises that are interesting. What is striking about each of your stories is that in medical emergencies, that your insurance policies had shortcomings which have limited your career options.

Mr. Null, in your testimony you mentioned that you had to lower your income in order to qualify for Medicaid. I understand that because you are a small business owner, that decision affected your business. I gather it related to having to turn away business to reduce your income so that you could qualify for Medicaid. Is that statement true?

Mr. NULL. Yes, it is.

Mr. DINGELL. Tell us a little bit more about it, if you please.

Mr. NULL. Well, the limit was $1,613. And because I am self-employed, I am the salesman for the company, I am the collector, so I know exactly how much I am going to make. If I knew I was going to make too much, in order to be able to requalify for Medicaid, we would have to turn business away and I would be unable to take on that business because I knew I would make too much for the Medicaid limits.

Mr. DINGELL. Thank you.

Now, Mr. Wilkes, you told us how you had to leave a company that you liked to work for in order to get better coverage for your son. What would you like to tell us about that, please, sir?

Mr. WILKES. Well, they didn't want me to go. I was basically employee No. 9, the lead engineer of the company that we started in 2000. The company survived the dot-com bust. The company then was stuck facing these rising premiums, and they kept me around. For over a year, while we were dealing with this. I literally walked the halls of the company, felt like I had a big giant target on my back.

I am very close to other members of the hemophilic community. I hear horror stories every time I talk to these people about how they started a great job—they were doing well, they were performing, they were the top salesperson—and as soon as somebody in the company found out that they had a kid with hemophilia with the high cost of illnesses, they were terminated or let go, or their job was no longer needed.

So I felt I had that target on my back. I felt I had that target on my back for over a year.

When it came time to leave—I have to go; I don't have insurance unless I do this—they didn't want me—they didn't want me to go. They worked with me. They did everything they could, and I feel blessed that—a guardian angel looking over me and my family,

that they were able to do that. But I know that is not the case for a lot of companies and a lot of people across this country.

Mr. DINGELL. Now, I gather that you on the panel have all had to shop around for insurance policies in order to meet your needs. Did you find that to be an easy process?

And did you have an easy time of comparing your policies or, rather, your choices amongst policies so that you could come up with the best choice for you and your family? Did you find it easy to know what the benefits would be, what the restrictions and the constraints were, what would be the costs, and what would be the duration of the policy and the other circumstances, including preexisting conditions and questions of that kind?

Would you want to start, Mr. Null?

Mr. NULL. We found shopping for insurance to be very confusing. In fact, in Texas it requires a licensed agent in order to even be able to come talk to you about policies, it is so confusing.

My wife and I, we are both college educated. We believe that we are able to make good decisions. But being able to look at these policies and tell the difference—for example, this policy that we were on when Tatum had her illness, this policy was only 25 percent less than the policy I had been on previously with traditional caps in it that would have done our family much more service. It was only 25 percent less, and yet the cap was 1/40th of a comparable policy.

No, we did not recognize anything along those lines when we were shopping for that policy. Had we seen something like that, that would have raised red flags; and we probably would have recognized that policy for being the worthless piece of trash it was.

Mr. DINGELL. Mr. Wilkes, do you want to make a comment on that?

Mr. WILKES. Yes.

Our family had been dealing with this issue about 5 years by the time it came time for us to actually shop for a plan. The policies themselves were very difficult to comprehend. The one thing that was really in my favor is that I was able to find an insurance broker who had cancer herself and really believed that the private insurance market has no business even existing in this country, and knew all the ins and outs and knew what to look for. I had her in my favor, who was being an advocate for our family.

And I also took the plans—in Colorado there are like 20-some different insurance companies that you can pick. We went to our hemophilia treatment center and said, Which of these companies is least likely to deny care, is least likely to give you any problems, is least likely to cause us problems when we go to the hospital? And out of those, there were only two that they said they have the least problems with and they can work with, that pay bills on a regular basis.

So, in the end, we had two insurance companies out of the many that offered that were really an option for us. And beyond that, then we had to work with our insurance broker, who had fought the fight that we fought before and knew what we were dealing with.

Mr. DINGELL. Thank you.

Ms. Howard, do you have any comments on the last question?

Ms. HOWARD. I do.

I feel like there is a real need to provide consumers with assistance in making sense of these plans, to give us an apples-to-apples comparison.

You know, like Mr. Null, I now have a master's degree, and I couldn't make sense of that policy. I really feel like it behooves the subcommittee to write into the bill that we just have to understand what we are signing up for: what would the cost be, what would the coverage be for unfortunate but common conditions like my own, like breast cancer or other common conditions, what would the financial ramifications be for an individual or family.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Members of the panel, thank you for your very fine testimony.

Mr. STUPAK. Mr. Welch for questions, please. We have two votes. Let's try to get through some more questions before we have to vote.

Mr. WELCH. I just want to, I think, express myself what I think all of us feel, and that is, you guys are amazing. To have gone through what you have gone through, to be going through what you are going through with the medical anxiety and then—getting that news, and then learning that you actually didn't have insurance. And at a time when you need to have total concentration on your health, your child, your partner, to find that you are in constant warfare with the insurance companies is just astonishing.

And what I am amazed at is that you all seem to be very nice, normal people, and it hasn't worn you down into smithereens. Now, you may be fooling us, but I don't think so. However you managed to have that strength—a lot of folks don't have it and really shouldn't have to have it.

And, if anything, I think what you have given us are very vivid examples, irrefutable, that if you are going to have insurance, it ought to be real coverage. You shouldn't have to be somebody with extraordinary personal emotional reserves to wade through it, willing to make extraordinary sacrifices in the long term to get through it.

And what you are describing really is a business model where insurance companies make their money by denying coverage or writing policies with obscure loopholes that make it impossible for people to get the coverage they need when they need it; and it is our responsibility here to change that.

And I think there really is some desire to have insurance reform, but the bottom line, I think the insurance company reform, if it is going to be across State lines, has to be with some consumer protection so that if you buy a policy from Kansas or California or Vermont, when that diagnosis comes and you need the care, one of your worries is not whether you have got the coverage.

So you have done just a tremendous service for us here, and I think all of us really admire just the personal strength that each of you has displayed. Because I think you are—but we don't want others to have to go through what you have done. That is really the goal here.

So thank you so much for coming and being so helpful.

Mr. STUPAK. The confusion you see on policies—this committee has been doing 2 years on private insurance. We have the same sit-

uation with Medicare Advantage. People signed up, they had no idea what they are signing up for; and that is one of the things we are trying to work on with health care reform.

Ms. Christensen for questions, please. We still have 9 minutes before we have to vote.

Mrs. CHRISTENSEN. Thank you. I will just ask one.

Another troubling aspect of the underinsurance, besides the medical debt, is that it encourages policyholders to put off care in order to cut costs.

And Commonwealth has done some work on that: People don't pay for home heating or food or rent—all of that is needed to really sustain your health—and then those with chronic diseases don't take proper care of their health.

So I wonder—and I guess I would ask each of you about your experiences and have you—for example, Mr. Wilkes, did you ever avoid taking time to see the doctor because you knew he was near his cap?

Mr. WILKES. Absolutely. You know, not only did we have coworkers that were putting off primary and acute care, but, as we were facing the looming specter of the cap coming up, there were times when Thomas would complain about an injured joint. And the normal procedure would be treat it right away. That is standard. Treat it right away. And if it is a bleed, the factor will take care of it. But we were facing this cap, and every single dose was precious to us. I mean, we are talking about a thousand dollars or more a dose at the time or even $10,000 or more for full treatment. So we would wait and see.

At least three or four different times during that year, he would complain about something in his joint hurting, and we didn't know if it was his leg falling asleep or what, so we would wait. Rather than do the standard care of treat first, then check it out, we would wait a few hours, we would wait overnight. And, invariably, it would actually turn worse, and it would cost us, you know, $80,000.

Mrs. CHRISTENSEN. And probably damage the joint in the process.

Mr. WILKES. Yes. And for 3 months, there was a period for 3 months, he had an ankle bleed, where he was confined to a wheelchair the whole time.

Mrs. CHRISTENSEN. Thank you.

Ms. Howard, did you ever skip any of your treatments?

Ms. HOWARD. I did not. I, without regard for expense, went forward. And, as I said before, if I don't die, I will just figure out how to pay for this later. But it has come at tremendous cost to my family and to my personal finances and has also affected how I choose to live my life—where I work, where I live, how I live.

Mrs. CHRISTENSEN. Mr. Null, did you ever?

Mr. NULL. No, ma'am, we never let that be a consideration.

Mrs. CHRISTENSEN. I, too, appreciate your coming forward. I think your personal histories are very important testimony to what we are trying to achieve. And we have great admiration for your strength, your courage, and your perseverance.

Thank you, Mr. Chairman.

Mr. STUPAK. Thanks, Mrs. Christensen.

Mr. Burgess for questions. There is 5 minutes before we have to vote, so we will have to keep it at 5.

Dr. BURGESS. OK. I can walk faster than 50 older Members, so maybe I will make it.

Mr. STUPAK. For other members, we will come back.

Dr. BURGESS. Ms. Howard, let me just ask you. And I probably won't take the full 5 minutes, but I did want to come back and visit with you. You know, we heard Mr. Welch talk about how confusing insurance policies can be. And they can be; no question about that.

I don't know if any of you have taken the time to read through the legislation that this committee passed on July 31st. It is pretty confusing, as well. And, for many people, it has been hard to discern will their lives be, in fact, better or more complicated if this bill passes.

But you referenced in your testimony having at least paid attention to one amendment that was passed, dealing with internal and external review. And I want to commend you for your ability to sort through a large number of words and dig up pieces of what almost would seem to be miniscule events.

To me, that was very important, to get that included. Obviously, I was concerned about the development of a public option plan without internal and external review being available.

Would that have helped you in your situation?

Ms. HOWARD. Absolutely.

I had previously had a group policy with the same provider that was excellent. And so, when it came time for me to buy a private policy, I went back to them willingly and said, "What do you have to offer for me? I have been a great customer of yours for several years." And had I been able to compare the disparity in coverage between a private and a group plan—how if I had been through this same illness and recovery under a group plan, I would not be in the financial circumstances that I am now.

So if I could have seen that apples-to-apples comparison and been told, "Hey, kid, if you get cancer, this is what it is really going to cost you," I might have made a different choice. But I don't know that there would have been really anything better for me out there.

Dr. BURGESS. And, of course, this gets to the larger point. When a larger corporation is negotiating for insurance coverage and prices, they bring a certain amount of clout to the table. I had a policy in the individual market at one point in my life, and you are correct, you are negotiating as a single individual. If they will even talk to you, you feel grateful, because you got the audience with the insurance company.

But there are many of us who believe that if we would permit more aggregation of consumers—it doesn't always have to be working for the same company; it might be members of the same church or alumni association or people who work in dentist offices or physicians offices.

I was always stuck with having to provide—not stuck, but faced with having to provide a competitive insurance policy for 50 employees. And, yes, while that is better than finding for just one individual, still, you are a pretty restricted purchaser in that. And we don't seem to be sensitive to the fact that, if we would allow aggre-

gation of much larger groups with some sort of similarity in their business models, that we would give people more purchasing clout.

Now, interestingly, you have chosen to work out a payment schedule, and while it is one that seems aggressive, I was a practicing physician for years and certainly can recall, as long as a patient was making an honest effort to pay off the bill, that was all that our office would do as far as collection. Now, the hospital being owned by a big corporation—on national TV we won't mention any names, but their initials were—well, we won't even say their initials because they know who they were—they were less likely to work with the patient.

But as far as the individual physician's office—and oftentimes I could go to bat with hospital administration and say, look, you can put these folks to a collection agency and you will get 30 percent of what you otherwise would have gotten if you are willing to wait whatever length of time it is where they can pay this out.

And I just commend you for doing that and for thinking through that. Again, your payment schedule is aggressive. I never had a patient who paid me that promptly. But I don't think people are aware that this is available to them.

And I got to tell you, Mr. Chairman, I practiced for 25 years, and I can remember probably getting two bankruptcy discharges in my practice. And not that I pushed this person into bankruptcy, but, as a creditor, I had to be notified that the debt was discharged and I could make no further—if I was doing anything to effect collection, that I would have to cease and desist. It just was an infrequent occurrence in the years that I was practicing. And then I set here listening to opening statements on this committee, and it seems like it is rampant.

One last final thought, Mr. Null. Did you talk to the Texas Department of Insurance, the commissioner of State commercial insurance, about the problems you had?

Mr. WILKES. No, I did not.

Mr. STUPAK. OK. I have to cut you off. You are over time. And Mr. Doyle wants to get a question or two in before we have to go. Time has expired on the vote for Ms. Schakowsky and us.

But, Mr. Doyle, go ahead.

Mr. DOYLE. Thanks. And I will try to be quick, Mr. Chairman.

First of all, to the witnesses, thank you so much. It is a tremendous help to us for Americans to put a face on this, and we appreciate you doing this.

Mr. Null, I wanted to put your policy up on the screen. I have been reading your policy that you bought from United. I am licensed in all lines of insurance; I have been for 30 years. I have to tell you, as a licensed insurance agent, I was having a hard time understanding your policy.

When you look up there and it shows you that surgical—part four, surgical, 100 percent, I mean, how did you read that when you first bought that policy? Did you read that to mean that they were going to cover 100 percent of surgery?

Mr. NULL. Yes, in Texas, that is what that means; 100 percent is 100 percent.

Mr. DOYLE. And then you have to go a couple pages further into this, and then there is another schedule like this that lists different procedures and what they will pay for the procedures.

Did you have any idea what any of these procedures actually cost?

Mr. NULL. No, I had no idea. I had never seen a medical bill before in my life prior to this experience.

Mr. DOYLE. Mr. Chairman, this is one of the things, when we look at insurance reform, when we talk about transparency, that we have to get back to consumers to help them out. If it says you will pay $5,000 for a procedure and the procedure costs $25,000, then would you have bought the policy?

Mr. NULL. Well, no. That wouldn't seem like 100 percent to me. I mean, that wouldn't make sense.

Mr. DOYLE. Exactly. And this is the problem. People buy insurance policies all the time that have these schedules. Your daughter's surgery wasn't even on this schedule, is that correct?

Mr. NULL. It is not on there. I can't find it.

Mr. DOYLE. So there would be no way for you to—you just assumed it said 100 percent of surgery and so it was going to pay.

Mr. NULL. Unless listed otherwise, yes.

Mr. DOYLE. Yes. I mean, the need for health insurance reform is just so obvious. And the thought of companies selling across lines and nobody watching how these policies are written would be a national nightmare.

But we need transparency. People need to know what procedures cost and what their insurance companies are going to pay in plain language that you don't have to be an insurance agent or an attorney to understand. And, as an insurance agent, I still don't understand your policy.

So I see what you have gone through, and I am sorry that you went through it. And we are going to try to fix it.

Mr. NULL. Thank you. That makes me feel better.

Mr. STUPAK. Thank you, Mr. Doyle.

Tatum, did you want to say anything to this group? We are going to go do some votes and come back. But did you want to say anything to this committee?

Miss TATUM NULL. I just wanted to say that, knowing what is going on right now, I do want to be able to live my American dream, and right now I am not able to. So hopefully you can fix that.

Mr. STUPAK. I hope we can, too, for everybody.

Ms. Schakowsky, do you want to say something quick before we leave?

Ms. SCHAKOWSKY. Yes, if I could just thank them so much.

I know you have been here for a long time. We have a couple of votes, so I am going to waive my questions, but just say that you are emblematic of what could happen to anyone in our country. Everyone is one catastrophic illness away from the kinds of problems.

I would love to know who told you to get a divorce. I would also just be interested—and I am sure you spent endless hours of your precious time in the face of illness dealing with this. And we are going to address this issue. And I thank you for your contribution to that.

Thanks.

Mr. STUPAK. OK. We are going to stand in recess. I urge members to vote and come back. We have one more panel to go. I am going to excuse this panel. I am sure we all have more questions. We can follow up in writing.

But I know we have kept you all afternoon. We appreciate your being here. And thank you for sharing your story and putting a face on this.

We are in recess. I urge members come back immediately, get to panel number two.

[Recess.]

Mr. STUPAK. The hearing will now come back to order.

For the record, I talked to Mr. Walden. We were scheduled to be in tomorrow, but because some of the appropriation bills are stalled they have dismissed us for the night. So a number of Members are trying to catch airplanes with this weather, and they are already facing some delays, so a number of Members are going to leave.

I checked with Mr. Walden, the ranking member, and he said, "Give my regards to the next panel." He had to leave, but he was going to—he has asked us to continue with this hearing.

Members will be back early, even though we may be off Monday, members will be coming back early because we have another hearing on Tuesday on health insurance, private health insurance, especially how it affects small businesses.

So we are very pleased that our second panel can be here: Dr. Collins, Dr. Sara Collins, who is vice president of the Affordable Health Insurance Program of The Commonwealth Fund; and Dr. Stan Brock, who is director of the Remote Area Medical Volunteer Corps.

I would like to thank both of you for being here and being patient with us today.

It is the policy of this subcommittee to take all testimony under oath. Please be advised you have the right, under the rules of the House, to be advised by counsel during your testimony. Do you wish to be represented by counsel?

Both witnesses indicated they do not.

Therefore, I am going to ask you, please rise, raise your right hand, and take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect the witnesses replied in the affirmative. They are now under oath.

We would now like to hear a 5-minute opening statement from each of you.

Dr. Collins, if we may, we will start with you. If you would just turn on the mike there, a green light should go on, and pull it up there. And if you have a longer statement, that will be included in the hearing record. But you may begin. And thank you, again, for being here.

## TESTIMONY OF SARA R. COLLINS, PH.D., VICE PRESIDENT FOR THE AFFORDABLE HEALTH INSURANCE PROGRAM, THE COMMONWEALTH FUND; STAN BROCK, DIRECTOR, REMOTE AREA MEDICAL VOLUNTEER CORPS

### TESTIMONY OF SARA R. COLLINS

Ms. COLLINS. Thank you, Mr. Chairman, for this invitation to testify on the growing number of people who are underinsured.

The soaring cost of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a very large share of their income. 46.3 million people lacked health insurance in 2008. This is up from 45.7 million in 2007.

Among people who do have health insurance, The Commonwealth Fund estimates that, in 2007, 25 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increased from 16 million in 2003.

As the extraordinary testimonies of the first panel underscore, both these trends have had serious financial and health consequences for U.S. families. This committee and the other key health committees in the House and the Senate are to be commended for pursuing health reform that will help families secure access to affordable and comprehensive health insurance.

The combination of rapidly rising health care costs, very slow growth or no growth in real family incomes, and greater cost-sharing in health plans are contributing to the growth in underinsured adults. Based on analysis of The Commonwealth Fund's biennial health insurance survey, between 2003 and 2007 the share of underinsured adults climbed from 9 percent to 14 percent of the under-65 population.

We defined underinsured adults as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income if their incomes were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their incomes.

Adults with low incomes are the most likely to be underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007. This is up from 19 percent in 2003. But the problem of cost exposure is moving up the income scale. The share of adults with incomes of 200 percent of poverty or more who are underinsured nearly tripled over the time period, growing from 4 percent to 11 percent. The most rapid growth occurred among adults earning between $40,000 and $60,000.

Underinsurance is associated with health plans that cover fewer health benefits. More than one-quarter of underinsured adults reported a deductible of a thousand dollars or higher, compared to 8 percent of adults who are not underinsured. Forty-eight percent reported that their health plan placed limits on the total dollar amount that their plan would pay for health care each year. Nineteen percent reported that their health plans limited the number of times per year they could see their physicians.

Underinsurance is also associated with reports of health plan problems. Forty-four percent of underinsured adults in our survey

reported that they had had expensive medical bills for services that were not covered by insurance. Thirty-eight percent of underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference.

Adults with health plans purchased in the individual insurance market are more likely to be underinsured. Thirty percent of adults who had purchased a plan on the individual market were underinsured, compared to about 17 percent of adults who were in employer-based health plans.

Underinsured adults report not getting needed health care because of cost at rates that are nearly as high as people who are without insurance coverage all together. Sixty percent of underinsured adults in our survey reported at least one cost-related problem getting care.

Underinsured adults also report high rates of medical bill problems. Three of five underinsured adults reported a problem paying medical bills or had accrued medical debt over time. This is more than double the rate of those who had adequate insurance all year. Nearly half of adults who are underinsured reported that they are paying off medical debt over time.

Several provisions in the "America's Health Choices Act," or H.R. 3200, would reduce the number of people who are underinsured. The bill replaces the individual insurance market with a regulated insurance exchange. The new market regulations would extend to all health plans. Guaranteed issue and community rating would ensure that people could not be denied coverage, charged a higher price, or have a condition excluded from their coverage because of a preexisting condition.

Insurance carriers could not impose annual or lifetime limits on what their plans would pay and would be prohibited from the use of recisions. The bill would establish a new minimum benefit standard, which would ensure that families do not become bankrupt because of medical costs, encourage the use of timely preventive services, and protect against catastrophic costs.

The premium subsidies in Medicaid expansion substantially improve the affordability of health insurance for people with incomes up to 400 percent of poverty. The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty.

For people whose incomes exceed the income threshold for subsidies, premium costs will likely decline from current levels due to a decrease in administrative costs from restrictions on underwriting and reduced marketing and because of savings achieved through reduced provider payments and profits if a public option is included in the exchange.

Reducing out-of-pocket costs will also require national reforms aimed at improving the overall performance of the health system. The House bill includes key provisions for improving health system performance and lowering the rate of cost growth. These provisions will likely enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over time.

Thank you.

[The prepared statement of Ms. Collins follows:]******** INSERT 3–1 ********

Mr. STUPAK. Thank you.

Mr. Brock, your testimony please. If you will turn that light on, pull that mike up a little bit. And we look forward to your testimony. You may begin. Thank you.

**TESTIMONY OF STAN BROCK**

Mr. BROCK. Thank you. Thank you, Mr. Chairman, members.

In 1992, Remote Area Medical, a charity formed to provide free medical relief services overseas, began receiving requests for service here in the United States, including dental procedures, eye exams, free eyeglasses, and primary health.

Today, 64 percent of our work is in America, and we run about 30 expeditions per year and have completed 581. Some 45,000 volunteers have delivered $40 million worth of free care in over 400,000 patient encounters and treatment to more than 64,000 animals. Our most sought-after services are dental and vision, with over 55,000 patients served in the U.S. in each specialty.

Demographics reveal that 94 percent of the patients are adults, with 83 percent between the ages of 21 and 64, reflecting a transition from childhood-covered programs to uninsured status prior to receiving Medicare. Sixteen percent of them visit a hospital emergency room in the event of sickness, undergoing extensive tests caused by the practice of defensive medicine, while dentists and eye doctors are unaffordable, leading to long lines of desperate Americans at RAM free clinics.

The greatest impediment the RAM programs face is regulation in 49 States preventing willing practitioners from crossing State lines to provide free care. Even during declared emergencies, reciprocity between States is a complex matter that current legislation under the "Uniform Emergency Volunteer Practitioners Act" cannot adequately address.

The sole exception is the "Volunteer Health Care Services Act" of Tennessee. Since 1995, a doctor can show up at a RAM event in Tennessee with license in hand, roll up their sleeves, and get to work. No bureaucratic application process, no fees, and no unnecessary background investigations.

In 1997, Representative John Duncan, Jr., introduced House Concurrent Resolution 69 in an effort to persuade States to adopt the Tennessee model. HCR 69 was referred to the Committee of Commerce. Despite endorsement by the American Medical Association in 1998, it gained no ground nationwide.

RAM attracts thousands of uninsured and underinsured patients and requires large numbers of doctors. Patient volume invariably exceeds the number of local providers willing or available to volunteer free services. This gap can only be filled by reinforcing our teams with volunteers licensed in other States.

There are more than 179,000 dentists in America and 800,000 physicians. They pass a nationally standardized competency test and graduate from a nationally accredited school. Many like to travel and will do so at their own expense to provide free care. Some do in other countries because volunteering outside of the U.S. is easier than overcoming bureaucratic hurdles to help those 47

million uninsured here in America. This demonstrates the need for all States to adopt the Tennessee model as proposed in HCR 69.

That need was recently emphasized at a Remote Area Medical event in Los Angeles. In 8 days, we treated 6,344 patients for a value of free care exceeding $2.8 million. But those numbers could have been doubled. We had 100 dental chairs and 20 lanes of eye exam equipment, yet on some days we could only recruit 25 California-licensed dentists and five or six eye specialists. By comparison, in rural southwest Virginia, where laws were relaxed to allow the partial use of out-of-State doctors, RAM treated 2,715 patients in only 2 1/2 days, a patient number not attained in Los Angeles until the 4th day, while thousands of uninsured California residents were turned away.

RAM patient surveys indicate that some 46 percent carry no insurance, 23 percent are on Medicaid, and 18 percent on Medicare. Dental and vision insurance is carried by less than 1 percent.

Self-induced health issues wrought by the culture of poverty caused by fast foods, smoking, and lack of exercise are aggravated by the problem of access. Patients don't have access to the doctor. The doctor cannot cross State lines to have access to the patients. And the doctor does not have reasonable access to protection from lawsuits.

RAM data proves that allowing doctors to cross State lines dramatically increases service to the underserved. If the Tennessee statute was enacted by all 50 States or possibly at the Federal level, for example under the interstate commerce provisions of the Constitution, volunteers would respond en masse and serve millions of uninsured Americans at no cost to the government and no cost to the taxpayer.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Brock follows:]******** INSERT 3–2 ********

Mr. STUPAK. Thank you, Mr. Brock.

I will open up for questions now.

Ms. Schakowsky, would you like to go first? I know you have a pressing appointment.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I really appreciate it.

First, let me just extend my thanks to The Commonwealth Fund for the incredible work that has been done to advance our knowledge about this whole area of health care and health care reform.

And, Mr. Brock, let me thank you for the Remote Area Medical foundation. And, for me, I guess what I would like to say about that, it has highlighted and really underscored a failure of the American health care system. Obviously, no discredit at all to you, because you are filling a gap.

But what I take away from that is that you should be doing this work in developing countries, in places where there is no capacity. But we are the United States of America. And I just feel ashamed when I see that people have to line up at 3 o'clock, at 4 o'clock in the morning, even people that have some kind of insurance.

My hope is that your organization will flourish and be able to serve people in truly remote areas around the world and that your work should be not only applauded but supported.

I wanted to talk, Dr. Collins, about the issue of health insurance market concentration. Today, because of mergers and acquisitions by large private health insurance companies, consumers in many parts of the country, I think most parts of the country, have few choices.

And I don't know if you have Figure 25 that has a map that shows the country and the concentration of private health insurance companies in the States. In eight States, you find just two private health insurance companies control 80 to 100 percent of the market. And in medium-blue States, the two leading companies have 70 to 79 percent of the market share. And in the majority of States, those that are shaded light blue, or lighter if you don't have color, two insurance companies control more than half the market.

As you said in your written testimony, there are only three States in which the two biggest private health insurance companies control less than half of the market. Is that right?

Ms. COLLINS. That is right.

Ms. SCHAKOWSKY. And what kind of effect, then, does this market concentration have on consumer premiums and out-of-pocket costs that American consumers face?

Ms. COLLINS. What it means is that insurance companies, if they are facing concentrated markets, concentrated provider markets, so there is not a lot of competition in provider markets either, and if they are not able to negotiate lower rates with providers, because of the lack of market competition in the insurance market, they can simply pass those costs off to consumers and employers.

And we are certainly seeing that now. It is probably contributing to the rapid increase in premiums and health care costs that we are seeing over time. So we really do need an increase in competition in the insurance market to counteract that dynamic.

Ms. SCHAKOWSKY. And how do you see H.R. 3200 affecting competition in the insurance industry? And what effect would this have, then, on underinsurance?

Ms. COLLINS. Well, 3200 includes a public plan option. So it means, in these markets, there would be a new option for people to choose from if they are buying through the health insurance exchange. It would mean, if the public plan was allowed to negotiate or to set provider payment rates, it would break up this dynamic that we are seeing where insurance companies just pass on their higher rates through to consumers and employers, inject some new price competition into those markets, likely lowering premium costs for everyone over time and contributing, really, to lower rates of growth in overall health care costs.

The other thing it would do is help spread innovation and payment reform, delivery system reform, having this presence of a public option.

So, really, introducing some needed price competition and also innovation on the payment and delivery systems reform side.

Ms. SCHAKOWSKY. Why don't more insurance companies try to enter these concentrated markets? What are the barriers, then, under our current system?

Ms. COLLINS. Well, many insurers are already contracting with current provider networks. So it is really difficult for an insurance company to come in and get those providers into their network. So

that concentration in the market really does act as a barrier for other companies or insurance companies coming into the market.

Ms. SCHAKOWSKY. Thank you.

Thank you both.

Mr. STUPAK. Any further questions, Ms. Schakowsky?

Ms. SCHAKOWSKY. No.

Mr. STUPAK. OK. Mr. Green for questions, please.

Mr. GREEN. Thank you, Mr. Chairman.

During our first panel, we heard from our witnesses about problems with transparencies in insurance policies. And we took some time to look at the policy that David Null brought. He thought that it would protect him in a catastrophe. As it turned out, the policy didn't protect him as he expected it would.

I understand people should be responsible for reading their policies carefully, but all too often policies are confusing and loaded with technical jargon.

Dr. Collins, do you see a widespread problem with transparency in health insurance policies, or are consumers generally well-informed about their health plans?

Ms. COLLINS. I think the problem really does happen in individual and the small group markets, where people are really on their own when they are choosing plans. They are not often aware of what their plans cover. They may think that a lifetime limit of a million dollars is a lot until they get really sick and it really turns out not to be enough.

So it is a pervasive problem. I think minimum standard benefits and much increased transparency is really needed in both of these markets. The House bill really does do that with the minimum standard benefit packages just in this new environment of transparency that would be available through the exchange.

Mr. GREEN. In your view, what reforms would help ensure that consumers are informed better about their policies?

Ms. COLLINS. Well, I do think there needs to be much more regulation of the individual market. There needs to be, as Massachusetts has done, a way for people to look at what their policies have, to know that there is a minimum standard so that their policies won't fall below that standard, that there won't be limits on what their plans will pay. They will know what their deductibles are; they will know what their plans will pay.

And so, having that kind of standardization for this market, where people are on their own, is really important to counteract a lot of the testimony and experience that we saw on the first panel.

Mr. GREEN. And I know it was mentioned earlier, but one of the—it came out of this Oversight Committee over a number of years of hearings on transparency and hospital bills. And both Chairman Stupak and Ranking Member Barton and Congressman Burgess and I put an amendment on H.R. 3200. Most people don't think that that bill had the bipartisan effort in it, but a lot of the language in that bill actually came out of both sides of the aisle. It is just that we didn't get any votes in our committee on it.

But we did have a transparency amendment that would require hospitals to disclose the average prices for their common services. And would this help with transparency in insurance policies if we did something like that on a national basis for insurance policies?

Ms. COLLINS. I think having more transparency on the hospital pricing side—so, having both the Federal Government having those prices much more clear so that the cost is much closer to what prices are. Right now there is often no clarity on what the costs are for hospital procedures, what the prices are. So people who are uninsured, for example, are often charged far more than what insured patients would be under negotiated contracts.

So I think having that kind of transparency in pricing will be very useful to both Federal Government and also private insurers.

Mr. GREEN. OK. Thank you.

And I yield back my time.

Mr. STUPAK. Thank you, Mr. Green.

Mr. Dingell for questions.

Mr. DINGELL. Thank you, Mr. Chairman.

I would like to commend the panel for their very helpful testimony, and I have no questions.

Mr. STUPAK. I have a number of questions I would like to ask.

Mr. Brock, you indicated that legislation was introduced to help you to let doctors come and volunteer their time, dentists and all that, and that was introduced one time.

Has that been addressed yet? Do you still face that same problem today, where doctors cannot come to one of your operations in this country and volunteer their time?

Mr. BROCK. This is the most difficult problem that we face everywhere, except in the State of Tennessee where we have treated thousands and thousands of patients using predominantly practitioners from outside the State.

What we do, which is on a massive scale where we are dealing with thousands of people, it requires hundreds and hundreds of doctors to do that. And it is just not possible, in most cases, in virtually every case, to recruit enough local providers.

Mr. STUPAK. So, like, when you mentioned Wise County, Virginia, you had to use doctors from Virginia, then.

Mr. BROCK. Yes. Now, Tennessee, to my knowledge, is the only State that has this across-the-board open-door policy. What you have in Virginia is an effort in that direction, which has not reached a point where it is really very, very workable. We can bring in people for no more than 3 days into Virginia, but it was a measure that was opposed by the dentists. So if we want to bring in dentists, we have to have them jump through a certain number of hoops.

Mr. STUPAK. I see.

Mr. BROCK. The most dramatic case in point, really, was just last month—well, August—in Los Angeles, where we treated 6,344 patients, but we had such an inadequate force of California-licensed doctors despite the fact that we petitioned to bring in volunteers from outside the State.

We had a hundred dental chairs set up, we had 20 lanes of eye exam equipment. And the best we could do with 25 very fine dentists, volunteers from California, and four or five very fine optometrists from California, and a dozen or so doctors. Meanwhile, we had given out 1,600 numbers. There were 1,600 people waiting on day 1. We had to turn all of them away except the 700 that we could do with the limited force.

Had we been allowed to bring in people from anywhere in the country who would have been more than willing to come—we had so many requests, and we had to say, "No, you are not allowed to come because we are going to a State that doesn't allow it," we could have treated 15,000 people instead of 6,344.

Mr. STUPAK. Let me ask you this. You also indicated that, whether it was in Tennessee or in Virginia, I understand you conducted some surveys to determine, among other things, what portion of your patients had health insurance.

What did you learn from these surveys regarding how many people had health insurance but were still seeking free health care provided by your fine organization?

Mr. BROCK. Well, it is all across the board, really. There are about 42 percent that do have insurance.

Mr. STUPAK. Some type of insurance.

Mr. BROCK. Of some type. The problem with—so this is not just treating people who are the unemployed and the homeless. We are getting people just like these wonderful folks that were in the first panel, people that have jobs, people that have reasonable incomes, but they have issues that are not covered on their insurance policy.

And, in many, many cases, it is a lack of dental coverage and a lack of vision coverage. And they simply cannot afford—or their deductible is too high.

So even though we may have a thousand people that come on a particular morning for treatment—and looking at the profile of these patients, you can see that they all have some pretty far-reaching medical problems: a large percentage of them smoking, a large percent of them with obesity problems. But they can take some of those problems to the emergency room when they run into a problem, but they cannot take dentistry and they cannot take vision problems to the emergency room.

In fact, in our neighborhood, every emergency room has a sign up there: "If you are here because you have a bad tooth or you can't see properly, go and see Remote Area Medical, because we don't do that here."

So virtually a hundred percent of the patients that come to our clinic are there because they are in pain and need the dentist and they have vision problems and they need a pair of eyeglasses, even though they need to see the doctors, but they are preoccupied with dentistry and vision.

Mr. STUPAK. And that 42 percent that had some insurance, it made no difference whether you were in rural areas or urban areas; it was basically the same.

Mr. BROCK. It is very similar across the board, yes.

Mr. STUPAK. Well, thank you for the remarkable work you and your volunteers do and your staff that is with you here today. We appreciate your being here.

Dr. Collins, Mr. Brock said something very interesting, and he indicated that, you know, these are people who have insurance and policies. And you indicated that the most rapid growth of underinsured are people between $40,000 and $60,000, whose incomes are $40,000 and $60,000, based on your survey. Is that correct?

Ms. COLLINS. That is right.

Mr. STUPAK. See, like, in my district, my median household median is only $38,000. So we would be struggling.

Your survey included 2007, right?

Ms. COLLINS. That is right.

Mr. STUPAK. So you would not have any statistics—because the economy really took a nosedive about August, September of 2008. I am sure your uninsured and underinsured figures would be much greater, would they not?

Ms. COLLINS. That is right. And it is also compounded by the fact that real median incomes actually dropped between 2007 and 2008. So there is that dynamic. As well, health care costs are rising at 6 percent a year. And we know more employers are cutting back on their benefits. People have lost their jobs, which means that they are either buying on the individual market or they are going uninsured. So those numbers have probably definitely worsened.

Mr. STUPAK. And most of your numbers are—when you talk about underinsured, those are basically people below 65, because at 65 most Americans have Medicare, right?

Mr. BROCK. That is right.

Mr. STUPAK. And, Mr. Brock, I think you said the same thing in your testimony, that the adults you see are 21 to 64 and not 65 or over. Is that basically because of Medicare coverage?

Mr. BROCK. Yes, right. Eighty-three percent are in the age group of 29 to 64, simply because after they pass that threshold out of childhood into adulthood they start letting these problems of dentistry and care go by the boards, and so that is the age group where they start to run into problems.

Mr. STUPAK. Sure.

Dr. Collins, if I can go back to you, you indicated that the problem of underinsured and uninsured, but really uninsured, comes from a combination of rapid rise in health care cost, slow growth in family income, and a shift of the burden of cost that leaves the family or the policyholder to pay more for the health care cost.

And we have heard testimony and opening statements from members saying that premiums have risen 131 percent in the last decade, more than three times that of the average family wage increase.

So, Dr. Collins, what kinds of health care costs are families now being expected to absorb that they weren't 5, 10 years ago?

Ms. COLLINS. Well, we know from our survey that many more people are paying large shares of their income out of pocket, whether they are underinsured or insured, have adequate insurance. And that has moved dramatically up the income scale. So about 30 percent of people who are privately insured are paying more than 10 percent of their incomes on out-of-pocket costs and premiums.

So we are seeing rates among even middle-income families that we weren't seeing when we did this survey in 2001, for example. So those rates among middle-income families, median-income families are up where low-income families were in 2001. So it is really spreading up the income scale, this issue.

Mr. STUPAK. We have heard testimony today, and our last panel mentioned it, and we've talked about it, and I think we all have some idea, but could you explain a little bit more for me about health networks?

I know we had the map up there of the States, and most of them only have, like, two or three dominant providers. But Ms. Howard talked about health networks, I think Mr. Null did, and I think Mr. Wilkes did too, about they had to stay within their network.

What does that mean from an insurance perspective? Could you explain that?

Ms. COLLINS. What it means is—and it is also related to what you are responsible for paying out of pocket. So if your provider is in-network, you are likely to face lower costs. Likely your costs will be lower than they will be if you go out of network.

Now, what happens when you go out of network? You may understand that your insurance company pays a certain percentage of your costs, but not knowing, as that policy that was on the screen showed, not really knowing what the cost is. So just not going out of network because your insurance company doesn't cover out-of-network costs and being left with a big bill because of that.

This map really shows the massive concentration in the insurance industry right now. And it really has had an increasing pressure on overall health care cost growth, certainly on premiums. There just is a lack of competition in those markets.

Mr. STUPAK. So, like, my State of Michigan there, Blue Cross Blue Shield, it is our biggest carrier. So if I go outside of Blue Cross Blue Shield, then I have higher out-of-pocket or I may have to pay the whole amount because I am not in the Blue Cross Blue Shield network?

Ms. COLLINS. Right. So they will have some providers that are contracting with you that are in-network. If you are out of network, depending on your policy, your costs will be covered at some percent of the total cost.

But what is hard to know is what, even if they say they will cover this percent, it is hard to know what the total cost will be. And so, often, they will cover the share but you won't know what your margin of responsibility is until you get your bill.

Mr. STUPAK. Sure. And I live on a border community in the Upper Peninsula, and most of my medical care—in fact, we only have one doctor in my community—is in Wisconsin. So I am almost always out of network, just about. So, therefore, I pay more out of pocket with my policy.

For the record, I don't have the Federal employees health benefit package. I should, but it is a promise I made. I wouldn't take it until everybody had health care, so I don't have it. So I am doing myself, probably, a disservice.

But these are decisions that families are doing every day. And if you live on a border, like I do, it can be a lot different and greater. So the network is being within there.

And so, if you only have two of your large providers, if you are not one of those two, and they are probably not offering you a good plan, and you are out of network, it is going to cost you more money.

Ms. COLLINS. Probably, yes.

Mr. STUPAK. Let me ask you one more question. And you mentioned it in your testimony, about you learned about the types of treatments for medical care that underinsured individuals forego for financial reasons. And some of the other panels, like Mr.

Wilkes, he didn't take his son when he thought maybe he should, because the cost could be as much as $10,000. And I think your survey was showing the same thing. People were not filling a prescription, not seeing a specialist, skipping appointments.

Is that pretty common?

Ms. COLLINS. It is very common among people who are either uninsured or underinsured. The striking thing about our survey findings is that people who are underinsured have rates of avoiding necessary care because of the cost at rates that are nearly as high as people who are without insurance coverage altogether.

So it is a very real problem. We see it in our data. And it is a problem that has increased over time.

Mr. STUPAK. Has your organization been able to develop, or developed, any data which would show, if I am skipping my doctor's appointment or not getting the screening test, how much that is costing us in health care? Have you been able to put a financial value on these underinsured who are skipping payments, premiums—or not payments, excuse me—doctor offices, doctor visits, treatment, specialists? Can you put a value on that?

Ms. COLLINS. You know, we asked people about their chronic health conditions, and then we asked that group of patients, people in our survey who had a chronic health condition like heart disease, diabetes, asthma, whether they had ever skipped a prescription drug, tried to cut their pills in half in order to make their prescriptions last longer. And about 46 percent of people who had a chronic disease who were underinsured said "yes" to that question. Again, those rates are really high, almost as high as people who were uninsured.

And then we also asked this group whether they stayed overnight in a hospital or gone to an emergency room because of their health condition. And we found that about 32 percent of underinsured patients said "yes" to that question.

So you can expect that if people are skimping on their prescription drugs, they are probably having more serious health conditions. And there is a substantial amount of research in the literature that also underscores this finding.

Mr. STUPAK. We have the chart up there, and it is pretty interesting. Did not fill a prescription; did not see a specialist. The highest bars there are the underinsured or not insured, or not insured for part of time in the past year, those numbers.

I am sure, Mr. Brock, you see the same thing, because then they must turn to you for trying to get some care, especially since you said, in a basic health plan, dental and optical are probably not included. But you even see people who need basic coverage that are coming to you who have some sort of insurance. Is that true?

Mr. BROCK. Yes. In fact, large numbers of them are coming now that have insurance, but it doesn't cover those two specific areas.

We are getting people now that are coming hundreds and hundreds of miles, buying an airline ticket to come from Florida all the way up to Tennessee. We have had a request from a nongovernmental organization in Massachusetts wanting to bus people down from one of the richest States in the country to one of the poorest, to Tennessee, so that we could fix their teeth and make them eyeglasses.

So this is becoming even more common. Even though we are really not seeing any more patients in many areas than we have been seeing in the last 20-odd years, they are coming from a lot further away.

Mr. STUPAK. Well, all the great work your organization does—and you have some of your staff here with you today—and all the doctors and dentists and ophthalmologists and optometrists that have volunteered their time, how do you support your organization? Do you receive grant funding? Do you get donations? How do you support your organization.

Mr. BROCK. Well, our organization is largely supported by members of the public who send in those $10 and $15 donations. We do have some foundation support.

You know, up until early in 1998, the only people who knew what Remote Area Medical were doing were the poor, the people that came to our clinics. And then "60 Minutes" on CBS focused on us, and so this has caused a great increase in the interest in what we do and, I am glad to say, a certain increase in donations.

But we don't have any corporate support—I wish we did—of any magnitude, but we do have some foundation support. We do not take any government money. And, in fact, we would never apply or want any money from the government.

Mr. STUPAK. So if we passed health care, it would be a good idea if we, sort of, put you out of business, right?

Mr. BROCK. Oh, yes. It would be marvelous if we could go back to concentrating on places like Haiti and the Dominican Republic and India and Africa, which is what I formed this organization to do in the first place.

Mr. STUPAK. Did you imagine you would be coming to the United States and there would be such a great demand for your services here in this country, the richest country in the world?

Mr. BROCK. Well, you know, without digressing from that question very far, the sixth man to walk on the moon, astronaut Ed Mitchell, asked me basically the same question just several weeks ago. We had breakfast together.

I said, "Well, you know, where I grew up, we were 26 days on foot from the nearest doctor." This was in the Upper Amazon. And he said, "Well, gosh, I was on the moon, and I was only 3 days from the nearest doctor." I said, "Well, the people that we are treating right here in the United States might as well be on the moon or might as well be in the Upper Amazon, for the opportunity that they have to receive the care that they need in this country."

Mr. STUPAK. Well said. Well said.

Dr. Collins, anything you want to add?

Ms. COLLINS. No.

Mr. STUPAK. OK. That concludes all the questioning. I want to thank you for your patience and the witnesses for being here today and for your testimony. This panel will be dismissed. Thank you.

The committee rules provide that members have 10 days to submit additional questions for the record, and I am sure some members will submit some.

I ask unanimous consent that the contents of our document binder be entered into the record, provided the committee staff may redact any information that is business proprietary, relates to pri-

vacy concerns, or is law-enforcement-sensitive. Without objection, the documents will be entered in the record.

[The information follows:]******** COMMITTEE INSERT ********

Mr. STUPAK. That concludes our hearing. This meeting of the subcommittee is adjourned.

[Whereupon, at 5:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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