LIVING WITHOUT HEALTH INSURANCE: WHY EVERY AMERICAN NEEDS COVERAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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LIVING WITHOUT HEALTH INSURANCE: WHY EVERY AMERICAN NEEDS COVERAGE

WEDNESDAY, APRIL 25, 2007

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

The subcommittee met, pursuant to call, at 10:08 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Eshoo, Green, DeGette, Capps, Allen, Schakowsky, Dingell, Deal, Wilson, Shadegg, Pitts, Rogers, Burgess, Blackburn, and Barton.

Staff present: Amy Hall, Christie Houlihan, Purvee Kempf, Bridgett Taylor, and Robert Clark.

OPENING STATEMENT OF HON. FRANK PALLONE JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I will call this hearing to order.

Today we have a hearing on "Living without Health Insurance: Why Every American Needs Coverage."

This week, as many of you may know, is Cover the Uninsured Week, and as part of our efforts to highlight the growing number of Americans who go without health coverage, we are holding a hearing today on the issue. The statistics, I must say, are truly frightening. There are nearly 47 million Americans who go without health coverage for an entire year, and that is more than the populations of Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island and Vermont combined. Millions more experience periodic gaps in coverage over the course of a year, and even more are considered to be underinsured.

The question is, who are these 47 million people? They really are no different than you or I. They are hardworking American families. They go to work every day. They pay their taxes and they play by the rules yet because of rapidly rising health care costs, insurance coverage is out of reach for many of them. As a parent and a husband, it is hard for me to imagine the uncertainty these families must face from day to day hoping and praying that their health holds out, and I don't think any American family should have to live this way.

Now, what has led to this growing problem? First and foremost, increasing health care costs have weakened employer-sponsored insurance, which has traditionally been a reliable source of health

coverage for a majority of Americans. As a result, more and more employers have been forced to shift costs to their workers, who are in no better position to bear this grave financial burden. Alternatively, employers have begun to offer policies with less-adequate coverage, or stopped offering health insurance benefits altogether. Since 2000, the total number of Americans with employer-sponsored coverage has fallen dramatically. According to the Kaiser Family Foundation, since 2000 the total number of Americans with employer-sponsored coverage has declined from 66 percent in 2000 to 61 percent in 2004.

If it were not for our safety net system consisting of Medicaid and SCHIP, the erosion of employer-sponsored insurance would have had a much greater impact on the number of uninsured Americans, and this is especially true for low-income children. But thanks to these public health insurance programs, our Nation's children have largely been able to access the medical care they need to grow up healthy. In recent years, however, the number of uninsured children has also begun to increase, and that is why as a first step to addressing the problem of the uninsured, we must take every effort to strengthen our public programs which provide health coverage to those who would otherwise be unable to access care. Reauthorization of the Children's Health Insurance Program, or SCHIP, will be our first step on a path to provide every American with access to meaningful health care coverage, and it is my hope that today's hearing will reemphasize the need for a strong and comprehensive SCHIP program.

I know, however, that not everyone necessarily agrees with me. For instance, the President and many of my Republican friends in Congress have proposed to reduce payments to States that cover children above 200 percent of the Federal poverty line. Similarly, there are proposals that would further cut Medicaid spending, which provides health care services to millions more low-income families, and this would undoubtedly result in the loss of health care coverage for our most vulnerable citizens. It strikes me as both illogical and even immoral for anyone to suggest that we move in a direction that would actually increase the number of Americans without health coverage.

But strengthening our public programs is only part of the solution. We must also look at private insurance markets and how to increase access, adequacy and affordability. Unfortunately, I do not believe that the administration's proposal to tax the health care benefits of hardworking Americans would achieve any of these goals. Instead, the President's plan would take a bad situation and make it substantially worse by taxing Americans who have worked hard to secure good health insurance coverage in order to subsidize less generous policies in the volatile non-group market.

Now, we certainly have to look for more creative ideas. The States, as you know, have been making strides and they have been experimenting with new policies on how to achieve universal health coverage. From Massachusetts to California to my home State of New Jersey, States have been taking it upon themselves to develop new ways to provide their citizens with the means to afford and access health coverage. While I am eager to learn more about what is going on in the States, and we will today, their efforts do not

mean that the Federal Government has been absolved of its duty to address the situation also.

In the end, I am not telling you anything new here. We have had a growing problem with the uninsured for quite some time now in large part due to what I view as the failures of President Bush and some Republican policies designed to address this issue, but I think there is now a bipartisan momentum building behind efforts to tackle this problem, and I am looking forward to hearing from our witnesses today and learning from them on how we might achieve this goal.

I now recognize our ranking member, Mr. Deal, for 5 minutes for the purposes of making an opening statement.

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

Mr. DEAL. Thank you, Mr. Chairman.

I think we all agree that one of the biggest problems facing our health care delivery system is the growing number of uninsured and underinsured Americans. In almost every year since 1989, the number of uninsured has increased. Continued growth of this population is not only unsustainable, it is unacceptable. I believe that members on either side of the aisle here would not dispute that we must address the problem in this committee of the uninsured. However, the composition of the uninsured in this country highlights the reality that the simple expansion of public programs and provision of government-dictated health care will not properly and efficiently solve the problem of the uninsured.

According to a recent study, nearly a quarter of the uninsured population was eligible for public coverage but were simply not enrolled. Additionally, approximately 8.8 million, or another 20 percent of the uninsured could probably afford coverage but remained uninsured. These statistics indicate this problem goes beyond eligibility or affordability and reforms focused only on the expansion of eligibility criteria will fall short of providing coverage for every American.

In the meantime, proposals which expand Government programs like Medicaid or Medicare to cover the uninsured will exacerbate existing struggles with these programs. The financial burden on State and Federal budgets will increase dramatically and it is shortsighted to assume the sustainability of our current programs will be improved by the expansion of eligibility to even greater populations, especially when the Medicare trustees reminded us on Monday of the rapid growth of Medicare spending, estimating that the Medicare Part A trust fund will be exhausted in 12 short years.

To me, the growing number of uninsured stems from a broken health care system of soaring costs and limited efficiency. If we truly want to address the complex problem of the uninsured, we must consider broad reform of the health care industry in this country. As a guiding principle, I believe we must reduce the cost and increase the overall quality of our health care delivery system. The high cost of insurance has led to a downward spiral as the uninsured population only makes coverage expensive and in turn making it more difficult for the uninsured to buy coverage. This is why I am convinced that we must focus on lowering health care

costs which would not only help cover the uninsured but make our existing programs more sustainable.

There is a long list of reforms which could help transform our health care delivery system and in turn provide coverage for the uninsured, improving health information technology and the creation of an electronic system to track medical records will sharply reduce the number of medical errors and help eliminate inefficiencies and waste in the system, thereby lowering costs. State insurance mandates drive up the cost of purchasing health insurance and should be addressed. Moreover, we should consider allowing patients to purchase insurance from other States to find the plans that best fit their needs. Cost growth could be addressed by medical liability reform, which would address the issue of wasteful practice of defensive medicine and the astronomical cost of medical malpractice insurance.

This list is by no means complete but it indicates the type of broader reforms which would begin to heal our health care system. I would hope that the growing uninsured population would focus our attention on broad-based reforms which address many of the underlying problems in our health care system and allow patients, not the Government, to control the system.

I yield back my time, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal, and we will continue with opening statements. Next is our vice chair, Mr. Green.

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

Mr. GREEN. Thank you, Mr. Chairman, and following our ranking member, I have to admit, I come from the State of Texas and we have some of the harshest medical liability laws in the country and yet we also have some of the highest percentage of uninsured in the country, so I don't know if it is a combination of us needing to do more with malpractice legislation on the national level because the States typically are taking care of it, but we still a lot of uninsured, I think the highest percentage in the country.

Mr. Chairman, I appreciate the hearing on the important health issue. We couldn't ask for a better hearing topic for this week as we recognize "Cover the Uninsured Week" and examine ways to improve health insurance coverage levels across the country. More than 46 million Americans live without health insurance despite the fact that this country spends more money on health care as a percentage of GDP than most industrialized nations. Poll after poll indicates that Americans view health insurance, health care, and access to health insurance as a top priority as well as it should be since everyone ends up paying for the uninsured one way or the other. With less access to care, the uninsured are less likely to seek preventative care and only get care once their health problems reach emergency proportions. In fact, nearly 50 percent of the uninsured have postponed seeking health care because they can't afford it. Only 15 percent of individuals with health insurance have postponed care for this reason. The difference can literally be life or death.

Unfortunately, the state of health insurance in Texas is worse than almost anywhere else in the country. Twenty-four percent of

our Texans are uninsured compared to 16 percent for all Americans. Despite programs like Medicaid and SCHIP, the situation for Texas children is not much better with 21 percent of all Texas children currently living without health insurance as compared to 11 percent nationwide. Everyone can agree that something must be done to stem the tide of the uninsured yet it is important that we put in place policies that not only increase the number of Americans with health insurance but also ensure they have a quality of comprehensive insurance.

Make no mistake about it though, health savings accounts and association health plans are not the magic answer. The success of insurance plan health insurance is that you spread the risk. However, both the HSA and the AHP models would separate out the healthy and the wealthy, leaving sicker and poor Americans to fend for themselves in an individual health insurance market that already is out of reach for most low-income Americans. It is not the way to ensure Americans are healthy and productive members of our society.

We do need assistance for small businesses who want to offer health insurance to their employees yet find themselves doing their best to meet payroll and monthly expenses. Again, Texas is a small-business State yet only 28 percent of our Texas small businesses with less than 50 employees offer insurance. I am glad to hear that our colleague from Maine will be introducing the Small Business Health Plans Act to create small-business health employer plan that offers small-business employees adequate coverage and benefits, and without question, the SCHIP reauthorization offers us our best opportunity this year for increasing the level of health insurance coverage in this country. With two-thirds of the uninsured children in the country eligible for SCHIP that are not enrolled, we should do all we can to expand the program and dismantle many of the bureaucratic hurdles that are barriers that serve to suppress the enrollment in this important program. I look forward to working with the chairman and our committee to ensure that all low-income children have access to coverage under SCHIP as we move through the reauthorization process.

I want to thank our witnesses, today, Mr. Chairman. We have a great panel, a number of panels, and particularly the first panel, and with that I will yield back my time.

Mr. PALLONE. Thank you, Mr. Green.

I recognize the gentleman from Arizona, Mr. Shadegg.

OPENING STATEMENT OF HON. JOHN B. SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. SHADEGG. Thank you, Mr. Chairman, and thank you for holding this hearing.

I worked on health care reform my entire tenure in the United States Congress. Indeed, I dropped my first bill to address the issue of the uninsured in 1998, just 2 years after entering this body. I believe this is a serious problem confronting our Nation but I believe it is one that is deeply misunderstood. I think indeed it can be broken down into a simple matrix. Do we put patients in charge of their health care or do we leave third parties in charge of their health care? The last 50 years, we as a Nation have pur-

sued a policy that said we are not going to empower patients, we are going to empower third parties, namely employers, and so the decisions about health care made for virtually all Americans today are not made by the patients themselves, we decided we cannot trust them to make health care decisions. We have put the power to make the decisions about their health care in the hands of some third party. Who is that third party under the current scheme? That third party under the current scheme is a corporate manager, someone who does not consume the service, someone who largely does not know the individual to whom the service is being rendered, someone who markets and takes products and bids from insurance companies, from doctors and from hospitals without even knowing who they are going to provide the service to, and now we are shocked that that system doesn't work.

In 1998, I introduced the Patients' Health Care Choice Act, now called the Patients Health Care Reform Act, to put patients back in charge of health care, and we certainly can do that and it is time that we should do that. We trust Americans to make their own decisions about their auto insurance, about their homeowner's insurance, about their life insurance, about thousands of decisions in their lives. We give them choices in every grocery store of hundreds of products to pick from but when it comes to health insurance, we tell them you are not bright enough to make this decision, that right now your employer will make those decisions for you, and some in this room will advocate we should have the Government make that decision. If you want to know what is wrong with socialized medicine, which is what is being advocated as the next step, you don't have to go to England, you don't have to go to Canada to see the failures of either of those programs, go to Walter Reed. You will discover a campus of people enrolled in a Government health care program and the Government couldn't even keep track of them with them living on the campus. Those soldiers did not have choice in health care. They could not pick their doctor, they could not pick the facility where they were treated. They were trapped and they were lost and Government failed them. I understand that those who advocate socialized medicine believe it is a better answer and are sincere but I suggest they are sincerely wrong.

What we can do is empower patients to make their own choice. How do you do that? The bill I introduced would give every single American a tax credit to buy health insurance. We decided as a Nation long ago that no one should go without basic health care in this country and yet we don't provide them the mechanisms to do that. My bill not only gives a tax credit to every American to buy health insurance and to make their own choices, it is a refundable bill. That is to say, for every American and the 44 million we are now currently worried about who are uninsured, it would actually give them cash to go buy a health insurance policy that meets their needs. This is not a complicated debate. It is a simple debate. Do we want to move from one third-party payer, corporate America that is not making the right decisions and is wasting lots of money and running up the cost, to another third-party payer, the Government, or do we want to empower patients to make choices for themselves and allow them to keep any money they save and in-

vest it and the tax save mechanism to pay for future health care bills?

Mr. Chairman, I am glad you are holding this hearing. I hope that we will bring some rationality to this debate.

Mr. PALLONE. Thank you.

Next is the gentle woman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. I am pleased we are having this hearing during the "Cover the Uninsured Week."

Throughout the world, United States health care is considered to be the best. We have the most advanced medical technology, the most highly trained medical professionals and institutes and centers dedicated to finding cures for countless diseases. But at the same time, as you mentioned, Mr. Chairman, the United States has about 47 million uninsured including 9 million children. Each day throughout our country, emergency departments are overwhelmed as they serve both those with critical needs and those who simply have no place else to turn for basic medical care. In the wealthiest country in the world, we have children who are unable to get the basic care they need to grow up to be productive and healthy. This is simply not acceptable.

In addition to the medical problems resulting from the large number of uninsured, our country also faces financial challenges. Our inability to create a sustainable health care model in this country is dramatically impeding our ability to compete in the global marketplace. Over $1,700 of every car built by General Motors goes to providing health insurance to employees, retirees and their dependents, and just today it was announced that Toyota, who pays a fraction of the cost of GM, just took over as the No. 1 car manufacturer in the world. If we are going to continue to be an economic leader, we have to have a health care system that doesn't hamstring our businesses, particularly our small employers. We really need to have real health care reform.

To that end, I think that the first step towards covering the uninsured is to provide health care access for all children. The fact of the matter is, children by and large are the easiest and cheapest people to provide adequate health care for. Unlike older Americans, who have a number of health conditions, most children only need well-child visits and basic dental care to deal with common maladies. However, if those minor problems like an ear infection go untreated, they can develop into something much more serious and result in a hospital stay or worse. When we work on reauthorizing SCHIP, I think we have to meet three goals. Number one, we have to have sufficient resources so all children can be enrolled. Second, we need to have outreach to allow the States to enroll the 6 million kids who are eligible for SCHIP but not enrolled. And finally, we need to make sure that it is appropriately designed for all of the kids who are eligible. If we achieve these goals, Mr. Chairman, children will go to their doctor for an ear infection, not to the emergency room with pneumonia.

I look forward to working with you on reauthorization of this important bill and all of the health care challenges we have facing us in this committee.

Thank you.

Mr. PALLONE. Thank you.

Dr. Burgess, 3 minutes.

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

Mr. BURGESS. Thank you, Mr. Chairman, and I will try to go fast.

Once again, we are having a hearing where I am a little mystified. We don't have an insurance company or a doctor on the panel but I do appreciate the panelists who are here today. We seem to be preoccupied with the details of health insurance rather than the access to care. Mr. Green is quite right. There are a large number of uninsured in Texas but I also know that many of the uninsured get top-notch care. They did certainly during my residency at Parkland Hospital and during my over two decades in private practice, sometimes as frequently as every other night. Never less frequent than once a week I would provide care to unassigned patients who came to my hospital.

A little history. During World War II, the country imposed wage and price controls in order to deal with shortages and prevent inflation. Companies began offering health insurance in order to recruit employees and the courts ruled that health insurance did not have to be taxable. The economic boom following the war led to widespread adoption of this practice and we became entrenched with a system that is largely employer-based. By not taxing health insurance as income, the Federal Government has encouraged it, in fact subsidized it. Europe's monolithic system grew out of the battlefields where they were largely vanquished or even victorious, their economies were in tatters. In order to avert a humanitarian crisis, a monolithic system needed to be stood up quickly in order to provide care in that environment.

But a lot has changed since the 1940's. According to the Bureau of Labor Statistics, the average American holds 10 jobs between ages 18 and 40. While employer-based health care has provided excellent care for the majority of Americans for many years, it doesn't travel well. It does not provide the health security that Americans need and want in an increasingly mobile society. For those who suggest more Government regulation, even to the point of a single-payer system, this is troubling. One of our witnesses today will talk about the problems that he has had. It seems that in 1993 the State of New York imposed community rating and guaranteed-issue laws on the individual market. Insurance prices jumped between 20 and 60 percent. How in the world was that individual supposed to find health insurance when the Government, in a misguided attempt, had driven prices up like that? Chairman Pallone would describe that as immoral. The President has proposed that we give people who are trying to buy health insurance on their own the same tax advantage. It is actually a relatively small change. The average family pays insurance worth about $11,000 per year. By making private health insurance affordable and easily avail-

able, we can create a system that is flexible and personalized in ways that a government-run system never could be.

The American health system in general has no shortage of critics home and abroad but it is the American system that stands at the forefront of innovation and new technology, precisely the types of system-wide changes that are going to be necessary to efficiently and effectively provide care for America's seniors in the future. Tyler Cohen, writing in the New York Times last October, "When it comes to medical innovation, the United States is the world leader. In the past 10 years, 12 Nobel Prizes in medicine have gone to American-born scientists working in the United States, three to foreign-born scientists working in the United States, and just seven have gone to researchers out of the country." He goes on to point out that five of the six most important medical innovations in the past 25 years have been developed within and because of the American system. The fact is, the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, physicians and pharmaceuticals. Because our experience is unique and different from other countries, the difference should be acknowledged and embraced when reforming either the public or private health insurance programs.

I certainly look forward to hearing from our witnesses today and I yield back the balance of my time, Mr. Chairman.

Mr. PALLONE. Thank you.

I now recognize the chairman of our full committee, Mr. Dingell.

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

Chairman DINGELL. Thank you, Mr. Chairman. I commend you, Mr. Chairman, for holding this hearing and thank you for the good work that you are doing here on behalf of the people. Mr. Chairman, we have before us a great opportunity, an opportunity to move forward with legislation to address concerns that every American has.

I want to express my thanks to all of the witnesses for joining us today. We have a distinguished panel of witnesses as we observe the annual week of the uninsured, some 46 or 47 million of them. Unfortunately, during the past decade this conversation has not prodded the Congress to act on even incremental solutions but beyond that, as a Nation it seems we haven't come to a consensus on the need for universal coverage in this country, something which curiously not only American labor but American business and ordinary American citizens seem to understand is desperately needed.

I want to express my personal thanks to our former colleague and dear friend, Mr. Daschle, for being here this morning. He is a valuable leader on all kinds of important issues and we are grateful to him for not only his presence but for what he does, and I want to express my personal welcome and gratitude to my dear friend, Mr. Gerald McEntee, for being here this morning. He has been a great leader for not only labor but for all Americans and not only in health care but in all kinds of important concerns.

Eighty percent of Americans who are not covered by health insurance come from working families. It is interesting to note that

a prodigious erosion of employer-sponsored coverage threatens more coverage of Americans every day. Total annual health insurance programs now exceed the annual salary for a full-time minimum-wage worker. Medical debt is the cause of more than 50 percent of bankruptcy each year in this country, and worst of all, 18,000 annual debts are attributable to the lack of health insurance and failure to provide adequate access to care. We live in a country that spends $1.9 trillion a year on health care. This is 16 percent of our American gross domestic product. We have some of the best medical institutions, finest doctors and the best practices in the world but we rank 22d in average life expectancy and 25th in infant mortality. To be uninsured means getting fewer and less appropriate medical services, to not get treatment when needed and to not be able to have access to preventive care at a time when it could save lives or make lives much better for the people, and it means huge risks for people, especially children. It means health care providers do not have a reliable source of reimbursement for their services and those who treat high numbers of uncompensated-care patients are at risk of closing, leaving communities with a threadbare safety net to care for these uninsured people. The uninsured weaken a productive workforce and cost those with employer-sponsored health insurance an average of $922 more each year.

My dear old dad introduced legislation that would provide national universal health insurance to all Americans during his years in Congress, and I have kept the commitment to the uninsured, introducing H.R. 15 each Congress as well. In addition, today I will be reintroducing the Medicare for All Act with my good friend, Senator Kennedy. This bill brings the promise of a quality, affordable health insurance program to all Americans.

This year I note is the 10th anniversary of the State Children's Health Insurance Program. It is also the end of that program unless we in the Congress authorize the Act again. Before us are two important tasks that will ensure that health care is adequate and available to all Americans. It is time for action, and I look forward to today's hearing on this important subject, and I look forward to seeing to it that your leadership on this matter, Mr. Chairman, moves us forward towards a desperately important national goal.

Thank you.

Mr. PALLONE. Thank you, Chairman Dingell.

I next recognize the gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Mr. Chairman, I waive.

Mr. PALLONE. And then we go to the gentle woman from New Mexico, Mrs. Wilson.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. I appreciate your holding this hearing and I thank the witnesses who come here today.

New Mexico faces a huge challenge with respect to the uninsured, and in New Mexico 21 percent of our population and 18 percent of our children are uninsured, making us rank 49th in the country. Only Texas has more uninsured citizens than New Mexico does. A lack of insurance no doubt has an impact on the lives of

the uninsured, and I am sure several of our witnesses today are going to testify to that fact, that there is a delay in access to care, that health outcomes are worse and generally those who do not have insurance are not in as good of health as those who do have insurance.

But there are also impacts on our health care system. In New Mexico, the fact that we have so many folks who are uninsured puts a burden on the health care system for others. One of the things that we have the most difficult time with in New Mexico is attracting and keeping health professionals in the State, particularly oncologists and neurologists and trauma surgeons. Part of it is that we come from a rural State but there is also clearly the opportunity to make more elsewhere where the rates of insurance are higher. The uninsured have higher rates of using emergency rooms, of uncompensated care, of driving up costs in the health care system elsewhere for those who do have insurance and hence making health insurance less affordable for those who still have it.

I believe very strongly that we have to start with the children and reauthorize the SCHIP program this year. That will give us an opportunity to relook at this program, how well it has worked, because in States like New Mexico, frankly, it has not worked very well. New Mexico, with a very high rate of uninsured children, has year after year had to turn money back to the Federal Government because this program was not set up in a way that New Mexico can take advantage of it. We need to fix that so that States that do have a high percentage of children who are uninsured have the flexibility to use those Federal funds.

We have a report coming out just this week in New Mexico that is going to make some recommendations to our State government on an approach to covering the uninsured and in many cases States have taken the lead and been the laboratories for innovation and ideas. I don't believe that we will have a single point Federal solution for health insurance and for the uninsured, nor should we. I think one of the strengths of our system in America is that we have a variety of options. We can all agree that covering the uninsured and access to effective care is a priority. We may have disagreements on how best to accomplish that goal.

I have supported a variety of things: tax credits for the uninsured, association health plans, health savings accounts, the SCHIP program and a strong supporter of Medicaid, but we need to make sure that these funding mechanisms also put the priority on improving the health of the people who depend upon it, and too often we have a system that pays for episodes of illness rather than focusing on improving the health status of low-income Americans who depend upon it. I look forward to hearing new ideas today, sharing those ideas and bringing those ideas to reality.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Next is Mrs. Capps.

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

Mrs. CAPPS. Yes, this is Cover the Uninsured Week and I thank you, Chairman Pallone, for holding this very important hearing.

As we are going to hear over and over again today, the 46 million Americans that are currently uninsured is resonating across this Nation. My constituents understand that this Nation pays more for health care than any other nation in the world and yet its outcomes are among the least of the developed nations. This translates into their lives personally, and taxpayers have the right to be asking why this happened. We know the lack of access to affordable health coverage means delaying or even avoiding important medical care.

As a nurse I have a responsibility to provide the best possible care I can to my patients. As a Member of Congress, I translate this into a responsibility to find ways for all of my constituents and really all Americans to access the best possible care. This administration has ignored our Nation's uninsured. Instead of supporting initiatives that would expand coverage, we find the White House promoting risky health savings accounts and association health plans. These would pave the way to diminish, not improve, health coverage for Americans. Congress must act now to expand access to health coverage. We must do it in a way that promotes primary and preventive health care. I am proud to be a cosponsor of the Health Partnership Through Creative Federalism Act introduced by our colleague, Tammy Baldwin. Unfortunately, our country has dug itself in a hole so deep that I am afraid there isn't one simple solution to the puzzle of covering the uninsured. However, it has been encouraging to watch as individual States begin to take their own initiatives to improve health coverage for their residents and I think we need to be creative just as the bill proposes because there are multiple ways in which the Federal Government can partner with States to devise programs that are best fitted for different populations.

As a Federal representative, I pledge myself to improving health access for all citizens but I think it is important for us to look more closely at the models being talked about and even implemented in different States. In California, State Senator Sheila Kuehl has introduced a bill to provide coverage for all of our State's residents through a State health insurance plan. What I especially like about it is that it relies upon regional directors who can tailor this program to meet local population's needs. So again, I think it is really so important that we continue this conversation here and really take the proactive steps to encourage engagement by Congress with the State and local governments to improve health care access for all.

I look forward to the testimony of our witnesses, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

The gentle woman from Tennessee.

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

Mrs. BLACKBURN. Thank you, Mr. Chairman. I appreciate that and I appreciate our witnesses taking the time to be here and to talk about the uninsured and what we can do about the situation, and I hope we are going to, Mr. Chairman, look at things from both

the private sector and the public sector and the solutions that are out there because one of the things that we have learned is that there is a right way and a wrong way to go about approaching this issue.

Now, in my home State of Tennessee, we have a program called Tenn Care, and I think everybody knows right now and has learned through the past many years, the past decade, this came about because they needed a place to test Hillary Clinton's health care, so a deal was struck. It came to Tennessee. Well, let me tell you something. Tenn Care at this point in time is over 30 percent of the State's budget. It is making it very difficult for the State to have ends meet. They have had to go in under a Democrat Governor now and restructure the program because guess what? They cannot afford it. So when I grew up in my little hometown, there was a used car dealer. He had a sign up at this dealership that said "We tote the note." When I was a kid, I used to ask my dad what does that sign, "we tote the note" mean, and my dad said somebody has to help you pay for this. Well, that same lesson applies to health care when we look at health care and health care programs. Somebody is going to pay, so I hope, Mr. Chairman, that today we will talk a little bit about how we make the system fair, how do we make it fair for American taxpayers, how do we make it fair for the uninsured. I would also like for us to talk about how we encourage people to make health care a personal priority and see them take the responsibility that is necessary when they have access to a program to be a good steward of that opportunity. That has been one of our big problems in Tennessee, is making certain that everyone that has that wonderful opportunity was a good steward of that opportunity, and how do we make certain that this is affordable for all of our citizens because our goals should be preserving access to affordable health care. In Tennessee, that is my goal. I hope that we as a nation will say how do we work together to make certain that everyone has access to affordable health care.

Thank you, and I yield the balance of my time.

Mr. PALLONE. Thank you.

The gentleman from Maine, Mr. Allen.

OPENING STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Mr. Chairman, thank you for convening this hearing today on the growing number of the uninsured in America.

The erosion of employer-sponsored health care is contributing to the growing ranks of the uninsured. Employer-sponsored health insurance provides coverage for 160 million Americans including nearly three of every five of the non-elderly. However, the percentage of firms offering health benefits to their employees has fallen significantly from 69 percent to 60 percent just in the last 5 years. Small businesses in particular are struggling to provide health insurance for their workers. According to a recent Kaiser Family Foundation survey, the smallest firms are the least likely to offer health insurance. Only 48 percent of firms with 3 to 9 workers offer coverage compared to 73 percent of firms with 10 to 24 workers and 87 percent of firms with 25 to 49 workers. In stark contrast, over 90 percent of firms with 50 or more employees offer health in-

surance coverage. Small businesses have higher administrative costs, fewer people over whom to spread the risk of catastrophic costs, and they lack the purchasing power of large firms to negotiate with insurers. Because health care coverage is especially costly for small businesses, their employees make up a large proportion of the Nation's uninsured individuals.

Tomorrow I am introducing my Small Business Health Plans Act, which would establish a health benefits program for businesses with up to 50 employees. Under the bill, small businesses, their workers and the self-employed would be provided a choice of at least two health plans that are comparable to the insurance coverage currently available to Federal employees. Premium assistance would be available for smaller businesses and lower-wage workers. Insurance companies would be eligible for Federal reinsurance coverage up to 75 percent of costs for catastrophic cases. My bill would improve the integrity of the health insurance market and protect individuals and families facing unexpected medical expenses. It would lower costs and improve quality by encouraging integration of health information technology tools, better management of chronic illness, a focus on disease prevention, and reliance on evidence-based medicine. These policies would provide guaranteed quality coverage at affordable rates to small businesses and their workers without preempting State requirements. I invite my colleagues to join me in cosponsoring this legislation.

I do want to welcome Senator Daschle and all the panelists today. I look forward to hearing your testimony, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

Next is the ranking member of the full committee, Mr. Barton.

Mr. BARTON. Mr. Chairman, I will submit my opening statement for the record and reserve my time for questions. I want to welcome the panel but also especially the former majority leader, who I think was in the House before he went to the Senate. So it is good to have you back and I appreciate the many courtesies that you have extended to me when you were the majority leader in the United States Senate. It is good to have you in the House.

[The prepared statement of Mr. Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you Mr. Chairman,

I commend you for holding this hearing on the important topic of the uninsured. I know there have been several proposals to help address this issue including the President's recent proposal. The President has proposed a standard deduction for health insurance as a reform of the Tax Code to make private health insurance more affordable and to level the playing field so those who buy health insurance on their own get the same tax advantage as those who get health insurance through their jobs. For those who still can't afford coverage, the President's Affordable Choices Initiative will help eligible States assist their low-income and hard-to-insure citizens in purchasing private health insurance. I'm sorry to read in the news that the Democratic majority already has declared these proposals dead on arrival without even conducting a hearing.

Many of us think it is important to look to ideas that go beyond bureaucracy and employ consumer choice, competition, and accountability for value. Socialized medicine is notoriously bad at determining the right price for services. Socialized medicine doesn't innovate and it doesn't explain itself to either patients or payers. Those types of Government systems lead to mediocrity in health care and create a burden

on private sector systems. Not every disease requires another program run by a centralized bureaucracy with pricing by politics.

Our two big programs—Medicare and Medicaid—have enormous budget problems. They've dominated the health discussions in Washington for decades, and it's a good bet that people will be still sitting in these hearing rooms, still trying to get it right long after all of us are gone.

We also need to realize that every Government increases the cost of health care and along with it, the cost of insurance. Each new, confusing regulatory regime that politicians in Washington load on the backs of employers, workers, insurers and doctors is one more reason for companies to throw up their hands and stop providing health insurance.

As we continue to look at the uninsured, it is obvious to most people that the right solution will give people the ability to choose what's right for them in the ever-changing landscape of medical treatments and preventive services. Will 80-year-olds opt for pregnancy coverage? Only if the Government is involved.

If we can't get it right, Federal policy will continue to stifle innovation, reduce private sector coverage, and reduce the incentives for quality care while increasing costs and the bureaucracy.

On Monday, the Medicare Board of Trustees released their annual report on the financial status of the program. The overarching theme is that entitlement spending is still growing so fast that it is outrunning growth in the U.S. economy. The good news in the Medicare report is the cost estimates for the Part D program continue to decline, and that's thanks to consumer empowerment and competition.

As we examine options to increase the affordability of health care coverage we should not be in a race to see how many people we can lure into government programs. That is literally a race to the bottom, and we cannot afford either the rising cost or the declining quality. Instead we should look for ways to increase competition, provide more choices and flexibility in obtaining coverage, and ensure that consumers are aware of the health care they consume.

I look forward to hearing from today's witnesses to get their perspectives and ideas on this important topic.

Mr. PALLONE. Thank you.

The gentle woman from Illinois.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. Because I am anxious to hear the witnesses, and I too want to welcome our former colleague, Senator Daschle, and one of the great leaders for working Americans, Gerald McEntee of AFSCME.

I just want to say that this is perhaps the most important issue on the minds of the American people. If we can grapple with how are we going to be able to reform our system that is completely disintegrating and not working for employers or employees, for older Americans for children, it is simply broken, and I look forward to working with this wonderful committee under your leadership and that of Mr. Dingell to solve the problem.

I yield back.

Mr. PALLONE. Thank you.

I recognize the gentleman from Michigan, Mr. Rogers.

Mr. ROGERS. I pass at this time, Mr. Chairman.

Mr. PALLONE. And then the gentle woman from California, Ms. Eshoo.

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

Ms. ESHOO. Thank you. Mr. Chairman, I am going to place in the record my full opening statement.

I didn't think I was going to say anything, but I can't resist. I have been in the Congress now, this is my 15th year, and when I first came here in 1993, at the top of my list was to address health

care in the country. There are some that rejoiced that the attempt failed but I think gauging all the years that have gone by and where we are now, it is not a cause for celebration. The issue of health care is front and center to America's competitiveness. It makes all the difference between life and death for too many people in the country. There are children that have dropped through the cracks. There are parents that can't get what they need for their children. There are small businesses that can't afford to insure their workforce, and with all due respect to whomever said something about a tax credit, I have yet to meet someone at a town hall meeting that has come begging for a tax credit to resolve their day-to-day problems, the health care that they face with their small business or with their family. It is very easy for Members of Congress to throw stones. We have got one hell of a good health care policy and the United States Government pays for part of it.

So I am really looking forward to the ideas and the statements of the people that are here today. Perhaps it is going to take a national election and the details might be hammered out by this committee, and I hope I am here for that. But when I look over America's history, it was a struggle for Medicare to be enacted, for Social Security to be the law of the land, and that generations now have benefited from that and we keep building on that system. I think it is going to take a national election, a new President, a reinvigorated Congress to do this, but if we get to it before that, I look forward to being up at home plate to help knock the ball out of the park. This is serious business, and I have to tell you at this point, I am tired of the incrementalism.

So I look forward to hearing from the very distinguished former majority leader. Thank you for coming to us, to Mr. McEntee, to talk about where the grass roots are that are going to help lift this country, get us going in a better direction, and thank you, Mr. Chairman, for always caring about this issue and having the hearing, yet another hearing on it. Thank you.

[The prepared statement of Ms. Eshoo follows:]

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

Mr. Chairman, thank you for holding this important hearing on the crisis of the uninsured.

This truly is a crisis that is nearing critical levels, with roughly 47 million uninsured individuals in the U.S. today. Approximately 6.5 million uninsured people live in my home State of California.

We all agree that the high cost of health care is the biggest obstacle to care. Due to annual double-digit premium increases, private health insurance is not an affordable option for many families and individuals. Small businesses are increasingly unable to offer health insurance benefits, and many companies that are able to provide benefits find it necessary to pass more and more of the costs on to their employees.

With respect to low-income families and individuals, many are simply unaware that they or their children may qualify for State or Federal insurance programs.

When we look at the patchwork of public services that are available to the most vulnerable populations, we see different categories of people eligible for services from State to State. This creates gaps in eligibility that particularly children fall through. That's why we need to make sure that eligibility requirements are reasonable and consistent, and that eligible children are actually enrolled in plans.

I believe first and foremost we should immediately address the 9 million uninsured children in our country. I'm proud to be an original cosponsor of the Children's Health First Act, which makes improvements to the successful Medicaid and State Children's Health Insurance Program (SCHIP) to help these public programs work better at finding and enrolling eligible children.

We also have our work cut out for us to address the 40.5 million uninsured adults in America. I think there are several ways we can extend health insurance options to more Americans, including:

• Allowing broader access to insurance plans available to Federal employees and Members of Congress under the Federal Employees Health Benefits Plan;
• Improving and expanding State programs (including Medicaid and SCHIP) to cover young adults, pregnant women and very low-income single adults; and
• Establishing State and national multi-insurer pools to provide comprehensive and affordable health insurance choices to small employers and the self-employed.

It's encouraging that so many groups and States are working to tackle the problem of the uninsured. In my congressional district (CA–14) the county of San Mateo is working to put together a program for insuring all its residents. California Governor Schwarzenegger released a proposal to cover all uninsured adults and children, and in his State of the Union address, President Bush outlined a proposal for addressing the crisis of the uninsured. We should debate the merits of each proposal and I hope that today's hearing will be instructive to us.

We cannot continue to ignore a problem as large as 46 million uninsured people and certainly not the 9 million uninsured children.

Thank you, Mr. Chairman, and I look forward to working with you in addressing this important issue.

Mr. PALLONE. Thank you, and I think that concludes our opening statements. Other statements for the record will be accepted at this time.

[The prepared statements of Ms. Baldwin and Ms. Solis follow:]

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

Thank you, Mr. Chairman, and thank you to the witnesses who are joining us for this very important discussion.

Mr. Chairman, I commend you for holding this hearing, highlighting America's uninsured crisis. When I first came to Congress in 1999, I came with a clear goal of reforming America's crumbling health care system and making sure that every American has access to affordable, comprehensive health care.

While there are many Members of Congress who share this goal, such as yourself Mr. Chairman, I was shocked and disappointed at how many Members were content sit back and watch as the number of uninsured Americans grew year after year. For far too long, no hearings were held on the uninsured and our former majority simply recycled tired, ineffective proposals which they claimed would reduce the uninsured but which did not.

So I am delighted that now, just 4 months after retaking the majority, that you, Mr. Chairman, have worked with Chairman Dingell to draw attention to this vitally important matter.

I think that many in this room know that it was Chairman Dingell's father, John Dingell Sr., who first proposed legislation calling for national health care. That bill was H.R. 2861 and the year was 1943. And we're still talking about the need for this legislation over 60 years later.

Last night, I led a special order hour on the House floor, highlighting the issue of the uninsured. We all know the numbers:

• 46 million Americans do not have access to needed health care
• That's 15 percent of our population.
• Millions more are underinsured.

But what I highlighted last night is that there's a face, and a story, and a family behind every single one of these 46 million Americans. They are mothers, fathers, sons, daughters, workers, and above all Americans. I believe that health care is a right, not a privilege for some.

I look forward to today's discussion and again, thank you Mr. Chairman for drawing attention to this hugely important issue during "Cover the Uninsured Week."

PREPARED STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Today's hearing is extremely timely, because this week marks the fifth anniversary of "Cover the Uninsured Week". This past Monday, I led a Special Orders hour with my colleagues from the Congressional Black Caucus and Congressional Asian and Pacific American Caucus in honor of National Minority Health Month. Chairman Pallone also joined us in talking about the health disparities that communities of color still face.

Although preventive medicine and advances in medical technology have improved life expectancy and overall health for a large number of Americans, not all Americans are benefiting equally. Not everyone has the means to access our health care system. Communities of color continue to suffer from significant disparities in the overall rates of disease incidence, prevalence, and mortality in the population as compared to the health status of the general population. Disparities continue to persist, and we must eliminate health disparities by identifying significant opportunities to improve health.

The reauthorization of SCHIP is one such opportunity, especially since the number of uninsured people affects us all. It is a national problem that needs a national solution. Reducing disparities in children's access to health care is extremely important because minority children are less likely to see a doctor when they are uninsured. For example, uninsured Latino and African American children are more likely to forgo needed medical care than other uninsured children. Public insurance programs are vital to communities of color; more than half of insured Latino children are covered by Medicaid and SCHIP.

I believe that SCHIP reauthorization should support community health workers and should allow States to provide health coverage to legal immigrants. Community health workers have been proven effective in enrolling children in public insurance programs. As a Member of Congress who is committed to providing health coverage for children, reducing health disparities, and increasing the enrollment of low-income children in SCHIP and Medicaid, I strongly believe that we must redress the arbitrary exclusion of lawfully residing immigrants from these programs by including the Immigrant Children's Health Improvement Act in SCHIP.

I applaud the States' efforts to provide coverage for their residents, and I also believe that the Federal Government has a responsibility to make sure that everyone has access to health insurance. The cost of private health insurance continues to rise astronomically, and very few affordable options are left. I talk about health disparities, because members of racial and ethnic minority groups make up a disproportionate share of the uninsured population. The uninsured rate for Latinos was 33 percent in 2005. In a country that prides itself on equality, it is evident that our health care system is broken when people suffer from a lack of access to health insurance. We must make access to affordable, quality, linguistically and culturally appropriate health care for all Americans a national priority.

Mr. PALLONE. We will now turn to our witnesses, and I would ask our first panel to come forward and take their seats behind your nametags there.

Thank you, and I want to welcome our distinguished first panel. Let me start from left to right and introduce the witnesses that are here. First is Senator Tom Daschle, who of course has been mentioned was the majority leader. He is now a distinguished senior fellow at the Center for American Progress, and I would just say by way of introduction that a day does not go by without your being mentioned in the context of health care. Yesterday I spoke at a minority health care event and they were talking about your Health Care Disparities Act, which you took the lead on, and now today right as we speak, the resources committee is marking up the Indian Health Care Improvement Act, which you were another lead sponsor of, so thank you for being here today.

Next is Mr. Michael Smith, who is the secretary of the Agency of Administration from the State of Vermont, and then we have Gerald McEntee, who is the international president of the American Federation of State, County and Municipal Employees. Several

members have already mentioned him and his and AFSCME's contribution to this health care debate, which has been really crucial. Thank you for being here. And then we have Ms. Grace-Marie Turner, who is president of the Galen Institute in Alexandria. Next is Mr. Rotzler. Mr. Gary Rotzler is from Utica, NY, and he is here testifying on behalf of the American Cancer Society. And then next is Mr. Tony Montville, who is president and CEO of Healthtek Solutions Inc. from Norfolk, and then last is Ms. Colburn, Susan Colburn, who is vice president of benefits for AT&T Services from San Antonio. I also want to give you a particular welcome because you have a lot of people that work for AT&T that live in my district.

Let me just mention, we are going to have 5-minute opening statements from each witness. Those statements will be made part of the hearing record. Each witness may in the discretion of the committee submit additional brief and pertinent statements in writing for inclusion in the record. I will start with Senator Daschle.

STATEMENT OF HON. THOMAS A. DASCHLE, DISTINGUISHED SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS

Mr. DASCHLE. Thank you very much, Mr. Chairman and members of the committee. I am very grateful for the opportunity to testify and I am especially thankful to each of you who mentioned me. It is so good to see so many of my former colleagues again. I am also honored to appear on such a distinguished panel.

Clearly America has so many challenges, but I can't think of one that is any greater than health care. You all have mentioned the extraordinary problems we face with the uninsured and we mark the week of the uninsured this week, and note that there are 45 million Americans who don't have health insurance today but that is just the beginning of the problem. Costs, as several of you have mentioned, have gone up exponentially, 80 percent in just the last 6 years alone. As a result of costs, as a result of the lack of access, we see the denial of care, the delay of care and in many cases premature death. So like some of you, I wonder why this has not obtained the kind of priority in this country that it so richly deserves, and I think in part we failed to address it successfully because we have lived under a certain set of myths, and those myths have acted in some ways like a minefield, destroying this opportunity to move ahead on meaningful health care over and over again, and that minefield has been devastating as we have attempted to address this issue in the past.

Time doesn't really allow the opportunity to talk about all the myths but I want to talk just about three. One is that we have the best health care system in the world. It is a myth. Far from it. We rank 28th in infant mortality, 35th in life expectancy today. We have already mentioned the number of uninsured. We are told that about 100,000 people a year die because of medical mistakes. And I would ask, with 28th and 35th, where would we be if that is where we came out in the Olympics? How long would it take us to come up with an Olympic champion? We have the Mayo Clinics and the Cleveland Clinics and other wonderful institutions around the country but I refer to them as islands of excellence in a sea of

mediocrity. So we don't have the best health care system in the world.

The second is that universal care somehow is going to cost more money. Every other country in the world that has had universal care has brought down costs, now added to the costs, and as so many of you said, we have actually seen dramatic increases in the cost over the course of the last several years, in part because we can't contain those costs as a result of universal coverage. We have cost shifting that goes on in our system that causes the average taxpayer to pay about $900 in additional costs out of the $6,700 per capita that we all pay as Americans in taxes, premiums and out-of-pocket expenses. Businesses now cite health costs as their single biggest challenge. We spend more on health care at Starbucks than we do on coffee, more on health care at General Motors than we do on steel, and now we are going to see next health costs in business in the Fortune 500 exceed the amount of profit that that Fortune 500 group will make. Costs are a problem and universal coverage is one way to address it.

The final myth we live under is that somehow reform means rationing. Well, we ration today in the most unfair and egregious way. We do it on the ability to pay. I can't think of a more egregious way, to do it and in the United States today 30 percent of Americans are all we have today that actually get first-day coverage when they need health care, one of the lowest of all the industrialized countries.

So Mr. Chairman, we have grappled in part with the effort to deal with climate change living under these myths, and while we have failed in the past to address comprehensive health care, we have attempted to deal with it incrementally, as some of you have mentioned. And while we have succeeded in working around the edges, even in the most recent years we have fallen short in our efforts to address the problem even on an incremental basis. This year we have the opportunity to deal around the edges in a very important way, with the SCHIP program, and what a disappointment and a disaster it would be if we didn't actually extend through reauthorization the SCHIP program. We need to pass mental health parity. We need to ensure that we pass genetic discrimination prohibition. Those are incremental steps we can take this year but even if we do all of that, I have to tell you, we are not going to solve the problem.

The only way we are going to solve the problem is to deal with it in a comprehensive way, and there are three things that have to be done. First, we need leadership, political, business and organization. As part of the Center for American Progress, I have been very, very pleased to see the coalition of business leaders and labor leaders come together for the first time to say now we must pass comprehensive reform; we can't delay. We also have to think out of the box. We have to use paradigms that work in other forms in our society, and I am one who believes the Federal Reserve System would work very well in our health care system too. We need a private system and a public infrastructure. We need a decision-making board that is partially insulated from the day-to-day political pressures that otherwise Members of Congress feel. The Federal Reserve System applied to health care could do that. Finally, we

have to realize that even if we create the best framework, unless we deal with one other issue, we will never solve the problem, and that is, our change in lifestyle. A recognition that we have to address meaningful wellness and preventative-care efforts. We have to do for obesity in this country what we have done with safety belts and with helmets and with tobacco. If we can apply the same approach, that same ability to encourage wellness and health promotion, I think we can solve this problem.

Teddy Roosevelt once said that the greatest joy in life is to work hard at work worth doing. I can't think of a job more worth doing than this.

Thank you very much.

[The prepared statement of Mr. Daschle follows:]

TESTIMONY OF HON. THOMAS A. DASCHLE

Health Reform is the Most Important Domestic Policy Issue

• It affects our health, security, and global competitiveness

One of the Obstacles to Reforms is Myths

• Myth one: We have the "best" system, when in reality there are islands of excellence in a sea of mediocrity
• Myth two : We cannot afford reform, when the reality is we can't afford the status quo
• Myth three: We don't "ration" care, when we have the worst kind of rationing: by income and illness, by age and disability

Recent Efforts Have Focused on Incremental Reform

• There have been a number of major pushes for comprehensive reform in the United States.
• Since the last one, energy has been spent on incremental reform
• What has been done, and should be done this year—SCHIP, mental health parity, genetic non-discrimination, for example—are critical and meaningful
• But such policies are plugging the holes in a failing system

Comprehensive Reform of the Health System and Beyond Is Needed

• New leadership is needed, including businesses, with the goal being an accessible, affordable, and quality-based health system for all by 2012
• A new framework is needed, which allows for private delivery in a public system
• Health reform is necessary but not sufficient to deal with the 21st century health challenges—in particular that of obesity and chronic disease

Good morning, Chairman Pallone, Ranking Member Deal, and distinguished members of the Committee. It is good to be with you this morning, in the midst of Cover the Uninsured Week, to discuss this critical topic.

This Congress, and this country, faces numerous challenges, at home and abroad. Few, in my opinion, are as critical as those facing our health system. About 45 million Americans lack coverage altogether. Being uninsured means delayed care, denied care, preventable disease, and premature death. Millions more who are insured remain at risk of bankruptcy due to health bills. These bills add up. At $2 trillion per year, we outspend the next most expensive Nation by 50 percent. American businesses pay about $500 billion of this. This cost has crowded out wage increases, business investments, and hurt our global competitiveness. And we pay more for less, not always getting quality worthy of our spending. Stated simply, health reform is the most important domestic policy issue.

MYTHS BLOCKING HEALTH REFORM

Despite these clear problem, health reform has not made it to the top of the political agenda. One reason is myths about our current system and reform. These myths are like "landmines" that have derailed past efforts to create a universal, value-oriented health system.

The first myth is that the United States has the best health care system in the world. There's no doubt that some Americans have access to the best care anywhere. Any real solution needs to maintain our leadership at the cutting edge of medicine. But we need to be honest with ourselves. Not all our care is excellent.

Thousands of people die from medical errors every year. Americans are more likely to experience medical, medication or lab errors than people in countries like Germany and the United Kingdom.

Plus, few American realize that we are far behind and falling relative to comparable nations in the basic measures of health. Can we say we have the best system when our life expectancy is 35th in the world, lower than Cyprus and Singapore? And, can we say we have the best system when our infant mortality rate is 41st in the world and rising? A story over the weekend documented a spike in infant deaths in Mississippi and the South. There is simply no excuse for such deaths that might have been avoided with better health care policy.

The second myth we need to debunk is that the U.S. cannot afford to do any better. In point of fact, we cannot afford to continue this current system. We spend 16 percent of our economy—or $2 trillion—each year on health care. We spend nearly $6,700 per person, which is roughly 50 percent more than the number two country, Switzerland. GM pays more for health benefits than steel. Starbucks pays more for health benefits than coffee. If trends persist, health benefit costs will eclipse profits in the Fortune 500 companies by 2008. As a matter of health policy and economic policy, we need to act to rein in the Nation's health spending.

The third myth is that universal coverage will inevitably lead to rationing. This ignores the fact that we ration now. Health care is delayed or denied to the uninsured and under-insured. Cancer can mean bankruptcy and asthma can consume college funds. Being older or sicker, or even having a family history, can make a person uninsurable—doomed to spend years worrying about the next illness's financial rather than health implications.

Even on the traditional measures of "rationing", we fare worse. Thirty percent of sick Americans have access to same-day care, compared to 45 percent in the United Kingdom. Americans find it three times harder to get care at night and on weekends without going to emergency rooms compared to those in New Zealand. And we are more likely to have to wait to see a specialist than sick people in Germany. It's ironic that the U.S., compared to its competitor nations, offers fewer people less accessible care.

INCREMENTAL REFORM

I know that you, and many other lawmakers, recognize the truth of our health system crisis, and have tried to act on it. Several presidents, and even more Congresses, have attempted but failed to enact health reform. I, myself, have some scars to show for it.

The response has been to focus on incremental reform. In the late 1990's, a number of policies were enacted and implemented that make coverage better and more accessible for millions of Americans. This year, you may be able to take additional strides in improving the system. For example, you have the opportunity to extend insurance parity for mental illness and protect Americans from genetic discrimination. Perhaps most importantly, the State Children's Health Insurance Program is up for reauthorization. Improving and extending this successful program that has served millions of low-income children is not just an option but a necessity.

But it would be a mistake to believe that these policies are more than fingers in the dam. They cannot solve the health system's problems. There is no pathway of incremental steps that will improve and expand health coverage for all. The only solution is comprehensive reform.

COMPREHENSIVE REFORM

So, what will it take to finally pass comprehensive reform? First, we need to have to have leadership. There has to be a President and a Congress that both say, "The time has come for us to deal with real health reform." Success will demand that everyone check ideology at the door—and that everyone focus not on what ideology dictates should work, but on what experience shows will work.

To get to that point, there needs to be business leadership. Businesses are a major payer of health care and player in the political system. At the Center for American Progress, we helped form Better Health Care Together, a business-labor coalition with the goal of comprehensive reform by 2012. I am optimistic that the CEOs of companies like AT&T, WalMart, and CostCo will force the debate in the halls of Congress.

Second, we need to think outside the box. One idea that I've been working on is to run our health care system in a way similar to our Federal Reserve system. Our Federal Reserve system works, in large measure, through the private sector but is governed by decisions made within a Federal Governmental infrastructure. Just as the Federal Reserve System protects difficult decisions on monetary from political

pressure, I would like to see a framework that insulates health care decision-making about cost and financing. If we could fix our financing system, I think we could fix a lot of the other problems involved with our health care system today.

Lastly, health reform is absolutely necessary to improving our Nation's health. There is no excuse in the wealthiest nation in the world for a person to suffer or die needlessly due to financial barriers to care. We can and must end uninsurance. But this will not be sufficient to improve health. A growing tide of chronic illness, in part induced by obesity, will strain our health system and Nation. It could mean that the next generation of children may have shorter life expectancies than that of their parents for the first time in this Nation's history. As we consider how to make critical health policy changes, we should consider broad-based interventions beyond the health system, in schools, workplaces, and communities. This would give the Nation, at long last, the health it deserves.

Mr. PALLONE. Thank you so much, and I forgot to mention on the prevention side your being a runner and you are always promoting that as well. That is very important. Thank you, Senator.

Next is Mr. Smith.

STATEMENT OF MICHAEL K. SMITH, SECRETARY, AGENCY OF ADMINISTRATION, STATE OF VERMONT

Mr. SMITH. Thank you, Mr. Chairman, and thank you for the opportunity to testify before your committee on health care. As you are aware, this is one of the most significant and challenging issues we face as a Nation and as individual States. We simply cannot afford to continue the status quo of high insurance costs, high health care costs and inadequate quality in our health care system.

Ten months ago, Governor Douglas, a Republican, and the Democratic-controlled legislation in Vermont, reached consensus on a groundbreaking health care reform package in our State. This reform is comprehensive in that it has over 35 different initiatives to cover our uninsured, improve our health care quality and curb the growth in health care costs. It is being hailed by many experts as the most comprehensive legislation to provide universal access while at the same time lowering health care costs and improving quality.

I am going to focus today on just two of these initiatives in my testimony, but in the written material supplied to the committee we provided a full description of our reforms.

The first initiative is called the Catamount Health Plan, a product available on the private market in October 2007 that will be available for the uninsured Vermonter. Catamount Health is mandated in statute to be comprehensive in benefits, and affordable. The benefits will be subsidized by the State of Vermont, depending on your income, up to 300 percent Federal poverty level, and if you have employer-sponsored insurance and cannot afford it, your premiums for that insurance will be subsidized depending on income. If it is less expensive for the State to do so, you can make a choice on which plan you want to be on, depending on which is less expensive for the State. The only requirement is that the employer-sponsored insurance plan be substantially similar to the Catamount Health Plan in terms of benefits and deductible costs. In Vermont, many employers have such plans. The goal is to reach an insured level of 96 percent by 2010. The plan is financed by increases in the tobacco tax, premiums, Federal Medicaid match, and an assessment on those employers not now offering health insurance. The

plan has been carefully crafted to conform with ERISA requirements.

The second major component of our health care reform is called the Blueprint for Health, which is our statewide initiative to provide all Vermonters who have chronic conditions and those at risk of developing them with the information, tools and support they need to successfully manage their health. Over 50 percent of all adult Vermonters have one or more chronic conditions and caring for people with chronic conditions consume 70 percent of the $3.5 billion spent in Vermont in 2005 on health care. National data indicates that only 55 percent of people with chronic conditions get the right care at the right time. We must do better to improve the outcomes and bring down health care costs.

Launched by Governor Douglas in 2003 and endorsed by the Vermont General Assembly in 2006, the Blueprint for Health is not the typical disease management program. Instead, the Blueprint is proactive and holistic and is designed to change our health care system to focus on chronic care equally with that of acute health care. To accomplish this, the Blueprint creates public policies that support healthy lifestyles and effective health care. It provides community-centered programs and activities to encourage and maintain healthier lifestyles. It provides self-management tools for individual participation and empowerment. It develops new electronic health systems for physicians' offices and other health care settings statewide. It coordinates reimbursement and care coordination approaches across all payers including insurers, State government and nonprofit health care organizations. Our goal is to have this new health care delivery approach in place statewide by 2011.

In conclusion, in order for health care reform to be successful, it needs enormous buy-in from a variety of organizations and people. We found that out in Vermont. Governor Douglas was just one of 10 people awarded an Impact Award by AARP for his work in health care. The first line of the write-up of the award said, "Sometimes politicians can rise above politics." I urge you to remember this line as you move forward with your deliberations regarding health care reform. We need to put aside party affiliations and act on behalf of all our country's citizens and businesses who are struggling every day with these issues.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Smith follows:]

STATEMENT OF MICHAEL K. SMITH

Thank you for the opportunity to testify before your committee on health care reform. As you are aware, this is one of the most significant and challenging issues we face as a nation and as individual States. We simply cannot afford to continue with the status quo of high insurance costs, high health care costs and inadequate quality in our health care systems.

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The goal is to reach an insured level of 96 percent by 2010. The plan is financed by increases in the tobacco tax, premiums, Federal Medicaid match (assuming Federal approval of an amendment to our 1115 waiver), and an assessment of those employers who do not offer health insurance. The plan was carefully crafted to conform with ERISA requirements.

The second major component of our health care reform is the Blueprint for Health, which is our statewide initiative to provide all Vermonters who have chronic conditions, and those at risk of developing them, with the information, tools, and support they need to successfully manage their health.

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- creates public policies that support healthy lifestyles and effective health care;
- provides community-centered programs and activities to encourage and maintain healthier lifestyles;
- provides self-management tools for individual participation and empowerment;
- develops new electronic health systems for physicians' offices and other health care settings statewide; and
- coordinates reimbursement and care coordination approaches across all payers, including insurers, State government and non-profit health care organizations.

Our goal is to have this new health care delivery approach in place statewide by 2011.

In conclusion, in order for health care reform to be successful, it needs enormous buy-in from a variety of organizations and people. Governor Douglas was just one of 10 people awarded an "Impact Award" by AARP for his work in health care.—The first line of the write up for the award said, "Sometimes politicians can rise above politics." I urge you to remember this line as you move forward with your deliberations regarding health care reform. We need you to put down your party affiliations and act on behalf of all our country's citizens and businesses who are struggling every day with these issues.

Mr. PALLONE. Thank you, Mr. Smith.

Mr. McEntee.

STATEMENT OF GERALD W. MCENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. MCENTEE. Thank you, Mr. Chairman and members of the committee.

We have a health care crisis of unprecedented proportions. Cost of coverage is exploding. It threatens the economic security of working families. It strains State budgets. It overwhelms safety net providers, it reduces the competitiveness of American businesses,

and 45 million people live with the fear that they or a loved one will need care for which they cannot pay.

One such person is Joann Baumer of Fort Madison, Iowa. Joann is a homecare attendant who works full time providing services to the elderly and the disabled. Joann has no health coverage. After having necessary surgery, it took Joann and her husband 5 years to pay off her hospital bill. Now she and her husband spend $400 per month for prescription medication.

Joann Baumer's story is far from unique. The crisis of the uninsured is a problem for everyone in America and that includes the 1.4 million members of our union, AFSCME. A significant share of the premium paid by AFSCME members and their employers goes to offset the cost of uncompensated care. There are scores of proposals to address this crisis and so we have developed principles to evaluate them. But ultimately this is not a matter solely of policy or resources. It has been said earlier today, it is a matter of political will. America's working families demand relief from this crisis and they expect their national leaders to have the vision and political resolve to forge a bold solution. The starting point for health care reform must begin with a commitment to cover every man, woman and child in America. This is both a moral and economic imperative.

Let me give you our vision of what health care reform should look like. First, everyone should have affordable, comprehensive coverage. Second, while the market has an important role to play, our Government must play the central role in regulating, financing and providing health care. Third, financing should be fair and shared by all. Fourth, frontline health care workers must have an active voice in improving the quality of our health care system. Who else knows more about it? And finally, as we approach reform, we must be mindful to do no harm. This means that until we have a comprehensive reform, changes in the health care system must not undermine existing coverage.

Unfortunately, the health care plan proposed by the President in his budget this year does exactly that because his plan makes fundamental changes in the tax treatment of coverage. It would actually encourage employers to drop health benefits for their workers. Ultimately, the President's plan would make those who have adequate coverage pay more for it without achieving universal coverage. We oppose his proposal and other plans that would break up risk groups and send families into the individual market where costs are higher and coverage is also denied. We must also realize that the absence of action at the Federal level has forced States to pursue their own reform initiatives. We are concerned about the direction of some of these reforms. For example, the Massachusetts model attempts to achieve near-universal coverage through the use of individual mandates. The most recent cost estimates for coverage of a Massachusetts family with an income of $50,000 would include a $7,000 premium and a $2,000 deductible. Health care costs that approach 20 percent of total income are unaffordable and unacceptable to working families.

It is our hope that the State efforts prompt action at the Federal level. Ultimately, only the Federal Government has the resources and the legal authority to implement the changes that are needed.

Among the health reform initiatives under discussion in this Congress, two deserve particular mention. Chairman Dingell's Medicare for All plan offers a viable path to attaining universal coverage, provides the security of extending the trusted Medicare plan to everyone under age 65 but also includes choice for families. We are also supportive of the Americare plan introduced by Representative Stark and cosponsored by a number of committee members including Representatives Waxman and Schakowsky. This bill would also leverage the administrative efficiencies of Medicare.

In closing, I would like to add a note about the importance of quickly reauthorizing the State Children's Health Insurance Program, a top priority for our union and all unions. It is crucial that the Congress build on the success of this program by allowing States to expand coverage to the millions of children who remain uninsured. In particular, we urge you to remove the prohibition that excludes the children of low-wage State workers from SCHIP and we also urge that you address the funding inequity of the Commonwealth of Puerto Rico.

I appreciate the opportunity to testify and will be happy to answer any questions you may have. Thank you, Mr. Chairman.

[The prepared statement of Mr. McEntee follows:]

TESTIMONY OF GERALD W. MCENTEE

America's health care system is in crisis. The cost of coverage is exploding. It threatens the economic security of working families, it strains State budgets, it overwhelms the capacity of safety net institutions and it reduces the competitiveness of American businesses. And shamefully, 45 million people live with the fear that they or a family member will need care for which they cannot pay. Those fortunate enough to have coverage too often receive poor quality care.

The crisis of the uninsured is a problem for everyone in America, and that includes the 1.4 million members of my union, the American Federation of State, County and Municipal Employees.

The United States is a great nation—we can, and must, do better.

Unlike European health care systems to which it is frequently contrasted, the American health care system is not a monolithic, unified system. Rather, it is a complex system of many inter-related parts, all of which must function efficiently to keep the system in optimal order.

Like the links in a chain, if one link exhibits stress or cracks, it puts more strain on the other links. The uninsured represent a broken link in our system, putting enormous pressure on both employer-sponsored health plans and public programs. Moreover, this broken link is a moral failure for our Nation. Much of the massive growth in the uninsured is attributable to individuals losing coverage through their jobs. The erosion of employer-sponsored health coverage is a particularly troubling trend for America's labor unions, and it should be of primary importance to every American because of the damage it represents to our overall health care system.

In the year 2000, 69 percent of Americans under age 65 had employer-sponsored health coverage. By last year, that figure had dwindled to 60 percent.

Clearly, many employers are dropping insurance for their workers, because of its cost and the growing complexity of administering benefits. However, other large, profitable companies never provided health insurance to the majority of their workers in the first place, instead directing them to public programs at taxpayer expense. And an increasing number of workers who have employer-sponsored coverage are paying more in out-of-pocket costs for scaled-down benefit plans.

For those workers still fortunate enough to have health insurance, the specter of underinsurance is all too prevalent. Far too many American working families are just one serious illness away from bankruptcy. In fact, medical debt is now the second leading cause of bankruptcy in our Nation, and 29 percent of low-to-middle income families report that medical debt contributes to their chronic credit card debt. The lack of adequate health care coverage is making the American Dream more and more of an illusive target, rather than an attainable goal, for working families.

Sometimes, when I talk about the crisis of the uninsured, members of the media or the public ask me, "Why does your union care about the uninsured? Union members have good health benefits. This doesn't affect them."

First of all, most of our members have good health insurance coverage, but not all of them. Some of the workers in new sectors that we are organizing, including those who perform home health care/personal service attendant work and those who provide in-home child care, do not receive health benefits as part of their job. I think most Americans would agree with me that it is a travesty when those on the frontlines of providing care to our children, our elderly and our disabled do not have health coverage themselves. We are working hard to find ways for these often low-wage workers to get access to health coverage, but it has been a difficult and complicated task.

But the full answer to that question about union members and health coverage is that, yes, most AFSCME members do have good health insurance coverage. In many cases, we have had to fight long and hard to develop these health benefit plans. But just because union members have good health benefits does not mean that we are not impacted by those without coverage.

It cannot be overstated that the crisis of the uninsured is everyone's problem, including those of us who have insurance. The elaborate shell game of cost-shifting that is built into our insurance rates to pay for uncompensated care means that each time the number of uninsured rises, so do our premiums. In one recent analysis of uncompensated care, it was estimated that two-thirds of uncompensated care is being absorbed by private payers and passed along in the form of higher insurance premiums. In 2005, this cost added over $900 to the average annual premium for family coverage.

The number of uninsured would be doubled without the safety net provided by the Medicaid program. As a union that represents many workers throughout the Medicaid program in States across the Nation, we are proud of how effective this system has been at providing vital health services for low-income families and individuals. But the Medicaid system has been strained to the breaking point by absorbing more and more individuals who have either lost employer-sponsored coverage or who cannot afford to pay sky-rocketing premiums.

The effect of rising Medicaid costs has been devastating to State budgets. Although States have admirably tried to keep their Medicaid costs under control, the growing strain of the newly uninsured represents huge opportunity costs in the public sector. States cannot adequately invest in their education system or their public infrastructure in general because of the growing budget share assumed by Medicaid. This inability to invest will leave a harsh legacy on future generations who will be ill-prepared to compete globally, or even to contribute fully to our society. To date, the Administration has failed to respond to the gravity of the challenges presented by Medicaid cost growth. Instead, it only offers States greater flexibility and block grants. Neither approach can adequately address the needs of a safety net health care system that is straining to assist a larger and sicker population.

The problem that the growing number of uninsured represents for both the employer-sponsored system of health coverage and the public system of coverage makes it the number one policy priority for AFSCME and the entire labor movement. The question of health coverage has been the primary point of contention in every major contract our union has bargained over the past several years. For years now, our members have foregone wage increases to maintain their valued health benefits. Yet, even this imperfect trade-off is becoming unsustainable as soaring health care costs far outpace wage increases nationally, and American workers fall further and further behind.

America's working families demand relief from this crisis. And they expect their national leaders to have the vision and the political resolve to forge a bold solution to this problem. Many proposals have been put forth to address this crisis. But ultimately, this is not simply a matter of policy or resources, it is a matter of political will.

To help evaluate these plans, my union has worked with the AFL-CIO to create a set of guidelines for what comprehensive health care reform should include. This is what we think effective health care would look like:

- Everyone should have health care coverage, without exclusions or penalties.
- While the market has an important role to play, our government—as the voice of all of us—must play the central role in regulating, financing and providing health care.
- Coverage should be accessible through the largest possible groups that pool risk to ensure coverage regardless of gender, age, health status or other factors.
- Coverage should be affordable and comprehensive.

• Unions and employers should continue to play a role and retain the ability to supplement coverage.

• Individuals must retain the ability to select their own health care providers.

• Financing should be achieved through shared responsibility, which means that risk should be shared broadly to ensure fair treatment and equitable rates, and everyone should share responsibility for contributing to the system through progressive financing.

• Reform efforts must include effective mechanisms for controlling costs, requiring information on provider performance and enhancing efficiency.

• Frontline health care workers must have an active voice in improving the quality of our health care system and making it more efficient.

As the debate over reform proceeds, we must be mindful to do no harm. This means that until we have a comprehensive alternative for everyone, reform efforts should not undermine existing coverage or put people at risk of unmet health care needs.

And finally, it is our firm belief that only the Federal Government has the resources and legal authority to implement the systemic reforms necessary to create comprehensive change. Therefore, the ultimate responsibility for health care reform lies with the Federal Government.

Now, I want to comment briefly on how current reform plans line up with our guidelines and which we think will be effective in achieving lasting reform.

As the crisis of the uninsured has expanded, the administration's response has been inadequate at best. In his latest budget request, President Bush put forward an initiative based on tax credits. In its analysis of the President's proposal, the Commonwealth Fund estimates it would cover an additional nine million individuals at most. Because of the fact that his proposal treats employer-sponsored health coverage differently under the Federal tax code, it would actually encourage employers who currently offer coverage to drop health benefits for their workers. Ultimately, the President's plan would fail to achieve universal coverage while forcing those who have adequate coverage to pay more for it.

The underlying philosophy of this plan is that employers, and our Nation as a whole, should abandon collective responsibility for health coverage, along with the shared risk associated with it. Instead, according to this view, each individual must take responsibility for his or her own health coverage, through high-risk schemes like high deductible health plans and health savings accounts (HSAs), even if this coverage requires increased out-of-pocket costs and eventually causes the individual to lose coverage altogether.

We oppose his proposal and other plans that would break up risk groups and leave families on their own to purchase coverage in the individual insurance market.

The absence of action on health care reform at the Federal level has forced States to pursue their own reform initiatives, largely out of desperation. Although systemic reform requires Federal action, we commend States for attempting to address the issue comprehensively. However, we are concerned with the direction reform efforts have taken in some States.

For example, the Massachusetts reform model attempts to achieve near-universal coverage through the use of individual mandates that require those without access to coverage through their jobs to buy coverage in the individual market. Although there are subsidies to help low-income families, many working families will be forced to pay much higher prices for coverage. The most recent estimates for coverage under this initiative for a family with an income of $50,000 would include a $7,000 premium and a $2,000 deductible. Health care costs that approach 20 percent of total family income are unaffordable and unacceptable to working families and they will ultimately doom this plan to failure.

Among the new health reform initiatives being discussed in this Congress, two deserve particular mention. The Medicare for All plan, proposed by Chairman Dingell, offers a viable path to attaining universal coverage. It offers the security of extending the trusted Medicare plan to everyone under age 65, but it also features attributes of choice by allowing enrollees to select any one of the health plans offered to members of Congress.

We are also favorably impressed by the AmeriCare plan introduced by Rep. Stark. This plan would build on our existing employer-sponsored system of coverage, but would also leverage the administrative efficiencies contained in Medicare to create a new system of universal coverage.

Both of these initiatives meet our guidelines of covering everyone, offering comprehensive benefits, exerting effective cost controls and employing equitable finance mechanisms.

In closing, we would like to add a note about the importance of Congress expeditiously reauthorizing the State Children's Health Insurance Program. It is crucial that the Congress build on the success of this program by allowing States to expand coverage to the millions of children who remain uninsured. In particular, we urge you to remove the prohibition from coverage that excludes the children of low-wage State employees and also many local government employees. A janitor who cleans a State building or a local school should not be treated differently than a janitor who cleans the bank building down the street. For many low-wage workers, the employee premium for family coverage is simply unaffordable. The children of these workers should not be denied coverage, just as the children of workers in the private sector and in the Federal sector are not denied coverage.

We also urge you to address the funding inequity for the Commonwealth of Puerto Rico. This program is quite modest, covering only children up to 100 percent of poverty. We believe that the Federal Government needs to be a full partner in that program.

The health care crisis poses a serious threat to the future of our Nation. We have a moral and economic imperative to solve this problem, and the starting point is to provide coverage for every man, woman and child in America.

Mr. PALLONE. Thank you.

Ms. Turner.

STATEMENT OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Chairman Pallone, Mr. Deal, distinguished members of the committee, thank you very much for the opportunity to testify during Cover the Uninsured Week, which interestingly coincides with Small Business Week. I think that is an interesting convergence that shows the added attention we need to bring to small business in America.

Our core focus at the Galen Institute is finding ways to increase access to health insurance for Americans, particularly private insurance. In expanding access to coverage, it seems wise to focus on who is most likely to lack coverage and why. As several members have mentioned, 160 million Americans have access to coverage through the workplace, but this system is not meeting the needs of an increasingly mobile workforce. Young people, minorities, workers for small businesses and lower-income workers are most likely to be uninsured. With so many competing demands for taxpayer dollars, it seems wise to look at the opportunities to build on this source of private coverage and take advantage of not only these efficiencies but also of the resources that are already on the table.

There have been suggestions this morning about expanding access to public coverage but I would like to offer two thoughts and present some research that I think may help to consider Hippocrates' warning to first do no harm to the system as those programs are considered. Researcher Jonathan Gruber from MIT has said that, and this is a quote, "Despite an enormous expansion of public health programs over the past 20 years, the number of insured continues to grow." His estimate suggests that expansion of public insurance is crowding out private insurance at the rate of about 60 percent. He finds that this crowd-out is most likely to affect those in higher income categories who are eligible for these programs and who are the main target populations for SCHIP expansion.

Further, I believe it is incredibly important that we not make it more difficult for businesses and especially small businesses to pro-

vide and to afford coverage. Milliman and Company actuary Mark Litow has said that expanding Government programs is putting added pressure on private health insurance and that is because public programs pay sometimes only 30 cents on the dollar of hospital and doctor's fees, and if those businesses are to stay afloat, they have to find someplace else to go to recoup the resources, and that is forcing up the premiums for private health insurance. People wonder why are these costs going up, and as public programs expand, it forces more of those costs onto private insurers, which pay an average of about 67 percent of costs.

If we were to think about how can we fit our health care system into one that is a 21st century system that recognizes we have a mobile workforce, four in ten workers change jobs every year, allow health insurance to be more portable, take advantage of the opportunities for private coverage that are out there, I think there are some policy initiatives that could help support that goal. First of all, making the tax break equal so you can get the same tax break whether you purchase your health insurance through the workplace or on your own through new kinds of groups. For a lot of people, that is not going to be nearly enough and I have heard a lot of talk about some kind of added cash support whether it is refundable tax credits, health certificates, vouchers, whatever kind of credit to help people, especially those who are left out of the current system to provide coverage and purchase coverage. Further, there are a lot of people who are eligible for public programs, eligible for Medicaid, eligible for SCHIP. Many of them may have jobs that may take up the private coverage at work if they had a little more help, allowing premium support for SCHIP dollars and Medicaid dollars to give them that extra boost to be able to purchase private health insurance at work, and then also to create new opportunities for people to purchase group health insurance. Representative Shadegg's bill to allow cross-state purchasing of health insurance I think would also really liberate the market and force new efficiencies in the market.

Building of private coverage, in conclusion, I think would be both more economical for taxpayers and also give workers eligible for public subsides the dignities of private insurance coverage with its broader access to private physicians and medical facilities.

Thank you, Mr. Chairman. I look forward to your questions.

[The prepared statement of Ms. Turner follows:]

STATEMENT OF GRACE-MARIE TURNER

With the increasing ability of the medical profession to save and improve our lives, Americans value the security of health insurance to cover their health costs. For public policy solutions to be effective in reducing the number of those who do not have the security of health insurance, we must look beneath the numbers to see who is uninsured, why, and what solutions are likely to work to expand coverage.

Analyses show those who are most likely to be uninsured are young adults, those working for small businesses and their dependents, lower-income workers, and minorities. Either we can dramatically expand public programs to cover this population or we can find new ways to help them access private coverage. I would suggest that, with so many competing priorities for taxpayer dollars, we find ways to strengthen access to private health insurance.

Research by Jonathan Gruber of MIT shows that despite an enormous expansion in public health programs over the last 20 years, the number of uninsured continues to grow. Gruber's research suggests that most of the rise in public insurance comes

from a fall in private insurance. He finds that crowd-out is most likely to take place with those in upper income categories—the target category for SCHIP expansion—because they are more likely to have options for private coverage.

Further, it is essential that legislative changes not make it more difficult for employers to provide coverage by inadvertently driving up their premiums. Milliman Actuary Mark Litow argues that expanding government programs puts added pressure on the cost of private health insurance. Public payers pay less to doctors and hospitals, and as these public programs expand, private plans must pay more. Their costs rise, driving up premiums and causing more people, especially individuals and small businesses, to drop out of the market, thereby swelling the ranks of the uninsured.

Changes are needed to our health care system to meet the challenges of a changing workforce and 21st century economy. America can lead the way by putting in place new policies that combine a general tax deduction or credit with additional financial assistance for lower-income people, and flexibility to turn SCHIP and Medicaid benefits into defined contributions, thereby retargeting existing funds to increase access to private health insurance. Building on this base of private coverage would both be more economical for taxpayers and also would give workers eligible for public subsidies the dignity of private insurance coverage, with its broader access to private physicians and medical facilities.

Chairman Pallone and distinguished members of the committee, thank you for the opportunity to speak with you today during this week of national attention on "Covering the Uninsured." To introduce myself, I am Grace-Marie Turner, president of the Galen Institute, a non-profit public policy research organization that I founded in 1995 to focus on market-based policy solutions to the problems in our health sector.

Our core focus at the Galen Institute is offering solutions to expand private health insurance to the tens of millions of people in this country who are without coverage.

With the increasing ability of the medical profession to save and improve our lives, Americans value the security of health insurance to cover their health costs. When we look at the trend lines for health insurance coverage in the U.S., it is clear that we must chart a new course.

The number of people without health insurance is steadily rising, now 44.8 million, according to recent revised Census Bureau estimates, [1] and the number of people with coverage through the workplace is falling, from 69 percent in 2000 to 61 percent in 2006. [2]

If public policy solutions are to be effective in reducing the number of uninsured, it is important to look beneath these numbers to see who is uninsured, why, and what solutions are likely to work to expand coverage.

Analyses show those who are most likely to be uninsured are young adults, those working for small businesses and their dependents, lower-income workers, and minorities. I would like to offer suggestions for new strategies to increase coverage for those who are most likely to be without insurance.

A profile of the uninsured

About 80 percent of the uninsured are workers or their dependents. These are people who make too much to qualify for public programs, such as Medicaid and the State Children's Health Insurance Program, but don't have the good, higher-paying jobs that come with health insurance. These are the people that are in what we call the "Galen Gap." Our logo is a conceptual depiction of this group that represents our largest public policy challenge. [3]

We have two choices: Either we can dramatically expand public programs to cover this population or we can find new ways to help them access private coverage. I will describe research by Jonathan Gruber of MIT which suggests that the former may not be the best strategy and suggest ways that existing public funds could be used to expand access to private coverage for this target population.

Who is most likely to be uninsured?

• Young adults: Among young adults aged 19–24, 38.2 percent do not have health insurance.[4] For this population of people who are overwhelmingly healthy and believe in their invulnerability, the cost of insurance is the biggest issue.

• Employees of small businesses: Only 60 percent of small firms offered coverage in 2006. And the smallest firms are least likely to provide coverage: Only 48 percent of firms with 3 to 9 workers offer health insurance to their workers. The drop in employment-based health insurance has been primarily among small companies employing 3 to 199 workers. In contrast, 98 percent of large firms with 200 or more workers offered health insurance in 2006. [5]

The reason firms cite for not offering health insurance is the high cost of coverage, with 74 percent saying that the high price of premiums is a "very important" reason

they don't offer health insurance. [6] And some firms are just too small to manage their businesses as well as the complexities of health insurance. The National Restaurant Association says, for example, that some employees may only work for a restaurant for a few days, making it almost impossible to enroll these workers in health plans and for their job to be a stable source of coverage.

• Lower-income Americans: In 2005, 37 percent of non-elderly people with incomes under 100 percent of Federal poverty were uninsured compared to just 7 percent of those with incomes of 300 percent of poverty or above. [7] Lower-income workers need targeted subsidies to help them afford insurance.

• Minorities: An estimated 32.3 percent of Hispanics are uninsured, compared to 10.7 percent of whites and 19 percent of blacks. [8] This suggests that outreach to the Hispanic community with new options and information about those options would be an important component of an effort to increase enrollment in health insurance.

And even though a profile of the uninsured captures these primary categories, the actual faces in this group without coverage are ever-changing. According to the Congressional Budget Office, the uninsured population is constantly shifting as people gain and lose coverage. Furthermore, the length of time that people remain uninsured varies greatly. Some people are uninsured for long periods of time, but more are uninsured for shorter periods. About 45 percent are uninsured for four months or less. [9] This is primarily a phenomenon of our system of job-based health insurance where people lose their health insurance when they lose their job and have periods of uninsurance while they wait to get covered again.

And many of the uninsured are eligible for public programs. Twenty-five percent of the uninsured are eligible but not enrolled in public programs. Another 20 percent have incomes high enough to afford coverage, defined as 300 percent of poverty or above, according to a report published in Health Affairs. [10]

The CBO says that 16 percent are continually uninsured for more than two years, and they tend to be people with less education, those with low incomes, and Hispanics. These longer-term uninsured would seem to be an important group for Congress" attention as they clearly have fewer opportunities for private coverage.

Crowd out

As Congress focuses on the problem of the uninsured, it would be helpful to look at the success of past strategies in expanding access to public coverage, especially through Medicaid expansions and the creation of the State Children's Health Insurance Program.

Over the past two decades, the number of people without health insurance and the number of people with publicly-supported health insurance both have risen. [11] According to Jonathan Gruber of MIT, from 1984 through 2004, the share of the non-elderly population in the U.S. that is uninsured rose from 13.7 percent to 17.8 percent. At the same time, the share of the non-elderly U.S. population that is publicly insured rose from 13.3 percent to 17.5 percent. In other words, Gruber shows that despite an enormous expansion in public health programs, the number of uninsured continues to grow.

Gruber's research suggests that most of the rise in public insurance comes from a fall in private insurance. His data show that, between 1984 and 2004, the share of the U.S. non-elderly population with private health insurance fell from 70.1 percent to 62.4 percent. His estimates suggest that expansions of public insurance are crowding out private insurance at the rate of 60 percent. That means, in general, that private insurance coverage is reduced by 60 percent as much as public insurance rises.

Because there is a great deal of attention to expanding the State Children's Health Insurance Program, it is important to look at these findings to make sure that a program expansion wouldn't simply be replacing private insurance with taxpayer-supported coverage. Gruber finds that crowd-out is most likely to take place with those in upper income categories—the target category for SCHIP expansion—because they are more likely to have options for private coverage.

It is only logical that people would opt for public coverage if it were offered because taxpayer-supported insurance is almost always less expensive for recipients than private insurance. But it may be worth rethinking this strategy if the goal of the added spending on SCHIP is to reduce the number of uninsured. Gruber's research suggests that expanding SCHIP could add more children to public rolls but not have a significant effect on reducing the number of uninsured children.

According to the Kaiser Commission on Medicaid and the Uninsured, a surprising percentage of poor and near-poor adults—those earning 200 percent of poverty or below—have employment-based or other private health insurance. [12] The Kaiser study shows that 45 percent of non-elderly people who earn between 100 percent and 199 percent of poverty (up to $20,420 in 2007) have private health insurance,

either coverage they get through work (39 percent) or individual policies (6 percent). About a third of lower-income adults are uninsured and one-quarter have public coverage, primarily through Medicaid or SCHIP.

Clearly it would be a mistake, with so many competing priorities for taxpayer dollars, to replace private coverage for those who have it with expanded public health programs.

MAKING PRIVATE INSURANCE MORE EXPENSIVE

It also would be helpful to examine the consequences of a major expansion of SCHIP or other public programs on the market for private insurance.

Expansion of government health programs drives up the cost of private health insurance, according to health actuary Mark Litow of Milliman Consultants and Actuaries. Here's why: He estimates that private health plans pay about 64 percent of the full charges of doctors, hospitals, labs, etc. Medicare pays about 37 percent of these "undiscounted" charges. And Medicaid pays only about 30 percent. [13]

It's only logical that the more of the market that is taken up by programs paying only 30 percent of a provider's charges, it is going to put more pressure on others to make up at least some of the difference. Litow argues that expanding government programs puts added pressure on the cost of private health insurance. As public programs expand, private plans must pay more. Their costs rise, driving up premiums and causing more people, especially individuals and small businesses, to drop out of the market, thereby swelling the ranks of the uninsured.

With 160 million Americans receiving their health coverage through the workplace, it is essential that legislative changes not make it more difficult for employers to provide coverage by inadvertently driving up their premiums through expansion of public programs.

Hippocrates' dictate to "First, do no harm" would seem useful guidance.

ALTERNATIVE IDEAS TO EXPAND COVERAGE

Changes are needed to our health care system to meet the challenges of a changing workforce and 21st century economy.

Tying health insurance to the workplace is not meeting the needs of a workforce that is increasingly independent and mobile. The Labor Department reports that four in ten Americans leave their jobs every year, with virtually all of them moving on to a new job. [14] With this kind of job mobility, it is extremely difficult to tie health insurance to the workplace and expect people to have continuity of coverage. We need a system that allows people to have health insurance that is portable, insurance that they can own and control, and insurance that fits the needs of families and their budgets.

Portability of health insurance would help not only those who are uninsured, but also those who are worried they could lose their coverage. It would give new security to millions of workers who are worried that if they lose their jobs, they will lose their health insurance. With the cost of health insurance and health care rising every year, they fear they would not be able to afford coverage on their own. The middle class is increasingly afraid that they are one premium payment away from joining the ranks of the uninsured.

America can lead the way in creating a health care system that fits with our 21st century economy by putting in place new policies that respond to consumer demands for more affordable, portable health insurance.

- The first step would be giving favorable tax treatment of health insurance to people whether they buy coverage on their own or get it at work, as President Bush has proposed.
- Congress also could offer refundable tax credits for those in lower-income categories who need additional help in purchasing policies.
- Further, Congress could allow those eligible for public programs to apply the value of the subsidies for which they are eligible toward the purchase of private health insurance. This would mean that citizens could take the value of their Medicaid benefit and apply it toward employer-offered coverage. Or they could take the value of their SCHIP subsidy to add their children to their policies at work.
- And legislators could create new opportunities for people to purchase group health insurance through organizations that may be more stable forces in their lives than their jobs, such as churches, labor unions, and professional and trade associations.

This combination of a general tax deduction or credit, with additional financial assistance for lower-income people, and flexibility to turn SCHIP and Medicaid benefits into defined contributions would retarget existing funds to increase access to private health insurance.

Building on this base of private coverage would both be more economical for taxpayers and also would give workers eligible for public subsidies the dignity of private insurance coverage, with its broader access to private physicians and medical facilities.

Consumers, not just in the United States but in all developed countries, are demanding a much greater role in decisions involving their health care. Women, especially, believe that they, rather than a corporate human resources director, could make better decisions involving health coverage for their families if only they were given the chance. [15]

Giving people more power and control over their health care and health insurance creates new incentives for people to be more engaged in managing their health.—Many companies realize this and are instituting new programs to give employees incentives to better manage their health spending. A number of studies have shown that if people are given the tools, the information, and the incentive to manage their care, outcomes can be dramatically improved. And we could transform our health care system into one that responds to the changes of a 21st century workforce and meets the needs of a diverse population of health care consumers.

Thank you for the opportunity to talk with you today about these important issues. I would be happy to answer any questions you might have or to provide additional information.

Endnotes

[1] "Census Bureau revised 2004 and 2005 health insurance coverage estimates," U.S. Census Bureau, March 23, 2007. "http://www.census.gov/Press-Release/www/releases/archives/health—care—insurance/009789.html"

[2] "Health benefits offer rates," Employer Health Benefits 2006 Annual Survey, Kaiser Family Foundation, Washington, D.C. September 26, 2006. "http://www.kff.org/insurance/7527/"

[3] The Galen Institute logo is a conceptual depiction of a central problem in the health sector that affects Americans under age 65 without health coverage. The horizontal axis represents a given individual's income. The vertical axis represents the likelihood that individual is eligible for health coverage and the value of taxpayer subsidies for the coverage.

People on the left side of the scale with the very lowest incomes are most likely to qualify for taxpayer-supported health programs, especially Medicaid, although in some States, even the poorest residents may remain uninsured if they don 't meet certain qualifications.

As an individual moves up the income scale, the likelihood of qualifying for government health programs declines. Those on the right side of the scale with higher incomes are much more likely to have job-based health coverage, which is generously subsidized through the tax code.

Working Americans with modest incomes are most likely to be uninsured and are caught in the trough, which we call the Galen Gap. They earn too much to qualify for public programs but are unlikely to have the good jobs that provide health insurance as a tax-free benefit.

[4] "The uninsured in America, first half of 2005: Estimates of the U.S. civilian noninstitutionalized population under age 65," Statistical Brief #129. June 2006. Jeffrey A. Rhoades, PhD. Agency for Healthcare Research and Quality, Rockville, MD. "http://www.meps.ahrq.gov/papers/st129/stat129.pdf"

[5] "Health benefits offer rates," Employer Health Benefits 2006 Annual Survey, Kaiser Family Foundation, Washington, DC, September 26, 2006. "http://www.kff.org/insurance/7527/"

[6] "Health benefits offer rates," Employer Health Benefits 2006 Annual Survey, Kaiser Family Foundation, Washington, DC September 26, 2006. "http://www.kff.org/insurance/7527/" http://www.kff.org/insurance/7527/

[7] "The uninsured: A primer. Key facts about Americans without health insurance," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. October 2006."http://www.kff.org/uninsured/7451.cfm"

[8] "Revised estimates of persons without health insurance: 2005," U.S. Census Bureau."http://www.census.gov/hhes/www/hlthins/hlthins.html"

[9] "The Uninsured and Rising Health Insurance Premiums," testimony by CBO Director Douglas Holtz-Eakin before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 9, 2004. http://www.cbo.gov/showdoc.cfm?index=5152&sequence=0

[10] "The uninsured and the affordability of health insurance coverage," Lisa Dubay, John Holahan and Allison Cook. Health Affairs. Nov. 30, 2006. "http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.1.w2

[11] "Crowd-out ten years later: Have recent public insurance expansions crowded out private health insurance?" Jonathan Gruber and Kosali Simon. National Bureau of Economic Research Working Paper 12858, January 2007. "http://www.nber.org/papers/w12858"

[12] "The uninsured: A primer. Key facts about Americans without health insurance," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. October 2006. "http://www.kff.org/uninsured/7451.cfm"

[13] Release of data pending by Milliman Consultants and Actuaries, Mark Litow, Principal and consulting actuary. Information from private e-mail exchange April 20, 2007. "http://www.milliman.com"

[14] "Job openings and labor turnover: November 2006," Bureau of Labor Statistics, United States Department of Labor, January 10, 2007. "http://www.bls.gov/news.release/archives/jolts—01102007.pdf"

[15] "In America. Focus on women," Bob Herbert, The New York Times, September 28, 2000.

Mr. PALLONE. Thank you, Ms. Turner.

Mr. Rotzler.

STATEMENT OF GARY ROTZLER, UTICA, NY, ON BEHALF OF THE AMERICAN CANCER SOCIETY

Mr. ROTZLER. Good morning, Mr. Chairman, members of the committee. I very much appreciate the opportunity to testify here today. My name is Gary Rotzler and I am a private citizen speaking on behalf of the American Cancer Society. I am also speaking for millions of American families who cannot afford or do not have access to meaningful health insurance. As a result, they have little access to preventative care and preventing sickness and death.

I speak with authority on this matter because my wife, Elizabeth Jean Harvey, died of breast cancer. Had we had insurance and had she had timely care, the treatment that might have arrived, she might be alive today and certainly would have had more time. I married Betsy in 1978 and I will never regret it.

In 1979, I took a job with Bendix, an aerospace manufacturing company. One of the most pressing questions on my mind during the interview, besides the wages, of course, was "tell me about your health coverage," and it was good coverage. By 1989 I had worked with Bendix, then known as Amphenol, still known as Amphenol, for 10 years but the economy in upstate New York had undergone some profound transformations. Manufacturing jobs had been lost. While putting together company functions like Unity Day, management was secretly negotiating buyouts. It was one in a long line of buyouts and takeovers that affected a lot of Americans. The business ended up being owned by a finance company, LPL, and later KKR, who major interest was downsizing. Seeing the handwriting on the wall, I got lucky and took a job with ShopVAC. They had been offered some financial incentives to open a plant in a nearby town.

A few years later, the plant closed. Although I found temporary work in construction, sometimes 7 days a week, and Betsy was doing daycare, we found ourselves for the first time and only time without health insurance. In the meantime I continued to look for engineering positions in the area. In the fall of 1994, I began to wonder how we were going to make it through the winter. Then I received what in retrospect turned out to be good news and bad news. The good news was, my old aerospace company, Amphenol, was in the process of qualifying electrical connectors for the Inter-

national Space Station and had a temporary job for me. The bad news was, they offered no benefits. I took the temporary job with the hopes of turning it into a full-time position so that I might obtain health insurance for my family. In the meantime, I checked into health insurance through the temp agency but the cost was way beyond my budget. Some of the other coworkers that I worked with were in similar situations

By the summer of 1996, I was still no closer to getting a full-time job and by September of that year Betsy indicated that she had some trouble. She had always been energetic and strong and dynamic but she began to lose energy and feel fatigued and complained of back pain. She didn't want to go to the doctor's because it was too expensive and we really thought we needed to save the money for more real medical emergencies like my daughter Amanda, who had injured a leg the year before and it ended up costing $600. Neither of us realized how dire Betsy's medical condition was. She had gone 2 years without medical exams and lived with the pain, hiding it from us. And once she leveled with me, we got her to a free clinic, and the diagnosis was breast cancer, which was confirmed at a local hospital through an MRI. Once we knew how sick she was, I was able to get her to a specialist at Memorial Sloan Kettering Cancer Center. Betsy died 4 days later, leaving me and my three children alone, 17, 13 and 9. Betsy was 36.

In retrospect, we may have been able to do more but we had no idea how truly sick she was. You can't imagine going to a doctor's office and confessing you have no insurance. There is an instant reaction. You become a second-class citizen and questions of payment supersede questions of treatment. The fact is, we had no health insurance because I couldn't afford it. Other Americans have insurance that turns out to be inadequate for their needs. Others find the system so complicated and confusing, they don't know which way to turn. Yes, when you find yourself with cancer, you figure out the system, but by that time it is too late.

Numerous studies including one that has come out from the American Cancer Society demonstrate that people who lack insurance delay going to the doctor until they are sick and their outcome is worse for that.

For those that would like to know more about my testimony and my story, you could refer to a book that just came out, "Sick" by Jonathan Kahn.

Mr. Chairman, the American Cancer Society has developed a statement of four essential principles that define meaningful health insurance. They call these the four A's. In its most basic form, meaningful insurance must be adequate, available, affordable and administratively simple. It sounds good to me and I would ask that the American Cancer Society's Statement of Principles be included in your hearing records.

Thank you, Mr. Chairman, and members of the commitment, for this opportunity to speak to you today.

[The prepared statement of Mr. Rotzler follows:]

TESTIMONY OF GARY DONALD ROTZLER

Good morning, Mr. Chairman, and members of the committee. I very much appreciate the opportunity to testify today. My name is Gary Rotzler, and I am a private

citizen speaking on behalf of the American Cancer Society. I am also speaking for the millions of American families who cannot afford, or do not have access to, meaningful health insurance. As a result they have little access to preventive care that prevents sickness and death.

I speak with authority on this matter because that is what happened to my wife Betsy Jane Harvey. She died of breast cancer. Had we had insurance, and had she had timely care and treatment, she might be alive today—we certainly could have given her more time than she had.

I married Betsy in 1978, and I will never regret it.

In 1979, I took a job at Bendix, an aerospace manufacturer and one of the most pressing questions I asked during the interviews was "tell me about your health coverage." It was good coverage.

By 1989, I had been working for the same company for 10 years but times had changed. The economy of upstate New York where I live was undergoing a profound transformation. Manufacturing jobs were being lost. While we were asked to pull together in company functions like "Unity Day," management was secretly negotiating a buy-out. It was one of a long line of buy outs and takeovers that affected a lot of Americans.

The business ended up being owned by a financial company (LPL and later KKR) whose major interest was downsizing. Seeing the handwriting on the wall, I got lucky and took a job with ShopVAC, a commercial vacuum cleaner manufacturer that had been offered financial incentives to open a plant in a nearby town.

A few years later the plant closed down.

Although I found temporary work in construction seven days a week and Betsy was doing daycare, we found ourselves, for the first time, without health insurance. In the meantime, I continued to apply for engineering positions.

It gets cold in upstate New York and in 1994 I began to wonder how we would make it through the winter. Then I received what in retrospect turned out to be good news and bad news. The good news was that my old aerospace company was in the process of qualifying products for the International Space Station and had a temporary job for me. The bad news was that they offered no benefits.

I took the temporary job with the hope of turning it into a full time position so that I might obtain health insurance for my family. In the meantime, I checked into health insurance through the temp agency, but the cost was way beyond our budget. My other coworkers were in a similar situation.

By the summer of 1996 I was still no closer to getting a full time job. By September of that year, Betsy gave me the first indication at what we might have in front of us. I knew it wasn't good, that she was in danger.

She had always been incredibly strong and energetic—it was her dynamic energy that kept the five of us together. She began to lose energy, feel fatigued, and complain of a chronic pain in her back. She didn't want to go to the doctor because she said it was too expensive. We needed to save our money for what we thought were real medical emergencies—like my daughter Amanda's leg injury the year before, which ended up costing $600. Neither of us realized how dire Betsy's medical situation really was.

She had gone two years without a medical exam and was living with her pain—hiding it from us really. But finally it got so bad she leveled with me. We took her to a free clinic, where the doctor examined her for just a few minutes, and delivered the news—she probably had breast cancer.

We took her for an MRI at the local hospital where her cancer was confirmed.

Once it was clear how sick she really was, we were able to get her into Memorial Sloan Kettering Cancer Center, but it was too late. Betsy passed away in my arms four day later leaving me and our three children aged 17, 13, and 9.

In retrospect, we may have been able to do more for her—but we had no idea how truly sick she was. And you can't imagine what it is like going into a doctor's office and confessing that you have no insurance. There is an instant reaction—you become a second class citizen—questions of payment supersede questions of treatment.

The fact is, we had no health insurance because I could not afford it. Other Americans have insurance that turns out to be inadequate to their needs. Others find the system so impenetrable and confusing that they don't know where to turn.

Yes, when you find out you have cancer, you figure out the system. But by then it's often too late.

Numerous studies, including ones that have come out of the American Cancer Society, demonstrate that people who lack insurance delay going to the doctor until they are sick and then they have worse outcomes.

Mr. Chairman, the American Cancer Society has developed a statement of four essential principals that define meaningful health insurance. They call these "the four A's." In its most basic form, meaningful insurance must be adequate, available,

affordable, and administratively simply. It sounds right to me, and I would ask that the American Cancer Society's Statement of Principles be included in your hearing record.

Thank you, Mr. Chairman and members of the committee for the opportunity to speak to you today.

Mr. PALLONE. Thank you, Mr. Rotzler. Without objection, we will put that document into the record, but I just want to thank you for coming here and telling us personally your account with your wife, and it had to be very difficult but it is really helpful to us, and that is why it is important you be here. Thank you.

Mr. PALLONE. Mr. Montville.

STATEMENT OF TONY MONTVILLE, PRESIDENT AND CEO, HEALTHTEK SOLUTIONS, INC.

Mr. MONTVILLE. Chairman Pallone, Ranking Member Deal and members of the Health Subcommittee, thank you for the opportunity to be here with you today. I am Tony Montville, founder and CEO of Healthtek Solutions. For the past 18 years my company has provided IT software and consulting services to hospitals in the United States and Canada. I am also here on behalf of the U.S. Chamber of Commerce. I am an active member of the Small Business Council.

I have had a unique perspective watching the evolution of our health care industry over the last two decades. The majority of our work has been on business office systems and hospitals. That means every time there were regulatory changes that impacted patient information, we were the company that was called in to modify the hospital systems to comply.

I am also a small business owner and have to deal with the same trials and tribulations that all small business owners deal with which include offering my highly skilled employees health care benefits in order to retain their talents. To that end, I made it my goal to offer health insurance to my employees and pay 100 percent of their premiums. Unlike many companies my size, I have a geographically diverse workforce with employees living and traveling all over the country. I need to have a health plan with a national network of physicians and reasonable out-of-network fee schedule. Because I have fewer than 50 employees, there are only eight companies currently offering a national plan that meets my needs and only three that will underwrite a policy for my company because less than 50 percent of my employees reside in Virginia.

Several years ago I was taught a very hard lesson about the business of insurance. About 2 months after renewing my health insurance policy, one of my employees, a 24-year-old human resources assistant, was diagnosed with a very curable form of cancer. Within 1 month of that diagnosis, my insurance was canceled without notification for clerical issues and within a few weeks my employees started to get claims denied, saying we no longer had insurance. When I contacted my insurance carrier, I was informed that they had every right to cancel my policy and they had no intention of reinstating it, however, they would be more than happy to write a new policy with significantly higher premiums. I had to scramble at the 11th hour to avoid problems with preexisting conditions for my employees and selected the most cost-effective com-

petitor. Even with a new carrier, my premium was doubled. The following plan year, my HR assistant left Healthtek, and when my insurance came up for renewal, my rate dropped back down by 35 percent.

I have since migrated to a plan with a high deductible pairing with the option of choosing a health reimbursement account or health savings account. Most of my employees chose the HRA option, which I fund at 75 percent of their deductible. By offering this type of plan, we can put some accountability for health care spending habits in the hands of my employees and have them become more cognizant of how they spend their health care dollars. This plan sponsors a wellness program that focuses on prevention and lifestyle. The spotlight on prevention includes ensuring my employees get annual physicals that include blood pressure, cholesterol, mammogram and prostate screening among other necessary routine care. The focus on lifestyle offers employees perks and recognition for hitting various levels of participation and goals. I would designate a wellness coach, who communicates the success of my employees. We share who is taking a karate class, yoga, Pilates, walking their dog after work or trying to quit smoking. I am encouraged by the efforts and changes that my employees are making and I believe that prevention and wellness is a vital factor in long-term cost reduction in health care.

A small business should not be penalized for its lack of size or diversity of its workforce. We want to offer affordable, dependable health insurance to our employees and the type of flexibility that will keep us competitive in our respective marketplaces. To ensure this, we call upon Congress to help. Congress should examine legislative proposals that can help drive down costs and increase flexibility and employer options in our health system such as promoting widespread adoption of health information technology and by reforming our medical liability system.

I have also been a longtime supporter of small business health plans. This type of national plan would be beneficial to my employees who live and work all over the country. I am also supportive of legislation that would amend the Tax Code to allow small businesses to set up simple cafeteria plans and flexible spending accounts for their employees.

Lastly, I encourage Congress to take note of the success that many employers and employees are experiencing by changing our focus from a sick care system to a health care system through preventative care. The Chamber shares my dedication to prevention, wellness and overall health management and believes, like I do, that this is the only way we will see true savings in our health system. Proposals that would offer tax credits to employers who provide comprehensive wellness programs for their employees would be a great help in promoting these efforts.

Thank you for the opportunity to join you today. I look forward to working with you to find health care solutions and I am happy to answer any of your questions.

[The prepared statement of Mr. Montville follows:]

Statement on
Small Business Health Care Struggles
Hearing before the

House Committee on Energy and Commerce
Health Subcommittee

on behalf of the

U.S. CHAMBER OF COMMERCE

By
Tony Montville, HealthTek Solutions
April 25, 2007

Chairman Pallone, Ranking Member Deal, and members of the Health subcommittee, thank you for the opportunity to be here with you today. I am Tony Montville, founder and Chief Executive Officer of HealthTek Solutions. For the past 18 years, my company has provided IT Software and Consulting services to hospitals in the United States and Canada. I am also here on behalf of the U.S. Chamber of Commerce, where I am an active member of the Small Business Council. The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region. Over ninety-six percent of the Chamber's members are small businesses with fewer than 100 employees. I am pleased to be able to submit the following testimony for the record and commend the Energy and Commerce Committee for holding this hearing.

When I started my business in 1989, I had a belief that being successful in business boiled down to one simple philosophy: If at all times you do the right thing for the right reason, you will achieve whatever goals you set. I chose to build a service business to be able to help others achieve their goals and to that end I feel I've been very successful. I've celebrated having a strong reputation and very loyal customers.

I have a unique perspective watching the evolution of our healthcare industry over the last two decades. HealthTek started working exclusively on business office systems in hospitals. That means every time there were regulatory changes that impacted patient information, we were the company that was called in to modify the hospital's systems to comply. Anything related to insurance reporting and reimbursements, medical record keeping, patient communication, or confidentiality was ours to fit into the existing Hospital IT infrastructure. Today we've grown to a 10 million dollar consulting firm and software developer that has expanded to include clinical informatics, medication management, HIPAA compliance, and patient safety consulting.

I am also a small business owner and have to deal with the same trials and tribulations that all small business owners deal with. We all have human resource issues, financial challenges, competition, changing markets and employee benefits. We are always spread too thin and rarely have a huge safety net beneath us.

Being in the consulting business, I employ highly trained and highly specialized people. Several of my employees are CFOs, CIOs, nurses, pharmacists, certified lab and radiology technicians who chose to continue their career in consulting. These individuals are highly sought after and my organization must have a very strong compensation and benefit structure to attract and retain the top talent. To that end, I have made it my goal to offer health insurance to my employees and pay 100% of their premiums.

By far, the biggest challenge I've dealt with has been providing affordable and comprehensive healthcare to my employees that is as flexible and comparable to the larger firms that I compete with. Unlike many companies my size, I have the added complexity of a demographically and geographically diverse workforce. My employees live and travel all over the country. I have an employee living in Chicago that works every week in Miami, another who lives in Iowa working in Alabama, and one in St. Louis working in Los Angeles. I need to have a national plan with the flexibility of having a large, national network of physicians and a reasonable out of network fee schedule. Because I have fewer than 50 employees, there are only 8 companies offering a national plan that meets my needs, and only 3 will underwrite a policy for my company because I have less than 50% of my employees residing in Virginia. All 8 are expensive, and to make matters worse, the average age of my workforce is 41 years old.

Several years ago I was taught a very hard lesson about the business of insurance that I will never forget. Over the years, I had seen normal and reasonable increases in my insurance premiums as I expanded my business and my staff. I was loyal to one carrier and had renewed my insurance for, I believe, the eighth year in a row. About two months after renewing the policy, one of my employees, a 24-year-old human resources assistant, was diagnosed with a very curable form of cancer. Within one month of that diagnosis, my insurance was cancelled for a supposed missed premium payment, without notice or warning. It was brought to my attention when, several weeks later, my employees started to get claims denied saying we no longer had insurance. When I contacted my carrier, I was informed that they had every right to cancel my policy and had no intention of reinstating it; however they would be more than happy to write a new policy with significantly higher premiums. I turned to the few other carriers that offered the kind of plan I needed and chose the most cost effective one. I had to scramble at the eleventh hour to avoid problems with preexisting conditions for my employees based on a gap in coverage that I didn't even know existed. Before this crisis, I was paying $12,000 per month to provide insurance to my 34 employees and their families. It immediately jumped to over $23,000 per month. Yes, nearly a 100 percent increase. During the following plan year, my HR assistant was cured of her cancer and decided to have a family. She left HealthTek in 2003 and when my insurance came up for renewal, my rates dropped back down by 35 percent and put me at a level comparable with what I should have expected all along. In the subsequent two years, I was faced with premium rate increases of 13 and 31 percent, which was the same for competing plans.

Since then I have tried several things to keep the level of benefits as high as I can while maintaining some level of affordability. In 2005 I was presented with an alternative to our traditional insurance plan: a plan with a high deductible paired with the option of a

Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA). Most of my employees chose the HRA option which I fund at 75% of their deductible. By offering this type of plan, we could put some accountability for healthcare spending habits in the hands of my employees and have them become more cognizant of how they spend their healthcare dollars. We invested a great deal of time educating them on how to use the plan and the consequences of inappropriate use of emergency rooms and ambulatory centers. Unfortunately, during the first year on the new plan, spending habits didn't change much and we were faced with a 20 percent rate increase. Our insurance carrier sponsors a wellness program and provides a discount for participation, so last year I encouraged everyone to participate. Spending habits began to improve, but their wellness participation did not.

This year I have strongly urged and encouraged the participation in our wellness program. The plan is divided into two distinct sections: prevention and lifestyle. The focus on prevention includes ensuring my employees get annual physicals that include blood pressure, cholesterol, mammogram, and prostate screening, among other necessary routine care. The focus on lifestyle offers employees perks and recognition for hitting various levels of participation and goals. I have a designated wellness coach who communicates the successes of my employees. We share who is taking a karate class, yoga, Pilates, walking their dog after work, or trying to quit smoking. The peer-to-peer involvement is catching on and employees are encouraging their colleagues to participate—and it is spreading. I have also informed my employees that the incentives to participate will continue to increase. I am encouraged by the efforts and changes that my employees are making and I believe that prevention and wellness is a vital factor in long term cost reduction in health care. While the transition to the high deductible health plan has had its share of headaches, I am staying with the plan.

Looking to the future, I hope to see a time where other small business owners and I will have more options to choose from when purchasing health insurance and the free enterprise system ensuring that affordable health care is available to everyone. A small business should not be penalized for its lack of size or its diversity of workforce. Every small business owner I know shares this sentiment. We want to offer affordable, dependable health insurance to our employees and the type of flexibility that will keep us competitive in our respective marketplaces. To ensure this, we call upon Congress to help.

Small businesses are the engine that drives our nation's economy and must be a top priority for lawmakers. An overwhelming majority of firms in this country are businesses that employ less than 20 people; and 80 percent of new jobs are created by these small businesses. Many businesses want to offer health insurance, not only because it is good practice that helps them compete for good workers, but because it is the right thing to do. Congress can, and should, consider legislation that can help small business owners like me.

For years, the Chamber and I have pushed for legislation that would provide relief to small businesses through Association Health Plans (or Small Business Health Plans).

Small Business Health Plans allow trade and professional associations to provide cost effective and accessible health insurance across state lines to their membership. This type of national plan would be beneficial to my employees who live and work all over the country. Small business health plans also greatly reduce administrative expenses that needlessly inflate the already burgeoning cost of health care. These plans would also spread risk among a much larger group, thus strengthening negotiating power with plans and providers.

Another proposal with merit would create a national market for health insurance that would allow employers and individuals to buy an insurance product from a state other than their own, which would help with unnecessary state regulation. Congress should examine legislative proposals that can help drive down costs in our health system, such as promoting the widespread adoption of health information technology and by reforming our medical liability system. Also needed in our health care system are improvements to Medicare and Medicaid reimbursements that place greater emphasis on incentives for quality and outcomes.

I am also encouraged by proposals that would provide tax credits to small businesses to help provide insurance, and that would allow a level playing field for individuals and the self-employed by giving them deductibility of health insurance premiums. Congress can also take a look at improving Health Savings Accounts, to which 4 million Americans have already subscribed. Giving more flexibility to funding and using these accounts will make the products, which are an affordable alternative to traditional PPO plans, more attractive to employers and employees. I am also supportive of legislation that would amend the Internal Revenue Code to allow small businesses to set up simple cafeteria plans to provide nontaxable employee benefits to their employees, to make changes in the requirements for cafeteria plans, flexible spending accounts, and benefits provided under such plans or accounts.

Lastly, I encourage Congress to take note of the success that many employers and employees are experiencing by changing our focus from "sick care" to true "health care" through preventative health care. The Chamber shares my dedication to prevention, wellness, and overall health management and believes, like I do, that this is the only way we will see true savings in our health system. Proposals that would offer tax credits to employers who provide comprehensive wellness programs for their employees would be a great help in promoting these efforts. Toward that end, the Chamber is leading efforts to encourage maximum business participation in wellness programs that enhance healthy lifestyles of employees and their dependents. The Chamber, in collaboration with the organization Partnership for Prevention, will soon release an employer-specific best practices guide designed to enhance the effectiveness of wellness programs.

Thank you for the opportunity to join you today. As a small business owner, I look to you to continue to protect small business' ability to be competitive and to create jobs by solving one of our biggest challenges. Fixing our nation's health care system is no easy task, but I hope it is one you will carefully deliberate and constructively approach in this Congress.

Mr. PALLONE. Thank you.
Ms. Colburn.

STATEMENT OF SUSAN COLBURN, VICE PRESIDENT, BENEFITS, AT&T SERVICES, INC.

Ms. COLBURN. Mr. Chairman and members of the subcommittee, AT&T is pleased to have this opportunity to discuss the state of health care today and why every American needs health care coverage.

First, I need to start and say that AT&T would like to thank Chairman Dingell for his leadership in this area. We applaud the fact that he has introduced health care legislation every session since he became a Member of Congress in 1955 and for his efforts to reduce the cost burden of health care in America.

Today there is a lot of debate about what to do. AT&T believes every person in America should have access to quality, affordable health insurance coverage. We also believe business, government, individuals must work together and share responsibility in this endeavor.

I would like to discuss with the subcommittee what AT&T is facing as a company and with regard to health care some of the actions we have taken to address this growing concern.

AT&T is one of the largest private healthcare providers in the Nation. We cover more than 1.2 million lives. We spend more than $5.5 billion annually. This includes over 175,000 union members, about 125,000 management employees, over 300,000 retirees and the dependents of all of those groups.

AT&T has continued to provide its employees and retirees with affordable health care coverage at a time when many companies are cutting back significantly or eliminating coverage entirely. We are very proud of the fact that AT&T continues to provide these benefits to our employees and retirees and their dependents. We view employer-provided medical benefits a competitive differentiator and an important tool in building a quality workforce but the financial commitment is large and it is getting larger.

While it is our desire to continue providing these benefits to our employees and retirees, we find ourselves in an industry where competitive pressures may threaten our ability to do that. Our competitors typically do not provide this same comprehensive benefits coverage that is almost entirely subsidized by their employer to their active employees and even less likely to provide health care coverage to their retirees. This puts AT&T at a distinct cost disadvantage at a time where speed and efficiency is critical to the Nation's broadband development.

At the same time, we face the realities of the global marketplace. We compete with firms from around the world which do not have the same health care costs and health care costs are one of the factors which affect a company's decision regarding location of its employees.

Given this backdrop, the natural question is, what can be done to address these problems. AT&T has worked diligently to control its own health care costs but we believe no single employer can solve the problem on its own. It will take a concerted effort on be-

half of employers, individuals and the health care industry to tackle these very difficult issues.

Employers should provide tools and education to employees in order for them to properly utilize their plan. Employers need to stress the importance of wellness to the participants in their health care plans. Regular physicals and screenings should be a part of every health care plan in order for individuals to detect issues before they become problematic.

It is critical that accurate quality and cost data be available to consumers so that they are able to make informed decisions, and to that end, AT&T was an early supporter of Secretary Leavitt's Four Cornerstones of Value-Driven Health Care, which include a call for transparency of provider data including cost and quality data. Another cornerstone addresses increasing the use of technology in the health care sector. AT&T believes the use of technology is absolutely critical in order to introduce more efficiency into an inefficient and fragmented health care industry. AT&T is in direct discussions with our service providers on how technology can be better utilized by their contracted physicians and facilities.

Finally, as plan sponsors, we should incorporate efficient and effective design and concept into our plans in an attempt to mitigate costs. But one of the other key components of this equation is the individual patient. The time is critical for individuals to be responsible for their own health. This responsibility includes lifestyle changes that improves their health such as engaging in weight management and smoking cessation programs and following treatment protocols prescribed by their physician, particularly adherence to drug therapies.

Another issue is the uninsured. Large numbers of uninsured increase the cost of coverage for the population that actually provides insurance. The cost of caring for the uninsured, particularly by hospitals, is partially subsidized by providers adding their unreimbursed costs to the price they charge patients with insurance. This cost shift is a problem for companies like AT&T that are trying to do right by their employees. In addition, as you know, the lack of insurance directly affects the type and amount of health care services the uninsured receive.

In terms of the health care industry, it must step up and adopt technology that improves efficiency in operations at a faster rate than they are today. In addition, the industry can do more in the way of reporting both quality and cost data for individuals to make informed decisions.

Regarding the Government, it must continue to support employer-based systems by not eroding the protections provided under ERISA. Having a common set of rules for a national employer like ourselves to follow increases the efficient provision of health care coverage across the Nation.

Mr. PALLONE. Ms. Colburn, you are over a minute so if you could summarize.

Ms. COLBURN. Certainly. To summarize then, any legislation should proceed only after assessment of the effects of reform on numerous considerations and these have to include the effect on quality, efficiency and cost of health care, preservation of patient choice, reduction and elimination of systemic costs driven by health

care, nondiscriminatory impact on American corporations, and the elimination of the drag on global competitiveness.

Thank you for the opportunity to speak today.

[The prepared statement of Ms. Colburn follows:]

Statement of Susan M. Colburn
Vice President of Benefits
AT&T
Before the House Energy & Commerce Subcommittee on Health

April 25, 2007

Mr. Chairman, Chairman Dingell and members of the subcommittee, I am Sue Colburn, Vice President for Benefits at AT&T. We are pleased to have this opportunity to discuss the state of health care today and why every American needs health care coverage.

AT&T would like to thank Chairman Dingell for his leadership in this area. We applaud the fact that he has introduced health care legislation every session since he became a member of Congress in 1955 and for his efforts to reduce the cost burden of health care in America.

Today, there is a lot of debate about what to do. AT&T believes every person in America should have access to quality, affordable health insurance coverage. We also believe businesses, governments and individuals must work together and share responsibility in this endeavor.

I would like to discuss with the subcommittee what AT&T is facing as a company with regard to health care and some of the actions we have taken to address this growing concern.

AT&T is one of the largest private health care providers in the nation, covering more than 1.2 million people and spending more than $5.5 billion annually. This includes over 175,000 collectively bargained employees and about 125,000 management employees and their dependents. It also includes just over 300,000 retirees and their dependents.

AT&T has continued to provide its employees and retirees with affordable health care coverage at a time when many companies are cutting back significantly or eliminating coverage entirely. Currently, only one third of large employers provide health care coverage to their retirees and that number is shrinking every year.

We are very proud of the fact that AT&T continues to provide these benefits to our employees, retirees and their dependents. We view employer-provided medical benefits as a competitive differentiator and an important tool in building a quality workforce. But the financial commitment is large and getting larger. Total health care spending has increased over 20 percent for our retiree population since 2001. Our per capita annual health care cost increase reached 12 percent in 2004, despite many efforts to contain cost inefficiencies. Recently this trend has declined slightly, due in part to general market trends and also because of plan design changes put in place in 2006 for our managers and some of our management retirees.

While it is our desire to continue providing these benefits to our employees and retirees, we find ourselves in an industry where competitive pressures may threaten our ability to do that. Our competitors typically do not provide this same comprehensive benefits coverage that is almost entirely subsidized by the employer to their active employees and are even less likely to provide health care coverage to their retirees. This puts AT&T at a distinct cost disadvantage at a time where speed and efficiency is critical to the nation's broadband deployment. In addition, we find ourselves covering the working dependents of our employees and retirees because either the dependent's employer does not provide coverage as attractive as ours, or doesn't provide coverage at all.

At the same time, we face the realities of the global marketplace. We compete with firms from around the world which do not have the same health care costs. And health care costs are one of the factors which affect a company's decision regarding location of employees.

Given this backdrop, the natural question is, what can be done to address these problems?

AT&T has worked diligently to control its own health care costs, but we believe no single employer can solve this problem on its own. We believe the problems facing the country's health care system cannot be addressed by employers alone. It will take a concerted effort on behalf of employers, individuals, the health care industry and the government to tackle these very difficult issues.

Employers should provide the tools and education to employees in order for them to properly utilize their plan. Further, employers need to stress the importance of wellness to the participants in their health plans. Regular physicals and screenings should be a part of every health care plan in order for individuals to detect issues before they become problematic.

It is critical that accurate quality and cost data be available to consumers so that they are able to make informed decisions. To that end, AT&T was an early supporter of Secretary Leavitt's "4 Cornerstones of Value Driven Health Care", which includes a call for transparency of provider data, including cost and quality data.

Another "Cornerstone" addresses increasing the use of technology in the health care sector. AT&T believes this is absolutely critical in introducing efficiency into an inefficient and fragmented health care industry. AT&T is in direct discussions with our service providers on how technology can be better utilized by their contracted physicians and facilities.

We believe having portable, secure personal health records is extremely important for the individual to truly control their health care destiny. Shortly, we will announce our financial and operational participation with a number of other employers, on the development and introduction of a utility that will do just that.

Also, we have been working in conjunction with the Communications Workers of America, in the analysis of gaps in health care delivery and its potential impact on our employees. We are currently developing a communication campaign to alert employees of these gaps, and provide them specific guidance on what they can do to correct those gaps.

We believe the problems facing the country's health care system cannot be addressed by employers alone. Instead it will take the support of employers, individuals, the health care industry and the government to tackle these very difficult issues.

As plan sponsors, we should incorporate efficient and effective design and concepts into these plans such as account based plans and high performance networks to attempt to mitigate costs.

But one of the other key components in this equation is the individual patient. The time is critical for individuals to be responsible for their own health. This responsibility includes lifestyle changes that improves their health such as engaging in weight management and smoking cessation programs and following treatment protocols prescribed by their physician, particularly adherence to drug therapies.

Another issue is the uninsured. Large numbers of uninsured increase the cost of coverage for the population that has insurance. The cost of caring for the uninsured, particularly by hospitals, is partially subsidized by providers' adding their un-reimbursed costs to the prices they charge patients with insurance. This cost shift is a problem for companies like AT&T that are trying to do the right thing by their employees. In addition, the lack of insurance directly affects the type and amount of health care services the uninsured receive. The uninsured do not always receive needed care.

In addition, the health care industry must step up and adopt technology that improves efficiency in operations at a faster rate than they are today. While the U.S. health care industry is known worldwide as the leader in development and deployment of medical technology, it is woefully slow in accepting and deploying technology as an aid to efficiency and accuracy.

The industry can do much more in the way of reporting both quality and cost data for individuals to make informed decisions. The development of accurate and fair criteria with which to measure efficiency and quality is in its infancy and will evolve, but progress is being made. Once developed, the industry should embrace and foster reporting by physicians and hospitals in order to quickly release the information.

It is critical, that government support the employer based system by not eroding the protections provided under ERISA. Having a common set of rules to follow increases the efficient provision of health care coverage across the nation and is critical in ensuring continued employer involvement. State regulation will undermine national employers' efforts to provide quality coverage .

In addition, supporting the efforts currently underway by Medicare in collecting and publishing cost and quality health care data is extremely important in aiding individuals in navigating a complex system.

Pricing transparency in the medical services industry should be supported by the government. Today, certain pricing within the health care industry is unclear and disguises the true cost of the service. This is especially true in the prescription drug area. Government should support efforts to remove any pricing strategy where the consumer cannot ascertain the true value of the service at the time of purchase.

Finally, the government should continue to support employer flexibility in providing health care coverage. While certain coverage minimums can improve coverage for individuals, broad, all encompassing mandates inhibit employers from either entering the market or continuing to provide coverage. We must be careful of unintended consequences.

Any legislation should proceed only after assessment of the effects of reform on numerous considerations, including but not limited to:

- the effect on quality, efficiency, and cost of health care;
- preservation of patient choice;
- reduction or elimination of systemic costs driven by the health care needs of today's uninsured;
- nondiscriminatory impact among American corporations; and
- elimination of the drag on global competitiveness of American corporations given the existing employer-provided health-care system.

In summary, the U.S. spends more per capita on health care than other developed countries, yet our outcomes are not materially better, and are, at times, worse. We have an unacceptably large number of uninsured for a country with the means and wherewithal to do better. The health care industry is inefficient and is in need of reform.

Individuals must realize they have a stake in their health and in the health care system, the health care industry must face its deficiencies and address them head on, employers need to be the catalyst for change and government should support moving the system forward for the betterment of its citizens and in the interest of keeping American business competitive.

Thank you for this opportunity to speak with you today.

Mr. PALLONE. Thank you. That concludes our statements by the witnesses, and I am just going to recognize myself for 5 minutes to ask some questions.

I wanted to start out with Senator Daschle, and I know you have addressed why to some extent why you think that the crisis of the uninsured really is a crisis and why it impacts us, but I know that every time we do polling we see that people care more about health climate change and the crisis in health care than any issue, but if you could tell us why having so many uninsured really is a threat to our country, and I know there are a lot of competing ideas about what to do about it but what specifically do you think we should do about it?

Mr. DASCHLE. Well, Mr. Chairman, I think that is such a good question and I would just give three parts to the answer. I think you just heard from one of our witnesses whose wife had an extraordinary demonstration for all of us as to what happens when we don't have insurance, the tragedies that are multiplied by the millions around the country. That in and of itself is one huge reason why I think we as a country need to be concerned. The lack of productivity that is resulting from it in addition to the tragedy is something we certainly need to recognize. The second part of it is that, as I said earlier, the cost shifting that occurs is really something we need to be very concerned about. You look at all costs in health care in my view as balloon and there are three components. There are taxes, out-of-pocket expenses and premiums. We can squeeze down the premiums by providing more tax credits but somebody is going to pay for that balloon. That $2 trillion is still going to be paid for. The cost shifting we are told by many studies that have been put out now is about $900 of the $6,700 per person that we pay. So we are all paying more as a result of the cost shifting that goes on. Finally, I think it is just the humanitarian thing to do. We are the only industrialized society that doesn't have health care and I can't imagine what we want to say about society, what we want to say about our children and grandchildren in the future if we say that somehow we are willing to accept the reality that 45 million today, perhaps 55 million in 20 years, won't have insurance, not to mention all the underinsured besides.

Mr. PALLONE. Thanks. I appreciate that.

President McEntee, I wanted to ask you about the employer-sponsored system, a couple questions. If employers that you negotiate with were to drop the health coverage they provide, what kind of alternatives would the employees have? Is it really possible for them to go out in the individual market? That is No. 1. And second, I know you have seen workers laid off and as a result losing their health coverage, what do you think about the employer-sponsored system? I know we talked about public systems versus employer-sponsored. Obviously you still think that the employer-sponsored system is critical.

Mr. MCENTEE. Yes, we do. We think that an employer mandated part of this system is critical to us. Our people, we have 1,400,000 members and I would say that a good guess would be that they are all public workers or at least 95 percent, they average probably about $25,000 to $30,000 a year in terms of salary. If they would

lose their health care coverage, have to go through the individual market, which is much more expensive than group coverage, these individuals themselves would actually be denied coverage in the individual market for minor health issues and it wouldn't be affordable to them in the private market to get health care coverage. That is why we believe that an employer pool is mandated in this particular case. Our people just couldn't afford it. There is no question about that, and we have had the opportunity to see this because we have thousands and thousands and thousands of people in the population who are childcare workers and home health care workers who have no health care through the employer. We are trying to negotiate it for them as we organize these workers. But what they end up is through the private sector and through the private system with no health care at all, and as a result——

Mr. PALLONE. I wanted to ask in the same vein because my time is running out, what about what the President has proposed in this regard? He is talking about a tax on employer coverage and that would help people if they want to go in the individual market. Do you want to comment on that in the context of this?

Mr. MCENTEE. Well, we just think that it is misdirected, that it would encourage employers to drop their health plans when over time in the beginning some but then over time probably all and that they would drop their health plans because they lose this tax rebate that they now receive and that the President would take away. It would force in our judgment our people we represent, workers in general, to pay more for what in fact would be skimpier coverage in the individual market. It would not help low-income families who already have little or no tax liability. The tax benefit for them will not pay for health care insurance policy at all.

Mr. PALLONE. Thank you. I appreciate it.

I recognize Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

I am going to ask questions that hopefully we can get everybody to respond to. The first question is, we have heard reference to the Tax Code treating people fairly. Is there anybody on the panel that would be opposed to the concept that the Tax Code should treat everybody fairly when it comes to paying for the cost of health care whether it be a small business versus large business, individual, et cetera? Should we equalize or at least try to equalize as much as possible the Tax Code treatment of the cost of health care? Anybody disagree with that proposition? I see no response.

If we have public programs such as Medicare, Medicaid, SCHIP, should we allow a portion of those benefits if the individual chooses to do so or the State, as it may be, should we allow them to use a portion of those benefits to buy into an existing employer-offered health policy if the individual has that option? Would anybody agree that we should not afford that option in these programs? I don't see anybody. Yes, Ms. Turner.

Ms. TURNER. I believe that is a very good idea so I think if the question is a yes or no, that yes, we do agree.

Mr. DEAL. OK. I think everybody seems to agree to that. It is getting a little tougher as we go down my list. Does anybody disagree with the proposition that small businesses ought to be treated the same as large businesses in particular as it comes to the as-

sociation health plans to allow them to pool together to be able to purchase at a lower rate by pooling their people together? Does anybody oppose those, and if so, why.

Mr. DASCHLE. I want to address both of your last two questions, if I could for just a second.

Mr. DEAL. OK.

Mr. DASCHLE. First of all, on the SCHIP question, I think obviously we want to provide as much flexibility as possible to those who are in need of insurance. I worry a lot about the inefficiency and the complications that would come from something like that. Vouchers sometimes work, sometimes don't. I don't know that I have seen any record with regard to vouchers where we have seen that they have worked all that well, but that would be the one concern I have is whether we further complicate it. Obviously we don't have enough money right now to provide SCHIP funding for the universe of children that are in need of it. We are about 9 million children short today and we are still struggling with how we are going to find ways to provide the funding for SCHIP. Under the current circumstances, I think this would probably add to the complications.

Mr. DEAL. But we know, Senator, that many of those SCHIP children, their parents work for companies that do provide health insurance benefits, they just do not participate sometimes because they don't feel they can afford the extra premium. I think we would have to have a standard, in other words, it would have to meet the same equivalent as good or better than the SCHIP program that the State offers, otherwise they wouldn't choose that option anyway. I guess that was my point.

Mr. DASCHLE. With regard to the associated health plans, as long as they aren't allowed to get out from under the ERISA needs that are there across the country. That has always been the issue is, there are real serious problems as the attorneys general have all noted that we would have to address with regard to ensuring that the benefits and the viability of the associated health plan can be maintained. Oftentimes they can't because they get out from under ERISA requirements which as our witness from AT&T noted is really one of the most problematic parts of dealing with the associated health plans as they are currently proposed.

Mr. DEAL. Let me go to another area.

Mr. MCENTEE. Could I make a comment on those AHPs? We are willing to look at it. We are all here willing I think to look at everything because the problem is so dire. But at least preliminarily in what we have looked at, that there is a possibility that with these small business flexibilities that you would give, it could possibly override the regulations in terms of States that presently give better benefits and may end up costing the small businesses more and may end up giving less benefit to the worker, but we are willing to look at anything and everything——

Mr. DEAL. Well, I think you should since none of your members apparently are going to be affected by it, and ERISA does override those small restraints already.

Mr. MCENTEE. Of course, ERISA is a problem for every State in terms of trying to put into effect their own particular State benefit and plan.

Mr. DEAL. Unfortunately, my time is out.

Mr. PALLONE. Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. Thank you to all the witnesses. I could just keep listening and listening and listening.

Senator Daschle, thank you for trying to separate fact from fiction with the myths in our system. I have the privilege of representing one of these islands of excellence, Stanford Medical Center and everything that is attached to it, but I have a community that may be about a mile and a half east of that medical center, East Palo Alto, not Palo Alto but East Palo Alto. It is the poorest community in the area. Most people don't think that there is anything poorer in Silicon Valley. So I agree with what you said.

Mr. Rotzler, thank you for being here today. I think to honor you and all those that you are speaking on behalf of that we really do something meaningful, that we really get something done. All these different moving parts, what I think are the smaller things. I think it would be a big step for the committee to take it, but in the context of health care in our country, we should insure all kids in this country. Imagine the United States of America struggling to come up with something to insure something. They are the cheapest to insure. Whatever the bugs are in the plan that we have now, we should debug it and insure them all. That would be one heck of a down payment and a confidence builder in the American people that we can get something done. Health information technology, Mr. Rogers and I are working on that. I like all those things. I try working on them to make a difference. But I think what we need to examine, and I am fascinated about what is going on in my own State of California. We have a Republican Governor that is trying to negotiate with the legislature really a universal plan where it is mandatory that every Californian be in it and be insured. The Democrats are kind of hedging. They are saying they are doing the same thing but it is really not the same thing. It is a model worth watching. I appreciate, Ms. Colburn, what your company is doing. I don't agree with your telecommunications policies here in the Congress but I salute you for what you are doing with your employees.

Now, what I would like to ask is, because our country's health care insurance has really been employer-based in our country, that has been the nub, that has been the heart of it, now these legacy costs, the costs relative to competition are killing businesses. We hear it, we know it, we experience it in our own communities. Major corporations come in here and tell us that. What can you tell us from AFSCME's point of view? You are talking to major employers.

Senator Daschle, you are a smart man. You have your pulse on the larger things and the movements that are taking place in the country. Is there a possibility in your view that major businesses will come around to universal care? Now, this term scares the hell out of the Republicans but I have to tell you that I think if major corporations came here and said it is time to revise this system, I think that there may be some converts, and if we can speak to at the same time about lowering the costs, you mentioned, Senator Daschle, the three things that balloon, so universal coverage but also with universal coverage comes a reduction in costs. Boy, would

we have a deal. Do you see any glimmer of hope relative to American businesses and what they are experiencing driving this? See, I think that is where the answer is going to come from and that is what is going to put some spine in the Congress, I think, because when businesses come around, it kind of sanctifies things. They drive all of this too. Can you comment on it? Do you have any stories you can share with us or some kind of movement in that arena?

Mr. DASCHLE. A couple of thoughts, first of all, the fact that AT&T is at the table I think is a real exciting development and you are seeing more and more business, whether it is Dupont or GE or so many of the companies that have gotten involved now in coalition building with labor and with other organizations like AARP. I think that is an extremely positive thing and it goes to the point I was making earlier. We have got to have the commitment of business and leadership in business to be able to move this forward. On the flip side, one of the sad things I just experienced a couple months ago was talking to the chairman of a large corporate entity who decided to move to another country because they didn't want to pay the health costs in the United States, and I worry about our global competitiveness if we are not more effective in dealing with cost containment than we have today, and the only way you can truly deal with cost containment is to look at it in a universal context. You can't simply say we are going to take a piece of it and contain that cost because it affects all the other pieces.

Ms. ESHOO. It is like punching a pillow. You put a dent in it and something else pops up.

Mr. DASCHLE. Exactly, and so we really have to look at it in a comprehensive way.

Ms. ESHOO. Thank you.

Mr. MCENTEE. Yes, I would just mention back with that Clinton health care plan, there was a point in time that in discussions with the labor movement and big business in this country, because they were getting hammered then in terms of health care costs and globalization but then it finally didn't work out in part. I know that former leader Gephardt is now holding discussions with big business and big labor, particularly the industrial unions, whether it is the machinists or whether it is steel, whether it is auto, who are genuinely affected by this, as well as their employers to look at some kind of move, some kind of plan. I know they are looking seriously at Medicare for all. I know that. What will come of it, I don't know, but at least it is a try and a step in the right direction.

Mr. PALLONE. Thank you.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you to all the witnesses. I think you have really been outstanding.

Mr. PALLONE. Thank you, Ms. Eshoo.

Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. Since Ms. Eshoo brought up the issue of universal health care, let us just go down the table and ask the question. If our goal is universal health care, Ms. Colburn, should that be an employer mandate, an individual mandate or just back off and let the Government do it all?

Ms. COLBURN. Well, I think what we would say is that we are not really prepared today to say that we are totally locked in on

any one idea nor have we alienated any idea and I think to your point we have got to be open to work with Government, with the unions, with other large business. There has obviously not been the answer that has surfaced——

Mr. BURGESS. So you would like flexibility. All right.

Ms. COLBURN. But we are looking at everything.

Mr. BURGESS. Mr. Montville, the same question. Employer mandate, individual mandate or let the Government do it all?

Mr. MONTVILLE. I am all about options. I am a small businessman and——

Mr. BURGESS. So you like flexibility also?

Mr. MONTVILLE. I really like flexibility, yes.

Mr. BURGESS. Mr. Rotzler, do you have a thought on that?

Mr. ROTZLER. I will defer at this point. I don't have any comment on policy.

Mr. BURGESS. Ms. Turner?

Ms. TURNER. I think we need to get the market working properly and find out how many people would buy health insurance on their own if it were more affordable, more flexible and people had more options than they do now. We need a truly competitive market for insurance. Then I think we can see what do we need to do to get to universal coverage. But I think we need to start first by fixing the market.

Mr. BURGESS. President McEntee?

Mr. MCENTEE. We think it is well worth looking at a combination of all but we think a major pillar has to be an employer mandate but we are willing to look at a combination of all.

Mr. BURGESS. Well, a combination of all would include letting the Government do it all would then be mutually exclusive, but I appreciate your point and so the employer mandate would be part of what you would——

Mr. MCENTEE. Yes, that would be a main pillar of it, of course.

Mr. BURGESS. Mr. Smith?

Mr. SMITH. Sure. We incorporated the private market with Government assistance in terms of making sure that we did get the uninsured insured. We steered away from the individual mandate until 2010 to give our outreach programs a chance to succeed. We found that we have mandated insurance for car insurance in the State of Vermont yet we still have 10 percent of people who are uninsured for car insurance. We wanted to take this other approach first. The product that we offer with the cost we think will be enough so that we don't need an employer mandate as we move forward.

Mr. BURGESS. And Senator Daschle?

Mr. DASCHLE. I believe we ought to have a private system in a public framework. One way to accomplish that is an individual mandate with employer responsibility. We ought to get the employers out of health management but I do believe that the employers have a responsibility to be part of the larger effort to finance our health care system.

Mr. BURGESS. The issue always comes up, if we were going to make the Medicaid system today, say we didn't have it and we were going to start it from scratch, surely we wouldn't design a sys-

tem that requires 2,700 waivers in order to work. Would what you envision be your Federal Reserve Board type of structure?

Mr. DASCHLE. Well, there always is going to be a need for a Federal role just as we have in our banking system. There is a specific role that only government seems to be able to function within our economy and our society and I think that is certainly going to be true in health care in the future. But you are right, I think the Medicaid/Medicare system was primarily a product of compromise all the way through beginning all the way back in 1965. You could design a lot more efficient system. You could design a lot more effective coverage. But nonetheless, I think we are always going to have to have some option for those who can't afford to pay for themselves.

Mr. BURGESS. I need to get back to the Medicare issue but Ms. Turner, I wanted to come back to you and the concept of getting the market more involved and we have actually heard it approached from several ways. Mr. Montville talked about his experience. Mr. Rotzler, I guess I would be interested to know when you found yourself between jobs and without insurance, was there an option in the private market for you to go to and it was simply unaffordable or was there no product available?

Mr. ROTZLER. It was unaffordable at the time, and I was working and figured that it would be a full-time job and had no reason to believe that my family was in any kind of danger.

Mr. BURGESS. It is nowhere near the tragedy you sustained but I had an adult child at that same year and tried to buy an individual policy for her because she was unemployed, and I just simply couldn't find one. No one really wanted to talk to me. I was willing to write a big check but no one was willing to do that. I do like what Mr. Montville talks about, his health reimbursement accounts with the health savings account. I think that would be my vision of a first-class system. I had a medical savings account when I was in medical practice after you guys allowed them in 1997 but fast forward from 1994 to 2004, 2005, and a young person today can go on the Internet and buy, albeit a high-deductible policy but they have got some coverage if the catastrophe strikes. They are going to pay for their routine care sure enough out of pocket because the deductible is so high and for some people that will be a barrier. They won't get their routine care done. But I guess when someone said we have done nothing, that is not exactly true and there are options that were not available there as short as 10 years ago and I know because I did try to buy that policy in 1994 and it just was unavailable to me for an individual purchasing it for an individual.

I have gone over time, Mr. Chairman. I appreciate your indulgence.

Mr. PALLONE. Thank you, Doctor.

Next is the gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I appreciate our panel and their patience.

Senator Daschle, I want to thank you for being here today and your wealth of experience on the subject. Yesterday our Oversight and Investigation Subcommittee heard from a family whose child now needs a kidney transplant as a result of her eating spinach contaminated with *E. coli*. The family indicated they can no longer

pursue any advancement in their careers that would lead to a change in employers because the child's access to health care is dependent on their employer-sponsored health insurance. They fear that a future employer would either not cover the child or they would be faced with unaffordable premiums due to the child's preexisting condition, maybe even for the year period of time that is traditional. Can you speak to that situation that specifically affects how many Americans who want to advance their careers and improve their productivity and are making these kind of decisions and also would a public system free the family from this situation?

Mr. DASCHLE. Well, this is just another example. Dr. Burgess was just talking about one of his own children having lack of access to health insurance because of a preexisting condition. I know of people in South Dakota, Congressman Green, that drive 50 miles in one direction not because they want the job but because they want the health care. It is affecting lifestyle in South Dakota as it is in virtually every State in the country. Health care is becoming one of the largest motivation in seeking employment today because in large measure there are so many people either with preexisting conditions or the inability to afford the health insurance they can buy without a preexisting condition. It shouldn't be that way in a country. How many times are we making decisions on jobs that have nothing to do with the value of the job or the productivity that one might consider in a job more well suited for that individual but is not taking that job simply because they don't have access to health care. So I think your question is a very appropriate one and it is one of the many policy implications here that we have got to address.

Mr. GREEN. Mr. McEntee, we recently had a case in our district of a woman who had a brain aneurysm, and I am not one to pick on certain companies, but she had health insurance through her employer at Wal-Mart and she was originally misclassified as a part-time employee that had a $25,000 cap on the coverage. We were lucky enough, we had Memorial Hospital in Houston who agreed to assist the lady. In hindsight, Wal-Mart found out she was misclassified and she was a full-time employee and had been there for more than a year and so she did have hospital coverage. In my view, we have enough pressure on our charity systems, because that is what Memorial Hospital did to a person who was working full time and individuals with health insurance shouldn't be part of that program. Can you or any of the panelists speak about how many employers may have these limited maximum policies because when you have a brain aneurysm that is $100,000 and you have a $25,000 cap on your insurance?

Mr. MCENTEE. Well, we do have a number of them that have a cap but it is getting tougher and tougher and tougher out there. Our people in the public sector, not all but many, have pretty decent health care plans that they gave up wages, vacation days, sick time in order to get these health care plans. Number on their minds all across this country no matter who the employer is, whether it is the State of Pennsylvania or it is the State of California or whomever, in our negotiations today the first thing that is mentioned is, you have got a halfway decent health care plan but we have to change it, it is too costly, we have to change it and as

a result if we keep it the way it is, there will be no wage increase. Now, once again I said our people average about $25,000 to $30,000 a year. So at every negotiation we go in today, that is the primary topic between the employer and the people that we represent. Every poll that we take, every meeting that we go to, the first thing that is mentioned is how about health care, what is the Congress going to do, what is the Government going to do, what are they going to do about universality, what are they going to do about these co-pays, what are they going to do about these kinds of things. It has been mentioned here, we are the strongest, wealthiest country in the world. We still don't insure all of our kids. And now instead of going in the direction where we are going to have better insurance, we are going in the direction at least as we see it where we are going to have less.

Mr. GREEN. Mr. Chairman, I know my time is out but I want to thank Ms. Colburn from AT&T, and just for the record, I have had the CEOs of a lot of companies sit down with me, and I will quote Shell Oil particularly, because of the high price of natural gas in our country and the high price of health care, they are transferring production to the Netherlands, and North Sea gas is cheaper than what we can get in Texas even for our natural gas but the health care costs, and so following my colleague from California, we have a problem and whether it is a CEO or a blue-collar worker, we know it and we need to deal with it in Congress and hopefully it will be at the suggestion of both sides of the bargaining table that we can deal with it, so thank you.

Mr. PALLONE. Thank you.

The gentle woman from New Mexico.

Mrs. WILSON. Thank you, Mr. Chairman.

Ms. Turner, I had a couple of questions I wanted to direct to you. As I understand it, the current SCHIP program allows States to provide premium assistance for eligible children to purchase employer-provided health care but there hasn't been a lot of participation in this approach. I wonder if you could talk about any impediments that States have encountered in setting up these programs and offer any suggestions about how we might be able to address these impediments.

Ms. TURNER. Thank you, Mrs. Wilson. I do think a lot could be done to allow SCHIP dollars to be used to help people add their children to their employment-based coverage, but right now the rules and regulations make it incredibly cumbersome for States to actually comply with the rules governing this part of SCHIP. We have actually done some research on this, and there are only a few States that have gone through multiple hoops to try to comply. They have to qualify the employer's insurance as consistent with SCHIP insurance. They must continue to regularly monitor the business to see if that employee is still working for that company. It is cumbersome for employers. It is cumbersome for the States and most States just throw up their hands and say that is just too difficult. So I think giving added flexibility to the States, looking at some of the States that have been able to do this and learn from them. We can provide you some additional research on what some of those States. The General Accounting Office recently did a study looking at this particular issue and I do think that added flexibility

could really allow those dollars to be used more efficiently and to allow families to stay together on the same policy by allowing an SCHIP allocation to be used to buy into employer coverage, but the rules and regulations right now are incredibly cumbersome.

Mrs. WILSON. Are there any particular States that have worked out these problems and done well or are there particular barriers in the regulations that you would recommend that we look at when we reauthorize SCHIP?

Ms. TURNER. There are several States. I have not looked at that research recently. I believe Rhode Island is one of them that has actually had some success, maybe Connecticut.

Mrs. WILSON. Without putting you on the spot, perhaps if you could——

Ms. TURNER. I will send you that paper, because there are some States that have said this is important to us, we will do this, and we will provide that information to you, Mrs. Wilson.

Mrs. WILSON. There is a separate issue, and that has to do with health savings accounts and I understand that you were one of the proponents of establishing them and in many cases they are more affordable for people than regular insurance plans. Can you talk about the impact of health savings account on the uninsured and particularly how many enrollees in health savings accounts have been previously uninsured? Is it expanding access?

Ms. TURNER. American's health care plans actually recently released a study looking at all of its members that offer health savings accounts insurance and they found that a quarter of those purchasing insurance, and these are primarily big companies, were previously uninsured and they find that one of the reasons that they are particularly attractive is that the insurance is less expensive. It is a higher deductible policy but it protects people against losing their homes, losing their cars, losing their life savings if they do have a major medical event. So people are buying insurance in sort of the true form and then a surprising number of them also are funding the accounts but I think that the numbers for some of the smaller companies may even be higher. So between a fourth and a third of previously uninsured.

Mrs. WILSON. Do you think that the low-hanging fruit is already gone out there for health savings accounts or is there more potential for them to expand or reduce the number of uninsured?

Ms. TURNER. Absolutely. The Labor Department's figures are showing that four in 10 Americans change jobs every year, I think there is an ever-growing need actually for people to find other options for more affordable health insurance.

Mrs. WILSON. Thank you very much.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. Montville, you talked about moving from an insurance-led health care product to kind of a consumer-led product, HSAs, if you will. You said you saw and witnessed in your company a change in lifestyle. Can you talk about that briefly?

Mr. MONTVILLE. Sure. I chose to fund 75 percent of the HRAs when I switched to a high-deductible plan and I considered funding

100 percent but felt that by there being a level of accountability on the part of my employees, they would be more responsible with their health care dollars, and I had a lady that worked for me that every time her son was sick she would run off to the emergency room, but as soon as she realized that once the funds were depleted in that health reimbursement account, once they were depleted there was money out of her pocket before the plan kicked in, people were a lot more fiscally responsible with the way they were spending their dollars.

Mr. ROGERS. So you saw a change in their behavior because they were responsible for their own administration of health care? Is that correct?

Mr. MONTVILLE. That is correct.

Mr. ROGERS. And so they did turn into more of a preventative consumer, did they not?

Mr. MONTVILLE. Slowly.

Mr. ROGERS. But you did see it?

Mr. MONTVILLE. Yes, I did.

Mr. ROGERS. And as the economics caught up with it, certainly their attitude changed, right?

Mr. MONTVILLE. Very much so.

Mr. ROGERS. Ms. Colburn, you mentioned the foreign competitors. Do you feel the European Union, would that be included in your foreign competitors component when you talked about competing globally?

Ms. COLBURN. European Union. Also, even the emerging domestic telecommunications market. When we talk about competitors it is a whole new ballgame and a lot of those don't offer health care.

Mr. ROGERS. Sure, but let me just give you an example with the French, 75 percent of those bills are paid for by payroll contributions from both employers and employees so that is a pretty heavy tax, isn't it, when you start talking about those kind of numbers? And then the last 25 percent comes from Government, patients and supplemental insurance. That is a pretty expensive health care system that is supposed to be free, isn't it?

Ms. COLBURN. Well, it certainly sounds like it, yes.

Mr. ROGERS. And in some cases, you said that their health care is better, and let me give you another European competitor of yours. In Great Britain, you have to wait more than a year after being diagnosed to begin chemotherapy. The British Government is now spending a small fortune and they are trying to correct this by 2010 to get it down to 3 months. Is that a better health care system than the United States when you are diagnosed with cancer?

Mr. COLBURN. It certainly doesn't sound like it.

Mr. ROGERS. So if you had—God forbid, and I am a cancer survivor so I don't make light of this easily, but would you rather get sick in France or Canada or where they have these waiting periods or would you rather get sick in the United States if you had cancer?

Ms. COLBURN. I would really rather not——

Mr. ROGERS. I guess I say that because I had a very big manufacturer tell me how great the British system was and he was a very senior CEO and I would argue that the AT&T executives are

well compensated, probably in higher tax brackets and rightly so, given your levels of responsibility. Fair to say? This particular manufacturer said this is a great system, and I said oh, really did you like the waiting periods, and he said I didn't go to the waiting periods, I bought my own plan. Do you think it is fair that we shove into this is a government-run system and then have those who have a little more affluence be able to buy out of that system? Is that a good system?

Ms. COLBURN. Well, first of all, we haven't espoused any government-run system. In fact, if anything, where we are today is much more in line with Mr. Montville. We have put in a consumer-directed plan for our management and many of our management——

Mr. ROGERS. That is a very important distinction, so you are not here today saying that the Government ought to run health care?

Ms. COLBURN. I'm really saying that we are looking at everything and we are really very much willing to work with all parties——

Mr. ROGERS. Would you support a government-run health care system?

Ms. COLBURN. We haven't espoused to it but we haven't alienated it.

Mr. ROGERS. That is interesting.

Mr. Montville, when you went through this process of changing, there are a lot of rules and regulations.

Mr. MONTVILLE. Constantly.

Mr. ROGERS. Lots of rules and regulations.

Mr. ROGERS. Some estimates in America are as high as 30 percent of it, maybe even more, almost a third, is rules and regulation compliance, has nothing to do with x-rays or prescriptions or seeing a doctor. In your experience, it was pretty heavy, wasn't it, the rules and regulations that you as a small business had to kind of wade through to get your employees connected to a health care plan?

Mr. MONTVILLE. Yes, it was very extensive.

Mr. ROGERS. And that is expensive, isn't it? You know as a small businessperson that rules and regulations and Government intervention is expensive.

Mr. MONTVILLE. Yes, it is.

Mr. ROGERS. That is interesting. So I find it interesting that the panel today, and I think we all want to get to the same place, but what we are calling for is this huge intervention in a system that I think is pretty expensive because the Government has intervened so heavily already.

Ms. Turner, you talked about HSAs and getting back to that free market. Do you believe that Government rules and regulations and a complicated system and 2,700 waivers under our Government-run health care system that we have because we can't quite get it right is the most efficient way to allow somebody to buy health care in the United States of America?

Ms. TURNER. I think that if consumers had more control over the dollars, they would say this paperwork is nonsense. People are buried in paperwork when they go to the doctor, the hospital. They don't understand it. And it is incredibly expensive for our system. I think a lot of that inefficiency could be wrung out if consumers were to say I am going to buy health insurance from a company

that doesn't burden me with all that paperwork and one of the things that health savings accounts do is allow people to access physicians for routine care with much less of that paperwork. I think about Jiffy Lube, for example. Imagine if our car insurance covered an oil change or having the car lubricated. You wouldn't be able to see through the Jiffy Lube. It would have a huge back shop asking "what is your insurance company?" "Well, you are not due yet for your oil change and what is your co-payment? And here is your insurance and all this paperwork." The oil change would cause two or three times what it does. If we can pay for some of those routine changes for those who can afford it on our own and leave the insurance for the big stuff, I think we could bring a lot of people——

Mr. ROGERS. Isn't the great part of HSAs that first $5,000 in deductible which sometimes the employer matches and sometimes not but there is some match program. That is money that would normally go to the insurance company, wouldn't it?

Ms. TURNER. Absolutely.

Mr. ROGERS. And that is now going into consumers' pockets instead of going to the insurance company, isn't it?

Ms. TURNER. And some employers, it is $1,000 deductible. It is not always a $5,000 deductible. You are absolutely right that that is money that people get to keep to spend on their health care bills rather than sending to the insurance company.

Mr. ROGERS. That is a pretty good bet. If we went after things like defensive medicine and we did health information technology, there is a way, maybe not one solution but isn't there a way that we can line up events that we can do to make health care less complicated and confusing and as one witness said, more affordable, more accessible without losing the quality? Don't you think that if we have the real courage to do this, we have to take all of the individual pots and put them together?

Mr. TURNER. Absolutely, and I am headed to Las Vegas for the Consumer Directed Health Care Congress, and it is astonishing to see the Expo Center, the number of private companies, entrepreneurial people coming up with solutions to make our health sector smarter, faster, better, cheaper by using new technologies and engaging some of those technologies.

Mr. ROGERS. And where we have seen the private sector intervene in health care markets, costs have either stabilized or gone down, have they not? Just a simple yes or no.

Ms. TURNER. Absolutely.

Mr. ROGERS. Last question for Mr. Daschle, if I may, sir. Senator, thank you for your service to your country. We certainly appreciate it. Thanks for still being involved in policy debate. Don't you think we are obligated, given all the things that we are trying to do with health savings accounts, which isn't going to be for everybody and with health IT and defensive medicine and all these artificial costs in the system, before we go and blow that up and go to this centralized Federal Reserve System or whatever you want to call it that has heavy Government regulation and oversight and all those things, don't you think we are obligated to try all of these other things to get people connected to health care first so that we can expand our health care pool?

Mr. DASCHLE. I am so glad you asked that, Congressman Rogers. I think that we have got to leave ideology at the door if we are going to make decisions at all on the left and on the right. I think if you look at the Medicare Program, you can say that we have done a lot with it in the last 30 years, about 4 percent administrative costs versus something like 15 to 20 percent on the private sector. You have got universal access. You have got costs on a per capita basis at a much lower level. So all things considered, I think one can say that there is always going to be a role for Federal programs. There is always going to be a role to cover children and cover those who don't have the means to purchase insurance, those who like Congressman Burgess's son or daughter didn't have the ability because of a preexisting condition. We are going to have to deal with those and that is going to involve public programs. But that isn't to say that public programs alone should be the exclusive way with which we provide care. There ought to be a choice. There ought to be opportunities if they exist and can be provided in an administrative way that ensures universal access and quality. I see no reason why private systems don't have a role as well but they have to be merged together in a way that allows one system rather than the multiplicity of systems we have today.

Mr. ROGERS. But you would——

Mr. PALLONE. We are over, Mr. Rogers.

Mr. ROGERS. But we were just getting warmed up, Mr. Chairman.

Mr. PALLONE. Yes, but we have to move on. Thank you. And let me thank all of you. This was a very good panel and I appreciate your responses.

Mr. BURGESS. Mr. Chairman, if I could just make one last point if I wasn't clear that 25-year-old in 1994 who could not get health insurance in 2004 can go on the Internet to Google and type in health savings account and probably find a high-deductible policy which they can afford, between $55 and $65 a month for a 25-year-old nonsmoker in my home State of Texas. So the landscape has changed and it has changed largely because some of the things you did in 1997 and some of the things we did in 2003 with the Medicare Modernization Act.

Mr. Chairman, I would also like to submit one question in writing to the panel——

Mr. PALLONE. Yes. Well, the members can submit additional questions. I should mention to you that you may get additional questions in writing from the members.

Mr. BURGESS. Several people brought up ERISA and I am just not clear on all of the ways that——

Mr. PALLONE. All right. We have to move on here. You may get questions in writing within the next 10 days from us, and again, thank you so much for participating. This was really worthwhile. Thank you.

I will ask the next panel to come forward, if you will. We are going to be changing the name cards and then you can figure out where to sit.

Let me welcome all of you, and I would like to go left to right here and introduce each of you. We have two New Jersey people here today. First on my left is Reverend Heyward D. Wiggins III,

who is with the PICO National Network from southern New Jersey, and then we have Dr. Robert E. Moffitt, who is director of the Center for Health Policy Studies at the Heritage Foundation, and then our second New Jersey guy is Dr. David Knowlton, president and CEO of the New Jersey Health Care Quality Institute in Trenton, and then Dr. Joseph Antos, who is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, and last is Dr. Jeanne Lambrew, who is associate professor at George Washington University School of Public Health and Health Services here in Washington, DC.

I would ask each of you to give us an opening statement for 5 minutes, and I will start with Reverend Wiggins.

STATEMENT OF REVEREND HEYWARD D. WIGGINS III, PICO NATIONAL NETWORK

Mr. WIGGINS. Thank you, Chairman Pallone. Members of the Energy and Commerce Committee, thank you for inviting me to speak about the moral imperative to provide health coverage to the millions of our Nation who are uninsured, beginning this year with our most precious resource, our children.

I pastor the Camden Bible Tabernacle Church in Camden, New Jersey. It is a city where more then one-third of the families lack health coverage. I worked over the past decade with the Camden Churches Organized for People to revitalize my city. I am proud to be here on behalf of the faith-based PICO National Network. Since 1973 PICO has brought people of faith together to revitalize communities and expand opportunities for families in 150 cities and towns across the country.

A generation ago the faith community led the civil rights movement. Today PICO's more than 1,000 congregations and 1 million families nationwide are a driving force behind the movement to expand health coverage in America beginning with covering all children. For communities of faith, the force behind both movements is the same. God created each of us in his image and we have a sacred responsibility to protect the dignity and well-being of every person.

Two weeks ago the New Jersey State Police airlifted Governor Jon Corzine to Cooper University Hospital in my city of Camden. Cooper is a level-one trauma center that fights as hard to save a young person shot on the streets of Camden as it does to heal a Governor. Like Jesus, our trauma centers open their arms to the poor and the forgotten. The value that our hospitals place on every person's life is sacred whether they be a poor child, a drug dealer, prostitute or a public official. It is a fundamental cornerstone of our society that has deep roots in our religious traditions and the teachings of Moses, Jesus and Mohammed. None of us in this room would wish to live in a nation that did not value every person as a child of God.

Yet when it comes to the uninsured, we have lost our moral compass. We have deceived ourselves that a slow death is no death. The National Academy of Science estimates that 18,000 people, adults and children, die prematurely each year because they lack health coverage. Hundreds of thousands more face unnecessary pain and suffering. Go to the Cooper Hospital emergency room. You

will see hundreds of people waiting all day to see a doctor. They come too late, they wait too long and they pray that in the end charity care will cover the cost. Yet it is society that ultimately pays the price when we deny people the health coverage they need to keep themselves and their families healthy.

When people have reliable health coverage for their children and themselves, they have the tools to bring strong, healthy families and communities. Access to health care is a conduit to a vibrant and productive society. Indeed, we have a moral and constitutional obligation that the founders of our country thought important enough to include as part of our inalienable rights to protect the right to the pursuit of life, liberty and happiness. All of us are not able to pursue their dreams and their vocations in a society that has no viable way to heal all of its people. We join with the prophet Jeremiah who asked this question, "is there no balm in Gilead, is there no way for us to get healing in this land?"

PICO's faith-based federations and congregations have led many different efforts to cover the uninsured and improve health conditions in our communities. For example, we have established mobile health care clinics that visit public housing complexes and low-income communities in Orlando, Florida. We fought for and won increased funding for safety nets and coverage for the uninsured in California, Colorado and Virginia.

For the faith community, it is unacceptable that a nation as wealthy as ours would leave 44 million Americans uninsured. As we work to find resources to cover the uninsured, which must be a high priority for Congress, our Nation needs to invest in more prevention. We begin with our young people but we don't end with them.

With your commitment, the movement to cover the uninsured beginning with children will not be deterred. Together we will make this the healthiest, most successful generation in American history. We will see a day when every person has access to good health and all of God's children, young and old, can travel from coast to coast and not be concerned with having an unplanned health crisis and perishing because they cannot get treated in the land of the free and the home of the brave. The songwriter says, and I end with this, "My country tis of thee, sweet land of liberty, of thee I sing; land where my fathers died, land of the pilgrims' pride, from every mountainside, let freedom ring." We need to cover our children and our Nation.

Thank you so much for listening.

[The prepared statement of Reverend Wiggins follows:]

TESTIMONY OF REV. HEYWARD D. WIGGINS III

Chairman Pallone, members of the Energy and Commerce Committee, thank you for inviting me to speak about the moral imperative to provide health coverage to the millions in our Nation who are uninsured—beginning this year with our most precious resource, our children.

I pastor Camden Bible Tabernacle Church in Camden, New Jersey, a city where more than one-third of families lack health coverage. I have worked over the past decade with Camden Churches Organized for People to revitalize my city. I am proud to be here on behalf of the faith-based PICO National Network. Since 1973 PICO has brought people of faith together to revitalize communities and expand opportunities for families in 150 cities and towns across the country.

A generation ago, the faith community led the Civil Rights Movement. Today, PICO's more than 1,000 congregations and one million families nationwide are a driving force behind the movement to expand health coverage in America, beginning with covering all children. For communities of faith, the force behind both movements is the same. God created each of us in his image. We have a sacred responsibility to protect the dignity and well being of every person.

Two weeks ago the New Jersey State Police airlifted Governor Jon Corzine to Cooper University Hospital in my city of Camden. Cooper is a level-one trauma center that fights as hard to save a young person shot on the streets of Camden as it does to heal a governor. Like Jesus, our trauma centers open their arms to the poor and the forgotten. The value that our hospitals place on every person's life as sacred—whether they be a poor child, a drug dealer, a prostitute or a public official—is a fundamental cornerstone of our society. It has deep roots in our religious traditions, in the teachings of Moses, Jesus and Mohammed. None of us in this room would wish to live in a nation that did not value every person as a child of God.

Yet, when it comes to the uninsured we have lost our moral compass. We have deceived ourselves that a slow death is no death. The National Academy of Sciences estimates that 18,000 people, adults and children, die prematurely each year because they lack health coverage. Hundreds of thousands more face unnecessary pain and suffering. Go to the Cooper Hospital Emergency room. You will see hundreds of people waiting all day to see a doctor. They come too late, they wait too long and they pray that in the end charity care will cover the cost. Yet it is society that ultimately pays the price when we deny people the health coverage they need to keep themselves and their families healthy.

When people have reliable health coverage for their children and themselves they have the tools to build strong healthy families and communities. Access to health care is a conduit to a vibrant and productive society. Indeed, we have a moral and constitutional obligation that the founders of our country thought important enough to include as part of our inalienable rights, to protect the right to the pursuit of—life, liberty and happiness.— Today, the reality is that we are not all able to pursue our dreams and our vocations because our society does not viable system to heal all its people. We join with the prophet Jeremiah who asked, "Is there no Balm in Gilead?" Is there no way for us to get healing in this land?

PICO's faith-based federations and congregations have led many different efforts to cover the uninsured and improve health conditions in our communities. For example,

- We've helped establish mobile health-care clinics that visit public housing complexes and low-income communities in Orlando, FL and other cities
- We've fought for and won increased funding for safety net clinics and coverage for the uninsured in California, Colorado, Virginia and other States.
- We've worked to pass Tobacco Tax measures to provide care for the uninsured in Missouri and California

These efforts and other efforts to protect the uninsured are important. The health care system is broken and increasingly out of reach of too many families. It can only be fixed with participation from the faith community, business and civic leaders and local and State government. We find hope in the creativity of local initiatives on the uninsured. But our Nation cannot succeed, cannot live up to our promise, without strong and determined health care leadership from Washington.

For the faith community it is unacceptable that a nation as wealthy as ours would leave 44 million Americans uninsured. As we work to find resources to cover the uninsured, which must be a high priority for Congress, our Nation needs to invest more in prevention. We must be good stewards of our resources, so that people get early intervention that prevents expensive treatment down the line. As Congress works to expand coverage for the uninsured we urge you to build on the success of existing programs and initiatives. This year PICO and the broader faith community have united behind an effort to strengthen and expand the State Children's Health Insurance Program to help States cover uninsured children.

We begin with our young people because they are our future and because we have a chance this year to get results. No child should rely on an emergency room for their treatment or run the risk of life-long disability because they lack health insurance. With help from SCHIP we have reduced the number of uninsured children by one-third; but morally we cannot abide with having millions of children without health coverage in the United States; we cannot abide with rising infant mortality rates; we must start by making certain that every child has health coverage and access to high quality medical attention.

That is why PICO has engaged in the SCHIP reauthorization debate since it began, testifying before this committee and engaging hundreds of clergy in a united

stand on covering uninsured children. We continue to urge Congress to move quickly to deliver on its commitment of $50 billion in additional resources for SCHIP reauthorization. We urge Congress to strengthen SCHIP by giving financial incentives and support to encourage States to reach and retain all eligible children. And we support giving States the option to cover pregnant women and documented immigrant children and continue to support State efforts to expand eligibility. We will be working closely with Congress—and keeping a close eye on Congress—over the next three months to ensure passage of a good SCHIP bill that strengthens children, strengthens families, and strengthens communities.

While our policy focus this year is on SCHIP reauthorization and children's coverage, our faith communities will remain engaged in this issue until everyone has access to affordable health coverage. After all, we are all children of God, regardless of our age.

With your commitment the movement to cover the uninsured, beginning with children, will not be deterred. Together we will make this the healthiest, most successful generation in American history. We will see a day when every person has access to good health, when all of God's children—young and old—can travel from coast to coast and not be concerned with having an unplanned health crisis and perishing because they cannot get treated in the land of the free and the home of the brave. The song writer said it this way, My country 'tis of thee, sweet land of liberty, of thee I sing; land where my fathers died, land of the pilgrims' pride, from every mountainside, let freedom ring!

Thank you all for listening.

Mr. PALLONE. Thank you, Reverend.

Dr. Moffitt.

STATEMENT OF ROBERT E. MOFFITT, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION

Mr. MOFFITT. Chairman Pallone, members of the committee, I just want to express my deep appreciation for the opportunity and the honor and the privilege to testify before your committee today on this important issue. The views that I express in this testimony are my own as director of the Center for Health Policy Studies. They do not necessary represent an official position of the Heritage Foundation. I think that should be clear.

Mr. Chairman, given Washington's gridlock on health policy over the past few years, it is not surprising that many States are starting to take a bold lead in health care reform. It is also not surprising that survey research shows that the American people are supportive of the States taking the lead in health care reform and trying out different options to expand coverage for our people. State officials are wrestling with rising employer costs on the ground, the increasing access problems, especially for low-income working people. Health insurance markets in many States are also deeply flawed, resulting in less competition, more market concentration and oftentimes characterized by excessive Government regulation.

The professional literature on the uninsured shows that this problem is not simply a problem of people having difficulty getting access to health insurance. It is also even more of a difficulty of people keeping it once they get it. Perhaps the best single analysis of this data on the uninsured was conducted by Pamela Short and Deborah Graefe of Pennsylvania State University and it was recently published in Health Affairs, and Mr. Chairman, with your permission I would like to submit that Health Affairs article for the record.

Mr. PALLONE. Without objection.

Mr. MOFFITT. In their analysis of the Census Bureau data over the period 1996 through 1999, they found that only 12 percent of the uninsured population was uninsured over the entire time. In fact, the overwhelming majority of the uninsured are persons who are in and out of coverage, getting coverage, losing it, often with a change of employment. So in effect, the vast majority of the uninsured Americans are people who are transitioning in and out of an unstable health insurance market.

The policy problem then is how to make health insurance stick to the person, not simply the job, and that policy problem is acute for persons who work for small businesses. Small firms that do offer coverage usually offer workers and their families no choice of coverage, and if a worker tries to buy health insurance on his own, he must pay for it with after-tax dollars. This was a topic mentioned in your last panel. But this could mean on the ground adding between 40 to 50 percent to the cost of a policy for the same level of benefits that that worker may have gotten through the place of work.

So the Federal Tax Code is not neutral about where you get your health insurance. If one gets health insurance outside of the conventional employment-based arrangements, one is punished with a very heavy tax penalty.

Mr. Chairman, my focus is on the State issue and I would just like to mention briefly the situation in Massachusetts. During the initial stages of the debate in Massachusetts, Governor Romney invited me and my colleagues to travel to Boston to discuss the health insurance markets in Massachusetts. In response to that request, we helped the Governor design an entirely new market for health insurance which would get around the current limitations of the Federal Tax Code which are so problematic in this system which undercuts both the choice of health insurance and the portability of health insurance coverage, particularly for employees in small businesses. The model for this approach was the stock market, basically a new market that would operate like a consumer-based market for stocks and bonds and equities and securities, a single place where an individual would be able to buy a product and keep it regardless of one's change in life or circumstance or job.

Mr. Chairman, we have published an article in Health Affairs on the Massachusetts plan. I would also like to submit that for the record with your permission.

Mr. PALLONE. So ordered without objection.

Mr. MOFFITT. Because employees would be able to designate the exchange or, as the Massachusetts legislature called it, the connector, as their employer planned for the purpose of the Federal Tax Code, all of the premiums for health plans offered in that exchange or that connector would be tax-free and therefore all the benefits for the employees would also be tax-free just as they are today under conventional employment-based health insurance. So the achievement then is that with an exchange or a connector, you would be able to have broad employee choice of health plans without compromising the tax-free status of health insurance coverage. Individuals and families would be able to pick the plans of their choice. They would have a property right in their health insurance just like they do in other types of——

Mr. PALLONE. I am going to ask you to summarize. You are over your time.

Mr. MOFFITT. OK. And take it from job to job without a tax penalty.

Mr. Chairman, there are a number of things we could do but the first thing I would mention is that we would have to change the tax treatment of health insurance and at least establish equity in tax policy. A second point is that Congress could promote State experimentation and the Health Partnership Act that has been sponsored by Congresswoman Tammy Baldwin and Congressman Tom Price would go a long way to promoting that State experimentation. And finally, I think that States ought to look at the opportunity for grants from the administration under its affordable choices program. That also offers States a great opportunity to advance coverage.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Moffitt follows:]

TESTIMONY OF ROBERT E. MOFFIT

Mr. Chairman and Members of the committee, my name is Robert E. Moffit. I am director of the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Given Washington's gridlock on health care policy over the past few years, it is not surprising that many States are taking the lead in health care reform. It is also not surprising that the American people are supportive of States taking the lead role in reform. According to a Dutko Worldwide poll conducted in January 2007, 74 percent of voters prefer to give more power to State and local government, and 72 percent prefer that State and local government experiment with strategies for expanding health care.

The States differ markedly in the range of their problems and their internal capacities to cope with them. States vary radically in their demographics, their economic profiles, their level of employment and poverty, the strength of their employment-based health insurance, and the functioning of their individual health insurance markets.

Most States are struggling with a number of common problems: Top among them is the problem of Medicaid costs and the functioning of the Medicaid program itself. Low reimbursement rates discourage doctors from taking new Medicaid patients. Meanwhile, Medicaid obligations have been consuming a far greater portion of State budgets, squeezing out other priorities. The National Governors' Association reports that Medicaid has surpassed education spending in many States.

Beginning this year, States are faced with a new fiscal challenge. The Government Accounting Standards Board will require States to begin calculating and disclosing the expected future costs of their retiree health benefits, just as the Financial Accounting Standards Board requires such disclosures for private companies. State retiree benefits are often more generous than private sector benefits, and that means that many States are going to be faced with large unfunded liabilities for State and local retiree health benefits. This will impose new pressures to raise taxes or to reduce other budget categories. Failure of State officials to act will hurt State bond ratings.

Beyond that, State officials are wrestling with rising employer costs, and increasing access problems, especially for low-income working people. Health insurance markets in many States are also deeply flawed, resulting in less competition, more market concentration, and excessive government regulation.

THE NATURE OF INSURANCE

As a practical matter, health insurance problems are heavily concentrated in small businesses, where employers often cannot afford to offer their employees a policy and where the administrative costs and tasks of securing a policy are particularly daunting.

The professional literature on the uninsured shows that the problem is not simply a difficulty with people having access to affordable coverage; it is more a difficulty

of people keeping it once they have it. Perhaps the best single analysis of the data on the uninsured was conducted by Pamela Short and Deborah Graefe of Pennsylvania State University and published in Health Affairs (2003). In their analysis of the Census Bureau data over the period of 1996 through 1999, they found that only 12 percent of the uninsured population was uninsured over the entire time. In fact, the overwhelming majority of the uninsured were persons in and out of coverage; getting coverage, losing it, often with a change of employment. So, in effect, the vast majority of uninsured Americans are people who are transitioning in and out of an unstable health insurance market.

The policy problem, then, is how to make the insurance stick to the person, not the job. That policy problem is acute for persons who work for small businesses.

There is another facet of this problem. Can employees get the specific kind of coverage they want or need? Small firms that do offer coverage usually offer workers and their families no choice of coverage. If a worker tries to buy health insurance on his own, he must pay for it with after tax dollars. This could end up adding between 40 percent to 50 percent to the cost of a policy for the same level of benefits that the worker might have been able to get through his employer.

The Federal tax code, then, is not neutral about where persons get their health insurance. If one gets health coverage outside of conventional employment-based arrangements, one is punished with a heavy tax penalty.

THE CONCEPT OF A HEALTH INSURANCE EXCHANGE

In order to tackle these related problems, a number of health policy analysts have suggested the creation of health insurance exchanges: new markets for health insurance for small businesses employees that ease their access to coverage, reduce the administrative costs for small businesses owners, and allow individuals to own their own health insurance policies.

In the initial stages of the health care debate in Massachusetts, former Governor Mitt Romney invited me and my colleagues at Heritage to provide advice and assistance on the creation of a health insurance exchange as part of a comprehensive reform of the health care system in that State. In response to that request, we helped the Governor and his staff design an entirely new market for health insurance that would get around the current limitations of the Federal tax code, which undercuts both the choice and portability of health insurance coverage, particularly for employees in small businesses.

The model for this approach was the stock market, and the new market was designed to work like a consumer-based market for stocks, bonds, equities, and securities: a single place where one could buy the product that one wanted and keep it regardless of changes in life circumstances and employment. The concept of the stock exchange was thus grafted onto the health insurance market as an "insurance market exchange." The Massachusetts legislature renamed it "the Connector" and significantly modified its authority beyond what we had originally proposed.

It is vital to understand what the health insurance exchange, as proposed by my colleagues at Heritage, is not. It is not a regulatory agency; it is not purchasing agent, buying health plans on behalf of individuals or businesses; it does not negotiate the rates and benefits of health plans like the Federal employees program; and it does not enforce a comprehensive standardized benefits package for health insurance. Its functions are purely administrative: It simply processes premium payments, government subsidies for low-income persons, and the paperwork for small employers.

The role of employers would be retained, but changed. Instead of the traditional defined benefit approach to employees' coverage, the model would encourage defined contributions, particularly for smaller firms that do not have the financial wherewithal to participate in today's employer-based health insurance system. So the new market would function through defined contributions to the health plans of the employees' choice.

Former Governor Romney added another feature to the exchange: If an employer did not want to contribute anything to an employee's health insurance, the employer nonetheless would be required to offer a flexible spending account, a Section 125 plan, so that the employee could make tax free premium payments and benefit from the generosity of the Federal tax code.

In the exchange, individuals, not employers, purchase health insurance plans. The exchange will ease access to health insurance coverage for many workers in nontraditional jobs, including part-time and seasonal employees, contractors and sole proprietors, and individuals with more than one job. Small business employees would be able to pick and choose health insurance plans, including health savings account plans.

Because employers will be able to designate the Connector as their employer plan for the purpose of the tax code, all of the premiums for health plans offered in the exchange will be tax free, and the benefits for the employees will also be tax free, just as under conventional employer-based health insurance. The achievement, then, is that the Connector will provide for broad employee choice of health plans without compromising the tax-free status of health insurance coverage. Employees would be able to pick health plans of their choice, have a property right in their insurance policies, and take their coverage from job to job without a tax penalty. Personal ownership and control of health insurance policies would thus characterize the new market. This is a major structural change in health insurance.

HELPING LOW-INCOME WORKERS

For years, health care economists have been debating the best way to integrate low-income individuals and families into the private health insurance market, as an alternative to rising uncompensated care costs or Medicaid expansions. On a bipartisan basis, many policymakers have proposed refundable tax credits—basically vouchers—to help people buy private health insurance.

Within the $2.2 trillion in national health care spending, there is a great deal of cost shifting, including reimbursements from both the private sector and the public sector for uncompensated care. One thing that States could pursue, especially in cooperation with the Federal Government, is a policy that would use existing government funding for the uninsured to provide them with the means to secure private coverage. Once again, in Massachusetts, policymakers pursued this approach and redirected, with waivers from the U.S. Department of Health and Human Services, hundreds of millions of dollars in existing government subsidies to provide coverage for the uninsured through a sliding-scale voucher program.

Massachusetts's taxpayers spent $1.3 billion in 2005 on hospitals and other institutions to provide care for the uninsured and those who did not pay for it. Federal law, of course, requires hospitals to care for persons entering the emergency room regardless of their ability to pay.

The new Massachusetts law transforms these subsidies into direct financial help to individuals, in the form of "premium assistance" for the purchase of private health insurance. Subsidies will be available to individuals and families with incomes up to 300 percent of the Federal poverty line. Eligibility, in other words, broadly tracks an earlier Bush Administration proposal for a refundable health care tax credit program for low-income families that would phase out at $60,000 per year. This also is a major change in health care financing.

The Massachusetts compromise reflects the political coloration of Massachusetts. There is plenty of room for criticism of the Massachusetts law on strict policy grounds. How it will work is another matter. But it is well to remember that it is in the early stages of its implementation, which will continue for another three years. In any case, it is far too early to make definitive evaluations.

What Massachusetts does prove is that with the political will, compromise at the State level is possible. Unsurprisingly, other States are looking at this very carefully, and they should be.

A SUPPORTIVE FEDERAL ROLE

There are a number of steps Congress could take to aid State experimentation in health care reform. First, Congress could help States cope with the uninsured in one simple step: provide tax equity in the purchase of health insurance. There are a couple of ways to do this. President Bush has proposed a universal standard deduction, which would go a long way toward eliminating the current distortions in the tax code and providing fairness in the tax treatment of health insurance. Others have proposed refundable tax credits. At the very least, Congress should provide tax breaks or subsidies to people who do not or cannot get health insurance through the place of work. A combination of the universal standard deduction and a system of refundable tax credits would be the best solution.

Second, States could aid State experimentation with special grants. There are two promising approaches. The first is congressional assistance to the States through the enactment of broad goals to reduce the uninsured, the provision of policy tools to accomplishing this objective, and special grants to enable States to achieve coverage expansion using their preferred policy approaches. This approach has broad bipartisan support and is embodied in the Health Partnership Act legislation, sponsored by Representatives Tammy Baldwin (D-WI) and Tom Price (R-GA). Similar legislation is sponsored by Senators Jeff Bingaman (D-NM) and George Voinovich (R-OH).

Another approach is being advanced by the Administration. The Bush Administration has signaled its intention to provide grants to the States—known as the Affordable Choices program—to help them cover the uninsured. This is an Administration priority and a real opportunity for States to enter into an agreement with the Federal Government to address this pressing policy problem.

The Founding Fathers designed the Federal system as a way of allowing a diversity of options in a very diverse and dynamic country, the most revolutionary society in the world. We can improve our health care system, and we can do it because of the opportunities afforded by our unique Federal constitution, the product of the Founders— peerless political wisdom.

Thank you. I will be happy to answer any questions you may have.

Mr. PALLONE. Thank you.

Mr. Knowlton.

STATEMENT OF DAVID L. KNOWLTON, PRESIDENT AND CEO, NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Mr. KNOWLTON. Thank you, Mr. Chairman, members of the committee and invited guests and staff.

I am president and CEO of the New Jersey Health Care Quality Institute. It was founded 10 years ago. It is a nonprofit, nonpartisan foundation. Our purpose is to ensure the quality, accountability and cost containment are all closely linked to the delivery of health care services in New Jersey.

I want to thank you for giving me the opportunity to give you a brief glimpse into the state of health care in our home State of New Jersey. As you know, Mr. Chairman, in New Jersey we are proud to be at or near the top of a number of statistical categories. We have one of the Nation's highest per capita incomes. We are home to more high technology, pharmaceutical and biotechnology companies per square mile than any place in the world. We are home to the University of Medicine and Dentistry of New Jersey, the largest freestanding public health university in the country. Our college and professional sports teams, particularly our women's basketball team and varsity football team at Rutgers, compete at a championship level.

Unfortunately, we also rank near the top statistically in some categories where we are not quite so proud. According to the United States Census, we are home to more than 1.3 million uninsured. Almost a quarter-million of those are children. The New Jersey Business and Industry Association reported just earlier this month that for small businesses, the cost of providing coverage has increased 80 percent in the last 5 years. As a result, businesses in New Jersey providing coverage have dropped dramatically in the past 4 years so that now in every five small business owners simply cannot afford health insurance.

It is important for us to understand why so many Americans and New Jerseyans are uninsured if we are going to be successful in forging a solution. Some of the uninsured are between jobs. Some are starting new jobs with an insurance waiting period. There are those who work for employers who do not offer insurance and some lost their insurance when they had to stay home or reduce their working hours to care for aging parents, sick kids or a disabled spouse. For most uninsured Americans, there is no health care system but rather a blotchy, frayed patchwork of unreliable and inconsistent programs, providers and facilities. The bottom line is that

in many cases the uninsured live shorter lives than comparable insured populations. Their crime is merely being too poor or too disabled or underemployed or simply holding down a part-time job.

For all of these reasons, the Quality Institute decided to become involved in our home State on the issue of health care reform. We knew where to start. We knew that we needed to do all we could to enroll all who are eligible for State-sponsored coverage and we knew we would have to properly utilize and manage the Federal dollars available to us for that purpose. Then we knew we would have to make sure that those who have health coverage were able to keep it. We simply could not afford to lose more ground in this struggle. Beyond that, we knew we had to get creative and find solutions that would provide affordable and adequate coverage for every man, woman and child in our State.

Last summer New Jersey State Senator Joe Vitale and I gathered together stakeholders and experts and we engaged in weekly frank and open dialog directed toward finding a lasting solution to the tragedy of the uninsured in New Jersey. We quickly came to some consensus and established some basic elements or pillars for our reform. They included the following: Universal health insurance coverage is our goal. That health insurance coverage must be affordable and it must be portable so individuals can take it with them. In order to achieve universal coverage, our plan includes a mandate that every individual residing in New Jersey have health insurance. Individuals will be responsible to provide proof of health insurance when they file their State income tax return. Those who do not have coverage will be placed into a new State health plan. We intend to implement FamilyCare to the extent permitted and to enroll all New Jerseyans who are currently eligible for Medicaid and FamilyCare but not presently enrolled. If a New Jersey resident presents for care without insurance, their provider will place them into the new plan and provide billing information.

Unfortunately, even with comprehensive universal coverage, there will be some who will remain uninsured, undocumented populations, homeless and others who are hard to reach. For those people we created a safety net, a network of care centers who will partner with hospitals to provide primary care and specialty care to these populations. This will mean better quality care and it will contain costs.

Our plan moves the uninsured into one self-funded plan to take advantage of the law of large numbers so that the healthy and sick balance each other out and result in more affordable health coverage. This new health insurance plan will be a commercial-grade product with commercial reimbursement and with benefits modeled after the current standard plan in the New Jersey employer market.

Mr. PALLONE. I am going to have to ask you to summarize as well because you are over the time.

Mr. KNOWLTON. Mr. Chairman, we believe the time to act is now. The pessimism and gloom which permeated the Nation for much of the last decade after we failed to tackle this issue has been replaced by new optimism and openness and hope in this century. We feel we have a Governor who is very supportive of trying to get this

universal coverage done and with the leadership from Senator Vitale, we think we are going to get it done.

[The prepared statement of Mr. Knowlton follows:]

TESTIMONY DAVID L. KNOWLTON

Mr. Chairman, members of the committee, invited guests and staff.

My name is David Knowlton and I am president and CEO of the New Jersey Health Care Quality Institute. The Quality Institute was founded 10 years ago and is a non-profit, non-partisan foundation. Our purpose is to "undertake projects that will ensure that quality, accountability and cost containment are all closely linked to the delivery of health care services in New Jersey." We achieve this by fostering collaboration amongst all stakeholders in the State's health care delivery system so that purchasers and health care consumers more fully realize the benefits of the linkage between quality, accountability and cost containment.

The Quality Institute seeks to empower health care purchasers and consumers by publishing the results of objective research, comparative data on providers, and other pertinent educational information so that purchasers and consumers may adopt value-based purchasing practices and be able to make informed decisions on the merits of various health care programs, treatments and services. We were designated as the lead agency in New Jersey for the national Leapfrog Group effort in 2002.

I want to thank you for giving me the opportunity, on behalf of the group I lead, to give you a brief glimpse into the state of healthcare in our home State of New Jersey. More importantly, I want to share with you the work we are undertaking to come to grips with New Jersey's uninsured population.

As you know Mr. Chairman, in New Jersey, we are proud to be at or near the top in a number of statistical categories. We have one of the highest per capita incomes. We are home to more high technology, pharmaceutical and biotechnology companies per square mile than any place in the world. We are home to the largest free-standing public health university in the county, the University of Medicine and Dentistry of New Jersey. Our college and professional sports teams, particularly our women's basketball team at Rutgers, consistently compete at a championship level.

Unfortunately, we also rank near the top statistically in some categories of healthcare for which we are not particularly proud:

According to the United States Census, we are home to more than 1.3 million uninsured, 240,000 of them children.

Research conducted for New Jersey's outstanding Robert Wood Johnson Foundation tell us that one out of every seven children in our State received no medical care last year as a result of being uninsured.

The New Jersey Business and Industry Association reported earlier this month that for small businesses, the cost of providing coverage has increased 80 percent in the last five years. As a result, businesses in New Jersey providing coverage for their workers has dropped dramatically in just the past four years and now, one in every five small business owners simply cannot afford health insurance.

Research conducted for New Jersey's Hall Institute of Public Policy by Dr. Sherry Glied and Edward Broughton revealed the following:

The cost of healthcare in our State consumes 11 percent of the State's Gross Domestic Product and has been rising rapidly since the turn of the last century. In fact, at $6,500 per capita healthcare costs are a full 10 percent above the national average. Those rapidly rising costs come after a 1998 benchmark which revealed that New Jersey paid the highest premiums for single plans and the third highest for family plans of 40 States studied. In fact, research from the Kaiser Family Foundation shows that New Jersey pays amonth the highest costs in the Nation in both health insurance costs and health care costs.

The Glied-Broughton study further found that the "high cost of health care and health insurance in New Jersey affect the State's residents, both as consumers of health care services and as taxpayers. High health costs make it harder for people to afford coverage, whether purchased in the non-group market or through employment. High costs also mean higher taxes to support State-financed health programs, including the States share of Medicaid and NJFamilyCare and the State employee health insurance program."

But while New Jersey may be suffering a little more as a result of its high costs, its situation is not unique. The problem of the uninsured in America is not confined to any particular State or region.

In America, the most powerful economic force mankind has ever known, there are amongst us citizens who have seen loved ones die because they did not have medical coverage.

There are Americans who have been forced to declare bankruptcy or sell their homes to pay for medical care. There are horrendous disparities which reveal that Hispanics and African Americans are more likely to be uninsured than white Americans, even though white Americans constitute the absolute majority of the uninsured. One out of every three young adults between the ages of 18 and 24 in the United States lacks health care coverage.

It is important for us to understand why so many Americans are uninsured if we are to be successful in forging a solution.

Some of the uninsured are between jobs. Some are starting new jobs with an insurance waiting period. Others work for such low salaries that they cannot afford insurance. There are those who work for employers who do not offer insurance at all. Some of the uninsured work for small businesses with limited cash flow. Some are uninsured because of shifting family situations. Some lost their insurance when they had to quit work or reduce their working hours in order to care for aging parents, sick children, or disabled spouses.

The consequences of being uninsured or underinsured are significant. Finding yourself uninsured is not simply an inconvenience—it is often life threatening.

For most uninsured Americans, there is no health care "system," but rather a blotchy and frayed patchwork of unreliable and inconsistent programs, providers, and facilities. Most of the uninsured routinely experience delays in getting care for a variety of medical problems

The uninsured rarely if ever go to the doctor for a checkup. They rarely receive ongoing supervision of chronic problems, and they almost never get treatment until their pain becomes unbearable or intractable complications set in.

The uninsured are left to their own devices to manage their health problems. The uninsured learn who is willing to write a prescription or give out free drug samples without examining them. Some will take only half of a prescribed drug dose so that their medicine will last longer. The uninsured will share prescriptions with friends and relatives. They will skip doses until they can afford a refill. The uninsured play a high-stakes guessing game when they choose which of their several prescriptions they can afford to purchase. They will self-medicate in ways that would appall trained health care providers and they will take large and frequent doses of over-the-counter pain medications such as ibuprofen and Tylenol in order to get through the day or night.

The Institute of Medicine has concluded that the uninsured receive less preventive care and poorer treatment for both minor and serious chronic and acute illnesses.

The bottom line: In many cases, the uninsured live shorter lives than comparable insured populations. Their "crime" is being too poor or too disabled or underemployed or simply someone holding down three or four part-time jobs. Their sentence is sometimes the death penalty.

For all of these reasons, the New Jersey Health Care Quality Institute has decided to become involved in our home State on the issue of health care reform. We understand that without access to care, you cannot possibly have quality care.

We know where to start. First, we must do all we can to enroll all who are eligible for State sponsored coverage through SCHIP programs. We have to properly utilize and maximize the Federal dollars available to us for this purpose. We have to make sure that those who have health care coverage are able to keep it. We simply cannot lose more ground in this struggle.

Beyond that, we must get creative at the State level and find solutions that provide affordable and adequate coverage for every man, woman and child in our State. That is the journey on which we now find ourselves in New Jersey. Last summer New Jersey State Senator Joe Vitale and I gathered together stakeholders and experts and engaged in a weekly, frank and open dialogue directed toward a lasting solution to the tragedy of the uninsured in New Jersey—all of them. Those around the table included health care professionals, business and labor leaders, public policy makers and many of the State's leading opinion leaders.

We quickly came to some conclusions and established "pillars" for our reform effort:

Universal health insurance coverage is our goal. Health insurance must be affordable, and it must be portable so individuals can take it with them as they move in and out of employment or from one region of the State to another.

In order to achieve universal coverage, our plan includes a mandate that every individual residing in New Jersey have health insurance—an "individual mandate." Under our reform individuals will be responsible to provide proof of health insur-

ance when they file their State income tax return. If they do not provide proof of health insurance, they will be placed by the State into the new State health insurance plan.

We intend to expand FamilyCare to ensure that we are using all the Federal dollars we have available to us. We also must enroll all New Jerseyans who are currently eligible for Medicaid and FamilyCare but who are not yet enrolled.

If, for whatever reason, a New Jersey resident presents for care without insurance, the hospital will place them into the new plan and provide billing information to the new plan.

Unfortunately—even with a comprehensive universal coverage plan—there will be some who remain uninsured. They are the undocumented populations, homeless, and others who are hard to reach. For those people, we must have a safety net. Our plan will create a network of Collaborative Care Centers who partner with hospitals to provide primary and specialty care to these populations, so hospitals are only responsible for their emergent care. This means better quality care, and it contains cost. The hospitals and centers will be eligible for reimbursement for actual care provided to the remaining uninsured.

This new plan will replace the current plans offered in the State's individual market. This successor plan will be sold to individuals and their families (not employers), and will be licensed by our Department of Banking and Insurance and administered by our State Health Benefits Plan.

In the current Individual Health Coverage market, coverage is unaffordable because people are spread out among many plans and policies, and because of adverse selection (where sick individuals buy coverage and the healthy do not). Our plan combines all individuals together so we can take advantage of the "law of large numbers," so the healthy and the sick balance each other out and we are able to provide an affordable health insurance product.

The health insurance plan will include a statewide network of providers, and will be designed as one plan with two options: A standard HMO and a PPO with an out-of-network option. This plan will be a commercial grade product, with commercial reimbursements and with benefits modeled after the current Standard Plan in the Small Employer Market. We will require that where an employee does not have coverage, his or her employer must provide them access to a Section 125 flexible-spending account so the employee can purchase their health care coverage with before tax dollars.

Our plan will be offered to all New Jersey residents, and State subsidy will be provided on a sliding scale based on what is affordable to the individual or their family based on their income level and family size. Our current charity care and related hospital subsidies will be redirected over time to provide premium assistance in the new plan.

In New Jersey today, two-thirds of those who have health insurance coverage receive it from their employers. We must pursue reforms in the current employer-based markets to ensure that employers who are providing coverage to their employees now can afford to continue to do so.

Last, we must ensure that quality and cost-containment are important elements of our reform. Increased transparency of quality and cost data, public reporting of that data, advances in the interoperable use of health information technology, providing consumers the tools to make the best health care decisions, and attention to chronic disease management are all part of that solution,

We still have some details to work out but we believe we are on the verge of transformational reform in New Jersey.

Furthermore, we believe the time to act is now. The pessimism and gloom which permeated the Nation for much of the last decade after we failed as leaders to tackle this issue has been replaced by new optimism and hope in this new century.

Particularly in New Jersey, the stars are aligned: we have a governor who is committed to transformational change. In fact, I would suggest to you that Governor Jon Corzine today understands the value of quality and accessible health care better than any other chief executive in the Nation. We also have stakeholders who have decided to roll up their sleeves and be part of the solution rather than sit on the sidelines and be part of the problem.

In the coming months legislation will be introduced in both houses of our Legislature to establish affordable and accessible health care coverage for each and every one of our State's citizens. It will be a real plan that can work. More importantly, it will make a very real difference—not only in the everyday lives of more than a million of our State's uninsured citizens—but in how we feel about ourselves and our responsibility to those less fortunate.

I would like to leave you today with the words of the Founding Father for whom this city is named. In his Farewell Address as George Washington was leaving pub-

lic service at the end of two terms as our President, he warned future leaders against "ungenerously throwing upon posterity the burden which we ourselves ought to bear."

We believe New Jersey is at a crossroads. We can continue to ignore Washington's sage advice; or, we can do something. We have made our choice and are ready to lead. We believe this is a burden that we ourselves need to bear. We hope others will soon follow.

Thank you for providing this forum for what may very well be the Nation's most urgent issue.

Mr. PALLONE. Thank you.

Dr. Antos.

STATEMENT OF JOSEPH R. ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Mr. Chairman and members of the committee. It is a real privilege to appear here today to discuss the challenges facing the uninsured.

We have an opportunity and an obligation to seek solutions to the health system problems that have put insurance out of the reach of millions of Americans. However, we must also recognize the limitations of policies that are narrowly focused on increasing the number of newly covered individuals without also addressing broader system issues. Those issues have an impact on everyone who uses health care in this country whether or not they have insurance. Certainly we need to make progress for the uninsured but we should also be realistic about what we can and cannot achieve by expanding access to health insurance.

Unfortunately, this is not a panacea. Access to health insurance does not guarantee that care will be either appropriate or affordable. Access to health care unfortunately does not guarantee good health and further, there is no magic bullet that will solve the problems facing the uninsured. Expanding subsides for health insurance will prove to be unsustainable unless we also undertake more fundamental reforms. Bluntly, universal coverage will not lower costs, not unless we also undertake the reforms that address the drivers of health care costs in this country.

The uninsured are not easily characterized. They come from every sector of society. Their reasons for not having coverage vary but cost is the dominant concern. Some individuals simply cannot afford insurance even though they need it. Others may be able to purchase coverage but do not think the value outweighs the cost.

The mismatch between cost and value is at the heart of our health system crisis. We spend over $2 trillion annually for health care but there is a growing sense that we are not getting our money's worth. This crisis is driven principally by perverse economic incentives, massive information failures, uncompetitive markets and a health system that does not adequately meet the needs of high-cost patients.

However, work is proceeding on many fronts to correct these problems and to promote a more efficient and effective health system. Many States, most notably Massachusetts, have developed innovative solutions through the use of Medicaid waivers. Employers, insurers and providers are developing new approaches that could

reduce unnecessary health spending and enhance the quality and effectiveness of health care.

Congress has numerous opportunities to build on what works and improve what doesn't. That includes reforms such as the insurance market reforms that people have talked about earlier including the proposal by Mr. Shadegg, promotion of information transparency—we need more information in the system—and support for the kinds of clinical studies and the kinds of information development that will help determine what works in medicine and what doesn't.

Congress also has an opportunity to correct a defect in Federal tax policy that fuels rising health care costs and disadvantages those who most need our help to purchase insurance. As you know, premiums paid for employer-sponsored health insurance are excluded from taxable income. For the average earner, that tax break can reduce the cost of coverage by nearly a third. This provision provides greater advantages to those with higher incomes and those who have more generous health insurance coverage though their employers; in other words, people with good jobs. Lower income workers and those who do not have access to employer coverage do not get the same help.

President Bush has proposed to replace the open-ended tax exclusion of employer-sponsored health insurance premiums with a standard tax deduction. The deduction would be available to everyone purchasing insurance whether they purchased it through their employer or they got it on their own in the individual market. Persons buying a lower cost policy would benefit from the full deduction. Those buying a more expensive policy would not receive additional tax benefits above the standard amount. That is a push in the direction of fairness.

The proposal is not perfect. The most common criticism is that the deduction should be augmented with a refundable tax credit for low-income individuals. I agree with that. Nonetheless, the proposal is bold. It would rein in a massive entitlement that promotes inefficient forms of insurance and exacerbates the problems of the uninsured. This is a positive step. Congress should embrace it.

The Congress has indicated its intention to expand the State Children's Health Insurance Program by $50 billion over the next 5 years. Such an expansion could draw substantial numbers of children out of private coverage that they already have and into the public program. Better targeting of the funds and enhanced State flexibility to manage their programs would minimize this crowd-out effect and direct our subsidies to those who are most in need. That is particularly important when budget resources are scarce, as they are this year.

To conclude, although a great deal of attention will be paid to the SCHIP reauthorization and appropriately so, Congress should take the opportunity to address broader health system problems. The high cost of health care is——

Mr. PALLONE. Dr. Antos, again if you could summarize.

Mr. ANTOS. I am almost done. Thank you, Mr. Chairman.

Mr. PALLONE. OK.

Mr. ANTOS. Congress has an opportunity to build upon the efforts that have already been made in the public and private sectors to

promote better value for our health care dollars. We can and must find ways to slow the growth of health spending, improve the effectiveness of care and make health insurance more accessible for the uninsured and more affordable for everyone.

Thank you very much.

[The prepared statement of Mr. Antos follows:]

Testimony Before

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Hearing on

"Living without Health Insurance: Why Every American Needs Coverage"

Joseph R. Antos, Ph.D.

Wilson H. Taylor Scholar

in Health Care and Retirement Policy

The American Enterprise Institute

April 25, 2007

Mr. Chairman and members of the Committee, it is a pleasure to appear before you today to discuss the challenges facing the uninsured. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute for Public Policy Research (AEI). AEI is a private, nonpartisan, not-for-profit institution dedicated to research and education on issues of government, politics, economics, and social welfare.

We have an opportunity and an obligation to seek solutions to the health system problems that have put insurance out of reach for millions of Americans. However, we must also recognize the limitations of policies that are narrowly focused on increasing the number of newly-covered individuals without also addressing broader system issues. Those issues have an impact on everyone who uses health care in this country, whether or not they have insurance.

Three points must be emphasized. First, access to health insurance does not guarantee that the care will be either appropriate or affordable. Being able to finance treatment is only the first hurdle for patients. Financial incentives encourage the provision of services that may offer little benefit to patients. The lack of solid clinical evidence on the effectiveness of alternative therapies and on provider performance confounds decision-making by patients and their physicians.

Second, access to health care does not guarantee good health. There are limits to what the best clinical intervention can do if individuals do not accept personal

responsibility for their life styles, health habits, and adherence to treatment regimens. That responsibility also includes making appropriate provision for financing care through the purchase of insurance.

Third, there is no magic policy bullet that will solve the problems facing the uninsured. Expanding subsidies for health insurance, through the purchase of private coverage or broader eligibility for public programs, will prove to be unsustainable unless we also undertake more fundamental reforms. The policy agenda must include efforts to improve the efficiency of the health system, expand the knowledge base available to providers and patients, increase transparency of prices and quality of care, improve the functioning of the health insurance market, encourage individual choice and responsibility, and promote effective competition.

Barriers to Affordable and Appropriate Care

The nearly 45 million people without health insurance cannot be easily characterized. They span across the spectrum of ages, genders, family makeup, ethnicity, labor force participation, health status, and tastes. Their reasons for being uninsured also vary, but cost is a dominant concern.[1] Some individuals simply cannot afford insurance even though they need it. Others may be able to purchase coverage but do not think the value outweighs the cost.

[1] This point is made by Mark Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," *Health Affairs*, January/February 2001: 9-26.

The mismatch between cost and value is at the heart of our health system crisis. We spend over $2 trillion annually for health care, but there is a growing sense that we are not getting our money's worth. This crisis is driven principally by perverse economic incentives, massive information failures, uncompetitive markets, and a health system that does not adequately meet the needs of high-cost patients.

Work is proceeding on many fronts to correct these problems and to promote a more efficient and effective health system. Many states, most notably Massachusetts, have developed innovative solutions through the use of Medicaid waivers. Employers, insurers, and providers are developing new approaches that could reduce unnecessary health spending and enhance the quality and effectiveness of care.

Incentives. Perhaps the most significant factor contributing to the cost-value mismatch is the complex array of perverse economic incentives facing every actor in the health system—patients, providers, insurers, and employers. Traditional first-dollar coverage[2] largely insulates patients from the direct cost of care, and guarantees higher payment to providers who deliver a larger volume or more complex services. As a result, the third-party payment system promotes the use of services that, at the margin, are not worth their cost.

The overuse of services adds to the cost of insurance and drives up premiums. In other markets, rising prices would be met with consumer resistance. However, health insurance is typically purchased through employers, and workers are not fully cognizant

[2] That is, insurance with low deductible and cost-sharing requirements.

of the full cost of their coverage. There is a kind of "premium illusion" that confounds public understanding of insurance costs. Few people realize that the employer's premium contribution is ultimately paid by the worker himself, who would otherwise receive higher wages or other forms of compensation.

In addition, federal tax policy promotes the purchase of excessive and inefficient insurance coverage. Premiums paid for employer-sponsored health insurance are excluded from taxable income.[3] For the average earner, the tax break can reduce the cost of coverage by nearly a third.[4] However, this provision provides greater advantages to those with higher incomes and those who have more generous health insurance coverage. It disadvantages lower-income workers and those who do not have access to employer coverage.

Recent federal initiatives have begun to improve financial incentives in health insurance. The introduction of Health Savings Accounts (HSAs) is a major milestone. Consumer-directed health plans, which combine high-deductible insurance with health savings accounts, promote greater awareness of the cost of care on the part of both consumers and providers. The HSA provision extends a tax break for contributions to the accounts that partly levels the field between insured health expenses and expenses that are paid out of pocket.

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[3] The self-employed receive a partial tax break. They may exclude their premium payments from income subject to the personal income tax, but not from the payroll tax. Others who purchase coverage on the non-group market do not receive any tax benefits.

[4] The average earner pays a 15 percent marginal federal income tax, a 15.3 percent payroll tax rate, and some additional state and local income tax.

According to a recent survey, 4.5 million people were covered by HSA-compatible health plans as of January 2007.[5] The growth of such plans demonstrates the interest of employers and insurers in the potential such insurance products have to lower costs. Importantly, the introduction of HSA-compatible insurance has focused attention on the fact that consumers cannot become smarter purchasers without information about their treatment alternatives, the quality of care offered by different providers, and the price of care. Such data are needed by all patients, not only those with consumer-directed health plans.

President Bush's proposal to replace the open-ended tax exclusion of employer-sponsored health insurance premiums with a tax deduction represents an even greater departure from convention. The proposal would offer a standard amount that would be deducted from taxable income for anyone purchasing health insurance, either from an employer or from the individual insurance market. Individuals buying a lower cost policy would benefit from the full deduction; those buying a more expensive policy would not receive additional tax benefits above the standard amount.

The proposal is not perfect. The most common criticism is that the deduction should be augmented with a refundable tax credit for low-income individuals. Nonetheless, the proposal is bold. It would rein in a massive middle-class entitlement that promotes inefficient forms of insurance. By advancing the proposal, the President

[5] America's Health Insurance Plans (AHIP), *January 2007 Census Shows 4.5 Million People Covered By HSA/High Deductible Health Plans*, April 2007, http://www.ahipresearch.org/PDFs/FINAL%20AHIP_HSAReport.pdf.

has opened the door to a serious debate on the economic incentives driving our health system.

Information. The health system is a knowledge-based industry that does not have the information it needs to function well, and that does not use the information it does have to best advantage. The evidence basis for determining proper medical treatment is limited, and we have few studies comparing the effectiveness of alternative clinical interventions.

Complicating this issue is the fact that treatment decisions usually involve some degree of uncertainty. The average patient may not fit the profile of those who participated in clinical trials or other studies, or may have comorbidities that must be taken into account in treatment. Providers often do not have ready access to laboratory tests or other patient information relevant to the course of treatment because of the lack of electronic medical records or other systems that can communicate that information from one provider to another.

Patients as consumers also have limited access to vital information. Information on the clinical effectiveness of treatment alternatives is limited and difficult to interpret without professional guidance. Price information is becoming more available, although that information is also limited. Even if the provider's charge for a specific service can be learned, the patient is unlikely to know what the entire episode of care will cost. Indicators of the quality of care offered by providers are also available in some markets,

but such indicators may not provide information about the skill and experience of a provider in delivering the specific service that a patient is about to receive.

The acute need for better information is widely acknowledged, and a variety of initiatives have been undertaken in both the public and private sectors to fill the gap. The Veterans Health Administration has been a leader in developing interoperable computer-based medical records systems. Considerable effort by federal officials and private firms has gone into developing standards for such systems.

Employers, including those participating in the Leapfrog Group, have taken steps to promote high-value health care and information that can inform the purchase and use of health care. Insurers are experimenting with ways to more efficiently provide information on treatment alternatives, cost, and quality of care to their enrollees. The federal government also is promoting greater information transparency for consumers.

There is widespread interest in creating a data base of information from billing records and other patient-specific information collected by Medicare and private insurers. Such a resource could provide valuable insights into the effectiveness of health services, the performance of providers, and the management of patients with multiple conditions. These and other activities will ultimately contribute to improvements in health care delivery that could improve the effectiveness of treatment and reduce unnecessary spending.

Competition. The power of competitive markets to bring about needed improvements in the health system is frequently questioned. Health care, it is sometimes said, is different from other consumer goods and should be carefully controlled by the government. However, the health system is an amalgam of competitive and regulatory elements that cannot be pried apart. The policy challenge is finding a balance that ensures consumer protection without stifling either consumer choice or medical innovation.

Much needs to be done before we will see widespread and effective competition in the health sector with informed consumer and provider decision-making. Essential reform steps are already under development, including policies to improve financial incentives, promote price transparency, and improve evidence on clinical effectiveness and quality of care. Indeed, most observers acknowledge that such actions are necessary even under a more regulatory approach to health system management.

The new Medicare drug benefit demonstrates the advantages of effective competition. As a result of competition, Part D premiums paid by seniors fell from $37 a month, as originally expected, to about $22 a month for 2006.[6] Most enrollees in Part D have opted for an alternative to the standard plan defined by Congress, and 80 percent of enrollees have indicated that they are happy with the new benefit.

[6] Joseph R. Antos and others, "Medicare Part D and Prescription Drug Prices: Policy Fact Sheet," January 9, 2007, http://www.aei.org/publications/pubID.25420,filter.economic/pub_detail.asp.

High-Cost Patients. One of our most vexing problems is providing affordable health insurance to chronically-ill patients whose high medical costs persist year after year.[7] Private insurers can offer affordable protection for unforeseen expenses since they can spread those costs over a pool of healthier enrollees. If they are to remain in business, insurers would be forced to charge people with predictably high and persistent costs enough to at least cover those costs—in some cases, hundreds of thousands of dollars a year. As a result, high-cost patients are often medically uninsurable.

State high risk pools are designed to provide coverage to those who are medically uninsurable. Such pools, which have been implemented in 34 states, offer discounted insurance coverage to persons who have been denied coverage by private insurers.[8] Although the states provide substantial subsidies, individuals in those pools must also pay sizeable premiums (albeit lower than the full market price). Enrollment in the pools has been low, due in part to high premiums, limited benefits, and limited outreach by states concerned about keeping program costs down. Additional state and federal funding would help to promote this health insurance safety net.

Obtaining insurance is only one of the health system challenges facing high-cost patients. These patients typically rely on a number of physicians, health professionals, and health facilities for their treatment. Patients could benefit from a more coordinated approach to their care, which would at least simplify their dealings with providers and

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[7] John F. Cogan and others, *Healthy, Wealthy, and Wise: Five Steps to a Better Health Care System*, AEI Press, 2005.
[8] Lori Achman and Deborah Chollet, "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools," Commonwealth Fund, August 2001.

might also reduce costs and improve quality. That requires the development of improved treatment protocols, more efficient sharing of patient information among multiple providers, and financial incentives to manage complex cases.

Elements of a Policy Agenda

The Congress has indicated its intention to expand the State Children's Health Insurance Program (SCHIP) by $50 billion over the next five years. Such an expansion could draw substantial numbers of children out of the private coverage that they already have and into the public program. Better targeting of the funds would minimize this crowd-out effect and direct our subsidies to those who are most in need. That is particularly important when budget resources are scarce, as they are this year.

Congress could also grant the governors additional flexibility to expand access to employer-sponsored insurance using SCHIP funds. Enabling low-income workers to purchase family coverage through their employer can make limited federal and state funds go further.

Although a great deal of attention will be paid to the SCHIP reauthorization, Congress should take the opportunity to address broader health system problems. The high cost of health care is driving efforts in both the public and private sectors to improve the performance of the health system. Congress has an opportunity to build upon those efforts with policies that promote better value for our health care dollars. We can and

must find ways to slow the growth of health spending, improve the effectiveness of care, and make health insurance more accessible for the uninsured and more affordable for everyone.

Mr. PALLONE. Thank you.
Dr. Lambrew.

STATEMENT OF JEANNE M. LAMBREW, ASSOCIATE PROFESSOR, THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Ms. LAMBREW. Chairman Pallone, Congressman Deal, members of the subcommittee, thank you very much for inviting me here to testify. I am Jeanne Lambrew, an associate professor at George Washington University.

Comprehensive reform has not been seriously discussed in Congress for over a decade, but as the first panel suggests, the problems are large and expanding. Stated simply, millions are uninsured, millions more are underinsured. We overpay for an underperforming system and this poor performance has literal life and death consequences.

Public support for change is growing along with the problems. One recent poll found that guaranteeing health insurance for all Americans is the top domestic issue, ranking higher than cutting taxes. And we have recent proof as we have heard that health reform is possible to achieve. Massachusetts enacted legislation last year. California is debating how, not whether, it should cover all residents and other States like New Jersey and Vermont are not far behind.

These bipartisan successful efforts shatter the prevailing wisdom that the status quo is inevitable. They challenge the belief that ideological wars will wage on forever, and they also shed light on what might be the pathway to get from our current system to universal coverage. Romney's plan to a lesser degree, Schwarzenegger's plan, some of the presidential candidates' plans all resemble a plan similar to one that myself and my colleagues put out in 2005. Our plan would achieve universal coverage by building on what works in the system. Medicaid, SCHIP, possibly Medicare will be expanded to become gap-free safety nets. Employer-based coverage would be supplemented with a new purchasing pool for group health insurance. Assistance would be provided to ensure that people who cannot afford it will get that coverage and all Americans would share in the responsibility for getting and keeping health coverage.

Covering all Americans is necessary but not sufficient to forge a 21st century health system. We need to lay the groundwork for improved efficiency and quality. In addition, we need to emphasize prevention. We at the Center for American Progress would cover prevention out of health insurance and create a new wellness trust to pay for it directly in all settings like schools and the workplace.

Laying this infrastructure for ensuring and expanding coverage will require an investment. My colleagues and I propose to pay for it with a small targeted value-added tax. Other ideas exist as well. But irrespective of the financing source, Federal spending probably needs to be raised to lower national health spending. Lower costs would result from insuring all Americans in a simpler, seamless system. We could reduce administrative costs which on a per-person basis are nearly six times higher than comparable nations. Lower costs would also result from emphasizing wellness since nearly 80 percent of our health costs today result from chronic ill-

ness. And efficiency policies like harnessing information technology could yield tens of billions in system-wide savings. Simply, we cannot sustain Medicare or even reduce our structural budget deficit if we fail to control health care cost growth.

A consensus on reform is neither elegant nor ideal but the fact that policy leaders on both sides of the aisle are beginning to circle around this kind of framework for reform suggests that we are within reach of figuring this out. Progress is not possible without leadership though. Encouraging support for reform among business leaders, political leaders and health care leaders is part of the work we do at the Center for American Progress. We are making headway. For example, AT&T, who we heard from before, Wal-Mart, SEIU are all involved in this Better Health Care Together coalition which is committed to trying to get to a reform system that has everybody in, that is value-oriented by the year 2012.

But unfortunately, insuring all American does not seem to be a priority of the current President. His budget's tax policy would likely accelerate the erosion of employer-based coverage while providing no viable alternative. High-deductible plans and scaled-back Medicaid benefits could replace uninsurance with underinsurance. And, his budget would underfund children's health, causing a decline in the number of children covered. Such policies could make matters worse.

This Congress does have an opportunity, however, to make inroads. This committee could advance health information technology, prevention, comparative effectiveness research, among others. These would lay the foundation for reform. But most importantly, this committee could successfully reauthorize the State Children's Health Insurance program. SCHIP has covered millions of low-income children through a strong Federal-State partnership. Extending and improving it would prove that where there is a will, there is a way.

So in closing, I encourage you to do what you can do this year so in 2009 we can come back and have this debate that hopefully is on our doorstep.

Thank you.

[The prepared statement of Ms. Lambrew follows:]

TESTIMONY OF JEANNE M. LAMBREW

Reasons Why Health Reform Should Be On the Agenda

- Serious health system problems
- Public opinion support
- Recent proof that reform is possible

Emerging Consensus On How to Get from Here to Universal Coverage

- Build on what works and make sure coverage is affordable
- Improve as well as expand coverage
- Recognize that we need to spend up-front to save in the long-run

What Needs to be Done

- Build leadership
- Block policies that go in the wrong direction
- Lay the groundwork for reform (e.g., information technology, prevention)
- Successfully reauthorize SCHIP

Chairman Pallone, Congressman Deal, and members of the Committee, I am Jeanne Lambrew, an associate professor at George Washington University and senior fellow at the Center for American Progress. I thank you for the opportunity to

testify today. I am particularly encouraged that you are focused on the challenge of covering all Americans. Comprehensive health reform is daunting. Presidents from Truman to Clinton tried and failed to enact legislation, and numerous bills to expand and improve coverage have languished in Congress. Considerable political capital, legislative skill, and will are needed to change a system that affects one-sixth of our economy and every single American. But, we are coming to the point where the effort it takes to repair the crumbling system may be greater than what it will take to build a better system.

Comprehensive health reform has not been seriously discussed in Congress for over a decade, but as the first panel suggests, the problems are large and expanding. The number of uninsured is roughly 45 million and growing. People who lack coverage have neither the same access nor the same outcomes as those with coverage. [1] Adding to their ranks are an estimated 16 million under-insured: people who, despite having coverage, are inadequately protected against health costs. [2] These same people who work hard to pay for coverage and care don't always get their money's worth. One study found that only 52 percent of people received care that clinicians recommend. [3] And, we have the most expensive system in the world by any measure. We pay $2 trillion or about 16 percent of our gross domestic product on health care—about $700 million more than peer nations, adjusted for wealth. [4] Stated simply, we overpay for an underperforming system. And this poor performance has literal life and death consequences.

In addition, public support for change is growing. A March New York Times / CBS News poll found that guaranteeing health insurance for all Americans is the top domestic policy issue, ranking far higher than immigration or cutting taxes. [5] For the last decade, the idea of a Federal guarantee of health insurance for all Americans had had more than 56 percent support, rising to close to two-thirds support in the last year. [6]

And, we have recent proof that health reform is possible to achieve. Massachusetts enacted legislation that will insure all State residents beginning on July 1. California is in the middle of a debate over how, not whether, to insure all of its residents. And States like Pennsylvania, Illinois, Vermont, and Maine are not far behind.

These bipartisan, successful State efforts shatter the prevailing wisdom in Washington that health care interests, protecting the status quo, are uncooperative and insurmountable. They belie the belief that the ideological wars will wage on forever. They also shed light on what might be the pathway from our current system to universal coverage. Romney's plan, to a lesser degree, Schwarzenegger's plan, and some of the presidential candidates' plans resemble one that my colleagues and I proposed in 2005. [7] It would achieve universal coverage by building on what works in the system. Medicaid, SCHIP, and possibly Medicare would be extended to become gap-free safety nets. Employer-based coverage would be supplemented with a new purchasing pool for group health insurance. Assistance would be provided to ensure that all people could afford coverage. And, all Americans would share the responsibility for getting and keeping health coverage, and keeping themselves well.

Covering all Americans is necessary but not sufficient to forge a 21st century health system. We need to lay the groundwork for improved efficiency and quality. This requires comparative effectiveness research to guide our payment and quality promotion policies. Health information technology is needed to improve system performance. And, new ways of setting health policies that lower political interference and raise private-sector trust are in dire need. Senator Daschle has been exploring an idea to model health system governance on the Federal Reserve. [8] In addition, emphasis must be placed on prevention. We would carve prevention out of health insurance and create a new Wellness Trust to pay for it in all settings, like schools and workplaces. [9]

Laying this infrastructure and insuring the uninsured will require an investment. My colleagues and I propose paying for it with a small, targeted value-added tax. Other ideas like an employer "pay or play" have been proposed as well. Irrespective of the financing source, Federal spending probably needs to be raised to lower national health costs. Lower costs would result from insuring all Americans in a simpler, seamless system. We could reduce administrative costs, which on a per-person basis, are nearly six times higher than in comparable nations. [10] Lower costs would also result from emphasizing wellness. Today, nearly 80 percent of our health costs result from chronic disease, much of which is preventable. And, harnessing information technology could yield system-wide savings of over $100 billion per year. [11] These investments are not only beneficial but necessary. We cannot sustain Medicare—or reduce our structural budget deficit—if we fail to control health care cost growth.

Consensus on health reform, by definition, is neither elegant nor ideal. A feasible plan cannot solve all the system problems. It will be called too bold by some and too timid by others. But the fact that Republican governors and Democratic presidential contenders are circling in on the same approach to improving and expanding coverage for all Americans suggests that reform is within reach.

Progress, however, is not possible without leadership. Encouraging support for reform among political, business, and health care leaders is part of the work of the Center for American Progress. We were encouraged by the show of support for universal coverage at the presidential forum on health reform that we co-sponsored with SEIU in Las Vegas last month. [12] We are making headway in collaboration with the Better Health Care Together coalition in cementing support for legislation to provide coverage for all, greater value, and shared responsibility for managing and financing a new American health care system by 2012. [13]

Unfortunately, it seems clear that insuring all Americans is not a priority of the current President. He did not embrace the recommendation of the bipartisan Citizens' Health Care Working Group to cover all Americans by 2012. [14] Instead, the President proposed replacing the employer tax exclusion with a standard tax deduction for health insurance. This would likely accelerate the erosion of employer coverage while providing no affordable alternative for many. [15] His advocacy for high-deductible plans and scaled-back Medicaid benefits could replace the problem of uninsurance with under-insurance, as people gain coverage that may not afford them access to care. [16] And, his budget would under-fund children's health, causing a decline in the number of children insured in public programs, according to the Congressional Budget Office. Such policies could exacerbate our health system problems.

This Congress, however, has an opportunity to make inroads into reform. This committee may advance and enact legislation on health information technology, prevention, and comparative effectiveness research. Most importantly, this committee has the responsibility to reauthorize the State Children's Health Insurance Program. This program has successfully reduced the number of uninsured children. It has built good working relationships between Federal and State governments, Republicans and Democrats, and special interests and advocates. Strengthening the program with the same support that created it would prove that, where there is a will, there is a way. And it would help pave the way for the next Congress, in 2009, to begin the legislative process on comprehensive health reform.

Notes:

[1] Hadley J. 2007. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," JAMA, 297(10): 1073–84.

[2]K Schoen C, Doty MM, Collins SR, Holmgran AL. (June 14, 2005) "Insured but Not Protected: How Many Adults are Underinsured?" Health Affairs Web Exclusive, *:http//content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.*

[3] McGlynn EA, Asch SM, Adams J, et al. (June 26, 2003). "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, vol. 348, no. 26, pp. 2635–45.

[4] National Health Accounts, National Health Spending, 2005 available at: *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf*;
McKinsey Global Institute. (January 2007). Accounting for the Cost of Health Care in the United States. New York: McKinsey Global Institute. *http://www.mckinsey.com/mgi/rp/healthcare/accounting—cost—healthcare.asp*

[5] Toner R. and Elder J. (March 2, 2007). "Most Support U.S. Guarantee of Coverage," the New York Times.

[6] Teixeira R. (March 23, 2007). "Public Opinion Snapshot: Universal Health Care Momentum Swells," The Center for American Progress, available at: *http://www.americanprogress.org/issues/2007/03/opinion—health—care.html*

[7] Lambrew JM, Podesta JD, and Shaw T. (March 23, 2005). "Change In Challenging Times: A Plan For Extending And Improving Health Coverage," Health Affairs Web Exclusive: W5–119–132.

[8] Daschle T. (December 15, 2006). "Trading Power for Progress: A Health Care "Fed" to Reform Coverage," Center for American Progress, available at *http://www.americanprogress.org/issues/2006/12/health—fed.html.*

[9] Lambrew JM and Podesta JD. (October 17, 2006). "Health Prevention as a Priority: Creating a Wellness Trust," Washington, DC: washingtonpost.com. *http://www.washingtonpost.com/wp-dyn/content/article/2006/10/16/AR2006101600880.html.* Lambrew JM and Podesta JD. (2006). Promoting Prevention and Preempting Costs: A New Wellness Trust for the United States. Washington, DC: Center for American Progress; Lambrew J.M. (April 2007). A "Wellness

Trust" to Prioritize Disease Prevention. Washington, DC: Brookings Institution, The Hamilton Project.

[10] McKinsey Global Institute. (January 2007). Accounting for the Cost of Health Care in the United States. New York: McKinsey Global Institute. *http://www.mckinsey.com/mgi/rp/healthcare/accounting—cost—healthcare.asp*

[11] Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, and Taylor R. (2005). "Can Electronic Medical Record Systems Transform Health Care? Potential Benefits, Savings, and Costs," Health Affairs24(5): 1103–17.

[12] For information on the forum, see: *http://www.americanprogressaction.org/events/healthforum/*

[13] Freudenheim M. (April 6, 2007). "New Urgency in Debating Health Care," The New York Times, available at: *http://www.nytimes.com/2007/04/06/business/06schism.html?ex=1177473600&en=679393f4626c26e6&ei=5070*

[14] For information on the Citizens" Working Group, see: *http://www.citizenshealthcare.gov/*. The law creating the group required the President to respond to its recommendations. This response was transmitted by Secretary Leavitt to Speaker Pelosi on March 13, 2007.

[15] Burman LE, Furman J, Leiserson G, and Williams R. (February 15, 2007). "The President's Proposed Standard Deduction for Health Insurance: An Evaluation," Tax Policy Center, available at: *http://www.taxpolicycenter.org/publications/template.cfm?PubID=411423*

Mr. PALLONE. Thank you, and thank you all. We will take some questions now and I will start by recognizing myself for 5 minutes.

I wanted to ask Mr. Knowlton, obviously a State like our own has major problems in terms of financing anything new and yet you believe and I believe that we are embarked soon on this effort to try to achieve universal coverage. So maybe explain to us why New Jersey sees the benefit of universal coverage and how that outweighs the financial costs that might be involved.

Mr. KNOWLTON. Mr. Chairman, I think that you can't afford not to do it. I think that what happens is, the cost has been escalating in New Jersey, the cost of what we are providing in charity care and hospital subsidies is about the same as what our actuaries tell us it will cost us to cover everybody universally. So we are going to have a concern on how we do a transition to a new system and help our hospitals out but by and large we are going to be spending about the same amount. We are just redirecting how we are spending it. And yet we are giving astronomically better care to people and people better access to care. You heard the gentleman whose wife died talk about what it felt like to be uninsured. We are going to step away from that, I think, so I think it will be a good investment.

Mr. PALLONE. And in that same regard, the plan you proposed creates a new health care market rather than using the currently existing market. Why did you design it that way?

Mr. KNOWLTON. We wanted to get one large pool and we wanted to get the underwriting advantage that we got from the law of large numbers. We wanted to stay away from a basic and essential plan or a catastrophic plan or a high-deductible plan. I am not going to comment on whether that is good for people on the commercial market who may choose it but we did not want it to be creating windows of uninsurance for people that were coming in from the uninsured. In New Jersey, hospitals are seeing a larger growing segment of bad debt that is coming from high deductibles and from people that aren't being reimbursed, so we didn't want to substitute one problem for another.

Mr. PALLONE. Thank you.

I wanted to ask Dr. Lambrew, we have heard about how some of the members on the other side have commented on how or some of the other witnesses from the previous panel that if you expand public programs, Medicare, Medicaid or SCHIP, that that might lead to crowd-out, so to speak, and specifically you talk about the role that these public programs play and whether they are good use of Federal dollars and whether expansions would help with the uninsured, whether that is smart and link it to the whole crowd-out issue.

Ms. LAMBREW. Well, it is an excellent question and I think you all anticipated this question when in 1999 Congress authorized a Federal evaluation of the State Children's Health Insurance Program. That evaluation found "The program did not lead to widespread substitution of SCHIP for employer coverage, even though almost all families enrolling their children had at least one working parent." A related study found that of those working parents, most of them were not in employer-based coverage. They were in jobs that did not offer health insurance coverage, and in a survey they found that of those recent enrollees in SCHIP, 43 percent were uninsured, another 29 percent were previously on Medicaid whose families earned too much income to then stay in that program, and of the 28 percent that had private coverage, fully a fourth said their families could no longer afford that coverage. So this is not a program, according to the Federal evaluation, that is in trouble. But I also think it is important to go back to the study that Grace-Marie Turner talked about. Jonathan Gruber, who is a former colleague of mine, wrote a letter in response to some of this use of this research saying, "I am somewhat disappointed to see my recent research being used to attack this valuable program. We find no evidence of crowd-out associated with SCHIP per se." He goes on to say that there is always some degree of crowd-out in any sort of public program expansion but "I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to buy out the base of insured without providing much new coverage." So I think we have to be very clear about the studies that we are using as we debate this program so we design our programs effectively.

Mr. PALLONE. Just a general question, I guess I will ask it of you because otherwise it will take all afternoon if I go through the whole panel, but we keep having this debate about improving or making employer-based coverage more robust versus expanding the public program, and I don't have any ideological basis, at least I don't think I do in that regard. If I could find a way to get all the employers to cover everybody who is working and that we wouldn't need as much Federal dollars, that would be fine with me. And there have been proposals out there like Senator Kerry had a proposal to take catastrophic off the table so that employers wouldn't have to pay for catastrophic care. How do we juxtapose those two? It would be great to expand the employer-based system but I know there are limitations. If you just would comment on it.

Ms. LAMBREW. It is a great question and a very difficult one. I would potentially argue that if the goal is to solve the one problem that we could solve, which is covering the uninsured, that I think

we have to look at a mix of public and private programs. 150 million people are insured through the employer-based system today. That is not going to go away overnight. People mostly like that coverage. We need to provide alternatives. I will be very clear about that. We all need to look at pools, look at what Massachusetts has done, look at what other people have proposed to find viable alternatives but I think a mix of public-private programs is probably the unique American solution to this. But I do want to go back to this issue of, does the President's proposal, which we have heard about a lot today with this tax fairness really get at that and because it doesn't actually work on the where people get insurance, there is a real risk that it actually is unfair because what it would do is, take away a worker's tax subsidy, tell that worker that you may get an amount, a standard deduction which could be less for a union worker or an older worker or people in high-cost areas and then they have no place to get insurance. In most States, there is no guarantee issue, meaning that you are guaranteed a coverage policy to be offered to you, nor a guarantee that that coverage is meaningful and affordable. So I actually think it is unfair to think through the idea of taking away what we have now and not replacing it with something fully developed.

Mr. PALLONE. I have to say that I think one of the mistakes that was made in the Clinton days was that the impression was being given, even if it wasn't true, that people were going to lose what they have and I think whatever we do, we have to make sure that if you have good coverage and you like it, that we don't reduce it and we don't take it away.

Thank you. I know I went over, and I am sure my colleagues will take note of that.

I recognize Mr. Deal.

Mr. DEAL. We would never take advantage of you.

We are going to be dealing with the reauthorization of SCHIP, of course, one of the issues that is going to be before this subcommittee and full committee. Dr. Knowlton, I understood from your testimony that you had 240,000 uninsured children in the State of New Jersey. Is that correct?

Mr. KNOWLTON. Yes, sir.

Mr. DEAL. The information that I have would indicate that over half of those, in other words, 125,000 of those are from families that are under 200 percent of poverty. In other words, 22 percent of all children in your State from families that are under 200 percent of poverty are still uninsured.

Reverend Wiggins, before we expand a program to include families of four with incomes of $82,600, which most of us in my State don't consider to be the poor of the poor, wouldn't it be reasonable to require that we get at least 90 percent of those that are in families below 200 percent of poverty, get them covered first before we start spending this money on the richer families? Wouldn't that seem reasonable?

Mr. WIGGINS. I think processes is key and eventually everybody should be included. I think it is just a matter of just really determining where we are in this process. If the lower number is not being covered under 200 percent of poverty level, we need to definitely include them and that may be the first step. It may be back-

wards possibly now but everybody should be included and that is our aim. That is the moral objective.

Mr. DEAL. But I know your program does a great deal of outreach and trying to get people covered. But the program was initially established to insure children in families under 200 percent of poverty.

Mr. WIGGINS. That is correct.

Mr. DEAL. And yet in your State that goes up to 350 percent of poverty, you still have 22 percent of those children that are below 200 percent of poverty are uninsured. Shouldn't we put more emphasis on increasing the number of those children that are covered first?

Mr. WIGGINS. I would agree.

Mr. DEAL. OK. I am not going to take advantage of the chairman's time but I do have a number of other questions that I think we need to try to explore, and the first is, Dr. Lambrew, I agree with you that wellness has to be a component of this. I am going to look into more about your wellness trust, I think that you advocate. One of the things that I have advocated is that as we look at SCHIP, if we are looking at trying to get that increase on the number of children under 200 percent of poverty enrolled or whatever the State establishes as its percent of poverty, one of the key places to do that is to find the children where they are and that is schools, and I notice your testimony alludes to you think that schools are a component in this wellness factor.

Would anyone think it was improper for the reauthorization of SCHIP to allow States to use a portion of their SCHIP funding to establish things like a school nurse program? I personally believe that that is where you are going to find the sick child. That is where you are more than likely to have somebody to call that parent and say your child needs to see somebody else and if they say, well, we don't have any insurance, to find out why they don't have any insurance. Does anybody think that would not be a good flexible option in SCHIP?

Ms. LAMBREW. I would just say that States can do this today with what is called their 10 percent funds. Up to 10 percent of their allotments are allowed to be used for direct services, administrative costs, et cetera.

Mr. DEAL. But I don't know of any that are doing that, do you?

Ms. LAMBREW. It is a question I don't know offhand but I would say that I think it is something in the reauthorization process, emphasizing the use of the 10 percent funds for wellness, obesity reduction, which is a huge challenge that we must address would be some way to do this as well as linking health insurance to school lunch programs and some of the free and reduced food programs that we have at schools. That would be a great way to find some of those children.

Mr. DEAL. OK. I realize that this is a very complex problem and I think all of you have acknowledged that it is not one simple solution to any of it.

Dr. Moffitt, I thought it was very interesting in your testimony that looking at who the uninsured really are, that most of them are people who are sort of in and out of jobs.

Mr. MOFFITT. Overwhelmingly.

Mr. DEAL. They lose, I believe you said only 12 percent were consistently there.

Mr. MOFFITT. Only 12 percent. That was the finding of the study, and I will tell you, Congressman, it is the best single thing in the English language I have ever read on the uninsured because what Graefe and Short did is take that data and look at that in great detail and they found that basically the problem is people losing coverage.

Mr. DEAL. And we know that a good portion of the uninsured are in that 17- or 18- to 24- or 25-year bracket, presumably the largest portion of the uninsured and they presumably are the healthiest.

Mr. MOFFITT. Yes, they are.

Mr. DEAL. And I don't know that we can get an answer but I guess the next question I have never seen answered is, what is the health status of the uninsured? If a large portion of them are these younger healthier people but they are uninsured, how does the overall uninsured picture stack up as to where they fit in the overall climate of health in the country?

Mr. MOFFITT. I think you have answered your own question. We know that health status and health conditions vary with age. That is why, for example, you have insurance rating that rates differently between people who are higher in age than lower in age. But the truth is that most young people who are uninsured are overwhelmingly healthy. The number of people who are uninsurable, that is to say people who are very, very ill, people who are uninsurable technically is actually a relatively small proportion of that population. Now, we have to design programs that are going to deal directly with them and I am very much in favor of doing precisely that. But the burden of my point was, is that the current employment-based health insurance arrangements we have today are not compatible with a 21st century economy where anywhere between one in three and one in four people are changing jobs every year. We have got to have a situation where people have stability in their health insurance coverage. If they have stability in their health insurance coverage, they are going to have continuity of care, and if you have continuity of care, you are going to have better outcomes.

Mr. PALLONE. Thank you.

Dr. Burgess.

Mr. BURGESS. And Dr. Moffitt, I would just add to that last thought that if you have continuity of your health insurance, the administrative burden borne by the individual trying to figure out what is the co-pay, what forms do I have to fill out, when does this trigger this event, all of that is known to the individual and they are less likely to be lost in the morass of regulations, which is one of the things we heard about at the last panel.

Mr. MOFFITT. That is correct.

Mr. BURGESS. I want to talk to you a little bit about the Massachusetts plan. When I first read about that I was certainly prepared not to like it and someone came from Massachusetts and talked to me about it and I thought well, maybe it doesn't sound so bad, don't tell anyone back in Texas I said that, and then Governor Romney came and spoke to a group of 14 or 15 of us here when he was still Governor and on some levels it did make some

sense. A lot of things about Massachusetts you cannot extrapolate to the rest of the country.

Mr. MOFFITT. No, you cannot.

Mr. BURGESS. And in my home State of Texas, Massachusetts doesn't even make up a decent-sized county, but I really like the concept of coupling an HSA which is bought with after-tax dollars and through that insurance connector that you talk about, it is suddenly available with pre-tax dollars. That seems to me to be a powerful step that you have taken in Massachusetts or that you have outlined for Massachusetts and one that I would like other States to emulate. I took that concept to my State senator, who now is working on the Lone Star connector, and while there will be no plan that mirrors Massachusetts in Texas any time soon, that concept is one that I think could extend the availability, the reach and the grasp of the health insurance that is available in an HSA to particularly that population that you referenced, the 17- to 24-year-old that is generally bulletproof; why do I have to spend all this money on this product, that amount of money could in fact fill up the SUV and the bass boat for the weekend and I could have a lot better time. But if there is a way to get it to them and get into their consciousness that this is a good investment, I think many more people will take it. It is interesting to me too that the flexibility that we provided in the Deficit Reduction Act of 2005 for all of the arrows that we have caught over that bill, the flexibility provided to States to allow them to begin to experiment with these things—again what is applicable and viable in Massachusetts may not be reasonable in Texas but we have got Massachusetts with Governor Romney, Vermont with a Republican Governor, California with a Republican Governor, and Texas is looking into doing some things with a Republican Governor. Of course, Jeb Bush before he left office was experimenting with some things. These are positive steps that are being taken by the States as a result of the flexibility that we built in for them in the Deficit Reduction Act. We passed that in 2005. is there anything you would like to add to that?

Mr. MOFFITT. No, I think that is exactly my point. You mentioned the Deficit Reduction Act and the waiver authority by the administration. Right now there are about 18 States that are experimenting with significant Medicaid reform. That is wonderful. One of the points that I tried to convey in my formal statement to the committee is that we are the heirs of political genius. The Founding Fathers designed a Federal system to enable a diversity of policy options. There is profound disagreement in Congress over which we should go in health care policies.

Mr. BURGESS. As you have seen today.

Mr. MOFFITT. Certainly. There is profound disagreement at this table, but nevertheless, the point is that we have a tremendous opportunity to promote experimentation at the State level, we can learn from that. We will find out what works in Massachusetts and what doesn't in California or any other State. But the point is, we will have a chance to see on the ground how these attempts to change the financing and delivery of health care are actually working out in improving outcomes and coverage.

Mr. BURGESS. Thank you.

Dr. Antos, if I could just briefly, you talked about insurance market reforms. I am not entirely in agreement with you about the President's plan though I am grateful that he brought it up but in so many ways, and I don't want to be heretical when I say this, in so many ways it seems like this is a plan for insurance companies and not for patients. That is, insurance companies are going to sell more insurance as a consequence of perhaps the premium-supported tax subsidy at the lower end. Do we need to be concerned about that? Do we need to be concerned that this is a policy that seems to be directed more toward an insurance company than it does towards taking care of patients?

Mr. ANTOS. I am not sure I agree with your characterization but isn't it better for insurance companies to sell insurance to people who don't have coverage now than for those people not to have coverage?

Mr. BURGESS. Well, obviously that is the thrust of this committee and hearing today and I referenced that in my opening statement. I wonder if we are taking the wrong approach to this. I like the concept of transparency. If we are going to do a consumer-directed health plan, transparency is key. Again, Texas has done I think a great thing by putting *TXpricepoint.org* up on the Internet. Anyone can go there. In my home county, in fact there is a significant difference between getting your hip fixed at one hospital versus another. The information now that is lacking is the information about doctors and again, I will probably get some pushback from this from my friends in the physician community but that information is going to be important for patients to have as well if we are truly going to develop a plan that is reasonable for people. Is there a point at which the health care premium, is there a percentage of the health care premium that should be returned for patient care, for paying for health care or is that a number that just is simply unknown?

Mr. ANTOS. The so-called loss ratio is a magical number in politics but it isn't a very magical number in health insurance. There is an excellent article by Jamie Robinson at the University of California at Berkeley who explains all this. I will be delighted to send that to the committee.

Mr. BURGESS. Please.

Mr. ANTOS. And he makes the point that, a fundamental point about life in this country, accountants rule us, and so depending on how you organize your business structure, you can make the administrative costs look very high or very low. The fact is that at least some of the administrative costs are absolutely necessary, if we are going to have the kind of insurance that we are talking about, third-party payment, if we are going to have somebody else pay the bills, then that somebody else has a fiduciary responsibility to us to make sure that the bills are appropriate and to negotiate reasonable prices and so on. That costs money. We wouldn't have the kind of take-up of generic drugs in this country—we are up over 60 percent now—if it weren't for the fact that somebody was pushing us to do it. So it is not all waste. Another point that I think needs to be made is that while insurance companies can certainly become more efficient, they can do a better job of embracing the kind of health information technology that is appropriate at

that end to make it easier for you and me to use our health insurance and to get better information and do the right thing in the first place rather than to go from doctor to doctor and make the wrong decisions consecutively. There is work being done in that area. It is slow but then everything else is in the health sector.

Mr. BURGESS. Isn't that the truth?

Mr. PALLONE. We are at 3 minutes over almost so——

Mr. BURGESS. Dr. Lambrew, can I just ask you, you said an increase in Federal spending, do you have an idea as to what that——

Mr. PALLONE. Doctor, please. We have got to move on. It is 3 minutes.

Mr. BURGESS. Let her answer the question. Do you have an idea——

Mr. PALLONE. I have to stop. Listen, thank you all. I really appreciate it. I think this was—no, I know, but it is 3 minutes. We have to stop. Thank you all really. You gave us some real insight into what we have to do and particularly to what some of the States are doing. So I want to thank you all. We have a process whereby members can submit additional questions for the record and then you would answer them, and those will be submitted within the next 10 days.

And without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured

Stability merits consideration as an explicit goal of health insurance coverage reforms.

by Pamela Farley Short and Deborah R. Graefe

ABSTRACT: This study assesses the stability of Americans' health insurance status over a four-year period. Relatively few Americans were continuously uninsured for the four years 1996 to 1999, but a sizable number of the uninsured lacked a stable source of coverage. At least as many people were repeatedly uninsured as experienced a single gap in otherwise stable coverage. Given these dynamics, policymakers should think of "uninsured" as referring not to people, but rather to gaps in coverage over time. Reforms that stop short of universal coverage should be evaluated in terms of their likely effects on the continuity and stability of coverage.

NATIONAL SURVEYS OVER THE PAST QUARTER-CENTURY have shown considerable turnover in the uninsured population over time. A persistent finding, going back to the first survey estimates of the all- and part-year uninsured from 1977, is that half to two-thirds of the people who are uninsured over the course of any year move into or out of coverage during that year.[1] High turnover means that many of the approximately forty million people who are now uninsured will not be among the forty million who are uninsured a year from now.

In addition, experts agree that many people who lose their health insurance regain coverage within a relatively short time. Indeed, studies published during the past ten years consistently show that half of uninsured spells end within five or six months.[2] However, experts also agree that many people who are uninsured at a point in time are uninsured for much longer than five or six months.[3] This apparent contradiction arises because a snapshot of the uninsured at a point in time catches only a fraction of the ongoing stream of people who flow quickly into and out of the uninsured "pool." This fast-moving stream corresponds to people with short uninsured spells. People who move slowly through the pool, by contrast, remain there for long periods of time. Thus, most people with long uninsured spells

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are captured in any snapshot of the pool, no matter when it is taken.

One important aspect of health insurance dynamics is still largely unexplored: the stability or instability of coverage over time. Whether uninsured spells are typically isolated incidents or part of a recurring pattern is important for policymakers to understand as they assess the consequences of being uninsured and public policies to expand health insurance.

To date, data limitations have prevented a good assessment of stability. Surveys that interview frequently enough to identify short coverage gaps, such as the Medical Expenditure Panel Survey (MEPS) or the Survey of Income and Program Participation (SIPP), have followed participants for only two to two and a half years—a period too short to observe many recurring spells. Surveys that follow people over longer periods, such as the National Longitudinal Survey of Youth or the Health and Retirement Survey, interview participants less often, because of cost and burden on respondents. However, interviews spaced a year or two apart are likely to miss short-term coverage changes.

Our study takes advantage of a unique opportunity afforded by the 1996 SIPP panel to study monthly health insurance status over a long enough time to assess stability. The U.S. Census Bureau redesigned SIPP in the mid-1990s and fielded the 1996 panel for four years; however, future panels will last for only three years.

In the first look at stability with the 1996 SIPP panel, using three years of data, the Congressional Budget Office (CBO) recently reported that more than 40 percent of the people who started an uninsured spell between July 1996 and July 1997 experienced at least one more uninsured spell in the next two years.[4] In this paper we assess stability by examining in more detail the number and types of health insurance changes experienced by the uninsured over the four years 1996–1999. We summarize these dynamics as general patterns over time. Then we count the total number of people associated with each pattern and the number of months, out of a maximum of forty-eight, that each person was uninsured.

Data And Methods

■ **Survey of Income and Program Participation.** SIPP, conducted by the U.S. Census Bureau since the 1980s, is a multiyear panel survey that interviews the same people every four months for several years. One-quarter of the sample, assigned to one of four "rotation groups," is interviewed each month. The first wave of interviewing, covering the four months preceding the month of interview, began for the 1996 panel in April 1996. The last interviews were conducted in March 2000. Consequently, the forty-eight-month reference period varied by rotation group, beginning as early as December 1995 for the first rotation group and ending as late as February 2000 for the fourth rotation group.

Health insurance questions covering the preceding four months were asked at each interview. Respondents could report changes in insurance and other aspects of their lives in any month. However, there is a well-known tendency for SIPP re-

spondents to report changes at the "seam" between interviews instead of between months covered by the same interview.[5] This so-called seam problem means that counts of insured and uninsured months over the panel cluster at multiples of four. For example, uninsured spells lasting four or eight months are reported far more often than spells lasting six months.[6]

■ **Population studied.** Longitudinal survey weights created by the Census Bureau project to the U.S. civilian noninstitutionalized population and adjust for nonresponse and attrition over multiple interviews.[7] In constructing the longitudinal weights, the Census Bureau restricted the population and the sample to people in the target population at the start of the survey. As a result, newborns, immigrants, and others who subsequently joined the target population were excluded. In addition, our health insurance analyses were restricted to people who were younger than age sixty-five throughout the survey period. An estimated 225.6 million people in the 1996 population cohort were in this age group at the end of 1999. The unweighted sample size was 40,731, including 13,759 people who were ever uninsured.

Although the longitudinal weight developed by the Census Bureau adjusts for differential nonresponse and attrition associated with many characteristics (including age, sex, ethnicity, race, household/family structure, employment, family income and assets, welfare receipt, education, and geographic location), it does not specifically consider health insurance status. Consequently, we made a final adjustment to the longitudinal weight to match weighted counts of coverage status by age and family income in the last month of the survey according to the monthly weight also provided by the Census Bureau.[8]

■ **Monthly health insurance and patterns of coverage over time.** Using monthly health insurance variables on the longitudinal public-use files, we assigned participants to a single coverage category according to the following hierarchy for people with multiple sources of coverage in a month: Medicaid or State Children's Health Insurance Program (SCHIP), Medicare, employer, nongroup private, and uninsured CHAMPUS/CHAMPVA and other military insurance were included with employer insurance. SIPP does not distinguish between Medicaid and SCHIP.

The variables that assigned people to a single type of coverage in each month were used to assign everyone who was ever uninsured to one of seven different patterns of coverage over time, based on the number and types of changes in monthly coverage status in four years. For example, one pattern was to remain uninsured throughout the four years. In addition to this "hard core" of uninsured people, we identified four other patterns that involved no more than two changes in coverage over four years. Although some typically involved long periods without insurance, while others typically involved long periods with insurance, we characterized all patterns involving no more than two changes as "relatively stable." We characterized two other patterns among the uninsured, distinguished by three or more changes in coverage over four years, as "unstable."

■ **Long-term family income as a percentage of poverty.** We assigned people

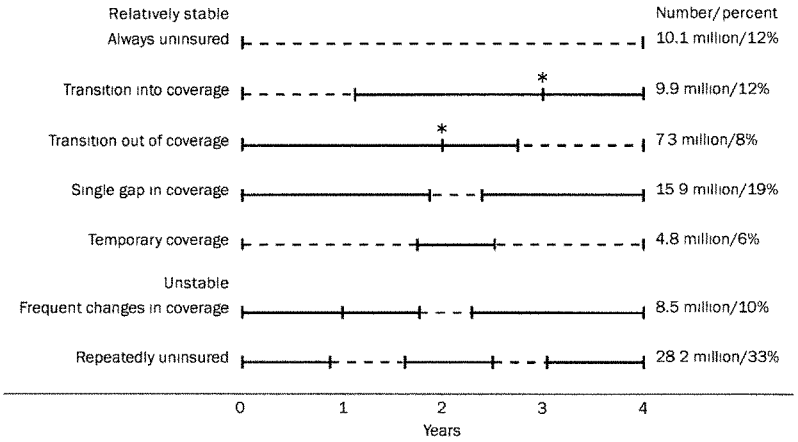
to categories of family income as a percentage of the federal poverty level by taking a long-term view of their economic well-being. The first step was to sum monthly family income for each person over the forty-eight months. We also summed the monthly poverty thresholds assigned monthly by the Census Bureau to each person. The latter calculation defines the total family income that would have maintained each person at the poverty standard over the four years, with the usual adjustments for family size. Finally, we divided the summed income by the summed poverty thresholds, to assign the person to a percentage of the federal poverty level

Study Results

■ **Basic patterns over four years.** A total of 84.8 million Americans under age sixty-five were uninsured for at least one month in the four years from 1996 through 1999. Reflecting turnover in the uninsured population, this figure is much larger than estimates of the uninsured for a year or a point in time: One out of three people had a lapse in coverage some time during the four years. Relatively few of the uninsured were without coverage for the entire four years—only 10.1 million, or 4 percent of the nonelderly population—so most of the uninsured had one or more changes in coverage over time (Exhibit 1).

Relatively stable. One of the simplest patterns occurred when people who were initially uninsured moved into coverage for the rest of the four years. Ten million people fit this pattern. The large majority of this group (7.1 million, data not

EXHIBIT 1
Patterns Of Health Insurance Coverage Over Four Years, U.S. Uninsured Population Under Age 65, 1996–1999



SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP).
NOTES: Dashed lines denote periods of uninsurance, solid lines, periods of insurance Asterisks denote transitions experienced by some, but not all, of the people with the specified pattern Total number of people ever uninsured 84 8 million

shown) got and kept employer insurance. Others got and kept Medicaid/SCHIP (1.4 million), nongroup insurance (400,000), or Medicare (150,000). Another 900,000 people moved seamlessly into a second type of coverage after becoming insured (as indicated by the starred transition in Exhibit 1). Typically, transitions into coverage were associated with more, rather than less, coverage over the four-year period (Exhibit 2). Less than one-third of the uninsured in this category were uninsured more than half the time—that is, more than twenty-four months.

Conversely, 7.3 million people were covered at the start of the survey and moved out of coverage for the rest of the four years (Exhibit 1). In this group, 37 percent were uninsured for more than two years (Exhibit 2), a slightly higher percentage than for transitions into coverage. More than four million of these people started with employer insurance and lost it. Two million began with Medicaid/SCHIP and then became uninsured. About 700,000 changed sources of coverage once before becoming uninsured, as indicated by the starred transition in Exhibit 1.

Sixteen million people were initially insured and experienced a single, temporary gap in coverage (Exhibit 1). Usually this gap lasted a year or less (Exhibit 2). People who lost and regained employer insurance (11.2 million, data not shown) or Medicaid/SCHIP (2.6 million) mainly accounted for this pattern. Those who left one type of coverage and took up another were also included here.

While those who experienced a single gap in coverage were typically uninsured for a relatively short time, those who experienced the next pattern—"temporary coverage"—were typically uninsured longer. This pattern involved nearly five million people who were initially uninsured, moved into some type of coverage, and then lost it (Exhibit 1). Nearly 90 percent were uninsured for more than two years (Exhibit 2). Two-thirds were temporarily covered by employer insurance, while

EXHIBIT 2
Percentage Distribution Of The Uninsured By Total Months Uninsured Over Four Years, According To Coverage Patterns, U.S. Population Under Age 65, 1996–1999

		Number of months uninsured (%)			
	Millions	**1–4**	**5–12**	**13–24**	**25–48**
Total	84.8	24	22	19	35
Coverage pattern					
Always uninsured	10.1	0	0	0	100
Transition into coverage	9.9	24	22	23	31
Transition out of coverage	7.3	24	20	19	37
One gap in coverage	15 9	64	22	10	5
Temporary coverage	4.8	0[a]	4	8	87
Frequent changes	8.5	64	22	10	4
Repeatedly uninsured	28.2	4	33	34	30

SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP)
NOTE: Row percentages might not sum to 100 because of rounding
[a] Less than 0 5 percent

Medicaid/SCHIP covered around one-third (data not shown).

Unstable. Two additional patterns, which we characterized as unstable, involved three or more coverage changes over four years. People with these patterns remained in each type of coverage (or uninsured) for an average of one year or less before changing (Exhibit 1). We divided people with numerous changes into two distinct groups, based on the number of times that they were uninsured.

The first group, "frequent changes," was by far the smaller, involving 8.5 million people who experienced only one uninsured spell but made several changes in coverage. This pattern might be characterized as "scrambling for coverage." For example, about a half-million left employer insurance, switched to nongroup insurance, became uninsured, and then returned to employer insurance. Generally, the lapse in coverage was relatively short (Exhibit 2).

The other unstable pattern, "repeatedly uninsured," involved at least two uninsured spells and at least two covered spells. This was the most common of the seven patterns we identified (Exhibit 1). Given their intermittent coverage, many people in this group were insured for much of the four-year period (Exhibit 2).

■ **Differences by age.** Although the percentage of people ever uninsured was lowest among people age thirty-five and older (Exhibit 3), older adults (ages 55–64) who were uninsured were the most likely to lack coverage for the entire four-year period. Uninsured children, on the other hand, were the most likely to experience repeated spells without insurance and to have a single gap in coverage Young adults (ages 19–24) were particularly distinguished by the relatively high percentage who simply moved out of coverage for the rest of the four years, as well as a relatively high percentage who were repeatedly uninsured.

EXHIBIT 3
Patterns Of Coverage Over Four Years For The Uninsured By Age, U.S. Population Under Age 65, 1996–1999

	Age at end of four years				
	Under 19	**19–24**	**25–34**	**35–54**	**55–64**
Total ever uninsured					
Millions	25.5	12 3	19 6	22.6	4 9
Percent of population	42%	55%	51%	28%	21%
Percent distribution of the uninsured					
Always uninsured	7%	8%	11%	18%	22%
Transition into coverage	8	8	15	14	13
Transition out of coverage	7	14	7	9	8
One gap in coverage	22	15	18	19	15
Temporary coverage	4	6	7	6	7
Frequent changes	12	11	8	9	13
Repeatedly uninsured	40	39	33	25	22

SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP)
NOTE: Column percentages might not sum to 100 because of rounding

■ **Differences by long-term income.** More than two-thirds of the people in the two income groups below 200 percent of the poverty level were uninsured at some point during the four years (Exhibit 4). Although the percentage ever uninsured was higher for the poor than for people just above the poverty level, rates of uninsurance in the two lower-income groups were more similar to each other than to those of the higher-income groups. Among the uninsured, the percentages of people uninsured for four years or repeatedly uninsured were similarly high, and the percentages of people with a single, temporary gap in coverage were low relative to the uninsured in the two higher-income groups.

There were two main differences between the two higher-income groups with respect to the dynamics of being uninsured. People at 400 percent of poverty or more were more likely to have a single gap in coverage, and people at 200–399 percent of poverty were more likely to have multiple spells without coverage

■ **More details on the repeatedly uninsured.** We found that repeated spells of Medicaid/SCHIP or employer insurance were quite common among people who were repeatedly uninsured. Consequently, we further classified the repeatedly uninsured into four groups involving reentry into Medicaid/SCHIP or employer insurance. One group alternated between Medicaid and uninsured spells. Another group alternated between employer insurance and uninsured spells. A smaller group repeated both Medicaid and employer insurance as well as uninsured spells. The last group moved from one type of coverage to another without returning to Medicaid/SCHIP or employer insurance. Three to five transitions over four years were the most common, but more transitions were often reported.

Children below 200 percent of poverty. Eight million children below 200 percent of

EXHIBIT 4
Patterns Of Coverage Over Four Years For The Uninsured, By Income, U.S. Population Under Age 65, 1996–1999

	Long-term family income as percent of poverty			
	<100	100–199	200–399	400+
Total ever uninsured				
Millions	16.6	28 6	28 6	11.0
Percent of population	70%	66%	34%	15%
Percent distribution of the uninsured				
Always uninsured	14%	16%	9%	6%
Transition into coverage	7	11	14	14
Transition out of coverage	10	9	8	8
One gap in coverage	15	12	23	31
Temporary coverage	6	7	5	3
Frequent changes	8	9	11	13
Repeatedly uninsured	41	36	30	23

SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP)
NOTE: Column percentages might not sum to 100 because of rounding

poverty were repeatedly uninsured (Exhibit 5). Medicaid/SCHIP covered 81 percent at some point, and employers covered 76 percent at some point (data not shown). Many left and reentered Medicaid/SCHIP (4.9 million, including one million who also left and reentered employer insurance). About two million reentered employer insurance but were not on Medicaid/SCHIP more than once (if at all). The remainder moved through some other combination of nongroup insurance, employer insurance, and Medicaid/SCHIP that left them uninsured more than once. About a quarter who reentered either Medicaid/SCHIP or employer insurance (but not both) were uninsured for more than two years, while 41 percent of the residual group who did not recycle through either Medicaid/SCHIP or employer insurance were uninsured for more than two years.

Adults below 200 percent of poverty. More than nine million adults below 200 percent of poverty were repeatedly uninsured (Exhibit 5). Three-quarters were covered at some point by employers, and two-thirds were enrolled in Medicaid (data not shown). A little more than three million were on Medicaid intermittently,

EXHIBIT 5
Detailed Patterns Of Coverage For The Repeatedly Uninsured, By Total Months Uninsured Over Four Years, According To Age And Income, U.S. Population Under Age 65, 1996–1999

		Number of months uninsured (%)			
Age/Income group	**Millions**	**1–4**	**5–12**	**13–24**	**25–47**
Children under 200% of poverty	8 0	2	38	36	24
Repeated Medicaid	3.9	1	38	39	23
Repeated Medicaid and repeated employer	1 0	6	50	36	9
Repeated employer	2 1	3	38	34	25
Other	1.0	2	26	31	41
Children 200% or more of poverty	2.3	4	43	31	21
Repeated Medicaid	0.3	–[a]	–[a]	–[a]	–[a]
Repeated Medicaid and repeated employer	0.1	–[a]	–[a]	–[a]	–[a]
Repeated employer	1.6	5	48	31	17
Other	0 3	–[a]	–[a]	–[a]	–[a]
Adults under 200% of poverty	9.1	2	26	33	39
Repeated Medicaid	3 3	2	26	30	41
Repeated Medicaid and repeated employer	0.6	4	42	41	13
Repeated employer	3 6	2	24	36	38
Other	1 6	1	21	30	48
Adults 200% or more of poverty	8 8	6	33	33	27
Repeated Medicaid	0 5	–[a]	–[a]	–[a]	–[a]
Repeated Medicaid and repeated employer	0 1	–[a]	–[a]	–[a]	–[a]
Repeated employer	6 7	7	34	33	26
Other	1 5	5	28	34	33

SOURCE: Authors' tabulations of the 1996 panel of the Survey of Income and Program Participation (SIPP)
NOTE: Row percentages might not sum to 100 because of rounding
[a]Sample size is too small to estimate distribution

"Efforts to target 'pockets' of the uninsured with incremental coverage reforms must target the right people at the right time."

without being covered more than once by employers. A similar number were repeatedly covered by employers but were not repeatedly on Medicaid. About a half-million were in and out of both types of coverage. Compared with children who were repeatedly uninsured at the same income level, adults tended to go much longer without coverage. Overall, 39 percent of adults were uninsured for more than two years, compared with 24 percent of children.

Children and adults above 200 percent of poverty. Far fewer children with household incomes above 200 percent of poverty were repeatedly uninsured than were those below 200 percent of poverty (Exhibit 5). The number of repeatedly uninsured adults was similar above and below 200 percent of poverty. In the higher-income group, roughly three-quarters of children and three-quarters of adults were covered repeatedly by employer insurance. A good number of adults (1.5 million) did not go through multiple periods of employer insurance (or Medicaid) but typically had a single spell of employer insurance in combination with other sources of coverage (including one spell of Medicaid/SCHIP, one or more spells of nongroup insurance, or Medicare). Eighty percent of adults in this last group were covered at some point by nongroup insurance (data not shown).

Discussion And Policy Implications

As the classification of the uninsured into seven dynamic patterns makes clear, relatively few people remain uninsured for long periods of time. Under these circumstances, efforts to target "pockets" of the uninsured with incremental coverage reforms must target the right people at the right time. Indeed, in designing almost any reform that stops short of universal coverage, policymakers should think of "uninsured" as referring not to people but to gaps in time. On the other hand, incremental reforms should be evaluated in terms of effects on people, specifically on the continuity and stability of each person's coverage over time.

■ **Isolated versus repeated gaps.** Our findings confirm that gaps in coverage are often relatively short However, this observation could mislead policymakers in several ways. First, it understates the exposure of the uninsured to health and financial risks. Although 70 percent of new uninsured spells in the 1996 SIPP panel lasted for a year or less, we found that the majority of the uninsured were uninsured for more than twelve months over a four-year period.[9] Second, focusing on the length of each uninsured spell ignores the issue of stability and fails to distinguish between isolated coverage gaps and those that are part of a recurring pattern. Finally, the distinction between isolated and repeated gaps is important not only in assessing the overall seriousness of the uninsured problem, but also in designing policy solutions.

Isolated gaps in otherwise stable coverage are common enough to warrant pol-

icy consideration, especially among the uninsured at higher income levels. About 20 percent of the uninsured at all income levels and nearly one-third of the uninsured above 400 percent of poverty exhibited this pattern over the four years we studied. Most of these one-time gaps were relatively short. For the 70 percent of these situations that involved the loss of and return to employer insurance, Consolidated Omnibus Budget Reconciliation Act (COBRA)–like strategies for extending employer-sponsored insurance seem well suited to bridging the coverage gaps. Indeed, because the gaps are generally short, continuation strategies would provide more stability than moving temporarily into the nongroup market or public insurance. Among other people with stable coverage except for a single gap, most lost and returned to Medicaid/SCHIP. This observation raises issues about retention strategies for Medicaid/SCHIP, which we discuss further below.

Even more people had repeated gaps in coverage. They occurred more often at lower income levels, especially among children, but they were the second most common pattern even at the highest income levels. During the four years we studied, twenty-eight million people were repeatedly without health insurance. Statistics showing that most uninsured spells were relatively short are misleading for these people. With recurring gaps in their health insurance, they were exposed to more financial risk and faced more impediments to accessing services than is evident from the length of each uninsured spell.

■ **Strategies for Medicaid retention.** Turnover in Medicaid contributed to this instability, especially at lower income levels. Slightly more than half of the people below 200 percent of poverty who were repeatedly uninsured at the end of the 1990s left and reentered Medicaid or SCHIP. Both administrative simplifications and changes in eligibility rules could stabilize these programs' coverage. For example, states could do more to simplify procedures for renewing Medicaid or SCHIP, and many more states could exercise the option of enrolling children in Medicaid for twelve months at a time, without regard to changes in eligibility criteria [10]

■ **Strategies for unstable employer coverage.** Where repeated gaps are caused mainly by the instability of employer-sponsored health insurance, policymakers should focus on developing more stable alternatives in the nongroup market or under public auspices—especially for people at lower income levels. Even with subsidies to low-income workers who lose employer insurance, COBRA-like strategies are not likely to work well in these circumstances Employers will likely resist the idea of providing continuation coverage to low-wage workers who move quickly in and out of their health plans. In a recent national survey of employer coverage, firms with a high concentration of low-wage workers were far more likely than other employers to impose waiting periods before new employees could qualify for coverage.[11] For a large segment of the uninsured, employer insurance is not likely to serve as a stable platform for constructing coverage expansions.

Furthermore, "crowding out" periods of employer-sponsored insurance with enrollment in a public program might not be bad policy if it provided a stable

source of coverage for people who would otherwise cycle in and out of employer plans. One can imagine arrangements where employers might sometimes contribute to the cost, when a person's employment situation warrants, without actually administering the coverage.

■ **Stability as a policy goal.** The overarching implication of these data is that stability merits consideration as an explicit and important goal of coverage reforms. Furthermore, if coverage stability is to be taken seriously, then longitudinal surveys such as SIPP must be designed and consistently funded to track problems and progress in relation to that goal. Greater stability would bring a sense of security to people who are constantly at risk of losing their health insurance. Continuity of coverage is also likely to facilitate continuity of care. We estimated that nearly thirty-seven million people who were uninsured in the latter half of the 1990s lacked a stable source of health insurance, as indicated by at least three changes in health insurance status in four years. Instead of being plugged into a dependable source of coverage, they were covered by battery-powered health insurance.

■ **Caveats.** These estimates of the extent of change over time could be colored by idiosyncrasies of the time period covered by the 1996 SIPP panel Federal welfare reforms were enacted in 1996, SCHIP expanded children's coverage, and the U.S. economy was booming. The number of children who left and returned to public insurance could reflect the implementation of SCHIP during the period.

Inconsistencies and errors in survey responses could also contribute to the apparent number of health insurance changes in SIPP, especially the apparently short-term interruptions and changes in coverage lasting only for the four months covered by a single interview. While reporting errors could exaggerate the amount of change, we report less change by ignoring transitions from one employer group to another. In addition, biases associated with panel attrition that are not corrected by the adjusted longitudinal survey weights would probably overrepresent people with stable lives over the four-year period. That would also cause us to underestimate changes in health insurance.

Finally, the specific numbers we report are a function of the four-year window of observation offered by the survey. A longer survey would reveal more people with repeated gaps in coverage and fewer people who were continuously uninsured. Also, further research that went beyond these numbers and examined the circumstances accounting for frequent transitions or repeated gaps, such as changes in Medicaid eligibility or employment instability, would be helpful in designing policies to improve stability.

DESPITE THESE CAVEATS, the basic policy messages are clear: Few people are continuously uninsured for as long as four years, but many of the uninsured are exposed to major financial and health risks over time. Many uninsured people lack access to a stable source of health insurance. And at least as many people are repeatedly uninsured as experience a one-time interruption in

generally stable coverage. Any incremental policy that stops short of trying to insure all of the people all of the time must give careful consideration to these health insurance dynamics.

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NOTES

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STATEMENT OF THE AMERICAN CANCER SOCIETY

Dear Chairman Dingell, Rep. Barton, Chairman Pallone and Rep. Deal:

On behalf of the American Cancer Society, we welcome your invitation to participate in the Energy and Commerce Committee's Health Subcommittee hearing entitled "Living Without Health Insurance: Why Every American Needs Coverage."

The testimony of Mr. Gary Rotzler speaks to the experience of millions of American families who are either seriously underinsured or who have no health insurance at all. In the case of Mr. Rotzler, his beloved wife Betsy died prematurely because she did not have access to preventive health services that might have revealed her breast cancer at an earlier, perhaps treatable stage. We know that the research is clear—people who lack insurance delay going to the doctor until they are sick and then they have worse outcomes.

While some Americans have no insurance, others have varying levels of inadequate coverage with little real understanding of how financially vulnerable they may be. Over the years, the Society has worked to provide information, comfort and assistance to people who have learned they have cancer. Our Health Insurance Assistance Project (HIAP) operates 24 hours a day in 26 States providing patients information about the disease, medicines, available clinical trials, doctors, and insurance. Incidental to this process, we have captured the stories of thousands of people for whom the health care system has failed in some serious way.

Out of these real-life experiences, we have developed four essential principles that define meaningful health insurance as part of a larger effort to elevate the importance of access to care to the country's ability to defeat deadly diseases like cancer. The principles state that health insurance must be:

- Adequate—with timely access and coverage offering the full range of evidence-based healthcare services, including prevention and early detention, and supportive needs, including acute treatment with access to clinical trials, chronic disease management and palliative care.
- Affordable—with total costs not excessive and based on the patient's ability to pay.
- Available—with coverage available regardless of health status or claims history, and that it be renewable and continuous.
- Administratively simple—with benefits, financial liability, billing procedures, and processes for filing claims that are easy to understand, and so consumers are able to compare plans when making choices about health insurance.
- These principles highlight major problems in the health care system—problems which continue to impede progress against cancer and other major diseases. As you move forward with your examination of health insurance, we would like to work with you to incorporate and operationalize these basic principles into health insurance reform legislation. Thank you again for inviting the American Cancer Society to testify today, and we look forward to working with you.

Sincerely,

Daniel E. Smith
National Vice President,
Federal and State Government Relations

Wendy K.D. Selig,
Vice President, Legislative Affairs

AMERICAN CANCER SOCIETY STATEMENT OF PRINCIPLES ON WHAT CONSTITUTES MEANINGFUL HEALTH INSURANCE

The American Cancer Society is the nationwide community based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society has set ambitious goals for significantly reducing the rates of cancer incidence and mortality along with measurably improving the quality of life for all people with cancer.

"The ultimate conquest of cancer in America is as much a public policy aspiration as it is a scientific and medical challenge. There are many stakeholders in the cancer fight actively doing their part to defeat this disease, but it cannot be done without the sustained leadership and strong commitment of government. We are poised to make gains so substantial that we now can talk about a time when cancer is no longer a killer and is instead just a chronic condition, or even better, a disease for which a cure is a realistic, frequently achieved goal. Our Nation's current health

care system is not up to this challenge. If we are to ultimately conquer cancer our system must ensure that all Americans have access to high quality care." [1]

Improving the Nation's health care system requires a new partnership for the Nation that will facilitate the coverage and delivery of quality evidence-based cancer care and work to eliminate disparities and inequities in the current system. This will require a commitment from the private, public, and not-for-profit sectors and individuals. Stakeholders in the health care system, from doctors, hospitals, and insurers, to employers, and not-for-profit organizations, all have critical roles to play. All Americans have an obligation, as well, to take responsibility for their own health to the extent possible, by pursuing healthy lifestyles, and educating themselves about their health needs, including ways to prevent and detect cancer.

A critical aspect of improving the health care system is to define and ensure access to meaningful public or private insurance. This includes adequate financing. Our Nation has had much conversation on the insured and uninsured and less on what it means to be meaningfully insured. Below is the statement of the American Cancer Society on what constitutes meaningful health insurance.

STATEMENT OF PRINCIPLES

It is a fundamental principle of the American Cancer Society that everyone should have meaningful public or private health insurance.

Meaningful health insurance is adequate, affordable, available and administratively simple.

Adequate health insurance means:

• timely access and coverage of the complete continuum of quality, evidence-based healthcare services (i.e., rational, science-based, patient-centered), including prevention and early detection, diagnosis, and treatment
• supportive services should be available as appropriate, including access to clinical trials, chronic disease management, and palliative care
• coverage with sufficient annual and lifetime benefits to cover catastrophic expenditures

Available health insurance means:

• coverage will be available regardless of health status, or claims history
• policies are renewable
• coverage is continuous

Affordable health insurance means:

• costs, including premiums, deductibles, co-pays, and total out-of-pocket expenditure limits, are not excessive and are based on the family's or individual's ability to pay
• premium pricing is not based on health status or claims experience

Administratively simple health insurance means:

• clear, up-front explanations of covered benefits, financial liability, billing procedures, and processes for filing claims, grievances, and appeals are easily understood and timely, and required forms are readily comprehensible by consumers, providers and regulators
• consumers can reasonably compare and contrast the different health insurance plans available and can navigate health insurance transactions and transitions

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TESTIMONY OF SISTER CAROL KEEHAN, DC

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of Catholic health care providers, I would like to thank Chairman Pallone for this opportunity to provide testimony on the problems associated with the approximately 46 million [1]

CHA and its members are longtime advocates on behalf of the uninsured. In our most recent history, particularly following the failed attempt in the early 1990's to

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1 Dr. John Seffrin, American Cancer Society CEO, Statement to ACS Board of Directors during January 2006 meeting.

1 U.S. Census Bureau figures originally estimated the number of uninsured in 2005 to be 46.6 million, but have recently been revised to 44.8 million (*http://www.census.gov/Press-Release/www/releases/archives/health—care—insurance/009789.html*) uninsured persons in the United States. We in the Catholic health ministry believe that the number of uninsured in our Nation represents both a health crisis and a moral crisis on an unprecedented scale, and I would like to begin by thanking the subcommittee for taking the time to examine this urgent issue.

address this problem, CHA has made covering the uninsured a top advocacy and public policy priority for the Catholic health ministry year after year. We do so for many reasons. As health care providers, we know that access to affordable care is vital to the individual's health and to the overall health of our Nation collectively. We also see the tremendous problems in our facilities associated with the lack of health insurance—the time and resources that are spent in providing acute care when regular and preventive care would have been more suitable, and the desperate situations of those lacking coverage that force them to turn to their local hospital after the rest of our health care system has failed them. Along with other health care provider groups, we have made Congress aware of these problems in the past and will continue to do so as we seek a solution to them.

But above all else, the Catholic health ministry believes that in a nation so richly blessed as ours it is simply immoral that anyone should go without access to adequate care. This central belief—that health care is not a privilege afforded to the wealthy but a basic human right for all—is at the heart of our ministry's history and mission. Long before any Government regulations were established concerning the care given in hospitals, our ministry's facilities welcomed all those who sought their services. Catholic hospitals and clinics, largely run by religious congregations, tended the poor and sick who had no where else to turn. We believe that our advocacy and service on behalf of the Nation's uninsured continues that very tradition. Many of our facilities have responded to current health care needs through such measures as establishing health clinics in their communities to provide care for low-income families or providing other innovative services to promote good health among the uninsured. Over the past five years, we have seen a 16.8 percent increase in the number of health clinics sponsored and supported by Catholic hospitals in response to the growing number of uninsured and underinsured. But as these needs continue to grow year after year it is becoming increasingly difficult for hospitals and clinics to fill in the gaps.

Simply put, our Nation cannot and should not continue to suffer the ill effects of having members of our society, so many of whom are working hard to support their families, go without health insurance. Unfortunately, their numbers continue to rise. From 2000 to 2005 the number of uninsured rose by nearly 7 million. During this time, from 2001 to 2005, Catholic hospitals also registered this increase in the number of uninsured through a rise in the provision of uncompensated care. The average uncompensated care cost to Catholic hospitals increased by 47 percent during this period, and continues to grow. [2]

We also know that many of the uninsured do not seek or delay seeking care. According to the Kaiser Family Foundation, over three times (47 percent) as many of the uninsured report postponing care due to cost as those with insurance (15 percent), and a much higher percentage of the uninsured (35 percent versus 9 percent) report situations in which they needed care but did not receive it. [3]

Clearly, even though our Nation's hospitals continue to provide care to so many who have no other options, the number of those who do not seek care at all or only seek care at its costliest point has cast a pall of inefficiency over the entire U.S. health care system. This situation cries out for change.

But the problem of the uninsured goes well beyond being an issue that should concern only the Nation's hospitals. Can anyone imagine what the consequences would be if we were to report that approximately 15 percent of the entire population was being denied access to such necessities as food or clean water? Or even to a basic education? Why should we think the number of uninsured is any more acceptable, particularly given that nine million of these are children? This problem does not represent simply a financial burden on the health care system or a challenge for U.S. policymakers—it is a question of justice that highlights our failure to promote and protect the dignity and well-being of every single person. As long as any individual, particularly the poorest and most vulnerable among us, goes without access to adequate care we are diminished as a nation and as a moral society.

Thankfully, Americans increasingly seem to view this situation as unacceptable and are beginning to demand a solution. In a public opinion survey done for CHA last year, the percentage of respondents ranking "providing affordable quality health care"/ as a priority for the Government was greater than "creating jobs" and "reducing Government spending and taxes" combined, and only equaled by "ensuring homeland security." [4]

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2 AHA Survey of Hospitals, 2001–2005 (2005 is the latest year of data available from this study)

3 Kaiser 2003 Health Insurance Survey, *http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Oct–2004.pdf*

4 Public Opinion Strategies, National Survey, May 9–13, 2006

As the demand for a solution continues to grow, we also recognize that there are many beneficial interim steps that Congress and the Administration could take to help alleviate the growing problem of the uninsured, particularly in regards to the scandal of having so many uninsured children in the U.S. CHA continues to work with members of Congress on both sides of the aisle to ensure that this year's reauthorization of the State Children's Health Insurance Program contains at a minimum adequate funding to help cover the children currently eligible for this program but not yet enrolled. We are grateful for the efforts of Chairman Dingell on this issue and for his introduction of the Children's Health First Act to help accomplish this. Ensuring that none of our children has to go without access to care is a vital first step in helping to cover the uninsured, and hopefully will give all who care deeply about this issue the necessary momentum to keep moving forward.

As this subcommittee knows, when it comes to considering how best to find a solution to provide health coverage for everyone, there has been no lack of widely varying ideas to accomplish this. People of good faith from many different philosophical and political perspectives have proposed ideas relying on Government, individual and free market solutions over the past several years. I believe this is a positive sign, showing concern about the uninsured across the political spectrum and inviting participation from diverse groups to tackle the problem. At CHA we have welcomed ideas from many different perspectives to help cover the uninsured, and we continue to welcome them. We also have identified some critical characteristics for a proposed solution that we hope will be beneficial to those seeking action. We believe that any proposal to cover the uninsured should:

- Make health care accessible and affordable for everyone, regardless of employment status, one's age, financial means, or health status;
- Provide basic health benefits to everyone including services across the life span of care—preventive, primary, acute, long term, and end of life;
- Provide for the poor and vulnerable with special attention to the particular needs of low-income families and individuals, immigrants, the elderly and individuals with disabilities;
- Share responsibility for financing among Government, employers, and individuals;
- Encourage effective participation in decision making by providing patients and their families with information about health care providers, plans, and procedures, based on their quality and efficacy.

Legislative solutions must embody these characteristics in order to ensure access to care for everyone. Any legislation that does not will only serve as a stopgap measure and push the need for a comprehensive solution even further down the road.

Let me close by once again urging this subcommittee, and indeed all in Congress and the administration, to keep pushing for a solution to provide health coverage for everyone in our Nation. Looking back through our history there are so many outstanding examples of seemingly insurmountable problems that we collectively have faced and overcome—many would say that this is in fact a defining characteristic of our country and its people. Given that history, surely we can move ahead to solve the problem of the uninsured despite how difficult this situation seems. It is a problem that has gone on for far too long, and one that Americans from all walks of life and political backgrounds agree is simply unacceptable. This is the moment to take action, and the Catholic health ministry stands ready to assist all those who seek a solution.

Thank you.

April 25, 2007

Senate Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Re: April 25, 2007 hearing on "Living Without Health Insurance: Why Every American Needs Coverage." Testimony submitted by John H. Graham IV, CAE, President and CEO, American Society of Association Executives, 1575 I Street NW, Washington, DC 20005.

American Society of Association Executives. The American Society of Association Executives ("ASAE") is a section 501(c)(6) individual membership organization of more than 22,000 association executives and industry partners representing nearly 12,000 tax-exempt organizations. Its members manage leading trade associations, individual membership societies, and voluntary organizations across the United States and in 50 countries around the globe. We advocate for voluntary organizations so that they may continue to improve the quality of life in the United States.

Importance of Associations. From early on in America's history, associations have been key vehicles for attaining higher quality or hard-to-attain products and services. This sense of collectivity, that individuals might enhance their access to personal and professional growth and a vast array of resources by belonging to a like-minded group, is at the core of all associations.

Associations are organized for the sole purpose of serving the needs of their members. By extension, many association member benefits ultimately serve the general public. For instance, an association that sets product standards ensures the integrity and performance of the industry it represents; but it also protects the health and safety of the consumers who ultimately use those products, and helps cultivate consumer confidence in the marketplace.

Associations are also organized for purposes greater than selling insurance, a critical distinction in the debate over the underlying motivation of the sector in the health insurance industry. Associations are not affinity groups or businesses with the goal of profiting from the insurance market. They are, however, already structured to represent their members, and possess the infrastructure,

administrative and communication mechanisms, and experience necessary to unify employers and employees into stalwart consumers of health services.

The value of associations and their need to provide insurance. The need to ensure that Americans have access to health care is apparent. A vehicle for reform is taking an existing structure (associations and small businesses) and expanding their ability to cover their members and members' employees with health care.

The trend, however, has been for associations to relinquish on providing health insurance coverage to members across state lines. A recent example in California illustrates this problem. The California Association of Realtors were forced by their insurance provider to drop health insurance coverage for their members, forcing 8,000 Realtors and their families to now be uninsured. The National Association of Realtors cannot cover these uninsured members because of the barriers to association health insurance.

ASAE recently completed a survey of its members asking them about their health care offerings to their members. Previous ASAE health care studies showed an 11% increase in associations' employee health care costs last year, but our "2007 Health Care Summary" was exclusively for associations' members. The survey was comprehensive and wide-ranging: over 1,000 associations responded (90% of respondents were CEOs) from all fifty states, representing IRS classified 501(c)6s, 501(c)3s, and others. The results were revealing about the need for reform: ***half*** of respondents replied to a question about the necessity of health care reform (without prompting to a means of reform) that health care was "***one of the most significant problems facing our industry.***" When asked if their association offered health insurance to their members, only 24% said they did. However, when asked if the barriers to offering pooling arrangements for health insurance were removed, 61% of associations said they would consider offering an association plan to members.

As this survey shows, the ability of associations to offer insurance is dwindling, yet if the barriers were removed, more Americans could have access to employee-sponsored care. Allowing associations to pool their insurance to extend coverage to their members would be a major step in ensuring health care for all Americans.

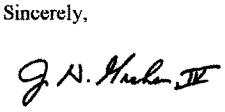
Association health plans (AHPs) are supported by more than 170 associations representing over 12 million employers and 80 million American workers. These associations' memberships also encompass a huge range of trades and professions. These associations are vital to enabling small businesses to compete in their marketplaces and be good community citizens.

Association health plans allow small business owners to pool together across state lines through their membership in a trade or professional association to purchase health coverage for their families and employees. Associations have been sponsoring health plans for more than 50 years. In 1990, there were reportedly more than 1,000 AHPs. Today, that number has dropped to fewer than 200 due to the tightening of state regulations over the past decade that have made operating an AHP across state lines an administrative nightmare. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulations for corporate and union organizations, but not for AHPs.

Studies show that AHPs would save small business owners between 15 and 30 percent on the cost of purchasing health insurance, savings that would enable many more small employers to offer coverage and/or pay a higher share of workers' premiums. Additionally, AHP legislation would minimize the competitive disadvantage some small employers face in attracting and retaining quality employees.

Conclusion. The "Health Insurance Marketplace Modernization Act of 2006," introduced in the Senate in the 109th Congress by a bipartisan group of Senators, would allow for pooling of health care across state lines. The bill would have respected state mandates by requiring plans to cover mandates in the five largest states in population. Although it failed to pass in the 109th Congress, ASAE feels this bill (and issue) should be considered when health care is debated in this Congress.

Sincerely,



John H. Graham IV, CAE
President and CEO
ASAE
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Washington, DC 20005
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April 24, 2007

The Honorable Frank Pallone, Jr.
Chairman, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Nathan Deal
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Pallone and Ranking Member Deal:

On behalf of Associated Builders and Contractors (ABC), and its more than 24,000 contractors, subcontractors, suppliers and construction-related firms across the country, I commend you for holding this week's hearing titled, "Living Without Health Insurance: Why Every American Needs Coverage." We hope your attention to this significant problem will result in a renewed commitment towards a solution.

We firmly believe that any legislative solution to the uninsured problem must effectively address the inaccessibility to affordable rates facing small businesses. A survey conducted last year by the Commonwealth Fund found that employees in the nation's smallest firms (those with fewer than 10 workers) pay, on average, 18 percent more in health insurance premiums for the same benefits than do those in the largest firms.

Sadly, these escalating costs make health insurance out of reach for many small business employees. According to an October 2006 report by the Employee Benefit Research Institute, nearly 63 percent of all uninsured workers in 2005 were either self-employed or working in small businesses with fewer than 100 employers.

We recommend you consider the solutions presented in H.R. 241, the "*Small Business Health Fairness Act of 2007,*" introduced by Rep. Sam Johnson. This legislation, which has passed the House of Representatives in previous Congresses with bipartisan support, allows small businesses to band together and purchase health insurance as a group. The bill puts small businesses on a level playing field with unions and large corporations, who because of their size have access to far better rates.

ABC knows from first-hand experience that the type of market-based pooling proposed in H.R. 241 is essential to solving the uninsured problem. ABC established an association health benefits plan in 1957, and for over 40 years offered insurance plans to our members, most of whom were small business owners who would otherwise not have been

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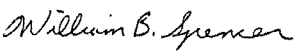
able to afford health insurance for their employees. However, in 2001 ABC was forced to discontinue the health insurance portion of our association plan when our insurance carrier terminated coverage because of incompatible and inconsistent state laws, making it too expensive to provide coverage.

We strongly urge you to take our experience into account as you look for ways to expand health care coverage. Thank you again for your commitment to addressing this problem. Please let us know how we can help.

Sincerely,



William B. Spencer
Vice President, Government Affairs

CC: Chairman John D. Dingell
Ranking Member Joe Barton
Members of the Subcommittee on Health, Committee on Energy and Commerce.

House Energy and Commerce Committee
Subcommittee on Health

"Living without Health Insurance"

Statement for the Record by Joseph M. Stanton,
Senior Staff Vice President for Government Affairs

National Association of Home Builders

April 25, 2007

On behalf of the over 235,000 members of the National Association of Home Builders (NAHB), I thank you for the opportunity to submit this statement for the record in support of Association Health Plans (AHPs).

NAHB's 235,000 members employ more than 8 million workers nationwide. The vast majority of NAHB members are small businesses that employ 10 or fewer employees. NAHB members are involved in home building, remodeling, multifamily construction, property management, subcontracting, design, housing finance, building product manufacturing and other aspects of residential and light commercial construction. Known as "the voice of the housing industry," NAHB is affiliated with more than 800 state and local home builder associations around the country.

Day in and day out, the one issue we hear constantly from our members is the rapidly rising cost of health insurance and the increasing frequency of members losing access to coverage because their local small group market provider will no longer cover their small business. Although many building firms offer some sort of health insurance to their employees, these employers are finding it increasingly difficult to provide coverage at an affordable price, and ultimately, this additional cost is passed on to the housing consumer.

Health insurance coverage for employees is very important to NAHB's members. In our extremely competitive industry, which has suffered labor shortages for some time, the ability of a builder to recruit, train, and retain high-quality, hard-working employees is essential to the builder's ability to meet contractual commitments and have a solid team of reliable employees. As it becomes more and more difficult for builders to offer benefit packages that include stable, affordable health care plans, employees are more likely to leave smaller builders for positions with other companies that are able to provide a consistent benefit package. For many of our members, providing health insurance is a necessity benefit to retain their best employees.

NAHB strongly feels that the health insurance market in the United States is severely broken when small businesses can no longer obtain coverage, or are forced out of coverage by yearly double-digit premium increases. The most recent U.S. Census Bureau estimate indicates that approximately 46 million Americans lack health insurance. As has been the case for over a decade, the Census Bureau continues to believe that approximately 60 percent of the uninsured are employees of small businesses and their dependents. Small-business owners struggle with

annual double-digit insurance premium increases that make providing and maintaining coverage progressively difficult. Some estimates indicate that insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000. As the ranks of the uninsured continue to increase dramatically, small businesses and their employees continue to bear the brunt of the costs, yet Congress has not addressed the problem.

NAHB's members strongly support association health plans, not because we believe AHPs will resolve the crisis of the uninsured in its entirety, but because we believe allowing AHPs to enter the small group marketplace at a level playing field will inject much-needed competition into the health insurance system. Today, small businesses, such as our members, have very few choices for health insurance coverage—and many have none at all. Strong health insurance monopolies in most states dictate coverage to our members, who do not have the necessary size or economy of scale to shop around for insurance.

NAHB believes that bona fide associations are well-positioned to negotiate on behalf of their members for stable, affordable, and high quality health insurance. Allowing association members to band together across state lines will provide them with the economies of scale necessary to obtain reasonably priced coverage.

NAHB believes that association health plans will offer millions of American small businesses the opportunity to obtain stable, affordable coverage. We believe that these types of plans—which level the playing field for small businesses—merit serious consideration and enactment by the U.S. Congress. Each year, a handful of insurers maintain their own segmented marketplace monopolies, while millions of Americans lose coverage or face premium increases so high that they must reduce the scope of their coverage in order to hold on to even basic protections. Congress has an obligation to enact legislation to allow small businesses the same opportunity and access to health care that large corporations and labor unions now enjoy.

Thank you for allowing the National Association of Home Builders this opportunity to share our opinion on association health plans. We look forward to continuing to work with the committee to bring common sense reform to health insurance, and give small businesses equal footing to obtain stable, affordable and quality health insurance coverage.

QUESTION FROM MR. DEAL TO GRACE-MARIE TURNER

Chairman Frank Pallone asked witness Dr. Jeanne Lambrew about studies which show that expansion of public health programs has an effect on crowding out private health insurance. Dr. Lambrew described a Federal study which she said shows that crowd out is not a problem, and she indicated that Jonathan Gruber's research does not indicate significant crowding out, as your testimony reported. Could you please help us to reconcile her comments with your testimony on the important issue of crowd out?

In a paper published by the National Bureau of Economic Research in January 2007, MIT Professor Jonathan Gruber and Cornell Professor Kosali Simon state that "crowd-out remains a pervasive phenomenon for recent public insurance expansions. Our central estimates suggest crowd-out of about 60 percent; that is, the number of privately insured falls by about 60 percent as much as the number of publicly insured rises." Gruber and Simon also find that that crowd-out is a "family phenomenon." They add that "Crowd-out estimates are much larger when family-wide effects of eligibility are accounted for, incorporating a spillover onto other family members of eligibility expansions."

Jonathan Gruber and Kosali Simon, "Crowd-out 10 years later: Have recent public insurance expansions crowded out private health insurance?" National Bureau of Economic Research Working Paper 12858. January 2007. *http://www.nber.org/digest/aug07/w12858.html*

In analyzing this data, Linda Gorman of the Independence Institute in Boulder, Colorado, observes that Gruber and Simon extend the literature on crowd-out by addressing family as well as individual eligibility and by using a variety of techniques to create robust estimates of crowd-out for the eligibility expansions that occurred between 1996 and 2002.

She says that Gruber and Simon find that there is considerable crowd-out associated with these recent expansions of public insurance and that anti-crowd-out provisions, such as waiting periods and cost-sharing, have increased crowd-out.

The estimates use the 1996 and 2001 panels of the Survey of Income and Program Participation (SIPP). They are based on 405,389 observations and include information on family and individual characteristics, individual and family public program eligibility by State, employment, and data on State waiting periods and cost sharing. Simple tabulations of changes in enrollment by income group suggest that crowd-out ranges from 47 to 92 percent. Estimates using regression analysis suggest that when the dependent variable is individual coverage, crowd-out is modest, from 24 to 37 percent. When a measure of family eligibility is substituted for individual eligibility, crowd-out is more substantial, ranging from 61 to 68 percent. Adding additional statistical controls to account for differences in State insurance trends increases the estimate of crowd-out to 78 percent to 81 percent."

Source: Linda Gorman, "Public Insurance Expansions Crowd Out Private Health Insurancee," NBER Digest, August 2007; based upon: Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research, Working Paper No. 12858, January 2007. http://nber.org/digest/aug07/w12858.html

In a comprehensive study on SCHIP published in May 2007, the Congressional Budget Office says it is difficult to authoritatively determine crowd out of private coverage. But it concludes: "On the basis of a review of the available studies, CBO concludes that the reduction in private coverage among children is most probably between a quarter and a half of the increase in public coverage resulting from SCHIP. That is, for every 100 children who gain coverage as a result of SCHIP, there is a corresponding reduction in private coverage of between 25 and 50 children." The study says that crowd out is most likely to take place among children whose parents have higher incomes and who are more likely to already have private coverage—the very populations that the Congress is targeting for its SCHIP expansion.

"According to CBO's analysis of data from the Current Population Survey, 50 percent of children in families with income between 100 percent and 200 percent of the poverty level had private coverage in 2005. The rate of private coverage rose to 77 percent among children between 200 percent and 300 percent of the poverty level, 89 percent among those between 300 percent and 400 percent of the poverty level, and 95 percent among those over 400 percent of the poverty level."

The State Children's Health Insurance Program, Congressional Budget Office, May 2007. *http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf*

Therefore, I believe the literature is clear, especially in light of the CBO study published after the committee's hearing, that crowd-out is a significant problem, especially with the expansion populations targeted in the SCHIP legislation passed by the House of Representatives on August 1, 2007.

QUESTION FROM MR. BURGESS TO JEANNE LAMBREW

In your testimony you said that $150 billion increase in Federal spending would cover the uninsured, and that you would propose covering this cost with a VAT tax. How accurate is this $150 billion estimate, and how would you structure the VAT?

The details of the proposal will determine the Federal cost to cover the uninsured. In an article in Health Affairs in 2005, my co-authors and I estimated that, depending on the nature of the financial assistance, the annual Federal cost of covering all Americans could range from $100 to $160 billion (see Lambrew JM, Podesta JD, and Shaw T. (2005). "Change in Challenging Times: A Plan for Extending and Improving Coverage," Health Affairs, W5–119–132). We based this range on estimates of a set of health proposals done for the Robert Wood Johnson by the Lewin Group, in addition to conversations with other cost estimators. Coverage for all could be achieved for less, or could cost more, depending on the policy. In my testimony, I used $150 billion as an illustration of the high end of this range.

There is a degree of uncertainty in any estimates, by definition. Health care cost projections must take into account future changes in coverage, technology, inflation, and other factors that are difficult to predict. In addition, how people, firms, and providers will react to a reformed health system is unclear, since we have little past experience in the U.S. on which to draw. It is not always the case that projections are too low; for example, both SCHIP and the Medicare drug benefit cost significantly less than the Congressional Budget Office predicted in their initial years of operation.

To the extent that policy makers are uncomfortable with this uncertainty, they can build in policy mechanisms to address it. For example, policy makers in Massachusetts allow a public-private Board to modify key aspects of the plan like the cost sharing and financial assistance schedule. This allows them to calibrate the plan design, without returning to the legislature, to meet budget constraints.

The VAT is one of many options for financing health reform. I have supported this option because it is broad-based and ensures shared responsibility: everyone both pays and benefits under health reform financed in this way. It is also consistent with how our competitor nations finance their health programs. To ensure that it is progressive, its revenue should be used for income-related financial assistance and certain exemptions should be included (e.g., small businesses, food, education, religion, and health care). With such exemptions, based on other research, a VAT of 3 to 4 percent should be sufficient to finance health reform.

QUESTION FROM MR. BURGESS TO HON. TOM DASCHLE

In your testimony, you mention the important protections that ERISA provides. Could you share with the subcommittee some of the concerns you see that State regulation poses to employers' efforts to provide health care to their employees nationwide?

The Employment Retirement Income Security Act (ERISA) has, among other provisions, provided firms with the option of self-insuring for health benefits. This option has been taken by a number of large employers to use their economies of scale to achieve better results in providing high-quality, affordable health care to workers than commercial insurers could. At the same time, ERISA has exempted health coverage through these firms from State consumer protection and health reform policies. This has posed barriers to some States that have aimed to enact legislation to reform their systems. As such, there are advantages and disadvantages of ERISA from the vantage point of health policy. But one thing is certain: national health reform is needed, and in that context, ERISA along with other laws that affect health benefits will likely be re-examined, modified, and/or overhauled.

QUESTION FROM MR. BURGESS TO MICHAEL K. SMITH

In your testimony, you mention the important protections that the Employment Retirement Income Security Act provides. Could you share with

the subcommittee some of the concerns you see that State regulation poses to employers' efforts to provide health care to their employees nationwide?

It appears that my testimony about the Employment Retirement Income Security Act (ERISA) may have been unclear or was misunderstood. As you know, ERISA was implemented in 1974 to regulate private sector pension programs, including health coverage, and it supercedes or preempts any State laws that relate to employee benefit plans. While the initial objective of ERISA—to encourage employers to sponsor plans and not be subject to multiple, varying State laws—was good, this preemption is now hindering States' goal to provide health coverage to all residents. For example, ERISA prohibits States from requiring that employers provide information to the State about their health benefit plans. Many States are trying to assure that all residents have comprehensive and/or affordable coverage, but cannot develop strategies, proposals or cost estimates without information from employers about their benefit structures. These strategies can take multiple forms, including assisting employers with affordability of their coverage plans or assisting employees to purchase employer offerings. For example, Vermont and other States are offering premium assistance to low income residents to purchase employer-based coverage, but ERISA prohibits States from requiring that employers participate or share information about their benefit plans with the State to facilitate implementation of these premium assistance programs. Finally, ERISA's preemption provisions are somewhat vague, creating doubt about what States can and cannot do with regard to requiring employers to help pay for broad-based financing to expand health care coverage for State residents.

Hopefully, this has adequately clarified the intent of my remarks about ERISA.