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3 HEARING ON ``MAKING HEALTHCARE WORK FOR AMERICAN FAMILIES:

4 ENSURING AFFORDABLE COVERAGE

5 TUESDAY, MARCH 17, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

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

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

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

|
30 Mr. {Pallone.} The subcommittee hearing is called to
31 order. Good morning and welcome to our witnesses on the
32 first panel. This is a second in our series of hearings on
33 health reform. Today the subcommittee will examine issues
34 surrounding the affordability of health coverage.

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

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

50 I am particularly interested to hear from our witnesses
51 today about new ideas like a health exchange or connector,
52 similar to the one in Massachusetts, a public plan option,

53 and an individual mandate that can help provide individual's
54 access to affordable options for meaningful coverage.

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

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

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

77 we have to look at.

78 I want to thank our witnesses again for being here

79 today. I know we have a very distinguished panel.

80 [The prepared statement of Mr. Pallone follows:]

81 ***** COMMITTEE INSERT *****

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82 Mr. {Pallone.} And I will now call on Mr. Deal for
83 opening statements, and then we will have opening statements
84 from other members, both Democrat and Republican. Thank you.

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

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

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

103 I look forward to the testimony of the witnesses. There
104 are a lot of issues that we have not talked about in previous

105 hearings, and I am sure that these two panels today will
106 broach some of those subjects that we have yet to explore.
107 And thank you for being here, and I look forward to your
108 testimony. I yield back.

109 [The prepared statement of Mr. Deal follows:]

110 ***** COMMITTEE INSERT *****

|
111 Mr. {Pallone.} Thank you, Mr. Deal. The gentlewoman
112 from California, Ms. Eshoo.

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

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

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

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

133 [The prepared statement of Ms. Eshoo follows:]

134 ***** COMMITTEE INSERT *****

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135 Mr. {Pallone.} Ranking member of the full committee,
136 Mr. Barton.

137 Mr. {Barton.} Thank you, Mr. Chairman. I have an
138 excellent statement that my staff has prepared. I am going
139 to submit it for the record, but in the interest of time, I
140 am going to just submit it.

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

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

152 [The prepared statement of Mr. Barton follows:]

153 ***** COMMITTEE INSERT *****

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154 Mr. {Pallone.} Thank you, Mr. Barton. I appreciate
155 what you said, and I think it is crucial that we work in a
156 bipartisan fashion. And that is certainly our intention.
157 Thank you. The gentleman from Texas, Mr. Green.

158 Mr. {Green.} Thank you, Mr. Chairman. I want to thank
159 you for holding this second hearing on health care reform.
160 Our state of Texas has the unfortunate distinction of having
161 the largest number of uninsured in the United States, nearly
162 5.4 million Texans or 25 percent of the population in Texas
163 without health insurance coverage, and nearly 1.4 million
164 children are uninsured. Of that 1.4 million, 900,000
165 children in Texas are S-CHIP eligible.

166 We need a national system designed so that every
167 American should be covered, either employer-based plan, an
168 individual plan, or a public plan not matter what state they
169 live. The largest rate of growth in the uninsured and
170 underinsured are middle class families who make too much to
171 qualify for public plans but don't make enough money to pay
172 costly premiums under the private plans, and those who work
173 in low-wage jobs without employer-based insurance.

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

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

179 [The prepared statement of Mr. Green follows:]

180 ***** COMMITTEE INSERT *****

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181 Mr. {Pallone.} Without objection, so ordered, and thank
182 you. The gentleman from Kentucky, Mr. Whitfield.

183 Mr. {Whitfield.} Thank you, Chairman Pallone, and I am
184 going to waive an opening statement.

185 [The prepared statement of Mr. Whitfield follows:]

186 ***** COMMITTEE INSERT *****

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187 Mr. {Pallone.} Next is the gentlewoman from Colorado,
188 our full committee vice chair, Ms. DeGette. Mr. Shimkus.

189 Mr. {Shimkus.} Thank you, Mr. Chairman. I too am
190 excited about getting into this debate, basically how do we
191 make sure we get insurance for those who have no insurance.
192 So my focus has always been affordable, portable, and access.
193 I do believe that the market-based system, which encourages
194 price transparency and shopping around is the best method. I
195 do fear a government backstop plan action which the
196 government control, and I am deadly in opposition to a one-
197 payer system, which I hope we don't segue into when this
198 fight really gets going. I do not want bureaucrats picking
199 health care decisions in the end.

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

203 [The prepared statement of Mr. Shimkus follows:]

204 ***** COMMITTEE INSERT *****

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205 Mr. {Pallone.} Thank you. Our subcommittee vice chair,
206 Ms. Capps.

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

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

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

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

227 [The prepared statement of Ms. Capps follows:]

228 ***** COMMITTEE INSERT *****

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229 Mr. {Pallone.} Gentleman from Missouri, Mr. Blunt.

230 Mr. {Blunt.} Thank you, Mr. Chairman. I have a
231 statement for the record. I do look forward to working with
232 you and with Mr. Deal and the subcommittee to find a solution
233 to this question of affordability.

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

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

248 [The prepared statement of Mr. Blunt follows:]

249 ***** COMMITTEE INSERT *****

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250 Mr. {Pallone.} Thank you. The chairman emeritus, Mr.
251 Dingell.

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

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

264 In 2007, 69 percent of the people who went without
265 medical care or delayed needed medical care cited worries
266 about cost, a 3.8 percentage increase from 2003. The average
267 cost of employer-based family insurance policy in 2008 was
268 \$12,680, an amount almost equal to the annual earnings of a
269 full-time minimum wage job.

270 It is not just the uninsured population that suffers
271 from the high cost of health care. More than 42 million
272 people with health insurance report having problems paying

273 medical bills. Of those who face medical bankruptcies,
274 almost three-quarters had health insurance at the time of the
275 illness that left them financially unstable.

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

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

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

293 Access to health insurance does not mean that
294 individuals can utilize available services. They are also
295 kept out of the circle of care due to high premiums,
296 deductibles, and other out-of-pocket costs. I look forward

297 to working with my colleagues and working with the leadership
298 here and the administration. There are a number of worthy
299 options being debated. I think public option is something
300 that should be seriously considered as we move forward on
301 health reform. While we have not decided the specifics of
302 what a public option should look like, I believe that such
303 option must be affordable, and it must have suitable
304 benefits. And it must provide healthy competition in the
305 marketplace.

306 Insurance market has a nasty habit of gaming the system,
307 of building barriers to affordable coverage, of excluding
308 coverage all together, or coverage for pre-existing
309 conditions, and charging higher premiums for certain
310 individuals, cherry picking, and other games that make
311 insurance unavailable to our people.

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

317 [The prepared statement of Mr. Dingell follows:]

318 ***** COMMITTEE INSERT *****

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319 Mr. {Pallone.} Thank you, Chairman Dingell. Next is
320 the gentleman from Pennsylvania, Mr. Pitts.

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

330 According to the survey, the cost of health insurance
331 remains the primary barrier to coverage. I believe any
332 health reform plan must contain several key principles to
333 empower the consumer. Among them, in-tax policies that
334 discriminate against an individual who purchases private
335 health insurance on their own rather than through their
336 employers make it easier to de-couple health insurance from
337 employers. Those who own their coverage should be able to
338 take their plan with them with they change jobs or quit
339 working and one they can take to another state. They should
340 be able to buy from another state. Also risk-pooling within
341 a state or across state plans. People should be able to

342 choose the plan and doctors and services they want. And
343 insurance and providers are accountable to them, not their
344 employer or government bureaucrats.

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

350 [The prepared statement of Mr. Pitts follows:]

351 ***** COMMITTEE INSERT *****

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352 Mr. {Pallone.} Thank you. The gentlewoman from
353 Chicago, Ms. Schakowsky.

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

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

367 And finally, Mr. Chairman, I would like to submit for
368 the record a report from the Institute for America's Future,
369 Massachusetts Health Reform, Near Universal Coverage but No
370 Cost Controls or Guarantee of Quality Affordable Health Care
371 For All, if I may submit it for the record.

372 Mr. {Pallone.} Without objection, so ordered.

373 Ms. {Schakowsky.} Thank you, Mr. Chairman.

374 [The prepared statement of Ms. Schakowsky follows:]

375 ***** COMMITTEE INSERT *****

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376 Mr. {Pallone.} Next is gentleman from Texas, Mr.
377 Burgess.

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

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

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

393 Now, the President wants to figure out what works. We
394 are going to hear a lot of about former Governor Romney's
395 proposal in Massachusetts that has now had a couple of years
396 to go through a couple of iterations. It is a bold
397 experiment. It deals with a connector. It deals with
398 mandates. But maybe we should also look at Wal-Mart, which

399 in the past four years now, covers without mandates 95
400 percent of its employees with affordable coverage. If we
401 want to learn from what works, maybe we ought to include that
402 in our broad-based discussion.

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

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

415 [The prepared statement of Mr. Burgess follows:]

416 ***** COMMITTEE INSERT *****

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417 Mr. {Pallone.} Thank you. Gentlewoman from California,
418 Ms. Harman.

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

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

428 Second, I urge that all of the expertise on this
429 committee, starting with our chairman emeritus, but including
430 every other member of the committee, Democrat and Republican,
431 be tapped as we draft a bill.

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

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

440 much.

441 [The prepared statement of Ms. Harman follows:]

442 ***** COMMITTEE INSERT *****

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443 Mr. {Pallone.} Thank you. The gentlewoman from
444 Tennessee, Ms. Blackburn.

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

455 Tenn Care kept a blind eye to rising costs and over
456 generosity. It imposed no limits on days in the hospital or
457 number of prescriptions that were allowed each month, and in
458 the mid '90s, each Tenn Care enrollee received an average of
459 30 prescripts per year. However, health outcomes in the
460 state did not improve.

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

466 care.

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

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

475 [The prepared statement of Ms. Blackburn follows:]

476 ***** COMMITTEE INSERT *****

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477 Mr. {Pallone.} Thank you. The gentleman from Texas,
478 Mr. Gonzalez. Mr. Gingrey.

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

486 But access to an insurance card, no matter if that card
487 is for a family health plan or a government program, it does
488 not guarantee access to quality health care. In my state of
489 Georgia, the number of general physicians has declined over
490 15 percent in the past 10 years. Unfortunately Georgia is
491 not an isolated case.

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

500 [The prepared statement of Mr. Gingrey follows:]

501 ***** COMMITTEE INSERT *****

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502 Mr. {Pallone.} Thank you. The gentlewoman from the
503 Virgin Islands, Ms. Christensen.

504 Ms. {Christensen.} Thank you, Mr. Chairman. I waive my
505 opening statement.

506 [The prepared statement of Ms. Christensen follows:]

507 ***** COMMITTEE INSERT *****

|
508 Mr. {Pallone.} Gentlewoman from Florida, Ms. Castor.

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

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

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

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

535 [The prepared statement of Ms. Castor follows:]

536 ***** COMMITTEE INSERT *****

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537 Mr. {Pallone.} Thank you. The gentlewoman from Ohio,
538 Ms. Sutton.

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

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

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

558 [The prepared statement of Ms. Sutton follows:]

559 ***** COMMITTEE INSERT *****

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560 Mr. {Pallone.} Gentleman from Iowa, Mr. Braley. Ms.
561 Baldwin.

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

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

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

579 In my last couple of seconds, Mr. Chairman, I just
580 wanted to respond to some of the comments we have heard about
581 having public sector options along with private sector
582 options. Medicare Part D is used as an example frequently.

583 I would note that in the state of Wisconsin, I think we are
584 the only state that has a public sector option in the
585 Medicare Part D program. It is very, very successful, and I
586 hope that we will be able to study it further as we have this
587 debate about whether there should be both public and private
588 sector options available to our constituents.

589 [The prepared statement of Ms. Baldwin follows:]

590 ***** COMMITTEE INSERT *****

|
591 Mr. {Pallone.} Thank you. Gentleman from Connecticut,
592 Mr. Murphy.

593 Mr. {Murphy of Connecticut.} Thank you, Mr. Chairman.
594 I hope that we spend some time this morning talking about the
595 fact that just because you have health care insurance doesn't
596 necessarily mean you have health care. This is an important
597 distinction that needs to be at the center of this debate.

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

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

613 [The prepared statement of Mr. Murphy follows:]

614 ***** COMMITTEE INSERT *****

|
615 Mr. {Pallone.} Thank you. Gentleman from Utah, Mr.
616 Matheson.

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

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

638 reform our health care system.

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

642 [The prepared statement of Mr. Matheson follows:]

643 ***** COMMITTEE INSERT *****

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

650 First again to my left is Dr. Uwe Reinhardt, who is a
651 professor of political economy, economics and public affairs
652 at Princeton University in home state. Thank you very being
653 here today. We have Ms. Sally Pipes who is president and
654 chief executive officer of the Pacific Research Institute,
655 and then we have Dr. Judy Feder, who is senior fellow of the
656 Center for American Progress Action Fund. She also has been
657 before our committee many times in the past, our
658 subcommittee.

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

662 Mr. {Reinhardt.} High tech.

663 Mr. {Pallone.} That is good.

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

|
669 ^STATEMENT OF UWE REINHART

670 } Mr. {Reinhardt.} I am from rural New Jersey, as you
671 know, and I have to learn these things.

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

679 Now, it is well known that we spend on a per capita
680 basis in purchasing power parity a lot more than other
681 nations, 56 percent more than Switzerland, which is viewed as
682 a very high quality health care system, and 83 percent more
683 than Canadians do. And yet if you look at health statistics,
684 you will not find that much different. In fact, I find it an

685 intellectual breakthrough of major proportions that the
686 business roundtable, which used to be the staunch defender of
687 our system as the best in the world, now comes out with a
688 report just last week talking about a 20 percent value gap,
689 saying relative to other nations, Americans get 20 percent
690 less value for their health care dollar than other nations.
691 That is a very important recognition by these important
692 people.

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

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

706 But I also would urge Congress not to say let us do cost
707 control first and then universal coverage because we have
708 said this for 30 years. We have never done the former, and I

709 don't think you can fool God that long with the excuse that
710 we cannot afford it. We have said this now for 30 years. It
711 is time to go to universal coverage.

712 In the second section, I look at the American family. I
713 use for this not health insurance premiums, which is a very
714 misleading indicator. I use the Milliman medical index,
715 which includes the premium for health insurance for the
716 family plus their out-of-pocket spending. But you can always
717 make premiums go down or slower just by cutting the benefit
718 package, raising deductibles, and so on.

719 So you really should look at the Milliman medical index.
720 Last year, on average, for a family of four, it costs \$15,600
721 for health care in America. It would be now \$16,500. Now,
722 compare that to the median household income in America in
723 2007 was \$51,000. So if one had the view that people should
724 be responsible for their own health care, you would be saying
725 for a median American family that they should spend \$16,000
726 out of their \$51,000. That is an awful heavy burden. Now,
727 for lower income families, as your statement correctly says,
728 30 percent of available discretionary income goes for health
729 care.

730 So what I predict that in the next decade--I have a
731 little table here. I use a family here with a wage base of
732 \$50,000 and say if that wage base grows at 3 percent and

733 health care spending per capita by 8 percent, which is what
734 it has been, for the next decade, then half that family's
735 wage base would be chewed up by health care 10 years from
736 now, half.

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

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

757 what the Congress faces.

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

771 So therefore I believe that people say we shouldn't have
772 a public option have a tall order to explain to the American
773 people why they should be deprived of a choice that they may
774 yearn to have. And I then go through later on how one could
775 make that a level playing field. It is after all only a
776 choice. You don't have to choose it. You can go private.
777 But it should be, in my view, I as a citizen would love to
778 have that option, and I might even take it. Thank you very
779 much.

780 [The prepared statement of Mr. Reinhardt follows:]

781 ***** INSERT 1 *****

|
782 Mr. {Pallone.} Thank you, Dr. Reinhardt. I want to
783 make sure I got this quote. When the going gets tough, the
784 tough run to the government?

785 Mr. {Reinhardt.} Yes.

786 Mr. {Pallone.} Okay.

787 Mr. {Reinhardt.} That is the marching order of the
788 rugged individualist.

789 Mr. {Pallone.} Thank you. Ms. Pipes.

|
790 ^STATEMENT OF SALLY C. PIPES

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

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

807 The long-term goal of the new administration and many
808 Democrats in Congress is Medicaid for all. As has been
809 pointed out, the U.S. today spends 16 percent of GDP on
810 health care, about \$2.3 trillion, and many people say that
811 that is too much. And if we are going to get that percentage

812 down and achieve universal coverage, how do we reduce the
813 number of uninsured from the 46 million Americans?

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

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

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

834 When the government is the monopoly provider of health
835 care, people wait and wait. When they get tired of waiting

836 or are too sick to wait further, they flee if they can, and
837 many come to the United States for treatment.

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

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

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

856 In June 2005, the Canadian Supreme Court ruled on a case
857 for the province of Quebec that the ban on private health
858 care and private insurance is illegal because of the long
859 wait times. Madame Chief Justice Beverly McLaughlin said

860 access to a waiting list is not access to health care.
861 Canada is opening up its system while the U.S., it seems to
862 me, is moving more towards a government-administered system.

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

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

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

879 When we get totally socialized health care in America,
880 where are we going to go? We can change the tax code, as has
881 been mentioned, by removing the tax advantage to those who
882 get their insurance through their employer. We could offer,
883 as McCain suggested, a refundable tax credit for everyone.

884 We want to empower patients. We want to reduce state
885 mandates, which add between 20 and 50 percent to the cost of
886 an insurance plan.

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

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

897 [The prepared statement of Ms. Pipes follows:]

898 ***** INSERT 2 *****

899

|

Mr. {Pallone.} Thank you. Dr. Feder.

|
900 ^STATEMENT OF JUDY FEDER

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

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

917 The problem of unaffordability is most apparent for the
918 now probably more than 47 million Americans who lack health
919 insurance, most of whom have incomes below twice the federal
920 poverty level, about \$44,000 per family of four. And if they
921 don't get health insurance through their employers, as most

922 of them don't until most of them are working, they simply
923 can't afford the \$13,000 roughly 2008 cost of a comprehensive
924 health insurance policy.

925 But affordability, as you have noted, is increasingly a
926 problem even for people who have health insurance. In 2007,
927 for example, the Commonwealth Fund identified 25 million
928 people under-insured or economically threatened due to high
929 out-of-pocket costs up from 15 million. So that is 15 up to
930 25 million in only four years.

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

943 Finally, not really surprisingly but ironically,
944 affordability problems are the biggest problem for people
945 when they get sick. In particular, individuals who are

946 older, have an activity limitation, a chronic condition like
947 diabetes or heart disease are most likely to be underinsured.
948 And if they don't get coverage through an employer-sponsored
949 health plan or if they lose this coverage, they are going to
950 have one heck of a time getting it from a non-group market
951 that systematically denies coverage, limits benefits, or
952 charges excessive premiums to individuals with pre-existing
953 conditions or whom insurers believe are likely to need health
954 care.

955 Now, I have been talking here about money problems, but
956 we all know that affordable health care is a problem of your
957 money and your life. There is lots of evidence and the
958 Institute of Medicine has come out with a new report
959 documenting once again that people without health insurance
960 are more likely than people who have health insurance to
961 delay care, to get less care, and actually to die when they
962 get sick.

963 Sadly, evidence suggests that increasingly people who
964 are underinsured are facing similar problems. One report
965 shows that they are postponing care, skipping recommended
966 medical visit or treatment, not filling prescriptions, and
967 skipping doses or cutting pills. The underinsured not only
968 struggle medically to survive, their medical struggle, as we
969 have heard from some of you and you hearing from your

970 constituents is forcing them into bankruptcy and increasingly
971 into foreclosure.

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

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

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

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

996 And finally, insurance must stop discriminating against
997 sick people. As long as insurers can deny coverage, limit
998 benefits, or charge higher rates based on people's age or
999 health status, insurance is going to remain unaffordable for
1000 people who need health care.

1001 Meaningful health reform cannot fail to ensure that
1002 health insurance is affordable for people who have been or
1003 whom insurers believe are likely to become sick.

1004 We know that enacting health reform is a challenging
1005 task, but now is the time. I commend you for your efforts
1006 and look forward to working with you to get affordable
1007 coverage for every American this year. Thanks.

1008 [The prepared statement of Ms. Feder follows:]

1009 ***** INSERT 3 *****

|
1010 Mr. {Pallone.} Thank you, Dr. Feder, and thank all of
1011 you really for your statements. Now, the way we work it, we
1012 have questioning now from members of the committee, and I
1013 will start by recognizing myself for 5 minutes.

1014 And my question really is to both Dr. Reinhardt and Dr.
1015 Feder. I would like to get your thoughts on the addition of
1016 a new public plan, which you actually did discuss a new
1017 public plan to a menu of health care tools available for
1018 expanding coverage.

1019 Obviously we want to build on existing programs like S-
1020 CHIP and Medicare and Medicaid. But the fact remains that
1021 with 46 million uninsured people in this country, we will
1022 need to build significant new capacity in our insurance
1023 system.

1024 Now, you know, we have talked about having the
1025 government do a health care marketplace. Massachusetts is
1026 sometimes cited as an example where the government would go
1027 out to private plans and, you know, see what their benefits
1028 are, their premiums perhaps, negotiate both those standards
1029 and premiums and offer group plans to people as an
1030 alternative to the individual market.

1031 But in the context of that is this possibility of an
1032 option to enroll in a new quality affordable public plan.

1033 And the goal of that would be to create healthy competition
1034 with private insurers, lowering overall costs and at the same
1035 time expanding access across the health care system. So I
1036 wanted to start with Dr. Feder and ask what you think about
1037 creating a new public plan, and is that a good idea in the
1038 context of some kind of health marketplace, national health
1039 marketplace?

1040 Ms. {Feder.} Mr. Chairman, I think you posed the
1041 question exactly right. It is very important to remember
1042 that what you put forward and what is being talked about is a
1043 choice for Americans and in choice of private and public
1044 plans, not characterized as a public takeover or Medicaid for
1045 all. That is completely incorrect. We are talking about
1046 choice.

1047 And the importance of that choice is actually to set a
1048 model, and insurance companies are no model for running this
1049 system efficiently, private insurance companies. And they
1050 are not getting us good deals and getting us adequate
1051 protection. So establishing a public plan that is a choice
1052 and that operates on a level playing field with private
1053 insurers can actually serve as a push to get more
1054 competition. I think competition is a goal that all of us
1055 have, effective competition, to get efficiency in the health
1056 care system.

1057 Mr. {Pallone.} Okay, thank you. Dr. Reinhardt, do the
1058 experiences of other countries that have successfully built
1059 universal health care systems suggest that a new public plan
1060 could be helpful to America, to the U.S.?

1061 Mr. {Reinhardt.} I think certainly it could. Not a lot
1062 of countries actually have this sort of mixture. The only
1063 one that comes close is Germany. They don't really have a
1064 public plan, but they have privately managed sickness funds,
1065 nonprofit, that work a little bit like Medicaid managed care
1066 where the government collects the taxes essentially but lets
1067 private competing health plan purchase the health care but
1068 under unbelievably tight regulation. So it almost is like a
1069 government plan.

1070 I too share the view that if choice is the mantra, and
1071 many Americans really do like choice, then having a public
1072 plan that people might like seems to be something that should
1073 be done because by what rights would one deprive the American
1074 people of a choice they might favor? Now, where would I get
1075 this idea that they might favor a government plan?

1076 Well, two. The first one is we do have Medicare, and
1077 the elderly do have a choice to go into private health plans
1078 or to stay in the government-run plan. And I don't know what
1079 the--I think 75 percent still choose the government plan in
1080 spite of the fact that the private health plans get--the

1081 taxpayer pays them 14 percent more to be able to offer a
1082 benefit. To me, that suggests there is a strong latent
1083 demand among the American people for a private health plan.

1084 And then people say well, that is socialized medicine,
1085 and I would urge the committee not to use that term anymore.
1086 And the reason I do is I will tell a little vignette. People
1087 will tell me socialized medicine is just terrible, and it is
1088 awful. And then I will say okay, I will accept it. Why do
1089 you not like my son? And then they look. What have you got
1090 to say--my son? I say my son is a veteran, a decorated U.S.
1091 Marine Corps veteran with a purple heart, and yet you give
1092 him socialized medicine called the VA.

1093 So why do Americans run down this concept? We are not
1094 even talking socialized medicine--e are talking about social
1095 insurance--run it down and yet give the very contract to the
1096 veterans, and I am a father of one.

1097 And I would like sometime if somebody in this room write
1098 to me and explain this paradox to an immigrant like me why do
1099 you give veterans socialized medicine when it is so bad.

1100 Mr. {Pallone.} Thank you. Mr. Deal.

1101 Mr. {Deal.} Thank you, Mr. Chairman. As I indicated in
1102 my opening statement, transparency of pricing is important to
1103 me, and I have introduced a bill. And I would like to give
1104 you some of the components of that and see what your reaction

1105 to it would be.

1106 First of all, the bill would allow uninsured patients
1107 and other patients who pay out of pocket for certain health
1108 care costs to be able to go to an HHS website, enter their
1109 families income and the health care services they need, and
1110 find out the prices they will be charged for these services
1111 by all the health care providers in their area.

1112 Second, it would allow doctors and hospitals to use the
1113 same website to find out what a particular insurance company
1114 will pay them for a particular item or service before it is
1115 delivered, and it will allow these providers to find out what
1116 their patients' copays will be.

1117 Third it would allow the insured patients to make better
1118 informed decisions by allowing them to use the same website
1119 to find out what their copayments would be for particular
1120 health care services in their area, depending on who the
1121 health care provider was.

1122 And finally, it would require HHS to publicly disclose
1123 all of their Medicaid data in a way that protects
1124 individual's privacy but allows the public to join in the
1125 fight against Medicaid fraud and allow patient advocates to
1126 make sure that Medicaid patients, for example, are getting
1127 the care that they need. It would allow citizens to know
1128 whether or not young children who are enrolled in their

1129 state's Medicaid program are getting their well child
1130 checkups, and whether older patients are getting their annual
1131 cancer screenings.

1132 Would a piece of legislation like that be something that
1133 each of you might support? And I will just ask you
1134 individually. Dr. Reinhardt?

1135 Mr. {Reinhardt.} As a general principle, price
1136 transparency is essential if you ever want to have models
1137 based on choice and competition. And, of course, the health
1138 system has been uniquely opaque in this regard. Now, there
1139 is a problem with posting prices. Hospital charge masters
1140 has close to 20,000 items, and a physician fee schedule has
1141 7,000 items in it. So prices would have to be reconfigured
1142 to be for complete procedures.

1143 I had in a paper proposed, in Health Affairs, that maybe
1144 the way to go is to say let us use the DRG system for all
1145 patients, no matter who the insurer is, because it is a
1146 relative value scale. But each hospital has the right to set
1147 its own conversion factor to monetize the thing, and they
1148 have to advertise that. And only one number would give you
1149 the prices of a hospital.

1150 Or one could have research that bundles all the services
1151 that go into a treatment like a coronary bypass graft or a
1152 hip replacement and then give you the price per procedure

1153 with everything bundled in.

1154 But I think the idea of transparency is one I would
1155 wholeheartedly support.

1156 Mr. {Deal.} Thank you. Ms. Pipes.

1157 Ms. {Pipes.} Yes, and I too support price transparency.
1158 We have price transparency in most aspects of our life,
1159 whether it is what service we use or what bank we use. I
1160 would be against government mandating price transparency. I
1161 think, you know, in consumer patient-centered health care, we
1162 have seen--we will see, if we encourage that and support it,
1163 I think we will see price transparency because when you put
1164 doctors and patients in charge of your health care, prices
1165 will be negotiated.

1166 I think if we change the tax code, as I mentioned, so
1167 that individuals can buy health insurance, as Ms. Eshoo said,
1168 on the same level playing field that those who get the tax
1169 benefit through their employer-based coverage. I think we
1170 will see much more competition. We will see new entrance
1171 into the insurance market, and when we have more competition,
1172 we will see prices being negotiated.

1173 I think even in Medicare, you know, we could open up to
1174 empowering Medicare patients and doctors, and we will see
1175 people negotiating. And we will get price transparency as we
1176 have in all other aspects of American life.

1177 Mr. {Deal.} I take that as a qualified yes?

1178 Ms. {Pipes.} Yes.

1179 Mr. {Deal.} Dr. Feder?

1180 Ms. {Feder.} I think that your proposal, Congressman
1181 Deal, makes a great deal of sense. I haven't seen it in all
1182 its details, but transparency in what--getting inside the
1183 black box of insurance is critical as a customer, as a
1184 taxpayer, every other way. And so I applaud your efforts,
1185 and I am happy to be of what help I can.

1186 Mr. {Deal.} Thank you. Let me explore very briefly
1187 because my time is running out. If we go to a government
1188 option proposal that would be offered as part of a package,
1189 would you anticipate that that government option would also
1190 have to take into account state mandates on what must be
1191 offered, which vary obviously from state to state, and would
1192 it also therefore take into account community pricing? And
1193 if it does all of that, don't we wind up with a system where
1194 a public plan would cost significantly more depending on
1195 where you lived? And how do we deal with that inequity in
1196 terms of explaining that to the public? Or would it simply
1197 be a uniform premium that you would anticipate that public
1198 plan would offer?

1199 Ms. {Pipes.} So I pointed that out in my testimony that
1200 things like guaranteed issue, community rating, and a lot of

1201 mandates add significantly, 20 to 50 percent, to the cost of
1202 a premium. And if, within this national insurance exchange,
1203 there is going to be a public plan and all of those things
1204 are going to be added onto it, you are right. We are going
1205 to see the cost of insurance go up rather than going down.
1206 And that is going to crowd out more people out of getting
1207 covered and reducing that number of uninsured.

1208 So under the health saving account patient-based health
1209 care, it is not for everyone, but we have seen prices come
1210 down as Mr., I think, Burgess mentioned. We have also seen
1211 that people who have HSAs are 30 percent more likely to get
1212 an annual checkup and be engaged in prevention because they
1213 don't want to be facing significant cost once they have a
1214 degree. And that work was done by McKinsey and Company.

1215 So I think we have to be very careful. I am very
1216 worried. New Jersey, New York, Massachusetts have community
1217 rating, guaranteed issue. Their insurance is very expensive,
1218 and if we do this plan, it is going to crowd out private
1219 insurers, and that is my main concern.

1220 Mr. {Deal.} I am sorry I can't have any time. I have
1221 already exceeded my time, and I am afraid I can't let the
1222 rest of you answer. But maybe we can get to it later. Thank
1223 you.

1224 Mr. {Pallone.} Thank you, Mr. Deal. Ms. Eshoo.

1225 Ms. {Eshoo.} Well, I want to thank the witnesses, each
1226 one coming from their own place and stating their case really
1227 forthrightly. I enjoyed your testimony, and I think that,
1228 while I might not agree with everything that I have heard, I
1229 like the way you have framed it and presented it to us.

1230 Since today is St. Patrick's Day and the one day where
1231 we are all Irish, Ms. Pipes--is it, yeah, Pipes. You quote
1232 P.J. O'Rourke. And you say if you think health care is
1233 expensive now, just wait until it is free. Where, in
1234 anything, is anyone talking about free?

1235 Ms. {Pipes.} Well, Michael Moore --

1236 Ms. {Eshoo.} I mean where does this come from?

1237 Ms. {Pipes.} Well, because people, as Michael Moore
1238 said in his movie ``Sicko''--

1239 Ms. {Eshoo.} We are not talking about movies. We are
1240 talking about reality.

1241 Ms. {Pipes.} Right.

1242 Ms. {Eshoo.} So when you say in congressional testimony
1243 if you think health care is expensive now, wait until it is
1244 free, who has suggested that health care is free? We are
1245 faced with 12 and 14 percent increases every year. It simply
1246 is unsustainable. We know that people are left out. We know
1247 that it is a system that is fractured. We know that we are
1248 spending too much as a nation and not getting back for people

1249 what they should have. And so I really think that the notion
1250 to say just wait until it is free is--it really doesn't
1251 belong here. I just--I feel strongly about that. I don't
1252 know if--you might not regret having said it, but I don't
1253 think it is really part of this.

1254 I mean you can defend it, but do you have a defense for
1255 it?

1256 Ms. {Pipes.} Yes.

1257 Ms. {Eshoo.} Yeah.

1258 Ms. {Pipes.} So thank you for that comment. What it
1259 means is when government takes over the total supply of
1260 health care, people think it is free because--

1261 Ms. {Eshoo.} Well, we can get into a real debate here.
1262 This is not a discussion about the government taking it over.
1263 This is about the government rewriting the rules of this
1264 because so much of it is not working, and we know that it is
1265 not. Insurers say that. Families say that, and so there is
1266 consensus on that.

1267 So now, let me move on and just as a few questions. I
1268 really want to kind of drill down on this whole issue of tax
1269 treatment. And while this is not the Weighs and Means
1270 Committee, you are all experts, and I really would like to
1271 hear your views on this and what your opinions are on the tax
1272 treatment of employer-sponsored insurance plans.

1273 As you know, those who get their insurance through work
1274 pay no tax, while those that purchase insurance without a
1275 group plan do. Do you think that all plans should be taxed?
1276 Do you think they should be taxed in part for certain
1277 services? What is your view on all of this? It is not a
1278 subject matter that is often discussed, and I am curious
1279 about it. So Dr. Feder, do you want to start?

1280 Ms. {Feder.} Sure. You raised it in your opening
1281 remarks--

1282 Ms. {Eshoo.} Right.

1283 Ms. {Feder.} --that it is concerning to you. And our
1284 employer-sponsored health insurance has grown up as the
1285 development preceded the special tax treatment, but that has
1286 strengthened it. And there is a concern about inequities
1287 because better off people get a better break than low income
1288 and certainly than low insured because it varies with your
1289 tax bracket. And so there are concerns about that.

1290 But I am very concerned about doing anything that
1291 undermines the employer-sponsored health insurance system
1292 because although it has significant limitations, it does
1293 create the groups, and you talked about ensuring access to
1294 group insurance. It creates those groups that enables us to
1295 pool risk rather than having everybody on his own, which we
1296 see in the non-group market.

1297 So I think that there are concerns about it. I think as
1298 we develop a system, we want it to be fair and share
1299 responsibility, whether it is through the tax system or other
1300 mechanisms for everybody. But I am very concerned about
1301 proposals to eliminate the tax break because it essentially
1302 does undermine the insurance system, the employer-sponsored.
1303 And also anything that would shift, that would make it come
1304 apart and throw everybody into the non-group market.

1305 Ms. {Eshoo.} Um-hum, thank you. Dr. Reinhardt.

1306 Mr. {Reinhardt.} Well--

1307 Ms. {Eshoo.} Well, you posed a question about
1308 socialized. It is a political phrase to scare people.

1309 Mr. {Reinhardt.} Yeah.

1310 Ms. {Eshoo.} That is what it is.

1311 Mr. {Reinhardt.} Yeah, but it is--

1312 Ms. {Eshoo.} It is a bumper sticker.

1313 Mr. {Reinhardt.} It is really peculiar when you--

1314 Ms. {Eshoo.} It is peculiar.

1315 Mr. {Reinhardt.} --are the father of a veteran to have
1316 that--

1317 Ms. {Eshoo.} Well, how about members of Congress
1318 receiving Social Security?

1319 Mr. {Reinhardt.} Yeah, or a--

1320 Ms. {Eshoo.} Right.

1321 Mr. {Reinhardt.} Who are on Social Security as you
1322 know.

1323 Ms. {Eshoo.} Right.

1324 Mr. {Reinhardt.} No, the issue of taxing employer-
1325 provided benefits, most economists in theory would be for
1326 that, but there is always the concern, and I have written a
1327 paper on the balance sheet for employment-based insurance.
1328 At the moment, it is the only really functioning risk pooling
1329 mechanism in the private sector and actually, for all its
1330 flaws, has worked and served Americans reasonably well.

1331 So an alternative might be to go and say well, self-
1332 employed people should have the same tax privileges, anything
1333 tax-wise that would cost that much money. And that seems
1334 fair to do, but there still is an issue of giving people in
1335 high income brackets a bigger tax break than in low income
1336 brackets, which you really sense with the flexible spending
1337 account, where when I get a tool drilled it costs me half,
1338 and the gas station attendant pays 85 cents on the dollar.

1339 So there are ways to deal with it. For example, one
1340 could say harvest some of the money. I am a full professor
1341 at an Ivy League university. I really don't need this tax
1342 break to get health insurance. I could be asked to pay taxes
1343 on it, and I think I would. So you could say if you are
1344 making less than \$75,000, you won't be taxed on it. If you

1345 make between \$75,000 and maybe \$150,000, we will take half
1346 what the employer pays and add it to your W-4. And if it
1347 over \$150,000 or over \$200,000 the whole thing is taxed.
1348 Then you say you are punishing the rich. Well, I don't
1349 consider that punishment. I consider asking me, who is so
1350 lucky to have a tenured job at Princeton, to pay for my own
1351 health care, I don't call that an imposition. I don't really
1352 need that subsidy from the gas station attendant, which I now
1353 have.

1354 So that is one way you could harvest some of the money
1355 without hurting the rank and file.

1356 Ms. {Eshoo.} Thank you very much to each one.

1357 Mr. {Pallone.} Gentleman from Kentucky, Mr. Whitfield.

1358 Mr. {Whitfield.} Thank you very much, and thank you all
1359 so much for your testimony today. We appreciate it very
1360 much. When we think about Medicare, Medicaid, the VA, S-
1361 CHIP, we know that that represents about 48 or 49 percent of
1362 the total health care delivery system in the U.S.

1363 And I think most people view those as government
1364 programs, which is providing a valuable service, but we also
1365 know that those programs are contributing greatly to the
1366 escalating costs in health care. Every time you visit with
1367 the Concord or a lot of groups, they say with Medicare
1368 increasing costs every year and Medicaid increasing costs

1369 every year and Social Security increasing costs every year,
1370 that we are going to have a financial disaster 22, 23, 24
1371 years down the road on top of our already economic crisis
1372 that we face today.

1373 So when we talk about reforming health care, I think
1374 many of us on this side of the aisle view it as the
1375 government taking it over. I mean and the government already
1376 runs Medicare, Medicaid, S-CHIP, the Veterans' health care
1377 system. And I know, Dr. Reinhardt, you mentioned that we--I
1378 had to leave during your testimony, but I think you said we
1379 need universal health coverage.

1380 And, Dr. Feder, I don't know that you said that, but I
1381 believe you set out certain principles that you had to
1382 consider to--

1383 Ms. {Feder.} And I do favor universal coverage.

1384 Mr. {Whitfield.} Yes, so if the government plan that is
1385 in operation today, I mean the ones that I mentioned, the
1386 costs are escalating every year. We can't control those
1387 costs. If we allow government to be basically responsible
1388 for the other 50 percent, why are we encouraged that the
1389 government could control those costs better than the way we
1390 are controlling costs today?

1391 Ms. {Feder.} Well, Congressman, I don't think we are
1392 proposing having government take over those other costs, and

1393 I actually think, as you look at the share the government is
1394 spending, some talk about it as a shifting from the private
1395 sector to the public sector because our public programs are
1396 taking care of older Americans, disable Americans. And
1397 Medicaid, the bulk of the spending in Medicaid is for people
1398 with disabilities and older people and long-term care. So
1399 they have particular responsibilities and have left the
1400 healthiest population to the private sector.

1401 And when you talk about the overall cost growth, we have
1402 lots of evidence--and I know that former CBO director Peter
1403 Orzack presented that to you as CBO director, and now as OMB
1404 director, he makes the same point. And that is that our
1405 public health insurance programs are not growing faster than
1406 the cost of health care in general. Everybody is buying in
1407 the same market; although, Medicaid really buys on the cheap.

1408 Mr. {Whitfield.} Yeah.

1409 Ms. {Feder.} But the costs are growing in general so
1410 that the only way to get a handle on the growing costs, which
1411 you rightly recognize, of Medicare, Medicaid, Veterans, any
1412 health insurance program that we have, is to pursue slower
1413 cost growth through investment in primary care and prevention
1414 and a host of other mechanisms--

1415 Mr. {Whitfield.} Right.

1416 Ms. {Feder.} --that affect the entire system and to

1417 make sure that everybody has coverage all the time so that we
1418 can promote prevention and better treatment.

1419 Mr. {Whitfield.} Now, you know, as you were talking--
1420 and, Dr. Reinhardt, I will give you an opportunity to reply
1421 also. But as you were talking, another government program
1422 that I think has worked very well is the community health
1423 centers. I mean I think the community health centers
1424 addressing the primary health care issue have worked very
1425 well. And basically they are paid for by the federal
1426 government working with local entities. And I always thought
1427 that community health centers and a partnership in the
1428 private sector with gigantic employers might be a way to
1429 expand accessibility too.

1430 Ms. {Feder.} Well, I share your view of the excellent
1431 performance and the value of community health centers, and
1432 they certainly are a part of the system in making sure that,
1433 as many have said, people don't just have access to health
1434 insurance, they have access to care.

1435 Mr. {Whitfield.} Right.

1436 Ms. {Feder.} But the community health centers, when
1437 less people have insurance coverage, they face tremendous
1438 problems once anybody gets beyond primary care.

1439 Mr. {Whitfield.} Right.

1440 Ms. {Feder.} They can't find specialists.

1441 Mr. {Whitfield.} Right.

1442 Ms. {Feder.} People need insurance coverage.

1443 Mr. {Whitfield.} Now, Dr. Reinhardt, if you will take
1444 about 30 seconds to reply, if you can, then I want to make
1445 one other comment.

1446 Mr. {Reinhardt.} The first point I want to support, if
1447 you look in November '07, Peter Orzack published a beautiful
1448 report on health care cost growth. And it is figure four.
1449 You can actually really see how each sector, public, private,
1450 is growing. And in fact, on a per capita basis, Medicare has
1451 grown less rapidly than the private sector. On the community
1452 health center--

1453 Mr. {Whitfield.} On the cost of it?

1454 Mr. {Reinhardt.} On the cost. You have to do it per
1455 beneficiary, and Marilyn Moon has done a lot of research.

1456 Mr. {Whitfield.} Okay.

1457 Mr. {Reinhardt.} And that is well understood. On the
1458 community health center, I think they are an important part
1459 of the landscape in American health care because they are so
1460 accessible, and they do a great job for the money they have
1461 used. But we had a commission on rationalizing New Jersey
1462 health care and looked at these centers, and this theme that
1463 they are great in primary care, but then they are not multi-
1464 specialty. Getting access to specialists was the Achilles

1465 heel. So yes, I think we should have them. It should stay,
1466 and the Congress might worry about how to have a larger range
1467 of services provided.

1468 Mr. {Whitfield.} Fine. Mr. Chairman, I would just make
1469 one other comment. Another thing that bothers a lot of
1470 people though when you talk about universal health coverage
1471 and you think about the Canada system and the Great Britain
1472 system and so forth, and Ms. Pipes went over this in her
1473 testimony. Maybe you all can address it later. But if it is
1474 true 750,000 Canadians are waiting for procedures and 3.2
1475 million out of the population are waiting to get a primary
1476 care doctor and Canada, the average wait for seeing a primary
1477 care doctor for getting treatment by a specialist was 17.3
1478 weeks and the rationalization of health care, that is a real
1479 concern to a lot of people.

1480 And you can't respond to it now, but later on I am sure
1481 we will have an opportunity to address that in more detail.
1482 Thank you.

1483 Mr. {Pallone.} Thank you. Gentleman from Texas, Mr.
1484 Green.

1485 Mr. {Green.} Thank you, Mr. Chairman, and following up
1486 on my colleague from Kentucky, I have a district, a very
1487 urban district in Houston. It is an under, underserved
1488 district. We have actually four community based health

1489 centers, and they are in financial trouble right now because
1490 so much of that we depend on is foundation funding. And
1491 foundation funding, because of the economy, is cratering. So
1492 we need more of them, but we also need to look at, you know,
1493 our authorization levels, that we upped the authorization to
1494 five-year authorization last time. Even with the stimulus
1495 money that was in there, in the Houston area, fourth largest
1496 city in the country, it helped two of our FQHCs. So, you
1497 know, we need to be better on the community based health
1498 centers. And hopefully whatever plan we have will make them
1499 where the rubber meets the road literally for the uninsured
1500 and the underserved. I mean it is a great program. It has
1501 been around for almost 50 years now, I guess, since President
1502 Johnson.

1503 And I would like to ask the panel how do you see these
1504 FQHCs because of the--my problem is the disparity of the
1505 location. Great example, Chicago is fortunate to have 81
1506 community health centers, and in Houston, Harris County, we
1507 have 10. And we are trying to create more even though we are
1508 the fourth largest city and may pass Chicago in the census.

1509 But we have a disparity in where these centers are
1510 located because of the local networks.

1511 Ms. {Feder.} It seems to me, Mr. Green, and I would
1512 have to look into it further as to what the problem is under

1513 the circumstances, but the best way that you can promote
1514 those delivery systems is to get everybody health insurance
1515 because then every patient who comes into a community health
1516 center is carrying money. They are not dependent on the
1517 federal grants. So the bottom line is that we need health
1518 insurance in order to enable the delivery systems to prosper.

1519 Mr. {Green.} Well, the problem FQHCs have is just like
1520 the problems of hospitals and doctors. You have a lot of
1521 uncompensated care.

1522 Ms. {Feder.} Exactly.

1523 Mr. {Green.} Even though people have to pay something,
1524 they don't pay enough that covers the cost of the service.

1525 Ms. {Feder.} Right, and valuable as they are, and as
1526 Mr. Whitfield said, is that even expanding community health
1527 centers is not a substitute for getting people insurance.
1528 They are a valuable part of the delivery system and should be
1529 supported by everyone having health insurance coverage.

1530 Ms. {Pipes.} I would just like to add that I support
1531 community hospitals, and Michelle Obama, during the campaign,
1532 you know, said being at the University of Chicago, people
1533 shouldn't be turning up at the University of Chicago
1534 emergency rooms for very, very expensive care. She supported
1535 the community hospitals. So that was a very good point.

1536 Just a point on the hidden tax. People keep saying that

1537 the uninsured are adding a tremendous burden to the cost of
1538 those who have private insurance. The work done by Dan
1539 Kessler at Stanford, he shows that the uninsured are adding
1540 about 1 percent to the cost of premium for those who have
1541 private insurance.

1542 The 10 percent cost addition to private payers' premiums
1543 comes from Medicare and Medicaid from the lower reimbursement
1544 rates paid by the government. So I think that we really need
1545 to focus on, you know, how, you know, if we are going to go
1546 down to the path to more Medicare, more Medicaid expanding
1547 these programs, reimbursement rates are low and as we see
1548 now, one in three new Medicare eligible patients is having
1549 trouble finding a primary care doc.

1550 Because in systems like Canada, when the government took
1551 over the health care, people talked about there would be a
1552 lot of increase in primary care, but in fact, med students
1553 didn't go into primary care because when the government
1554 determines how much you are paid, they would rather go into
1555 specialties. So that is why we have a tremendous shortage in
1556 Canada of primary care docs.

1557 Mr. {Green.} Well, I will give you an example of the
1558 FQHC doctors can't make a decent living there. You know, you
1559 can get \$135,000 or a family practice in a community based
1560 health center. The problem is that it is not, you know, not

1561 the specialties. And we know how high the specialties are.

1562 Dr. Reinhardt?

1563 Mr. {Reinhardt.} I would want to stress Dr. Feder's
1564 point. The important thing is to endow people with
1565 purchasing power to get health care because the trouble with
1566 institutional grants is you can have community health centers
1567 that are angelic. They have the budget. And you have others
1568 that are not, and to get performance is measured is not easy.
1569 But when customers can walk, competition will actually take
1570 care of it. That is why in general community health centers,
1571 as a delivery device are good. But I think it would be good
1572 that if their clients brought their own purchasing power with
1573 them.

1574 On this issue of cost shift, this is actually an
1575 interesting thing. People who believe in markets should not
1576 believe in my view that just because Medicaid or Medicare
1577 pays hospitals too little, private payers have to pay more.
1578 That is not true in a hotel. If somebody gets a discount,
1579 they don't call you up in the middle of the night and say
1580 hey, Smith just registered. We gave him a discount. We are
1581 going to raise your rate. So if you actually believe the
1582 private market works, why are private insurers not following
1583 Nancy Reagan's advice, just say no--

1584 Mr. {Green.} Well--

1585 Mr. {Reinhardt.} --we are not going to take it. So I
1586 don't believe this cost shift story of private payers picking
1587 up what Medicare doesn't pay. I don't believe in that story.

1588 Mr. {Green.} Well, Mr. Chairman, I know we have a
1589 situation in our country, Medicare pays so much. Medicare
1590 actually pays less, but in some cases, if you have a military
1591 base, got to see Champus and TriCare, don't even pay what
1592 Medicare makes in reimbursement. And we have run into that
1593 problem in a very urban area with our number of activations.
1594 So you are right. We need to look at the reimbursement rate
1595 to make sure they actually do fit the cost of the service.
1596 Thank you, Mr. Chairman.

1597 Mr. {Pallone.} Thank you. The gentleman from Texas,
1598 Mr. Burgess.

1599 Mr. {Burgess.} Thank you, Mr. Chairman. Let me just
1600 ask a question. I hate to do this because it is beyond the
1601 scope of this panel. But Mr. Green brought up in his opening
1602 statement that Texas has 25 percent uninsured. When
1603 Massachusetts did their program several years ago, they made
1604 a decision that they were not going to factor in or they were
1605 not going to include in their factoring any cost for people
1606 who were in the country without the benefit of a Social
1607 Security number. Of the uninsured in Texas, there are a
1608 significant number. We could never ignore that number of

1609 people who are in the country without the benefit of a Social
1610 Security number.

1611 So we failed on several attempts since my short tenure
1612 in Congress to deal with this issue. Can we really get to
1613 the point where we are talking about the type of reform that
1614 you three are discussing if we don't deal, in some way, with
1615 the problem we have with immigration and people who are in
1616 the country again without the benefit of citizenship?

1617 Mr. {Reinhardt.} Well, I served on the board of a
1618 Texas-based hospital company, and we had this very problem.
1619 On the front lines, you cannot tell when people come in
1620 bleeding or pregnant about to deliver. You cannot send them
1621 away. So we served them one way the other.

1622 Mr. {Burgess.} And, in fact, you are required to under
1623 federal law under IMTALLA.

1624 Mr. {Reinhardt.} IMTALLA, yes. And in New Jersey, it
1625 is even more. The whole thing has to be delivered. So most
1626 of the immigrants are actually working or have families where
1627 somebody works. And it seems to me we have let employers in
1628 this country off the hook much too easily. They should pay
1629 for the social services that the immigrants and their
1630 families consume, whether it is schooling or--they should be
1631 made to pay Social Security. And that includes even people
1632 who do shrubbery as they do in Princeton. One ought to be

1633 required by law to pay a prorated contribution to these
1634 people's social services. But we have never actually done
1635 that. Quite a few people who employ undocumented aliens pay
1636 nothing into Social Security and get away with it. They have
1637 them as a subcontract, and God knows. So yeah, I think you
1638 cannot not give health care to these families, particularly
1639 the children because, whether you like it or not, these
1640 children will one day be Americans.

1641 Mr. {Burgess.} Well, many of them in fact are by virtue
1642 of the fact of the--

1643 Mr. {Reinhardt.} That they were born here.

1644 Mr. {Burgess.} --they were born here. Again I am not
1645 seeing from congressional leadership or from the White House
1646 any serious attempt at dealing with this issue. And I just
1647 think it is--I stipulate the points you made, Dr. Reinhardt,
1648 are accurate. But it is just going to be very, very
1649 difficult for us to deal with us this issue when we have that
1650 larger looming problem in Texas, New Mexico, Arizona, and
1651 California where it is just going to be very, very difficult
1652 to overcome.

1653 Mr. {Reinhardt.} Well, there is a moral problem. If
1654 you make this great American health care available to people,
1655 people will flock here ever more.

1656 Mr. {Burgess.} And that was the argument.

1657 Mr. {Reinhardt.} That is why the Congress sometimes
1658 says let us not do this because we are creating a magnet.
1659 But--

1660 Mr. {Burgess.} But we did that in S-CHIP. We
1661 essentially said that we are going to remove some of the
1662 barriers. And we have turned off the jobs magnet to some
1663 degree, but we have to be careful not to turn on the benefits
1664 magnet.

1665 Mr. {Reinhardt.} In the end, there is a doctor and a
1666 nurse and a hospital looking at this human being, and they
1667 cannot say no.

1668 Mr. {Burgess.} Dr. Reinhardt, I will just stipulate
1669 that that is correct, and practically every night of my
1670 practice life, I was called to do just a delivery because
1671 IMTALLA said I would have a \$50,000 fine and some serious
1672 questions to answer if I did not respond within 30 minutes,
1673 and yet at the same time that same federal government failed
1674 to secure the borders. And the consequence, we in the
1675 hospitals are left on the front line.

1676 I didn't mean to get so far down into that. I did want
1677 to ask a couple of questions about the federally qualified
1678 health center issues that Mr. Green brought up because the
1679 distributional issues are significant. While he has four or
1680 what did he say? How many did he have in Houston? It was

1681 way too many, whatever he said. We only have four in Dallas
1682 County, one in Tarrant County, none in Denton County where I
1683 represent significant numbers of people. The infant
1684 mortality rate in Tarrant County in some of the zip code is
1685 phenomenally high, and we only have one federally qualified
1686 health center, not in the neighborhoods where those zip
1687 codes. So there it is not a question of access. We have a
1688 good county hospital in Tarrant County. The question is
1689 utilization. We have not put the clinics where the people
1690 are so that they will use them, and that is one of the great
1691 inequities.

1692 I have often wondered why we reimburse at a higher rate
1693 for Medicaid reimbursement for a federally qualified health
1694 center, and we won't do the same thing for a physician in
1695 practice in the community to keep that physician involved and
1696 in practice. So, Dr. Reinhardt, you almost went there with
1697 the money should follow the individual. Can you expound upon
1698 that just a little bit?

1699 Mr. {Reinhardt.} Yeah, I think in general, certainly in
1700 my profession, economics, we believe in competition. And
1701 therefore whether it is--scholarships should never be given
1702 to a medical school or a university. It should travel with
1703 the client, and that is why ideally people should have the
1704 same insurance. A doctor should get paid the same, no matter

1705 where they work. You are reimbursing a professional service,
1706 and it shouldn't really depend on what location you do that.
1707 And so I sympathize very much with your thought.

1708 Mr. {Burgess.} And what are the mechanisms--

1709 Mr. {Pallone.} We--

1710 Mr. {Burgess.} --that money could follow the
1711 individual?

1712 Mr. {Pallone.} Mr. Burgess, we--

1713 Mr. {Reinhardt.} Universal--

1714 Mr. {Pallone.} You are over. This will be the last
1715 question.

1716 Mr. {Reinhardt.} Universal insurance is, in fact, the
1717 mechanism. That is why some of us are so much for it. That
1718 if people have purchasing power, like a Canadian has a credit
1719 card, and with the credit card, every doctor gets paid the
1720 same, whether it is a poor child or a rich child. While in
1721 New Jersey, we have Medicaid \$30 for a pediatric visit, and
1722 for the commercial, \$120. Canadians don't do this. This is
1723 why I think the Canadian story is not really relevant to us
1724 at this time. They have a different social ethic. They look
1725 at life differently than we do.

1726 If you did a survey now in Canada, Canadians are not
1727 stupid. They are highly educated. They watch American TV.
1728 They have a democracy, and yet if you had a referendum

1729 whether they would want our system or keep theirs,
1730 overwhelmingly I would bet a lot of AIG stock on that,
1731 overwhelmingly, you would find--well, it is still worth
1732 something.

1733 Mr. {Burgess.} We will see to that actually. We will
1734 stipulate to that.

1735 Mr. {Reinhardt.} I will put real money on it, real New
1736 Jersey money. The Canadians would vote for their system.
1737 There are, of course, some who are not happy, and they can
1738 come here and do research. But by and large, when I go up--I
1739 am a Canadian too. When I go up there, by and large, people
1740 are very proud of their system. And I invite you to do it.
1741 Go to the airport. Talk to anyone.

1742 Mr. {Burgess.} Yeah, my father was a refugee from
1743 Canada so I understand.

1744 Mr. {Pallone.} All right, we have to move on here.
1745 Next is Ms. DeGette.

1746 Ms. {DeGette.} Thank you, Mr. Chairman. Dr. Feder, I
1747 was wondering if you wanted to respond very briefly to this
1748 issue of the undocumented immigrants coming in and taking
1749 advantage of our system.

1750 Ms. {Feder.} Thank you, Ms. DeGette. You saw me
1751 chomping at the bit.

1752 Ms. {DeGette.} I did.

1753 Ms. {Feder.} I will be brief. I just wanted to make
1754 very clear that, although immigration is a very serious
1755 problem that does create serious problems for health
1756 providers, particularly in some areas, that the problem that
1757 we are talking about is we should not ever think that the
1758 bulk of people without health insurance coverage or the bulk
1759 of people who are facing affordability problems are
1760 immigrants, whether they are here legally or not legally.

1761 And I also believe that when we are talking about--we
1762 asked universal coverage or were talking about universal
1763 coverage, we are talking about universal coverage for people
1764 who are Americans and are here legally. And I just didn't
1765 want that issue to get confused.

1766 Ms. {DeGette.} So if you were structuring the universal
1767 health care program, you wouldn't necessarily structure it so
1768 that we were inviting people to come in and enroll.

1769 Ms. {Feder.} I think that is absolutely true, and we
1770 have seen that people, as Dr. Reinhardt said, people are
1771 coming here as long as employers want to hire them and we
1772 don't enforce our rules.

1773 Ms. {DeGette.} Right.

1774 Ms. {Feder.} And with the decline in the economy, they
1775 are not coming in those numbers anymore.

1776 Ms. {DeGette.} Right.

1777 Ms. {Feder.} Although it is a very serious problem that
1778 I wouldn't minimize and faces some institutions in particular
1779 ways, it would be a mistake the hold the whole health care
1780 system and all Americans hostage to that problem.

1781 Ms. {DeGette.} Thank you. What I really want to talk
1782 to this panel about is this issue of a public plan
1783 alternative because I think that frankly as we move forward
1784 with drafting legislation in this committee, that is going to
1785 be one of the top issues of discussion and debate. And some
1786 people say well, we shouldn't have a public alternative, I
1787 guess, because it leads us down a slippery slope towards
1788 socialized medicine or single payer or so on.

1789 But we actually do have one of our largest public health
1790 care systems right now has a public option and a private
1791 option. That is Medicare, and the Medicare fee-for-service
1792 option is the most popular option, and people like that. But
1793 more importantly, I think, if we didn't retain the fee-for-
1794 service option when we did Medicare Advantage, we would have
1795 never realized that we weren't getting more efficiencies in
1796 the private option that we had adopted. And frankly I was
1797 here when we did Medicare Advantage, and I thought that when
1798 we did the private alternative that it would save us money
1799 and it would cause us to revamp our fee-for-service program
1800 to get more efficiencies in that program.

1801 We all know now that, of course, it has not been the
1802 case, and that we are spending far more in the private
1803 alternative than we would have in the public. And so I guess
1804 maybe, Dr. Feder, I will start with you. I would like your
1805 comments on why you think it is important to have a public
1806 option if we are going to maintain the private competition
1807 that we have.

1808 Ms. {Feder.} Yeah, I think you nailed it, Congresswoman
1809 DeGette, when you said that essentially the public system can
1810 keep the private system honest. But we have evidence that
1811 private insurers are not negotiating effectively in terms of
1812 getting affordable health care. And if we have a public
1813 health insurance option, and remember because I think it gets
1814 misrepresented as a choice, then we, you, the public can hold
1815 that plan accountable for bargaining effectively with
1816 providers, for delivering quality care, for being
1817 transparent, for all the things that we need insurance to be.
1818 And essentially it puts some pressure and makes a market that
1819 claims to be competitive but is not, it can make it work.

1820 Ms. {DeGette.} And just to follow up on something, Ms.
1821 Pipes. I never try to misconstrue what people who I disagree
1822 with say, but what I had heard Ms. Pipes saying is part of
1823 the way in Medicare and part of the way it would happen in
1824 this system that you would get the efficiencies is by

1825 ratcheting down reimbursement for medical services, and
1826 doctors wouldn't want to provide those services. What would
1827 your response be to that, Doctor?

1828 Ms. {Feder.} Well, I find these claims fascinating at a
1829 time when the Congress is responding to concerns about
1830 physicians in the Medicare program and responding to access
1831 problems by raising physician fee. And in Medicare, we make
1832 an extra effort to make certain that we are paying
1833 appropriately, but that when access problems arise, that we,
1834 essentially you, enact higher rates.

1835 And we are talking about then a responsiveness to--
1836 people need access to care, and your constituents hold you
1837 responsible for that. So I don't think this concern that
1838 somehow it is going to go to go nothing or Medicare for all
1839 is--I don't know where this is coming from.

1840 Ms. {DeGette.} Dr. Reinhardt?

1841 Mr. {Reinhardt.} Yeah, I agree. I served on the
1842 physician payment review commission, your commission, and we
1843 every year did a survey of the elderly and asked do you have
1844 access to health care--and that is still part of what Med Pac
1845 does--and monitored it very, very closely. And we have rules
1846 of thumb when we saw access becoming even a small problem, we
1847 would recommend to the Congress to raise rates. So that in
1848 the Medicare program has, I think, been pretty well

1849 modulated.

1850 But there is another thing that really I find puzzling
1851 around the business roundtable. On the one hand, they
1852 complain that we are spending too much on health care, and
1853 then on the other hand though they are saying the public
1854 sector isn't spending enough on health care, and then they
1855 also come out that government should stay small. And I
1856 sometimes in my simple mind try to put that all together.
1857 They say they want small government, but they want to pay
1858 more for Medicare so that their rates are somehow viewed the
1859 correct rate. Who is to say that private insurers aren't
1860 overpaying?

1861 They say I have so little bargaining power. In some
1862 places, say California, even a large company like Well Point
1863 cannot face down a hospital system. And who is to say the
1864 private sector isn't overpaying? You know, you could make
1865 that case.

1866 Ms. {DeGette.} Thank you, Mr. Chairman.

1867 Mr. {Pallone.} Thank you. Gentleman from Illinois, Mr.
1868 Shimkus.

1869 Mr. {Shimkus.} Mr. Chairman, I will defer to whoever is
1870 next on this side if I may since I just want to listen.

1871 Mr. {Pallone.} Thank you. Mr. Gingrey.

1872 Mr. {Gingrey.} Mr. Chairman, thank you. Ms. DeGette

1873 was just referencing in Medicare that we have a--

1874 Ms. {DeGette.} Would the gentleman yield? It is
1875 DeGette, and everybody including the President has been
1876 saying it wrong. So I would just like to--

1877 Mr. {Gingrey.} Ms. DeGette.

1878 Ms. {DeGette.} Thank you very much.

1879 Mr. {Gingrey.} And it is Diana and not Deana. Is that
1880 correct?

1881 Ms. {DeGette.} You got it.

1882 Mr. {Gingrey.} Thank you. I will remember that. But
1883 Ms. DeGette was talking about the public and private plan
1884 that we have within the Medicare system and that the private
1885 plan turned out to be so much more costly. The reason I
1886 bring that up, because, Dr. Reinhardt, in your presentation,
1887 you talked about the importance of rigorous cost
1888 effectiveness analysis. And I have concern that our way of
1889 scoring things in a static environment rather than a dynamic
1890 way of doing it.

1891 Medicare Advantage--and the President, of course, has
1892 certainly taken a swipe at Medicare Advantage and is going to
1893 cut that significantly to the chagrin, I think, of 10 million
1894 people who get their care through Medicare Advantage.

1895 If it is true that end-of-life cost is the biggest cost
1896 of Medicare, the last month of life, then I think we might be

1897 judging that cost of Medicare Advantage prematurely. Now, I
1898 am not saying that it should be 115 percent compared to
1899 Medicare fee-for-service. Maybe it is a little too high, but
1900 in the final analysis, it seems to me that if we looked at
1901 this in a dynamic way, follow it all the way to the end of
1902 life, then it may turn out that Medical Advantage, the
1903 private versus the public, would be much more cost effective.

1904 And I worry in regard to what you were saying, Dr.
1905 Reinhardt, in rigorous cost effective analysis in regard to
1906 medications, in regard to biologicals, in regard to durable
1907 medical equipment or devices. That maybe in fact these
1908 would, by some rigorous cost effective analysis, almost like
1909 a Federal Reserve Board for health care, that these decisions
1910 would be made too early. And if we had an opportunity to
1911 wait and see in combination with other things, whether it was
1912 a cancer drug or a new surgical procedure, that in fact, in
1913 the long run, it would be cost effective. So I would like
1914 for you to respond to that for us.

1915 Mr. {Reinhardt.} Well, I mean first of all your point
1916 of ideally we would like to have a dynamic view is correct.
1917 I agree with this. Ideally what you would really like to
1918 have a natural experiment where some people went into
1919 Medicare Advantage, some stayed with the traditional program,
1920 and you could follow them until they die and say what were

1921 the life cycle costs adjusting for illness and so on. That
1922 would be ideal obviously, and maybe you are right. It could
1923 be cheaper if they manage somehow the last month of life more
1924 efficiently. I am not sure there is any evidence--

1925 Mr. {Gingrey.} Well, I would say this. It is very
1926 likely that those were managed efficiently over a number of
1927 years in regard to wellness and taking care of themselves and
1928 taking care of their medications. When it comes to be their
1929 final day on earth, it might be a catastrophic event like a
1930 heart attack or a stroke but not in an intensive care unit
1931 for months suffering from multiple horrendoplasties, as we
1932 used to say in medical parlance.

1933 Mr. {Reinhardt.} No, it is possible, I mean, and it is
1934 researchable. One could research it even now. You could
1935 give the ARC some money--and I speak here with a conflict of
1936 interest. I am a health services researcher, but we could
1937 research this.

1938 Mr. {Gingrey.} Yeah, I think you could, and let me ask
1939 you one last question, Dr. Reinhardt, before my time runs out
1940 completely. You had an article published March 13 of this
1941 year in the ``New York Times.'' You pointed to two groups
1942 who comprised the ``opposition to cost effectiveness
1943 analysis.'' And you said one of those groups were
1944 manufacturers of pharmaceuticals and biotechnology products

1945 or of medical devices. But the second group, and this is
1946 what I want to address my question to. You said the second
1947 group are individuals who sincerely believe that health and
1948 life are priceless, and you went on and you said in
1949 describing this second group, you state that for them cost
1950 should never be allowed to enter clinical decisions. ``It is
1951 an utterly romantic notion, and if I may so say, also an
1952 utterly silly one. No society could ever act consistently on
1953 such a credo.'' That is the end of your quote.

1954 Dr. Reinhardt, do you believe that we, as individuals,
1955 in America should have the ability to value our own lives, or
1956 is this something we should ask the government to do for us,
1957 i.e., ration that care when you get to be 90 years old and
1958 you need a hip replacement, do you just let them fall and
1959 break the hip and die of pneumonia? Or do they get the
1960 opportunity, if they value that, to get that hip replaced?

1961 Mr. {Reinhardt.} I cannot even tell you, Congressman
1962 Gingrey, how much I hoped someone would ask me this question
1963 because this is how I would think about it. Every American
1964 should have the right to value their own life any way they
1965 wish. But then the question is at whose expense. If it is
1966 at their own expense, by all means. But if you are dealing
1967 with a collective insurance fund, then those who preside over
1968 those funds do have, at some point, to ask themselves at what

1969 price do I buy additional life years, quality adjusted--we
1970 call them quallies--or additional health? And to say we
1971 don't make airports as safe as they could be. Our air
1972 traffic control system is reckless, I think, from what you
1973 read, and what often near misses. And why don't we do it?
1974 Over money. We may calculate our some fault in an unarmored
1975 Humvee. That was a calculated decision to say well, it would
1976 cost so much to have armored vehicles. We are going to take
1977 a chance of some Marines, and that is what the Congress does.

1978 So what I listed there is a paper that shows the value
1979 of human life legislators and people routinely put on their
1980 own life, and they are rather low numbers in many ways. And
1981 I raise the question why should health care be the only area
1982 in an economy in society where I have the right to say spend
1983 the limit, spend \$5 million on me and let the taxpayer pick
1984 up the tab. I think that notion, to my mind, is romantic
1985 and, in fact, silly.

1986 Mr. {Pallone.} We are--

1987 Mr. {Gingrey.} Like a German philosopher of yesterday.

1988 Mr. {Pallone.} We have to move on, Mr. Gingrey. I am
1989 sorry, but we just have a lot of people, and we got another
1990 panel. Next is Ms. Capps.

1991 Ms. {Capps.} Thank you, Mr. Chairman, and I want to use
1992 my time really well with a great panel. And I have a

1993 question for each of you, starting with Ms. Pipes. In your
1994 testimony, you talked a lot about rationing care and waiting
1995 lists, and Canada does have bad wait times, but so does the
1996 United States. Twenty-three percent of adults reported
1997 having to wait over six days to get an appointment to see a
1998 doctor the last time they needed one. In the U.K., which
1999 also has a single payer system, it was only 15 percent.

2000 In addition, 34 percent of sick adults in America who
2001 had medical problems skipped important doctor visits because
2002 of cost. That is way more than the 4 percent in the U.K. and
2003 the 7 percent in Canada.

2004 Not to belabor that, because we are talking about
2005 American system that we want to try to reform, is there any
2006 data you can present to this committee showing that a new
2007 optional public health plan will create rationing times or
2008 wait times worse than what we are seeing right now?

2009 Ms. {Pipes.} Well, I haven't done the exact research on
2010 that particular issue, but I think--

2011 Ms. {Capps.} So there is no documentation that you know
2012 of?

2013 Ms. {Pipes.} Not that I know of, but I can look into it
2014 and find that out because I think--

2015 Ms. {Capps.} That would be great. If you can find it,
2016 I would love to have it for our--

2017 Ms. {Pipes.} Because I think, you know, Canada does
2018 have long waits, and people that have money come to the
2019 United States and pay out of pocket.

2020 Ms. {Capps.} You said that in your testimony.

2021 Ms. {Pipes.} So it is very important that we improve
2022 the U.S. system so that people can get better access.

2023 Ms. {Capps.} Exactly.

2024 Ms. {Pipes.} And that is why I support universal choice
2025 because a young man of 30, you know, wants to get a high
2026 deductible--

2027 Ms. {Capps.} Thank you.

2028 Ms. {Pipes.} --insurance plan. Why should he have to
2029 pay \$12,000 to \$15,000 to cover my in vitro fertilization?
2030 You know what I mean?

2031 Ms. {Capps.} Thank you very much, and if you can find
2032 that information for us, I think it would help us to make
2033 some good decisions. Dr. Feder, I mentioned the story in my
2034 opening minute about a constituent of mine who lost her job
2035 and had a reoccurrence of her cancer. She did well in the
2036 country that I represent because they have a particular
2037 public access program that worked for her.

2038 But I want you to be able to elaborate briefly but for
2039 our value what you were saying about how when someone loses
2040 employer coverage, their ability to purchase coverage in the

2041 non-group market is limited at best.

2042 Ms. {Feder.} Yeah, well it is. You are absolutely
2043 right, but in your community she had an option. She had what
2044 is called a pre-existing condition. She was sick, and you
2045 are going to hear on the next panel from my Georgetown
2046 colleague, Karen Pollitz, who can give you examples, a
2047 tremendous number of examples of this kind. That people in
2048 the non-group market essentially does not--either denies
2049 people who have conditions, rules out coverage for the body
2050 parts that have been damaged, limits the benefits, or charges
2051 higher rates.

2052 The market simply does not work for people. It is not
2053 any kind of safety net, and the evidence on the non-group
2054 market is that rather than people falling into that system
2055 and getting picked up, it ends up people are healthier in
2056 that market than in the employer-sponsored system.

2057 So this woman, without your plan, when she most needed
2058 care, would have lost any means to get access to it. And we
2059 know looking at the evidence in general on the uninsured that
2060 people are actually dying in that circumstance.

2061 Ms. {Capps.} Thank you very much, and I--

2062 Ms. {Pipes.} I mean because people get their insurance
2063 through their employer and it is not portable if they lose
2064 their job, this is the reasons why changing the tax code so

2065 that people can go into the individual market. And also I
2066 think we will see more competition and new insurance
2067 companies that will deal with specific people.

2068 Ms. {Capps.} Well, we will see about that.

2069 Ms. {Feder.} They don't compete for sick people.

2070 Ms. {Capps.} That is right. If there is anybody who
2071 can show a plan where they compete for sick people, we would
2072 love to hear about that too.

2073 There is another topic that is very dear to my heart,
2074 Dr. Reinhardt, I saved for you. In the United States, we
2075 spend nearly \$7,500 per person on health care. It is the
2076 most expensive system in the world, if I am not mistaken.
2077 Yet in terms of maternal mortality, women dying in
2078 childbirth, we rank 41st out of 171 countries. So there is a
2079 disparity there. How can we now as we want to reform our
2080 system--what are some proposals specifically that would
2081 improve issues like maternal health, a classic indicator,
2082 according to the millennium challenge, for the overall health
2083 of a nation while striving for lower costs?

2084 Mr. {Reinhardt.} Well, obviously part of the reason why
2085 women die has to do with issues outside of the health system,
2086 and every health services researcher would recognize this.
2087 But when you come to infant mortality or maternal death, the
2088 health system does have a contribution to make. And I think

2089 we are falling short. It is because people often do not have
2090 insurance particularly when you are just slightly over the
2091 Medicaid limit or live in a state with a low threshold.

2092 And I must say as a European and ex-Canadian, I am
2093 stunned at this. I believe the children are the treasure of
2094 a nation. They are the future generation. And I always have
2095 said to me, mothers are on par with soldiers. They do a
2096 patriotic service because they bring us the next generation.
2097 We should give them medals rather than the way we treat them.

2098 And I remember I once gave a speech called ``Motherhood
2099 and Apple Pie'' where I said I do buy the idea that Americans
2100 love apple pie, but I am not so sure about motherhood. I
2101 don't think in this country we respect mothers enough. And
2102 people who know me know that is a big deal with me. We do
2103 not respect mothers enough.

2104 Mr. {Pallone.} We--

2105 Ms. {Pipes.} It would be worthwhile you looking at some
2106 of the work that June O'Neill has done on infant mortality
2107 rates because other countries--we have the best neonatal
2108 procedures and clinics and facilities in this country. And
2109 often in other countries, people are not counted as live
2110 births. And so look at the work that June O'Neill has done
2111 because you have to compare apples with apples.

2112 Ms. {Capps.} I was talking about maternal mortality.

2113 Ms. {Pipes.} Right.

2114 Ms. {Capps.} But our infant mortality rate is not so
2115 hot either.

2116 Ms. {Pipes.} Well, but I think you have to compare on
2117 an equal playing field how other countries treat--what they
2118 count as infant mortality rate versus this country because we
2119 keep a lot of babies alive that wouldn't even be counted as
2120 live births in other countries. So it is very important,
2121 look at June O'Neill's work on this issue.

2122 Mr. {Pallone.} Thank you. Next is the gentleman from
2123 Arizona, Mr. Shadegg.

2124 Mr. {Shadegg.} Thank you, Mr. Chairman. Ms, Pipes, I
2125 would like to begin with you. I think I have heard you
2126 describe what you favor as universal choice. Are you
2127 familiar with plans that have been introduced that would
2128 provide every American with a stipend? That is either a tax
2129 credit or a refundable advancible tax credit that is cash to
2130 go buy a health care plan for every single person. Are you
2131 familiar with those? And would you describe that as
2132 universal choice?

2133 Ms. {Pipes.} Yes, I would, and Mr. McCain during the
2134 campaign was sort of hit by Mr. Obama saying--Mr. Obama said
2135 Mr. McCain would like to tax your health care. In fact, the
2136 plan would be--

2137 Mr. {Shadegg.} Well, I don't want to talk about his
2138 plan. I want to talk about some quick questions, and I have
2139 a long list.

2140 Ms. {Pipes.} So but I think it--

2141 Mr. {Shadegg.} Would you say we have a patient choice
2142 driven system now?

2143 Ms. {Pipes.} No, I would not. I would say 47 percent
2144 of health care is in the hands of government today, and we
2145 have a small sector 7 million people have patient-centered
2146 health care.

2147 Mr. {Shadegg.} Would you include in that patient
2148 centered health care plans that are picked by your doctor?
2149 Don't we really have a third-party control system in America
2150 today where your health insurance plan is picked by your
2151 employer, and then plan then picks your doctor, and you have
2152 virtually no choice?

2153 Ms. {Pipes.} Absolutely. And that is why if we can
2154 move away from employer-based care and move up the individual
2155 market, new competition will come in. New insurance plans
2156 will be available, and people will be able to choose the type
2157 of plan that fits their individual--

2158 Mr. {Shadegg.} What if we let them choose from the
2159 private market or choose their employer's plan, but put the
2160 choice with them?

2161 Ms. {Pipes.} That is an excellent idea, yes.

2162 Mr. {Shadegg.} Would you say that we have a healthy
2163 market in health insurance in America today?

2164 Ms. {Pipes.} No, I would not.

2165 Mr. {Shadegg.} This represents the northern Virginia
2166 residential phone book. All of the people in that book get
2167 to buy auto insurance if they have an auto, right?

2168 Ms. {Pipes.} Right.

2169 Mr. {Shadegg.} If I put up here the northern Virginia
2170 phone book, it would be a fraction of this size, would it
2171 not?

2172 Ms. {Pipes.} Yes.

2173 Mr. {Shadegg.} Maybe a fifth or less. Perhaps that
2174 kind of a graphic of the health insurance market versus the
2175 auto insurance market today. That is only employers get to
2176 buy health insurance, and they make the decision for their
2177 employees. Whereas in auto insurance, everybody gets to make
2178 their own choice and gets to pick a plan, and we have a much
2179 healthier market. Wouldn't you agree?

2180 Ms. {Pipes.} Absolutely, and, you know, the average
2181 employer spends \$12,000 per year on an employee's health
2182 plan, maybe even \$15,000. But the thing is that not all
2183 employees need that much health care, and there would be more
2184 competition if people could choose, like in the auto

2185 insurance, the type of insurance that fits their needs. And
2186 some will be a lot cheaper.

2187 Mr. {Shadegg.} So you would favor a system where they
2188 get to make their own choices?

2189 Ms. {Pipes.} Absolutely.

2190 Mr. {Shadegg.} And moving away from a system where
2191 there is a third-party control?

2192 Ms. {Pipes.} Right.

2193 Mr. {Shadegg.} I take it then you would not agree for
2194 moving from a system that is third-party controlled by your
2195 employer to third-party controlled by the government? Is
2196 that going to solve the problem in your view?

2197 Ms. {Pipes.} I think that if the government takes over
2198 the health care system, and including this public plan within
2199 the National Insurance Exchange, it is going to reduce
2200 people's choices, cost are going to go up, and ultimately
2201 care will have to be rationed as it is in countries like
2202 Canada and the U.K.

2203 Mr. {Shadegg.} Dr. Feder said, and I agree with her,
2204 that affordability is the real key here. We are worried
2205 about expense. We are worried about how expensive health
2206 care has become.

2207 Ms. {Pipes.} Right.

2208 Mr. {Shadegg.} And how expensive health insurance has

2209 become. Do you think it is a coincidence that we are
2210 experiencing a huge spiraling costs in health care costs
2211 where it is all third-party control and the market doesn't
2212 include all these people, it just includes this little
2213 business phone, that we are only experiencing that spiraling
2214 cost in the one place in America where there is genuinely no
2215 market? Is that a coincidence?

2216 Ms. {Pipes.} Well, as you have said, I mean we don't
2217 have a free market in health care. We have a lot of
2218 government in health care. We have the third party payer
2219 system, and people are not in charge of their health care.
2220 We don't get our life insurance, our long-term care insurance
2221 through our employer.

2222 Mr. {Shadegg.} We have pretty well divorced the
2223 consumer of health care services from the payer of health
2224 care services.

2225 Ms. {Pipes.} Right, exactly. Absolutely.

2226 Mr. {Shadegg.} And once divorcing them, costs have gone
2227 up dramatically once we have divorced the consumer from the
2228 payer.

2229 Ms. {Pipes.} Because we have in this country what you
2230 call first dollar coverage. When people they pay nothing--if
2231 employees don't pay anything for their premium or they pay a
2232 little bit, or they pay no copay or a small copay, first

2233 dollar coverage means when people think something is cheap or
2234 free, they demand a lot more but--

2235 Mr. {Shadegg.} And they think it is cheaper right now
2236 because their employer is paying for it.

2237 Ms. {Pipes.} Yes, and then--

2238 Mr. {Shadegg.} Wait, let me switch topics. A lot of
2239 discussion here today about a public plan. If we institute a
2240 public plan, won't politicians have a tendency to increase
2241 the subsidy of that public plan year after year after year as
2242 they have done with other public offerings?

2243 Ms. {Pipes.} Well, I think if you look at Canada, when
2244 the government took over the health care system in 1974, they
2245 were completely taken aback by how much demand there was for
2246 a program that people think of as virtually free because they
2247 don't know how much they are paying through the tax system.
2248 And it went up and up, and then government has to put a cap
2249 to say we can't--

2250 Mr. {Shadegg.} I am almost out of time, but if we let
2251 the government create a public plan and increase its subsidy
2252 year after year--I really have two questions. One, how will
2253 the private sector stay in competition with that if the
2254 government sector's subsidy goes up year after year? And
2255 second, if the government both offers a plan and also sets
2256 the rules for its plan and the private plan, aren't we

2257 allowing the government to be both a player in the game and a
2258 referee in the same game?

2259 Ms. {Pipes.} Right, and that was what I mentioned in my
2260 testimony. If you have guaranteed issue, community rating,
2261 and a lot of mandates, that is going to push up the costs of
2262 the plans. And if the government prices their plan slightly
2263 cheaper, you are going to crowd out the private insurers and
2264 leave us with a taxpayer funded plan, which ultimately will
2265 be too expensive and end up with rationed care.

2266 Mr. {Shadegg.} You--

2267 Ms. {Pipes.} It is not going to help the American
2268 people get the finest health care available.

2269 Mr. {Shadegg.} You would rather give them cash and let
2270 them make a choice?

2271 Ms. {Pipes.} Right, absolutely.

2272 Mr. {Shadegg.} Thank you.

2273 Mr. {Pallone.} All right, thank you. Gentlewoman from
2274 Illinois, Ms. Schakowsky.

2275 Ms. {Schakowsky.} Thank you. If I could just ask each
2276 of you. Do you think that health care is a right?

2277 Ms. {Feder.} Yes.

2278 Ms. {Pipes.} No.

2279 Mr. {Reinhardt.} Health care is too big a label. Some
2280 kind of health care is absolutely a right viewed in this

2281 country. It is not in the Constitution. However, think of
2282 someone lying in the street. A car hit them. They are
2283 bleeding. Does anyone in this room think you don't have a
2284 right to be picked up and brought to the nearest hospital?
2285 Does any American think that right does not exist? So yes,
2286 some health care, a lot of it, is a right, and some of it
2287 like plastic surgery is not.

2288 Ms. {Schakowsky.} Well, that is not necessary health
2289 care.

2290 Mr. {Reinhardt.} Cosmetic surgery.

2291 Ms. {Pipes.} And we do have, as someone mentioned
2292 earlier, IMTALLA. I think it was--that we have IMTALLA,
2293 which is a law that says no one can be denied access to
2294 emergency room--

2295 Ms. {Schakowsky.} I know. I am just asking if you
2296 think it is a right. You said no.

2297 Ms. {Pipes.} No, because how do you determine how open-
2298 ended that right is and what it will cost? And so I think
2299 that we are entitled to life, liberty, and the pursuit of
2300 happiness.

2301 Ms. {Schakowsky.} Yeah, I want--

2302 Ms. {Pipes.} You mean access--

2303 Ms. {Schakowsky.} It is my time, and I reclaim it.

2304 What would you say, Ms. Pipes though, that 87 percent of

2305 Canadians view the elimination of public health care as a
2306 negative? This is according to McGill professor Stuart
2307 Sirroca, author of the study. It was the highest ranking
2308 opinion in the entire survey, that they would not want to
2309 eliminate their public health care system?

2310 Ms. {Pipes.} Well, there are poll numbers that have
2311 come out of Decima that the majority of Canadians, 47 percent
2312 versus 41 percent, are dissatisfied with the Canadian health
2313 care system.

2314 Ms. {Schakowsky.} Well, you spend about 10 percent of
2315 GDP, you said, on health care--

2316 Ms. {Pipes.} Right.

2317 Ms. {Schakowsky.} --on health care in Canada. What do
2318 we spend, Ms. Feder, in--

2319 Ms. {Pipes.} Sixteen percent here.

2320 Ms. {Schakowsky.} Okay.

2321 Mr. {Reinhardt.} More than that.

2322 Ms. {Pipes.} But it is going up, yes.

2323 Ms. {Schakowsky.} Yeah, so in other words, perhaps if
2324 more were spent on the Canadian health care system, it could
2325 serve more people. But I am not looking for a comment now.

2326 I am concerned about this notion, and you referred to it
2327 earlier, Dr. Reinhardt, and I would appreciate if you or Dr.
2328 Feder would want to comment on that. The United States, it

2329 seems to me, does in fact ration health care. That the
2330 dollar bill is essentially that ration card and that when you
2331 have more than half of Americans who say that they haven't
2332 gotten health care, they have postponed or have completely
2333 eliminated health care that they need, that clearly this
2334 health care is being rationed. That people--we don't count
2335 the people not in line because they can't afford it. And I
2336 think this is really an important point about comparing our
2337 system with a Canadian system where they actually count
2338 people that wait in line. Either one of you or both.

2339 Ms. {Feder.} Yeah, I appreciate the question,
2340 Congresswoman Schakowsky. And the first point I would make
2341 is, as you were making earlier, is that we are not talking
2342 about turning the American system into the Canadian system.
2343 We are talking about slowing the growth and making sure--of
2344 health care costs, and making sure everybody has affordable
2345 insurance and affordable care.

2346 And as Dr. Reinhardt said earlier, that when people
2347 can't afford care, when they don't have insurance coverage or
2348 there are holes in their insurance coverage, care is being
2349 rationed. And I find very interesting not just people who
2350 aren't showing up because they know they can't afford it, but
2351 how much do you hear from your constituents about the
2352 runaround they get from their insurance companies, the

2353 denials, the submitting the claims over and over again, the
2354 not being able to get service?

2355 Ms. {Schakowsky.} All the time.

2356 Ms. {Feder.} Exactly, so what is it? We think the
2357 system works? It is being compared to a straw man. What we
2358 need to do is to fix our system, get better value for the
2359 dollar and make sure that everybody gets access to care when
2360 they need it.

2361 Ms. {Schakowsky.} And prescriptions left in the drawer
2362 because they can't afford to fill them. Dr.--

2363 Ms. {Feder.} Exactly. We have the evidence of it.

2364 Mr. {Reinhardt.} It so happens I have written three
2365 papers on this rationing issues. One, in fact, entitled
2366 ``Styles of Rationing: Canada Versus the U.S.''' And there is
2367 no question they do ration with a queue for some procedures
2368 up there, and there is no question we ration through price
2369 and ability to pay. And to deny that defies anything any
2370 freshman is ever taught if they have a good economic
2371 professor. I could show you textbook after textbook from
2372 people who are actually conservative politically who says the
2373 role of prices is to ration. And we use price as a rationing
2374 device.

2375 There was a recent study out--Judy, you may know it--
2376 that showed for low income people, they actually consume less

2377 health care because they very often are uninsured. But if we
2378 compare people who do not have insurance with those who have
2379 insurance, Jack Hadley's numbers, the uninsured get 43
2380 percent of the care that similarly situated insured get. And
2381 to deny that that is rationing borders on the mischievous. I
2382 think that is rationing, and we are discussing styles of
2383 rationing. Canadians have a different view about what is
2384 equitable than what apparently we have.

2385 Ms. {Schakowsky.} Thank you. Bottom line, we want to
2386 do an American system that works for everyone. Thank you.

2387 Mr. {Pallone.} Thank you. Gentleman from Illinois, Mr.
2388 Shimkus.

2389 Mr. {Shimkus.} Thank you, Mr. Chairman, and I did, by
2390 listening appreciate a lot of the comments, and I won't be
2391 long. Following up on John Shadegg's comments about buying
2392 power, just two quick questions. There is a debate for those
2393 who propose about it being a mandatory or voluntary system.
2394 If you use the automobile insurance debate, if you drive in
2395 states, you have to have insurance.

2396 I am of the point of view that if you went to a private
2397 option, what is called the public choice, however we are
2398 going to define that, that it would be--everyone would have
2399 to cover--I mean you would not have a choice to be out.
2400 Everyone would have to have something. You would also have

2401 to force then the insurers to have the wide breadth of
2402 everyone involved. I mean you couldn't allow them to cherry
2403 pick is kind of the terminology I use. And it is a mandatory
2404 system.

2405 And the final thing is there would have to be the basic
2406 package would have to be a catastrophic package. I mean the
2407 cost shifting, what goes on in a hospital, and what everybody
2408 is worried about is catastrophic care. And maybe you could
2409 allow people through health savings accounts or just their
2410 own dollars to do the preventative care, to go to the doctor
2411 for the cold and flu and all that other stuff.

2412 What do you think about that premise? And, Dr.
2413 Reinhardt, if you would just then mention, and Ms. Pipes and
2414 Dr. Feder? And that would be the only question I--that is
2415 what has been bubbling around in my thought process, how do
2416 you get to the 44 million or 47 uninsured Americans? They
2417 have to have insurance. They have to have a catastrophic
2418 package. What would you say to those comments?

2419 Mr. {Reinhardt.} Well, ultimately, when you discuss
2420 universal coverage and when do you know how have you reached
2421 this fairly. The only metric that really makes sense to me
2422 would be to say what fraction of a family's discretionary
2423 income, after food, housing, and shelter, should a family in
2424 America be required to contribute towards its own health care.

2425 And presumably that percentage would be small for a waitress
2426 or a cab driver, and it would be higher for a full professor
2427 at Princeton. You could easily ask me to contribute 10, 12
2428 percent of our household budget towards health care, and you
2429 would not ask a waitress to do that. So that is the first
2430 thing.

2431 Now with respect to the choice market for private
2432 insurance, if you put community rating on, say you must
2433 charge everyone the same, sick or healthy, and guaranteed
2434 issue, if you don't couple that with mandatory insurance, you
2435 will get a death spiral of private insurance, which we
2436 actually see in New Jersey happening. So those two go
2437 together.

2438 The alternative model would be that you say okay, we let
2439 the private insurers medically underwrite. So if somebody is
2440 sick, they pay a huge premium. Somebody has AIDS, they pay
2441 \$80,000 a year. And someone who is very healthy gets it very
2442 cheap. But then you would have to have a bureaucracy that
2443 could give subsidies to the chronically ill for the huge
2444 premiums that they are charged and subsidize them to the tune
2445 that ultimately you are happy with that percentage. And this
2446 is really something. I think my colleague Mark Polly at
2447 UPenn, and who is the co-author--had a very lovely paper on
2448 this. How do you know that you are equitable? And he

2449 proposes this metric. Adam Wagstaff at the World Bank had
2450 the same thing for the International--

2451 Mr. {Shimkus.} Yes, sir, and I don't want to cut you
2452 off, but I do want Ms. Pipes and Dr. Feder, briefly. I only
2453 have a minute left. If you could kind of summarize that
2454 quickly. Sorry, Dr. Reinhardt.

2455 Ms. {Pipes.} And you mentioned mandatory car insurance,
2456 but 15 percent of drivers in this country, even though all
2457 states but two have mandatory care insurance, are driving
2458 around without car insurance. And we have seen the
2459 experiment in Massachusetts where now after--it will be three
2460 years old in April--that still 2.5 percent of people are
2461 uninsured.

2462 And about 60 percent of the people who are people signed
2463 up for the Commonwealth Care, the subsidized thing. So it is
2464 very hard to take the American mind set and ensure and make
2465 them do--I mean Hillary Clinton said the only way you could
2466 enforce a mandate was to garnish the wages. I don't think
2467 that is the American way. And so I think it is very hard.
2468 But if we have, you know, universal choice, and people can
2469 choose the system that best suits them, I think we will get a
2470 lot of those 45.7 million Americans going into the insurance
2471 market. There is nothing wrong with having a high risk pool
2472 for people who are falling between the cracks.

2473 Mr. {Shimkus.} Thank you. Dr. Feder with the
2474 chairman's permission.

2475 Ms. {Feder.} Yeah, is it okay?

2476 Mr. {Pallone.} Yeah, sure.

2477 Ms. {Feder.} I will be quick. I was interested in what
2478 you said about making rules for insurance because as I listen
2479 to Mr. Shadegg, no matter how big that phone book gets of
2480 insurance companies, if 20 percent of the people account for
2481 80 percent of the spending we spend on health care when we
2482 get sick, insurers always win if they insure us when we are
2483 healthy and avoid us when we are sick. So you have to have
2484 rules. It has to be group insurance. That is the only way
2485 it can work.

2486 I am less concerned about mandates than I am concerned
2487 about making sure that everybody has the wherewithal to buy
2488 insurance so that means subsidies, making those adequate.
2489 And also I think facilitating enrollment in many ways can get
2490 everybody into the system so that we fix it no only--people
2491 don't walk around with a U for uninsured on their foreheads.
2492 There is a problem in the whole system, and we need to make
2493 it work for everybody.

2494 Mr. {Shimkus.} Thank you, Mr. Chairman.

2495 Mr. {Pallone.} Thank you. Mr. Gonzalez.

2496 Mr. {Gonzalez.} Thank you very much, Mr. Chairman.

2497 First just a couple of observations. Trying to use the car
2498 insurance as an analogy is a terrible mistake because if it
2499 operated like health care providers what would happen is your
2500 first accident or speeding ticket, the insurer would drop
2501 you. Then you would go to the next insurance company, and
2502 they would say you had a pre-existing condition and wouldn't
2503 offer you any insurance.

2504 The other observation is anybody that doesn't believe
2505 that our health care system is broken would be those
2506 individuals that presently have coverage, number one, but
2507 even out of those, you would have to say it be those that are
2508 healthy and haven't attempted to use the coverage.

2509 I am going to quote from a paper from 2004. I get these
2510 all the time from a physician friend of mine. Every time we
2511 have a hearing, he will send me an email and refer me to
2512 articles, but I am going to agree with this article. And I
2513 think it is going to embrace some of the concepts that have
2514 been advocated by members on the other side of the aisle here
2515 in the committee.

2516 And this is by Michael Porter and Elizabeth Ulmstead-
2517 Teasburg. ``We believe that competition is the root of the
2518 problem with U.S. health care performance, but this does not
2519 mean we advocate a state-controlled system or a single payer
2520 system.'' Of course what we have here is we are talking

2521 about a public option, which is separate because those
2522 approaches would make things only worse. ``On the contrary,
2523 competition is also the solution, but the nature of the
2524 competition in health care must change. Our research shows
2525 that competition in the health care system occurs at the
2526 wrong level over the wrong things in the wrong geographic
2527 markets and at the wrong time. Competition has actually been
2528 all but eliminated just where and when it is most important.
2529 The health care system can achieve stunning gains in quality
2530 and efficiency, and employers, the major purchasers, of
2531 health care services, could lead the transformation.''

2532 This paper was written 2004. Jury was out. Jury has
2533 come in. Employers have not been able to do it. Someone has
2534 suggested that a well-educated consumer will be able to do it
2535 as long as we give vouchers or some--and we know that we
2536 don't have that level of competency out there, through no
2537 fault of the consumer, of course.

2538 I would like comments from Dr. Reinhardt and Dr. Feder
2539 as to the way I view this without trying to be married to any
2540 kind of ideology to the point of a faith or religion that
2541 doesn't allow us to discuss this thing rationally and in good
2542 faith.

2543 I believe that what we are espousing here and hopefully
2544 will have a bill which is going to be a public option will be

2545 the vehicle that will allow us to bring into the marketplace
2546 those wonderful ideas of competition, consumer choice,
2547 education, quality, efficiency, and get our biggest benefit
2548 out of every dollar. Is this what we see here today? That
2549 is what I really think we are discussing. Because we are
2550 really talking about concept at this point. And we may bring
2551 into immigration and other things, but those are issues that
2552 we will have for another day.

2553 But overall, conceptually speaking, is that what this
2554 will bring to this debate as far as a public option? Dr.
2555 Reinhardt?

2556 Mr. {Reinhardt.} Well, this paper was in the ``Harvard
2557 Business Review'' by them and then followed by a huge tome
2558 that they wrote, and a number of us reviewed it in ``Health
2559 Affairs.'' My view is their vision is correct but very
2560 utopian because somehow they pretend that you can slice all
2561 ill health into episodes that begin and end and that you can
2562 get physicians and hospitals and convalescent centers to
2563 build little groups that specialize, little focus factories
2564 as Reggie Hertslinger calls them, that specialize in this,
2565 and then advertise their price for the whole bundle and have
2566 a quality rating. And they don't even say who would do that,
2567 who would rate the quality.

2568 So as a concept it is good, and I think we are gingerly

2569 moving that way. But it will take at least 20 years before
2570 you would have realized that. But it is true. A public
2571 health plan does have the advantage of being able to
2572 experiment with that just like a private plan.

2573 I would urge you to think--they always say Medicare
2574 wasn't an innovator. Who developed the DRGs? It was
2575 Medicare, copied now around the world. Who developed the
2576 resource-based relative value scale for physicians? It was
2577 Medicare now copied by every private insurance plan. So I
2578 believe the vision they had is good, and competition is a
2579 good thing. And none of us are against competition.

2580 But in the meantime, we have American families in dire
2581 need. We cannot wait for Utopia, and we have to make sure
2582 one of the principles the President said American families
2583 should not go broke over health care. I think on either side
2584 of the aisle--

2585 Mr. {Gonzalez.} Dr. Reinhardt, I do want to give Dr.
2586 Feder an opportunity, and I only have a minute left. I
2587 apologize.

2588 Ms. {Feder.} I am for affordability, to finish Dr.
2589 Reinhardt's sentence, but I--and I would say that what we are
2590 talking about in terms of paying more effectively for medical
2591 care is what we are talking about. So whether it is episode-
2592 based or better rewards for primary care or refining what we

2593 do in the existing system where we are overpaying within some
2594 DRGs, we have a lot of room for improvement. And what you
2595 have put forward is that a public health insurance option can
2596 be a leader, not only in payment reform but also in managing
2597 chronic illness and promoting prevention. And we focus so
2598 heavily on fees because that is, I think, another straw man.
2599 What we need to focus on is leadership and accountability to
2600 us as an option in the health insurance system.

2601 Mr. {Pallone.} Thank you. The gentlewoman from the
2602 Virgin Islands, Ms. Christensen.

2603 Ms. {Christensen.} Thank you, Mr. Chairman, and I want
2604 to also thank the panelists this morning. I think the
2605 discussion will hopefully guide us through the minefield that
2606 we face trying to get to universal coverage and hopefully
2607 help us to shape a bill that we can get passed here and in
2608 the Senate and signed by the President.

2609 My first question is to Dr. Reinhardt and to Dr. Feder.
2610 I have a little bit of discomfort around the public plan,
2611 which both of you support as well as many others because--
2612 help me understand. Is this the same as Medicaid or
2613 different than Medicaid? Are you going to have Medicaid for
2614 the poor, and would there be a public health plan for
2615 everybody else? Wouldn't that be continuing the same kind of
2616 two-tiered system that we are trying to get away from? And

2617 shouldn't it just be one public plan that Medicaid patients
2618 would have paid for them and others pay in according to their
2619 income? Or is that what you envision anyway?

2620 Mr. {Reinhardt.} Well, as a practical matter, you would
2621 probably have to go with a separate plan because Medicaid
2622 involves the state, and that system, to fuse that with a
2623 public plan, which I think would be ideal, would be very
2624 difficult because the states might object to that. And then
2625 there would be an issue of the fiscal transfers to make that
2626 possible.

2627 Ms. {Feder.} Yeah, I would just say to think of a
2628 public health insurance plan not as Medicaid, but think of it
2629 as a publicly owned, publicly accountable insurance option
2630 that you would be able to choose along side private insurance
2631 options, with everyone having a guaranteed standardized set
2632 of benefits. So they would compete on their ability to
2633 deliver care efficiently. Couldn't discriminate based on
2634 health status.

2635 And I would distinguish that from the importance of
2636 retaining Medicaid. Not only do we have statutory law that
2637 provides statutes that protect very low-income people that we
2638 should extend, I think, to all people below poverty.

2639 But the whole body of law defined through litigation,
2640 that actually protects very low-income people. And I think

2641 to disrupt that would be a mistake.

2642 Ms. {Christensen.} It is not that I want to disrupt it.
2643 It is just that Medicaid has not been really providing the
2644 kind of outcomes that we want to see.

2645 Ms. {Feder.} Your concern--

2646 Ms. {Christensen.} But, you know, we can fix that as
2647 well.

2648 Ms. {Feder.} Your concern is well taken, and that gets
2649 to whether we are paying providers adequately to serve
2650 people. So we want to keep the protections, which, if we
2651 have it as a public health insurance plan among choices, is
2652 not going to have as generous benefits as Medicaid has.

2653 Ms. {Christensen.} And, Dr. Reinhardt, one of our
2654 people on the other panel, Dr.--Professor Baiker, I guess,
2655 spends a considerable part of her written testimony on the
2656 problem of the sick and the uninsured, which is a population
2657 group that I am particularly concerned about. We spend a lot
2658 of our time and focus on eliminating health disparities in
2659 poor racial and ethnic minorities, rural individuals, and
2660 they would be sicker and prominently among the uninsured.

2661 And because they are sicker, bringing them into the
2662 system, Professor Baiker would say would drive up the cost of
2663 care. It drives up the cost of care now, affects the quality
2664 of care for the uninsured. So how do we insure that their

2665 high cost--because they are bringing them to make sure that
2666 they have access to care. How do we work the system so that
2667 it doesn't drive up--so that we keep insurance affordable and
2668 still provide that high level of service at the outlet? Or
2669 should we just make the investment and not worry, you know,
2670 know that it is going to pay off in the long run?

2671 Mr. {Reinhardt.} Well, I wouldn't say make the
2672 investment and not worry about it. I would say make the
2673 investment and then worry about a long-term strategy to take
2674 costs into our gun sights and really start looking at how
2675 much, for example, do we spend on administration that buys no
2676 health care that could be reduced, these Winberg variations I
2677 talked about in Medicare, and you have them in the private
2678 sector as well.

2679 So I think cost control, we ought to be able to do this
2680 more cheaply than we are in America. Even the business
2681 roundtable says that, but you can't wait. These American
2682 families are hard pressed. They are facing a deep recession.
2683 There will be ever more of them, and to say if there is
2684 somebody who is poor and sick and now we serve them, and that
2685 will drive up cost, I would say yes, it will. But that is
2686 why you are doing it.

2687 Ms. {Christensen.} And this does not eliminate the need
2688 for focusing more on prevention or other programs to

2689 eliminate health disparities. It is part of the testimony in
2690 the other panel, and I wanted to get a response on that.

2691 Ms. Pipes, despite your data that shows that the
2692 Canadian system may not be working as well as many purport it
2693 to be, how do you explain the 20 or 23 percent value gap?
2694 Our country is running 20 or 23 percent behind yours on the
2695 value we get for health care? How do you reconcile those two
2696 things?

2697 Ms. {Pipes.} Well, I think that, you know, Canadians, a
2698 lot of Canadians come to the United States and get health
2699 care when they are on waiting lists. So I think it is very
2700 hard, when the government runs the health care system, to
2701 actually measure, you know, actual comparisons between a
2702 totally government-run system and a system that is a hybrid
2703 of a number of different types. So I think, you know, I
2704 don't know where your number comes from. But, you know, I
2705 haven't analyzed that number, and I would be interested in
2706 it.

2707 But I will say that 250 Canadian doctors leave Canada
2708 every year to come and practice in the United States, not
2709 just for the money because they can make more money, but
2710 because they can practice the type of medicine that they are
2711 trained to practice because doctors in Canada are basically
2712 union members.

2713 I mean Dr. Reinhardt mentioned that when you work in a
2714 province, whether you work in British Columbia, your medical
2715 association negotiates your fee with the provincial
2716 government. My cousin is a corneal transplant specialist.
2717 He hasn't had an increase in four years because the
2718 government is in a deficit situation. And so doctors, you
2719 know, it doesn't matter whether you are the best cardiac
2720 surgeon or the worst, everyone gets paid the same. And it
2721 destroys the incentive to attract the best people into health
2722 care and into medicine.

2723 And so, you know, we want to continue to have--America
2724 has the best. People come from all over the world to get
2725 health care here. Whether it is Silvio Berlusconi coming
2726 from Italy to get a pacemaker. We need to make some changes
2727 to build on the system we have and not break it down and have
2728 a public health plan that I think will crowd out the private
2729 insurers because when you are adding tremendous cost with
2730 guaranteed issue, community rating, and these mandates.

2731 So I just think that universal choice will lead us to
2732 universal coverage because young people--17 million Americans
2733 earning over \$50,000 a year, two-thirds of them are young
2734 people. And they don't need every single aspect. They want
2735 insurance to be insurance for catastrophes.

2736 Ms. {Christensen.} Well--

2737 Mr. {Pallone.} Your time is over. Ms. Castor.

2738 Ms. {Castor.} Thank you, Mr. Chairman, and thanks to
2739 the panel. I would like to go back to what is driving these
2740 huge increases over the past decade in the cost of health
2741 care and recall that health insurance premiums have outpaced
2742 wage growth. From '99 to 2008, premiums grew at three times
2743 the rate of wages, and, Dr. Reinhardt, in your testimony, you
2744 said that we had seen that just over the past seven years,
2745 the average total outlay on health care for a family from all
2746 sources has nearly doubled.

2747 And folks back home, they want to know why. It is just
2748 out of control. One easy answer has been when I go to the
2749 hospitals, that is an easy case because they say the
2750 uncompensated care, the folks that come into the ER that do
2751 not have health insurance and have chronic disease or
2752 something. That translates to them. They get that, and they
2753 understand we are--if you have private insurance, they are
2754 subsidizing part of that uncompensated care.

2755 The hospitals in my area, in turn, have developed a
2756 clinic system with very low administrative costs. It is a
2757 partnership with the private doctors, private hospitals, and
2758 nonprofits. And it is saving everyone money. But what else
2759 is driving these astronomical increases? Lessons that we can
2760 learn moving forward as we develop this public choice option?

2761 Mr. {Reinhardt.} Well, the American system is expensive
2762 because we have structured it to make the demand side weak
2763 and the supply side strong. And all the other nations that
2764 are cheaper have a strong demand side or a stronger demand
2765 side and a weaker supply side. And it is really how you
2766 apportion the market power. I mentioned that even in a large
2767 insurer like Well Point had real trouble negotiating with the
2768 Sutter Health System in California. Because it is a big
2769 system, you cannot run a health insurance plan without having
2770 that in your network. And therefore they had all the market
2771 power.

2772 So I think it is quite clear. It is part of the reason
2773 why we have a very luxurious system overstocked. You read
2774 Med Pac. We have too many MRI machines. Canada may have too
2775 few, but everyone agrees we have too many. It is because we
2776 essentially turned over a disproportionate amount of power to
2777 the supply side of the system.

2778 Ms. {Feder.} To answer in a slightly different way, I
2779 think your constituents will have had the experience of being
2780 bumped from doctor to doctor, having tests duplicated,
2781 finding it impossible to get--being stuck in a hospital, not
2782 able to get out, seeing attempts at treatment that seem to
2783 be, not to work.

2784 What we are lacking and what we are talking about with

2785 comparative effectiveness research is to provide an
2786 information base, real evidence. So that you don't go to
2787 what Uwe is talking about, the supply side. You don't go to
2788 the pharmaceutical companies to find out which medication you
2789 need. You have an actual evidence base that enables you to
2790 know, enables doctors and patients to decide together on what
2791 works and what doesn't.

2792 And we can refine our repayment mechanism so that we are
2793 actually able to encourage and reward the provision of
2794 services that work and the discouragement of services that
2795 don't. There is no mechanism for that now, and we are
2796 talking about developing that, not in a punitive way, not in
2797 an arbitrary way. In a way that enables physicians and
2798 patients to choose.

2799 Ms. {Castor.} You know, let me ask you all this. I am
2800 starting to hear much greater concern as folks realize the
2801 astronomical salaries in the corporate sector in health care,
2802 and the HMOs are not immune to this. And I wonder if you see
2803 any analogy in what is going on in the financial system to
2804 health care. This is again a segment where the government--
2805 the taxpayers are subsidizing private HMOs, and CEOs are
2806 making a multi, multi-million dollar, we are talking about
2807 \$25 million, \$50 million per year. Is this also a factor in
2808 the high costs? Shouldn't some of this be plowed back into

2809 people's health and not paid out in these astronomical
2810 salaries?

2811 Mr. {Reinhardt.} Well, if you think of the United--
2812 former United CEO who had \$1.6 billion, the bulk of that
2813 income actually came from stock options, which is taken away
2814 from shareholders and customers. So one has to be somewhat
2815 careful of how that salary is composed. If \$50 million were
2816 a salary booked into payroll expense and added to the
2817 premiums, then, of course it would be driving health care
2818 costs. But if it comes out of stock options, then it is
2819 another story, and he got \$1.6 billion simply because during
2820 his reign, the stock went up and up.

2821 What is much more troublesome to me with private
2822 insurance is that, as an industry, I think they have not done
2823 enough to reduce the administrative cost of health care, that
2824 the amount of money they need to run the business is higher
2825 than I think it would be if they were all electronic, had a
2826 common nomenclature, common claims form, et cetera.

2827 The president of Johns Hopkins mentioned in a speech not
2828 long ago, he deals with 700 distinct managed care contracts,
2829 each with different terms. And so if you were to look at a
2830 Canadian--there was just a program. They were looking at a
2831 Canadian hospital and American hospitals in terms of the
2832 billing clerks. You would be shocked at the difference.

2833 That is where the real money is, not so much CEO salaries.

2834 Ms. {Pipes.} Well, also I think that Dr. Ben Zyker of
2835 the Pacific Research Institute did a study comparing
2836 administrative costs of government programs versus the
2837 private sector, and there are a lot of things that aren't
2838 included in the government Medicare and Medicaid. So I think
2839 you should take a look at the study.

2840 Ms. {Castor.} Well, that is interesting because the
2841 example of my local community that is a collaboration of the
2842 hospitals and doctors and our county government, our
2843 administrative costs are way, way low. And that has been
2844 proven out for a number--

2845 Ms. {Pipes.} Well, I urge you to look--

2846 Mr. {Pallone.} We are going to have to end on this one.
2847 Sorry. Mr. Braley from Iowa.

2848 Mr. {Braley.} Thank you, Mr. Chairman. Ms. Pipes, you
2849 have certainly been a prolific commentator on health care
2850 issues. Do you hold yourself out at this hearing as a health
2851 care policy expert?

2852 Ms. {Pipes.} Yes, I am an economist by training. Grew
2853 up in Vancouver, went to college there, and was an economist
2854 at the Fraser Institute in Vancouver, and then came to the
2855 U.S. in '91.

2856 Mr. {Braley.} One of the things that has been difficult

2857 for me to do is ascertain the extent of your educational
2858 background. Do you have any advanced degrees in economics?

2859 Ms. {Pipes.} I have an honors degree in economics from
2860 the University of British Columbia, and then I joined the
2861 Fraser Institute working under Dr. Michael Walker and, you
2862 know, started out as an econometrician. I won the Canadian
2863 Crystal Ball award.

2864 Mr. {Braley.} So the answer to my question would be no,
2865 correct?

2866 Ms. {Pipes.} No, I have an honors BA in economics but
2867 have worked in the economic research field for--

2868 Mr. {Braley.} And you don't have a masters or Ph.D. in
2869 health care policy?

2870 Ms. {Pipes.} No, I don't.

2871 Mr. {Braley.} Or in public policy as a general concept?

2872 Ms. {Pipes.} No, but I have worked in the field.

2873 Mr. {Braley.} All right, on the website for the Pacific
2874 Research Institute, you are identified in your individual bio
2875 as a scholar. Are you aware of that?

2876 Ms. {Pipes.} Yes, I am a scholar. I write a lot on
2877 health care. I write books--

2878 Mr. {Braley.} Have you published any scholarly
2879 treatises in a peer-reviewed journal of economics on health
2880 care policy?

2881 Ms. {Pipes.} Yes.

2882 Mr. {Braley.} And can you give us some examples?

2883 Ms. {Pipes.} I have done some things in ``Health
2884 Affairs'' over the past, and in--

2885 Mr. {Braley.} But can you just identify the scholarly
2886 journal that is a peer review journal of that kind?

2887 Ms. {Pipes.} Right, well ``Health Affairs'' is, I
2888 think. I don't know whether you would say it is but--

2889 Mr. {Reinhardt.} It is peer reviewed.

2890 Mr. {Braley.} All right, and do you have a CV or resume
2891 that you use for your official purposes?

2892 Ms. {Pipes.} Well, I use what we have on our website.
2893 I don't--I mean I have one in my desk from when I got my job
2894 in 1991. I don't keep it up to date, but I could--

2895 Mr. {Braley.} I mean do you have a listing of your
2896 publications, a listing of your appearances? Some people do
2897 this as a way to--

2898 Ms. {Pipes.} Right, and if you--

2899 Mr. {Braley.} --let people that they are speaking
2900 before know what the content of their background and
2901 expertise is. Do you have such a listing--

2902 Ms. {Pipes.} Yes, and if--

2903 Mr. {Braley.} --that you could provide to the
2904 committee?

2905 Ms. {Pipes.} You will see that I write for the ``Wall
2906 Street Journal'' and the--

2907 Mr. {Braley.} Just please answer my question. I don't
2908 have much time.

2909 Ms. {Pipes.} Sure.

2910 Mr. {Braley.} Could you provide that to the committee?

2911 Ms. {Pipes.} Of course, yes. So you can--

2912 Mr. {Braley.} Okay. Now, one of the things you asked
2913 about or you raised in the conclusion of your opening remarks
2914 was the need for medical malpractice reform. Do you remember
2915 that?

2916 Ms. {Pipes.} Yes.

2917 Mr. {Braley.} I am sure you are aware that the
2918 Institutes of Medicine has done a series of three important
2919 studies dealing with the issue of preventable medical errors
2920 and the cost that they contribute to the overall health care
2921 economy of this country. The seminal work was the first work
2922 in 2000 ``To Err is Human,'' and in that report, the
2923 Institutes of Medicine concluded that ``preventable adverse
2924 events are a leading cause of death in the United States.
2925 The results of the studied imply that at least 44,000 and
2926 perhaps as many as 98,000 Americans die in hospitals each
2927 year as a result of medical errors. Deaths due to
2928 preventable adverse events exceeds the death attributable to

2929 motor vehicle accidents, breast cancer, or AIDS.''

2930 That was then followed by another seminal study
2931 ``Patient Safety'' also from the IOM, and in that study, they
2932 included the finding that the committee strongly believes
2933 that patient safety is indistinguishable from the delivery of
2934 quality care. A new delivery system must be built to achieve
2935 substantial improvement in patient safety. A system that is
2936 capable of preventing errors from occurring in the first
2937 place while at the same time incorporating lessons learned
2938 from any errors that do occur.

2939 And then we had the important 2006 study from the
2940 Institutes of Medicine ``Preventing Medication Errors'' which
2941 concluded that medication errors are surprisingly common and
2942 costly to the nation. The committee concludes there are at
2943 least 1.5 million preventable adverse drug events that occur
2944 in the United States each year. The true number may be much
2945 higher. And they issued a conservative estimate that these
2946 adverse drug events cost our economy, at minimum, \$3.5
2947 billion a year.

2948 So what I am wondering is why when we talk about
2949 reforming our health care system don't people who come from
2950 your point of view come to the committee and talk about
2951 constructive ways we are going to reduce preventable medical
2952 errors, which we all know are the most dramatic way that we

2953 can reduce the cost of medical malpractice in this country?

2954 Ms. {Pipes.} Well, I think you should look at some of
2955 the work done by Dr. Betsy McCoy, who has done work on
2956 infectious diseases and shows that more people die in
2957 hospitals from infectious diseases by a major part compared
2958 to medical errors. So I think that is important.

2959 Mr. {Braley.} Well, let us talk about that though
2960 because are you familiar with the Joint Commission on
2961 Accreditation of Health Care Associations?

2962 Ms. {Pipes.} Yes.

2963 Mr. {Braley.} And are you familiar with their Sentinel
2964 Event Program?

2965 Ms. {Pipes.} Right.

2966 Mr. {Braley.} Do you know that in the first 10 years
2967 the Sentinel Event Program was in place over a 10-year
2968 period, only 3,000 sentinel event reports were filed with
2969 JACO, which is astonishing considering the incidents of
2970 preventable medical errors that resulted in deaths only, not
2971 serious injuries, when those numbers would suggest that they
2972 should have been receiving 44,000 to 98,000 reports at a
2973 minimum. So isn't it clear that the system of accountability
2974 that we currently use is completely failing American health
2975 consumers in making a more safe system?

2976 Ms. {Pipes.} Well, I think all doctors are interested

2977 in people living longer and healthier lives. And, as I say,
2978 more people are dying from infectious diseases in hospitals
2979 than from medical errors. Unfortunately--

2980 Mr. {Braley.} Well, I would disagree with that
2981 characterization because most people would tell you, who
2982 study this issue, that one of the most preventable forms of
2983 an adverse event in a hospital setting is nosocomial
2984 infection. And in fact, there has been a lot of research
2985 that indicates that despite overwhelming evidence from
2986 medical economists, hospitals are reluctant to move to a
2987 business model that will allow them to reduce the incidents
2988 of nosocomial infections. So I disagree with your
2989 characterization that a nosocomial infection is not a
2990 preventable medical error.

2991 Ms. {Pipes.} No, I--

2992 Mr. {Pallone.} All right, I am going to let you--

2993 Ms. {Pipes.} I see that you--

2994 Mr. {Pallone.} Ms. Peeps--Pipes. Sorry. I would like
2995 you to respond, and then we have to end because we are over a
2996 minute.

2997 Ms. {Pipes.} Right. No, I agree with you. We want to
2998 get infectious diseases in hospitals down because they are a
2999 tremendous problem and hardship. And on the medical
3000 malpractice reform, when they capped the noneconomic damage

3001 awards in Texas at \$250,000, a lot of docs who had left,
3002 OB/GYNs and neurosurgeons are now coming back into Texas
3003 because there is an environment there where doctors want to
3004 practice medicine.

3005 We have seen in states like Pennsylvania and Nevada
3006 where a lot of OB/GYNs and neurosurgeons have left the
3007 practice of medicine because the cost of their med now is so
3008 expensive that it is not profitable for them to practice
3009 medicine.

3010 Mr. {Pallone.} Thank you. Next is Ms. Baldwin.

3011 Ms. {Baldwin.} Thank you, Mr. Chairman. Professor
3012 Reinhardt, I enjoyed some of the points made in the end of
3013 your written testimony that you weren't able to make in your
3014 more abbreviated oral testimony. One of the things that I am
3015 interested in is the role--well, first your comment. You
3016 call it the electronic farmers' market. I think we are used
3017 to calling it the exchange or connector. But that that
3018 entity would have to be empowered with regulatory powers to
3019 supervise and enforce the reputability of the products being
3020 offered.

3021 We have also had a lot of comments about having the
3022 inclusion of a public option, and, in fact, Dr. Feder said a
3023 public system--I think I am quoting accurately--a public
3024 system can keep the private system honest. So I would like

3025 to hear your take on the interplay between the regulatory
3026 powers that are going to be necessary and having a public
3027 sector option sort of perhaps substituting for that or at
3028 least enhancing it.

3029 Mr. {Reinhardt.} Well, if you want to have any market,
3030 no matter what it is, has to be regulated. And we now find
3031 out, to our great dismay, that the market-for-credit default
3032 swaps also should have been regulated. So you need that, and
3033 in health care, with the insurance industry, it is still the
3034 Wild West in many ways when you come to the individual
3035 market. That is not true for the employment-based system.

3036 So you do need to be sure that these policies don't have
3037 fine print that ultimately leave you uninsured rather than
3038 insured. So you need regulation there.

3039 You then have to make a decision if you want community
3040 rating or not. If you say we allow medical underwriting,
3041 then the subsidies you give people have to be tailored to the
3042 health status, which is difficult to do. So I think such a
3043 body would, by nature have to be regulatory, endowed with the
3044 power to regulate, or it goes back to government.

3045 Ms. {Baldwin.} Dr. Feder, you address as, I think, your
3046 fourth point that you gave as take-home points that we have
3047 to stop discriminating against sick people in coverage. I
3048 want to hear your take on whether the high-risk pools that

3049 have been available as a tool to cover sicker populations,
3050 have then been a success story, a failure, somewhere in
3051 between? What is your take on that?

3052 Ms. {Feder.} Congressman Baldwin, my colleague Karen
3053 Pollitz, will be testifying on the next panel, and I will be
3054 drawing insufficiently on her expertise in answering the
3055 question. I think high-risk pools are problematic. One,
3056 they pull off people from the rest of the system, and I think
3057 we would be better pooling risk everybody together.

3058 Second, they have been completely inadequately funded.
3059 Charge the people who are high risk high rates so that many
3060 people who are sick can't get into the high risk pool.

3061 Third, as I understand it, they impose pre-existing
3062 condition exclusions on people who are sick or high risk,
3063 which I am laughing because that boggles the mind. So it is
3064 possibly true that adequately funded with good rules may all
3065 come together, and I urge you to ask Karen to tell you that.
3066 But as it has been treated, it is not a substitute for a
3067 well-regulated insurance market that everybody gets to choose
3068 a plan regardless of health status.

3069 Ms. {Pipes.} In some states, the high-risk pools work
3070 better than in others depending on funding.

3071 Ms. {Baldwin.} Mr. Chairman, I yield back the remainder
3072 of time.

3073 Mr. {Pallone.} Thank you. The gentleman from
3074 Connecticut, Mr. Murphy.

3075 Mr. {Murphy of Connecticut.} Thank you very much, Mr.
3076 Chairman. Ms. Pipes, I want to go back to this issue of wait
3077 times for a moment. I think we spent a little too much time
3078 obsessing over one system, the Canadian system, given the
3079 number of other examples.

3080 But one of the statistics that is often used is wait
3081 times for specific surgeries like hip replacements and knee
3082 replacements. And there certainly are longer waiting times
3083 in Canada for those procedures. For knee replacements, I
3084 think it is about three weeks. In Canada--about eight weeks
3085 in Canada, about three weeks in the United States.

3086 But what gets lost is that the payer for those surgeries
3087 in the United States is the government most often. 71, 70
3088 years old is the average age for a knee replacement surgery.
3089 And in the United States, Medicare seems to do a pretty
3090 decent job at moving those people through the system and
3091 getting care at a more expedient rate than Canada does.

3092 And so I guess it is a way of asking this question. You
3093 sort of in your remarks seemed to suggest that just an
3094 inherent flaw of a government system is longer wait time.
3095 But it seems that our experience with Medicare is that if you
3096 put the money behind the program, if you make the choice to

3097 get people care faster, then a public system or a public plan
3098 could work just as well as a private plan could.

3099 So do you think that it is inherent in a public versus
3100 private dichotomy, or do you think that if you choose to
3101 spend the money and get the provider network and get the wait
3102 times down that you could get wait times down in a public
3103 plan?

3104 Ms. {Pipes.} Well, in Canada, you could reduce the
3105 waiting times by putting more and more taxpayer dollars into
3106 the health care system. The problem is that Canadians are
3107 taxed at a much higher rate than Americans, and the
3108 government feels that where they are now they are taxed
3109 enough.

3110 And, you know, I did work at the Fraser Institute in my
3111 early years called Tax Facts where we developed a Canadian
3112 consumer tax index and compared the levels of tax in Canada
3113 versus the United States. And work, on average, two months
3114 longer because we have a lot more government in our lives in
3115 Canada.

3116 So, you know, in the case of my mother who needed a hip
3117 replacement, and she was a senior, she waited two years to
3118 get a knee replacement. And when they replaced it, they
3119 replaced it with a plastic knee because they said their
3120 actuarial records showed that at her age she would only live

3121 for five years and therefore the plastic knee was more
3122 efficient and more cost efficient--cost effective. But, you
3123 know, she lived eight years longer, and she was in severe
3124 pain.

3125 So, you know, this is how Canada, you know, controls
3126 costs, and people don't have access to Pap smears on a
3127 regular basis or PSA tests and things. We have a lot of
3128 prevention in this country, but these things are more
3129 expensive. But we have to decide in this country, you know,
3130 if you want a lot more government in your health care, you
3131 are probably going to end up rationing care because as we
3132 have seen in Massachusetts, the cost of being a lot more than
3133 what the original estimates were.

3134 Mr. {Murphy of Connecticut.} You know I think we both
3135 use anecdotes on both sides of this debate, but I would say
3136 that your testimony has been peppered with stories about
3137 Canadian health care experience. And I am just looking at
3138 the data on knee replacement surgeries that just don't back
3139 up that type of timeframe. And I do agree with you that it
3140 is a matter of choosing to invest in the system. I mean no
3141 one is talking about a United States health care reform
3142 proposal ratcheting down the percentage of GDP to what Canada
3143 spends today.

3144 You know, we would love to control costs, but we are not

3145 going to spend as much as Canada does, and we are going to
3146 hopefully get a little bit more than they do, which brings me
3147 to a question for Dr. Reinhardt.

3148 In your testimony, one of the things you talked about
3149 was the relative ineffectiveness of the private insurance
3150 system to get a handle on the cost of care in this country.
3151 And that has been a vexing question for me for years. The
3152 private sector health care system has obviously immediate
3153 incentives to bring down the cost of care because it
3154 increases value for the company for its shareholders and
3155 doesn't have the burden that some government systems does of
3156 having to go through a regulatory process to try to change
3157 behavior. And yet we don't have private insurers investing
3158 in simple, preventative procedures and costs that could bring
3159 down care.

3160 Why do you think that our private health care insurance
3161 system in this country isn't doing as good a job as it could
3162 controlling costs and investing in prevention?

3163 Mr. {Reinhardt.} I think that is an extremely
3164 interesting question because in the '80s, a lot of us,
3165 myself, thought the HMOs actually could do exactly what you
3166 said. And there were proposals to make Medicare into a
3167 defined contribution plan because there was talk that an HMO,
3168 well-run private plan, could do the same thing Medicare does

3169 much cheaper. Sometimes even people said 25 percent.

3170 So then we gave them 95 percent of the average actuarial
3171 per capita cost and said that is very generous. They should
3172 be able to shoot fish in a barrel, given Medicare is so
3173 inefficient as everyone said. But they couldn't. As you
3174 know, in the '90s, they all pulled out, and the only way they
3175 seem to have made it work is to get that 14 percent extra.

3176 I find that very disappointing as an economist that the
3177 private market that I usually believe in somehow failed us
3178 here. Why are there not more efficient? Why, for example,
3179 given Florida is a lot more expensive for Medicare than, say,
3180 Iowa would be, why wouldn't HMOs thrive in Florida managing
3181 care? I don't think they have proven yet that they can do
3182 it.

3183 I hope some day they can, but so far they have not, and
3184 it is a very intriguing question why they have not been able
3185 to reduce costs. And in the early decade, you know, premiums
3186 went up 14, 15 percent, and I always said it is stunning.
3187 Medicare has nothing like these increases, and yet the
3188 private sector came with these increases.

3189 Mr. {Pallone.} We have to move on.

3190 Mr. {Murphy of Connecticut.} Thank you, Mr. Chairman.

3191 Mr. {Pallone.} Gentleman from New York, Mr. Weiner.

3192 Mr. {Weiner.} Thank you, Mr. Chairman. I think to some

3193 degree this discussion about public versus private plans I
3194 think might be too--I mean it is too binary a way to look at
3195 it. What does Congress have? I mean it has a private plan,
3196 right. But we aggregate our many employees. We offer a
3197 phone book not dissimilar to the size of Mr. Shadegg's visual
3198 aide there of different options, of different prices, of
3199 different types of service. What does the panel think
3200 Congress has in the language of this discussion?

3201 Ms. {Feder.} You can argue that what Congress is an
3202 example of a connector in the federal employees health
3203 benefit plan, and for purposes of disclosure, I am the wife
3204 of a federal retiree. So I have it too. And we choose, from
3205 those of us who have it, from a set of private health
3206 insurance plans. So what is being talked about is talking
3207 about adding a public health insurance plan to that menu.

3208 Mr. {Weiner.} And, Ms. Pipes, would you too
3209 characterize what Congress has as a private model in the way
3210 you have described it?

3211 Ms. {Pipes.} Well, the federal employees health benefit
3212 plan, of course, is part of the government, but they have
3213 private plans within that. And my understanding is that the
3214 Blue Cross sort of traditional plan still costs members of
3215 Congress about \$400 a month because I think the plan is about
3216 \$1,200 a month. And it--

3217 Mr. {Weiner.} Right, but--forgive me for interrupting.
3218 But mightn't there be--I mean, look, I think we have a
3219 political imperative, and as we try to work this out is to
3220 try to take that large percentage of American citizens who
3221 have health insurance that they are satisfied with that would
3222 like to pay less would keep them invested in this discussion.
3223 It is important that they be involved.

3224 But I also think that this notion that government
3225 involvement, the moment it touches this, creates a problem.
3226 And letting everyone go out and deal with this problem on
3227 their own, as Mr. Shadegg and you have suggested, goes too
3228 far in the other extreme.

3229 For example, you know, what if you aggregated a whole
3230 bunch of businesses that were on their own not able to shop
3231 very competitively for health insurance plans, but you as the
3232 government, we as the government said you know what? We are
3233 going to take 100,000 employees of small businesses in New
3234 York City, and we are going to go out and we are going to put
3235 a book together of different insurance plans who now knowing
3236 they are getting 100,000 customers.

3237 And we are also going to do a couple of other things.
3238 We are going to say you can't exclude people because they
3239 have pre-existing conditions. There are certain minimum
3240 standards you need to have and the like. You are then kind

3241 of taking a little bit of the private model, a little bit of
3242 the public model, a little from column A and column B. Would
3243 you find that offensive to your notion that the government
3244 should not be involved in this?

3245 Ms. {Pipes.} Well, you know I was a very big support of
3246 association health plans, which would have allowed, under a
3247 lot of smaller businesses to group together and then go into
3248 the market and negotiate better rates. So I am a big fan of,
3249 you know, small business needs, you know--

3250 Mr. {Weiner.} So you would be fine with government
3251 putting its finger on the scale, having standards, having
3252 regulations, requiring certain coverage and the like, so long
3253 as the people writing the checks to the doctors were private
3254 insurance companies rather than government?

3255 Ms. {Pipes.} Right, and I think we have seen, you know,
3256 New York has community rating, guaranteed issue. New York
3257 and New Jersey have some of the most expensive insurance
3258 plans because of those. I would prefer to see some of the
3259 mandates and things like that removed.

3260 I mean if you want to get a plan that has community--

3261 Mr. {Weiner.} Yeah, I understand that. I just have a
3262 moment more. Dr. Reinhardt, can I ask you a question that
3263 touched on what Mr. Murphy concluded with? Do you think that
3264 insurance companies in the present model intentionally do

3265 things to make money on the float? Do you think the reason
3266 there are six major insurance companies that have six
3267 different forms, for example, is an example of them trying to
3268 build in inefficiencies that benefit their bottom line but
3269 make reimbursement slower, make it more difficult for
3270 doctors, more difficult for patients to navigate? Do you
3271 think they are trying to find ways--I mean are they not
3272 incentivized by a different set of impairments than perhaps
3273 Medicaid is? Maybe that is why the inefficiencies remain.

3274 I mean you go into a hospital administrator's office or
3275 a--and you sit literally inboxes and outboxes for all the
3276 different insurance companies because, despite the fact that
3277 they are asking for the same information, they intentionally
3278 keep that inefficiency in the system because they make money
3279 on it?

3280 Mr. {Reinhardt.} Well, I think if interest rates,
3281 short-term rates were 8, 9 percent, I think you have a point
3282 there. In fact, I teach a course in financial management,
3283 and that was one of my lecture notes, how much you could make
3284 off the float by just dragging out payment.

3285 But with low interest rates such as we have had, I think
3286 it would be unprofitable--

3287 Mr. {Weiner.} No, I was thinking more of the structure,
3288 the way the industry has structured itself to have these

3289 inefficiencies, not just for the moment. Do you think that
3290 is why it evolved to be so inefficient and so lumbering very
3291 often is because they make money on that? When you were
3292 giving that class in 2003 or '04, what were you--well, maybe
3293 that was too early. 2005, what were you saying?

3294 Mr. {Reinhardt.} Well, I mean there was definitely--I
3295 took a health plan in New York and showed that basically they
3296 made most of their money on the float, which is, of course,
3297 not necessarily dishonest. That is part of an insurance
3298 industry's source of income is to make money on the float.

3299 What was questionable is did they deliberately drag out
3300 payment so that they could make more money on the float? And
3301 that is easily fixed by saying if you don't pay within 30
3302 days, you will pay an interest rate. Just like in any trade
3303 credit in business, you could say you pay within 30 days,
3304 that is fine. If you drag it out longer, you have to pay the
3305 hospital one percent per month you drag it out. That would
3306 solve the problem, which is, in fact, what my class and I
3307 concluded could be done.

3308 Mr. {Weiner.} Thank you, Mr. Chairman.

3309 Mr. {Pallone.} Thank you. Chairman Waxman.

3310 The {Chairman.} Well, thank you very much, Mr.
3311 Chairman. I have been listening to the discussion. I had to
3312 miss some of the earlier presentations, but I think this has

3313 been an excellent panel.

3314 Dr. Reinhardt, you have indicated you think that
3315 whatever we do, employer-sponsored insurance is shrinking,
3316 and it will continue to shrink. And that this may be a good
3317 time for us to develop an alternative for people, an
3318 alternative based on a reformed individual market, a public
3319 insurance program, or both. That has been the basis of a lot
3320 of the discussion and debate.

3321 But I want to ask you what should a health reform bill
3322 do to make sure that health care coverage is affordable for
3323 those who no longer have access to employer-sponsored
3324 coverage? Should we look at the amount of money that people
3325 pay out of their income for health? Should we try to say
3326 that--not just look at the premium but all the out-of-pocket
3327 costs and then say that people shouldn't have to pay more
3328 than 10 percent, 7 percent plus or more of their income?

3329 Mr. {Reinhardt.} I think, Chairman Waxman, that would
3330 be the way to go. You have to focus on total health
3331 spending, not just premium, and then relate it to the ability
3332 of the family to pay for that. And that, in some way, is an
3333 ethical political decision where you put those numbers. If
3334 you were to say somebody making less than \$25,000, what
3335 should that percentage be? I personally feel 5 percent would
3336 stretch them already. While, as I said earlier, if it were

3337 someone like me, if you set that at 12 percent, I wouldn't
3338 cheer, but I think I could eat it. I could manage that, and
3339 it would be fine.

3340 In the short run, brining more people under insurance
3341 will cost money because they are consuming less than half
3342 what insured people get. So we would have to top it off, and
3343 the estimates are--some are \$120 billion to \$150 billion a
3344 year if you want really full coverage.

3345 But in the longer run, I do believe we can make health
3346 care in America a lot cheaper by doing the kind of cost
3347 containment candidates from both sides of the aisle had.
3348 Senator McCain also had ideas about cost containment, but
3349 they take longer to do.

3350 The {Chairman.} Would you put a limit on the out-of-
3351 pocket expenses at let us say for low-income people, 5
3352 percent of income? Would that make sense given the cost of
3353 food, rent, transportation? Would you try to figure out some
3354 kind of limit for those who have insurance and how much they
3355 will to pay out of pocket?

3356 Mr. {Reinhardt.} I would absolutely try to figure out a
3357 limit. Now, I am shooting off the hip. I said 5 percent
3358 might even stretch people. I always wonder, as someone on
3359 the upper strata of the income distribution, I wonder how
3360 people on \$25,000 family income make it. You know, I used to

3361 be there. I grew up poor, but I forgot. So I think it is
3362 quite conceivable that 3 percent would stretch them. One
3363 would really have to budget this out, and that may be a good
3364 research project for Judy Feder to figure out. That is what
3365 you do.

3366 Ms. {Feder.} Why, thank you.

3367 The {Chairman.} Right, in her spare time.

3368 Mr. {Reinhardt.} I mean obviously you can list what
3369 families need to spend on the basics.

3370 The {Chairman.} Ms. Pipes, what do you think about
3371 that? Do you think there ought to be some limit on how much
3372 people have to pay for their health care?

3373 Ms. {Pipes.} Well, you know, we have--people at \$25,000
3374 are obviously on Medicaid. And we have now an expanded state
3375 children's health insurance plan. So we have a lot of
3376 government. I would like to see, as I have said, open up the
3377 market and, you know, change the employer-based system.
3378 Allow it to still be there, but if you tax the employer
3379 benefits and then provide a refundable tax credit for those
3380 who go--for those people. And also then I think we would see
3381 then individual market expand, and we would see new
3382 competition, new insurers. And we would--

3383 The {Chairman.} Well, let us say we don't get what we
3384 want and people still, to get adequate insurance coverage for

3385 their health needs, have to pay so much out of pocket.

3386 Should we just assume that they just made a deal that didn't

3387 work out for them and let it go?

3388 Ms. {Pipes.} Well, if you look at Massachusetts, which

3389 had the individual employer mandate in their Romney care plan

3390 in 2006, I mean even after, you know, the Commonwealth Care

3391 and the subsidized and free plans, you still saw that 20

3392 percent of the people in the first year that should have

3393 bought insurance were excluded because the premiums were

3394 still too expensive. So it is very difficult for me. I

3395 don't know what the ideal number is, but--

3396 The {Chairman.} With the few seconds I have, I did want

3397 to ask you one other question.

3398 What would you think of the idea--and Mr. Weiner was

3399 sort of hinting at this--that people go to a connector and

3400 buy a private insurance policy, but the connector would be

3401 like the federal employees' benefit package where you have,

3402 in effect, a lot of private choices that are group plans so

3403 you eliminate the discrimination and all of that.

3404 What would you think of that kind of a connector to

3405 private plans--

3406 Ms. {Pipes.} Well, I would--

3407 The {Chairman.} --private insurance plans.

3408 Ms. {Pipes.} Yes, I would support a connector if it was

3409 totally private, but when you have government politicians or
3410 government bureaucrats determining, you know, what has to be
3411 on the insurance plan in the connector, then often I see
3412 price going up. And it becomes more difficult. So I would
3413 support a totally private connector, but I am not in support
3414 of a national insurance exchange such as President Obama has
3415 been talking about because I see the controls that would be
3416 set by government being--causing--

3417 The {Chairman.} So you don't seen that working? Dr.
3418 Feder, if we had that ability for people to go a connector
3419 and buy a private insurance plan, do you think it could work
3420 like the federal employees? And do you think you need a
3421 public option to provide some tension to keep the private
3422 insurance plans affordable and all of that?

3423 Ms. {Feder.} I think the combination is ideal. I think
3424 what we are looking for is we can think of it as a public
3425 choice plan. That essentially we create a place, as you say,
3426 where people are able to buy group insurance without
3427 discrimination based on health status. But to do that alone
3428 without a public health insurance option, we have not seen
3429 great competition, whether in the federal health employees'
3430 plan or any other. So that having the public health
3431 insurance option, as I said earlier, can make the whole
3432 market work more effectively because we can hold it

3433 accountable for delivery good benefits, delivery good care,
3434 and essentially working to negotiate good rates with
3435 providers.

3436 The {Chairman.} Thank you, Mr. Chairman.

3437 Mr. {Pallone.} Thank you, Chairman Waxman. And I think
3438 all of our members have asked questions, so I really want to
3439 thank you. This was a great panel. It was really thought
3440 provoking in terms of our efforts to draft legislation and
3441 address the whole issue of health care reform. So thank you
3442 very much. We appreciate it.

3443 Ms. {Pipes.} Thank you.

3444 Ms. {Feder.} Thank you.

3445 Mr. {Pallone.} And I would ask the next panel to come
3446 forward. Thank you all for being here. And let me introduce
3447 each of you starting on the left, and I hope I get the names
3448 right. First, is it Mila Kofman? Mila Kofman who is
3449 superintendent of insurance for the State of Maine Bureau of
3450 Insurance. Then we have Dr. Jon Kingsdale, who is executive
3451 director of the Commonwealth Health Insurance Connector
3452 Authority. And then we have Karen Pollitz who two Ls, not
3453 three. Your name tag has three Ls. Karen Pollitz, who is
3454 research professor at Georgetown University Health Policy
3455 Institute. And then we have Dr. Katherine Baicker, who is
3456 professor of health economics at the Harvard School of Public

3457 Health. And finally Edmund Haislmaier?

3458 Mr. {Haislmaier.} Haislmaier.

3459 Mr. {Pallone.} Haislmaier.

3460 Mr. {Haislmaier.} Thank you.

3461 Mr. {Pallone.} Who is senior research fellow at the

3462 Center for Health Policy Studies with the Heritage

3463 Foundation. Thank you all for being here. I know some of

3464 you have actually been here since the beginning, which is, I

3465 am sure, been difficult.

3466 But in any case, we will have statements from each of

3467 you, about 5 minutes each, starting with Ms. Kofman.

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3468 ^STATEMENTS OF MILA KOFMAN, J.D., SUPERINTENDENT OF
3469 INSURANCE, STATE OF MAINE BUREAU OF INSURANCE; JON KINGSDALE,
3470 PH.D., EXECUTIVE DIRECTOR, COMMONWEALTH HEALTH INSURANCE
3471 CONNECTOR AUTHORITY; KAREN POLLITZ, M.P.P., RESEARCH
3472 PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE;
3473 KATHERINE BAICKER, PH.D., PROFESSOR OF HEALTH ECONOMICS,
3474 HARVARD SCHOOL OF PUBLIC HEALTH; AND EDMUND F. HAISLMAIER,
3475 B.A., SENIOR RESEARCH FELLOW, CENTER FOR HEALTH POLICY
3476 STUDIES WITH THE HERITAGE FOUNDATION

|
3477 ^STATEMENT OF MILA KOFMAN

3478 } Ms. {Kofman.} Good afternoon, Mr. Chairman. I thank
3479 you and the committee for your leadership and willingness to
3480 address the health care crisis in America. It is both an
3481 honor and a privilege to be here before you to testify on
3482 this matter. I did submit a written statement, and I ask
3483 that the full written statement be admitted as part of the
3484 record.

3485 Mr. {Pallone.} And that will be the case for each of
3486 you. We will enter your full written statement in the
3487 record.

3488 Ms. {Kofman.} Thank you. My name is Mila Kofman. I am

3489 the superintendent of insurance in Maine. My agency serves
3490 and protects the public through regulation and oversight of
3491 the insurance industry. It is my job to ensure that
3492 insurance companies keep their promises. My views about
3493 reforms and the private market have also been informed by my
3494 experience as a federal regulator and through my research on
3495 private health insurance as an associate professor at
3496 Georgetown.

3497 I believe it would be optimal for us to address the
3498 health care crisis in America in its entirety and for the
3499 federal government to ensure that all Americans have access
3500 to affordable, adequate and secure health coverage.

3501 We live in the wealthiest nation in the world, yet we
3502 allow 18,000 Americans to die preventable deaths each year on
3503 our soil, not overseas but here. The uninsured problem is
3504 estimated to cost our economy as much as \$130 billion
3505 annually.

3506 Maine has been at the forefront of reforms, developing
3507 innovative initiatives to help finance medical care.
3508 Governor Baldacci has been a leader in establishing
3509 meaningful new health coverage options for individuals and
3510 small businesses, coverage that actually works for people
3511 when they are sick.

3512 Today I will discuss the types of problems I am not

3513 seeing because of the insurance reforms we have in Maine.
3514 First, it is important to remember that the private market is
3515 not a free market where purchasers have meaningful options.
3516 A free market assumes that everyone who wants to buy a
3517 product can choose among sellers competing for their
3518 business.

3519 Insurance companies do not compete to insure sick
3520 people. Insurance companies do not compete to insure sick
3521 people. An insurance company's success depends on its
3522 ability to minimize its risk. This provides incentives to
3523 cherry pick healthy people and limit the number of unhealthy.
3524 It creates a private market from which many Americans are
3525 shut out. Even minor conditions like an allergy could be the
3526 basis for not selling you a policy.

3527 Also in most states, insurers are allowed to charge
3528 higher rates for people with medical needs. This includes
3529 charging small businesses with sicker workers higher rates
3530 than small businesses with healthy workers.

3531 Maine is one of five states, in addition to New Jersey,
3532 Massachusetts, New York, and Vermont, that prohibits
3533 discrimination against individuals. We do this through
3534 guaranteed issue and adjusted community rating laws.
3535 Guarantee issue laws prohibit insurers from turning you down
3536 because of your health. Adjusted community rating laws

3537 prohibit insurers from charging sicker people higher rates.

3538 In addition to allowing people with medical needs to
3539 access private coverage, the combination of guaranteed issue
3540 and adjusted community rating laws has protected Maine
3541 consumers from some of the problems experienced by consumers
3542 and small businesses in other states.

3543 For example, we do not have rescissions, the problem
3544 that Chairman Waxman examined extensively as chairman of the
3545 oversight committee last year. This is a problem of having
3546 your policy retroactively cancelled and being responsible for
3547 all the claims paid while you had the policy. Rescissions
3548 leave people on the hook for their medical bills and
3549 uninsurable, completely shut out of the private market.

3550 In Maine, a consumer does not fear losing his or her
3551 insurance because he or she may have completed the
3552 application for insurance incorrectly by mistake. In other
3553 states, consumers reported having their policies cancelled
3554 retroactively for forgetting to report seeing a marriage
3555 counselor years before. In Maine, because insurers are not
3556 allowed to consider current or past medical needs in the
3557 first place when selling or pricing a policy, we have not had
3558 a problem with rescissions.

3559 We do have a problem, however, with affordability. The
3560 health care crisis is like a slow disease slowly killing off

3561 the middle class. It is a huge burden on employers of all
3562 sizes, on workers, and families. Health insurance premiums
3563 are expensive because medical care is expensive. The private
3564 health care financing system has not effectively switched its
3565 focus and incentives from paying for sick care to promoting
3566 wellness. The current system rewards inefficiency. Carriers
3567 have not been able to negotiate effectively enough with
3568 providers to keep costs contained.

3569 Many factors contribute to the price of coverage. That
3570 includes the cost of medical care, administrative costs, and
3571 profits. Since 2002, our state's largest insurer has
3572 declared nearly \$152 million in dividends.

3573 As far as next steps, there is a strong and appropriate
3574 role for federal policy makers. Americans need and demand
3575 meaningful health insurance coverage options to access and
3576 pay for necessary, and in many cases, life-saving medical
3577 care and services. Working together, the federal government
3578 and the states, we can address the health care crisis facing
3579 our nation's employers, workers, and families.

3580 I encourage you to build upon the foundation that you
3581 established in 1996 through HIPAA, a federal floor of
3582 protections, recognizing that states have and should be
3583 allowed to create and enforce higher levels of consumer
3584 protections as their populations need.

3585 In addition to improving and having strong protections,
3586 it is equally important to have strong regulators to enforce
3587 the law. State regulators have a long history of effectively
3588 protecting insurance consumers. I encourage you not to
3589 duplicate or replace the existing effective state-based
3590 insurance oversight system. Thank you, and I look forward to
3591 assisting you as you move forward in addressing the health
3592 crisis.

3593 [The prepared statement of Ms. Kofman follows:]

3594 ***** INSERT 4 *****

3595

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Mr. {Pallone.} Thank you. Dr. Kingsdale.

|
3596 ^STATEMENT OF JON KINGSDALE

3597 } Mr. {Kingsdale.} Thank you, Mr. Chairman and members of
3598 the committee for this opportunity and more importantly for
3599 tackling this tough subject. I am executive director of the
3600 Commonwealth Health Insurance Connector Authority, which is
3601 one of the principle agencies of health reform in
3602 Massachusetts, and I want to share with you a couple lessons
3603 learned.

3604 First of all, I would note we do have 97.4 percent of
3605 our residents covered with insurance. Before I heard that
3606 characterized in the former panel, I actually thought that
3607 was good. It is, by far, the highest insurance level in the
3608 United States, which sadly is below 85 percent nationally and
3609 declining as we speak.

3610 Two years ago, after beginning implementation, we
3611 reached the principle goal of Massachusetts Chapter 58 of the
3612 Acts of 2006, near universal coverage. As a result,
3613 financial barriers to obtaining care have fallen markedly.
3614 An Urban Institutes survey conducted midway through
3615 implementation, and I emphasize midway, found that
3616 Massachusetts rates of deferring needed care, because of
3617 financial barriers, were between one-half and one-third of

3618 the national average. And I think it is reasonable to
3619 assume, as enrollment continued to grow, the financial
3620 barriers continued to fall.

3621 Importantly, Massachusetts has been able to achieve near
3622 universal coverage without a surge in medical inflation. In
3623 Commonwealth Care, a program run by the Health Connector for
3624 lower income adults without access to employer sponsored or
3625 other public coverages, annual premium increases average
3626 under 5 percent, and that is better than the national
3627 experience, in fact, most private experience in
3628 Massachusetts.

3629 Last week, we actually completed bidding and plan
3630 selection for the next fiscal year, starting this July, which
3631 has produced the following rather extraordinary results:
3632 choice of health plans and access to new primary care
3633 physicians will increase, and both the government spending
3634 per enrollee and what our 165,000 enrollees contribute
3635 monthly will decrease. And I have been in the insurance
3636 business for 35 years, and I don't usually use premium and
3637 decrease in the same sentence.

3638 The connector runs actually two distinct programs. So
3639 its second program, Commonwealth Choice, unsubsidized
3640 enrollees enjoy a broad array of commercial health plans.
3641 They can compare 37 private options that we offer, confident

3642 that these plans have received the commonwealth seal of
3643 approval for quality and value. On the day we initiate
3644 Commonwealth Choice and the individual mandate, July 1, 2007,
3645 purchasers of non-group plans experienced a huge gain. Their
3646 choice of plans increased suddenly. Their average premiums
3647 dropped markedly, and shopping for a plan became far easier.

3648 The result has been a resuscitation of the non-group
3649 market in Massachusetts. Prior to reform, non-group
3650 enrollment had been falling and premiums rising. A year
3651 later, the number of Massachusetts residents buying insurance
3652 directly on their own had doubled, and the premiums for
3653 standard coverage in the largest non-group plans had declined
3654 by 25 percent.

3655 Although we only offer 37 of the 180 options now
3656 available to individuals in Massachusetts and they are priced
3657 the same in the connector or if purchased outside the
3658 connector, our growth has accounted for 50 percent of the
3659 growth in non-group coverage in Massachusetts.

3660 Health care reform in the state is a shared
3661 responsibility. One-third of the some 440,000 newly insured
3662 residents in the commonwealth are in employer-sponsored
3663 plans. Near universal coverage is the product of shared
3664 responsibility among employers, taxpayers, and those directly
3665 involved in providing and reimbursing care. Our governor and

3666 legislative leaders are committed to maintaining coverage and
3667 sustaining access.

3668 Now, let me just say a couple things about the two
3669 connector programs that I briefly described. The Connector
3670 organizes a market to provide meaningful choice. Like any
3671 retailer, we ask our customers what they want. What they
3672 tell us is they want quality, meaning insurance options they
3673 can trust, they want value, meaning that we compare and
3674 showcase those plans which offer the best benefits for prices
3675 charged, and they want to be able to compare and shop online
3676 as opposed to calling each carrier, asking a bunch of
3677 questions, being put on hold, and then trying to compare
3678 notes at the end of the day.

3679 In both Commonwealth Care and Choice, we set standards
3680 for covered benefits. We rigorously evaluate the products
3681 before offering them, and we organize the choice of plans so
3682 that members can readily compare them. At enrollment and
3683 afterwards, we work with members and health plans to resolve
3684 member issues.

3685 With Commonwealth Care, since we are spending public
3686 monies for coverage, the Connector specifies a set of
3687 benefits and conducts a highly competitive bidding process.
3688 But enrollees choose the plan. They choose the provider
3689 network, and if they choose a more expensive plan and they

3690 earn above 100 percent of FPL, they pay the additional cost.

3691 With Commonwealth Choice, which is the unsubsidized
3692 plan, our members are making a major buying decision. They
3693 are spending somewhere between \$1,500 and \$15,000 a year on
3694 insurance, depending on family size, age, zip code, et
3695 cetera, and the plan they choose. The Connector sets four
3696 very different levels of benefits from which customers can
3697 choose and offers at least six different carriers on each of
3698 these benefit tiers. Our customers can shop by entering
3699 three pieces of information: age, household size, and zip
3700 code.

3701 We do offer customer telephone service, but 80 percent
3702 of the buying is online, typically in 20 to 30 minutes, spend
3703 somewhere between \$1,500 and \$1,500 a year. And whichever
3704 plan they buy, enrollment is guaranteed as is the next year's
3705 renewal regardless of any change in members' medical
3706 condition.

3707 And believe it or not, after spending all that money,
3708 our members consistently thank you, even though we all know
3709 this is outrageously expensive. Frankly this is--and I have
3710 been in the insurance business for over 30 years--the most
3711 consumer friendly, consumer-driven offering that I have
3712 encountered. Thank you for your time and interest, and I
3713 will be happy to do my best to answer questions.

3714 [The prepared statement of Mr. Kingsdale follows:]

3715 ***** INSERT 5 *****

|
3716 Mr. {Pallone.} Thank you. Ms. Pollitz with two Ls, not
3717 three.

|
3718 ^STATEMENT OF KAREN POLLITZ

3719 } Ms. {Pollitz.} Like Mr. Pallone. Thank you, Mr.
3720 Chairman, members of the subcommittee. Health reform
3721 presents you with an opportunity to provide for more health
3722 insurance markets through a connector, as Dr. Kingsdale
3723 discussed, or an exchange. You can organize markets around
3724 explicit outcomes that you want to achieve from health
3725 insurance.

3726 I would like to briefly review five key goals. The
3727 first is to promote risk spreading and stability in health
3728 insurance. We have already talked today about how a small
3729 minority of people accounts for most health care spending,
3730 and this creates an overwhelming financial incentive for
3731 insurance companies to avoid risk. So we need rules to make
3732 that stop.

3733 I have testified before about medical underwriting
3734 practices that make it harder for consumers to get coverage,
3735 but other marketing practices make it difficult for consumers
3736 to keep affordable coverage. Age rating raises your premium
3737 steadily, and when you reach your 50s and 60s, when the
3738 incidents of most health conditions starts to increase,
3739 health insurance becomes very unaffordable.

3740 Carriers also use durational ratings to actually apply a
3741 surcharge to premiums based on how long you have held your
3742 policy. The idea is to encourage people who can still pass
3743 underwriting to not renew, but to go out and buy a new
3744 policy, go through underwriting again to get a good rate.
3745 But the people who can't do that get stranded in policies and
3746 see their premiums spiral.

3747 Health reform can help by changing the rules of health
3748 insurance marketplaces, require guarantee issue, community
3749 rating, no pre-ex, so that we stop competition on the basis
3750 of risk avoidance.

3751 The second goal must be to assure adequate coverage.
3752 Today we have 57 million Americans struggling with medical
3753 debt, and three-quarters of them are insured. Some are
3754 underinsured because their policy doesn't cover key benefits,
3755 but increasingly the problem lies with high deductibles and
3756 high cost sharing.

3757 We have accepted higher cost sharing year after year in
3758 an effort to try to hold premiums down, but as soon as we get
3759 sick, we realize what a failed strategy this is. Especially
3760 for patients with chronic conditions, high deductibles hit
3761 relentlessly year after year. Even modest copays will mount
3762 quickly, and as a result, people have difficulty affording
3763 basic care management for chronic conditions like asthma and

3764 diabetes. And as a result, avoidable and expensive medical
3765 complications arise.

3766 In short, underinsurance is becoming a threat to the
3767 public health. It also drives up bad debt and collections
3768 costs for doctors and hospitals. The industry experts tell
3769 us that the collections rate for low deductible plans is
3770 about 87 percent, but for high deductible plans is only 43
3771 percent. So it adds to that administrative cost and hassle
3772 for providers as well.

3773 Reform can help by setting comprehensive standards for
3774 what health insurance covers and make sure that in the
3775 marketplace only good choices are available.

3776 A third choice is to assure affordability. In the
3777 interest of time, I won't belabor this point. I think the
3778 other panel talked very convincingly about the need for
3779 subsidies for both premiums and for cost sharing to make
3780 health care and health coverage affordable.

3781 The fourth goal is cost containment. Most private
3782 health insurance markets today are dominated by a few, large
3783 carriers, and yet these dominant carriers have not used their
3784 market clout to control costs. Instead, they have passed out
3785 health care costs to consumers while increasing profitability
3786 at the same time. Reform can help by organizing health
3787 insurance markets to generate new forms of competition and

3788 more effective cost containment strategies.

3789 You have a number of options to consider. As is the
3790 case in Massachusetts, the exchange can have the option of
3791 not including all carriers as participants but instead
3792 selecting those that are the most effective and the most
3793 efficient. As also was discussed earlier at great length, a
3794 public health insurance plan option can and should be offered
3795 to heighten competition.

3796 And finally, Mr. Chairman, transparency and
3797 accountability are critical to a well-functioning health
3798 insurance market. Mr. Deal spoke earlier this morning about
3799 price transparency and the importance of that, and I
3800 completely agree. But we need transparency throughout our
3801 health insurance system and market. Health insurance
3802 policies themselves need to be transparent and
3803 understandable. Policies are so complex today they leave
3804 most consumers confused and frustrated. A recent industry
3805 survey found that most people would prefer to do anything,
3806 including working on their taxes, rather than trying to read
3807 through their insurance policy to figure out what it covers.

3808 And we need transparency of market behavior as well.
3809 Too many market practices are hidden from view. It is very
3810 difficult to track who is enrolled, who is disenrolling, when
3811 claims are paid, when they are pending, when they are denied.

3812 These questions are important, and they are answerable if
3813 only we will insist on the data.

3814 In an organized insurance market we can do that. In the
3815 past few months, as financial markets in the economy have
3816 struggled, how many times have you heard or you yourselves
3817 made the call for greater transparency and accountability?
3818 These themes must allow apply to health insurance and guide
3819 your efforts on health care reform. Thank you.

3820 [The prepared statement of Ms. Pollitz follows:]

3821 ***** INSERT 6 *****

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3822

Mr. {Pallone.} Thank you. Dr. Baicker.

|
3823 ^STATEMENT OF KATHERINE BAICKER

3824 } Ms. {Baicker.} Thank you very much for the opportunity
3825 to be here. I would like to draw a couple of key
3826 distinctions at the beginning. First, health is very
3827 different from health care, and second health care is very
3828 different from health insurance. I know we have all hit on
3829 these points already, so I will be brief. But we know many
3830 things affect health outcomes besides the health care system.

3831 By the time someone shows up at the hospital in critical
3832 condition, it is already too late in some senses. That means
3833 that comprehensive reform should address investment in all
3834 sorts of things that promote health including health
3835 behaviors, access to nutritious foods, exercise, et cetera.
3836 It also makes international comparisons of health systems
3837 particularly different because when we look at the value our
3838 health care system is producing, the health outcomes are the
3839 product not just of that health care system but of all those
3840 other factors that may be different across countries as well.

3841 The second distinction I wanted to draw was between
3842 health care and health insurance, and that sounds obvious,
3843 but it is often conflated in the debate. And this goes to
3844 the point that Representative Christensen raised earlier

3845 about what our responsibility and what our goals should be
3846 for helping sick people who are uninsured.

3847 People need health insurance because health care is
3848 uncertain because the risks are uncertain, not because health
3849 care is expensive. There are lots of things that are
3850 expensive that we might want to redistribute resources for to
3851 low-income people but not through the form of insurance
3852 because those expenses aren't so variable, so unknown.
3853 Whereas health insurance exists to protect people against the
3854 risk of needing a lot of resources to pay for an expensive
3855 health care condition when those resources could save their
3856 life.

3857 So what do uninsured sick people need? They need health
3858 care, but they don't necessarily need health insurance. And
3859 we might want to design a reform to help those people that
3860 gets them access to care that doesn't necessarily build on an
3861 insurance system designed to help the majority of people who
3862 get insured when they are healthy, some of whom then fall
3863 sick and some of whom don't.

3864 The problem that sick people who are insured have is one
3865 of insuring the affordability of that care going forward.
3866 People want protection not just against high expenses today,
3867 but against the risk of high expenses next year. And that
3868 means having an insurance policy that you can count on if you

3869 or a family member get sick. Your premiums shouldn't go up.
3870 You shouldn't lose your insurance. You have done what you
3871 needed to do to get insurance when you were healthy. We need
3872 to ensure that that insurance stays around to protect people
3873 should they fall ill.

3874 A second principle I would like to bring up is the idea
3875 that covering the uninsured doesn't pay for itself. It would
3876 be wonderful if we could recoup the investment that we make
3877 in covering the uninsured through less spending on emergency
3878 departments and inefficient care that we know the insured
3879 differently from the uninsured right now.

3880 Unfortunately, I don't think we can count on saving
3881 money by covering the uninsured, but that doesn't mean that
3882 it wouldn't be money extremely well spent. If we invest
3883 money in covering the uninsured, they will gain enormous
3884 health benefits from it. So the money is worthwhile, but it
3885 is not free. And it doesn't save money on net to extend
3886 insurance coverage because we know the uninsured are
3887 consuming too little health care today. So extending
3888 coverage to them would give them access to more care that
3889 would cost more money. So we need to design reforms that can
3890 pay for that.

3891 A corollary to that idea is that preventive care doesn't
3892 pay for itself by and large either. There are a few

3893 exceptions. Flu shots for toddlers more than pay for
3894 themselves. Most preventive again is a good investment in
3895 health. It promotes health in the long run, and it is worth
3896 spending money on, but it doesn't reduce costs. Most
3897 preventive care buys quality adjusted life years at a pretty
3898 good price, and we should invest in that. Some preventive
3899 care is very expensive for the health that we buy and is in
3900 fact less cost effective than care that wouldn't be
3901 characterized as preventive. So we shouldn't think of
3902 preventive care as a uniform cure-all either. It is a mix of
3903 highly cost effective and highly non-cost effective care as
3904 well.

3905 Another principle that I would like to bring to the
3906 debate is that insurance alone doesn't guarantee access to
3907 high quality care. We hit on that, the questions discussed
3908 that a fair amount in the first panel, so I won't spend a lot
3909 of time on here. But there is ample evidence, largely
3910 derived from the Dartmouth data on variations in health care
3911 within Medicaid that high spending on health doesn't
3912 guarantee high-quality care. And even people in the same
3913 insurance program, Medicare fee-for-service, get wildly
3914 different health care benefits in different parts of the
3915 country.

3916 Next I would like to raise the idea that employees bear

3917 the burden of employer-provided health insurance. This means
3918 that if we want to foster the employer system, if we want to
3919 put employer-based policies on a level playing field with
3920 non-group markets, the reasons to think about doing that
3921 involve risk pooling and economies of scale in large
3922 purchasing, not the idea that employers somehow bear the
3923 burden of health costs through profits.

3924 In the long run, when health care costs go up for
3925 employer provided plans, employees bear that cost in the form
3926 of lower wages. That is part of the reason we have seen
3927 slower wage growth over the last decade. It is because an
3928 increasing share of compensation that workers get has come in
3929 the form of health insurance rather than wages. In some
3930 cases, when wages can't accommodate that increase in health
3931 care costs, that results in unemployment. So ultimately
3932 workers bear the burden either through lower wages or in some
3933 cases through losing their jobs.

3934 The last point that I would like to make is that high
3935 deductible health plans can introduce cost sharing that
3936 promotes efficiency, but they aren't the magic bullet. There
3937 is no reason to think that the high deductible health
3938 policies that we see today are the perfect structure. What I
3939 think the tax system should aim to do is promote innovative
3940 insurance coverage that fosters high value care. That might

3941 mean higher deductible for some kinds of care and subsidizing
3942 other kinds of care. Maybe we should pay people to go get
3943 flu shots because those are particularly cost effective. It
3944 should have a negative copayment associated with it.

3945 Any reform design should promote that kind of high value
3946 insurance structure that I think is unlikely to be generated
3947 by a monolithic single public payer plan but it unlikely to
3948 be generated by a prescribed particular form of deductible.

3949 So in conclusion, I think we should address the issues
3950 of coverage and cost together, not because they are equally
3951 important necessarily, although I think both are very
3952 important, but because each goal is more likely achieved when
3953 the two are considered together. It is very difficult to
3954 design a system to cover the uninsured that we can afford
3955 tomorrow if we don't take health care costs into account.
3956 And if we don't get costs under control, more people will
3957 find themselves falling into that uninsured bucket as their
3958 employer provided plan or the non-group market plans become
3959 less and less affordable.

3960 [The prepared statement of Ms. Baicker follows:]

3961 ***** INSERT 7 *****

3962 | Mr. {Pallone.} Thank you, Doctor. Mr. Haislmaier.

|
3963 ^STATEMENT OF EDMUND F. HAISLMAIER

3964 } Mr. {Haislmaier.} Thank you, Mr. Chairman and members
3965 of the committee for inviting me here today to testify. I
3966 have submitted prepared remarks which I will summarize
3967 briefly. Let me just make a couple of points, and I would
3968 particularly like to follow on what Dr. Baicker just said
3969 about silver bullets.

3970 In 20 years of doing health care policy, it has been my
3971 observation that too often too many of us, regardless of
3972 where we are on the political spectrum, are tempted to try to
3973 latch onto something as a small silver bullet solution to
3974 health care. I have come to the conclusion that while each
3975 and every one of those things has some value, none of them
3976 are a magic silver bullet to fix the problem. Rather you
3977 have to take them in a context, and you have to look at them
3978 as pieces of the puzzle.

3979 We also have a tendency to run towards fads. That is
3980 the silver bullet, if you will, that is most popular at the
3981 given moment. Again this can be on either side of the aisle.
3982 We have seen it with HMOs, HSAs, public plan, this, that, and
3983 the other. Again I would encourage you to refrain from that.

3984 In looking at the situation we have today, what strikes

3985 me, not only based on my experience over 20 years, but
3986 actually based on the last five years of working with about
3987 18 different states. Literally I was in the period of seven
3988 days testifying in Anchorage and Tallahassee. So it is
3989 across the country, in very different circumstances. How
3990 diverse the situation in on the ground in your different
3991 states and also how much more amendable it is to solution at
3992 the state level.

3993 I have also at a policy then intrigued by the few things
3994 that are really needed in my view to make measurable
3995 progress, and let me summarize them as I do in my testimony.
3996 I think the Massachusetts Connector, which is the first
3997 example, and now Utah--unfortunately Representative Matheson
3998 isn't here--last week enacted something very similar--is the
3999 first couple of examples of what I think needs to be done in
4000 one area, which is to create an individualized solution for
4001 employers and their workers.

4002 This is not the same as the traditional individual
4003 insurance market, as Mr. Kingsdale points out. This
4004 functions just like an employer market. You are guaranteed
4005 the coverage. You have a right to pick an open season. In
4006 fact, it works like FEHBP, which was discussed earlier.

4007 In fact, they are doing the things you would have to do
4008 if you were to say we are going to take FEHBP and instead of

4009 having it be one employer, the federal government, we are
4010 going to have a state do it for any employer in the state to
4011 participate in. That is what the unsubsidized Commonwealth
4012 Connector reforms that they are rolling out right now are
4013 designed to do and what other states are looking at doing.
4014 Any state can do that today, and we have shown them how they
4015 can do it working as Massachusetts and now Utah are doing
4016 within federal law.

4017 Point two is if you want to apply guaranteed issue to
4018 the individual market, that can be done. It can be done at
4019 the state level. Some states have done it, as Ms. Kofman
4020 pointed out. It could be required at the federal level. The
4021 important thing is to do it right. It should not be an
4022 unlimited pick-it-up-drop-it-anytime-you-want kind of
4023 guaranteed issue, but rather as the federal government set
4024 forth in HIPAA, a set of standards for guaranteed issue in
4025 the group market for individuals when it is reasonable for
4026 people to do that.

4027 The other two points in my testimony are that the way to
4028 make those reforms work in an optimal fashion is to support
4029 them with risk adjustment mechanisms. And I noted in my
4030 testimony that in my discussions with folks in Massachusetts
4031 and in my observations, I think if I was to go back and say
4032 what did they leave out that they should have included. And

4033 that was they didn't include a risk-adjustment mechanism for
4034 making sure that nobody was disadvantaged as an insurer
4035 getting more of the sick cases than somebody else.

4036 Interestingly enough, learning from that lesson, that is
4037 the first order of business in the Utah reforms is to set
4038 that piece of it up.

4039 And then finally if you are going to move to guaranteed
4040 issue in the individual market, and you are going to give
4041 people the right to buy coverage, then for that to work
4042 economically and socially, people have to take of the
4043 obligation to take advantage of that right when they are
4044 healthy and pay into the system and not simply avoid it until
4045 they need it and then want to take out of the system.

4046 Finally what strikes me about all of this is that any of
4047 this stuff and all of this stuff can be done by states now.
4048 It is not necessary for the federal government to do it for
4049 them. The federal government, however, could do things to
4050 aid and encourage them. And I will be happy to discuss that
4051 later.

4052 And then finally to Representative Deal's question,
4053 again I think price and transparency is essential to making
4054 this work even better down the road. But again I think this
4055 is something, given that states regulate insurance and the
4056 practice of medicine, that states are looking at doing

4057 themselves to one degree or another and is certainly
4058 something I would encourage there to support it. Thank you.

4059 [The prepared statement of Mr. Haislmaier follows:]

4060 ***** INSERT 8 *****

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4061 Mr. {Pallone.} Thank you, and I want to thank all the
4062 panelists. We are going to have questions now. Each member
4063 gets 5 minutes, as you probably know, and I will start out
4064 with myself. And I wanted to ask Mr. Kingsdale. You have
4065 achieved remarkable results in Massachusetts with your two
4066 connectors. Our national rate of uninsurance is 17 percent.
4067 In Massachusetts, just 2.6 percent are uninsured. But to
4068 achieve this result, you have in place a requirement that all
4069 residents must have health insurance coverage that meets
4070 minimum standards for adequacy, and I just want to ask a few
4071 questions about this individual mandate and how you ensure
4072 that the coverage people are required to buy is affordable.

4073 I have four questions. I am going to try to go quickly
4074 here. What type of coverage does Massachusetts require its
4075 residents to have, and how is that individual mandate
4076 enforced? Of course, I heard about this during the
4077 presidential campaign, but I want your opinion.

4078 Mr. {Kingsdale.} Thanks for the question. If you
4079 require insurance or anything, you have to set a minimum
4080 standard. Obviously a dollar of coverage per year does not
4081 constitute real insurance. And that has been one of the two
4082 thorniest problems, which the legislature in its wisdom as
4083 the board of the connector to resolve rather than to do in

4084 legislation.

4085 And we have used a couple principles to develop what I
4086 would call minimum credible coverage. One is that, like any
4087 insurance, it ought to protect people from catastrophic costs
4088 so there are some maximum cost sharing elements to it. And
4089 the second is that because this is health care, which does
4090 differ in some important respects from other kinds of
4091 insurance, we actually require coverage up front of
4092 preventive care before a deductible and coverage with or
4093 without a deductible of a broad array of services, such as
4094 you would expect from coverage in your own health plan.

4095 Mr. {Pallone.} And how about the enforcement of the
4096 individual mandates? How do you do that?

4097 Mr. {Kingsdale.} The enforcement is through the tax
4098 code. The enforcement has been on the principle that it is
4099 good to have insurance and we want to help you get there, not
4100 got you. So the actual requirement went into effect July 1
4101 of 2007. As long as you had insurance by December 31 of
4102 2007, you did not pay a penalty. And if you did not have it,
4103 the penalty was pretty modest, \$219. That penalty goes up
4104 and becomes month by month as we move into 2008 and 2009.

4105 We have exceptions for religious beliefs, a much bigger
4106 exception for affordability. Of course, we have significant
4107 subsidies to low-income people who are not eligible for

4108 employer-sponsored insurance to help them afford it. And
4109 then we have a robust and generous appeals process for
4110 individual cases. So we bend over backwards to try to get
4111 you there rather than penalize you for it.

4112 Mr. {Pallone.} Let me see if I can get to these other
4113 three questions. How did the state decide what combination
4114 of premiums, deductibles, coinsurance, other out-of-pocket
4115 payments were affordable for individual and families?

4116 Mr. {Kingsdale.} That is the other very tricky
4117 question. Again the legislature asked the connector board to
4118 do that. And we kind of did a bookends approach. So at the
4119 bottom of the income scale, zero is affordable. And we
4120 defined that as 150 percent of federal poverty level. That
4121 is a fairly arbitrary decision but a gut check. And at
4122 median income--and ours is a wealthy state, so that's about
4123 550 percent of federal poverty--we said you have to have
4124 insurance. There is no exception for affordability.

4125 And in between, we basically do a scaled progressive
4126 schedule, but the principle underlying that is that by the
4127 time you get to 200 to 300 percent of federal poverty, so
4128 that would be an individual making \$21,000 to \$32,000 a year,
4129 where 80 percent of our citizens who get their insurance
4130 through employer-sponsored insurance, pay something like
4131 about \$100 on average per individual per month toward that.

4132 We thought that was a reasonable affordability basis. It had
4133 political equity. It would reduce or avoid crowd-out, and it
4134 seemed sort of gut check fair.

4135 Mr. {Pallone.} Now what about, have any studies been
4136 done to determine if rates of medical debts or bankruptcy
4137 have declined since Massachusetts achieved this near
4138 universal coverage?

4139 Mr. {Kingsdale.} That is a great question. I actually
4140 have asked several times to have such a study done. It is on
4141 somebody's project list, and I keep looking for outside
4142 research to do it. I am hopeful that the answer would be
4143 medical bankruptcies would go way down if you compare '08 to
4144 '06, but we have not done the study.

4145 Mr. {Pallone.} Let me just ask Ms. Pollitz, this issue
4146 again with the individual bankruptcy or debt. There was a
4147 study published by the Senate for Studying Health Systems
4148 Change that showed that 75 percent of those with medical debt
4149 in 2007 were actually insured. They had health care
4150 coverage, but they still had debt. Can you explain that? I
4151 mean this whole issue of people who actually have coverage
4152 going bankrupt or going seriously into debt.

4153 Ms. {Pollitz.} It can be a number of different factors.
4154 It could be that their policy doesn't cover all of the
4155 services that they need. May not have a prescription drug

4156 benefit, for example. If you have HIV and you don't have a
4157 prescription drug benefit or MS or something that has very
4158 expensive pharmaceutical need, then you could run up very
4159 high medical bills because those services aren't covered by
4160 your insurance.

4161 There may be caps on what is covered. You see policies
4162 that, you know, only pay so many mental health visits a year,
4163 and then, you know, a kid gets an eating disorder. Or a
4164 policy that, you know, caps total benefits at \$10,000 a year,
4165 and then you have a heart attack that costs \$100,000. So
4166 that can happen.

4167 Typically the literature on medical bankruptcy suggests
4168 though that it is not six-figure medical debt that is sinking
4169 families. On average, it is less than \$12,000 or \$15,000 in
4170 medical debt that will run a family over the limit and leave
4171 them to declare bankruptcy. And so we need to also look at
4172 cost sharing, and cost sharing that we might think of even as
4173 modest.

4174 One study that I cited in my testimony looked at medical
4175 copays in the range of \$6 to \$25, and what those meant for
4176 people with chronic conditions, asthma and diabetes and so
4177 forth. If you are needing to, you know, take medication
4178 several times a day every day for your entire life and you
4179 are always refilling these prescriptions, those little copays

4180 add up and become thousands of dollars. And if you add on to
4181 that, deductibles, copays for other medical care that you
4182 need, it really adds up remarkably quickly.

4183 Mr. {Pallone.} Okay, thank you. Mr. Deal.

4184 Mr. {Deal.} Thank you. I want to get my transparency
4185 question out of the way real quickly. I think most of you
4186 were in the audience and heard my description of the proposed
4187 legislation. And I will just go down the list. Do you
4188 generally believe that pricing transparency is something that
4189 we need to enhance in our system regardless of what that
4190 system may ultimately turn out to be? Ms. Kofman, start with
4191 you, and we will go down.

4192 Ms. {Kofman.} Thank you. I think it is critical when
4193 you have a private market to have transparency to provide
4194 consumers with useful information they can understand and use
4195 in making decisions. Right now, if you were shopping around,
4196 you couldn't get your policy ahead of time, the full
4197 contract. You can get a benefits description which may or
4198 may not be accurate.

4199 So transparency in my view includes everything, from how
4200 your contract, how your insurance will work when you need it,
4201 to choosing your provider and to making more informed choices
4202 from start to finish. Right now, that just does not exist in
4203 the private market.

4204 Mr. {Deal.} Dr. Kingsdale?

4205 Mr. {Kingsdale.} I would strongly endorse the idea of
4206 making prices and benefits and everything else transparent.
4207 In fact, in our programs, that is exactly what we do. I have
4208 been in the insurance business for over 25 years before
4209 becoming a bureaucrat. And so I am pretty realistic about
4210 how much is achievable. Price is absolutely--and other
4211 information--requisite to a functioning market, but so is
4212 competition.

4213 In Ms. Kofman's state and in most towns in my state, you
4214 don't have but one hospital, period. So you can know all you
4215 want about their prices. You really don't have a choice, and
4216 so it doesn't do you much good. So I am realistic about what
4217 you can do with it.

4218 Mr. {Deal.} But even in those situations where there is
4219 one hospital, who you are and who is paying the bill will
4220 determine what the price from that one hospital is because
4221 you have negotiated prices by government agencies. You have
4222 negotiated prices by private insurers, and generally, the
4223 ones that wind up in the bankruptcy court are the ones that
4224 don't have anything, and they are generally charged the
4225 highest price of all. Ms. Pollitz?

4226 Ms. {Pollitz.} I agree it is very important, and I
4227 commend you for your legislation. And I would just agree

4228 also that looking at all of the dimensions where transparency
4229 is necessary is important to do, and I hope that will be part
4230 of this effort as well.

4231 Mr. {Deal.} Thank you. Dr. Baicker?

4232 Ms. {Baicker.} Agreed. Transparency is a prerequisite
4233 for a well-functioning market, and the prices that we could
4234 publish now would be very useful. And even more useful would
4235 be building together bundles of prices that would really let
4236 people choose how much does it cost to have this condition
4237 taken care of by this group, not line by line. It is harder
4238 for them to aggregate, but you have to start with what is
4239 available.

4240 Mr. {Deal.} Mr. Haislmaier?

4241 Mr. {Haislmaier.} Yes, Congressman, as I mentioned in
4242 my remarks, I do agree with you on that. I would simply, as
4243 I mentioned in my remarks, encourage everyone to recognize
4244 that this is one very important piece of the puzzle, but it
4245 is not the only thing.

4246 To follow up on what Mr. Kingsdale was saying, the first
4247 question is what does it cost. The next question is what am
4248 I getting for my money. And that is where you start
4249 comparing the data on quality and outcome. So you always
4250 have to ask that first question before the second question
4251 gets asked. That is true.

4252 There are ways where you can do that not only in
4253 insurance but also in the provider side, which is really
4254 important. And I would also encourage folks to think not
4255 about the consumer versus the provider interaction but
4256 creating a common data set that all the insurers can use to
4257 act as the agents, as the experts, on behalf of the consumers
4258 in these decisions. And so a number of states are looking to
4259 do that.

4260 And I think the regrettable thing about it, if
4261 Massachusetts's mistake in the beginning was not to have a
4262 risk adjustor, their mistake in implementation was that the
4263 governor and this administration recently cut back the cost
4264 and quality commission that was designed to do that in the
4265 legislation.

4266 Mr. {Deal.} Could I follow up with less than three-
4267 quarters of a minute? Would you contrast the Utah situation
4268 with the Massachusetts? What improvements do you think they
4269 made that were important? What other changes, if any, would
4270 you suggest the state look into?

4271 Mr. {Haislmaier.} Well, I think the most striking thing
4272 about this--and you all as members of Congress will probably
4273 think of the very different politics of those states--but I
4274 would encourage you to realize that the most striking thing
4275 to me about this is when you rank the 50 states by the per

4276 capita cost of health care, Massachusetts is the single most
4277 expensive, and Utah is the absolutely cheapest. So those are
4278 vastly different in their health care systems.

4279 That said, Massachusetts had a large amount of money
4280 that it was giving to hospitals, public dollars, to pay for
4281 the uninsured, which is now being converted into buying those
4282 people insurance. Utah is on the other end. They have
4283 almost no public money going to insurance. So what they are
4284 doing is, while Massachusetts focused on expanding coverage
4285 by subsidizing low-income individuals with the dollars they
4286 already had and is only now rolling out the reforms to allow
4287 employers and unsubsidized workers to have a choice of
4288 coverage.

4289 Utah is going about it the opposite way. They are
4290 starting in the private market and then working towards the
4291 public side. That is my point is states are very different.
4292 Each can use the same things, but they have to find their own
4293 way and their own order for doing it that suits them.

4294 Mr. {Deal.} Thank you.

4295 Mr. {Pallone.} Thank you, Mr. Deal. Mr. Gonzalez.

4296 Mr. {Gonzalez.} Thank you very much, Mr. Chairman. I
4297 apologize to the witnesses. There are so many conflicting
4298 appointments today and another hearing of the judiciary. So
4299 I missed the testimony of the witnesses, except for the first

4300 witness, and I apologize. I may go over something that you
4301 all covered, and again do understand though that you have
4302 written statements in here. We have memos that are prepared
4303 by staff. We are going to have many hearings. Much of what
4304 you say here today, if not listened by individual members of
4305 the committee, believe me, these statements will be reviewed
4306 and may well serve as the basis for some of the memos in the
4307 future as we take on different panels.

4308 I will start with pronunciation. Is it Dr. Baicker?
4309 How would you pronounce that?

4310 Ms. {Baicker.} Baicker.

4311 Mr. {Gonzalez.} Baicker, okay.

4312 Ms. {Baicker.} Just spelled funny.

4313 Mr. {Gonzalez.} No, it is spelled in a very interesting
4314 way. But you were here for the witnesses statements by the
4315 previous panel, were you not?

4316 Ms. {Baicker.} Yes.

4317 Mr. {Gonzalez.} Okay, and in your own statement, and I
4318 couldn't agree with you more, and I am sure everyone that is
4319 here--in your statement, you indicate while there are many
4320 open questions in the design of the ideal system, with
4321 millions uninsured and rising costs threatening to swamp
4322 public and private budgets alike, we cannot afford to wait to
4323 act.

4324 Obviously this committee is going to move forward. This
4325 administration is going to move forward, but I think you
4326 highlight the biggest obstacle. And that is something I
4327 referred to earlier when I was quoting from the two authors
4328 from the ``Harvard Business Review'' in the article No Doubt,
4329 but we still face the same problem.

4330 How one balances these tradeoffs is likely driven as
4331 much by philosophy as economics. And any reform will involve
4332 tough choices between competing values, and I think that is
4333 the biggest problem. If we can just stick on the economics,
4334 the efficiency of what we do, we are well served. But you
4335 have already heard words like socialism, the Big Brother, and
4336 such. We need to get past that.

4337 So the question is do we move forward now? And we do
4338 so, we are not talking about a single payer. Is that
4339 correct? Now, there are many here that would like that, but
4340 I am just saying is it is going to be a public option. That
4341 is the way I like to think of it. And as we move forward
4342 again, leaving back ideologies, we have always said that we
4343 probably could form the most efficient system if the
4344 employer, which is the greatest purchaser of insurance, could
4345 lead that fight. That is what I had in the ``Harvard
4346 Review'' article, but that hasn't transpired in the past few
4347 years.

4348 So employers haven't been able to identify a better
4349 system. The consumer is ill equipped. Ms. Pollitz, thank
4350 you very much for your comment. It was very sad in that
4351 ``Time'' article about someone from San Antonio who had an
4352 insurance policy that was totally worthless when his kidneys
4353 failed. So you can't say that the consumer is equipped to
4354 deal with this. The health care providers aren't doing it,
4355 not the medical professions. As a matter of fact, we have
4356 the specialties that compete with one another depending on
4357 what is going to be covered and when and how much.

4358 So wouldn't it be appropriate for the federal
4359 government--and I know someone has suggested let every state
4360 do it individually. But what are your views today about
4361 where we are going and what we are going to be proposing as
4362 far as the federal government coming in and playing a major
4363 role? Yes, Dr. Baicker?

4364 Ms. {Baicker.} Thank you for the question. I think you
4365 have hit on so many important issues. One of the things I
4366 would like to pick up on is that there are things that we
4367 cannot expect a private market to do. Private markets are
4368 great at pooling risks, and there are regulatory requirements
4369 to ensure that they do so fairly and effectively. But we
4370 can't expect private markets to redistribute money from rich
4371 to poor or from people with low health risks, the healthy, to

4372 people with high health risks, the sick. That kind of
4373 redistribution of resources is fundamentally social insurance
4374 not private insurance. Social insurance need not be
4375 socialized. It could be done through the form of risk-
4376 adjusted vouchers where people with high health risks take
4377 extra money that they are given. Maybe particularly low
4378 income people get more generous risk-adjusted vouchers to
4379 ensure that they have access to the care that they need.

4380 That kind of redistribution happens a little bit now
4381 because of the way that we subsidize employer-provided health
4382 insurance. The way that we subsidize it encourages some
4383 risk-pooling in the employer market by encouraging high-risk
4384 people and low-risk people to stay in the same pool, whereas
4385 otherwise low-risk people might flee.

4386 Now, is that the most efficient way to do that kind of
4387 subsidization of high-risk people? There are probably other
4388 ways that we could accomplish that goal that might have
4389 better distributional implications while preserving what is
4390 good about the risk pooling that is occurring right now.

4391 Any reform going forward that is going to take care of
4392 our most vulnerable citizens is going to have a component of
4393 social insurance, and that is the way we should be thinking
4394 about that function, not trying to impose that on private
4395 markets that are ill equipped to do redistribution.

4396 Mr. {Gonzalez.} Thank you very much. I yield back, Mr.
4397 Chairman.

4398 Mr. {Pallone.} Thank you. Dr. Burgess.

4399 Mr. {Burgess.} Thank you, Mr. Chairman. Dr. Baicker,
4400 if we could just continue on that line for a moment. One of
4401 the things that was talked about in the fall campaign was
4402 using the best practices of the states that had high-risk
4403 pools and trying to construct or constructing rather a
4404 mechanism for dealing with individuals who had conditions of
4405 medical fragility that would apply to their unique situation
4406 without changing the landscape for everyone else. Is that
4407 still a realistic possibility in the environment that we find
4408 ourselves today, taking the best practices from the states
4409 that have high-risk pools?

4410 Ms. {Baicker.} I think we certainly want to learn from
4411 the diversity of state experiences, and some states have
4412 high-risk pools that are functioning much better than others.
4413 And there are some general principles we can draw from that,
4414 more broadly subsidizing the high-risk pools rather than
4415 trying to subsidize them from narrow tax bases, for example,
4416 seems to be a more productive way of subsidizing them. Again
4417 that is falling under the role of social insurance where you
4418 are explicitly trying to redistribute some money to high-risk
4419 people who are otherwise uninsured.

4420 I would think the first goal of a reform would be to get
4421 people insured as early as possible while they are healthy so
4422 they can invest in their health so they get the most
4423 efficient they can. And a system that is designed to
4424 minimize the number of people in that condition in the first
4425 place could spread dollars a lot further. Then I think it
4426 would be great to learn from best practices at the state
4427 level to deal with people who fall through the cracks and to
4428 ensure that there is a broad enough subsidization that it
4429 doesn't drive a cycle that leads to more health people being
4430 uninsured for example.

4431 Mr. {Burgess.} All right, thank you. Dr. Kingsdale, on
4432 the Massachusetts experience, do you have a figure on the
4433 number of people who are paying the fine rather than buying
4434 the insurance?

4435 Mr. {Kingsdale.} We have a lagging indicator because
4436 you file in April, of course, for the year before, and some
4437 people get extensions. So we have it only for 2007, and that
4438 was about 100,000 people--

4439 Mr. {Burgess.} And so you will--

4440 Mr. {Kingsdale.} --about 1.5 percent of our population.

4441 Mr. {Burgess.} And then you will have comparable data
4442 that you will generate this--in your file period, April 15,
4443 like the federal income tax?

4444 Mr. {Kingsdale.} Right, although 10 percent extend
4445 until October, but we will have pretty good data.

4446 Mr. {Burgess.} Yeah, I do that too.

4447 Mr. {Kingsdale.} Got to try that.

4448 Mr. {Burgess.} Mr. Haislmaier, if I could ask you on
4449 the--you pointed out that a lot of things are being done by
4450 the states now, that they have a great deal of flexibility.
4451 In fact, I think we gave them a great deal of flexibility in
4452 the Deficit Reduction Act in 2005. Ezekiel Emmanuel writing
4453 with John Lyndon in the ``Journal of American Medical
4454 Association'' in October of this past year alluded to that
4455 and said the one thing the states cannot do is to alter the
4456 federal tax code, that it is not within their power to do
4457 that. So could you speak to that?

4458 Mr. {Haislmaier.} Sure.

4459 Mr. {Burgess.} We heard a lot about taxing health
4460 benefits during the fall campaign. It appeared to me at the
4461 time to be something that was disfavored by the parties that
4462 won, but now it seems to be coming back in vogue. And I
4463 wonder if you might just address that.

4464 Mr. {Haislmaier.} Well, I think it all depends on what
4465 you do with the money once you have taxed them. Most of the
4466 proposals I am familiar with, and I worked on about eight
4467 different ones over the years from everybody from Mr. Army to

4468 Mr. McDermott on changing the tax treatment in Congress,
4469 would redistribute the money in the form of new tax credits
4470 to address some of the equity issues that were addressed
4471 earlier.

4472 The illustration would be the unsubsidized commonwealth
4473 choice plans that are now being rolled out in the Connector
4474 in Massachusetts and is envisioned in other states whereby an
4475 employer would say look, instead of offering you a group
4476 plan, I am going to take you down to the Connector and you
4477 will each, as employees, have a choice of that menu of plans
4478 that they have on offer. And you pick what is best for you.
4479 It is all guaranteed issue. If you leave me, you are still
4480 in the system. You still have your insurance. You take it
4481 with you, et cetera.

4482 That is structured in a way that under federal employee
4483 benefit law, it qualifies as employer-sponsored insurance and
4484 therefore qualifies for favorable tax treatment. The problem
4485 becomes that that favorable tax treatment is essentially the
4486 deduction against income and payroll tax. So if you are a
4487 lower wage worker who pays no income tax, that is worth 15
4488 cents on the dollar to you. That is your payroll tax. If
4489 you pay the employer/employee share 15 cent at payroll plus
4490 you are in the 15 percent income bracket, it is now 30 cents
4491 on the dollar up to like 50 cents on the dollar for somebody

4492 who is maybe making \$100,000 in the 28 percent bracket, et
4493 cetera, or the 31 percent.

4494 So the idea of tax reform is to change that to
4495 redistribute the money more equitably. The state can only
4496 maximize their citizens' access to those federal benefits.
4497 They can't change the federal benefits. There are other
4498 places in federal law where you could make changes that would
4499 aid the states.

4500 Mr. {Burgess.} Just one quick question. As I
4501 understand it right now, there is not a public option plan in
4502 the federal employee health--

4503 Mr. {Haislmaier.} No, there is no public option.

4504 Mr. {Burgess.} Would there be an advantage to putting a
4505 public option plan on the--

4506 Mr. {Haislmaier.} Well, my approach to the public
4507 option plan is I--you know, it strikes me as one of these fad
4508 and silver bullet things that go around as I talked about
4509 earlier. I look at it this way. No matter how you cut it,
4510 the government always sets the rules.

4511 Now, you in Congress have a set of issues because some
4512 of the rules are set at the federal level like this federal
4513 employee benefit law, Inirisa, HIPAA, COBRA, tax treatment of
4514 health care, the Medicare/Medicaid program. Okay, but then
4515 other rules like licensure of providers, regulation of

4516 insurance is done at the state level. So your issue is which
4517 one is going to set which set of rules.

4518 But beyond that, you then have this issue, whether it is
4519 federal or state is, you know, if competition is going to
4520 work, everybody competing has to be on the same set of rules,
4521 right? Okay, now you get to point three, which is okay, can
4522 the entity that is inherently the rule setter field the team
4523 in the competition and have that fair? I mean, you know, is
4524 the public plan going to have to meet the solvency
4525 requirements their a private insurer would have to meet in
4526 Ms. Kofman's regulations? Are they going to have to have
4527 prompt pay laws? Are they going to have to have, you know,
4528 can you sue them, or is sovereign immunity going to prevent
4529 you from suing them? When they deal with doctors, is it
4530 purely on a contractual basis, or is it like Medicare where
4531 if the doctor does something you don't like, you can say it
4532 is criminal because it is fraud.

4533 These are all questions you have to work out, and
4534 depending on how you answer them will depend on whether it
4535 will work well.

4536 Mr. {Pallone.} We have to move on here. Thank you.

4537 Mr. {Burgess.} To coin a phrase.

4538 Mr. {Pallone.} Ms. Castor.

4539 Ms. {Castor.} Thank you, Mr. Chairman, and thank you to

4540 the panel. Your testimony has been very thoughtful, and I
4541 was glad that you raised the value of the premium dollar for
4542 individual health coverage because I am very skeptical in the
4543 individual market that consumers are getting the value of the
4544 health benefits they need. And I have read testimony and
4545 understand a lot of that dollar that consumers pay is going
4546 for other purposes other than the health of that individual.

4547 And Ms. Kofman testified that in Maine, insurer
4548 administrative expenses have more than doubled in the past
4549 eight years. This is at the same time when all across the
4550 health care spectrum, the premiums are going way up, and what
4551 you receive, what a family receives, just isn't what it used
4552 to be.

4553 And you also noted that in the past three years, the
4554 state's largest insurance carrier has declared \$152 million
4555 in dividends. So as regulators and experts in the individual
4556 health care market, tell me, on average, how much of the
4557 individual health insurance premium dollar is spent on
4558 covered medical benefits, and how much is spent on marketing
4559 and administration including high executive compensation and
4560 profit? And then how does this percentage or medical loss
4561 ratio compare to the medical loss ratio in employer group
4562 health insurance products? And what explains that
4563 difference? And what do you recommend? How can families and

4564 consumers get a better deal? Why don't you start?

4565 Ms. {Kofman.} Thank you very much for your question. I
4566 apologize for my voice. I am trying to get over a cold. In
4567 Maine we have, excuse me, 65 percent medical loss ratio
4568 requirements. We have two companies in the individual
4569 market. One was not meeting the 65 percent loss ratio. They
4570 paid out, I think, 50 some cents on every dollar they took in
4571 for medical. And so exercising my authority as a state
4572 regulator, I ended up requiring them to refund the extra
4573 premiums they collected, and I also fined them \$1 million for
4574 violating the state law.

4575 The other major carrier, which is the majority of our
4576 market, they pretty much pay out over 90 cents on the dollar
4577 that they take in in medical. Now, there has been a whole
4578 lot of discussion about the cost of guaranteed issue and
4579 adjusted community rating requirements, those protections
4580 that allow sick people to access the private market. What
4581 that means is a lot of what the carriers take in, they do pay
4582 out in medical claims, but they also achieve healthy profits
4583 from being in the private market.

4584 Earlier, you heard that the private insurance market
4585 isn't really set up in a way where carriers can assume too
4586 much risk. I would say if you are going to have a private
4587 market where insurance companies are allowed to profit, it is

4588 equitable and fair for them to take on risk, and we shouldn't
4589 expect taxpayers to pay for the sick while insurance
4590 companies are very profitable and make millions and billions
4591 of dollars in the industry. So if you are going to have a
4592 private system, the carriers have to assume the risks, and
4593 the taxpayers should not bear the burden.

4594 Mr. {Kingsdale.} If I could add to that, I think it is-
4595 -to your question about how much administrative costs in a
4596 non-group market. It is highly variable with the rules that
4597 are set up. So in Commonwealth Care, our subsidized program,
4598 this is really kind of individual insurance. Individuals
4599 sign up. Their administrative costs run about 8 percent. In
4600 the non-group market more broadly in Massachusetts, they
4601 probably run twice that, maybe 12 percent, something like
4602 that, maybe not twice.

4603 In California, I am told, brokers earn 10 percent just
4604 for their services. So it depends very much market by market
4605 what the market rules are. And, of course, one of the great
4606 things, potentials, about the connector--remember my 20 to
4607 30-minute shopping. It is all on web--is we can take the
4608 distribution costs of non-group insurance because they are
4609 very, very high even without large commissions. In an
4610 unorganized market, they are just very high. There are no
4611 scale economies. It is a one-on-one, hand-to-hand combat

4612 kind of situation to sell a policy and explain it. We can
4613 take those way down. And if you add scale economies with, on
4614 a national level, millions of people buying this way, you are
4615 talking about a couple of percentage rather than 10, 15
4616 percent. But it does depend on the rules and how you have
4617 structured the market.

4618 Mr. {Haislmaier.} Ms. Castor, could I comment on that
4619 as well, or do you--

4620 Mr. {Pallone.} I am sorry. You can comment. Sure, go
4621 ahead.

4622 Mr. {Haislmaier.} I am sorry. This question comes up
4623 at the state level a fair amount, and I just would want to
4624 make the observation I have suggested to states that what
4625 they can do, and, in fact, Jon might be able to do this in
4626 connector too, is to simply publish, apropos of the
4627 transparency, the loss ratios. And you publish what last
4628 year each company for each plan paid out in claims and what
4629 they retained for administration, profit, et cetera with the
4630 proviso that you let them buy it down. So in other words,
4631 the dollar premium that was either paid out in claims or
4632 refunded to the policyholders.

4633 Now, in that kind of a world, imagine you have two plans
4634 that are pretty much the same and cover the same benefits, et
4635 cetera, but one does a better job of managing care than the

4636 other, okay. And the one that does the better job of
4637 managing care costs \$4,000 instead of \$5,000, but to get that
4638 care managed, their loss ratio is 70 percent not 80 percent
4639 because they had to spend more in administration. Which
4640 would you buy? Would you buy the one that spent more in
4641 administration but produced the \$4,000 premium because they
4642 did a better job working with providers to manage care?
4643 Would you buy the plan that was \$5,000 but paid 80 percent
4644 out in benefits? If you put the information out, people can
4645 make those decisions would be my suggestion.

4646 Mr. {Pallone.} Thank you. Mr. Gingrey.

4647 Mr. {Gingrey.} Thank you, Mr. Chairman. Dr. Kingsdale,
4648 in regard to the Commonwealth health insurance connector, I
4649 was curious to know in comparing the Commonwealth Care versus
4650 the Commonwealth Choice, what has been the experience in
4651 regard to what consumers are choosing? Maybe that was in
4652 your written testimony. I did read it, but it was the wee
4653 hours this morning. But what is the breakdown at this point?

4654 Mr. {Kingsdale.} Yeah, there are two very distinct
4655 programs so it is going to be hard for me to, I think, answer
4656 your question in a way that is going to satisfy probably the
4657 intent. So the four health plans that are available--and now
4658 we just could open that up to competition because they had
4659 restrictions in the original legislation. So we are adding a

4660 fifth, the first new entrant, major new entrant into the
4661 insurance business in Massachusetts in decades. But those
4662 four/soon five all basically serve Medicaid and lower income
4663 folks. And while two of them also participate in the
4664 unsubsidized program that has--

4665 Mr. {Gingrey.} So your Commonwealth Care is the
4666 subsidized program?

4667 Mr. {Kingsdale.} Right, and the Commonwealth Choice is
4668 unsubsidized. That is dominated by commercial insurers who
4669 are not in the low-income Medicare--

4670 Mr. {Gingrey.} So they really don't--

4671 Mr. {Kingsdale.} They are really very separate.

4672 Mr. {Gingrey.} The patients or the consumers don't have
4673 a choice. It depends on their income status.

4674 Mr. {Kingsdale.} Right.

4675 Mr. {Gingrey.} If they need a subsidy, then their
4676 choice is care.

4677 Mr. {Kingsdale.} Right.

4678 Mr. {Gingrey.} If they don't need a subsidy, then their
4679 choice is choice.

4680 Mr. {Kingsdale.} I will take a stab at one thing that
4681 might be helpful, which is because the transparency and
4682 because the price differential, the premium differential is
4683 100 percent borne by the individual making the choice, there

4684 is disproportionately large purchase of lower-priced plans
4685 even though the lower-priced plans may have by far much less
4686 brand name recognition than the higher priced plan offering
4687 the same.

4688 Mr. {Gingrey.} Well, let me ask you this follow-up. In
4689 regard to that, in the Care plan, the subsidized plan, I
4690 guess physician fees, reimbursement rates for provider care
4691 is set. And are you finding that the many physicians, the
4692 acceptable rate of the Care plan in the commonwealth is
4693 pretty high?

4694 Mr. {Kingsdale.} Well, yes, and that is--

4695 Mr. {Gingrey.} Are you running into problems with that?

4696 Mr. {Kingsdale.} Not really, and that is part of an
4697 ethos of shared responsibility. There is tremendous support
4698 for this program among physicians, hospitals, insurers,
4699 employers, et cetera. You know, all but 2 legislators, all
4700 but 2 of 190 voted for the thing.

4701 But Medicaid MCOs that serve that lower income
4702 population, Commonwealth Care, while the fees are not set, so
4703 they can get negotiated up, kind of the reference point, the
4704 starting point that people have in mind when they start those
4705 negotiations are Medicaid fees. And they say you are going
4706 to pay us 10 percent more than that. As opposed to the
4707 commercial side where they might say we are starting at 150

4708 percent of Medicare.

4709 Mr. {Gingrey.} Right.

4710 Mr. {Kingsdale.} So it is a bifurcated set of
4711 negotiations.

4712 Mr. {Gingrey.} Well, the reason I asked that question,
4713 of course, as we go forward and we are looking at all the
4714 options and hearing from all the experts in regard to, you
4715 know, the federal exchange connector, if you will, and the
4716 public option plan. And I just wonder if physicians are not
4717 forced, if they take any patients within the exchange that
4718 they would also have to take the public option.

4719 But if not and those fees are set so low, then you are
4720 going to have a lot of resistance, a lot of push back. And
4721 again what we are saying is what good is that card if there
4722 is no doctor that is going to accept the public option. So
4723 that is a concern of mine, other than the additional concern
4724 of the crowd out.

4725 Let me shift real quickly to--is it--

4726 Mr. {Haislmaier.} Haislmaier.

4727 Mr. {Gingrey.} I have already messed up once today on
4728 pronouncing one of my colleague's name. Doctor, I wanted to
4729 ask you on page three of your testimony, you speak at some
4730 length about market reforms that would ``realign insurer
4731 incentives away from avoiding risk and toward maximizing

4732 value'' and you cite in your testimony the need for risk-
4733 adjusted mechanisms to ensure the market works smoothly and
4734 fairly for all insurers and policy holders.

4735 It would seem to me that these market reforms that you
4736 talk about in your written testimony might address some of
4737 the major breakdowns in health care today without requiring
4738 government-controlled care. And I would like in the 15
4739 seconds left, could you elaborate on these risk-adjusted
4740 mechanisms a little bit more if the chairman would bear with
4741 me?

4742 Mr. {Haislmaier.} Yes, sir. Very simply--and I
4743 reference two papers in the footnotes in this testimony that
4744 are on our website that I wrote on the subject if you want to
4745 go into it in more length.

4746 But essentially in a market that is underwritten where
4747 the insurer could turn you away, okay, what we have created
4748 is a high-risk pool that says well, you can be guaranteed
4749 issue into there. Okay, so the person who is sick gets sent
4750 over there, all right. If you have a market where the
4751 insurers can't turn you away, as we are talking about in the
4752 employer group market when you go to the connector or if you
4753 would expand guaranteed issue to the individuals, then you
4754 can't send the sick person off there.

4755 So what you do is you create essentially the same

4756 mechanism. It is just the insurers get in the room together
4757 and they put in the pot all their claims. I have five
4758 diabetics, you have three cancer patients, and we are going
4759 to sort it out and do it in a fair way.

4760 Now there are many different ways to do that, but that
4761 is essentially the concept behind it. And my point is for
4762 the market to work well so that the insurer can say hey, you
4763 know, I do a good job of treating diabetes. I can help
4764 coordinate your care so you get better results at a lower
4765 price, and then they get all the diabetics and somebody else
4766 gets all the cancer patients. Well, they can work it out in
4767 the back room on their own. That is what a risk-adjustor
4768 pool does okay, and it spreads the cost among everybody else.
4769 As opposed to saying well, you are sick, go there, and then
4770 we are going to spread that cost over everybody else.

4771 So it is the same concept. It just depends on the
4772 market you have. Again the papers discuss it in more length.

4773 Mr. {Pallone.} Thank you. I am going to have to stop
4774 you because they are telling us we are going to have votes,
4775 and I want to get the last two members in here. Ms. Capps.

4776 Ms. {Capps.} I am sorry. Thank you very much, and I
4777 just got a tip, but I also have some questions I want to ask.
4778 This has been a very interesting panel, and I appreciate your
4779 contributions, each one of you. I will single out two people

4780 because five minutes goes very quickly. But I understand,
4781 Ms. Pollitz, before I ask you my question, which I am very
4782 interested in your response to, that you never got to weigh
4783 in on the risk adjustment or risk insurance.

4784 Ms. {Pollitz.} Well, I didn't think I was asked but--

4785 Ms. {Capps.} No, that is why I am giving you a chance
4786 to if you could briefly do it.

4787 Ms. {Pollitz.} Sure, I think reinsurance is a mechanism
4788 that has been tried on a voluntary basis in a lot of
4789 insurance markets. And public reinsurance has been tried in
4790 a few states as well. It is simply another way to subsidize
4791 health insurance at the end of the day if it is public
4792 reinsurance. Instead of subsidizing the premiums, which come
4793 regularly on the first of every month, you need to sort of
4794 reach in and find somehow the high-cost claims or the high-
4795 cost patients.

4796 So it, I think, can achieve the same thing. It is more
4797 complicated. There are many more transactions involved, and
4798 at the end of the day, you need to make sure that if the end
4799 result is to subsidize the premiums, if that is what you
4800 want, to have the premiums reduced, then you need to have
4801 very, very good transparency to make sure that all of those
4802 savings from the reinsurance actually find their way back
4803 into reducing the premiums. Otherwise, you know, kind of

4804 like we are having with AIG now.

4805 Ms. {Capps.} I hear you.

4806 Ms. {Pollitz.} You are putting a bailout in, and are
4807 you not getting the result that you want.

4808 Ms. {Capps.} Okay, thank you. Now, could I ask you the
4809 question that I had intended? And you will understand why
4810 when I tell you where I am coming from. I am hesitant about
4811 proposals that suggest that people should just purchase
4812 insurance in the individual market, whichever state they are
4813 from or wherever they are, because there are states like
4814 California that offer much stronger minimum protection for
4815 insurance.

4816 For example, California mandates screening for
4817 osteoporosis while most other states do not. That happens to
4818 be a topic I am personally very interested in. California
4819 also requires private insurers to cover treatment for eating
4820 disorders. More than half of the states do not. So that
4821 would make a huge difference to Californians if they got
4822 their insurance in another state that then refused to cover--
4823 and they came to California and refused to cover that.
4824 Wouldn't a public option be able to account for variances in
4825 state protections and be more consumer friendly? Also
4826 couldn't a public plan be formulated in a way that protects
4827 the strongest minimum coverage provided to individuals so

4828 that you would get the benefit from living in a state where
4829 these things were mandated?

4830 Ms. {Pollitz.} It is absolutely up to the Congress to
4831 determine whether you want to set these standards at the
4832 lowest or the highest common denominator or somewhere in
4833 between. So you absolutely could create a public program
4834 that provides for comprehensive coverage so that people get
4835 the care they need everywhere. And I would defer to Mila on
4836 the other issues about selling coverage.

4837 Ms. {Capps.} Right.

4838 Ms. {Pollitz.} In addition to the concerns about not
4839 being able to access benefits, I think there are real
4840 questions about--and I have enormous respect for Mila--but
4841 whether she has the resources to enforce against a plan in
4842 California. Or a resident of her state who would buy 3,000
4843 miles away and then get into trouble--

4844 Ms. {Capps.} Right.

4845 Ms. {Pollitz.} --I think would be very difficult.

4846 Ms. {Capps.} And some of us in states like California
4847 are worried about the opposite, but I could see it going both
4848 ways. For example, people who worked so hard in California
4849 to do the things like what I have just mentioned. This would
4850 be a huge step backward if we would be forced into what we
4851 would consider a step backward.

4852 And I am going to need a little extra time, Mr.
4853 Chairman, because I kind of did something else too. But
4854 because, Ms. Kofman, I am really interested. You can speak
4855 to this one issue if you would like to. But I wanted to
4856 learn more about programs that you have been able to create,
4857 which bridge the gap between Medicaid-covered individuals and
4858 those who are uninsured but don't quite qualify for Medicaid.

4859 For example, I will tell you where I am coming from in
4860 my district. In fact, in each of the three counties I
4861 represent, we have seen some very innovative proposals such
4862 as county-organized health systems which better capture all
4863 Medicaid eligible individuals in using a sort of managed care
4864 model, non-profit, but a locally organized one.

4865 And also then there is another program in Ventura
4866 County, which refers to the person I acknowledged this
4867 morning in my opening statement. Because she lived in
4868 Ventura County, those who are uninsured but don't qualify for
4869 MediCal or Medicaid in Ventura County have access to another
4870 program. And they have seen such a dramatic decline in
4871 emergency room visits for non-urgent care as a result. And
4872 that is the kind of outcomes we should strive for because
4873 they can put that money back into the system and help extend
4874 it to more individuals.

4875 The reason it works--and this is what I would like you

4876 to verify or add to--is because it is public-public
4877 partnership whereby the local government can provide the
4878 innovation and creativity in creating a system that works
4879 best for their particular population.

4880 Can you talk--I know it is briefly now--about how have
4881 you done this? How have you managed to tailor a plan that
4882 Maine really benefits from?

4883 Ms. {Kofman.} We have a slightly different partnership,
4884 public-private partnership which I call a bridge program. It
4885 is called Deargo Choice. Right now, due to funding
4886 challenges, it is not open for new enrollment. But
4887 essentially the state helps to pay for the premiums. There
4888 is a private insurance company that provides the coverage,
4889 but it is a Deargo agency that negotiates the benefits, the
4890 price, and people who really can't afford the private
4891 coverage but are working and make too much money to qualify
4892 for the public insurance program, that is the place where
4893 they can get coverage where there is a private payer that
4894 pays their medical bills. And the state helps them with the
4895 premiums.

4896 The program has served over 23,000 people, both small
4897 business workers, their families, as well as individuals.
4898 Unfortunately because of funding challenges, it hasn't been
4899 open for new enrollment. And as premiums have gone up even

4900 slightly in that program last year--I believe it was 11
4901 percent, which in our market is slight.

4902 I can tell you that the major carrier recently came in
4903 with a premium increase of 40 percent, and actually that was
4904 for their consumer-driven product higher than the other
4905 products they sell. So 11 percent premium increase for the
4906 Deargo Choice is not as high as the rest of the market is
4907 asking for. But that force some people to leave that program
4908 because they just couldn't afford even the 11 percent due to
4909 limited incomes. Their wages have not gone up, and
4910 everything else has gone up, the price of food, gas, energy.
4911 So it has been really different absent a strong and real
4912 financing mechanism.

4913 There has been a lot of talk here that states could do
4914 this. If we were able to address--

4915 Mr. {Pallone.} We are going to have to--I am going to
4916 have to cut your short because we have one more member, and
4917 we have three votes so--

4918 Ms. {Capps.} Well, could she finish her sentence? I
4919 just wanted to hear--

4920 Mr. {Pallone.} Sure, go ahead.

4921 Ms. {Kofman.} States need help. If we were able to
4922 tackle the health care crisis, we would have done it. We
4923 want to do it. We cannot do it alone despite Ed's comments

4924 earlier. We need help, and we want to be your partners in
4925 tackling the health care crisis.

4926 Mr. {Pallone.} Okay.

4927 Ms. {Capps.} Well, to make this work, there are times
4928 when the federal government should really shift the balance a
4929 little bit more when states are having a hard time. Or that
4930 is one of the ways that it could survive. Thank you.

4931 Mr. {Pallone.} Thank you. Mr. Shadegg.

4932 Mr. {Shadegg.} Thank you, Mr. Chairman. Ms. Kofman, I
4933 just want to make sure. Did I hear you earlier say that
4934 there are only two carriers in the individual market in
4935 Maine?

4936 Ms. {Kofman.} Actively selling. That is correct.

4937 Mr. {Shadegg.} Tragically I think that is the situation
4938 in most states where people forced into the individual market
4939 have almost no choice whatsoever. A public plan which they
4940 could buy as an individual would be another option for them
4941 that would give them at least one other choice? Is that what
4942 you understand?

4943 Ms. {Kofman.} Yeah, people want real choices. To the
4944 extent that the public plan offers good coverage, adequate
4945 coverage that pays for you when you are sick, that is a real
4946 new option that people would benefit from. I talk to
4947 providers and individuals alike, and people are losing faith

4948 in the private market.

4949 There is this perception out there because the profits
4950 have been so high that claims decisions are not made in the
4951 best interest of the insured person. And I can tell you they
4952 are, but the perception there is not the reality, and I think
4953 many people would choose the public option because of those
4954 reasons. And I think the public option would give--

4955 Mr. {Shadegg.} I understand that.

4956 Ms. {Kofman.} --real competition for the private plans
4957 out there.

4958 Mr. {Shadegg.} Well, I believe that there have been
4959 instances where benefits have not been paid in the interest
4960 of the beneficiaries. Indeed, I conducted a long campaign
4961 against HMOs who I think were denying care to try to make
4962 profit. But we have people forced into the individual market
4963 often because of the tax treatment. Some people can get
4964 health care inexpensively through their employer on taxpayer
4965 favored basis. But if you go buy it in the individual
4966 market, you pay with after-tax dollars, making it much more
4967 expensive.

4968 Would you then favor mechanisms that would create other
4969 group purchasing options so that people could pool through a
4970 mechanism other than their employer?

4971 Ms. {Kofman.} I think we need a more equitable way to

4972 help people buy coverage, and people shouldn't be
4973 disadvantaged because their employer doesn't offer--

4974 Mr. {Shadegg.} I couldn't agree more.

4975 Ms. {Kofman.} --in the individual market. I think in
4976 terms of pooling, the price of pooling--pooling in itself
4977 doesn't get you anything unless there are real protections
4978 and oversight around pooling. So I would be very supportive
4979 of increasing and incentivizing more pooling as long as there
4980 are real protections for people who want to be in those
4981 pools.

4982 Mr. {Shadegg.} Mr. Haislmaier, high-risk pools. As I
4983 understand it, you just tried to explain or discussed with
4984 Dr. Burgess the issue--or maybe it was with Dr. Gingrey--
4985 people who are high cost can either be put in a high-risk
4986 pool or kept within the existing pool of insurers in a given
4987 state. Is that what the paper you discussed addressed?

4988 Mr. {Haislmaier.} Basically what you are doing is you
4989 have a--both of them, a high-risk pool or a risk-transfer
4990 pool are mechanisms for pooling on a market-wide basis. So
4991 you start at the individual insurer level where they say
4992 well, I get some sick people and some healthy people, and
4993 there is a cross-subsidization of the sick by the healthy.

4994 The next step is to say well, we are going to take all
4995 the insurers in the market, and we are going to do this same

4996 sort of cross subsidization for the whole market, defined
4997 however you want, a region, a state, whatever. But for
4998 purposes of this probably a state.

4999 Now, at that point, you have a decision. If the
5000 insurance is provided to the individual on the basis of
5001 underwriting where the insurer--a seller-driven market where
5002 the insurer can refuse to offer coverage, then what you do is
5003 you send that sick individual over to a high-risk pool. The
5004 excess cost is then passed back onto all those people you
5005 did--

5006 Mr. {Shadegg.} I wrote the state high-risk pool.

5007 Mr. {Haislmaier.} Right.

5008 Mr. {Shadegg.} What is encouraging--

5009 Mr. {Haislmaier.} So all I am saying is a risk-transfer
5010 pool is simply the same mechanism, but it is for a market
5011 where it is guaranteed issue and you can't send the
5012 individual off. You take the individual, you send the claim
5013 off.

5014 Mr. {Shadegg.} Let me change topics. Ms. Capps just
5015 talked about the fact that she loved the California mandates.
5016 She likes certain things that are mandated under California
5017 law for coverage. You mentioned earlier one of your concerns
5018 about a so-called public plan--and I think you are right. It
5019 is the current system in vogue or the idea in vogue--would be

5020 well, what does it cover, what doesn't it cover. I think you
5021 also touched upon a point that I think I touched upon in my
5022 questioning earlier. And that is if the government offers a
5023 public plan and the government also sets the rules for that
5024 plan and for all the other plans, isn't the government both a
5025 player in the game and the referee of the game? And I would
5026 like to see if you do agree with that point and if you would
5027 expand upon it.

5028 Mr. {Haislmaier.} Well, very simply, the last point,
5029 the government will always be the rule setter. So in a
5030 state, any state right now, they could set up a public plan
5031 in competition. I mean Massachusetts could do it with the
5032 connector if they wanted to, okay. You will always have that
5033 question of do they play by exactly the same rules because
5034 what we know is that when you have different rules, then you
5035 will have market segmentation.

5036 We have seen this in Maryland. We have seen this--I
5037 mean I have just been dealing with Washington state where
5038 they allowed association plans one set of rules for the small
5039 group market and commercial insurers another set of rules,
5040 and it has created all sorts of problems. So the first rule,
5041 whether it is a public or private plan or two groups of
5042 private plans, is is everybody playing on the same rules.

5043 So that is one level of questions that you would

5044 confront regardless at any state. Now, if you are at the
5045 federal level, you have all those questions, but now you have
5046 an additional set of questions, and the additional set of
5047 questions is will the 50 states have different standards. As
5048 Representative Capps pointed out, whose standards are we
5049 going to apply nationally? Okay, so you have all the same
5050 set of questions you have to deal with, plus you have another
5051 set.

5052 Mr. {Pallone.} We are going to have to--

5053 Mr. {Shadegg.} Well, just, Dr. Kingsdale, you said
5054 there are 100,000 people who have not joined or not paid in,
5055 they are simply unenrolled. In the first year, right. That
5056 was going back to '07. What does the system do for or about
5057 them? How do they get care?

5058 Mr. {Pallone.} Quickly because we have to vote.

5059 Mr. {Kingsdale.} Okay, well if they are low income,
5060 they wouldn't be subject to that penalty. So they would
5061 basically be self-pay. They are part of the 2.5 percent that
5062 we haven't insured.

5063 Mr. {Shadegg.} Okay, and--

5064 Mr. {Pallone.} All right. Well, we are going to run
5065 out of time if we want to vote. Thank you all. Again this
5066 has been very helpful in our efforts to try to put together
5067 legislation. And you may get some additional questions from

5068 members that you can respond to in writing. The clerk will
5069 notify you of that. But without objection, this meeting of
5070 the subcommittee is adjourned. Thank you.

5071 [Whereupon, at 2:48 p.m., the subcommittee was
5072 adjourned.]