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DRAFT HEALTH REFORM LEGISLATION

TUESDAY, JUNE 23, 2009

House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:39 a.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Green, Degette, Capps, Schakowsky, Baldwin, Matheson, Barrow, Matsui, Christensen, Castor, Sarbanes, Murphy of Connecticut, Space, Sutton, Deal, Whitfield, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff Present: Karen Nelson, Deputy Committee Staff Director for Health; Purvee Kempf, Counsel; Sarah, Despres, Counsel; Jack Ebeler, Senior Advisor on Health Policy; Robert Clark, Policy

Advisor; Tim Gronniger, Professional Staff Member; Stephen Cha, Professional Staff Member; Allison Corr, Special Assistant; Alvin Banks, Special Assistant; Jon Donenberg, Fellow; Camille Sealy, Fellow; Karen Lightfoot, Communications Director, Senior Policy Advisor; Caren Auchman, Communications Associate; Lindsay Vidal, Special Assistant; Earley Green, Chief Clerk; Jen Berenholz, Deputy Clerk; Miriam Edelman, Special Assistant; Ryan Long, Minority Chief Health Counsel; Chad Grant, Minority Health Counsel; Brandon Clark, Minority Professional Staff; and Aarti Shah, Minority Health Counsel.

Mr. Pallone. The hearing of the Health Subcommittee is called to order. And I will start by recognizing myself for an opening statement.

Today we are meeting to examine a discussion draft on comprehensive health reform. The subcommittee will also convene to receive testimony tomorrow and Thursday.

In addition, the full committee will meet tomorrow morning to hear from the Secretary of Health and Human Services, Kathleen Sebelius.

Comprehensive health reform is a goal that has alluded reformers, Democrats and Republican alike, for over a century. As a result, the problems that plague our healthcare system have continued to grow worse. The ranks of the uninsured continue to swell. The cost of insurance and medical care continues to skyrocket. The quality of care delivered becomes more and more erratic.

After years of failing to address these problems, we find ourselves in a situation where our broken health care system is a clear and present danger, in my opinion, to the economic health of this nation. Government budgets are being overrun by the mounting costs of health care, crowding out funding for other key services. American businesses are disadvantaged as they try to compete in the global marketplace, and American families are being driven into bankruptcy by ballooning medical debt or forgoing critical

care altogether.

President Obama understands that these problems require urgent action, which is why he has called upon Congress to pass comprehensive health reform legislation this year. And health reform is an issue that generates great interest and controversy. That certainly we know. And while we may not all agree on a common solution, I think we also know that we can't let this opportunity pass us by.

Maintaining the status quo and allowing these problems to continue to fester is no longer an option. Nor can we simply resign ourselves to making marginal improvements as we have done in the past. The time has come for comprehensive reform, and the discussion draft we are reviewing this week is a starting point for that debate.

The discussion draft envisions a world where every American family has access to affordable and quality health coverage. Those who are currently unable to access coverage through our public programs, employers or the individual market will now be able to do so through a reformed insurance marketplace that guarantees access, quality and affordability. People who already have health coverage will be able to keep their coverage and their choice of doctors.

But health reform isn't just about improving coverage and access; it is also about improving the public health. Too many people are suffering from preventable illnesses and conditions,

such as cardiovascular disease, respiratory diseases, and obesity-related illnesses. Accordingly, we must change the way we think about medical treatment by focusing on preventive care, as well as the quality of care being given. And this discussion draft aims to do just that.

There are a lot of other important details about the discussion draft that I am not mentioning, which I hope will be explored over the course of the next 3 days. I just want to speak directly to those who will stand in opposition to our efforts. For those who have legitimate concerns with the draft, I simply urge you to talk to us about your ideas. We want to work with those of you who are truly interested in being constructive participants in enacting health reform this year. But for those who stand in opposition simply for opposition's sake, I urge you to rethink your position. After a century of inaction, the American people want to see change. They want to see health reform enacted, and we intend to deliver it to them. Thank you.

And now I will yield to our ranking member for the day, the gentleman from Texas, Mr. Burgess.

Mr. Burgess. Thank you, Mr. Chairman.

It seems like I have been waiting my entire career for just this time. I gave up a 25-year medical practice to run for Congress, and I didn't do so to sit on the sidelines with really what could be the biggest change in our system since the enactment of Medicare almost 45 years ago.

And here we are this morning calling up 10 panels to walk us through a legislative proposal released late last week, and it is pretty skimpy on some of the details. Now, I recognize what a draft is, and I understand that a draft means that everything is not completed, but for a draft that mentions "fee" 54 times, "tax" 58 times and "penalty" 98 times, isn't it odd that we have nothing as pertains to financing this legislation?

So, Mr. Chairman, will we have a legislative hearing on the actual bill that this committee might markup when that bill becomes available? I feel like we ought to emphasize the care part of health care, and this debate continues to be defined by two words, "cost" and "coverage." Yet we need to know how many people are covered under this proposal, or how much it will cost, or how we are going to pay for it.

Mr. Chairman, will you commit that we will at least have a CBO score on the bill that we will mark up, since we do not have one on this bill?

Now, everyone if the CBO were here to testify, which they are not, will they be able to tell us how much this bill will cost in the outyears? Every change in the Tax Code, every cut in spending that achieves savings only gets us out 10 years. From there on out, it will mean Congress will be having to find tens of billions of dollars a year to keep whatever program we enact, to keep that going.

And most importantly, as I said, coverage does not equal

access. What does this bill do for patients? What does this bill do to ensure that we will have an adequate supply of physicians?

Now, Mr. Chairman, the President said in his break out -- after one of the break out sessions last March, that he wanted to find out what works. He said it again at the American Medical Association last week. I applaud him for having an open mind. I wish this committee, I wish this committee had the same type of open mind.

You just said you want to work with people who are willing to work with you. Why, then, Mr. Chairman, have we been excluded from the drafting of this bill only to receive it, again, late last week and in a very incomplete form?

Now, I was hopeful and I am still hopeful that we can write a bipartisan bill. Since no Republican has been consulted thus far, the totality of this bill, I think that is a disservice to our constituents. I think that is a disservice to Americans.

Mr. Chairman, we do stand ready to work with you when it is possible; and when it is not, we stand ready to try to educate you where you are wrong. And that is what this process should be about. But it should be done in the arena in the full light of day and not behind closed doors in the dark of night. That is how our constituents are best served. That is how the American people are best served, and certainly for America's patients and doctors, we should do no less.

I would yield back the balance of my time.

Mr. Pallone. Thank you.

May I just mention, Dr. Burgess was sitting in as the ranking member, so I gave him the 3 minutes or close to it. But because we want to hear from the witnesses today and we have so many, I am asking members to try to limit their remarks to 1 minute today.

Hopefully you got notification of that, because remember, not only the Health Subcommittee members are able to participate today; any member of the Energy and Commerce Committee is able to give an opening statement or participate. So that is why we limited it to 1 minute.

Next is the gentlewoman from Colorado, Ms. DeGette.

Ms. DeGette. Thank you, Mr. Chairman.

I will just point out to my friend from Texas, here we are in the light of day, and we are going to have 3 days of hearing on this draft.

And I want to thank you, Mr. Chairman, for doing that.

This is a monumental undertaking, and it is going to take everybody's wisdom and advice. I want to talk about a couple of things that we all care about in this bill. I think we are all going to have to do that today because it is such a comprehensive bill.

First of all, automatic enrollment of newborns into Medicaid will ensure that all children have access to necessary immunizations and well-child visits during the first and most important year of life.

Secondly, primary care workforce incentives and training programs, like student loan repayments and higher reimbursements for primary care, will help with the workforce we need.

And finally, a strengthened infrastructure for health care quality will let us pay -- let us identify and track key health indicators.

I want to agree with you for the need for prevention, and I just want to close by saying, we are either going to pay now or we are going to pay later, and I suggest we focus on Americans' health.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Mr. Gingrey. Thank you, Mr. Chairman.

Mr. Chairman, I want to ensure that every American has quality health care.

Unfortunately, this legislation will do nothing but ensure that millions of Americans lose the coverage they currently have. By including a government health plan and a mandate that every American purchase health insurance, this bill guarantees that the only insurance plans available to Americans and businesses are those that are designed and sold by government bureaucrats.

For those that argue that the government plan will merely compete, studies have shown that such a plan will drive out competition and indeed become a monopoly.

This, the bill before us argues, is the responsible thing to do. By way of government-made products, mandates, taxes and partisan politics, this legislation will take quality market-driven health insurance away from millions of Americans and lead inexorably to a single-payer national health care system.

We can do better, Mr. Chairman. The minority party has some well-studied ideas for improving the affordability, the access and availability of health care.

So far, the majority party in the House has turned a deaf ear toward working in a bipartisan manner. For the sake of the American people and those patients I cared for, for over 30 years, I urge you to listen carefully to all voices, and I yield back.

Mr. Pallone. Thank you.

Vice Chair of the subcommittee, the gentlewoman from California, Mrs. Capps.

Mrs. Capps. Thank you, Chairman Pallone.

And thank you, Chairman Waxman and Chairman Emeritus Dingell, for your excellent leadership and the hard work that you and your staffs have put into this draft legislation.

As a nurse turned Congresswoman, this debate is one I have waited for, for a very long time. We have had many hearings on this topic, bipartisan hearings, and I thank for that opportunity, that it really, truly is coming from all the people we represent.

Our Nation's health care system is in shambles, and with legislation, we will finally take the most important steps we can

to fix it. We will put the emphasis on wellness instead of just illness. We will give patients greater choice and protection in the health insurance market. We will make sure that everyone has access to the care they need and deserve.

It is going to take a long time, some difficult choices, and perhaps a few pennies to get it underway. But we must act, and we must act now. The price of inaction is simply too high. I look forward to this coming week and the discussions we will have on how to perfect this legislative proposal.

I yield back.

Mr. Pallone. Thank you.

The gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. Blackburn. Thank you, Mr. Chairman.

As I have said so many times in this committee, what is on the table for us to consider is in essence the Tennessee TennCare experience all over again. And for those of you who do not know, that was Tennessee's attempt at an executive order program of the Governor's Office. This was their attempt at Medicaid managed care. The plan, that plan is what our Democrat Governor in Tennessee recently called, and I am quoting him, "a disaster."

Eventually that program consumed every single penny of new revenue in our State. I was a State Senator tasked with funding that program. That program nearly bankrupted the State of Tennessee. It is not a model for future success. It is a model for a looming fiscal disaster.

And I have no clue who the majority thinks is going to pay for this thing. I have no idea where they think they are going to get the money for this. Let me tell you, go look at the 10 care records. We cannot afford this program. There is no money to pay for it. You cannot borrow enough money to pay for this program.

In Tennessee, we know that this public option always costs more than initial projections. Cost overruns were through the roof. Patients are always going to choose free rather than out-of-pocket care. Employers will force their employees onto the system. That is why you are going to see more than 120 million Americans moving off of private insurance if this goes through. Sound the alarm bell. This is not --

Mr. Pallone. The gentlewoman, I just wanted you to know you are a minute over.

Mrs. Blackburn. Mr. Chairman, I thank you for that, and I think this is an incredibly serious situation. And I thank you for your patience.

Mr. Pallone. Thank you.

I am trying to keep people to a minute. I am not going to stop you if you go a little over.

Mrs. Blackburn. It is fine. I apologize.

Mr. Pallone. All right.

The gentleman from Utah, Mr. Matheson.

Mr. Matheson. Thank you, Mr. Chairman. I will do my best with a minute.

We use the terms cost, access and quality a lot around here, but we really do need to focus on all three. That is what we are trying to do here. I think this is the most complex piece of legislation we are going to work on in our careers. And just maintaining the status quo is not an option. Our health care system is driving up costs in a way, both the public sector and the private sector. We can't sustain the path we are on.

I fear this discussion has focused so much on access, we are not also looking at the unproductive system we have now. There is so much money in our health care system today that is spent in irrational ways. There are so many perverse incentives built into our health care system. And if we want to achieve what our President has asked us to do, which is to bend the curve, the cost curve, the plots where costs are going, if we want to achieve that, that is where we can really accomplish something as a group.

So I encourage this committee, as we look at this legislation, to look for ways to make our health care system more efficient, get rid of perverse incentives. And if we do that, I think we will secure a better future regardless of how we structure the plan.

Thanks, Mr. Chairman. I yield back.

Mr. Pallone. Thank you.

The gentleman from Pennsylvania, Mr. Murphy.

Mr. Murphy of Pennsylvania. Thank you, Mr. Chairman.

And I am thankful we are finally moving forward on this.

Certainly there is not a member in this room on either side of the aisle, no matter what one's political leanings, who is not totally dedicated to reforming our health care system as many of our witnesses are, too.

The question is, which direction? From the time I arrived in Congress in 2003 and through my time before as a State senator, I focused my energies on trying to reform this system. Just on the issue of hospital-borne infections alone since I have been in Congress, 350,000 people have died, hundreds of thousands more from other errors. And we have spent hundreds of billions of dollars in wasted health care.

Our current system of \$2.4 trillion wastes about \$700 billion a year. Our Medicare and Medicaid system are filled with problems. We need to address those first. But don't take my word for it. Take Members of Congress's word for it. In the 110th Congress, 452 bills were brought forward by Members of Congress to reform Medicare and Medicaid. Members of Congress signed up to cosponsor those 452 bills 13,970 times.

Members of Congress think we have trouble if the Federal Government is going to run a health care system. We are not there. A bill that looks at who pays for premiums and co-pays is not health care reform. A bill that looks for taxes to pay for these things is not health care reform. A bill that reduces costs by reducing payments to physicians and hospitals is not health care reform.

We have to reform that system. We have the talent and the ability to do that. And I hope that as we progress in the coming weeks on this health care reform system, we truly can look at focusing on outcomes and not quantity and really make health care more affordable and accessible for millions of Americans who right now can't afford it.

Thank you. And I yield back.

Mr. Pallone. Thank you.

The other gentleman from Georgia, Mr. Barrow.

Mr. Barrow. I will waive an opening.

Mr. Pallone. The gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. Christensen. Thank you, Mr. Chairman.

And I want to begin by using this opportunity to recognize the fair and open way in which the Chair Emeritus Dingell, Chairman Waxman and you, Chairman Pallone, have conducted the process of getting us to this point today and to thank you and your staff.

The bill acknowledges that insurance is not enough and takes steps to promote prevention and wellness, to expand services and to eliminate health disparities. We appreciate and applaud your efforts.

But if we are to truly transform our system, we will continue to push the committee to go further. One specific area where more progress is needed is in the treatment of the territories. Just

as we will willingly and proudly fight and die in every war and conflict in defense of our Nation, we believe that we deserve the same access to health care as every other citizen and legal resident of the United States. We understand "universal health care" to mean universal health care.

And finally, I believe that the health and well-being of every person living in this country is important enough and vital enough to our Nation's productivity, competitiveness, strength and leadership that passing a meaningful and effective health care reform bill should not require an immediate offset for every provision. Prevention saves. It saves lives first of all, and it saves money as well.

Thank you, and I yield back.

Mr. Pallone. Thank you.

The gentleman from Ohio, Mr. Space.

Mr. Space. Thank you, Mr. Chairman, for your time and your tireless work on behalf of American consumers.

We stand before a debate so historic and significant that it arises but once every several generations, and that stake is an issue of no less importance than the health of the American citizen, along with the health of the American economy. For, even though we boast of the most sophisticated health care, technology, and talented health care professionals in the world, their services are often out of reach of the average working American.

Today I offer three areas of critical importance where

improvements must be made. First, we must grow and nurture our rural health care workforce to ensure the same quality of care is offered to all residents of this country regardless of where they reside.

Second, we must make quality affordable health care a reality for every resident of this country by making reforms that capture the power of the free market, harnessing what is best about market forces.

And third, we must change how we treat chronic diseases, taking more steps to encourage prevention and managing care of those that they afflict. An investment on the front end will only result in a higher quality of life for those who suffer from chronic diseases and cost savings of billions of dollars to our health care system.

Just as history has judged our efforts to battle for democracy abroad and put men on the moon, we, too, shall be judged for our response to this critical moment in history. We truly cannot afford to fail.

I yield back.

Mr. Pallone. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

Ms. Schakowsky. Thank you, Mr. Chairman, for moving us closer to getting where we all want to be, and that is the goal of comprehensive reform of our health care system.

I want to thank Chairman Waxman and Chairman Emeritus Dingell

who have provided wonderful leadership.

This is a historic moment. Americans are counting on us for guaranteed access to affordable quality health care and we have to ask now -- act now. People are forgoing care, families are falling into bankruptcy, businesses are struggling to make ends meet. I want to focus on two provisions.

First and most important, the public health insurance option. Consumers need a real choice, and the insurance market needs real competition. A robust public option provides both. It is essential to meaningful reform.

Second is the inclusion of the nursing home quality and transparency act no-cost legislation, which as the title says, will improve quality and transparency, helping nursing home residents and their families. There are so many important provisions in this bill and I look forward to moving it and at long last creating an American health care solution that meets America's health care needs. I yield back.

Mr. Pallone. Thank you.

The gentleman from Texas, Mr. Green.

Mr. Green. Thank you, Mr. Chairman.

I want to thank you for holding this series of hearings on the health reform discussion draft. I am pleased we are starting the process on addressing the issues facing the 47 million uninsured individuals in our country. There is a lot of good things in the discussion draft that I know we will hear about and

we will talk about over the next few days.

One of the issues that I would like to point out is something I have been working on with a number of members on our committee that the discussion draft doesn't include, the elimination or the -- over a period of years, the 24-month disability waiting period for disabled individuals under 65 for Medicare. Unfortunately, once again, we leave these individuals out in the cold. Currently 1.8 million individuals are stuck in a 24-month waiting period. Of those individuals, 39 percent are uninsured, and 13 percent will die before they endure that 2-year wait.

Congress deliberately created the waiting period in 1972 to keep Medicare costs down. And I believe the 24-month waiting period is a shameful example of how we refuse to cover disabled individuals whose medical treatment is deemed too costly. I sponsored ending the Medicare disability waiting period for 5 years, and each year, we were unable to move the bill because it is too expensive. And again in this draft, we refuse to address the issue. So the reform drafts would allow some of the individuals to obtain a government subsidy to purchase insurance through the exchange. And if they live through the 24-month waiting period, once they receive their disability determination, they can then switch to Medicare.

Why would we want disabled and chronically ill switching insurance coverage and possibly switching physicians? And I am not sure the exchange will provide these disabled individuals of

the complex medical treatment and coverage for equipment that they need. And I strongly urge the committee not to push aside those who endure that 24-month waiting period, even after you wait to get a disability determination from Social Security just for monetary concerns. We can eliminate that waiting period over a period of years and show that we do recognize the problems the disabled have.

And I yield back my time.

Mr. Pallone. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. Baldwin. Thank you, Mr. Chairman.

And thank you to our witnesses for being here today. We have before us what is an amazing accomplishment, the work of many years of research and analysis and a collaborative effort of this diverse committee. It is difficult to overstate the importance of our task. We have been in this position before, but this time we simply must succeed.

As President Obama said earlier this year at our Joint Session, health care reform must not wait; it cannot wait, and it will not wait another year. As we debate the details and the intricacies of this draft, I want to be sure that we remember the people, the children and the families that are waiting with great hopefulness for us to act. Our country is suffering under this growing burden, and it is our responsibility to answer their call.

I am very pleased to see that this draft includes a public

health insurance option. I have been unwavering in my support for this aspect of reform, and I believe that this plan will lead the way for reforming our delivery system, emphasizing prevention and paying for quality.

I have a few suggestions for improvement to the bill, but I look forward to working with my colleagues on moving this forward.

Thank you again, Mr. Chairman. I yield back the remainder of my time.

Mr. Pallone. Thank you.

The gentlewoman from California, Ms. Matsui.

Ms. Matsui. Thank you, Mr. Chairman. I want to thank you, Chairman Waxman, Chairman Emeritus Dingell, on the excellent work to get this crucial legislation to where it is today.

I am particularly pleased with Section 2231 and Section 2301 of the draft bill. These sections build off legislation I wrote to create a public health workforce corps and to centralize prevention spending in a wellness trust fund. Public health and prevention are critical aspects of a strong health care system. They must be part of our national strategy to control health care costs, create better health outcomes for people, and ensure that the health care system works for all Americans.

Without public health and prevention, we will never drive down health costs, nor will we move our society from one focused on treating sickness to one that promotes wellness and healthy living. I urge my colleagues to support these critical components

of the draft bill before us today, and I yield back the balance of my time.

Mr. Pallone. Thank you.

STATEMENTS OF RALPH G. NEAS, CHIEF EXECUTIVE OFFICER, NATIONAL COALITION ON HEALTH CARE; RICHARD KIRSCH, NATIONAL CAMPAIGN MANAGER, HEALTH CARE FOR AMERICA NOW; AND STEPHEN T. PARENTE, PH.D., DIRECTOR, MEDICAL INDUSTRY LEADERSHIP INSTITUTE.

Mr. Pallone. The committee will now receive testimony from the witnesses. And I will call up our first panel. Let me introduce each of them at this time if I could. Starting on my left is Ralph G. Neas, who is chief executive officer of the National Coalition on Health Care. Next to him is Richard Kirsch, who is national campaign manager for Health Care For America Now.

Good to see you.

And then we have Dr. Stephen T. Parente, who is director of the Medical Industry Leadership Institute.

And this panel is on health reform coalition views. I am going to ask each of you to give a 5-minute statement. Of course, your full statement becomes a part of the record. And then when you are done, we will start having questions for the panel.

And we will start with Mr. Neas. Thank you for being here.

STATEMENT OF RALPH G. NEAS

Mr. Neas. Chairman Pallone and Ranking Member Burgess and members of the full committee and subcommittee, thank you so much for the opportunity to appear before you on this momentous occasion, day one of hearings to discuss the House Tri-Committee Health Care Reform Discussion Draft.

I am pleased and proud to be joined by the founder, the visionary founder, and president of the National Coalition on Health Care, Dr. Henry Simmons, who is sitting right behind me. Among many other things, Dr. Simmons was the deputy assistant secretary to President Richard Nixon for health in the early 1970s.

The National Coalition on Health Care is honored to be here and heartened by the progress made by the three committees. We hope that this draft bill can serve as the springboard for comprehensive and sustainable health care reform. Like you, we believe that the time for action is now, this year.

Reform of our health care system is a vital condition precedent for fixing the nation's faltering economy. The fiscal crisis facing us cannot be addressed successfully without the simultaneous overhaul of our health care system. America is on a dangerous path to sharp increases in the cost of health care and

the numbers of uninsured and underinsured Americans to unsustainable burdens on our economy and on Federal and State budgets, and to indefensible, avoidable harm to millions of patients and massive waste from substandard and uncoordinated health care.

The rigorously nonpartisan National Coalition on Health Care is the Nation's oldest, broadest and most diverse alliance of organizations working for comprehensive health care reform. The coalition's 78-member organization stands for more than 150 million Americans.

The Coalition's five basic principles for health care reform, coverage for all; cost containment; improved quality and safety; simplified administration; and equitable financing, are interdependent. We believe reform, to be effective, must address all of these issues in a systemic way that recognizes their interconnectedness.

After more than 18 months of deliberations, the Coalition developed a set of principles and specific recommendations. I would ask that they be included for the record, along with my written statement. As the Coalition operates on the basis of consensus, we have begun an expedited process of discussing the provisions of the draft bill with our members. Only as these internal consultations progress will we be able to provide more detailed views and consensus recommendations regarding optimal formulation of the final bill.

However, let there be no doubt that the Coalition strongly commends the cross-jurisdictional collaborative tri-committee effort to address the central challenges facing our Nation in health care, specifically how to slow the growth of health care costs; how to extend coverage to Americans without health insurance; and how to improve the quality of care and the efficiency with which it is delivered.

The draft is appropriately ambitious in its scope and its recommendations. We believe that reducing costs while expanding coverage not only can be done but must be done. Now is the time to be pragmatic and bold, to keep what is good and to fix what is broken in our Nation's health care system. We must come together to pass systematic reform that sets our Nation on a better path toward affordable, high quality care for all Americans and solid fiscal responsibility.

The Coalition members have long believed that securing coverage for all Americans should incorporate a range of mechanisms, including responsibilities for individuals and employers; the expansion of existing public programs, such as Medicare and Medicaid; information and framework to improve competition among private insurance plans; and the creation of an additional and carefully designed public option.

The Coalition would encourage consideration be given to adding detail to the definition of the service to be covered in an essential benefits package. Many of our members would want us to

emphasize the importance of calibrating the revisions regarding the public option to make sure that it would function as the drafters clearly intend on a level playing field with other plans.

We applaud the inclusion of a wide range of measures to improve the efficiency of health care liberally while enhancing the quality and safety of care and also providing support for evidence-based prevention. Escalating health care costs puts health care coverage out of the financial reach of tens of millions of Americans and their employers. Thus we suggest consideration of the use of short-term regulatory constraints to slow the pace of increase in the cost of essential coverage.

The Coalition applauds the chairman for the leadership. The enormous added momentum your joint efforts have given to the reform process cannot be overstated. Indeed, this is truly an extraordinary moment in history. Too much is at stake for us to risk failure due to partisanship. It is only through a commitment to shared responsibility and shared sacrifice that we can rise to meet this once-in-a-generation opportunity to develop an achievable and uniquely American solution. To protect the generations to come, let us work together to enact health care reform that is at once moral and fiscally sound.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Neas follows:]

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Mr. Pallone. Thank you, Mr. Neas.

And as I mentioned, all of your written testimony, your documents that you gave me, will be included in the record. So you don't have to make a special request for that.

Mr. Kirsch.

STATEMENT OF RICHARD KIRSCH

Mr. Kirsch. Good morning, Chairman Pallone, members of the committee. My name is Richard Kirsch. I am the national campaign manager of Health Care For America Now, a coalition of more than 1,000 organizations in 46 States that are committed to a guarantee of quality, affordable health care for all according to specific principles.

Those principles have been endorsed in writing by the President of the United States and 196 Members of Congress, including 176 Members of this House from both parties.

And I am so glad to be with you this morning because the legislation you have drafted meets those principles. It would deliver on the promise of quality, affordable health care for all in a system that is retooled to deliver better quality at lower costs. You have done so in this unique tri-committee process that recognizes the urgency and historic imperative of this issue.

Our current health care system is a huge stumbling block to

the American dream. No matter how hard we work or make responsible choices for ourselves and our families, our health care system too often gets in the way. For too many families, one serious illness can mean financial disaster. As medical costs contributed to more than three out of five personal bankruptcies and the great majority of those were people with insurance.

And even if you have good insurance, you find your choices limited and your dreams deferred. You want to look for a new job, start that new business, retire at age 59; trapped because you won't be able to get affordable coverage if you can get coverage at all. And, of course, there are there are too many families that can't get coverage at all.

Neither can many small businesses, that other great engine of the American dream, who want to do the right thing for their employees but can't as health care premiums skyrocket every year.

The good news is we can fix what is wrong with the system with a uniquely American solution. For those who say we can't do this, it is too complicated, it is too much to take on, it is too much at once, your legislation is proof positive that, yes, we can.

As Americans begin to pay attention to the health care debate, they will increasingly ask, what does this mean to me? Here is how I would explain how this works to the average American and why it will make their lives better. If you have good health coverage at work, you can keep it. But there will be two

important changes. Under your legislation, you no longer have to worry about your coverage at work getting skimpier every year or your employer taking a bigger chunk each year out of your paycheck. Your employer coverage will not be barebones. It will cover most of your health care. It won't stop paying if you get seriously ill. Your job will pay a good share of coverage for you and your family.

One more thing. Whatever job you take, you will have good health care. That is because all employers will either provide coverage or help pay for it.

If you don't get health coverage at work or you work several part-time jobs, you are self-employed, retire early or simply out of work, you will now be able to get good affordable coverage. You won't be turned down because of a pre-existing condition or charged more because you have been sick or you are a woman of childbearing age. You can still be charged more if you are older but only so much.

And how much will it cost you? The amount you pay will be based on your earnings and the size of your family, with assistance for low-, moderate-, and middle-income families. To get insurance, you go to a new marketplace called an exchange, one-stop shopping for health coverage. All plans will have a decent level of benefits and play by the same rules. No matter which plan you choose, your out-of-pocket costs will be limited, no more catastrophic medical bills.

You will have a choice of the new public health insurance plan, too. So you won't be limited to the same private insurance companies that have a record of denying or delaying care while they raise premiums three or four or five times more than wages.

As the President says, there are two reasons for offering the choice of a public health insurance plan. The first is to lower costs, a plan that doesn't pay the average CEO \$12 million a year or sky-high administrative costs. The mission of the public health insurance plan will be to drive the kind of delivery systems changes we need to innovate, provide better value, and invest in our community's health. A plan that will inject competition into 94 percent of markets that -- or into competitive under DOJ standards.

The second reason the President says we need a public option is to keep insurance companies honest. The 93 percent of Americans who don't trust private insurance companies know that no matter how much we regulate them, their first order of business, actually they are legal fiduciary responsibility to the shareholders, is to make a buck. And when they pay for someone's costly care, their profits go down.

An additional reason for the public health insurance plan is to ensure they make real progress at eliminating the barriers and disparities in access to needed services that are too often experienced today.

Poll after poll shows strong support for the choice of a

public health insurance plan with strong support on bipartisan lines.

This legislation also answers the crying need for small business for affordable coverage by offering tax credits, and allowing small businesses to enter the exchange, and gives them the advantage of large pools and lower costs.

The legislation does a great deal more for the poor through Medicaid, for seniors on Medicare, to address the lack of primary care providers and the disparities and access to health care.

I am almost done.

Are there ways of improving this draft? Although there are, they are not a great number. And I will detail that in my written testimony. Let me conclude by asking you to keep one question in mind over the coming weeks: As you hear from a myriad of interest groups complaining about this and that, it is the question that your constituents will ask at the end of the day, will I have a guarantee of good coverage that I can afford? The draft legislation you presented answers with a resounding yes. And if the answer remains yes next fall when you send the bill to the President for his signature, you will have done your jobs and in doing so made history.

Thank you.

[The prepared statement of Mr. Kirsch follows:]

***** INSERT 1-2 *****

Mr. Pallone. Thank you.

Dr. Parente.

STATEMENT OF STEPHEN T. PARENTE, PH.D.

Mr. Parente. Thank you, Chairman Pallone and members of this committee, for this opportunity.

We are in the midst of the seventh major attempt of national health reform, beginning with the Wilson administration. Since that first attempt, there has been President Roosevelt's second attempt in 1936; President Truman's third attempt in 1948; President Johnson's fourth attempt leading to a compromise that created Medicare and Medicaid; President Nixon's limited fifth attempt; President Clinton's sixth attempt.

With President Obama's call for reform, will seven be the lucky number?

My name is Steve Parente. I am a health economist from the University of Minnesota and a principal of a health care consultancy, HSI Network. My areas of expertise are health insurance, health information technology, and medical technology evaluation.

At the university, I am a director of an MBA specialization in the medical industry and a professor in the Finance Department with an adjunct appointment at Johns Hopkins School of Public

Health.

Most recently, I and my colleague, Lisa Tomai from HSI, have scored health reform proposals as they have emerged in the last 4 weeks. We are using ARCOLA, a microsimulation methodology initially funded by the Department of Health and Human Services and published in the journal, Health Affairs.

There are two things people most want to know about these proposals. One, how many of the uninsured will be covered? Two, what will it cost the Nation in 1 year and in 10 years? HSI estimates, like CBO's recent results, find there is no free lunch to expand health insurance coverage.

Our early assessment of the Senate Finance Committee proposal shows a 74 percent reduction in the uninsured with a 10-year cost of \$2.7 trillion using a public option plan modeled after the Massachusetts Connector.

We also modeled an FEHBP version of that plan and got a cost of over \$1.3 trillion, but with a 30 -- only a 30 percent reduction in the uninsured because the plan is generally more expensive and not enough incentives are given.

CBO scored the Kennedy bill last week at approximately a 30 percent reduction for \$1 trillion over 10 years. Using the ARCOLA model, we found nearly everyone will be covered if all elements of the Kennedy bill were enacted at a 10-year cost of \$4 trillion. That \$4 trillion estimate over 10 years assumes a public option plan with bronze, silver and gold levels and the proposed

insurance exchange with a subsidy for premium support that is income-adjusted and calibrated at the silver level.

The silver level is what most Americans would like in health insurance today. It is the equivalent to a PPO plan with medium levels of generosity, something with a 15 percent co-insurance, manageable co-pays and good access to physicians and hospitals.

We accounted for the public plan being reimbursed at 10 percent above Medicare reimbursement, which is also 10 percent below commercial insurance plans.

In the individual market, we assume the public option plans would be community rated and the rest of the individual market would be as it is today. For those offered insurance, we assume the public plan would be -- my teleprompter broke. Because the public plan can compete with the individual and group market offerings, we saw a crowd-out in the public plan of 79 million covered lives with the majority of people leaving employer-sponsored medium-sized PPOs and HMOs.

At this time, we are the only group yet to score the full Kennedy proposal. We released it last Sunday, June 14th, on our HSI network.com home page, 2 days before CBO's preliminary estimate. This work was completed as a public service without a funder from industry or a political sponsor.

Some proposals we have examined have specific pay-fors already scored by CBO that can substantially reduce their cost, such as the Coburn-Ryan bill, with a 72 percent reduction and a

10-year cost of \$200 billion with the pay-fors accounted for or \$1.7 trillion without.

One conclusion emerges every time we score a plan: None are revenue-neutral. Even with Medicare and Medicaid pay-fors, the savings in those programs need to deal with the cost pressures of those programs. In all likelihood, these proposals, if enacted, would escalate the rate of growth of our national debt, particularly the Kennedy plan.

As a Nation, we are on the verge of making a multimillion dollar gamble that more per-capita health care deficit spending will make us better off as a society. We are wagering with starting bids in trillions that have excessive spending in the health care system. Hoping that these billions and trillions will lead to a breakthrough medical technology that can eliminate whole diseases, such as diabetes and Alzheimer's. This is actually not a bad path. It happened before with tuberculosis, but not quite at this level.

It is not an unreasonable wager since Federal funding for heart disease and cancer either directly through research or indirectly through Medicare has yielded state-of-the-art medical care, but it is a wager nonetheless. And we find our reckoning is not only with the future debt of our children, but their security when the economic crisis has brought international scrutiny upon the U.S. from the principal purchasers of our treasuries.

Furthermore, saving businesses from paying health care costs

or a State government with Federal intervention is simply an accounting cost shift that only saps our long-term economic growth.

President Obama spoke recently in Wisconsin of the need to expand health coverage to bend the cost curve down. I watched him say it 3 times in 5 minutes.

May I respectfully suggest that bending the cost curve down starts with active management of Medicare. For 5 months, we have been without a CMS administrator while there have been over 400 billion in --

Mr. Pallone. Dr. Parente, I don't mean to interrupt, but you are a minute over, so If you could kind of wrap it up.

Mr. Parente. I will wrap up. Pardon me.

In summary, there is greater consensus today that health care reform must be undertaken. It will not be free. It will, as it always was, be a political decision that was more so political than economic. So much can be done now with great expansion, but it will come at great cost.

Thank you.

[The prepared statement of Mr. Parente follows:]

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Mr. Pallone. Thank you.

We will now have questions from the members of the subcommittee.

I should mention that everyone, again, that members of the full committee are going to participate in the same way and have 5 minutes each. And if you were here and passed on the opening, you will get an extra minute. But if you weren't here, then you don't get an extra minute. Just to make the rules clear.

And I am going to start with myself. I am trying to get two questions in here, one about the need for comprehensive reform and one about the public option. So I will start with the comprehensive reform. But if we go too long, I may stop because I want to get to the public option, too.

Mr. Neas, the National Coalition on Health Care has always envisioned the need to address health reform in a comprehensive manner, as your testimony sets out this morning. And in our discussion draft, we address issues ranging from the workforce and prevention and wellness to coverage costs and quality improvement. Is it possible to address this in a piecemeal fashion, or do we need the comprehensive approach to tackle this issue?

Mr. Neas. Mr. Chairman, it is absolutely essential that this be done in a comprehensive way, as we point out in our testimony and all of our published materials. It is essential that we have systemic, systemwide change in this country in our health care

system. To do it piecemeal, we could end up with a system much worse. You could cover everybody, but you don't have cost containment or you don't have it paid for in the right way or you don't have quality. All of these principles are interdependent. They rely on one another. You have to do it all at once. You can't do it incrementally, and you can't do it piece by piece.

Mr. Pallone. Okay.

Let me go to Mr. Kirsch, then, about the public option. We have a public option in the discussion draft in a manner that assures, in my opinion, the levellest possible playing field with the multiple private insurers who will also be competing with the public option. So I have four questions, and I am just going to read them and ask you to try to get through them in the next few minutes here.

First, why do we need a public health insurance option? Won't the exchange function better with just the competing private insurers?

Second, what do you think of the alternatives to the public option set out in or draft? People have mentioned co-ops or State By State options or a public option triggered only if certain criteria are met.

And then, third, you know, outside the Beltway, as I guess we don't really care much about the Beltway anymore, is the public option a partisan issue?

And fourth, would a public option help or hurt small

businesses?

If you could try to address those in 3 minutes or less.

Mr. Kirsch. And try to talk not too fast. Okay.

Why a public option? If we don't, we are just rearranging the deck chairs on the Titanic, and I guess the regulation is maybe giving those chairs a shiny coat of paint.

The fact is we have had a private insurance industry that has been running our health care system for quite a while now. We have had premiums go up several times as much wages -- in some states, multiple, multiple times as much as wages. At the same time people have poor quality care, and they are used to denial and delays all the time from health insurance companies.

We need a public option to do the two things the President says, to lower costs, to have an actor in the system that is mandated to have a kind of lower cost operations it can have, and also to keep insurance companies honest because their bottom line will always be hurt every time they pay for a significant claim.

Mr. Pallone. What about the alternatives, the co-ops that trigger --

Mr. Kirsch. The alternatives are basically ways to kill the public insurance option. The trigger is basically saying, we are not going to have it unless things get worse. There is an old expression: Fool me once, shame on you; fool me twice, shame on me. The insurance industry basically said in 1993, 1994, leave it to us to fix the system. We have seen what we have gotten. We

can't wait any longer. We have waited a long time for the insurance system to fix this system, and they have failed.

The co-op, an interesting comment from an Oppenheimer & Company analyst says, the co-op proposal is a great gift to publicly-traded insurance companies. It is doomed to fail. It was basically a political invention to try to placate Republicans who didn't want a government role in providing an option, and it has no policy benefits. We have lots of nonprofit insurers in this country that haven't done the market-changing factors we need to provide the kind of care.

Mr. Pallone. Third, would be outside the Beltway, is the public option a partisan issue?

Mr. Kirsch. No. It is extraordinarily popular. The first polling question we asked was, public, would you prefer a public plan, just a choice of just public insurance, private insurance, or public and private insurance? Not only did 73 percent of Americans say they wanted a choice; that included 63 percent of Republicans.

In the case of the New York Times poll just released over the weekend, 72 percent of Americans say they wanted a choice of the language of a government-administered plan like Medicare to compete with private insurance. So using the government word, and still 73 percent of Americans wanted it, including 49 percent of Republicans, which means more than -- and many fewer than that opposed it.

Mr. Pallone. What about the impact on small businesses?

Mr. Kirsch. And small businesses? Small businesses like everyone else need lower-priced coverage. And again, there are a lot of things in your legislation that make huge advantage of small business. We should talk about it. One of those is the public option because to the extent the public option is offering good quality at a lower cost, small businesses will benefit.

Mr. Pallone. Thank you.

Mr. Burgess.

Mr. Burgess. Thank you, Mr. Chairman.

Dr. Parente, first off, you were -- the buzzer or someone interrupted you where you were about to make a point about not having a CMS director. Would you care to finish that point?

Mr. Parente. Simply to say that there should be a CMS administrator given that there is \$400 billion that has already been spent by that program. If you want to bend the cost curve down, one of the places where the costs are going out the door right now is Medicare and Medicaid. That needs active management.

If even people were to put in modernization for some of the fraud, things that have been put on the table, some of it actually in the bill, that would be useful. But right now, because it is essentially a caretaker administration over at CMS, none of that can occur.

Mr. Burgess. Let me ask you a question, and certainly, you know, hats off to your group for doing that exhaustive work on the

Kennedy bill under such a short period of time. Are you going to do a similar scoring for the draft discussion that we have in front of us this morning?

Mr. Parente. Yes.

Mr. Burgess. And when might we expect for that information to be publicly available?

Mr. Parente. I am hoping that it would be on the HSI Web site by tomorrow morning at 8:00 a.m.

Mr. Burgess. Tremendous. Thank you for doing that as well.

Now, when you were here last fall, I think it was the day after Lehman Brothers failed, if I recall correctly, and the whole world changed. This \$4 trillion figure that you talked about for the three tiers of the public option under an FEHBP-type structure, you also referenced a low end that would be essentially Medicaid for all that would be much less expensive. And if I recall correctly, that was about \$60 billion a year or \$600 billion over 10 years. Do I recall that correctly?

Mr. Parente. That is correct.

Mr. Burgess. Now, assuming that the reality lies somewhere in between those two -- well, let me just ask you this. Have you looked at -- under the proposal before us today, Medicaid is offered -- a full Federal component of Medicaid is offered for everyone at 133 percent of poverty and below, not just the existing populations, but for all populations. Do you have an idea what the cost for that is?

[10:30 a.m.]

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[10:33 p.m.]

Mr. Parente. Not as specifically. Actually, the public option plans, with the subsidies that are proposed, at least in the Kennedy bill, addresses a fair bit of the population. A round guess on that cost would be probably somewhere in the vicinity of about -- no more than about \$30 billion or \$40 billion per year.

Mr. Burgess. Very well.

Let me ask you a question. And we hear the President all the time, in fact he said at the White House last March, that the only thing that was not acceptable was the status quo and, if you like what you have, you can keep it. Well, it is kind of tough to reconcile those two positions.

Do you think, under the bill that is under consideration today, the draft bill, the tri-caucus bill that is out there, do you think it is reasonable to assume that, if you like what you have, you can keep it, under the parameters of the bill that are before us today?

Mr. Parente. I think it is really determined by how the public plan is ultimately deployed. I mean, as you all know, it is a very long road from whatever this legislation is to enactment, which could be 3 to 4 years from now.

The concern, really, is crowd-out. It is hard to say what the public plan model would look like, in terms of logistical,

operational terms. It if it operates like TRICARE, that could be a crowd-out potential. If it operates like FEHBP, that would definitely be a crowd-out potential because it is more generous than the standard market today.

Mr. Burgess. Mr. Kirsch, let me ask you a question. In yesterday's Politico you have an opinion piece, and you talk about the three things that are likely to make this legislation happen. And the third thing, the organization where it counts most outside the Beltway -- now, I don't know how far outside the Beltway you have gotten. In north Texas, I will tell you that 65, 68 percent of the people in my district -- and it is not a wealthy district, it is a working district, a rural district, an inner-city district, as well as a suburban district -- but 65 to 68 percent of the people in my district are satisfied or very satisfied with the insurance coverage that they have today.

In spite of the fact that so many people are demanding change, that seems like a pretty high number that is accepting of where they are right now.

Mr. Kirsch. Well, it always depends, on all these things, on how the questions are asked. Basically, if we look at the views nationally, according to the New York Times, 85 percent of people believe that the health insurance system needs fundamental change or it needs to be completely rebuilt; 86 percent believes it is a somewhat -- 61 percent believe it is a serious threat to the economy.

What people are dealing with is they may be happy with their insurance at the moment, but what they are totally terrified of is what happens if they lose their job. And so they want a system --

Mr. Burgess. Correct. And let me just interrupt you there, because I think we can address those problems and correct those problems without turning the entire system on its head.

Now, the last New York Times-CBS poll that I guess is the one you are referring to, just a curious figure down toward the end of it: Of the people polled, 48 percent voted for President Obama, 25 percent voted for Senator McCain, and 19 percent didn't vote.

That is a curious sampling, and I wonder if that may not have skewed the results that were reported so widely on the Sunday shows yesterday.

Thank you, Mr. Chairman. You have been generous. I will yield back my time.

Mr. Pallone. Thank you.

The gentlewoman from Colorado, Ms. DeGette.

Ms. DeGette. Thank you very much, Mr. Chairman.

Dr. Parente, I read your testimony, and I wanted to talk with you a little bit about some of your analysis around the public plan and cost savings and so on.

I certainly agree with you that we need to try to get cost savings in Medicare and in other programs. But what we have seen, for example, in Massachusetts, since they have put together their connector system without a public plan, the good news is they got

almost everybody enrolled in health care. The bad news is they got absolutely no cost savings, and their costs are going up as much as everybody's.

So I am just wondering if you can tell me -- and I apologize, I didn't read your piece in Politico. But I wonder if you can tell me, do you think all potential public plans are a poor idea or just ones that would cause this crowd-out?

Mr. Parente. I don't think all public plans are a bad idea. I think, as I understand as an economist what you are trying to do --

Ms. DeGette. Or, at least, what you have done is you have analyzed the Senate bill.

Mr. Parente. Right.

Ms. DeGette. And I understand that was the bill that was out there. But we, as you know, are a little sensitive over here about having our own bill and having it be a work in progress. So you can give your opinion on the Senate bill, recognizing that is not our bill.

Mr. Parente. I understand. And there are similarities, so --

Ms. DeGette. Yeah.

Mr. Parente. -- a lot of the structure is very similar. Like I said, I applaud some of the things that are put in for Medicare that are related to cost savings and such.

A public plan is designed to inject competition into the

system. What concerns me is that there already is quite a lot of competition in the private insurance market space. A few things --

Ms. DeGette. Well --

Mr. Parente. A few issues -- just one clarifying comment. If you look at what Massachusetts did very well, it simplified the benefits so that most people can get a sense of what was available.

Ms. DeGette. Right.

Mr. Parente. But if you look at what actually did the deed to get everybody covered, it was mostly through high-deductible health insurance plans.

Ms. DeGette. Well, you know, I am sorry, I have a limited amount of time and we have two other witnesses. But there was a study that was just released by Health Care for America that found that 94 percent of the communities in the country do not have a competitive health insurance market. For example, in Pueblo, Colorado, they have one provider, WellPoint, that has 76 percent of the market share. And so, in fact, we don't have robust competition in 94 percent of the country.

So I am wondering, don't you think that a public plan might be able to help with competition in communities like that?

Mr. Parente. Not if it doesn't have active price competition. So my concern is what if the --

Ms. DeGette. Right. Well, let's say it does have active

price competition, then your objection is that everybody leaves the private plans because it is cheaper. But isn't that a noble goal?

Mr. Parente. To have everybody leave the private plans?

Ms. DeGette. No, that people be able to buy cheaper health insurance.

Mr. Parente. Yes, that is a noble goal. But if you are going to regulate the public plan to basically go into price competition with the private insurance industry, you have to ask with your question, how are you going to be able to price-fix those public plans to be able to do that?

Ms. DeGette. Oh, you know, just so you know, at least from the view of -- at least from my view, I don't think that we should price-fix the public plan and give them an artificially low price. I think most of us on this committee would think, if we have a public plan, they should be able to compete with the private insurance companies.

Mr. Kirsch, I am wondering if you can comment on that study by Health Care for America and why that necessitates the need for a public plan.

Mr. Kirsch. Right, yes, Congresswoman, as you said, 94 percent of the market -- this is actually AMA data that we use in our study -- are highly concentrated by Department of Justice standards, which means people don't really have choices in State after State, like in Pueblo, Colorado, and municipalities or areas

around the country.

It is also the question of the right kind of competition. It is having competition; it is also having competition for an insurance company that cares about people's health care more than a healthy bottom line. So it is both factors we are looking at.

Ms. DeGette. Yeah. And it would seem to me, for all the panelists, Mr. Neas and everybody, that one way that we could improve our health care system is to get the competition, but also to try to get cost savings through Medicare. And I don't think those things are mutually exclusive, do you, Mr. Neas?

Mr. Neas. Absolutely not. And I think we can applaud the work of some of the States, like Massachusetts or Tennessee. However, they were not systemic, systemwide reform that addressed cost containment, that addressed simplified administration and other issues. You have to do it as a comprehensive package.

This could be done. And I think the committee has done a good job, a good start, on the public plan, trying to make sure that it would be on an equal playing field, not giving an advantage, be fair and competitive.

Ms. DeGette. And I won't vote for a public plan that has an unfair advantage over the private plans. But I do think we need to find some place for competition, to keep everybody trying to find their best price points.

Thank you very much, Mr. Chairman.

Mr. Pallone. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Mr. Gingrey. Mr. Chairman, thank you.

I want to address my first question to you, Mr. Kirsch. You made a statement in response to one of my colleagues, I think the question of why the public option plan. And you said, well, the insurance company -- the health insurance companies are so egregious in what they have failed to do. I think you said, fool me once, shame on me; fool me twice -- or just the opposite -- fool me once, shame on you; fool me twice, shame on me.

Why do you feel that, based on that, that we should give the, as I think this will do, this bill, the death penalty, essentially, to the private market? Why not give them 30 years in prison rather than the death penalty? Why is it you want to come down so hard?

Why not let an exchange function, at least for a period of time, to see how that competition works to bring down prices, as it has indeed done by the prescription drug plans in Part D of Medicare?

Mr. Kirsch. So, let me just say that single-payer would be the death sentence. This option is, in effect, saying, "You get a chance, but you don't get to have the field to yourself." I want to address --

Mr. Gingrey. But let me interrupt you just for a second. You understand I feel like that a public option is a step, a giant step, toward a single-payer.

Mr. Kirsch. So I was just going to address, if I could -- and this level playing field thing drives me crazy.

Private insurance companies have 158 million to 170 million customers. There are networks in place, they have years of brand loyalty, they have contracts with businesses, they have a well-established place in American society. They are going to continue, as they have done in Medicare, to try to do everything possible to cherry-pick and avoid people who have high health care risks even in a regulatory scheme.

In terms of a level playing field, the public health insurance option is going to start at an enormous disadvantage because it doesn't have all those things in place. And when the private insurance companies whine that can't compete with the government, I have to begin to wonder, do they really believe the polls that say that 93 percent of Americans don't trust them, and that is why they can't compete?

Mr. Gingrey. Well, let me ask you this question. You say on page 2 of your testimony, and I quote, "The good news is that we can fix what is wrong with the system with a uniquely American solution" -- a uniquely American solution similar to what we did with AIG, uniquely American solution similar to what we did with General Motors?

What is uniquely American about interfering with the free-market system in this country?

Mr. Kirsch. Well, first of all, we are not talking about

bailing out the insurance industry like we bailed out General Motors and AIG. We are talking about giving the insurance industry some competition.

And what is uniquely American about this is saying, we are not going to have a system that is just private, we are not going to have a system that is just public; we are going to build on what works in America.

What works, in some ways is private insurance, has got problems, has worked for our parents and grandparents, is Medicare. We are going to use two systems you are familiar with and combine them, and that is the uniquely American part of the solution.

Mr. Gingrey. Let me switch to Mr. Parente.

Mr. Parente is an economist. I would like to get your opinion on what impact will the employer responsibility policies in this draft have on employers' ability to create jobs and put more people back to work? I want you to answer that.

And I also want to know if you have seen anything in this draft legislation in regard to the reserve funds that the public plan would have to come up with. And where would they get that money to be on a level playing field with the private health insurance plans that also would be competing in the exchange?

Mr. Parente. The employer question, first of all, it really depends on the size of the employer. There is -- I have to look at this more carefully, will before 8:00 a.m. tomorrow morning.

But there is the provision that there has to be some pay or play option that is in this. That will always impact employers in a way depending upon the size of those particular employers that are in place.

And your second question?

Mr. Gingrey. Well, let me switch it over to Mr. Neas on the second question.

Mr. Neas, do you see anything in this draft that calls for the public plan providing a reserve fund before they can do business, just like any other health insurance company doing business? Any State in this country would have to have a certain amount of money available before they could start offering a product so that they could cover these claims that occur. They would have to have that reserve.

Where would it come from in the Federal Government plan, and how much money are we taking about?

Mr. Neas. Mr. Gingrey, I must confess not to knowing every single phrase or sentence in the bill. My recollection from going over the materials over the weekend was that the committees plan to have this public insurance option compete on an equal level, be competitive.

And, as I understand it, also that there would be an initial investment with respect to the reserve at the beginning, and then the public insurance option would be self-sufficient after the second or third year.

I defer to counsel and others up there, the members, but I think that is my recollection.

Mr. Gingrey. Mr. Neas, thank you.

And, Mr. Chairman, thank you for your indulgence.

I assume that money would come from the general fund and from John Q. Taxpayer.

Thank you, and I yield back.

Mr. Pallone. Our vice chair, Ms. Capps.

Mrs. Capps. Thank you, Mr. Chairman.

And thank you for your testimony, to each of you.

Mr. Kirsch, your organization, Health Care for America Now, has good representation in my district, so I will be addressing my conversation with you, because it comes right from some of the people who have been talking with me.

But I did want to mention in this discussion of competition, which I am happy we can get in to, agriculture is the basis of my congressional district in California, and large parts of it are rural, therefore. And, in those areas, there is only one private option. I don't call that competition. Maybe that is why there is such enthusiasm among many of my constituents for change, because they see a monopoly in health care delivery. If you make too much money so that you can't be on Medicaid, then you have to buy this plan that they keep raising and they do. Plus, we have a provider issue because it is a locality problem with our low reimbursement rate.

So that combination is really -- in so much of America we didn't bring those points together. It is a part of our reform legislation, as well. So I am pleased that we have this opportunity to really get into what competition means.

And I want to get to that in a minute, but would you just expand for maybe a minute on so on why we cannot wait any longer?

There are a lot of people here in Washington, D.C., and some who are overwhelmed with our financial burdens, our economic situation, plus our debt, they are saying, "Why would you want to bring this up now?" to our President. And some of us, maybe, are wondering, too, because our agenda is really full.

Now, as I said in my opening, as a public health nurse, this is why I came to Congress, in large part because we have a system that isn't working, that is already is so costly. I mean, we are talking about the huge costs of health care. We are already paying more than any other country in the world for health care.

So why must we seize on this very crowded moment in our agenda to do this?

Mr. Kirsch. Well, I think you have answered the question yourself. I mean, you know, the fundamental point that to fix the economy in the long run we have to fix health care is just true. It is a point that the President has made, that Peter Orszag has made.

Our failure to do that, our failure to have a system which provides good coverage to everyone and systemic ways of

controlling costs, is why we continue to have a system where health care inflation is larger than greater inflation, why we continue to outpace the rest of the world in how much we spend and yet get poor results.

What is true about the rest of the world is they understand that health care is not a private good, it is a public good. And there are two things you do with a public good: You regulate it or you provide it directly.

Mrs. Capps. Let me interrupt you. Do you think that feeling is shared in this country, that that is what it ought to be?

Mr. Kirsch. Absolutely. And, again, the New York Times poll, great data from this about the public's feeling -- I will pull it out -- but that the government can do a better job of controlling health care costs than private insurance.

What the public actually understands is really interesting in this. They understand that nobody other than the government is strong enough to stand up to private insurance and the rule they have in their life, the kind of thing your constituents see all the time. They want a strong, public government role for regulating the private insurance industry and providing a choice, so the only choice isn't private insurance.

And, you know, if you look at why so many larger employers now are saying they want reforms, it is because they understand the current system is unattainable, and small business -- unsustainable.

Mrs. Capps. Let me ask you to use -- and I wish I had time to ask all three of you. I think there is a huge lack of understanding. And I hope that these hearings and our President's press conference today and all the other things are going to really help explain to the American people what a public option is, that it is a level playing field, that the public option isn't a government-subsidized program any more than any of the other options will be. If we have health reform, we are going to give an opportunity for everyone to be participating. And most people, so many people, up to 400 percent of poverty, are going to need help.

Mr. Kirsch. Right. And I think what I am finding as I talk to constituents, and you may find the same thing, is there is a huge confusion between the exchange and the public insurance option. This is a new concept for people.

So people ask me questions like, I was on the phone yesterday and they said, "Well, will the public option cover the following things?" I said, "This is the wrong question."

Mrs. Capps. Yeah.

Mr. Kirsch. We are going to have a system -- and what your bill does, which is great, is it says that every plan in the exchange will have to meet these benefits. And, actually, after 5 years, every employer will have to meet these benefits. So we are establishing a standard across the country.

And so much of what your legislation does, which is important

in terms of a level playing field, is it says we are going to create a basic standard of health care in the employer system, which is one reason that we won't have the crowd-out, as well as in the exchange, and the public option will be one more option in that.

But that gives everybody the question of, again, will I be guaranteed good, affordable health coverage? Well, you know it will be good if it meets those standards.

Mrs. Capps. Uh-huh. And I think you are absolutely right that what the public is asking for is certainty. The great fear that people have with the health plan that they may even like is that there is no guarantee that next year the premiums will go up.

We did this Managed Care Modernization Act, and seniors welcomed the opportunity for a chance at lower costs, but then they found out that, at any moment, those companies -- the insurance companies have had nobody overseeing the way they were able to manipulate the markets.

I will yield back for now, but thank you very much, all of you, for helping us have this conversation.

Mr. Pallone. Thank you.

The gentlewoman from Tennessee, Ms. Blackburn.

Mrs. Blackburn. Thank you, Mr. Chairman.

And I want to thank all of you for being here. And I have a list of questions that I would love to go through with you all.

Mr. Neas, I think I will start with you. You know, you make

a pretty bold statement on page 1 your testimony. "The economic crisis facing us cannot," which you underline, "be addressed successfully without the simultaneous adoption of a comprehensive, sustainable overhaul of America's health care."

Do you have specific research that are you citing in that, and would you like to submit that for the record?

Mr. Neas. Yes, I do --

Mrs. Blackburn. Great. I would love to have --

Mr. Neas. -- Congresswoman. I would love to depend on the chairman of the Federal Reserve --

Mrs. Blackburn. Okay. And let me ask you also --

Mr. Neas. May I finish that question?

Mrs. Blackburn. Do you have any program that was a public-private option, competition, that you can point to that has been successful or successfully implemented?

Mr. Neas. I think there are many examples of where there has been a public-private --

Mrs. Blackburn. Can you cite one for me for the record?

Mr. Neas. I would certainly say that the Medicare and Medicaid and Veterans, all the so-called public programs have much interaction with the private --

Mrs. Blackburn. Can you look at the States and give us one? Because we know in Tennessee and Massachusetts they have both been shown as being examples that do not work.

And, you know, there was a question, in our question period,

someone mentioned price-fixing with the public plan. What we found in Tennessee is that you cap what is going to be paid through that public plan and everything gets cost-shifted over to the private plans. And then you limit your access, and your private insurance becomes unaffordable. And rural areas like mine lose out.

So it just really -- it doesn't have a great track record. So I appreciate your willingness.

Second question for you: Do you think this can only be addressed by the Federal Government? Can the States not help address this? Can the private sector not address this?

Mr. Neas. The States have to be part of this. The private sector has to be part of this. But we also need a national plan that is systemic and systemwide --

Mrs. Blackburn. And you think everybody has to be in the plan?

Mr. Neas. Absolutely.

Mrs. Blackburn. Okay. Then do you agree with the premise over in the Senate where they are wanting to exempt the unions and the union workers would not have to pay? Let's see, those that are covered under collective bargaining agreements would not be subjected to the tax. The tax is on the health care benefits.

Mr. Kirsch, I see you weighing in on that. Do you want to speak on that one?

Mr. Kirsch. Sure. I mean, first of all, you are talking

about a question of whether or not we should be taxing people who have good health care benefits. And I think that is the wrong direction.

Mrs. Blackburn. So tax everybody but not the union.

Mr. Kirsch. No, no, no. We don't think you should tax --

Mrs. Blackburn. Okay.

Do you, Mr. Neas, think the unions ought to be exempted, or should union workers have to pay on this also?

Mr. Neas. I don't think there is any provision in the Senate that is trying to treat union members differently than any member of society.

May I answer a couple of your questions just for 20 seconds or so?

I do want to go back to the private-public blending, the partnership. But, most importantly, you just can't, as in Tennessee or Massachusetts, address coverage for all or one these principles. You have to look at the cost, you have to look at the financing and the administration. \$2.5 trillion a year in health care spending, approximately a trillion of that, according to dozens of studies, is waste and inefficiency. The money is there --

Mrs. Blackburn. Okay. Let me interrupt you. Reclaiming my time, I appreciate that. And I would like -- I am so limited on time, and I have so many things.

But Mr. Kirsch has just said that he is opposed to a

single-payer system. And then your group sponsored a rally last year, and here is a comment that was made by a Member of Congress, said, "I know many people here today are single-payer advocates, and so am I. Those of us that are pushing for a public insurance option don't disagree with the goal. It is not a principled fight. This is a fight about strategy, about getting there, and I believe we will."

So, you know --

Mr. Neas. Congresswoman --

Mrs. Blackburn. -- we have to look at this. If we have those that say, "I am not in favor of a single-payer system; we really don't want to go there," and then others that say, "Well, this is a step along that way," as others members, in their questioning, have asked you today, I think that that causes us tremendous, tremendous concern.

And, Mr. Kirsch, I think it is fair to say that maybe you don't like the insurance companies, but, nevertheless, would you -- your wanting to get to good, affordable coverage for all, that is a goal that I have. Going through what we have done, access to affordable health care for all of my constituents I think is an imperative. And everyone should be able to have access to that.

Now, are you completely opposed to a private-sector solution? Are you open to that? Or do you feel like it has to be done through government control?

Mr. Kirsch. Well, let me just quickly -- if you are saying

we are going to continue to have this solved through the private market that got us into this mess, yes, I am opposed to that.

Mrs. Blackburn. Okay.

Mr. Neas. Fifteen seconds, Congresswoman? We did not have a rally last year. No one said anything like that at one our rallies. I think your facts are incorrect.

Mrs. Blackburn. Okay, I appreciate the clarification.

Mr. Chairman, I will yield back. And I have some questions I didn't get to that I would love to submit for the record.

[The information follows:]

***** COMMITTEE INSERT *****

Mr. Pallone. Every member can submit questions for the record. I will mention it at the end, but I can mention now, within 10 days we usually ask members to submit their written questions and then we ask you to get back.

The gentleman from Georgia, Mr. Barrow.

Mr. Barrow. I thank the Chair.

We have heard a lot about how beneficiaries are going to benefit under various proposals in the tri-committee draft. I want to hear a little bit about how providers are going to benefit.

Where I come from, people are mighty concerned about being able to keep their choice of doctor and their choice of hospital, but it would probably be more accurate, where I come from, to talk about getting that choice back, because a lot of folks don't have a choice in the current system as to where they can go to get the treatment.

And you talk to doctors, and they have this problem writ large. The consolidation of business in the health insurance sector has allowed fewer and fewer insurers to exert and abuse what is essentially a monopoly power to decide what folks are going to get reimbursed.

So when I hear folks talking about how participating in a public plan is going to get you at least what you get with Medicare plus 5, or something on that order, you are talking about

a system that is already so bad it broke, where they were ignoring what is going on in the private sector, where the private insurers say, "If you are not in our network, you don't get to treat anybody, because we are the only insurer in town."

So what I want to know is, how are the rights of doctors and hospitals going to be strengthened here? I read a lot in the summaries about how the interests are going to be served pie-in-the-sky-wise, you know, down the road -- we are going to grow the universe of providers, we are going to provide incentives to get more folks into the game.

Well, that stuff sounds good, but what about the rights? What can folks expect, as a matter of law, if this draft were to be enacted, in terms of what doctors get to participate in what plans, how insurers can discriminate against doctors of good standing in their community? How is this going to change in terms of how the world looks to doctors?

Who can go first on that? Mr. Kirsch, do you want to take a stab at that?

Mr. Kirsch. Well, I think the first thing to note is that, while there are some access problems in Medicare, 97 percent of doctors accept Medicare. And, you know, seniors find that they get covered with a large variety of doctors in their community through Medicare, and you don't have the kind of network problems you have in private insurance, where you have restricted networks and, you know, you may change insurance plans and you lose your

choice of doctor.

Mr. Barrow. The range of the benefits package is good, or at least it is standardized. Folks have a pretty good idea of what to expect in terms of what is covered. Doctors don't like, though, the way we have abused the system with the constant -- you know, the sustainable growth rate issues have sort of abused that system so much that it is no longer the gold standard, in terms of what doctors look for and what they expect to get. They need to be reimbursed for the reasonable cost of what they are doing.

Mr. Kirsch. Right. And I know that, you know, one of the things about the STR fix will hopefully mean that we are on a long-term path to make that more comfortable for physicians. At the same time, from a point of view of physicians participating, they participate in Medicare, and one of the things about a public option, having a stable -- stability -- and we would expect physicians participating the same way they do in Medicare, particularly in your legislation, paying 5 percent more than Medicare. You would then solve a lot of this problem of choice and stability for individuals, and then doctors would have a system that they can enter in at an enhanced rate for Medicare, particularly with that STR fix.

Mr. Barrow. So, basically, what you are saying is, if the doctors are being pushed around by the one or two dwindling providers -- payers in the market, they have a place to go --

Mr. Kirsch. Absolutely.

Mr. Barrow. -- that they don't have right now? It is guaranteed to be open to them.

Mr. Kirsch. Yep.

Mr. Barrow. Okay. How about hospitals? How will hospitals come out of this, especially rural hospitals? How are their interests going to be strengthened or served by the draft?

Mr. Kirsch. Well, you know, a huge burden for hospitals is uncompensated care. It is an enormous, enormous burden. And, you know, hospitals are always faced with, what do you do when someone comes to the emergency room who needs medical care and isn't covered? Let's provide coverage for those folks. And that is a revenue sources for the hospitals, as opposed to having to collect -- you know, not have the revenues, hurt their bottom lines, cost-shift to other payers.

So, you know, the estimates are that, actually, insurance policies -- the average family insurance policy includes \$1,100 for uncompensated care. Most of that is in hospital settings. And it is one way that, over time, as we get everybody in the system, we can reduce other premiums and also have a revenue source for hospitals that they don't have now.

Mr. Barrow. Mr. Neas, do you want to chime in?

Mr. Neas. I just wanted to add, regarding the doctors, this is a very important point. I said in my testimony that we have 78 organizations that stand for 150 million Americans. One the best things is we have about 10 medical societies in the National

Coalition on Health Care. That was not the case in 1993 and 1994.

And I know, sitting down with the doctors and nurses and others, with Henry Simmons and others on the staff, I said, "Why are you doing it this time?" And they said, "This time is different. We see an attempt to have comprehensive, systemwide, systemic reform. We don't mind making some sacrifice, as long as it is a shared sacrifice, a shared responsibility. We can give up something if everyone is going to be giving up something."

They want predictability. They want to make sure they are getting reimbursed. But they want a system that works, that is sustainable. And I think "sustainability" might be the most important word that I am going to state today before this committee. But I think that is why you are getting so much participation from all the stakeholders. This is such a different environment than 15 years ago, and I think that is the reason why.

Mr. Barrow. Well, we are addressing the interests and the rights of the existing universe of health care providers. Let's go back to the subject I passed over for a second, and that is the long-term problem of supply and demand, the fact that we don't have enough primary health care providers, for example.

Mr. Neas. That is a big --

Mr. Barrow. Do you think the incentives and the proposals that are in this bill are adequate enough or robust enough or are muscular enough in order to be able to provide us the growth in the sector of the health care community that is being underserved

right now, not by area, but by area of practice?

Mr. Neas. We have been meeting with the medical societies and one of our newest members, the American Association of Medical Colleges and Teaching Hospitals, and they have been pointing out to us this extraordinary workforce issue.

And, as you know all too well, primary doctors now only account for about a third of all the doctors in the country, sort of the reverse of what it was just 20, 25 years ago. We need more nurses, we need more doctors, we need more training, we need more money. We have to invest in our providers and our doctors and our nurses.

Mr. Kirsch. And there are several measures in this legislation that do that. There are increases to the National Health Service Corps --

Mr. Barrow. My question was, though, are they adequate enough? Do you think they are strong enough to actually make a difference, to bend the curve in the areas that are being served by --

Mr. Kirsch. Well, there are significant investments in doing this, which is really neat, in a whole variety of measures that the bill includes.

Mr. Barrow. All right.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Ms. Christensen?

Mrs. Christensen. Thank you, Mr. Chairman.

Let me begin with Mr. Neas. And I thank all of you for being here this morning.

Mr. Neas, I agree with your statement in your testimony that this is not the time for halfway measures, but I also take the position that coverage alone doesn't reform the system. None of the principles in the national coalition address the huge gaps that exist in the health of people of color, in rural areas, or the poor.

Where and how does the elimination of these disparities that drain the system and our communities fit in your agenda, or is it included inherently in those five principles?

Mr. Neas. You raise such an important issue. I was just meeting last week with many of the groups who are working on the disparity issues.

The question has been asked about how urgent this issue of enacting this bill is, and what is the crisis. It is an extraordinary crisis; we cannot afford to wait.

And I am addressing your issues. It is not just the Federal Government's fiscal crisis and economic crisis or the State and local governments', but it is the people who are being affected. 400,000 Americans die every year because of preventable medical errors, infections that they get in hospitals, just by mistakes. Millions more are harmed.

Those who are uninsured or those who are underinsured --

many disproportionately are minority people without wealth -- are the most affected by this. But it affects all of society. It affects our productivity. It affects the bottom line of businesses and the State and local governments. This is a crisis of enormous proportions that cannot wait. The costs of inaction are unbelievable.

Mrs. Christensen. Oh, I am not suggesting that we should wait. I am suggesting that all of it ought to be included.

Mr. Neas. That is our position. That is why we say systemic, systemwide, which would address the issues that you are raising, which are very important. And without systemic, systemwide reform, you can't get to that.

And we have to make special efforts to make sure every American, including those who do not now have access or do not now have the affordability issue or the quality issues addressed, get those issues addressed.

Mrs. Christensen. Thank you.

Mr. Kirsch, I know that eliminating disparities is one of your principles. But to be able to answer the question, as you say, at the end of the day, "Will I have a guarantee of good coverage I can afford?", if to be able to answer that affirmatively we have to fund this bill without a complete offset, should we cut back on being able to answer that question fully just to meet the \$1 trillion limit? Or do you see us maybe budgeting for prevention, knowing that it will save money in the

long run?

Mr. Kirsch. Let me say that there are eight specific -- by our count, there are eight specific measures to deal with inequities in health care for communities and people of color in your draft legislation. So that is really encouraging, and we are glad to see that.

But to this question of should an artificial, a trillion-dollar figure be used for this? Absolutely not.

You know, I understand that the Bush tax cut was \$1.9 trillion over 10 years, and \$1.3 trillion of that was for the 20 percent of people in the upper-income brackets. You all made the right decision, I think the right decision, to spend about \$800 billion just for 2 years on the economic situation. We are going to be spending around \$42 trillion on health care in the next 10 years. That is assuming a 5 percent inflation rate for health care, which is actually probably an optimistic rate.

So if we are talking about, at \$42 trillion, adding \$1 trillion or \$2 trillion, it is really important to realize that if we believe what we do believe, which is that we have to create the kind of systemic reforms along with lower costs, we need to make the investment to realize those goals.

And these figures that sound so large, when we are talking about 10 years and the size of the health care system, are really not that large. So this should be driven on doing it right and coming with the resources to do it.

Mrs. Christensen. Thank you.

Dr. Parente, much of the savings and reduction in health care costs, although they maybe realized outside of the 10-year window, will come from community public health measures and broader policies implemented across all agencies, as well as for a more efficient system and the elimination of fraud and abuse.

Did you have any models that took into account community public health measures that would be implemented, or addressing the social determinants of health, and did that affect the costs?

Mr. Parente. The models just aren't precise enough to do that.

I mean, I personally recognize those are very good things. I actually brought along a book from 1932 that states that all of the same objectives that we want to achieve here today with this bill pretty much were there. This is a longstanding goal, what we are trying to do. This is from the Committee of the Cost of Medical Care from University of Chicago.

But they can't be accounted for. And, actually, a lot of things cannot be accounted for. Health IT savings cannot be accounted for easily. Prevention can't be accounted for quite easily, as well. And a 1 percentage point difference, in terms of the cost increases in health care, vastly change what these projections will look like, as well.

Mr. Pallone. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

Ms. Schakowsky. I want to talk about cost for a minute, because the cost numbers -- and let me ask you, Mr. Neas. Dr. Parente's study looks at the funding for the Federal Government as if that is the only factor that we ought to consider. And I don't know, the \$4 trillion or whatever, I have some disagreements over the -- or at least my staff suggest that, having looked at that, some problems with the methodology. But that is not the central question.

When do we consider total costs spent by Americans -- businesses, individuals, out-of-pocket, premiums, co-payments, all those things? When we talk about costs, don't we have to think about the aggregate and not just the Federal spending?

Can you answer that, Mr. Neas?

Mr. Neas. Absolutely.

Some people were upset last week by CBO, by Congressional Budget Office. And I am not saying I agree with how they scored everything, but we are going to look back and thank the Congressional Budget Office, because they put on the table the cost issue. And I think, for this to be sustainable, we have to, as the President has said, make this budget-neutral.

But you asked the right question. It is not just an issue of pay-fors or the issue of the Federal Government; it is looking at the entire system. The best phrase that I heard so far in the last 6 months, again, out of the President, is shared responsibility, shared sacrifice.

Let's take the pharmaceuticals, let's take the insurance industry. They are obviously very happy about where this is going in terms of 10, 20, 30, 40 million new customers. They are going to the table, they are participating, and I applaud them. And I know they want predictability. I know they are scared, like we all are, by the economic conditions. But they have to come to the table and give up something too.

There is a lot of money that has to be saved by the pharmaceuticals, by the providers, by all of us, by the insurance companies. I said before about that, \$2.5 trillion. The money is in the system; we just have to spend it well. We have to look at the cost containment --

Ms. Schakowsky. Okay. Let me see if anyone else wants to comment.

Dr. Parente?

Mr. Parente. Well, the cost issue is, I think, the dominant concern that you really need to address here. Because of the situation we were in, actually the day that I testified last --

Ms. Schakowsky. See, I don't even agree with that. I mean, I don't even agree with that. I mean, I think that the polling showed, too, that the American people, a majority, said they would even be willing to pay somewhat more to have universal health care.

So your -- but go ahead.

Mr. Parente. Let me put it back to you as a question.

Ms. Schakowsky. Yes, go ahead, sure.

Mr. Parente. Are the American people willing to take hyperinflation that could come if this thing basically capsizes treasuries? Because if that happens, it will come because of this bill.

Ms. Schakowsky. Mr. Kirsch?

Mr. Kirsch. Well, you know, I would say what Mr. Orszag says, which is that the current biggest threat to the Federal Treasury right now is the current health care system. And if we don't get our hands on that, we are really in a huge economic problem in the long run.

Mr. Parente. And the only way you can bring those costs down is a statist solution that would control costs, which -- let's be honest -- that is what you are advocating, a statist solution.

I am sorry, I was out of order.

Mr. Kirsch. We are actually advocating a system that has systemwide cost containment in a way that focuses on better delivery.

And, you know, there has been a lot of discussion of this trip from Dr. Gawande to McAllen, Texas, and looking at the perverse incentives there that lead to such high Medicare spending versus the, kind of, right systems that you have in a place like Mayo or others.

So we have to focus on good delivery, on prevention, all those things. And what I do think is important about your first

question is that we have to look at this as a whole system. For instance, if we don't provide coverage for someone with a benefit package, it doesn't mean, like, their health need disappears.

Ms. Schakowsky. Right.

Mr. Kirsch. If you don't, for instance -- I mean, I think you generally have a good benefit package. I would criticize one thing: You have left out dental. Now, you get that as part of your basic package in Congress.

Ms. Schakowsky. Very poorly.

Mr. Kirsch. Very poorly, but there is none in this. And it means that, you know, how many members of the committee may have been to a periodontist, and what would happen if you couldn't have it?

So, understand that leaving it out may save the Federal Government money, but it shifts tremendous cost onto that family, it makes their health more expensive, it makes them harder to be in the workforce. It is a whole system we have to look at.

Ms. Schakowsky. I wanted to just make a comment. I may have time for that.

This issue of competition, I think, is also bogus, because right now the insurance industry and Major League Baseball are the only businesses exempt from antitrust laws, from McCarran-Ferguson. And so, 94 percent of markets are noncompetitive right now. So this argument that somehow, you know, we ought to leave it to the private sector and competition

is just absolutely false.

The insurance industry has tried all its time to avoid competition, and it seems to me that the injection of a private health insurance option -- and, frankly, I cannot think of a public interest reason why that is not an advantageous thing to do. To have a choice would actually inject competition.

And I yield back.

Mr. Pallone. Thank you.

The gentleman from Texas, Mr. Green.

Mr. Green. Thank you, Mr. Chairman, for our first full hearing on the draft.

And I appreciate our first panel of witnesses for being here.

I have a district in Houston, Texas, and Texas has the highest percentage of uninsured in the country and also the highest number of uninsured. And I will give you an example of why we need, I think, a public plan to compete. If the private sector could have dealt with the 45 million estimated number of people, they would have already done it, because they would be making money on them.

I have huge refineries in my district, chemical facilities. About 3 years ago, the CEO of Shell Western Hemisphere sat in our office and said he was transferring some production jobs from their chemical facility in our district in Deer Park, Texas, to the Netherlands. Two reasons: The natural gas at that time from the North Sea was cheaper, and the cost for health care in the

Netherlands was cheaper than the cost in Deer Park, Texas.

Now, it is a union-organized plant, but that was the business decision they made. And for a number of years, sitting on this committee, I have been wanting to hear from the business community, saying, "Look, this is a cost issue that we have. We can't compete in Deer Park, Texas, because of our high cost of health care in our Nation."

So I know there are a lot of businesses who are part of the coalitions, various coalitions, on this. And I wish if could just address that. And I know it came up in the last questioning.

You know, we have polls all over the board, but I think the one that I saw over the weekend and talked about, 70 percent of the American people want some type of government-run insurance. Now, a public plan is not government-run insurance, by any means. But a public plan that will give the insurer hopefully not last resort because otherwise it will be so costly, but an insurance product that people can go to have a medical home instead of showing up at emergency rooms.

And I will start with you, Dr. Parente.

Mr. Parente. Yeah, I appreciate the concern about jobs. I mean, there has been research that shows that it is ambiguous just how much job loss is associated with essentially the provision of health insurance, or that cost that is associated there.

That said, let me tell you what I think could work. It starts with understanding, what is insurance? Insurance

technically is a provision of a policy, therefore fairly high-cost with low-probability event. That is not health insurance, nor is it health care. We throw those terms around quite a bit. If we were to offer insurance for all and call it really health insurance, that is a catastrophic plan, probably with a \$5,000 or \$6,000 or \$7,000 deductible.

And to answer the previous question about what we can do better to do with \$2.5 trillion a year, if you distributed that with an individual mandate to the entire country, you would have money left over. But that is not what we do. And because of that, we have, over a period of time, basically thrown in prevention, other services.

If you think about what the medical home originated from, it originated from the HMO Act of 1974, more or less saying let's move to a capitation model. It seems like it is back to the future. What was missing was health IT and actually some sort of cost accounting to make performance metrics come in. Maybe now with the stimulus bill that will happen, but that is still a long time coming.

The concern is that that design tried to emphasize prevention financially by having extremely low co-pays. The unintended consequences of that was that when pharmaceuticals went from basically nontrivial expenses to suddenly being covered by generous health insurance plans, those \$5 or \$10 co-pays got translated beyond just an office visit practice with a gatekeeper

that was mandatory to everyone. That is what has driven up our costs. We are the enemy of ourselves here.

So the way to fix it, if you want to fix it and have it be budget-neutral, individual mandate, catastrophic plans, let the rest buy up by State preference, however you want to do it, that is budget-neutral. And it would actually preserve the most important thing that I think Americans want, and I think it is in your surveys --

Mr. Green. Well, let me respond to that, because I only have, actually, 25 seconds last.

Again, coming from the State of Texas where we have individual State options, we have 900,000 children in Texas right now who are qualified for SCHIP or Medicaid who are not on it because the State won't pass the match.

The one thing that I asked the Chair: to have a national plan. And don't come up with something that will say the States will make this option, because we know what will happen in certain States. And, again, I was a legislator for 20 years in Texas, and so I bring that as experience to you.

I know I am out of time, Mr. Chairman. Thank you.

Mr. Pallone. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. Baldwin. Thank you, Mr. Chairman.

I wanted to just comment. I am going to sound a little bit like a broken record on this, because my fellow committee members

have heard me talk about the public option we have available in Wisconsin in our Medicare Part D program. And I don't know if any of the witnesses today have had a chance to study that, but, to me, it is ample evidence that a public option can be available and can compete favorably.

Let me just quickly comment on it. For perhaps a series of coincidences, we had a pharmacy waiver before the Medicare Part D program was implemented. We had a program available to seniors in Wisconsin called SeniorCare. Our congressional delegation fought on a bipartisan basis to keep that program when Medicare Part D was implemented and make it a choice available to seniors and other eligible folks in Wisconsin.

And it has operated at about a third of the cost per enrollee compared with the private-sector options. But for those who think that having such a public option would drive away the private-sector competition, I can also tell you that Wisconsin has among the most vibrant array of private options for its citizens, I think I have heard more than any other State in the union.

So I just want to draw that to people's attention and perhaps, when grilled about is there an example that you can point to anywhere in the country of an exchange that has been set up with a public option competing with private options, you can study this, and I think it is a great example.

I want to move from that to a related issue of State innovation as we move forward with this.

Mr. Kirsch, you are committed to a strong and robust public health insurance option, and I am interested in your perspective on the role of States. Do you think that the ability of States to play a role in running these exchanges will enhance a national exchange? And do you think that this ability will empower them to build upon the reforms that we pass at the national level?

Mr. Kirsch. Well, the legislation, as I read it, says States or groups of States can set up exchanges. And, you know, we think that that is an important option. It doesn't have to be just an individual State. I mean, you want these exchanges -- every time you create an exchange, you have to set up another entity. And so, if groups of States can do it, it may be more efficient than having individual States do it.

And, you know, if you have a national public health insurance option, such as we have posed, then it is going to deal with each exchange. And so it becomes one more way of -- less administrative hassle if it is dealing with fewer exchanges.

So it is fine to say States can do this, but we think groups of States doing it, looking at more efficient ways to set up exchanges, manage them, makes sense too. There is no reason, just because we have 50 States in the country, that we have to have 50 separate exchanges.

Ms. Baldwin. I don't know if Dr. Parente or Mr. Neas have any comments on the State role in this.

Mr. Parente. I think States are a tremendous place for

innovation. Actually, what I would welcome to see, how an exchange would go forward, is it actually would be something that would repeal McCarran-Ferguson and allow plans to compete across State lines. Because that would allow the innovations of those private players in Wisconsin that have demonstrated such innovation to actually compete in Santa Fe. I think that would be a nice solution.

Ms. Baldwin. Mr. Neas?

Mr. Neas. Congresswoman, I think this is an excellent question to ask, and it reminds me of a conversation I just had with my boss, Dr. Henry Simmons, a few days ago. We are talking, obviously, about having a comprehensive, systemwide, national health care plan.

However, this is only the first half of what we have to do. Once this is enacted this year, then we are going to have to implement it, oversee it, and enforce it. And I think the States are going to play an incredibly important role in that and be partnering with the Federal Government.

I think it does reinforce what this committee's role is going to be in overseeing whatever does get done at that level, as well as organizations like ourselves. The implementation and enforcement of this law, which will hopefully be done in conjunction with the States, is a question that should be addressed now and forevermore.

RPTS WALKER

DCMN HOFSTAD

[11:25 a.m.]

Ms. Baldwin. Thank you.

Mr. Pallone. Thank you.

The gentleman from Kentucky, Mr. Whitfield.

Mr. Whitfield. Thank you, Mr. Chairman.

Dr. Parente, you mentioned the staggering national debt. And we are on the verge of making a multi-trillion-dollar decision relating to health care.

In your mind, are there more cost-effective alternatives to expanding health insurance coverage than the Kennedy bill or the bill before us today?

Mr. Parente. As I said in the testimony, it is hard to, sort of, have a silver bullet for this at all. I think if you have a mandate on some very basic coverage, with some provisions for prevention, that will lower the price tag considerably, perhaps by half.

It still may not make it free; you are going to need to find some way to have this be paid for. But what it does is it actually, sort of, says to the American people, "You have a right so that if something happens and you face a catastrophic illness, you will be covered, and you will have choice of physician, and that is what we will guarantee."

But to actually go beyond that and to put it into "you have a

right to a public option plan, which is based on sort of an FEHBP model of a BlueCross BlueShield plan that has been morphing for the last 60 years" adds a little too much extra cost, approximately probably 70 percent extra cost than you need to have, and probably reinforces the same behaviors you have in the inefficient system we have today.

Mr. Whitfield. Well, you know, of course, all of us are concerned about cost, and that is particularly important today with the economy being what it is and the amount of money that we are spending. But, in addition to that, of course, the American people want a quality health care system that they all have access to. They want health insurance that they can afford. And we want models that can be adopted, that we do not have the spiraling costs in health care.

And I have been reading recently, and I know he has testified over on the Senate side quite a bit, the CEO of Safeway. And I know that when the Medicare program started in 1965, CBO estimated that by 1990 the cost would be somewhere around \$9 billion. As it turned out, in 1990 the cost was around \$100 billion or so.

The thing that I like about this Safeway model, it appears from the evidence that the CEO is providing that they have actually been able to control health care, the cost, but, more important, they have given their employees the right to make decisions on who they want to see. And they also have developed a system of transparency so that employees can shop around and

determine the costs that various providers charge, and there is a real disparity in that.

So I would like to get your comments, those of you familiar with the Safeway program. And, Mr. Neas, I know you would like to make a comment on that, so go ahead.

Mr. Neas. I do want to salute Steven Burd, I believe is the CEO of Safeway, and all those who make voluntary efforts with respect to well-being and prevention. I don't think there are any independent studies that corroborate what Mr. Burd has put before the committees of the House and the Senate.

And you are talking about cost, I do think that much of what is in the bill, whether it is the Kennedy bill or this bill or things that the President has brought up, there are good, long-range, cost-savings measures. I don't think anyone really has yet addressed the short term. And I think we are going to need some short-term regulatory constraints on the increase in the expenses systemwide.

As Congresswoman Schakowsky was saying, it is everyone's responsibility, but we need some short-term cost control in the bills that come out of the House and Senate, not just the long-term cost-saving measures. And I would hope that would be something that this committee and others would address.

Mr. Whitfield. Yeah.

Mr. Kirsch. I think what is good about what Steve Burd has done at Safeway and people have done at Pitney Bowes and a lot of

other companies in the country is they have actually looked at ways to control costs. And, as you said, the key has been to not have financial barriers to preventive care, to get people in the system early.

One of the reasons we want a hybrid system is to encourage that kind of innovation and encourage it more in Medicare. If you look at Senator Baucus's options paper, it is all these things that Medicare has done to be innovative. So let's have the private sector innovate, let's have the public sector innovate, let's look for better delivery systems. That is what we have to do if we are going to move toward a solution that makes this affordable for everybody.

Mr. Parente. Just a quick comment. I studied consumer-driven health plans, and actually there is a report I have that was published by HHS last year that looks in design very similar to Safeway and found that it actually saved costs, at least bent down the curve, and prevention wasn't touched.

That is why I am advocating that as a model, because I think that could be a very cost-effective solution if the financial incentives are structured that way.

Mr. Whitfield. Thank you. I guess my time has expired.

Mr. Pallone. Thanks.

The gentlewoman from Florida, Ms. Castor.

Ms. Castor. Thank you, Mr. Chairman.

And thank you all for your advocacy efforts.

Briefly, could you all, in 20 seconds, take a turn and characterize CEO profits of HMOs and CEO salaries, HMO CEO salaries and HMO profits over the past 10 years?

Mr. Neas. I would have to give you my personal anecdotal response to that, that it seems excessively high over the last 10 years. There seem to have been numerous press stories that underscore the extravagance of some of those salaries and some of those profits.

Mr. Kirsch. I think we are looking at average CEO salaries of \$12 million for the top 10 insurance companies in 2007; average profits of about \$12 billion, \$13 billion.

Ms. Castor. Did you say billion?

Mr. Kirsch. Billion for the profits. Top 10 CEO salaries of \$12 million. And I believe there was a 400 percent increase in profitability from around 2000-2007. I am doing this from, sort of, my visual memory, but it gives you a scale of the kind of increase in profits we have seen in the industry over the last years.

And I want to conclude with a quote from Angela Braly, the CEO of WellPoint, We are talking a financial analyst, about what kind of decisions they are making. She says -- this is a whole sentence -- "We will not sacrifice membership for profitability." In other words, we are not insuring more people if we are going to lose money on them because they cost us too much.

Mr. Parente. They have been going up; we all know that. The

question is whether or not they are returning value.

I spent 2 or 3 years working at a nonprofit BlueCross BlueShield plan. I liked the people, I liked the management. I was sort of disturbed by how inefficient everything could be. That is what drove me to become an academic, I suppose. And no comments there.

But what I found in terms of some of the good plans that are publicly traded is they introduced innovations that I was dying to see done in those nonprofit BlueCross BlueShields. And if there is anything that I think is of virtue to this public option plan, it is to put some competition into those plans for better business practices.

But keep in mind, those better business practices I see are coming mostly out of the for-profit plans that are being demonized. So I am of mixed mind when talking about what the return on investment of those salaries tend to be.

Ms. Castor. Well, let's just -- I think we can all agree the American people are concerned, to put it mildly. I would say that they are angry.

In my home State of Florida, there is a recent example of the largest managed care provider, private HMO, whose offices were raided some time ago by the FBI, charged by the Justice Department, and just settled the case because Florida had embarked on a pilot project to privatize Medicaid.

So this private HMO came in and won the bid, and it turned

out that they were paid money to provide health care services for children under Medicaid and under the State children's health insurance company. And rather than provide the medical services, they pocketed the money, and have just settled the case for \$80 million that they are going to pay back to the State of Florida.

Meanwhile, the CEO was receiving multi-million-dollar salaries. They were posting the highest profit margins in the history of managed care in our State.

So when we talk about cost, isn't there enough cost -- isn't there enough money in the health care system now? In fact, the CEO of a Florida HMO paid a visit last week, and that is exactly what he said to me: "There is enough money in the system. If you adopt a public option and a comprehensive health care reform bill, we can get this done."

In contrast to all that, what is happening to the average American family? Health care costs are driving Americans into financial ruin. A recent Harvard University study said that 62 percent of bankruptcy cases now are caused or influenced by medical bills -- 62 percent. In 2001 it was 50 percent, and in 1981 it was 8 percent.

And now with the rising numbers of uninsured, they are often completely hammered because they have to pay the entire bill, whereas if you actually have health insurance, you benefit from the negotiated lower prices.

Many people, in this day and age, really have nothing left because they took out a mortgage on their home; now their home is worth thousands and thousands of dollars less.

Isn't the real crowd-out issue the fact that Americans do not have access to affordable health care? Health care costs have skyrocketed, and their paychecks haven't kept up. Isn't that the real crowd-out issue we are going to tackle in this health care reform?

Mr. Kirsch. Absolutely.

Mr. Neas. Absolutely.

Mr. Parente. Just very -- I know I only have a second here. The reason why costs go up is that we like medical care and it works really well. And, societally, that is a decision we are taking.

Individually, everyone has their hardship concerns, and I do not belittle at all what you are saying. But understand why this is occurring. Health care is a good, and we all want it. And we are not willing, necessarily, collectively, or have found the right mechanism to distribute that desire to meet our economic challenges.

Mr. Kirsch. I would just say, if you look around the world, you see there is higher utilization in a lot of countries and they spend a lot less and get good quality. So I would disagree with Dr. Parente.

Mr. Parente. And let me make one personal comment back to

that.

I worked for the British National Health Services, my first job, because I believed in single payer when I was 21 years old. When I worked for the British National Health Service, I was in southwest London in a teaching hospital.

Here is how they saved money, because they still do it the same way. Would you like to guess here, anyone, how many long-term beds, skilled nursing beds, they had available to a quarter-million people in that space? Anyone? How about 31. That is how you save money and how they did it.

That is why U.K. has the most advanced hospice program in the world, because, in order to save those resources, with a soft, velvet touch, you basically were able to say to someone who was 80, "You have CHF. I am sorry. This is the end of the road. Let's make you comfortable." Here, we don't do that as much.

Mr. Neas. Congresswoman, you are really getting to the heart of the matter here as to why we have the kind of polling that we have. People are starting to find out about these outrages. And we do have some of the finest, if not the finest, health care in the world, but, as Mrs. Christensen said, if you can afford it. But there are tremendous disparities.

And I said a little while ago, 400,000 preventable deaths per year in our system -- 400,000 -- costing \$700 billion, \$800 billion a year. These are all costs that could be addressed by systemic, systemwide care. This is a scandal that this is

happening, absolutely a scandal. And you were talking about the cost for individuals and the bankruptcies, four times as much for health care costs as the increase in wages.

When people find out about this, as good as the polls are now, they are going to be even better. There is going to be a popular uprising on behalf of this kind of bill and for comprehensive health care reform this year. It is absolutely necessary.

Mr. Pallone. I let them go because I didn't want them not to have the opportunity to answer your question, but we have to move on. Thank you.

The gentlewoman from Ohio, Ms. Sutton.

Ms. Sutton. Thank you, Mr. Chairman.

Mr. Kirsch, I want to thank you for being here. I want to thank you all for being here. And, Mr. Neas, thank you for your leadership of your very diverse coalition. We appreciate it.

But, Mr. Kirsch, the coalition's five basic principles for health care reform: coverage for all, cost containment, improved quality and safety, simplified administration, and equitable financing.

That is how you -- or is that Mr. Neas? I am sorry, Mr. Neas. I apologize.

Mr. Neas. That is all right.

Ms. Sutton. I bet you agree with those.

Mr. Kirsch. Sure.

Ms. Sutton. Mr. Neas, those are the broad principles that your coalition is fighting for in health care reform; is that correct?

Mr. Neas. Those five principles, buttressed by many, many specifications that are part of our pamphlet. I bring this everywhere. Just like Senator Robert Byrd brings his copy of the Constitution, I bring this blueprint for reform, which has specifications that 80 organizations spent 18 months putting together to implement those five principles.

Ms. Sutton. And I appreciate that and I appreciate that commitment, much the way I appreciate the commitment to the Constitution.

Dr. Parente, do you agree with those five basic principles for health care reform?

Mr. Parente. Yes.

Ms. Sutton. Okay.

And I just have a question, Dr. Parente, about -- I apologize that I didn't get to hear your testimony, but I did get to read it. And so, based on that, you discuss at some length the parts of health care reform that can create costs without any regard for the many cost savers that will be included.

So, in particular, I am interested in your score of the public health plan option. You don't seem to consider that with a public health plan comes increased competition. You sort of almost scoff at that in your testimony, that it will increase

access and drive down premiums for beneficiaries.

Why do you choose to disregard that?

Mr. Parente. Because there is not a study to show that it would work.

Ms. Sutton. Okay. So, until somebody shows you a study -- and I heard Ms. Baldwin talking about what is true in her State. Are you saying that there is no demonstrable evidence based on what is happening there to support this kind of conclusion?

Mr. Parente. Not on a national scale.

I am from the upper Midwest, as well. We in the upper Midwest, as was in the New Yorker article, just do things differently. We are more cooperative, maybe because it is cold. But to generalize this out to the Nation is not easy to do.

I mean, just take the examples from Florida. I guarantee you, Wisconsin and Iowa and Minnesota are really low on fraud. Florida, on the other hand, is the capital for the world.

To find a one-size-fits-all solution is going to be difficult. That is why I propose, if you are going to do something like an exchange, let insurance companies buy in each other's markets or compete in each other's markets and not be constricted to the same State-specific things that McCarran-Ferguson does today.

Ms. Sutton. You know, a couple of things. You will concede then, though, that there is some, on a State-wide basis, evidence to support that a public plan can drive down costs and increase

competition?

Mr. Parente. No, I -- not at a national scale.

Ms. Sutton. I know. I said at a State level.

Mr. Parente. There is evidence of State innovation that is successful.

Ms. Sutton. Okay.

Mr. Kirsch, would you like to comment?

Mr. Kirsch. Well, Medicare has less than 5 percent annual inflation. Private insurance is about 7.5 percent inflation. Commonwealth Fund thinks the premiums -- if we use Medicare rates, you guys are talking about Medicare plus 5 percent, would have 20, 30 percent savings.

So there are studies. Urban Institute says it will save money. Jacob Hacker at Cal-Berkeley thinks it will save money. So there are a bunch of studies that say it will actually save significant money. And we have seen that Medicare has lower inflation than private insurance. So I would beg to differ.

Ms. Sutton. Okay, thank you.

Dr. Parente, can you tell me, do you think that the majority of the millions of uninsured Americans, do you think that they are just simply waiting for the right plan to come along?

Mr. Parente. No, I -- no. I think that there is a real problem. You know, most people would refer to this as a market failure, to have this level of folks be uninsured.

I think the question people have to ask is, when people hear

that 45 million or probably now 50 million number by the time this year shakes out, you know, it is -- the question I think people think about is, is that the number of people that started the year uninsured and ended the year uninsured and found nothing in between? Because that number is quite different. That number is a fraction of 50 million.

Ms. Sutton. With all due respect, I think people, when they hear that number, think that is totally unacceptable in a country as great as this, that we would have millions of people uninsured with access to care when they need it.

But I am going to move on. I just have --

Mr. Parente. I just -- I would agree. What I am saying is focus on the folks that start and finish the year uninsured. That is a priority.

Ms. Sutton. Do you think that the American people who have insurance through the private insurance industry are very pleased with their care?

Mr. Parente. I have seen surveys that suggest that they are not. But it is heterogeneous mix, and they are upset for different reasons.

Ms. Sutton. Do you think that it is appropriate that the pre-existing condition exclusions that exist in the private market should continue?

Mr. Parente. It all depends upon whether those pre-existing conditions actually really get premium to a point where insurance

is unaffordable, which, actually, in several States it has done.

Ms. Sutton. Okay.

I know that my time is up. Thank you.

Mr. Pallone. Thank you.

The gentlewoman from California, Ms. Matsui.

Ms. Matsui. Thank you, Mr. Chairman.

I would like to focus in on one area. I would really like to ask a lot of questions, but this is one area I am really focusing in on, and this is prevention as an overall part of the health care reform.

And we can't forget it, because we understand that we need to prevent people from getting chronic diseases like heart disease, diabetes, and asthma. And unless we do, the costs of our health care system will just go up, no matter how well an insurance exchange is structured.

More than 75 percent of the health spending in this country today is attributable to chronic illness, but only about 3 percent of our health care spending is for preventive services and disease promotion.

Mr. Kirsch, your organization platform states that health care reform will emphasize quality care, including coverage for prevention and primary care, and good management of chronic conditions. And, as you know, our draft bill requires insurance companies to cover preventive services and waives our co-payments for these services.

Is your organization's vision for preventive care fulfilled in this legislative draft before us today?

Mr. Kirsch. Well, yes, in terms of the benefit package, absolutely. Because what you have done is, as you have said, you have made prevention a standard part of the benefit package and, eventually, employer-based coverage, as well as the exchange, and you have done it without financial barriers to care. And you have also made a significant investment in the legislation into increasing the number of primary care providers, because we are going to need that to be sure this preventive care is delivered.

Ms. Matsui. But do you think the bill could be strengthened to place an even greater emphasis on preventive care?

Mr. Kirsch. Well, the benefit package in terms of prevention is good. Now, some of the details of the benefit package are going to be left, under your bill, to a board to set that. The question is how much is put in law now versus not.

But the point is, you have said prevention, you have said financial barriers, and you have made the investment in a primary care infrastructure. So we think these are really, really good.

Ms. Matsui. Okay. Given that the draft bill requires a certain level of coverage for preventive care services already, do you see any role for the public option in driving private insurance toward a model that focuses more on services that will help people avoid getting sick in the first place?

Mr. Kirsch. Well, we hope so.

You know, I had an interesting conversation years ago with the CEO of an insurance company who said, "It doesn't pay for us to invest in prevention, because we are only going to have these folks for a year or 2, so any savings won't accrue to our benefit." That is the kind of calculation you make if you run an insurance company. Or you just do your marketing to people who don't need a lot of health care in the first place.

A public option whose mandate is the public good, who is looking at the long term, will have a different set of incentives to look at: how do we promote the public health, how do we keep people in, how do we avoid them getting sick, having good chronic care management and innovate in that.

And it is very important that one of the goals you specifically laid out in this legislation for the public option is innovating delivery system options that do that. And so not being simply -- you know, Medicare has done some of that, Medicare needs to do better. But the fact that you all made that a specific mandate for the public option is incredibly important.

Ms. Matsui. So you think this is a real opportunity here on the public option aspect of it?

Mr. Kirsch. The public option, actually, specifically is charged by the legislation with doing that kind of innovation delivery system to focus on better chronic care management, to do the kind of things you are asking about.

Ms. Matsui. Mr. Neas?

Mr. Neas. I just want to add to that.

There are some excellent provisions in the bill, and I think there is more and more discussion with respect to best practices and looking at Intermountain and Cleveland and Mayo and other places.

But I think it is very important to make sure that your deliberations and your eventual decisions and how it is implemented is evidence-based. And I think that is so essential for making this all work.

Ms. Matsui. I believe that, too, and I think that there is evidence available. It is trying to get the evidence in the manner in which we can actually compare. And prevention and wellness, for many people, seem to be more something that is a fluffier side. But, for me, I would rather not get sick. And I think if we don't get sick, we will probably lower the health care costs anyway.

But I was also considering, too, what -- Mr. Neas, you did a lot of work on health care costs and how they hurt small businesses. And can we use the same model here that Safeway has used, as far as what they have done as far as prevention and wellness, as far as having small businesses do the same things too?

Mr. Neas. I had an opportunity to respond to another member regarding Steven Burd and Safeway and saluted him for his innovations and his well-being and prevention efforts. I also did

hasten to add that there hadn't been any independent study to corroborate some of the claims that have been made.

But, certainly, we want to welcome efforts by the private sector, by everyone, to try to keep people well, to prevent things from happening. That is an important part of the equation.

Ms. Matsui. I think I have run out of time. Just quickly.

Mr. Kirsch. Just quickly, though, I think the key and one of the reasons to have a strong public option is, how are we going to take -- it is great that Safeway or Pitney Bowes or IBM can do it; how are we going to translate that into small businesses?

If we have a public option that drives those things and then small business, in exchange, can benefit for their employees, we can make it more than just the innovators in the private sector.

Ms. Matsui. That is great. Thank you.

Mr. Pallone. Thank you.

The gentleman from Utah, Mr. Matheson.

Mr. Matheson. I waive.

Mr. Pallone. The gentleman from Massachusetts, Mr. Markey.

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

This is an historic time, and we are very proud in Massachusetts that we adopted a new law that puts us in the same role, as revolutionaries, that our State has historically played in many other areas, except we are not any longer talking about Minutemen but MinuteClinics up in Massachusetts, and not Red Coats but the white coats of doctors, in terms of this revolution that

we are trying to create.

What I would ask is, if we could, get your opinion as to this Massachusetts plan, and what lessons you draw from it, and what you would try to emulate or avoid in moving forward.

And we have moved now to 97.4 percent of our citizens with coverage, which is something that obviously we had as our goal. It has only been in place for a couple of years, but it obviously has been successful to that extent.

But, Mr. Neas, could we begin with you? And welcome back to this committee, for the many times you have been here. And whatever observations you have I would very much appreciate.

Mr. Neas. Mr. Chairman, it is an honor and a pleasure to be back here. And, as you know, as a product of Massachusetts, as the former chief counsel of Republican Senator Edward W. Brooke, I am very proud of what Massachusetts has done -- Senator Kennedy, yourself, the legislature, Mitt Romney, and others -- especially with respect to, I believe, including about 95 percent so far of the population of Massachusetts.

Having said that, I know Massachusetts made a political decision several years ago that it was not going to address the cost management issues at that time. So we have my very good friend, Governor Deval Patrick, going to the legislature right now and going around the State to make sure there is additional legislation that would address the skyrocketing costs and increase in costs that affects Massachusetts and every other State in the

Union and is such a national emergency.

So there are wonderful lessons to be learned from Massachusetts. There are also lessons that you expected, that it was not a sustainable plan unless the money was going to be raised and/or the cost-containment issues were going to be addressed. I think Massachusetts is starting to do that.

And I believe, with a national plan that addresses health care reform in a systemic, systemwide way and works in partnership with Massachusetts, the Paul Revere work that has been done will be completed over the next few years, the next number of years.

Mr. Markey. Thank you, Mr. Neas.

Mr. Kirsch?

Mr. Kirsch. Sir, I have a daughter who is a nurse at Children's Hospital in Boston.

Mr. Markey. Beautiful.

Mr. Kirsch. But, in terms of your question, more importantly, I have a daughter who just moved to Boston, Somerville, has taken not a very well-paying job between college and graduate school, but has good health insurance because of what you have done.

And when she was between jobs, we had to pay more than \$300 for a medication she is on for a chronic condition. That was a lot of money for us to pay. What would have happened if she weren't able to have that -- now be able to get that coverage through the plan?

The plan has been successful by expanding coverage to low-income and moderate-income people in Massachusetts. It is extraordinarily important.

Where are the things that we think can be improved?

One is, unfortunately -- and this is a fiscal problem because the State is just doing it -- the subsidies don't go more than 300 percent of poverty level, which means there are a set of people who have been exempt from the program because it is not affordable. What is good about your legislation is it goes up to 400 percent of poverty level. It also allows you to look at regional differences in costs, which is very important.

Second of all, it doesn't have a public option in Massachusetts. And by injecting that kind of role in controlling costs, that is an important factor.

Third, you don't really have employer responsibility because of the ERISA challenges and also because Governor Romney wasn't crazy about it. Employer responsibility is very important in terms of finding a lot more revenues. You are able to get away in Massachusetts because you are one of the highest employer-sponsored insurance penetrations in the country. You can't do that in other places.

So a lot of good things in the Massachusetts model were shown, but some things that we think can strengthen it. And, as Mr. Neas said, you are all starting to deal with the cost-control issues, which are being built into the Federal reforms.

Mr. Markey. Okay. Thank you, sir.

Dr. Parente?

Mr. Parente. I think you should be applauded for doing it. I think it is a landmark initiative.

Costs are the big issue, as are being discussed and have been previously mentioned. I think also there could be longer-term issues in terms of competition.

One thing that was learned that actually some of our work showed previously was that some of the higher-deductible plans or the low-option PPOs would be the magic price point to get many people to get the right incentives to come in. And we just have to be sure that if this happens, what we are discussing here, that those options are on the table as well.

One thing that -- I will make this very brief comment -- was that you really need to have as many private insurers to compete as you can. And I remember that that wasn't an initial concern, but that looks like it is being addressed.

Mr. Markey. Thank you, Dr. Parente.

But there are a lot of things in common, Mr. Chairman. You know, it includes expanding Medicaid, creating a connector to help patients select a plan, and helping to subsidize the low-income citizens so that they can have access to health care.

So I think the general principles are very similar. And we can learn, actually, from what went well and what needs to be reformed in the future.

And I thank you for your leadership.

Mr. Pallone. Thank you.

And I think we are done -- Mr. Dingell? Chairman Dingell?

Mr. Dingell. Thank you, Mr. Chairman.

Your study of the costs was just limited to the Kennedy bill; is that correct?

Mr. Parente. It was also done, one on Coburn-Ryan and also one on the Senate Finance Committee, as well.

Mr. Dingell. I see. You have not done one on the bill that is right now, the draft?

Mr. Parente. No. As I mentioned earlier, I hope to have estimates on that done by tomorrow morning at 8:00 a.m.

Mr. Dingell. Okay.

Now, I am curious, you have mentioned the English health system. Is there any significant similarity between the English health system, of which you appear to be critical, and the discussion draft that is before the committee?

Mr. Parente. Actually, I am not critical of the English system. I am just bringing it up as a comment. I think both systems grew out of, if you will, the socioeconomic history of each country.

Mr. Dingell. But there is no similarity between the two, is there?

Mr. Parente. Well, there will be increasing similarities if we have to ration care.

Mr. Dingell. Why do you make that statement?

Mr. Parente. Because the only way you can actually hold the cost curve down effectively with Medicare is effectively to limit patients.

Mr. Dingell. This is your assumption; is that correct?

Mr. Parente. It is an assumption --

Mr. Dingell. And, as in all other studies, the study is only as good as the assumption, isn't that right? Garbage in, garbage out.

Mr. Parente. Not necessarily. But if it is garbage in, garbage out, then all the Commonwealth stuff has to be thrown out, too, Congressman Dingell.

Mr. Dingell. Now, this is not a single-payer system that we are talking about here, is it? The European system is a single-payer system to which you are referring; isn't that right?

Mr. Parente. The European system is made up of many countries --

Mr. Dingell. Let's talk about the British.

Mr. Parente. They are not all single-payer systems.

Mr. Dingell. The British system is a single-payer system, is it not?

Mr. Parente. It is a single-employer system, yes.

Mr. Dingell. Now, your assumption that there will be rationing, there is rationing right now, isn't there?

Mr. Parente. Yes, there is.

Mr. Dingell. We have 47 million Americans who don't have any health care. And, during the course of a year, we have as many as 86 million who have no health care. Obviously, those people without health care are being rationed, are they not?

Mr. Parente. Yes, they are.

Mr. Dingell. Okay.

I guess that is all the questions I wanted to ask. Thank you, Mr. Chairman.

Thank you, gentlemen.

Mr. Pallone. Thank you, Chairman Dingell.

And I think we are done with questions, so I want to thank you all. It was very helpful. Appreciate it. And, you know, as we move along, we are going to certainly keep your ideas in mind. Thank you.

And I would ask the next panel to come forward.

And let me remind members that we are not taking a lunch break. And the reason for that is because I think, as the day goes on, we will get more members of the full committee, who, as I mentioned, can participate. So if you want to take lunch, maybe go while another member questions.

We are going to get right to it, so if the second panel would be seated, I would appreciate it. If you could take your seats.

Are we missing Dr. Shern? I think we will start, at least with the introductions. Is that Dr. Shern? Okay, thank you.

Let me introduce the panel. Again, this is the panel on

consumers' views. And from my left is Dr. -- I shouldn't say "doctor." You may, in fact, be a doctor, but she is certainly well-known in any case -- Marian Wright Edelman, who is president of the Children's Defense Fund.

Thank you for being here.

Next is Jennie Chin Hansen, who is president of AARP. And then we have Dr. David H. Shern, who is president and chief executive officer of Mental Health America; Dr. Eric Novack, who is an orthopedic surgeon with Patients United Now; and, finally, Shona Robertson-Holmes, who is a patient at the Mayo Clinic.

I assume in Rochester right?

Ms. Robertson-Holmes. Actually, no, Arizona.

Mr. Pallone. Arizona, okay.

Again, you know we have 5-minute statements. Your full statement will be submitted for the record, and whatever else you would like to put forward. And then we will have questions after. And we will get written questions, you know, in the next few days to be submitted to you in writing.

And I will start with Ms. Wright Edelman. Thank you for being here. You have been here so many times.

STATEMENTS OF MARIAN WRIGHT EDELMAN, PRESIDENT, CHILDREN'S DEFENSE FUND; JENNIE CHIN HANSEN, PRESIDENT, AARP; DAVID L. SHERN, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, MENTAL HEALTH AMERICA; ERIK NOVAK, MD, ORTHOPEDIC SURGEON, PATIENTS UNITED NOW; SHONA ROBERTSON-HOLMES, PATIENT AT MAYO CLINIC

STATEMENT OF MARIAN WRIGHT EDELMAN

Ms. Edelman. Well, thank you so much for the opportunity to testify on behalf of the 9 million uninsured children and the millions more underinsured children, which we have a chance to correct this year.

And we have said many good things about your proposals. They are in the written testimony. And I want to just limit myself to my hopes for true health reform for all children and pregnant mothers within any health insurance plan. So, whatever you adopt as a health insurance plan for all Americans, I want to just make sure that all children, all pregnant women are treated equitably and get affordable, comprehensive coverage.

And what a great opportunity this is. I am so pleased. And thank you for the CHIP bill that you enacted and the President signed, and that was a significant step, but we now have a chance to finish the job. That was not true health care reform for all children, and it is not the child health mandate that the

President promised. But here we can do it now.

The need for health care reform that expands coverage for all children, cure benefit inequities between CHIP and Medicaid children, and establish a national floor of eligibility of 300 percent to end the lottery of geography across 50 States and to simplify enrollment and retention, particularly in Medicaid and CHIP, are the key things that I would hope that you will address in your final health proposal.

In these particularly devastating economic times, when the number of poor children could rise by 1.5 million to 2 million more, the need for a guaranteed, strong health care safety net to ensure their continuous access to coverage and every opportunity for a healthy start in life is absolutely urgent.

I want to just address these four points for a brief moment each.

One is I hope you will ensure health care coverage is affordable for all children and pregnant women and with a floor of 300 percent of the Federal poverty level, which is about \$66,000 for a family of four.

Just as all children in the United States are entitled to a free public education, all children should be entitled to affordable health care. The high number of uninsured children exacts a high health, economic, and social toll on these children, the families, and our Nation. Uninsured children are at high risk of living sicker and dying earlier than their insured peers and

are almost 10 times as likely as insured children to have an untreated medical need. These consequences of untreated medical needs can carry on into adulthood, and we must prevent them.

The consequences of being uninsured fall disproportionately on children of color, who represent almost two-thirds of all uninsured children. Children of color are at higher risk than white children of having unmet health and mental health and dental health needs. And they are at greater risk of being sucked -- because of the absence of this preventive health and mental health coverage -- of being sucked into something the Children's Defense Fund is very concerned about that we call the cradle-to-prison pipeline.

Many children without mental health services are having to be locked up in order to get mental health care in their community, at an enormous cost of \$100,000 and \$200,000 a year. Children should not have to go to jail in order to get mental health coverage. You can cure that this year.

The need for health care begins with maternity coverage. We have 800,000 pregnant women who are uninsured and having babies every year. They receive less prenatal care than their insured counterparts. They face greater risk for expensive and tragic outcomes, including complications, low birth weight, preventable illness, and even infant and maternal death.

We have about 350,000 low birth weight babies in the most recent data. The cost is 25 times greater than normal birth

weight babies. We are the only industrialized country that does not provide prenatal care to all of its mothers. You can cure that. I hope your health reform act will do that.

All of our children need to be able to get what they need regardless of the State they live in. Today, each State sets its own income eligibility level for CHIP and Medicaid, which results in a profoundly inequitable patchwork of eligibility across the United States.

Imagine being a low-income parent or grandparent raising several children. One is eligible for Medicaid, the other is eligible for CHIP, with different income eligibility standards and benefit packages for each program. Why should a child in North Dakota be eligible for CHIP if their parents earn more than 150 percent of the Federal poverty level, while in 12 States and the District of Columbia families can earn twice that amount and children are still covered?

Children's ability to survive and thrive and learn must not depend on the lottery of geography of birth. A child is a child wherever they live. They should have the comprehensive benefits. We must end this inequitable system.

Ten States have no children eligible for Medicaid above 133 percent, but half of our States offer Medicaid to children of all ages with families with incomes above 133 percent of the Federal poverty line. Almost half cover children at 200 percent. Thirty-nine States offer CHIP to children of families between 185

and 400 percent of the Federal poverty line.

We urge a national eligibility floor of 300 percent for all children and pregnant women wherever they live. And we should not force parents to have to choose between paying for child care, paying for health care, paying their rent. And so this is our chance to, sort of, give them the kind of national health safety net that I, as a grandma, have. I think I am important, but I think my grandchildren are even more important, and we should treat them fairly.

Secondly, we hope that all children will have the same comprehensive benefit packages, which include health and mental health coverage. We like the EPSDT program. It was designed and is appropriate for children. Children are not little adults. It has health and mental health coverage.

We believe and if you believe that every child's life is of equal value and that children don't come in pieces and they should get what they have to have their conditions diagnosed and treated early and prevent later costs, I hope you will make sure that every CHIP child and every child in the exchange will get the same benefits that the Medicaid children get.

Mr. Pallone. I hate to slow you down, but you are a minute over.

Ms. Edelman. I am a minute over already? Good gracious. Two last quick things, and I will just end, Mr. Chair.

Thirdly, all of our eligible children should have simplified

ways of getting and keeping enrolled. The bureaucratic barriers that keep 6 million of the 9 million uninsured children now unenrolled need to be addressed. The package, as I see it, does not do that. We think that -- and we lay out in our testimony, our written testimony, and we lay out in specific legislative language in the All Healthy Children's Act the steps that you can take to make Medicaid work.

I am glad you have moved to 133 percent of the Federal poverty level for adults, but children are already eligible for 133 percent but they are not getting it because of the bureaucratic barriers which you must address through the simplification measures we lay out.

And lastly, I just want to say, I know people are saying cost and we can't afford it. Well, you know, we can afford whatever we want to afford. We do not have a money problem in our Nation with a \$14 trillion GDP. You found the money to bail out the banks, you found the money to bail out the insurance companies, you found the money to do the alternative minimum tax. We can find the money if we believe in it to make sure that we give our children a chance to survive and to thrive. That is cost-effectiveness.

And while CBO may not score prevention, we know that dollars invested in immunizations save States millions annually. And we know that if you give a child an office visit in a primary health care setting, which is about \$100 in Harris County, Texas, it is going to cost you \$7,300 if they go to the emergency room and have

to be hospitalized.

If you want to contain costs, children is where you do it. All of them should be covered. All should get the same benefits. It should be simple and easy. And you have a great opportunity to do it right this year.

Thank you.

[The prepared statement of Ms. Edelman follows:]

***** INSERT 3-1 *****

Mr. Pallone. Thank you.

Ms. Jennie Chin Hansen?

STATEMENT OF JENNIE CHIN HANSEN

Ms. Hansen. Thank you.

Chairman Pallone, Ranking Member Deal, and distinguished other subcommittee members, I am Jennie Chin Hansen, president of AARP. Thank you very much for inviting me to be here today and for your leadership on leading comprehensive health care reform.

Enacting legislation to give all Americans quality, affordable health coverage options is AARP's top priority this year. The draft tri-committee legislation marked substantial progress toward this goal.

Today, I am really proud to represent nearly 40 million members of AARP, half over the age of 65 and half below 65. Both age groups face serious problems in today's health care system, especially the 7 million people aged 50 to 64 who are uninsured.

The draft includes critical reform priorities for AARP members for all ages. For our younger members, it would curtail discriminatory insurance market practices that use age and health status to block access to affordable coverage. Reforms must include strict limits of no more than 2:1 on how much more insurers can charge to people who are in this age bracket of 50 to

64.

Reform must also provide sliding-scale subsidies for those who need help to make coverage affordable, as well as provide some strict limits on cost-sharing. The draft legislation achieves our goals on these vital points in health care reform.

For our older members, the draft closes Medicare's prescription drug donut hole so that they will be able to afford the medications that they need. This drop in coverage has been a major reason why one in five people who get drug coverage through Medicare delayed or didn't even fill the prescription because of that cost. Under current law, the hole keeps getting larger every year. The draft begins to close the donut hole and includes other steps to lower drug costs.

And for people with limited incomes, the draft closes the gap right away by strengthening the Part D low-income subsidy and eliminating its asset test that penalizes people who really did the right thing in saving for a small nest egg in retirement.

The draft also fixes Medicare's broken system for paying doctors and puts Medicare on a path to fiscal stability by revising payment systems to reward quality instead of quantity of care. It includes incentives to reduce costly and preventable re-hospitalizations. It strengthens our health care workforce that we know is actually, at this point, short already, let alone what will happen in the future. And it takes important steps to address racial and ethnic disparities in care.

Many challenges remain on the road to really full, comprehensive health reform. But AARP and many other stakeholders share a broad and growing consensus that any differences that we may have cannot stop us from finding common ground and enacting comprehensive health care reform this year. We know -- and it has been said time and time again -- the status quo is just unsustainable, and we cannot afford to fail.

Thank you all for your leadership, and we continue to looking forward to work with all of you in Congress to enact this comprehensive reform this year.

Thank you.

[The prepared statement of Ms. Hansen follows:]

***** INSERT 3-2 *****

Mr. Pallone. Thank you.

Dr. Shern?

STATEMENT OF DAVID L. SHERN

Mr. Shern. Mr. Chairman, members of the committee, Mental Health America is honored to participate in today's hearing on ways to reform our health care system.

I want to start by expressing our appreciation for the many important proposals included in the tri-committee bill released last week that recognize now integral mental health is to overall health.

You know, this is our centennial year; our organization is 100 years old this year. And for the last 100 years, we have advocated for people with mental health. And from the beginnings of our organization, we had kind of a dual vision. On the one hand, we were concerned with people who had severe and disabling illnesses, who would have traditionally been treated in State hospitals. But, on the other hand, from our very beginning we have had a commitment to a public health perspective and to prevention as the only real way to drive down the prevalence of illness.

So we are very heartened by this bill, because we see it as including many of the issues that need to be addressed in order to

become the healthiest nation. We think that it addresses historical patterns of discrimination by including parity for mental health and substance use services. And, importantly, it addresses the prevention and management of chronic diseases as the real strategy to control costs and improve overall health care status. We think these are very important.

You know, mental health and substance use conditions are really paradigm cases for what goes wrong when we discriminate against a class of illnesses and fail to prevent and appropriately treat them. And this resonates very much to what Ms. Wright Edelman was talking about, in terms of not addressing issues of mental health services in children.

Increasingly, our science is telling us that mental health and substance use conditions -- we used to think they were diseases of early adulthood. We now know that they are diseases of adolescence. They are developmental disorders that occur early in life. For all people who are going to develop a mental health diagnosis during the course of their life, 50 percent of those people will have that diagnosis by the time they are 14 years old. However, they will not receive services until, on average, they are 24 years old.

So, during that 10-year period, substantial disability begins to develop. Academic achievement starts to drop off; these are very strong predictors of academic achievement. Ultimately, occupational achievement is compromised. We need to do a much

better job at early identification and addressing issues of mental health and substance use disorders if we are going to develop the healthiest nation.

The reason that WHO estimates that mental health and substance use conditions are, in fact, the most burdensome of all health conditions, causing twice as much burden of disease as cardiac illnesses, is in part because they are diseases of early adolescence that we do not effectively address.

So, clearly, this bill, from our perspective, includes all the key components that are necessary to start to address this problem, at least structurally.

First of all, it clearly addresses the importance of preventative services. You know, I think in some contradiction to some of the things that were said earlier, we have a brand-new report from the Institute of Medicine that was released in March that is a comprehensive summary of what we know about the effectiveness of preventative services for emotional and behavioral disorders in children and young adults.

And we know a lot. Our science base is strong. We know that community-based interventions work, and we applaud the committee for emphasizing the importance of community-based interventions. We know that early identification when coupled with treatment works, as the Preventive Services Task Force has indicated. And we applaud the committee for including those services, as well.

It is also clear, if you look at what is required to manage

chronic disease, it is very clear that in order to that you need to address the entire person, not the person in segments or subspecialties. The notion of the medical home that is included in the bill I think is extraordinarily important, and the inclusion of behavioral health services in that medical home is absolutely critical.

Not only are mental health and substance use conditions the most chronic illnesses, they are the most common co-occurring illnesses with other chronic disorders. And when they co-occur, they drive costs way up, drive outcomes way down. So the medical home and comprehensive integrated care is clearly an important part of what we need to accomplish here.

You know, we have a tragedy in this country in that people with chronic mental illnesses who are served in our public system die 25 years early -- 25 years early. They are dying on average in their 50s. And they are dying from a broad range of the same disorders that will kill all of us in our 70s or 80s or 90s.

So it is a critical imperative that we address comprehensively the needs of that population as well as persons with other chronic conditions who are likely to have mental health and substance use conditions.

Finally, I would just like to say that closing the donut hole is very important for people who rely on psychiatric medications, which can be very expensive.

The committee's attention to workforce provisions is

critically important. As several people have noted, we have a very predictable workforce crisis coming up on us quickly.

And then, finally, a word about comparative effectiveness research. You know, I left academia 3 years ago at the University of South Florida, where I used to work for Ms. Castor's mother, to join an advocacy organization because of my frustration with our inability to get our incredible science base to people who need those services.

Comparative effectiveness research provides a framework for us to better codify and understand what works and to translate it into information that can be supportive of individuals and their clinicians, their caregivers, in making better decisions.

So I applaud the committee for all the components of the bill, which seem to nicely round out both improving the quality of care, emphasizing preventative services, and bringing better science to bear in terms of our decision-making processes.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Shern follows:]

***** INSERT 3-3 *****

Mr. Pallone. Thank you, Dr. Shern.

Dr. Novack?

STATEMENT OF ERIK NOVACK

Dr. Novack. Good afternoon. I want to thank Chairman Pallone and the rest of the committee for having me here today. My name is Eric Novack, and I am a medical doctor who has actually spent the last 23 years training and working in health care.

Make no mistake: The variability for everyone in this room and your families to seek out the kind of health care you believe is best is under direct assault. And the risk you will lose control over your health and health care has never been greater. Unbelievably, nowhere in the U.S. Constitution or in the Constitution of any of the 50 States do any of us have any right to be in control of our own health.

In November 2008, Arizona's Proposition 101 sought to place two basic rights into the State Constitution: first, to preserve the right of Arizonans to always be able to spend their own money for lawful health care services; and second, to prevent the government from forcing us to join a government-sanctioned health care system.

Because once we are forced into a plan, our health care options will be restricted by the rules of the plan, whether it be

public or private. It was a true grassroots campaign, and an idea went from concept to well over a million votes in less than 18 months and failed by less than one-half of 1 percent.

Fortunately, the Arizona legislature has courageously recognized the critical issues raised by the initiatives and, just yesterday, referred the Arizona Health Care Freedom Act to the ballot in 2010.

Unfortunately, the reforms that have recently passed Congress and the bulk of those that are being considered do not appear to have much respect for the basic freedoms that the Arizona initiative seek to protect.

The stimulus bill was used as a tool to vastly expand the Federal health care bureaucracy. By the end of 2014, every American will be forced to have an accessible electronic health record that can be viewed by government officials without consent, permission, or notification.

The stimulus bill created the Federal Coordinating Council for Comparative Effectiveness Research, whose ultimate function will be to become a Federal health care rationing board for all Americans, starting with seniors. As Health and Human Services Secretary Kathleen Sebelius said during her confirmation testimony, quote, "Congress did not impose any limits on it," referring to the council.

And now MedPAC may be empowered to make the full slate of recommendations for every condition and treatment. Congress will

only be able to make an up-or-down vote on the entire package.

The President recently spoke to the American Medical Association, touting the importance of using evidence-based medicine to figure out what works and what does not. When it comes to the best treatments for our ailing health care system, we have some compelling evidence.

Leaders in Congress regularly cite Massachusetts as the model for reform. But what really is going on in Massachusetts, and do we want to repeat it on a grand scale?

Costs are even more out of control than in the country as a whole. Use of the emergency room for care has not diminished despite the higher percentage of people with insurance. And there is exactly zero evidence -- there is exactly zero evidence -- that forcing people to have insurance has made any difference on slowing health care spending.

Medicare has tried several disease management and prevention projects. The idea that spending money upfront to prevent Medicare patients from needing expensive hospitalizations and disease complications will save money in the long run.

Unfortunately, the results do not bear that out. Among the conclusions in the June 2007 report to Congress on the trials, quote, "Fees paid to date far exceed any savings produced." In other words, the cost of administering the plan made the prevention plan more expensive.

Real research also suggests that obesity and smoking

prevention, while admirable, do nothing to reduce health care spending.

Supporters of the President have also reviewed the literature on the impact of electronic health records on spending and concluded, quote, "We need the President to apply real scientific rigor to fix our health care system rather than rely on elegant exercises in wishful thinking."

And research has been done demonstrating geographical variations in health care spending, but there is no evidence that having Washington forcibly taking money being spent in Massachusetts, New York, or California and sending it to lower-spending States will improve anyone's health.

We cannot afford to make mistakes that will mean our grandchildren will, in the words of the President, suffer from, quote, "spiraling costs that we did not stem or sickness that we did not cure."

Congress should fix Medicare first before radically changing the health care of every American. Congress should demonstrate that the government can prevent the disturbing failures even more exposed this week of the VA system before radically changing the health care for all Americans. And Congress should work very hard to increase the options and availability for the 3 percent of Americans who are truly, quote, "chronically uninsurable" before radically changing the health care for the other 97 percent.

Health care reforms are critically needed. Our path is

unsustainable. But jamming through a piece of legislation that few will have read and the American public will not have had time to fully review makes no sense.

The cynics who shout that we cannot have health care reform without sacrificing our personal freedoms are false prophets offering a false choice. I urge the members of this committee to consider health care legislation that protects individual liberty, preserves privacy, limits government power, and has reforms that have actually been shown to work -- in other words, reforms that protect patients first.

Thank you very much for the opportunity to present my views today.

[The prepared statement of Dr. Novack follows:]

***** INSERT 3-4 *****

RPTS KESTERSON

DCMN BURRELL

[12:30 p.m.]

Mr. Pallone. Thank you, Dr. Novak. Ms. Robertson-Holmes, thank you for being here.

STATEMENT OF SHONA ROBERTSON-HOLMES

Ms. Robertson-Holmes. Thank you. Thank you, Chairman and members of the committee. Four years ago sitting in my doctor's office, never did I believe I would be here in Washington talking about this situation. But I am here because I was fortunate enough to be able to in amongst my nightmare come to this country and get treatment.

I actually am the face of public insurance. We have -- I am from Canada and we do have public insurance, a mandatory monopoly on our insurance. And I am here to say when it doesn't work, it doesn't work. Unfortunately, in Canada we have 33 million people, which is approximately the size of the State of California, and we currently have 5 million people without family doctors.

What started many years ago as a seemingly compassionate move in our government to treat all equally and fairly by providing the same medical coverage has in fact turned into a nightmare of everyone suffering equally. Now we have limited resources and funds that offer timely treatment to our citizens.

A system like this starts to crack under pressure and special treatment is ultimately given to those who have contacts and resources to jump the line for treatment, and for someone like myself, the average Canadian citizen, forced to go to another country for care.

I will never get the time, money or life back that I have dedicated to the fight to basic treatment that I was promised by my government; but not only promised, it was ordered. I will never forget the experience of the treatment in a facility suffering so bad from government funding and shortages of staff and resources.

I know that the American health care system is not perfect, but I do credit the system for saving my life. It is because of the choices available here in this country that I was able to receive immediate care. We as Canadians have one insurance company, the government. We have no options. We can't choose another country, we can't supplement with after-tax dollars to purchase extra care.

We can purchase health insurance for our pets, but not our children. I have very few rights as a patient. Patients there have to fight for every basic service and care, much less any kind of specialized care.

Another thing that I would really like to point out is that our health care is not free. In fact, I would argue that the cost is much greater than the tax we pay each and every citizen towards

this care. The costs are loss of quality of life while living with pain, discomfort, or just the fear of the unknown and also for waiting long term for diagnostic testing, the cost of employers and self-employed people waiting for employees to be treated and be well enough to return to work.

Medications are also something that Canadians are struggling like Americans to pay for. We are not covered for our medications under our health care plans. We pay the cost of local ERs closing, losing a wealth of talented doctors that leave the country because they just don't have the resources to do their job properly at home. We have rationed services and treatments and a fear of living without a safety net.

The one thing that I wanted to sort of point out when I was making my testimony today was if I have gotten any criticism from anybody that I have done for what I have done is that I must have had the resources in order to be here today. I am here to say that I didn't. I am so average, and in order to get what I had to do, my husband took a second job, he put a second mortgage on our house. We owe every single person we know money. And I will never forget all of that that has happened, but I also want to wake up grateful for what happened to me in America. And I want to have those same options in Canada.

And I just felt from the very beginning of my experience that it was my job to point out to both Canadians and Americans what we can do together and what we need to learn from each other's

situation.

Thank you.

[The prepared statement of Ms. Robertson-Holmes follows:]

***** INSERT 4-1 *****

Mr. Pallone. Thank you. And now we have questions, 5 minutes from the panel. And I am going to start with myself. And let me just say I am not looking for a response. But I really appreciate, Ms. Robertson-Holmes, that you came today. I am not being critical in any way because I know you took your time. But I really have to stress that this draft is not meant in any way to put together a single payor system or emulate Canada. Canada is a nice place, but I am not really looking to create a Canadian system or even praise the Canadian system because I really believe that the draft implements a uniquely American system that in no way replicates Canada. But I appreciate your being here. I am not trying to denigrate it in any way.

Ms. Robertson-Holmes. The problem is it is a very slippery slope. Once you start on that sort of road -- and unfortunately a lot of the Americans that I am talking to have said to me, well, we are going to get free health care too, we are going to get Canadian style health care.

Mr. Pallone. Well, I think you are right, that there are some people who think that somehow this is single-payer, but I just want to stress I don't think it is and I don't see how it becomes a single-payer. But whatever, I appreciate your being here. And I don't want to take away in any way the fact that you came here and how difficult I am sure it was to be here.

Let me ask the question of Ms. Wright Edelman about Medicaid.

I am very proud of the fact that in this discussion draft we really discuss Medicaid in a major way in the sense that we are trying to cover and fill in the gaps with 100 percent Federal dollars for those who are not covered by the States now up to 130 percent, that we are increasing the reimbursement rates so that it is more like Medicare. A big part of this is Medicaid, And I think in many ways it hasn't really gotten attention, unfortunately.

But what I wanted to ask you is, there have been those who say that once we -- if we set up what is in the discussion draft, that Medicaid would no longer be needed and that those people who are in Medicaid should be put into the Exchange, be able to get their insurance with the Exchange. The draft doesn't do that and -- because we are concerned that that might be harmful, at least initially to Medicaid.

So I just wanted you to discuss the types of benefit and cost sharing protections available in Medicaid that are generally not found in private health insurance products. And if you could talk about the need to keep and improve the Medicare safety net undisturbed for years to come in response to those critics. We are not putting Medicaid in the health Exchange.

Ms. Edelman. I hope you will not. Do not put Medicaid into the Exchange. Nobody should end up worse off than they are currently. Medicaid is a crucial safety net. I applaud in my written testimony your extension of 133 percent for all. And the

adults that need that help, I applaud you for it. I am glad that you are reaffirming it for children, but all children are currently covered at that level. So it will not result in an increase.

But what we do hope you will do in protecting Medicaid -- in fact, I would like it if you want to take it up to 300 percent. That would be wonderful, too. I don't care how you do it, as long as you can kind of try to get all those folk who are uncovered, but I think that Medicaid is essential, it is comprehensive benefits. As I go for children, it is essential. The fact that it is an entitlement is absolutely crucial, and I think it is one of the strongest pieces of what you have done.

On the children's front, I hope that you will make sure that Medicaid's benefit protections are extended to CHIP children and children in the Exchange because we think it is the most appropriate benefit package. So we hope you will do that. But it also raises another important point because many of the children now at 133 percent of poverty under Medicaid are eligible but are not getting it because the bureaucratic systems are impeding that. So one of the things that is essential if the children under 133 percent of Federal poverty level are going to get their Medicaid coverage, we are going to have to simplify. And we have laid out a number of simplification steps.

One of the good things you have in your provisions is automatic enrollment of any child that is uninsured at birth. I

think that is fantastic. We would like to see automatic enrollment for any child that is in any means-tested program. We would like to have 12 months continuous eligibility. We have laid out a number of steps that can be taken to ensure that those children currently eligible for Medicaid will in fact get it. But you are going to have to do the systems reform to make it effective.

Mr. Pallone. I appreciate it. And I am sorry to stop you, but I want to ask another question of Ms. Hansen. Yesterday the PhRMA and the President announced some kind of a deal to cut costs for seniors with incomes up to 85,000 in the doughnut hole by 50 percent; in other words, to fill in the doughnut hole in part, the people whose incomes are up to 85,000, that they would only pay 50 percent for brand name drugs once they fall in the doughnut hole.

Now, I am not taking away from that. I appreciate the fact that the pharmaceuticals are doing that. But in the discussion draft, we fill about \$500 of this cost for the doughnut hole immediately and then phase out the doughnut hole for all Medicare beneficiaries over time. And we also reinstate the ability of the Federal Government to get the best price for prescription drugs for the most vulnerable low income Medicare beneficiaries. Those are rebates again to fill the doughnut hole.

How do you see this provision in the draft, the discussion draft as working together with the commitment by the pharmaceutical manufacturers yesterday? I don't see them as

mutually exclusive. I think they are both positive. But I just wanted you to comment on that.

Ms. Edelman. Well, I have actually --

Mr. Pallone. Well, I was going to ask Ms. Hansen originally. Go ahead. I am sorry. We are just out of time. Go ahead.

Ms. Hansen. Thank you. Mr. Chairman, we agree with you. This does not preclude the continuance of it because it is actually only 50 percent of the doughnut hole and for people who are at that income level. It doesn't cover every Medicare beneficiary. But it is -- part of what it does do for the people who are on drug coverage, as I stated briefly, that people who are falling in that hole are not oftentimes continuing with their medications.

So part of our job as an organization is to really get the most relief in the quickest time on behalf of people who are already in that conundrum. I mean, that even relates to people who are becoming bankrupt as well. So that cost element is real important.

I think what the draft does is importantly to continue to build on that so that we have a more whole, seamless coverage on behalf of people. So I do think that they can work -- and we are continuing to work with you on making sure that coverage continues.

Mr. Pallone. And I appreciate that. I know you were part of this deal. I don't know if that is the right word, or agreement

yesterday. But I also appreciate your working with us to try to completely fill the doughnut hole.

Ms. Hansen. I just wanted it to be really clear, I think it was Senator Baucus that really took the leadership role with PhRMA. And I know that the President supported it. And we again appreciated it because it makes such a big real difference in people's pocketbooks.

Mr. Pallone. We try not to talk about the Senate here, but there are occasions we have to acknowledge their existence.

The gentleman from Georgia, Mr. Gingrey.

Mr. Gingrey. Mr. Chairman, thank you. I want to ask Ms. Shona Holmes. First of all, thank you for your testimony. We really appreciate that. And I as a medical doctor, I mean, I understand, I think, what you were describing to us. I guess a benign pituitary tumor, the pituitary gland is about the size of your little thumbnail in the normal circumstance. But when it is growing so rapidly as in your case, it is right in front of the optic nerve where it crosses over and as it compresses on that optic nerve, as it gets larger, that is what would lead to the blindness and I am assuming the doctors at the Mayo Clinic in Arizona informed you of that and said that you really need to get this surgery done within about 6 weeks.

Now you went back to Canada and I understand from your testimony they said that there was no way they could do it in the 6 weeks. Did they say why? Did they have a reason for that?

Ms. Robertson-Holmes. The biggest problem in Canada is that the wait times even just to get in to specialists in order to get diagnostic testing done. So when I returned to -- in fact, I had this false sense of security when I was in Arizona because 2 of my doctors were, in fact, Canadian. I have never questioned the talent that comes out of the medical system in Canada. They just don't have the resources. And so when I saw these doctors, they said go home, you can get this done at home and you have insurance, this is what you should do. Here is your --

Mr. Gingrey. And you said it would probably have cost you \$100,000 to have it done in the United States.

Ms. Robertson-Holmes. In total, with all my expenses and everything being away, and I had to return -- I took 3 solid runs at this particular situation. So this is not just that I fell through a crack. And I had to go -- I had to go originally for diagnostic testing. I had to go back for surgery and I had to return for follow-up because I couldn't get any of those things done in Canada.

Mr. Gingrey. So there was a real problem with the rationing basically, a long queue, and getting --

Ms. Robertson-Holmes. And at the time I was also diagnosed with a potential tumor in my adrenal and it was recommended at the Mayo Clinic at that time that I have that surgery and, you know --

Mr. Gingrey. That additional surgery. And also that was going to be delayed in Canada as well?

Ms. Robertson-Holmes. Three years to the date.

Mr. Gingrey. Time is running out. I want to ask you one other thing. In your testimony you credit the United States health care system for saving your life. You just said that. You also mention your lack of rights as a patient in Canada. Tell me, as someone who has seen health care from both sides of the Canadian border, what advice can you give to American patients who may be following this debate in Congress?

Now, keeping in mind what our chairman and I know in all sincerity he mentioned that this is in his opinion not nor is it designed to lead to a single-payer, U.K. or Canadian type system. That is what Chairman Pallone said. You have some concerns about that. I have some concerns about that with this public option.

What would you say to the American people in regard to this?

Ms. Robertson-Holmes. It is my understanding from -- actually all my family is in Great Britain and it actually is a 2-tiered system. They actually have public and private, and they are almost in worse condition than we are. What I am saying is I am insured. I have insurance. But the money isn't there. It is expensive. Health care is expensive anywhere. And I was promised that I had insurance. But when it came to using the services that I was supposed to be covered for, they weren't there.

Mr. Gingrey. Yeah. So having an insurance, a plastic card doesn't guarantee you access, affordability, availability if there are no physicians there to provide that care.

Great point. Thank you very much for your testimony and for your response. I want to go now to Dr. Novak, Dr. Novak, thank you. I know you practiced orthopedic surgery -- is it in Arizona, I think you mentioned to us. And you reference in your testimony the study published I think May of 2009, the Journal of Health Affairs, one in five Massachusetts adults were told in this last year that a desired physician was not taking new patients. Here again, they had insurance, they had coverage, they just couldn't find a doctor. Do you know if the type of insurance a person carried influenced their ability to see their desired physician, whether it was the public plan option or a private plan option? There was a delta in regard to who can get --

Dr. Novak. I don't have an answer for you on that. What it is illustrative of is the regular attempts to conflate health insurance with health care. So here the 47 million number, which is a bit inaccurate in and of itself, that don't have health care, those are people who don't have health insurance. And since 20 million of these people change every year because of job changes, et cetera, about 10 million are in the country illegally, about 10 million are between 18 and 30 and don't think they will ever get sick. You are left with about, as I mentioned, about 3 percent of the country that is chronically uninsured. So just giving people health insurance, what we see in the Massachusetts example, is no guarantee that you have access to health care.

Mr. Gingrey. Mr. Chairman, if I might ask Dr. Novak to

submit a written answer to my question in regard to the different discrepancies between or among the plans where there were no doctor available, I would appreciate that. My time has expired and I yield back.

Mrs. Capps. [Presiding]. Yes.

[The information follows:]

***** COMMITTEE INSERT *****

Mrs. Capps. It is a pleasure now to yield 5 minutes to our chairman of the full committee, former chairman, John Dingell.

Mr. Dingell. Thank you, Madam Chairman. I would like to begin by welcoming our old friend and my very dear personal friend, Marian Wright Edelman, to the committee. I am delighted to see you here, Marian.

Ms. Edelman. Nice to see you.

Mr. Dingell. I want to get right down to the business at hand here and to say to you, Ms. Holmes, welcome. Your comments I found to be most interesting. Tell me, you are referring to a single-payer system you have in Canada; is that right?

Ms. Robertson-Holmes. I am, yes.

Mr. Dingell. You are aware that the draft that is before us is not a single-payer bill?

Ms. Robertson-Holmes. All I am aware of is I needed to tell what my story was.

Mr. Dingell. So then help me. How would your concerns with a single-payer system apply to the draft of the legislation we are working on today?

Ms. Robertson-Holmes. My concerns are basically in order to open up the communications so that people know the questions to ask when a bill is passed so that they know what is safe to get into --

Mr. Dingell. In other words, your comment is a warning

rather than a criticism?

Ms. Robertson-Holmes. Just my experience.

Mr. Dingell. Well, I think it is a very good criticism, and I thank you for it, or rather a very good warning as opposed to a criticism.

Now, Dr. Novak, I found your -- you made a very frightening comment here that I would like to address with you because if your fears are correct, this is a very bad situation. And in this -- and I can tell you that I am going to stay up night and day to get it out if there is anything like that in here. You made this statement. You said no matter what name the bureaucrats and politicians want to use, the plan being put forth by the committee will mean Washington bureaucrats will have the power to deny you care.

That is a very frightening statement, and I would appreciate it if you can tell me where in this draft that there is language that would authorize that so that I can get this out? I will work with you to get it out. Tell me where it is.

Dr. Novak. I think the issue here is when you -- what has been very vague of course is exactly how the cost control is going to happen.

Mr. Dingell. No, no, no, no. Where is the language? You made a bold, flat statement, and frankly I am scared to death. Now, I want you to tell me where it is in there so I can get it out.

Dr. Novak. I don't have the exact line for you, sir. But I can --

Mr. Dingell. But where is it, Doctor? I would probably be unfair to you because you are a doctor and I am a lawyer, and I would never presume to tell somebody how to take out an appendix or to replace a knee, but I do know a little bit about drafting law. I have been doing it for about 50 years and you made a statement that scares the bejabbers out of me, and I want you to tell me where it is.

Dr. Novak. Again, I don't have the exact line numbers for you, but I will get it for you.

Mr. Dingell. So you made the bald statement, though, which you are not able at this time to tell us where the language is in the bill that has caused you to make this statement, and I will repeat it again because quite frankly it is a very serious charge: No matter what name the bureaucrats or politicians want to use, the plan being put forth by the committee will mean Washington bureaucrats will have the power to deny you care. And you capitalized "deny you care."

Dr. Novak. Again, the answer here is that we know that care is going to be denied because you have to come up with a package -- the plan is to come up with a standard benefit package and then to give some authority the ability to determine which benefits are going to be accessible to -- it will start with seniors, I imagine, if we start applying this to patients in

Medicare first. If those benefits are different than the benefits that people currently enjoy today, that will potentially be care that will be either delayed or denied for what they are getting right now.

Mr. Dingell. That is the basis for your statement, is it?

Dr. Novak. Yes.

Mr. Dingell. I find that to be interesting. It is kind of like building a house of cards here or maybe setting up a straw man. And that is a good thing to do because then you can knock them down fairly easy. But I still want to hear you tell me what is the precise thing.

Let us go to something. You have got Blue Cross and Blue Shield. You have got Aetna. You have got all kinds of insurance companies in this country. Do you remember when we had the big fight over patient's bill of rights? Do you remember that?

Dr. Novak. Not entirely.

Mr. Dingell. The AMA was very, very interested in it, and they were very helpful to me in my efforts to try to get that legislation through. That was to stop a bunch of health insurance bureaucrats, green eyeshade actuaries from telling you as a doctor what you could do and telling me as a patient what treatment I could get. And I find your same apprehensions were joined in by my friends at AMA when we tried to correct this iniquitous situation which we have now. And I am trying to find out where the abuses that we complained about are to be found in the

legislation.

Dr. Novak. Sir, I think --

Mr. Dingell. And how this situation, even if it is as you say, is true, would be worse than that which we have now where we have 47 million Americans who haven't gotten any health care and who haven't got anybody to tell them what they can have or not have. The only thing they can say is you can't have treatment because you can't pay your bill.

Dr. Novak. Well, I think the question is what kind of tradeoff are we looking to make. It is true and I can tell you both as a provider and as a patient and as a patient advocate that there is often times no love loss between me and the bulk of the private health insurance industry. The tradeoff that the legislation appears to be making is to be moving away from green eyeshade private health insurers towards green eyeshade Washington bureaucrats. And I think at the end of the day when we look at examples where there have been abuses in the private health insurance industry, there is resource. When Blue Cross did recisions in California and other companies did recisions in California, there has been significant -- but my concern is, for example, in the VA system -- there is no resource to the 10,000 people that are exposed to HIV --

Mr. Dingell. My time has expired. Thank you.

Mrs. Capps. Thank you, Mr. Dingell. And I yield now 5 minutes for questions to Mr. Whitfield.

Mr. Whitfield. Thank you, Madam Chairwoman. Let me ask you, have any of you read this bill? Ms. Edelman, have you read this legislation?

Ms. Edelman. I have read or my staff has read it multiple times and we have struggled to make sure that I read the key portions of this bill that relate to children.

Mr. Whitfield. When did you all receive it?

Ms. Edelman. We got it on Friday and it is over 800 pages long, but we have done the best we could.

Mr. Whitfield. Well, I don't think any of you have read it. Certainly I have not read it. Not many members up here have read it. And one of the things we are concerned about, when you have this sort of dramatic change in health care -- and evidently this bill, they are going to try to bring it to full committee the first week of July or the second week of July. We don't really have a lot of time here.

But let me just talk philosophically about a couple of things and then I will get into some specific questions. I would ask all of you, does the American taxpayer have the responsibility to pay for nonemergency health care for illegal immigrants? Ms. Edelman, what do you think?

Ms. Edelman. I think all children should be covered because as a public issue if there are any children that are in our country or in our schools -- all children go to schools.

Mr. Whitfield. What about adults?

Ms. Edelman. I am here to talk about children. Our bill is all children being covered.

Mr. Whitfield. What about you, Ms. Hansen?

Ms. Hansen. We don't have a policy on immigration because that is not part of our public policy covering our --

Mr. Whitfield. So you don't have a position? Okay.
Dr. Shern, what about it.

Mr. Shern. Similarly we don't have a position on --

Mr. Whitfield. Dr. Novak.

Dr. Novak. I would just say currently as a provider -- and I take about 14 days of emergency room call every month, I take care in the Phoenix area of a whole lot of people who are not in the country legally and they get the same care, whether --

Mr. Whitfield. But I said nonemergency room care.

Dr. Novak. I think that given the tens of trillions of dollars of unfunded liabilities, that we ought to be directing the resources to people in the country legally first.

Mr. Whitfield. There has been a lot of discussion here about there is not going to be any government payor plan or government plan. And yet in section 203 of the bill, which very few of us have read, it says the Commissioner that will be established under this legislation shall specify the benefits to be made available under Exchange, participating health benefit plans during each plan year. And I have been told that that applies not only under the government option but also the private plans.

So do you think it is right that some government officer will be dictating what benefits will be available under private as well as the public option plan? Dr. Shern.

Mr. Shern. Well, I think that the intention, as I understand it of that provision, is to provide a floor of services that will be available for everyone upon which you can build. And I also think that if --

Mr. Whitfield. That is your understanding. Do you know that to be a fact?

Mr. Shern. No, I don't know that to be a fact.

Mr. Whitfield. What about you, Ms. Hansen?

Ms. Hansen. I can't answer it.

Mr. Whitfield. Have you read the bill?

Ms. Hansen. Not since Friday.

Mr. Whitfield. But you all have helped work on this legislation. You have been a part of drafting this legislation; is that correct, Ms. Hansen?

Ms. Hansen. We don't draft the legislation.

Mr. Whitfield. Did you have input into it?

Ms. Hansen. There have been conversations between our staff.

Mr. Whitfield. Now, the CBO says that they estimate 15 million people will lose their present insurance, health insurance coverage as a result of this legislation. So, Ms. Hansen, what would you say to your members who will lose their employer health coverage because of this bill?

Ms. Hansen. Well, we take the position that people -- the principle of choice -- and we also support that people who have insurance now can and want to keep that. And that is something that we actually believe in the maintenance of a public and a private --

Mr. Whitfield. Does this legislation give each individual the right to keep their current insurance?

Ms. Hansen. Those are the principles that we are supporting.

Mr. Whitfield. But do you know for a fact that it does it? Do you know for a fact that it does it?

Ms. Hansen. I don't know for a fact personally, but the principles I can ascribe to --

Mr. Whitfield. My understanding is that this legislation also includes an employer mandate which will force businesses to either provide health insurance to their employees, which is fine, or pay a tax of 8 percent of wages paid. Now, that is going to particularly hit hard small businesses. And there have been estimates that there may be 4.7 million Americans that would lose their jobs because of the additional tax that small business men and women will have to pay.

Does that concern you all? Does that concern you at all, Dr. Shern?

Mr. Shern. If those estimates are correct, that would be a concern.

Mr. Whitfield. Ms. Hansen?

Ms. Hansen. Right. We feel that the ability to cover should also be supplemented by understanding affordability and cost for both employer, as well as the employee.

Mr. Whitfield. Okay.

Ms. Edelman. But it is also my understanding that small businesses can buy into a public plan, but everybody should be contributing something.

Mr. Whitfield. Everyone?

Ms. Edelman. This should be a shared sacrifice.

Mr. Whitfield. Let me ask you a question. What do you think if we just took the money that this plan is going to cost and just put everyone under Medicaid? I mean, I know you are a supporter of Medicaid. It is a good system. What do you think about that?

Ms. Edelman. Well, I think that the committee can deliberate. I don't care how we do it. We should thoughtfully determine that we are going to get health coverage for everyone. What they are trying to do here is to give people --

Mr. Whitfield. Would you be opposed to everyone being under Medicaid?

Ms. Edelman. I would be not be opposed to all children being under Medicaid. That is what I know about.

Mr. Whitfield. What about adults?

Ms. Edelman. But I think that the issue here is how we are going to give everybody coverage and choice about a public or a private --

Mr. Whitfield. And my question is would you object to everyone being under Medicaid?

Ms. Edelman. I am here to talk about children today and to say whatever plan we do, that we should absolutely make sure that all children and pregnant women are covered, and I would love it if Medicaid took them all up to 300 percent, all of the children got the Medicaid benefits and the Medicaid entitlement.

Mr. Whitfield. I think my time has expired.

Mrs. Capps. Thank you, Mr. Whitfield.

May I just make a correction to a statement that was made? It is my impression or my understanding that CBO has not taken a position on this bill and that actually a private-public benefit advisory committee determines what the benefit is that should be on the floor -- or what is offered in coverage in the new marketplace or sold in the new marketplace, and that is just for the record.

And I now call upon or recognize our colleague from Colorado, Ms. DeGette, for 5 minutes.

Ms. DeGette. Thank you, Madam Chair. And I want to add my thank to Ms. Robertson-Holmes for coming today. It is always important to hear the patient perspective. When you were testifying about the great care that you got at the Mayo Clinic, I was thinking about my next door neighbor when I was a little girl, Randy West. I knew him since I was 6 years old. And about 2 years ago, Randy was diagnosed with prostate cancer and he was

treated and the doctor said they thought he was cured. And then the next spring when his private insurance plan came up for renewal, his insurance company said they would renew his insurance but that they would not insure him for any future complications he might have gotten from the prostate cancer. So he said, well, why should I get insurance then because that is the thing that is the most likely to affect me. So he didn't get the insurance renewal, and you know the rest of the story. Last summer, his symptoms returned, he went back to his old doctors, his old doctors would not now treat him because he didn't have health insurance anymore and he spent about 2 or 3 months trying to get on to Medicaid so he could afford to go see the doctor and get treatment for his now advanced prostate cancer. Last week, on Wednesday, was Randy's 57th birthday, And he died suddenly of a heart attack because of the advanced prostate cancer that had riddled his body.

So there is problems with the single-payer system in Canada, but there is real problems for 47 million Americans like my friend Randy West who died because he didn't get the insurance. And I don't even need a response to that. I just want to say what we are trying to do is make it so insurance companies don't deny people for those pre-existing conditions and so that people who have diseases in this country can go to the doctor.

And I just want to point out to you, Ms. Hansen, I want to thank you for mentioning the Empowered at Home Act in your written testimony because Chairman Pallone and I worked on this bill a lot

together, And what that does is it incentivizes States to provide home and community-based services which allows disabled individuals to stay in their homes. It is not only about better health outcome, it is also more cost effective. And so I want to thank you for that, and I think, Madam Chair, that is an important component to keep in the bill as we move along.

And finally, I have to thank my dear friend, Ms. Edelman, all of our dear friends and a real icon for children in this country for coming over today, and I want to ask you a couple of questions about kids. As you know, I have worked for many years on kids' health.

The first one is, do you think that as we design a program to try to enroll all kids in this country in health insurance or some kind of health coverage that we should look at their unique needs and not just assume that the adult programs will cover them?

Ms. Edelman. Yes, which is why we feel so strongly about the Medicaid benefit package which has been thought through as being the most child appropriate because it is targeted at children and it is targeted at early diagnosis and early treatment. So I don't think we need to reinvent anything, and I hope you will not come up with a benefit package, whatever it is, that takes away what children now have that works, and we want you to extend that package to all children because that is what we think they need.

Ms. DeGette. And that includes mental health and --

Ms. Edelman. Mental health. It is the comprehensive, all

medically necessary services. And we think that that should be Medicaid children, CHIP children and any children regardless of whether they are in an Exchange or not.

Ms. DeGette. And we talked earlier. I think you mentioned in your testimony the early and periodic screening diagnosis and treatment benefit. That is very expensive, though. And I am wondering if you can opine as to whether you think that additional cost is worthwhile and might even save money in the long run for kids and, if so, why.

Ms. Edelman. I think it would save money and when we had Lewin & Associates do cost estimates for extending coverage to all children and giving them the Medicaid benefit packets, they said that you could extend the EPST benefit packets to all 9 million uninsured children -- this was a 2-year ago study -- and for about 12 percent added cost.

So I think that the cost effectiveness of this in the long run is going to pay itself back. So we think it is not a big huge add-on.

Ms. DeGette. Part of the draft legislation, and part which I am sure you have read because it applies to children, is the part that if children come in at birth and their parents don't have insurance would automatically enroll them in Medicaid for the first year.

Do you think that is a good step in the legislation?

Ms. Edelman. I think that is terrific. And we would like to

have automatic enrollment when they go to preschool or if they are in any WIC program or early Head Start program. You want to get children in because they are prevention. You want to prevent them --

Ms. DeGette. And preventive care for children actually saves

--

Ms. Edelman. Many, many dollars on the other end. And we can give you added testimony that shows you the cost of doing that.

Ms. DeGette. I would appreciate it if you would supplement your testimony in that direction. Thank you very much, Madam Chair.

[The information follows:]

***** COMMITTEE INSERT *****

Mrs. Capps. Thank you, Ms. DeGette. And now I am pleased to recognize for 5 minutes Dr. Burgess from Texas.

Mr. Burgess. Thank you, Madam Chair. Ms. Wright Edelman, let me just ask you a question. Last fall, in the interest of full disclosure, I was a surrogate for the opposite side. I got to know President Obama's proposals last fall pretty well because I always had to prepare to argue against them. And one of the overarching themes that was always put out there first was that there was going to be a mandate to cover children under President Obama.

Have you talked to him lately about what happened to that?

Ms. Edelman. No. But he certainly knows that I am expecting him to keep his promise. And I know that he has expressed his great interest in seeing that we take care of all of our children, and I think that this is the time to do it and the individual mandate --

Mr. Burgess. I don't mean to interrupt, but I always had difficulty getting his surrogates to identify the definition of a child. Sometimes it was age 19, sometimes it was age 25, sometimes it was age 27. Do you have an opinion as to where that limit should be set?

Ms. Edelman. Well, I certainly -- we would take the definition of a child that is under Medicaid or CHIP now, but I think that we are talking about everybody getting coverage. And

we know that there are a lot of younger people in college --

Mr. Burgess. But in the interest of time, I have got to interrupt you. What is the difficulty with a child on Medicaid today? What is the difficulty with getting them in to see a dentist if they have dental coverage under Medicaid?

Ms. Edelman. Well, the first part -- Texas, since you have the highest number of unenrolled children and we --

Mr. Burgess. Let us just focus on those enrolled.

Ms. Edelman. Well, may I provide reimbursement rates? We all heard -- and because children do still face bureaucracies. But let us just take the child out in Prince George's County, Deamonte Driver, who -- Deamonte Driver died last year -- tried to get -- 25, 26 dentists his mother went to, couldn't get them to take him because of the low Medicaid, low reimbursement rates, and I know you are trying to do something about that in your proposal. And the upshot was his tooth abscessed and infected his brain and then he died. 250,000 emergency rooms have huge bureaucratic barriers first to even enrolled children and not enough providers, and in rural areas it is worse.

Mr. Burgess. But fundamentally the problem has been reimbursement rates.

Now, Dr. Novak, you talk about 14 days out of every month you cover the emergency room, and we have put a mandate on providers. We may not have a mandate for kids, we may not have a mandate on employers or a mandate on individuals, but you have a mandate

called EMTALA, which requires that within 30 minutes of somebody showing up at the door you have to see them. Is that not correct?

Dr. Novak. That is correct. And the consequence, of course, is that a very large majority of my colleagues just no longer have any privileges at the hospital. So for sometimes some complex things, where it might be nice to have a particular person available and when someone comes into the emergency room, you are no longer even able to get that person's assistance on a difficult case because of the regulations. People abandon their privileges completely.

Mr. Burgess. And this is an extremely -- and both of these issues are really getting to the same problem. And I recall back in -- I practiced obstetrics back in Texas for 25 years, And we made an agreement amongst ourselves that our individual practices would each take a certain number of Medicaid patients every month into our obstetrics practice so no one would be unduly burdened by a larger number of patients who reimbursed at a lower rate. And that worked great until you had somebody who had a complicating medical condition and they had to be referred to a specialist. And it was virtually impossible to find anyone because of just exactly what you described, those very low reimbursement rates.

As we sit up here and plan a national program that may very well be based on Medicaid, I just think we are obligated to make the program that is already there work first and demonstrate that it can work before we go extending it to increasingly larger

segments of the population.

Dr. Novak, do you have an opinion about that.

Dr. Novak. My sense is that it is no different than when I do something in orthopedics, which is you are not going to introduce a new procedure until there is some data in a small group that it works. And what is being proposed here is to push through massive legislation in an incredibly short order where there has not been full time for people across the country to look at it and examine the problems and try to get it passed before people realize what has happened. And then all of us as patients will live with the unintended consequences of those actions.

Mr. Burgess. So we should have evidence-based policy as well as evidence-based medicine?

Dr. Novak. I suspect the -- as Shona has demonstrated, look, there are good people in health care, whether they are physicians, nurses, all through the system, top to bottom in lots of places, not just the United States. But the system within which you are allowed to provide care is as important to the delivery as the people providing it. So if we are not willing to put the same level of attention and same level of attention to detail on the level of intellectual rigor into designing the system, it is doomed to fail.

Mr. Burgess. Doomed to fail. Shona, let me just -- I know I have no time left, but I just wanted to let you know that my grandfather was an academic OB at the Royal Victoria Hospital in

McGill and my dad also did his training at McGill Medical School. He did a fellowship at Mayo Clinic back in the 1950s, when there was only the one in Rochester, and never went back to Canada. And I am so grateful you are here today, and thank you for sharing your story with us.

Ms. Robertson-Holmes. I don't want to pull down any doctors or anything from either side of the border. It is just what they are able to do.

Mr. Burgess. The doctors and nurses are all good people. The systems they are having to work under are where we are encountering the stress. Again, thank you for sharing your story with us today.

Mrs. Capps. Thank you, Dr. Burgess. And now I would recognize myself for 5 minutes.

I want to just point out that this legislation is not coming out of nothing, that there are -- I will just mention three examples of best practices or good care, medical home, if you want to call them that. Cleveland Clinic is one, Mayo Clinic is another. John Hopkins. All have been very participatory. And many of our hearings have been focused on areas where practices have worked and where we see examples in small communities.

I want to start with you, Dr. Shern. Mental health and substance abuse are some of the most chronic and disabling of conditions. Treatment often does not begin until as long as 10 years after diagnosis. And diagnosis, we all know, oftentimes

happens much after the symptoms begin. This increases the risk of developing a very costly disability. Mental health and substance abuse conditions often also go hand in hand with other costly chronic conditions like diabetes and heart disease.

Can you comment -- and I want to turn to children as well as a former school nurse. We must address that. But I want you to comment briefly on how we might be able to improve the provisions of the draft bill to better guarantee earlier access to mental health treatment. We tried to take as many steps as we could, but this is a single -- with all the stigmas and stuff still around, please address this for us.

Mr. Shern. First of all, I would say that we are lucky to have the Institute of Medicine report on prevention in general, and there are many things we can do universally to drive down the rates of mental illness over a long period of time.

So one thing we should think about -- and I think that the community task force that is anticipated in the bill is, in fact, moving in the direction of the evidence about what is effective in terms of prevention. I also think that the inclusion of mental health screenings in adolescents, as recommended by the Preventive Services Task Force and as included in the bill, is a very important step forward.

It is ironic that we test eyes, we test hearing, we look to see whether or not there is a scoliosis in the spine, but we don't test kids for the things that they are most at risk for routinely,

and those are social and emotional problems. We have data that indicates that when we do that with an appropriate model, as the Preventive Services Task Force has recommended, we can effectively identify and treat those conditions and that will be beneficial in the long run. Anything we can do to strengthen those provisions I think would be very helpful.

Mrs. Capps. And I am going to have to ask you to submit this to the written record. If you have ideas about how we could better integrate -- support better integration of behavioral health and medical care, as well as in a way of maybe branching out. Hopefully this will be a beginning start and then we can expand upon it.

You mentioned children naturally. Because when you talk about health care and mental health, really, as you know, Dr. Edelman, Marion Wright Edelman, that is when we should start looking at screenings. I want you to focus on a different topic. When you mentioned children, I always think of the mother and I want to elaborate on the importance. I would like to hear you elaborate on the importance of ensuring that women receive adequate maternal care coverage and the effect of a mother's health on the health of her children. It is so clear to those who have studied it that if you have adequate prenatal care, your chances of having a healthy baby are that much more important.

Ms. Edelman. Well, a depressed mother is not going to be the best mother for her child. So what is good for the mother is

always good for the child. So it is in all of our self-interest to make sure that mothers do get prenatal care, that any problems that they have are -- substance abuse problems, domestic problems, other things that may lead to them being less able to do all they need to do for their children, those can be detected early and treated early because the impact on their children in the short and long term will be enormous, and we also just know the cost effectiveness of prenatal care, if they are having babies that are at low birth weight, are not adequately nourished, and don't know how to take care of themselves and their children. So you can't separate the two. So I think going forward we should make sure that the mother is in good shape and the children are in good shape.

And I am happy to submit additional evidence of the effectiveness of prenatal care and the effectiveness of maternal care and hope that there will be a full fledged capacity to make sure that all children have mothers who get full maternity care in this bill.

Mrs. Capps. Thank you very much. We have done a bit of work in Congress recently to recognize the situation around maternal mortality. But also the fact that -- I don't think many Americans realize that this country, the United States, has one of the highest rates of infant mortality, 27th out of 30 industrialized countries. That is a red flag for starters.

And I want to thank each of you again for your testimony.

And now I will recognize Mrs. Christensen for 5 minutes for her questions.

Mrs. Christensen. Thank you, Madam Chair, And I thank all of you for your testimony. Ms. Chin Hansen, AARP has taken a position back a few years ago in support of lifting the Medicaid cap for the Territories. This bill does not go that far.

Is it still the position of AARP that all of the Federal programs should be equally accessible to all Americans regardless of where they live?

Ms. Hansen. As you have in my written testimony, that it does speak to really supporting that elevation. So it is something that we continue to support.

Mrs. Christensen. Thank you. Dr. Shern, you talk about providing mental health care and the savings that we would realize from that and the reduction in the productivity losses that we experience, and you give some pretty good figures to back that up. But I wonder if just for the record you would speak to the impact of treating mental health, mental illness, and chronic disease and how that would also produce savings in terms of chronic disease treatment.

Mr. Shern. Mrs. Christensen, as I said in my verbal testimony today, mental health conditions are the most likely co-occurring conditions with other chronic illnesses. And when they occur, there is lots and lots of data that indicates that the course of treatment is much rockier, costs are much higher and

outcomes are much poorer. We have a study of older adults with diabetes, called the Prospect Study, who also had depression, half of whom were randomly assigned to effective depression treatment, the other half were assigned sort of a watchful wait and counseling but to balance off the amount of time that was spent. What we found was over a 2-year period, those people who didn't have their depression effectively treated died at twice the rate of the individuals who had their depression effectively treated.

And in this study we found that in the first year there was an overall cost increase for care, but in year two the overall cost of care for those people declined and their clinical status improved.

So we have lots of examples of what is called collaborative care models in which the entire person's needs are addressed. In this case we are talking about diabetes and depression.

Additionally and quickly, if you look at workplace presenteeism and productivity, there is also ample data -- and this gets to your earlier point about thinking about costs more broadly than simply the costs within health care sectors -- there is ample data that shows that these are very cost effective programs that have effective return on investment.

Mrs. Christensen. Thank you. And, Ms. Edelman, I think most of the questions that I wanted to ask you have already been asked. But you know that I have always shared your passion and your commitment to making sure that every child and pregnant female has

been covered.

We are expecting a PAYGO bill to come to the Congress shortly. I think it is still coming and, cost being the major barrier to achieving what we all know we need to achieve on behalf of children and really all Americans, do you agree that it is important enough to take this issue out of PAYGO if that is where it needs to be?

Ms. Edelman. Well, I don't think we have a money problem in the richest nation on Earth. I think we have a values and priorities problems and that if we can find the money for all the more powerful special interests, if we can continue without having had a PAYGO for the tax cuts, many of which came through the Bush administration, if we could find the money so quickly for bailing out the banks and the others, if we can continue to have these disparate things, I don't for a moment believe we can't afford to take care of our children. It is really about values. And if we are serious about cost containment and if we are serious about prevention and if we are serious about creating a level playing field for everybody and if we believe, as we profess to believe and which is America's promise, that every child's life is of equal value, then we will find the money to do what is right and cost effective. So I hope we will do it.

Mrs. Christensen. Dr. Novak, do you agree -- I don't agree with a lot -- some parts of your testimony, but I agree with your position on MedPAC, if I understand it correctly, and where you

say that using cost control as a driving force behind health reform will turn every American from being a patient to an expense.

Do you also agree that this ought to be done regardless of cost because we cannot, as the President said, afford not to do it?

Dr. Novak. No. I disagree. I think that if we look at overall government spending, government should work the same as families. And that at some point we have -- look, we actually have a health care bubble. It is like we had a housing bubble. Our overall unfunded liabilities are massive in health care, and that bill will come due some day no matter where people want to stick it on the ledger. So given all the bailouts -- and I share the concerns with the other members of the panel about some of the bailouts that have gone on since they seem to go with whoever has the biggest megaphone. But that is not an excuse to not use basic fiscal responsibility when we are trying to reform health care.

Mrs. Christensen. But families do it in emergencies, borrow to meet those emergencies and make sure that they are taken care of.

Mrs. Capps. Now I recognize Mr. Green for 5 minutes.

Mr. Green. Thank you, Madam Chairman.

Dr. Shern, I am a cosponsor of H.R. 1708, the Ending Medicare Disability Waiting Period Act, and it would actually phase out the 24-month disability waiting period for disabled individuals. And

I want to thank you for being a member of the coalition in the 2-year waiting period which has more than 120 members.

Can you speak on the importance of that elimination, that 24-month waiting period for individuals with mental disabilities and illnesses, even with the creation of this Exchange that is in the bill?

Mr. Shern. I think it is very important that we eliminate that waiting period. It is such a counterintuitive thing. And you know how difficult it is for someone to qualify for SSDI, to make it through the disability process. And people with mental health and substance use conditions have a particularly difficult time making it through. And then once one finally gets through to say, well, in 2 years -- it was now agreed that you have a chronic illness that needs to be treated and say, well, the good news is you made it through the SSDI. The bad news is we are not going to be able to provide you healthcare coverage for 2 years. It makes no sense.

So I think that that repeal is really important. Anything we could also do to expedite the elimination of the discriminatory 50 percent copay in Medicare. We took care of eliminating it over a 5-year period. We have good data to show that that, in fact, drives cost on the inpatient side by denying people or making it more expensive for them to get ambulatory care.

So we are very enthusiastic about reducing that 2-year waiting period, and anything we can do to drive down that copay I

think would also be very cost effective and beneficial.

Mr. Green. Dr. Edelman, in Texas we have the largest uninsured in the United States and approximately 900,000 children uninsured. Approximately 600,000 of those children are Medicaid eligible but unenrolled and the remainder are SCHIP eligible but unenrolled. This can be attributed to times in the past when Texas was facing budget issues and required parents to reenroll their children in SCHIP every 6 months and the same with 6-month re-enrollment for Medicaid. There are two pieces of legislation. In fact, my colleague, Ms. Castor from Florida, and I both are cosponsors of it.

In your testimony you mentioned 12-month continuous eligibility for Medicaid as part of the solution to the problem with the number of uninsured children in the U.S. Can you explain why that is important also, the 12 months for the SCHIP program?

Ms. Edelman. Well, I think that if you want to keep children enrolled, and you should make the enrollment and re-enrollment procedures as easy as you can possibly make it, rather than as difficult as many States, including Texas, has made it. And we lost a child last year to Bonnie Johnson whose mother tried to do everything right but couldn't get her paperwork sorted out in Texas, and this 14-year-old child died from kidney cancer, which could have been allayed had he not been dropped from coverage for 4 months.

And I have been so pleased that the business community in

Texas has come now and really understood the importance of investing preventively and that Texas is losing millions of dollars, in fact almost a billion dollars, by turning down a Federal match and the local taxpayers are paying for it in emergency care.

And so I just hope that we can -- and we have submitted as a part of our longer testimony all of the simplification things, including the 12-month eligibility, presumptive eligibility, express lane, and a number of things that can make it easy to get children in for preventive care. And I would love, Mr. Green -- and thank you for your comments this morning -- to submit for the record the new study done by the Baker Institute that talks about the cost effectiveness of investing in coverage for all children in Texas and nationally, and lastly, some of the studies the business community have done in Texas in support of their reforms for 300 percent eligibility in Texas, as well as for the 12-month continuous eligibility.

Mr. Green. And we know that the numbers -- you can actually decide if you want to keep children off of CHIP or even Medicaid, you know, if you make those parents go down and stand in line every 6 months as compared to the year. Now, during that year they can still be investigated. If somebody finds out that family may not be qualified for Medicaid or even SCHIP, they can go get that. I appreciate it.

Also, Congressman Doggett is working with the Ways and Means

Committee on the same issue for both SCHIP and Medicaid.

Hopefully we can at least get SCHIP. It is much smaller, but we need to do that, look at the total goal for Medicaid also.

Dr. Novak, let me just ask questions about your statements. Health care reform must be built on a foundation consisting of the protection of the right of individuals to control their own health and health care, not special interests of government bureaucrats. I would submit right now I don't know if it is controlled by government, but it is controlled by somebody on special interests. If you are lucky enough to have insurance and you get preapproval, I can tell you that it is already going to be controlled by someone that is -- whether it is insurance companies or Medicaid officials or someone else. So I agree with you. I want health care to be controlled by individuals, but we all have to answer to someone. And I can't just go to the doctor and get everything I want. They tell me that is not part of the policy or you not treated for that.

Let me go next to your statement on the first preserving the right to be able to spend their own money, and let me understand. In Arizona, there is a constitutional amendment that the goal is to preserve the right to always be able to spend your own money for lawful health care services?

Dr. Novak. That will be on the ballot in 2010.

Mr. Green. Is there something in Arizona law that prohibits people from spending their own money for their health care?

Dr. Novak. No, but it is in Federal law, from the 1997 Balanced Budget Act, that effectively prevents Medicare beneficiaries from spending their own money. If you are a patient on Medicare and you come to me as a Medicare provider -- and let me give you -- if you bear with me, because it only takes a moment to do an example. If you have had your hip replaced, for example, two or three times and you need it done for the fourth time, which happens, you want to go to somebody who really knows what they are doing. Well, the physician you want to go to who does a lot of replacements, what we are seeing more and more frequently is that those people are no longer doing what we call redo or revision operations. And the reason is why for a primary or first-time uncomplicated hip replacement, Medicare pays \$1,400. But for a redo --

Mr. Green. I understand where you are coming from. Let me give you another example, though.

Mr. Pallone. [Presiding.] Excuse me. You are over almost a minute and a half. So I would like to end this if I could.

Mr. Green. Let me ask you just to compare to that. If someone comes into you --

Mr. Pallone. Mr. Green, you can't ask an additional question.

Mr. Green. We don't have time?

Mr. Pallone. If he wants to respond, fine.

Mr. Green. I just wanted to make the comparison, Mr.

Chairman.

Dr. Novak. The difference is a \$250 difference for what would be three times the work. So if you say I want Dr. Jones to do the operation, I will pay you the difference out of pocket because it is extra time, the only recourse a physician has is to resign from Medicare and not see any Medicare patients for 2 full years.

Mr. Pallone. If you want to respond to that, you can. But I have got to move on.

Dr. Novak. It is technically an effective prohibition on spending your own money on health care.

Mr. Pallone. If you want to respond to that.

Mr. Green. There are a number of members here who voted for that Balanced Budget Act in 1997. There is a lot of things that have happened since then that I disagree with. But I also know one of the concerns is that in an area that I have that is not a wealthy area, if we didn't have that, if we didn't have the current provision in the 1997 act, we would not have people being able to find a doctor to be treated under Medicare -- because they couldn't afford that extra money plus what they are already spending on Medicare.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you. The gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. Blackburn. Thank you, Mr. Chairman, and thank you all

for taking your time to be here.

Ms. Holmes, I wanted to talk with you for a few minutes. It sounds like you had an incredible journey.

Ms. Robertson-Holmes. I did.

Mrs. Blackburn. And you were happy to be able -- and grateful and fortunate to be able to find health care. You were here during the first panel and you have heard what I have had to say about TennCare in the State of Tennessee and our concerns there, because what you outline in your testimony is what I see happening many times in our State. You had to fly 2,000 miles to access health care. In rural west Tennessee, because of all the cost shifting that has taken place, because people are not able to access health care and many providers are no longer taking TennCare, then they find that that health care is available a long way away from them. And sometimes 30 miles might as well be 3,000 miles if no one has the ability to take you there. And I am just assuming, from what I read in your testimony and listening to you, that your outcome had you had to depend on a single-payer system that allows you no recourse, that allows you no alternatives, which says take a number, get in the queue and wait your turn, that your outcome would have been very, very different.

Ms. Robertson-Holmes. Very, very different. And this is the whole reason why I am here because I feel very -- to stick my nose in American business, but I was fortunate to be able to come here. But not only did I have to just travel away from my home, I had to

travel outside my country. And when it gets like that -- because it is actually illegal for me to try and do what I did in Canada. And that is what we have to be able to -- to open the doors of communication about and realize that you get rationed care. It is one thing to not have insurance, and it is another thing to have insurance and not have doctors.

Mrs. Blackburn. So basically your government provided insurance. When you needed it, your government provided insurance was worthless to you?

Ms. Robertson-Holmes. Exactly.

RPTS DEAN

DCMN BURRELL

[1:25 p.m.]

Ms. Robertson-Holmes. Exactly.

Mrs. Blackburn. So you mortgaged your home, put a second mortgage on your home. Your husband picked up a second job.

Ms. Robertson-Holmes. That is right.

Mrs. Blackburn. And you got the money that was necessary, the \$100,000 to pay for that.

Ms. Robertson-Holmes. Yes.

Mrs. Blackburn. Now when you had flown back to Mayo and then you went back to Canada with your test results, and you said all right, here it is, I am going to be blind in 6 weeks, did a bureaucrat make the decision or a physician make the decision?

Ms. Robertson-Holmes. They wouldn't even look at my medical reports. It was get back in line and wait.

Mrs. Blackburn. So the bureaucrat turned to a citizen and said, you are out of luck, get in line?

Ms. Robertson-Holmes. Get in line.

Mrs. Blackburn. That is real compassion, isn't it?

Ms. Robertson-Holmes. No, absolutely zero compassion from a country that is known to be compassionate. The same country that will cover illegal immigrants the second they arrive in our country.

Mrs. Blackburn. Thank you, ma'am.

Ms. Hansen, a quick question for you, and thank you for being here and I know you all work hard for our Nation's seniors. I have lots of seniors in my district and I had the opportunity this weekend to visit with some of them. You know, they are really very concerned about what they have been hearing from the Obama plan, because they feel like they have had money taken out of their paycheck every week and now they get to near retirement or they get to retirement and they are being told basically that that is worthless to them, that if there is a nationalized plan that they are going to be treated more like -- they are feeling they are going to be treated more like Medicaid than Medicare and they are very, very concerned about losing Medicare Advantage, they are very concerned about losing options, and concerned with losing their Part D coverage.

What would you suggest that I tell these seniors that say I have been putting money in, it is my money and came out of my paycheck, I have been letting the government have first right of refusal on that money all of these years, and now it is basically people -- everybody is going to have the same thing? How do you respond to that? What should I tell the senior?

Ms. Hansen. Well, I think that what I think I have heard that the President said if you have current insurance and it works for you, you can keep it. So I don't know if in this discussion whether it is that everything comes back into the pot, and I don't think that the Medicare program is meant to be structurally

dismantled. So I think that my sense is that their assurance of whether it is the Medicaid program that Dr. Edelman has spoken about and Medicare. I mean, we have these right now codified in law with each of these different parts. So there is that.

I think one of the things that we want to do is to make sure they get best value for their hard earned money, for what they have spent. So in other words, we want to make sure they get safe care, we want to get timely care. We want to make sure when they need medications, and most older people have medications, of the fact that it is affordable for them.

So these are the things that I know AARP really strongly supports, and so I think the ability to really square as to what is discussed about President Obama's plan and the principles of maintaining choice, coverage, and private options.

Mrs. Blackburn. Thank you, I yield back.

Mr. Pallone. Thank you.

Gentlewoman from Ohio, Ms. Sutton.

Ms. Sutton. Thank you very much, Mr. Chairman. Five minutes isn't going to do it, but I am just going to request that Ms. Wright Edelman and Ms. Chin Hansen and Dr. Shern, if I can follow up with you outside the committee to talk about some ideas of how we might strengthen some things and make this work for our children and our seniors and those who have needs, Dr. Shern, you have so eloquently identified.

I want to thank you very much, Ms. Robertson-Holmes, for

coming and testifying. Dr. Novak. And I want to address the issue that I think you raise. And I think it is very important as we have this discussion to talk about the reality that this isn't just about getting people health care insurance. This is about improving the delivery of health care to people when they need it the most in a way that makes sense both for health outcomes and economically. And so your point is well taken when you talk about you paid for your insurance, right?

Ms. Robertson-Holmes. Oh, sure.

Ms. Sutton. And when you needed it, it wasn't there.

Ms. Robertson-Holmes. Right.

Ms. Sutton. I listen to you because I was so struck because I was in the State legislature in Ohio and did a lot of work related to the private insurance industry, and that very same problem, people who paid for care and then when they needed it and their doctor said they needed it, the insurer wouldn't pay for the coverage that they had been paying for all this time. And there is a person by the name of Linda Kerns, it is K-E-R-N-S, Doctor. And Linda was a witness who came in to testify. And Linda was a very special person and most people are, but she was special because she was actually an HR person for an insurance company. And Linda had a history in her family of breast cancer, that was a very aggressive form of breast cancer. And so her doctor when she went in for treatment, that she was vulnerable for this potential for breast cancer, the doctor wanted to treat her aggressively,

and the insurance company bureaucrats overruled the doctor and said no, I am sorry, you have been paying for coverage but that care is not going to be provided, we don't think you need it. So she didn't get it. She didn't get that coverage.

Now what she did was what you did. She eventually over time, with great delay, raised the money and went into debt to get that surgery, but there was a delay. So we really never know the value of that delay or the health outcome.

Ms. Robertson-Holmes. Irreversible tissue damage, no question.

Ms. Sutton. And in this country, unfortunately, there was no recourse for her even if there was a proven health consequence to the unreasonable delay or denial of that coverage, even though if a doctor had done it -- if a doctor had said we are not giving that to you and then he was found to have unreasonably delayed or denied then, there would have been a malpractice case against them. There was no accountability for that private insurer to be held accountable for the health outcome other than the cost of the procedure, not the loss of life or health.

Ms. Robertson-Holmes. That is the exact same situation as we have, and there is no accountability from the government.

Ms. Sutton. See, this is my point though, because you experienced that under your system. We see people experience that here under our system as well and people going into bankruptcy because the costs are spiraling or they don't have access to the

care they need when they need it. The problem is that I guess maybe what I would ask is that if you had -- and you talked about the need to have some competition for your government-run plan, and that is exactly what we are offering here. We are assuring that people have access to coverage in this country, and right now the private insurers are the only game in town. If they unreasonably delay or deny, no accountability. If we have a public option that also allows people to have the chance to purchase it, that that cannot only drive down costs but I would argue can drive up the quality of the delivery of care.

And so I just point that out, because I can't help but think of Linda.

Ms. Robertson-Holmes. And I understand and the major difference between the two of us is --

Mr. Pallone. Ms. Robertson, you have to turn that mike on, because otherwise you won't be transcribed.

Ms. Robertson-Holmes. The major difference between her and I is that what I did by coming to this country, mortgaging my house, et cetera, et cetera, was illegal for me to do at home. It is not an avenue for me to do at home. I cannot step out of that. I am mandated to use that, and that is it.

Ms. Sutton. And you would have preferred to have the option of buying private insurance and then you would be resolved?

Ms. Robertson-Holmes. Or if worse came to worse, the same situation that happened to me here, I could have at least stayed

in my house, had my children with me, had my father, you know months before he passed away still with me at my hospital bed. Instead I was in Arizona 2,000 miles away alone.

Ms. Sutton. I understand, and I thank you very much for your testimony.

I know I am out of time. So bureaucrats there, bureaucrats here. Of course this bill I know you had the question, Dr. Novak, from our chairman emeritus about the exact language that you used in your testimony to describe the bureaucrats that will in your opinion be performing the functions under this bill, but it really does provide, the bill, if you find the language, it provides for health care professionals to do the analysis and of course what we must tell the American people is that right now insurance companies are doing it.

So with all due respect, thank you.

Dr. Novak. My answer is --

Mr. Pallone. Listen, I am sorry. I don't think she was addressing a question to you.

The next person is the gentlewoman from Florida, Ms. Castor. I apologize that I passed over you by mistake.

Ms. Castor. Thank you, Mr. Chairman, and thank you to all of the witnesses who are here.

To Dr. Shern, you were an outstanding director of the Florida Mental Health Institute in Tampa at the University of South Florida. They miss you there, we miss you. USF is doing great

things, as you know, in medical, in health care policy and research.

Back in Tampa before I was elected to Congress, I served as county commissioner and the county government there had the responsibility for all health and social services, including very fairly robust children's services, compared to many other places across the country. But I was always floored by the total lack of mental health care services. There is nothing, there is nothing for these families that struggle day to day with what is going on in their homes.

Now of course the county government also had responsibility for law enforcement and the county jail, and the greatest advocate for mental health care services was always the sheriff and the folks that were running the county jail because they understood the population in jail, and that is the most expensive way to address mental health care in America.

So I am pleased that the discussion draft here in the House takes the first few steps in providing that comprehensive early integrated care, and there is no better place to start of course than with children.

As a mother, what would I do if I didn't have the same pediatrician that I have had for my daughter's 12 years of life to be able to just make that phone call, to call a nurse in the office. It is very cost effective rather than trying to chase down and go to a clinic or go into an emergency room. We are all

paying for that very expensive model out there. If you have health insurance and you think you are not paying for other people's care right now, you are wrong, you are. That is one of the reasons your health insurance bills and copays have been increasing over time to such a great extent because of the uninsured showing up in the ER.

But to promote this early integrated comprehensive care reform that we have taken a stab at here early in our discussion draft, I would like to you focus on a couple of things. Workforce. We know we don't have those primary care medical professionals, and I am not sure we have the mental health professionals that we need. Are we doing enough in our discussion draft to tackle that problem? I would also like you to address the terrible bureaucratic red tape. Ms. Edelman has emphasized that time and time again. You have some good recommendations in here, but I don't think the discussion draft goes far enough. In the State of Florida we have 800,000 children that do not have that easy access to the doctor's office. The State of Florida even one time quit printing the application form for SCHIP.

So what else can we be doing to knock down these crazy bureaucratic barriers that make it difficult for a parent just to walk into the doctor's office and make sure that their son or daughter gets a checkup? So the workforce issue and this terrible bureaucracy.

Mr. Shern. Workforce is a critically important component,

and I am heartened it is addressed in the bill, and of course we would always like to be able to do more, because we have a real pipeline problem in terms of people who were being trained to deliver the services that we need across the spectrum.

You talked about primary care physicians. I think we continue to rely more and more and more on primary care physicians in the medical home. As we know, the current incentive system isn't producing enough primary care physicians and we are not reinforcing them or rewarding them to the degree to which we can or should.

Additionally, I think we need to think about what we can to continue to improve practice of people who are in practice now. We don't have very good models for doing that. We have what has been characterized as the Nike model. We sort of train them and say go out and just do it. We give them CME but we know that the CME doesn't do what it needs to in terms of improving skills.

And there are other models, some with the hope of HIT is better support, and comparative effectiveness research is better support for people to make better decisions.

And I think I will defer to my colleague, Ms. Wright Edelman, to talk about bureaucracy.

Ms. Edelman. Well, I just think a single eligibility standard for everybody, for all children, that is why we suggest 300 percent will make it easier rather than have all these different eligibility standards. A single set of benefits that

are child appropriate, it will make it a whole lot easier.

And secondly and third, we talk about all the simplifications and we have it in legislative language, they are all included in the All Healthy Children Act, would be another terrific start. But getting rid of all the State lottery and all the disparate things and the two child health bureaucracies, whether the children are in Exchange or in EPS or Medicaid or in CHIP, they should all get what they need with a single eligibility standard, comprehensive benefits, and the simple sort of measures that we all know how to do.

And I just hope that you will look at the specific legislative language. We will be happy to submit it as part of our testimony. And these are the true child health reforms we need in order to make sure that all of our children get what they need.

Mr. Pallone. Mr. Sarbanes.

Mr. Sarbanes. Thank you, Mr. Chairman. I want to thank the panel. Mr. Chairman, I want to thank you and Chairman Waxman and everyone who has been working on this issue for so long, because this is it, this is not a dress rehearsal. These panels that we are having probably are kicking themselves that they are here to speak on an actual discussion draft that includes these critical proposed changes to our health care system. I just hope that Americans watching this realize that this is exactly what they were pushing for in the last couple elections where they were

expressing their frustration with the current health care system.

This is our chance to get this right. It doesn't have to be perfect, but we have to get a new framework in place, one that we can build on and one that answers the frustrations and the feeling of helplessness that millions of Americans feel out there.

I think the source of that is many fold, but I will point to a couple things, that sense of helplessness that I am describing. One is that you deal with an insurance industry that appears to be primarily engaged in the exercise of denying payment for the kinds of services that people need. And there is a paper chase. You get these things in the mail that say we will not pay, this is not a bill, this is your third notice, this is your fourth notice. Many Americans just give up after a certain point because they can't fight it.

So that is one source of the frustration. That why I think we need a public plan option to compete, and I am not going to revisit that discussion. But as a train leaves the station on health care, if public plan is not on the train, it is a train to nowhere. It has got to be there.

The second source of frustration on the part of many people is they know that there are certain kinds of things that if that was reimbursed in the system it would be better for their health, it would save the system money over the long term. They can see it, it is right there, but the system doesn't cover it.

Elderly patients know that if they can spend another

20 minutes with their physician or half an hour, God forbid, that in that time the physician could better understand their situation and probably prescribe a regimen that would make a lot more sense to that patient and save the system over the long term. But physicians who do that are penalized by a system that doesn't recognize that kind of primary and preventive care.

So that is another thing that needs to be on the train as it leaves the station, primary and preventive care. The other one is investing in the workforce. Because if we have the coverage, that is all very well, you show up with your insurance card, but there is no providers to deliver the care.

So these are all things that are a part of this draft, this is why people need to be incredibly excited that we are [\[talking about\]](#) this right now. This is it, this is it. This is the moment.

Now with that preface, let me go to health care delivery. I wanted to ask you, Ms. Wright Edelman, because you talked a lot about SCHIP and getting these services to children, but continue to be frustrated on kind of the delivery system. Congresswoman Capps and I have pushed to try to create more school-based health centers and also allow for reimbursement of services provided there if they would otherwise be reimbursed if delivered in a physician's office setting.

Could you just speak briefly to this idea of capturing people where they are, this concept of place-based health care, go to

where the children are, make it easier to access services at that point on the front end? Ninety-eight percent of our kids ages 5 to 16 are in one place 5 to 6 days a week.

Ms. Edelman. In school.

Mr. Sarbanes. For 6 or 7 hours. We ought to take advantage of that. So if you could speak to that as part of this overall perspective.

Ms. Edelman. I want to say amen. You go to where they are, you make it as easy as you can. We need to expand the community health centers, we need to expand school-based health centers. And if the mother is in WIC and that is where kids are coming in, you get them enrolled and you make sure that you are making it available. And one of these days I look, as we talk about health and school reform, is that we can really make the new schools that we construct real community centers and collocate services so that is easy rather than hard for people to get their care.

So whatever we can to go where children and families are and to make sure that it is accessible would be terrific. I think none of this is rocket science. I think we know how to do it.

And I just want to reemphasize what you have just said. This is it. You have got all the skeletons for what you need to get done in your plan. We just need to kind of finish it and make sure that you have got the instructional forms there.

And I would like to say one little thing, because this is not a dress rehearsal. This is a window of opportunity. If we miss

this opportunity, we are going to lose more generations of children and see escalating costs.

I just was looking for a thing that is in the written testimony about the President's statement. And I guess I think it states what you have stated in strong terms. He says I refuse to accept -- when he was signing the CHIP bill -- that millions of our kids fail to meet their potential because we failed to meet their basic needs.

In a decent society there are certain obligations that are not subject to tradeoffs or negotiations. Health care for our children is one of those obligations. This is the moment to fulfill that obligation, for you to fulfill it you know how to do it, you have got lots to build on. We have been working and many of the leaders here on Medicaid for 42 years. We know from the incremental problems how to make it simple, but we can address the health infrastructure. You made such a good start. I just hope you can just finish it and make sure that it is transformational and true health reform for all of us.

Mr. Sarbanes. Thank you very much. I yield back.

Mr. Pallone. Thank you, and I think we are done with the questions, but I want to thank all of you again. Obviously what we are doing is crucial and we do plan to move ahead and meet the President's deadline. Thank you very much. Again, you will get written questions within the next 10 days and we would ask you to respond to those.

Could I ask the next panel to come forward, please?

Could I ask those who were standing or talking to leave the room so we can get on with our third panel?

Let me introduce our three witnesses here. Again starting with my left is Dr. Jeffrey Levi, Executive Director for the Trust for America's Health. Next is Dr. Brian Smedley, Vice President and Director of the Health Policy Institute, Joint Center for Political and Economic Studies. And then we have Dr. Mark Kestner, Chief Medical Officer for -- is it Alegent Health?

Dr. Kestner. Alegent.

Mr. Pallone. Alegent Health. And this panel is on prevention and public health, certainly one of the more important parts of what we are discussing in the discussion draft. You heard me say before that we ask you to talk for about 5 minutes and your written testimony, your complete written testimony will become part of the record. And we will have questions after for 5 minutes from the members, and we may send you written questions afterwards which we would like you to respond to as well.

I see we are joined by our ranking member, Mr. Deal. And we will start with Dr. Levi. It is Levi?

Mr. Levi. Yes, it is.

STATEMENT OF JEFFREY LEVI, PH.D., EXECUTIVE DIRECTOR, TRUST FOR AMERICA'S HEALTH; BRIAN D. SMEDLEY, PH.D., VICE PRESIDENT AND DIRECTOR, HEALTH POLICY INSTITUTE, JOINT CENTER FOR POLITICAL AND

**ECONOMIC STUDIES; AND MARK KESTNER, M.D., CHIEF MEDICAL OFFICER,
ALEGENT HEALTH**

STATEMENT OF JEFFREY LEVI, PH.D.

Mr. Levi. Thank you, Mr. Chairman, and thank you for the opportunity to testify on the House discussion draft of health reform legislation.

Trust for America's Health and our colleagues throughout the public health community are delighted that this legislation recognizes that prevention, wellness, and a strong public health system are central to health reform. We also support the premise that without strong prevention programs and a strengthened public health capacity surrounding and supporting the clinical care system, health reform cannot succeed.

While my testimony will focus on the public health provisions of the discussion draft, I must first say that universal quality coverage and access to care are central to health reform. We believe this bill can achieve this goal. Inclusion of evidence-based clinical preventive services as part of the core benefits package with no copayments also assures cost effective health outcomes.

Trust for America's Health has worked with over 200 organizations to articulate the importance of prevention and wellness to health reform. Our joint statement is attached to my written testimony and I will briefly review its key components.

First, we have urged that as part of a renewed focus on

public health Congress should mandate the creation of a National Prevention Strategy. The discussion draft meets the central criterion by requiring the Secretary to develop a National Prevention and Wellness Strategy that clearly defines prevention objectives and offers a plan for addressing those priorities.

Second, the groups urged establishment of a trust fund that would be financed through a mandatory appropriation to support expansion of public health functions and services that surround, support, and strengthen the health care delivery system. We envision the trust fund supporting core governmental public health functions, population level non-clinical prevention and wellness programs, workforce training and development, and public health research that improves the science base of our prevention efforts.

We applaud the inclusion of the Public Health Investment Fund, which will support through mandatory appropriations the core elements of the public health title, including the prevention and wellness trust. By including mandatory funding for community health centers, the discussion draft also assures a much closer link between the prevention and wellness activities that happen in the doctor's office and those that happen in the community.

Let me now review some of the key activities associated with the investment fund and our rationale for supporting them. On workforce, the focus on frontline prevention providers and public health workforce places appropriate emphasis on where the need is greatest in our health care system. Assuring the development of a

robust public health workforce through creation of the public health workforce core, which will offer loan and scholarship assistance, finally places public health recruitment, training, and retention on par with the medical profession.

Community prevention and wellness programs are also critical. The expanded investment in these programs will be important to the success of health reform. There are evidence-based proven approaches that work in the community setting to help Americans make healthier choices, by changing norms and removing social policy and structural barriers to promoting healthier choices. We know that targeted uses of these interventions can reduce health care costs. We are particularly pleased to see that this draft recommends establishing health empowerment zones where multiple strategies can be used at one time.

In terms of support for core public health functions, we appreciate the recognition in this draft that the strength of our Nation's State and local health departments will significantly affect the success of health reform. Without the capacity to monitor population health, respond to emergencies, and implement key prevention initiatives, the health care delivery system will always need to backfill for a diminished public health capacity at a higher price in dollars and human suffering.

Improving the research base and revealing the evidence is also an important component of this legislation, and it makes a crucial investment in both public health and prevention research.

While we have a strong base of prevention interventions today, much more needs to be learned about non-clinical preventive interventions, including how to best translate science into practice and how to best structure public health systems to achieve better health outcomes.

Dr. Smedley will address in more detail the issue of inequities, but I want to note that we are pleased that this draft focuses on disparities in access and health outcomes. From better training to targeting resources in communities where disparities are greatest, we harness what we already know will work to reduce inequities. We must recognize that the goal of health reform is not just creating equality of coverage and uniform access. We need to assure equity in health outcomes, too.

Mr. Chairman, there are few times that we have the privilege of watching history being made. This may well be one of them. If the public health provisions of this draft become law, in the years ahead we will witness the transformation of our health care system from a sick care system to one that emphasizes prevention and wellness. This is what our Nation needs and what the American people want.

Recently, Trust for America's Health released the results of a national bipartisan opinion survey. Perhaps the most impressive finding in that survey was that given a list of current proposals considered as parts of health reform, investing in prevention rated highest, even when compared to concepts like prohibiting

denial of coverage based on pre-existing condition.

In short, by placing this emphasis on prevention and wellness in the discussion draft, this committee is responding to a compelling call from the American people.

On behalf of our partners in the public health community, Trust for America's Health thanks you for your leadership and looks forward to working with you to see these enacted into law.

[The prepared statement of Mr. Levi follows:]

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Mr. Pallone. Thank you.

Dr. Smedley.

STATEMENT OF BRIAN D. SMEDLEY, PH.D.

Mr. Smedley. Thank you, Mr. Chairman, for the opportunity to provide testimony on the potential to address racial and ethnic inequities in health and health care in the context of the tri-committee health reform legislation.

For nearly 40 years the Joint Center for Political and Economic Studies has served as one of the Nation's premier think tanks on a broad range of public policy issues of concern to African Americans and our communities of color. We therefore welcome the opportunity to comment on this important legislation.

Many racial and ethnic minorities, particularly African Americans, American Indians, and Alaskan Natives, native Hawaiians and Pacific Islanders, experience poorer health relative to national averages from birth to death. These inequities take the form of higher infant mortality, higher rates of disease, and disability and shortened life expectancy.

Health inequities carry a significant human and economic toll, and therefore have important consequences for all Americans. They impair the ability of minority Americans to participate fully in the workforce, thereby hampering the Nation's efforts to

recover from the economic downturn and compete internationally. They limit our ability to contain health care costs and improve overall health care quality. And given that half of all Americans will be people of color by the year 2042, health inequities increasingly define the Nation's health. It is therefore important that Congress view the goal of achieving equity and health and health care not as a special interest, but rather as an important central objective of any health reform legislation.

To that end, the draft tri-committee legislation contains a number of important provisions that will strengthen the Federal effort to eliminate health and health care inequities. Importantly, the legislation offers the kind of comprehensive strategy of targeted investments that are likely to help prevent illness in the first place, manage costs when illness strikes, and improve health.

Over the long haul these provisions will result in a healthier Nation with fewer health inequities, greater workforce participation and productivity, and long-term cost savings. These provisions do several things.

They emphasize and support disease prevention and health promotion. For example, the legislation would require the CDC Clinical Preventative Task Force and Community Preventative Task Force to prioritize the elimination of health inequities.

In addition, the legislation would authorize health empowerment zones, as Dr. Levi has emphasized, locally focused

initiatives that stimulate and seed coordinated, comprehensive health promotion and community capacity building.

Provisions in this draft legislation would also improve the diversity and distribution of the health professional workforce; for example, by increasing funding for the successful programs such as the National Health Service Corps and Health Careers Opportunity Program, expanding scholarships and loans for individuals in needed health professions in shortage areas, particularly nursing, and encouraging the training of primary care physicians. It will also strengthen Medicaid by expanding eligibility and by increasing reimbursement rates for primary care providers. And it will improve access to language services; for example, by requiring a Medicare study and demonstration on language access.

While the tri-committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the Federal investment in health equity. These include encouraging the adaptation of the Federal cultural and linguistic appropriate services standards which would help improve access and quality of care for diverse populations, expanding successful community-based health programs such as the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health Program, addressing health and all policies by funding and conducting health impact

assessments to understand how Federal policies and projects in a range of sectors influence health.

Strengthening the Federal health research effort by elevating the National Center on Minority Health and Health Disparities to institute status. The national center has led an impressive effort to improve research on health inequities at NIH and needs the resources and influence associated with institute status to continue this work.

Strengthening Federal data collection by establishing standards for the collection of race, ethnicity, and primary language data across all public and private health insurance plans and health care settings, and insuring that immigrants lawfully present in the United States face the same eligibility rules as citizens for public programs, including Medicaid Medicare and CHIP.

Mr. Chairman, in conclusion, addressing health inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources and a focus on addressing equity in all Federal programs in all elements of health reform legislation. To failure to do so ignores the reality of important demographic changes that are happening in the United States and fails to appreciate the necessity of attending to equity as an important step in our effort to achieve the goals of expanding insurance coverage, improving the quality of health care, and containing

costs.

Encouragingly, the tri-committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to achieve this goal.

Thank you, Mr. Chairman, and we look forward to working with you on this important legislation.

[The prepared statement of Mr. Smedley follows:]

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Mr. Pallone. Thank you, Dr. Smedley.

Dr. Kestner.

STATEMENT OF MARK KESTNER, M.D.

Dr. Kestner. Good afternoon, Mr. Chairman and members of the committee, and thank you for the opportunity to be with you today. My name is Dr. Mark Kestner, and I am the Chief Medical Officer for Alegent Health.

Today I want to give you a brief overview of Alegent Health's experience with prevention and wellness. We are both the large employer and a substantial provider of health care, which gives us a unique perspective on these issues.

Alegent Health is a faith-based, not-for-profit healthcare system that serves eastern Nebraska and western Iowa. We have 9,000 employees and 1,300 physicians that are proud of the care we provide in our 10 hospitals and in our 100 sites of service. Alegent is the largest nongovernmental employer in Nebraska, and each year we serve more than 310,000 patients.

As a provider, we believe we are a model for post-reform health care systems. We employ substantial health care information technology to improve the quality and safety of the care we provide. Through the dedication and commitment of our physicians, a combination of both employed and independent

physicians, we have standardized care and implemented evidenced-based care order sets across more than 60 major diagnosis fees that are continually raising the bar on the quality of care we provide.

Our CMS core measure and HCAP scores are consistently among the highest in the Nation. In June of 2008, the Network for Regional Health Care Improvement identified Alegant as having the best combined health care quality scores in the Nation. Through the implementation of health IT and adoption of evidence-based care, Alegant is increasing the quality of care we provide while simultaneously lowering the costs that we provide. Last year we reduced our resource utilization, and the cost of the care continues to decline.

We are proud to have shared these and other initiatives with Health and Human Services Secretary Kathleen Sebelius 10 days ago when she paid a visit to us. And yet, Mr. Chairman and members of the committee, in our estimation the efforts of providers to raise quality and lower costs is only a small portion of what we need to do. We adamantly believe that people must be more accountable for their health. And in doing so, we must incentivize them and give them good information.

We began our journey with greater consumer involvement in health care 3 years ago when we made a commitment as an organization to more fully engage our workforce and their health. We spent a year designing a new benefit plan that promoted health

and wellness among our employees. In pioneering the new benefit plan, we identified incentives to encourage healthier behaviors and tools to provide meaningful costs and quality information as areas where Alegant could foster individual engagement in health care.

There are two important constructs to Alegant's employee health benefit plan. First, preventive care is free. This ranges from services like annual physicals and mammography to childhood immunizations and colonoscopies. If it is preventative, it is free. As a result, our workforce is consuming more than two and a half times the preventive care than the Nation at large. That is an investment we are willing to make even without longitudinal studies to quantify the financial benefit to our organization.

Second, through an innovation called Healthy Rewards Program we pay people to make positive changes in their lifestyle. If an employee quits smoking, loses weight, more effectively manages their chronic diseases like diabetes, or makes other positive changes that affect their lifestyle, Alegant provides a cash reward. To encourage wellness and prevention and help our employees get healthy, we offer a variety of assistance programs free of charge, free weight loss counseling, free smoking cessation, and chronic disease management programs. For those who need a little bit of extra help, we offer free personal health coaches.

Our objective was first and foremost to improve the health of

our workforce, and we believed by doing so our costs would decline. And while we are still building data on the effects of our efforts that had been on productivity and absenteeism and organizational health care costs, I can report that a majority of our employees take an annual health risk appraisal and today have lost 15,000 pounds as a workforce, and more than 500 employees of our employees have quit smoking.

Our approach has allowed us to substantially slow the growth of our health care spending. Over the first 2 years our cost increases were limited to an average of 5.1 percent despite trends in the 8 to 10 percent range. As we approach a new benefit plan year, we are carefully constructing a advanced medical home pilot for our chronically ill employees and several large employers in the community.

Key to our results was their use of the HSA and HRA accounts, which give employees better control in their health care dollars and allow us to directly reward people for changing unhealthy behavior.

The data we examined developing our benefits plan suggests to us that people would be more inclined to take advantage of health and wellness programs, even free ones, if they were incentivized to do so. For us the use of HSAs and HRAs facilitate this process and provides employees an immediate tangible benefit in the form of subsidized health care costs. But to give our employees more control required us as providers to make other dramatic changes.

First and foremost, we created tools to provide meaningful and relevant cost and quality information. We have a quality Web site where we publicly report our 40 quality measures, CMS 20, the 10 skip and the 10 stroke measures, and our compliance with these measures ranges anywhere from 97 to 100 percent.

In January of 2007, we introduced a Web-based cost estimating tool called MyCost, which is the first of its kind in the country. By working with third-party payer insurance database, MyCost was able to verify insurance policies and deductibles in order to provide patients an extremely accurate price estimate on more than 500 medical tests and procedures. In a little over 2 years, 85,000 individuals, employees and members of our community, have used it.

In summary, Alegent Health began our health care reform several years ago when we made an organizational commitment to dramatically improve quality, lower cost, and adopt health information technology. We knew that this would help us become more effective and efficient providers, and the data shows that we are becoming successful in reducing our costs and our resource utilization. And yet, Mr Chairman and members of the committee, that was simply not enough. Our challenges as a country as physicians, nurses, Members of Congress and employers, individuals, and families is to find a way to help people become more individually responsible for their health care.

Thank you.

[The prepared statement of Dr. Kestner follows:]

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Mr. Pallone. Thank you. Thank all of you, and we will now take questions, and I will start with 5 minutes.

I wanted to really focus, if I could, on the questions to Dr. Smedley, because of the disparities issue. All of you talked about the importance of prevention and wellness, and that is certainly what we hear in regard to health reform. And specifically experts tell us we have to address prevention and wellness at the community level if we want health reform to lead to the best health outcomes for our constituents. That is definitely the case for elimination of health disparities. Disparities arise not just because of differences in medical care, but also because there are factors that make it harder for some people than others to make healthy choices.

Dr. Smedley, I have been most familiar with this with Native Americans because I am a vice chair of the Native American Caucus. I don't have any tribes in New Jersey, but over the years being on the Resources Committee, I have paid quite a bit of attention to the Native American issues. Best example probably was with the Pima, the Tohono O'Odham, where you saw that traditional diet, ranching, desert products were lost and they using, eating processed foods, and it was hard to go back to traditional diet because the ranches were gone and the desert had changed and it just wasn't possible to do that.

So in the draft proposal we target funds to community based

interventions or services with the primary purpose of reducing health disparities. Can you tell us how the recommendations from the Community Prevention Task Force, that is housed at CDC and whose work is strengthened in the draft proposal, can be used to target health disparities? And anything else about addressing health disparities within the context of prevention and wellness. What do you see as some of the areas that require new or additional research?

All in about a minute because I have a second question to you.

Mr. Smedley. Sure, Mr. Chairman, I will try to be very brief. As you pointed out, place matters for health. Where we live, work, study and play is very important. Certainly it is important that we all take responsibility for our individual health choices, but sometimes those health choices are constrained by the context in which we live, work, and play. Since you pointed out in many communities of color we face a number of health challenges, often the retail food environment is poor in segregated communities of color. You have a relative abundance of fast food outlets, poor sources of nutrition, a relative lack of grocery stores where you can get fresh fruits and vegetables. Similarly in many communities of color we lack safe places to play, recreational facilities, places to exercise. It is harder to encourage an active lifestyle under those conditions. So the CDC Preventative Task Force is an evidence-based process that

tries to identify what are the kinds of community-based prevention strategies that will help to address these kinds of conditions. We think that is very important. So I certainly applaud the provisions in the draft bill that would strengthen that process.

Mr. Pallone. Now on the workforce, again I will use American Indians because I am most familiar, I think there are maybe, over 2 million Native Americans and last count less than 500 American Indian doctors, 400 something. They have an organization. I went to speak to them once, and that is the entire membership.

In the discussion draft there are a number of provisions that will increase representation of racial and ethnic minorities. We have additional investment in the National Health Service Corps. Basically, how would these workforce provisions help address health disparities? Why is increasing the diversity of the workforce and not just its scale important in reducing health disparities? You could argue why do you need more Native American doctors, why can't other people take care of Native Americans. But I know that there is an issue there, and I would like to you discuss it.

Mr. Smedley. Absolutely. The research is very clear that when we increase the diversity of the health provider workforce all of us benefit. So for example, we know that providers of color are more likely to want to work in medically underserved communities. Their very presence increases patient choice. We talk a lot about many patient choice. For many patients of color

it is often harder to bridge those cultural and linguistic barriers without a provider of your own racial or ethnic background.

It is also true that diversity in medical education and other health professions education settings increases the cultural competence of all providers. We need to be thinking about ways to improve the cultural competence of all of our health care systems, because as I mentioned in my testimony, very soon, in shortly over 30 years, this is about to be a Nation with no majority population. Our health systems need to be prepared to manage that diversity. And so this is one of the many reasons why diversity among health professions is important, and the provisions in the draft bill such as strengthening the title VII and VIII of the Health Professions Act are a very important toward increasing the diversity and distribution of providers.

Mr. Pallone. Thank you.

Mr. Deal.

Mr. Deal. Thank you, Mr. Chairman. This whole panel is supposed to be dealing with prevention and public health, and I appreciate all of you being here. But I have heard a lot of words and I have heard little examples of specifics on this thing. Because it seems to me if we talk about the words "prevention" and "wellness," we are talking about changing of lifestyles.

Now we heard Dr. Kestner talk about his company and the way that they incentivized wellness was through financial type

rewards. We heard Dr. Smedley just a minute ago talk about community-based strategies and the fact that you don't have enough grocery stores in some communities to sell fresh fruits and vegetables, [don't have] safe playgrounds that cause us not to get enough exercise.

In a health bill, a health reform bill, what are the specifics we can do to change people's lifestyles? Because you don't think of that in the normal context of a health care reform measure.

Now specifically, and I am going to use this is a specific example of a question that I think we ought to address, in the Food Stamp Program, for example, we are pouring millions and hundreds of millions of dollars into it, and the recent stimulus package has poured even more money into the Food Stamp Program, but we don't have any guidelines like we have in the WIC Program, as I understand it, to make sure that the taxpayers dollars that are helping fund the purchasing of food doesn't go to buy things that work at counter purposes with what we are [talking about] here of wellness.

Dr. Levi, let me start with you and ask if you would just comment on that.

Mr. Levi. I think your point is very well taken. If we think of this as not a health care financing bill but a health bill, then we need to be addressing all of the elements that comprise helping people be healthier, and a lot of that is about

exercising personal responsibility but then creating the environment where people can, not just through financial incentives, but really we change the norms of our society so people make healthier choices.

To that end, there is actually an experimental program now that is getting underway within the Food Stamp Program, so that people will be will in a sense get higher credit if they buy healthier food. So that is one way of incentivizing people. There are certainly other things that can be done within the Food Stamp Program that would incentivize the purchase of healthier foods.

But we also have to make sure those healthier foods are available, which is not the case in all communities. We need to make sure that people understand and know that the healthier foods are indeed what they should be eating. And so what it really takes is the kinds of community interventions that I think are envisioned in this legislation that, particularly under the concept of health empowerment zones, look at multiple aspects of the community. Is healthy food accessible? Do people know about the healthy foods? What is happening in the schools in terms of educating kids and changing norms? How active are kids able to be? How active are adults able to be? And taking all of those elements and developing comprehensive strategies. We have examples of successes like that. We have them in the Steps Program funded by the CDC, in the Reach Program funded by CDC, in

the Pioneering Healthier Communities that are organized by YMCAs and other national organizations to bring communities together to identify what their communities need to make healthier choices, easier choices for the average person.

That is what is going to change. You know, we are talking about bending the cost curve. If we do that, we can have a dramatic impact on people's health and what they will be demanding of the health care system.

Mr. Deal. I think we all agree we want our children and everybody to be healthier and exercise better choices in their lifestyles.

Dr. Smedley, are we talking about subsidizing grocery stores to come in to certain communities as a way of providing these kind of choices? Is that what you are talking about?

Mr. Smedley. Well, Congressman, there actually are some very interesting initiatives that have leveraged public investment to stimulate private investment. For example, the Commonwealth of Pennsylvania has the Fresh Food Financing Initiative, which has provided that double bottom line of benefits both to private investors as well as to government investing in creating incentives so that we can create a healthier retail food environment.

I think that many of the examples that Dr. Levi just mentioned are important examples of comprehensive strategies, because often we find that there is not just one issue that is a

problem in the community. It is not just a problem of food resources and food options, but there are many multiple and systemic problems. Addressing those comprehensively as the Reach Program does and other programs is the way to go.

Mr. Deal. I think in our educational activities maybe we should teach people how to turn the television set off a little bit.

Mr. Levi. Absolutely.

Mr. Deal. Thank you.

RPTS WALKER

DCMN SECKMAN

[2:25 p.m.]

Mr. Pallone. Chairman Dingell, is he here? I am sorry, our Vice Chair, Mrs. Capps.

Mrs. Capps. Thank you, Mr. Chairman.

I would like to say, as someone who spent my life in the last couple of decades in public health as a school nurse, this is a panel that I really appreciate, the testimony of each of you, and I also look forward to this 5 minutes being just dedicated to proving the worth of prevention, in other words, my frustration with CBO for not being able or not scoring this topic.

And Dr. Levi, I will start with you, but I hope I give a chance for each of you to comment.

Your testimony mentions a report from Trust of America's Health released last year showing the return on investment from proven community level prevention. Can you explain briefly the methodology of this report if you think this could help me or help us all in our case towards scoring savings? We have to learn how to do this as government as well; otherwise, we are not going to be able to counter some of the front costs that are entailed here.

Mr. Levi. I agree, and you know, I think making the case to the Congressional Budget Office is going to be critical at some point. I would preface my explanation of our report in our work by saying, whether or not CBO is convinced should not stop us from

investing in prevention because whether we meet the narrow criteria that CBO is forced, in some respects, by law to address shouldn't mean that we don't see this as a worthwhile investment in improving the Nation's health.

We worked with the New York Academy of Medicine, Prevention Institute and, above all, the Urban Institute economists to develop a model that looked at successful community level prevention efforts, in other words, efforts that took place outside of the doctor's office, to see whether, through education, through changing the environment, changing policies, we could see improved health outcomes.

We focused ultimately on smoking cessation, physical activity, and nutrition, which are the drivers of some of the most expensive health care costs that we see today. And what we found was that there are, indeed, successful examples of those interventions. What we found also is that we probably can implement those at probably less than \$10 per person, and even if we saw only a 5 percent impact of those interventions, which is very much on the conservative side in terms of what the evidence shows, we could see a \$5.60 return for every dollar we invested.

The challenge here is that the winners in this, if you want to call it the winners, the people who save, are better care, the private insurers, and to some degree also, Medicaid. In the CBO scoring system, a discretionary investment that has pay off on the entitlement side can't be scored in anyone's favor, and that is

actually a congressional rule. But just as importantly, I think what we need to think about is that those who benefit are not necessarily contributing, and so we need to think of this as a public investment that will ultimately reduce overall health care.

Mrs. Capps. My question to you now is very pragmatic, and I am going to expand it to all three of you, and time is of the essence. I mean, this is really an obstacle, in my opinion, to the pushback against the huge cost, as it is portrayed, of this health care legislation. Can you give us some advice, what can Congress do to facilitate the process of enabling CBO, or whatever term you want to use, to be able or have that capability of scoring prevention?

And you know, you are not even talking about quality of life for consumers of health. We will take that off the table, because that is probably hard to measure, or longevity, that has been held up by some to be a deterrent because as people live longer, they are going to get more chronic diseases over the course of their lifetime. You know, what should we do on this committee to begin that process? I will start with you briefly.

Mr. Levi. Two very quick comments. One is, Congress can remove this firewall between discretionary investment and entitlement savings.

I think the second is to start a dialogue with the economics community and the Congressional Budget Office, because not everyone agrees with this notion that you just mentioned that if

we reduce these chronic diseases, then people are going to live longer, and they are ultimately going to cost more. There is this whole concept we call compression of morbidity which suggests that if we actually reduce obesity, and there are a number of models from a number of different economists now that tend to show, for example, if you reduce obesity, you are not necessarily prolonging life, but you are improving the quality of life and reducing health care costs because the chronic diseases are additive. They don't necessarily shorten life, and so I think those are two examples. Start that dialogue and remove some barriers.

Mrs. Capps. Thank you. I know I have used my time. I don't know if there is a way for a quick response from the other two if they want to.

Mr. Pallone. Go ahead, sure.

Mr. Smedley. I would just add, I think that Dr. Levi answered that quite well. We also need to consider the next generation is likely to be less healthy than the current adult population.

Mrs. Capps. Why is that?

Mr. Smedley. Because they are more obese. They are at risk for more chronic diseases. So we need to be considering the fact that this is the generation that will support my colleagues and I in our old age. So hopefully we will be forward thinking.

Mrs. Capps. Is that documented that they are less healthy?

Mr. Smedley. Yes.

Mrs. Capps. Any further point from you?

Mr. Smedley. Be happy to provide reference.

Mrs. Capps. Please do.

Dr. Kestner. I would just comment that we have senior experience in showing that preventative care decrease our expenses.

Mrs. Capps. So there is data out there? Any of you want to supply any information, I would appreciate it very much.

Mr. Pallone. Sure. Any follow-up in writing is appreciated. Thank you.

Gentleman from Texas, Mr. Burgess.

Mr. Burgess. Thank you, Mr. Chairman.

Dr. Smedley, I am very interested in some of the things to which you testified and may be beyond the scope of what we are doing and dealing with in these hearings, but I have similar neighborhoods in my district, and there is not a grocery store from one end of the community to the other. Plenty of places to buy alcohol, typically in 40-ounce containers, and plenty of places to buy fast food, and of course, cigarettes are available on every street corner.

This just points to one of the difficulties that we have, and we had worked with a group Social Compact. They are so far away from our last Census in 2000, it is very difficult to get private grocery stores interested in moving back to the area because they say, well, the demographics just won't support a grocery store,

but in fact, the demographics have changed and the purchasing patterns have changed, and again, we are still far away from the Census. Social Compact was able to put out some data that showed perhaps this is worthwhile of a Wal-Mart Supercenter, for example, locating in the area. We are actively trying to push that, but it is just extremely difficult to get those things accomplished. No problem at all getting another liquor store to move in. It is really hard to keep them out in fact.

I just wonder if we shouldn't allow a little more flexibility in some of our Federal food stamp programs. You can't buy alcohol; that is correct. Can't buy cigarettes; that is correct. Can't buy hot food, but there are some hot foods like a rotisserie chicken, for example, that may serve a family's nutritional needs very well. And the fact that that activity is restricted may be putting an undue burden on people who are willing to move into the community.

And I don't purport to have any of the answers. I have worked with some of the people at Robert Wood Johnson in trying to craft language that we might put in a bill, but it is extremely difficult. But I appreciate what you are doing, what you are trying to do because I think that gets to the root of a lot of the problems that I know I see it at home. And you are correct; the next generation is only going to be successively less healthy because some of the learned behaviors that are going on today.

I want to talk about Alegent for just a moment because you

are a success story, and we heard from a previous panel that maybe we should be pursuing evidence-based policy, and your policies at Alegant are clearly something that are worthy of not just our attention and study but perhaps our emulation. And you have showed rather dramatically, I think, you and Wayne Sensor have shown, you can't just make things free; you have got to make them important, and the way we make things important is attach money to them.

So I hope that this committee will look seriously at what you have done with your health reimbursement accounts and your health savings accounts and your ability to bring people in not just to effect things on a small scale but to effect things on a large scale. And the impressive thing is you did it with your 9,000 workforce first before you went forward and began to sell it to the rest of the community.

So, again, I hope we will look seriously at what you have done and what you have been able to accomplish. My understanding -- and tell me if I am correct, Dr. Kestner -- on the consumer based health plan, if you look at high-option at PPO plans, they are going at about a 7.5 percent year rate of growth as far as costs; Medicare and Medicaid, 7.3, 7.8 percent, depending upon who you want to read; but consumer directed health plans are growing at about 2, 2.25 percent a year. Has that been your experience as well?

Dr. Kestner. Our cumulative 2-year experience is 1.5.

Mr. Burgess. 1.5?

Dr. Kestner. Excuse me, I am sorry, 5.1. And I think we recognize that the impact going forward will be on preventative measures. We still have patients that have problems with obesity, with smoking, and those are things that we are going to have to -- that are going to be expensive for us in the long run. So, on the short term, we have already seen a benefit in implementing a strategy, and on the long term, we anticipate seeing an increasing decrease in our health care expenses.

Mr. Burgess. Now, I don't know if you have had a chance to read the draft that is before us today for discussion, but as far as you are aware does the draft that has been proposed by the majority, does it increase or decrease your ability to do what you want to do particularly with health savings accounts?

Dr. Kestner. Right. I think any strategy needs to engage the patient in the dialogue, empower them in economic decisions regarding access, but allowing open access. And I think the most important thing from my perspective is the ability to engage the dialogue when they are well. All too often we access health care at a point of sickness, and really preventative care is engaging people and starting the dialogue when they are well. So any strategies that focuses on prevention and begins that dialogue early I think are benefits to the population at large.

Mr. Burgess. Just one more brief question. Do you allow for partnering with your physicians and your facility at all? Are

there like inventory service centers where there is physician ownership involved in any of Alegent's facilities?

Dr. Kestner. Yes. We have joint ventures in ambulatory service centers.

Mr. Burgess. Are you aware that the draft under discussion today would prohibit such activities in the future?

Dr. Kestner. I am superficially aware of discussions that are going on.

Mr. Burgess. Do you believe in the pride of ownership? I mean, when a physician has an ownership position in an entity, my feeling is it makes it run better.

Dr. Kestner. I believe with the dialogue that we have had in our health system our physicians feel pride of ownership, whether they have an investment interest or not. I think that has been part of our culture of giving physicians decision making and the ability to drive health care through evidence-based care and empowering them to make decisions for our health care delivery model. So, whether they have an investment interest or not, I think we have tried to make sure they have a pride of ownership in our system.

Mr. Burgess. Do you think this bill before us today fosters that empowerment?

Dr. Kestner. The one that is up for discussion at this point in time?

Mr. Burgess. Yes.

Dr. Kestner. Yes.

Mr. Burgess. Thank you.

Mr. Pallone. Thank you. Gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. Christensen. Thank you, Mr. Chairman, and thank you for being here to all of the panelists.

Dr. Levi, we have really appreciated the work from the Trust for America's Health, and we appreciate also your support of the health empowerment zones.

One of the basic services that is not covered for adults is dental care. How important do you think that it is that it be included in terms of prevention or its impact on chronic diseases and other health care problems?

Mr. Levi. We believe access to dental care is a vital component to keeping people healthy and keeping people functioning and economically productive. There is growing evidence, especially on preventive care, of links of good dental health with even heart disease. And so there is, indeed, a correlation with some chronic diseases, but just as importantly, I think, you know, good oral health keeps people healthier, keeps people functioning, keeps people out of pain and, therefore, probably more employable. So it is both a health benefit and an economic benefit.

Mrs. Christensen. Thank you.

Dr. Smedley, welcome back.

Mr. Smedley. Thank you.

Mrs. Christensen. The Iowa Medical Treatment Report on equal treatment of which you are the lead author and editor was a landmark document, and the recommendations from that report have been held up as the standard for eliminating health disparities. You mentioned a few areas, but if there are any others, to what extent does this draft legislation meet and address those recommendations? And where are we falling short?

Mr. Smedley. Sure, yes, thank you.

There are a number of provisions within this draft bill that address some of the provisions or the recommendations of the Iowa Medical Treatment Report. As I mentioned in my oral testimony, there are some areas where we can go further in terms of adopting the Federal Cultural and Linguistic Appropriate Services Standards, ensuring that we strengthen our Federal health research.

Data collection is also one of those areas where I think it is clear that we are going to have to have a much more robust systematized system of collecting data on race, ethnicity, primary language and probably other demographic variables in order to understand when and under what circumstances we see inequality in both access to and the quality of care as well as outcomes.

I will even go a step further and suggest that we ought to publicly report these data because that will give us a level of accountability both for consumers, for providers and health systems, as well as government. One of the responsibilities of

government, of course, is to ensure that there is not unlawful discrimination in the provision of care, and until we publicly report and more carefully collect this data, we will not know when that occurs.

Mrs. Christensen. Thank you.

Dr. Kestner, I really applaud the fact that in the absence of the longitudinal data showing what that investment might pay back from providing that free preventative care, you did provide it for all employees. And you have talked about some of the shelter and benefits that you have already seen.

But in looking at the public plan that we are proposing, and the possibility that it would allow for innovation, you are a not-for-profit. Is there something in your experience that can inform and maybe support what we are trying to do in a public plan and its ability to do the kind of innovation that we see that you are doing at Alegent?

Dr. Kestner. I would hate to see any plan be nothing more than a reproduction of what we already have, which is people seeking care when they hurt; people being given a pill and not understanding the cost of that pill; and then not returning unless they have been noncompliant or haven't gotten better.

And so I think that any plan that engages the consumer in the dialogue about not only the consequences of their health care decisions but the cost of their health care decisions is going to be important.

Mrs. Christensen. Thank you.

And Dr. Smedley, in my last couple of minutes, we talked about diversity in the health care workforce. You weren't just talking about doctors and nurses, were you?

Mr. Smedley. Yes. We need diversity in all of our health professions. Allied health professions, mental health fields, dentistry.

Mrs. Christensen. What about some of those commissions and councils and task forces?

Mr. Smedley. The CBC task forces -- yeah, absolutely, we need diversity on all of the policy-making bodies that are outlined either in this draft legislation, as well as existing bodies because, again, with the changing demographic of this Nation, with the importance of addressing demographic and equity issues, we need to put these issues front and center in all of our conversations around health policy. So I would strongly encourage diversity in all of its forms to be represented on these task forces and panels.

Mrs. Christensen. Thank you.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Gentleman from Georgia, Mr. Gingrey.

Mr. Gingrey. Thank you, Mr. Chairman.

Dr. Smedley, in your testimony you talked about racial and ethnic minorities and disparity in care. You state, a potentially

significant source of racial and ethnic health care disparities among insured populations lies in the fact that minorities are likely to be disproportionately enrolled, and I think we will quote, lower tier health insurance plans. There are large access problems in the Medicaid program where many beneficiaries are unable to find a doctor that accepts Medicaid because of inadequate reimbursement and high administrative burdens. Do you believe the government-run Medicaid program and how it is administered exacerbates health disparities?

Mr. Smedley. Well, Congressman, I think that, in the case of Medicaid, you are absolutely right, that low reimbursement rates simply make it prohibitive for providers to accept, in some cases, Medicaid patients.

But this draft bill would increase reimbursement rates in ways that I think will hopefully encourage take up of Medicaid patients. Unfortunately, we have associated stigma with Medicaid, despite the fact that it is a very comprehensive benefit plan. As Ms. Wright Edelman pointed out earlier, it offers a number of very, very important benefits particularly for children who are at risk for poor health outcomes.

So I think we can build on the Medicaid program, improve it, and ensure that patients who have Medicaid coverage are actually able to get the care that they need.

Mr. Gingrey. Thank you for that response, and of course, you mentioned that there would be improved reimbursement. That is

true for primary care physicians and medical home managers, but certainly, the reimbursement is likely to be less for specialists, general surgeons, OB/GYN doctors, et cetera. So you think if Medicaid beneficiaries had an opportunity, and we have suggested that from this side, our ranking member has suggested a number of times, if Medicaid beneficiaries had the opportunity to opt into a private policy with government assistance, so-called premium support, do you believe they would find it easier to find a doctor that would take them?

Mr. Smedley. Congressman, I am not aware of any data that you would inform an answer. I know that some of the proposals that were offered in terms of tax credits and so forth were insufficient to cover the cost of private health insurance. I believe the cost estimates now for a family is about \$12,000. So, clearly, we would need a sizeable tax credit for a low-income family to afford a private plan like that.

Unfortunately, I have no data.

Mr. Gingrey. Well, reclaiming my time, certainly, it would remove the stigma, and when you are talking about let's say the CHIP program, rather than having the child or children running all across town trying to find a doctor that would accept CHIP, it would be wonderful if they could, with premium support, be enrolled in a family policy so everybody could kind of go to the same medical clinic.

Let me switch over to Dr. Kestner for just a second because

you were talking about HSAs. I think, Dr. Kestner, in your testimony, you credited HSAs and HRA's as keys to disease management lifestyle changes.

Earlier, I don't know if you heard on the first panel, Dr. Parente of the Medical Leadership Institute, he suggested that rather than what is recommended in this 800-page draft document from the tri-committees that would require everybody to have first dollar health insurance and also for employers to provide it; his suggestion was, if there is going to be a requirement on the part of the so-called patient, maybe it should be a requirement for catastrophic coverage and not first dollar. The catastrophic coverage, of course, would prevent all these bankruptcies, these three out of five bankruptcies that people talk about that are brought about by basically serious medical illnesses that folks can't pay for. What do you think about that suggestion?

Dr. Kestner. Well, our strategy has been to be transparent with costs so that consumers can make educated decisions. So, if I have a condition that requires immediate care, I have an option of going to an urgent care center, see my primary care doctor or an emergency department, and each of those costs something different.

Part of my decision-making will be, what is coming out of my pocket as far as the first dollars, and certainly, it is a more cost-effective strategy to go to a primary care physician, if I know I am paying \$10 for that visit, as compared to an emergency

department, where I potentially would be paying far more.

And so I think it is important for us to have a strategy that engages the consumer in the day-to-day decision-making that they have with regards to that.

Mr. Gingrey. Let me reclaim my time in the 1 second that I have got left, Mr. Chairman, if you will bear with me.

You know, it is estimated that of the 47 million or 50 million people that don't have health insurance in this country, that maybe 18 million of them are folks that make at least \$50,000 a year, and I would suggest to you that a lot of them are going bare, opting out of getting health insurance because they feel like they don't really need it. They are 10 feet tall and bulletproof, and they are kind of wasting their money. And they know, at the end of the day, if they pay over a period of 15 or 20 years with an employer-based system, and then all of the sudden they get sick and they lose their job, that the insurance company is going to either say, you are not insurable, we are not going to cover you, or if we do, we are going to charge you 300 percent of standard rates.

Maybe, you know, there is a place here for insurance reform in regard to people like that who have done the right thing and have credible service, and therefore, they shouldn't have to pay these exorbitant rates or even get in a high-risk pool because they have done the right thing.

Mr. Chairman, I know I have exhausted my time. There is

probably not time for a response unless you want to allow --

Mr. Pallone. If you would like to respond, go ahead.

Dr. Kestner. No, thank you.

Mr. Levi. Mr. Chairman, if I can make one very short point.

The question was about first dollar coverage, but as I understand Alegant's program, there is first dollar coverage for preventive services, and since this is a panel about prevention and public health, I think it is really important to keep in mind that the things that are going to save people's lives and ultimately save health care costs are the things that really need to have first dollar coverage without copayments because that is what is going to incentivize better.

Mr. Gingrey. Certainly with the preventive care I would agree with that.

Mr. Pallone. Thank you.

Gentlewoman from Illinois, Ms. Schakowsky.

Ms. Schakowsky. Thank you, Mr. Chairman.

I wanted to ask Mr. Kestner a question. Your Web site says, "we are proud to offer a generous financial assistance program." But then it goes on to say, "medical bills are limited to 20 percent of a total household family income."

So a family of four making \$55,000 a year, with a \$200,000 medical bill, my staff -- they are always right -- calculated that the family would have to pay \$11,000. So as we are sitting here talking about affordability, do you think a family of four making

\$55,000 should be paying \$11,000 in medical bills?

Dr. Kestner. I believe we do have a very generous commitment to our community with regards to indigent care. We have contributed \$60 million --

Ms. Schakowsky. But indigent -- \$55,000 is probably not indigent. So the statement that you have -- I guess really what I am getting at, even with your program, which may be more generous than most, we are still talking about really significant out-of-pocket costs that could be overly burdensome for a family, right?

Dr. Kestner. That could be, yes.

Ms. Schakowsky. Here is one of the things I want to get at. This issue of the necessity of patients to really understand the cost of health care presumes that medical decisions are mostly patient-driven, and I just -- I unfortunately didn't hear your testimony. I was with a doctor. I just fractured my foot, and you know, I didn't go in there and say, give me some X-rays and I think I need a boot, which I now have, and you know, I mean these are things that the doctors tell us.

And when we looked at that article about McAllen, Texas, versus El Paso, probably everybody's read it in the New Yorker, about the amount of difference in Medicaid payments per patient, wouldn't you all agree that this is by and large overwhelmingly provider-driven as opposed to consumer-driven?

Dr. Kestner. I will just comment on our experience. Since

engaging our physician workforce in the discussion of evidence-based care and standardizing our processes and having a transparent, quality Web site, we have been able to demonstrate a decrease in our cost of care. I think that is where the discussion begins is when we have to engage people in the discussion about what the evidence shows, what is necessary, and have that healthy dialogue that we all loved in medical school, as compared to being driven by the decisions that are made today which may be fear of malpractice --

Ms. Schakowsky. May be self-referral and profit.

Dr. Kestner. I think by and large most physicians want to do the right thing, but I think we have put them in a system where doing the right thing may not be evidence-based and, at times, may not be the best for the patient.

Ms. Schakowsky. So, Dr. Smedley, would you agree that mostly patients don't decide about their health care?

Mr. Smedley. I think that is absolutely right. Patient decisions are often shaped by the options presented by doctors. In the cases of patients of color, which is my concern, there is some evidence that patients of color are not provided with the same range of options as the majority group patients. So if that is the case, then I think we need to be very concerned that these are not truly consumer-informed decisions.

Ms. Schakowsky. Also, one of the things that this article, if you handle it right, the way I read it, at McAllen, Texas, is

that the doctors actually were not directing people to preventive care, that a decision had been made in certain places and I guess other places around the country, too, not to engage in preventive care. And again, I am assuming your testimony was even cost-wise, aside from health-wise, this is a bad decision.

Mr. Smedley. That is correct.

Ms. Schakowsky. Okay. Thank you.

Mr. Pallone. Thank you.

Mr. Green.

Mr. Green. Thank you, Mr. Chairman. And I would like to thank our panel for being here, the last panel.

We know that diabetes and obesity sometimes are economic-related, but we know in the minority community, whether it is African American, Hispanic, Asian American, it is almost an epidemic. And one of the best ways you deal with that is through prevention. Don't wait for that diabetic to know they are diabetic. Maybe it is pre-diabetes, and they have a diabetic episode before they go into an emergency room. That is what is so important about the prevention.

On our committee, I get frustrated because literally 2 years ago with our current OMB director, we were on a health care panel for U.S. News and World Report, like most Members of Congress get frustrated because we try and get a score on prevention, and he told me in front of all the other folks, this is not your -- he was former CBO, Congressional Budget Office, director -- he said,

this is not your father's CBO. Send us those, and we will score them better.

We are not seeing any changes. Granted he is at OMB now, and I don't know if OMB has changed, but I would sure like it.

And that is our frustration, and Dr. Levi, you talked about it.

There are so many things we need to do for health care in our country that needs to push the envelop further back instead of waiting till someone finds out that they have these chronic illnesses.

Dr. Levi, as you know, school-aged children is the population group that is most responsible for transmission of contagious respiratory viruses like influenza. Just recently, I introduced a bill, H.R. 2596, the No Child Left Unimmunized Act, which would authorize HHS to conduct a school-based influenza vaccination program project to test the feasibility of using our Nation's schools as vaccination centers. And what are your thoughts on making it school-based vaccinations, especially for some of the influenza virus vaccines? We already use, in our district, and I know a lot of school districts use their schools for vaccinations for the mandatory vaccination programs throughout the school. But what do you think about making them for other vaccines, including influenza?

Mr. Levi. I think it is a very good idea, and I think we need to be as creative as possible to make sure that as many

people as possible are immunized. I think, in reality, that as we are facing this pandemic of H1N1 influenza and seeing that young people may be among the most vulnerable, they may be highly prioritized for a pandemic vaccine come the fall, and using our schools may be one of the most effective ways of doing that, and that could be a wonderful proof of concept for your legislation.

Mr. Green. Any other from anyone else on the panel?

If not, thank you, Mr. Chairman.

Ms. Schakowsky. Will the gentleman yield?

Mr. Green. I would be glad to yield to my colleague from Chicago.

Ms. Schakowsky. This business of how we score is a really troublesome thing. I am just wondering, is there the kind of research conducted, not just on health outcomes where we concede prevention pays and it really works, but how it actually saves dollars? You know, I really think when we are talking about 10 years, you know, we are looking out into the future when we talk even about the costs, then we ought to have something. Is there some research that can help us quantify that?

Mr. Levi. Well, ironically, the wider the net you cast, the more research there is, certainly in terms of productivity, in terms of contributing to a tax base, in terms of not requiring disability payments, all those kinds of things. You know, you can't mix and match those things in the scoring process, and I think I want to come back to --

Ms. Schakowsky. Did you say we cannot mix and match? Why not? I think we need some advocacy help here from those who believe that prevention is the key to help us do that.

Mr. Levi. But some of these rules have been set and can be changed by Congress, and that is what -- that may indeed be what it takes.

I think it is also important to think about sort of the evidence standard, and you know, we look for, you know, there are different levels of evidence that you may need to make it move forward with a decision. But I think when you have so many businesses voting with their feet around prevention programs, whether it is clinical preventive services or even nonclinical preventive services --

Ms. Schakowsky. By that you meaning buying them?

Mr. Levi. By buying it, investing in it, and saying they have the evidence for their stockholders that this saves them money. It seems odd that the private sector can be ahead of the public sector in recognizing the value.

Ms. Schakowsky. That is a really good point. Maybe we ought to enlist some of those findings. I know my nephew does preventing back injury at a lot of factories, and it works. Anyway, thanks.

Mr. Green. Mr. Chairman, I know I am out of time, but I would hope we would push back just what this panel is about and look at prevention and as best we can to fund that and use our own

examples maybe over the next 10 years and show we can reduce obesity, we can reduce diabetes, and some of things that we are going to pay a lot of money for if we don't in some of type of national plan.

Mr. Levi. And that is certainly part of the goal through the Recovery Act in terms of the community-based prevention programs that are being funded there, and that I know that HHS is working very hard to make sure that the evaluation system that is developed for that investment will be able to help us answer these questions.

Mr. Pallone. Thank you.

Gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. Blackburn. Thank you, Mr. Chairman.

You all must feel like you are batting cleanup. You have been here all day I bet listening to all of these, and I appreciate the focus that you have on prevention and wellness programs. I think many times we look at medical care, but we don't look at health care and don't look at health, and it is frustrating for us.

And so many times I have said I thought one of the greatest disservices that we have done to children is they no longer have physical education, and they don't take life -- when they are all through school, they don't have physical education classes that they are attending, and then secondly when they get into high school, they don't have life skills classes, so they don't

understand the impact of what they eat, of the different food groups or the food pyramid and how that affects their lives, the importance of the interface between exercise and also what they eat and how that weighs in on some of the health issues, as we have read in testimony that has been given to us today and heard from some of our witnesses.

Obesity, diabetes, chronic heart disease, if you address those, you would move a long way toward addressing some of our Nation's health care woes. And many times people say, well, change how you are looking at this; look at it as health, as opposed to looking at it with medical care delivery. And of course, having been -- as someone who served in a State legislative body and looking at these issues and bringing that to bear here at the Federal level, sometimes, you know, you do stop and think a little bit about that.

What I would like to hear from each of you in the 3 minutes that I have, I want each of you to tell me if this 852-page bill, if you think, at the end of the day, it is going to provide a structure for Americans to be healthier and thereby need to consume less medical care, because the quality of life and the way this affects individuals should be a focus of the policy that we decide what is going to happen as we look at health reform. We all know that the system needs some reforms. I am one of those that favors handling it through the private sector so that it stays patient-centered and consumer-driven.

But I would like to hear from each of you, at the end of the day, the draft before you, would it allow for greater emphasis on wellness, for prevention, for healthier lifestyles, and individuals to consume less medical care?

Dr. Levi, we will start with you.

Mr. Levi. Absolutely, on both the clinical side and the community side, and I will make three very quick points.

First, solid coverage there are no copayments of the evidence-based clinical prevention services I think is critical. Whether it is a public program, a private insurance plan, it has to be there.

Second, the investment in community prevention will get at the very things that you are talking about. Some of the best community-based prevention programs are the ones that target kids, get them to change their lifestyles, and through the kids, they educate their parents, because some of us are just over the hill and uneducable unless we are reached through kids. And we can make those permanent lifestyle changes, and that is why the investment in community preventive programs is going to be so important.

And third, and I think just as importantly is this investment in the core public health capacity because if we strengthen our State and local health departments then they will be able to provide the services that surround the normal health care delivery system.

Mrs. Blackburn. I need to move on. I am running out of time.

Dr. Smedley.

Mr. Smedley. As you know, we spend less than 5 cents out of every health care dollar on prevention. This draft bill takes a step toward righting that equation.

It is also true that we have not paid enough attention to the issues of achieving equity, ensuring that everybody has access to primary care. These are all important elements that are reflected in this draft bill which I think are going to save costs.

Mrs. Blackburn. But should it be mandated or be personal choice?

Mr. Smedley. I don't believe this bill creates that kind of mandate. But what it does, through the investment in prevention, is it creates healthier communities.

Mrs. Blackburn. Okay.

Dr. Kestner.

Dr. Kestner. I think the bill addresses the access issue as well as the investment in primary care and public health, and I think that is where the first relationship should be established with our citizenry is in a public health sector and primary care, as compared to outside of care that we experience today.

Mrs. Blackburn. Thank you very much.

I yield back.

Mr. Pallone. Thank you.

Gentlewoman from Wisconsin, Ms. Baldwin.

Ms. Baldwin. Thank you, Mr. Chairman.

I appreciate the fact that you have had this panel today devoted to public health and prevention and health care disparities.

I am introducing a bill today that is very relevant to this topic. What the bill does is it takes the first steps in identifying and addressing health care disparities faced by lesbian, gay, bisexual and transgender Americans. The bill is based in large part on the extraordinary work of the tri-caucuses on racial and ethnic health care disparities; the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Asian, Pacific Islander Caucus have done extraordinary work teaming together to put together a bill that is called the Health Equity and Accountability Act which I believe will also be introduced this week.

We know that there are disparities in health care faced by the LGBT community, but we know this largely based on anecdotal information or some data derived from locally administered or privately administered health surveys. And I can tell you that it was, in some cases, quite challenging putting together this legislation because of the lack of data and the lack of evidence.

And so I want to just ask some very basic questions, starting with you, Dr. Smedley. Having studied racial and ethnic health care disparities, how important is data collection to

understanding and addressing health care disparities?

Mr. Smedley. It is absolutely vital.

In the case of LGBT populations, as you pointed out, lacking data, it is difficult to understand when and under what circumstances these populations face both health status and health care inequities. So it is very important to have that data. Once we have that data, we not only raise public awareness, but we can focus and target our intervention so we are addressing the problem successfully.

Ms. Baldwin. The National Health Institute survey, which I understand to be the Federal Government's most comprehensive and influential survey, does not include any questions on sexual orientation or gender identity. Do you think it should?

Mr. Smedley. Yes.

Ms. Baldwin. And to my knowledge, actually, no Federal health survey at all includes any questions on sexual orientation or gender identity. Do you think this would be important as a routine inclusion in health surveys where we are trying to collect information?

Mr. Smedley. Yes. I believe that, I may be mistaken about this, but I believe that BRFSS, the Behavioral Risk Factor Study, may allow that as an option, but we should certainly ensure that we are understanding all of our populations where we see inequalities in health and health status.

Ms. Baldwin. I would ask you also, Dr. Smedley, how

important and relevant are goal setting and aspirational documents like Healthy People 2010? I know there is an effort under way to revise and update for Healthy People 2020 document. How important are these goal-setting documents to reducing health care disparities?

Mr. Smedley. Again, vitally important. Some have criticized Healthy People 2010 for having goals that are difficult to attain, but unless we articulate what our vision is of a healthy society, it is going to be very difficult to put in place the policies and indeed to create the political to achieve those goals. I believe it is very important that we have strong aspirations for equity for millions of populations that face inequity.

Mr. Levi. If I could just add one point here, I think one of the criticisms in the past of the Healthy People process has been we set goals, and we don't have the data sets to tell us whether we are even achieving those goals, and part of what is in this discussion draft is creating an assistant secretary for health information, which would increase I think the transparency of the data and create a process by which we would do a better job of answering some of the questions that you want to have answered.

Ms. Baldwin. I would note, from the Healthy People 2010 document, this is sort of a vicious cycle because it is silent to LGBT health issues because the authors of that document said, we don't have any data to point to any disparities, so we can't talk about how we need to address those disparities.

Dr. Levi, I know your organization has done terrific work on demonstrating that community-based prevention programs can have a significant return on investment, and it is also my understanding that different communities targeted often respond differently to different interventions.

So tell me a little bit about targeting those interventions, and how much do these programs need to be targeted or tailored to do different cultural subgroups?

Mr. Levi. I guess I would answer it in two ways. One is we have a lot of evidence that from some national programs like the REACH program, Access program, or the Pioneering Healthier Communities Program, where there is an overall goal of trying to reduce the prevalence of certain conditions and a recognition on a community basis what is happening in that community. Some communities need more exercise promotion. Some people need more nutrition promotion. Some people have higher rates of smoking. Those kinds of particular issues need to be addressed in the context of the community.

And then there is a second part, which is what sub communities. That is thinking more geographically. And then when you are thinking about racial and ethnic communities or the LBGT communities, what particular issues do you also need to think about?

And I think the LBGT community is a perfect example. If we had thought about community prevention at the very beginning of

the HIV epidemic, we would have been addressing what Ron Stall from, formally at CDC, talks about syndemics, which is, the risk for the disease you are wanting to prevent, in this case HIV, is related to other factors, such as experience of domestic violence, mental health issues, alcohol issues. It can be smoking, depending on what aspect you are looking at. That all needs to be addressed together.

And when you are thinking about community prevention, that is what you want to do; you want to bring all of these pieces together. But coming back to the beginning, you can't do it without data.

Ms. Baldwin. Thank you.

Mr. Pallone. Thank you.

Gentlewoman from Florida, Ms. Castor.

Ms. Castor. Thank you, Mr. Chairman. Thank you all for your testimony.

I am fortunate that back in my hometown I have a great College of Public Health, and the dean there is Dr. Donna Peterson. I have been keeping her informed all the way along during the health care reform discussion dialogue from the outline now and into the discussion draft.

And her initial comments were, boy, you all are on the right track when it comes to community health centers, and there is certainly a consensus in the Congress, many of them rooted on issues of Chairman Waxman, Chairman Pallone, Mr. Clyburn, the

Whip. We are on track with workforce issues. Everyone, there is great consensus around improving the primary care of the workforce, and the SGR, how we are going to compensate those folks.

She expressed some concern on whether or not we are really doing enough for community's public health initiative. We see the initial draft here, the discussion draft, and I thought that Ranking Member Deal raised a good point, too, about personal responsibility and how we get parents to turn off the TV and encourage their kids to exercise. And it can't just be that we hope that people see President Obama and the First Lady work out in the morning, and that is going to be a great inspiration. We need a Surgeon General, I think, that is going to be very proactive. And we don't have that yet. We need the CDC to take an even more proactive role.

We know back home, our local governments and school districts and States, many are in severe budget crises, and oftentimes, the first things to go are the sidewalks, the other -- the parks initiatives, summer programming for kids.

Tell me, what is out there right now, what do local communities depend on right now from the Federal Government on those community public health and investing in infrastructure initiatives? What grants are there now? And then we can talk about what is in the discussion draft and where we need to go.

Mr. Levi. There certainly are Federal programs that will

support this kind of community prevention, but we are talking a fraction of the level of investment that is in the discussion.

Ms. Castor. And it is out of which -- is it out of HHS?

Mr. Levi. Mostly out of HHS and mostly out of CDC, but the budgets for those programs have either been relatively flat or declining over the last 5 years. Our entire effort around chronic disease prevention has been declining over the last 5 or 6 years. Obesity is a perfect example where we recognize that this is a huge public problem, and we haven't even found the resources to fund every State to have an obesity program, and particularly now, in a time of economic crisis, it is not like State and local governments have the resources to backfill. And in an economic recession, it becomes even more important for us to be thinking about those issues because it is harder to eat healthier --

Ms. Castor. I have a limited time. Is there another Federal pot of money or initiative you identified besides this CDC?

Mr. Levi. The other pot of money, the big pot of money is the \$650 million in community prevention that is in the Recovery Act and that will be released shortly.

Mr. Smedley. If I could add, not only are those funds from the prevention and wellness also good, I think the entire stimulus package can be looked at as a public health intervention because of the many provisions around housing, transportation, early education. We know that early start, healthy start programs work. They save money, as Dr. Levi indicated.

So if we can think about the stimulus dollars as a public health intervention and ensure that those dollars are going to communities to create safe public transportation to stimulate healthy lifestyles, then this can meet multiple purposes.

Ms. Castor. And in your health reform bill, we need to build upon those historic investments that come out of the Recover Act. I mean, Donna Christensen has a great empowerment zone initiative, but it seems like our local communities need a new healthy communities block grant initiative that is consistent over time that maybe doesn't compete with the other -- if there is anyone from the Association of Counties Or League of Cities that you all work with, I would like to investigate that.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you, and I think we are done for today.

I want to thank all of you, and again, as I mentioned, you will probably get some written questions that we would like you to get back to us as soon as you can, but again, this is a very important part of what we are doing, the prevention and the public health provisions. So thank you as we proceed.

And let me remind Members we are going to recess because we will be reconvening tomorrow as well as Thursday. Tomorrow, at 9:30, the full committee will meet to hear from Secretary Sebelius, but after that is done, we will reconvene as a subcommittee and have a number of panels to continue with the subcommittees activities.

So, without objection, this subcommittee will recess and reconvene tomorrow following the conclusion of the full committee hearing that begins at 9:30 a.m.

[Whereupon, at 3:25 p.m., the subcommittee was adjourned.]