RPTS SMITH

DCMN NORMAN

This is a preliminary transcript of a Committee Hearing. It has not yet been subject to a review process to ensure that the statements within are appropriately attributed to the witness or member of Congress who made them, to determine whether there are any inconsistencies between the statements within and what was actually said at the proceeding, or to make any other corrections to ensure the accuracy of the record.

DRAFT REFORM LEGISLATION

WEDNESDAY, JUNE 24, 2009

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

He subcommittee met, pursuant to call, at 1:15 p.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Gordon, Eshoo, Engel, Schakowsky, Weiner, Matheson, Gonzalez, Castor, Sarbanes, Green, Space, Sutton, Waxman [ex officio], Whitfield, Shadegg, Buyer, Pitts, Myrick, Blackburn, and Gingrey.

Also present: Representative Hill.

Staff Present: Karen Nelson, Deputy Committee Staff Director for Health; Andy Schneider, Chief Health Counsel; Purvee Kampf,

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, Minority Communications Director/Senior Policy Advisor; Caren Auchman, Minority Communications Associate; Lindsay Vidal, Minority Special Assistant; Early Green, Minority Chief Clerk; Jen Berenholz, Minority Deputy Clerk; and Miriam Edelman, Minority Special Assistant.

The Chairman. And I want to call on Mr. Pallone to convene the subcommittee so that we can get a further record from witnesses on the health care issue.

Mr. Pallone. The hearing of the Health Subcommittee is reconvened. And we are now going to our next panel which is the Panel on Single-Payer Health Care. And I would like to start by introducing each of the witnesses.

Beginning on my left is Dr. Sidney M. Wolfe, who is Director of Health Research Group at Public Citizen. And then we have Dr. Steffie Woolhandler, who is Associate Professor of Medicine at Harvard Medical School and Co-Founder of Physicians for a National Health Program. And, finally, Dr. John C. Goodman, who is President and CEO of the National Center for Policy Analysis.

STATEMENTS OF SIDNEY M. WOLFE, M.D., DIRECTOR, HEALTH RESEARCH GROUP AT PUBLIC CITIZEN; STEFFIE WOOLHANDLER, M.D., ASSOCIATE PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, CO-FOUNDER, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM; AND JOHN C. GOODMAN, PH.D., PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS.

Mr. Pallone. And I think you know how we proceed, but I will mention that we ask you to give us a 5-minute, approximately 5-minute opening statements. So your full testimony is submitted

for the record, and when you are done we will have questions from the subcommittee.

And I will mention again that, because of the importance of this issue, we are having full committee members participate. They will be after the subcommittee members, but they will participate with their questions as well. And we will start with Dr. Wolfe.

Mr. Buyer. Mr. Chairman, may I ask unanimous consent to speak out of order for 1 minute?

Mr. Pallone. Sure.

Mr. Buyer. I want to thank you. What I want to do is I want to extend my apology to the Secretary. In the last hearing during my questions to the Secretary, I had stated that the State of Kansas Medicaid program had received a D rating when she was the Governor of the State. According to the health reform dot org Web site run by the Department of Health and Human Services, she was given -- a D rating had been given to the U.S. health care system. And I meant to ask the Secretary whether the Kansas Medicaid program merited a D rating.

I misspoke and created the impression that while she was Governor that she specifically -- her program had been rated a D. That is wrong. And with that I extend my deepest and sincerest apologies to her for creating such an impression. And for that I apologize personally to the Secretary.

Mr. Pallone. Well, thank you. I thank the gentleman.

Dr. Wolfe.

STATEMENT OF SIDNEY M. WOLFE, M.D.

Dr. Wolfe. Thank you. What if you picked up the morning paper tomorrow and saw the following headline: 50 People Died Yesterday Because They Lacked Health Insurance? The next day the same headline, and the next as well.

This is the average number of people in the United States who, according to a 2004 report from the National Academy of Sciences, die each day; more than 18,000 a year, because they lack health insurance.

How should we respond to this unacceptable and embarrassing finding? Not by saying, as President Obama has said, that if we were starting now from scratch we would have a single payer, but it is too disruptive. Or as the health insurance industry said last week, having the public option that is just an option would be too "devastating". What could be more disruptive and devastating than being one of 45 million people who are uninsured, from whose ranks come 18,000 people who die each year because of that dangerous status?

The real question is why should we tolerate the fragmented, highly profitable, administratively wasteful private health insurance industry any longer?

In this regard, the public is way ahead of either President

Obama or most people in the Congress in its distrust of the health insurance industry.

In a recent national Harris poll last fall, the following question was asked: Which of these industries do you think are generally honest and trustworthy so that you normally believe a statement by a company in that industry? Only 1 in 14 people, or 17 percent, thought that the health insurance industry was honest and trustworthy. The only industries that were worse than the health insurance industry were HMOs, 7 percent; oil, 4 percent; and tobacco, 3 percent.

The Congress, on the other hand, trusts the health insurance industry and feels compelled to come up with a solution that avoids a big fight with them, not only writing them into the legislation, but assuring further growth of that industry. The Congress wants to believe that the health insurance and pharmaceutical industries will be good citizens and voluntarily lower their prices to save some of the money that is necessary to fund health insurance.

Several weeks ago, the collective forces of the health industry promised that they could voluntarily save $2 trillion over the next 10 years. But the amount that can be saved over the next 10 years by just eliminating the health insurance industry and the $400 billion of excessive administrative costs it causes every year is $4 trillion, in one fell swoop. This would be enough to finance health care for all, without the additional

revenues the Congress and the administration are desperately seeking.

As an example of administrative waste, over the last 30 years or so, there may have been two to three times more doctors and nurses, pretty much in proportion to the growth of the population. But over the same interval of time, there are 30 -- 30 -- times more health administrators. These people are not doctors. They are not nurses. They are not pharmacists. They are not providing care. Many of them are being paid to deny care. So they are fighting with the doctors, with the hospitals, to see how few bills can be paid. That is how the health insurance industry thrives, by denying care, paying out as little as it can.

There is no question that we have a fragmented health insurance industry and it thrives on being fragmented, avoiding any kind of serious centralized examination or control which could affect -- improve quality, costs and everything.

The drug companies make much more money with this insurance fragmentation because there is no price control. The insurance companies make much more money because they can push away people who aren't going to be profitable, let public programs take care of those patients who are "unprofitable".

What the President and the Congress are really realistically advocating, since there is absolutely no possibility of having enough money to cover all people in this country as long as the private for-profit health insurance industry is allowed to exist,

is more incremental reform, not national health insurance.

It is now 44 years since Medicare and Medicaid. In the interim there have been many experiments in this country and abroad to try and provide universal health coverage. Other countries have uniformly rejected the private for-profit insurance industry and have adopted national health insurance.

There are little experiments going on in Germany and Australia, but mainly it is national health insurance. Is everyone else wrong and only the United States is right?

A recent study by OECD, which is the Europe-based Organization for Economic Cooperation and Development, provided health insurance data from its 30 member countries, including Europe, the United States and others. The latest data showed that 27 of the 30 countries had health insurance coverage for more than 96 percent of the population, with only Germany having any non-public coverage, 10.3.

The other three that didn't have 96 percent coverage were Mexico, with 60.4 percent; Turkey, with 67.2 percent; and the United States, with 84.9 percent, of which 27.4 percent was public coverage.

In Canada back in 1970, they were spending the same percentage of their gross national product as we were on health. They also had millions of uninsured people and many of the same insurance companies, such as BlueCross BlueShield. They decided to just get rid of the health insurance industry. They had

experimented with it in Saskatchewan ten years earlier and it had worked so well they couldn't wait to do it nationally. So where there is a will there is a way.

There is no way we are ever going to get to having good health insurance for everyone as long as there is a health insurance industry in the way of obstructing care.

One more recent experiment abroad includes Taiwan, where in 1995 they said we don't like the fact that 40 percent of our population are uninsured. They passed essentially a single-payer plan, and within a few years, 90 to 95 percent of people were covered.

In the U.S. we have had experiments as well, with seven States having instituted various versions of the public-private combination that this legislation seeks to provide. In none of these States has this worked. Once several years had elapsed with little improvement in insurance coverage, it was back pretty much to where it started, despite initial enthusiasm and short-lived decreases in uninsured.

So as we consider what to do, which experiments do we follow? The ones that were successful, all of which for practical purposes eliminated the private insurance industry, or the failed U.S. State examples, all of which were built on this industry?

If instead of saying that a single-payer program is not politically possible, the President and the Congress need to say it is not only politically possible, politically feasible, but it

is the only practical way national health insurance will ever happen. And anything short of that is essentially throwing tens of billions of dollars at the insurance industry. And if you are afraid of the insurance industry, then you are afraid of doing the right thing, which is having everybody in and nobody out.

[The prepared statement of Dr. Wolfe follows:]

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

Mr. Pallone. Dr. Woolhandler.

STATEMENT OF STEFFIE WOOLHANDLER, M.D.

Dr. Woolhandler. Members of the committee and Mr. Chairman, I am Steffie Woolhandler, a primary care doctor in Cambridge, Massachusetts, and associate professor of medicine at Harvard. I also co-founded Physicians for a National Health Program, and our 16,000 physician members support nonprofit single-payer national health insurance because of overwhelming evidence that lesser reforms, even with robust public plan option, lesser reforms will fail.

Private insurance is a defective product. Unfortunately, the tri-committee plan would keep private insurers in the driver's seat and, indeed, require Americans to buy their shoddy products. Once failure to buy health insurance is a Federal offense, what comes next? A Ford Pinto in every garage, lead-painted toys for every child, melamine chow for every puppy?

Even middle-class families with supposedly good coverage are just one serious illness away from financial ruin. My colleagues and I recently found that medical bills and illness contribute to 62 percent of all personal bankruptcies, a 50 percent increase since 2001. Strikingly, three-quarters of the medically bankrupt had health insurance when they first got sick. In case after

case, the insurance families bought in good faith failed them when they needed it most. Some were bankrupted by copayments and deductibles and loopholes that allowed their insurer to deny coverage. Others got too sick to work, leaving them unemployed and uninsured. And insurance regulations like those in the tri-committee bill cannot -- cannot -- fix these problems.

We in Massachusetts have seen in action a plan virtually identical to the one you are considering. In my State, beating your wife, communicating a terrorist threat, or being uninsured all carry $1,000 fines. Yet despite these steep penalties, most of the new coverage in our State has come from expanding the Medicaid-like programs at great public expense.

According to the State's disclosure to its bondholders, our health reform has cost $5,000 annually for each newly insured adult. That is equivalent to over $200 billion annually to cover all Americans with this style of program, or about $2 trillion if you want to do it over 10 years.

But even such vast expenditures haven't made care affordable for middle-class families in Massachusetts. If I were to lose my Harvard coverage, I would be forced to lay out $4,800 for a policy with a $2,000 deductible before the policy paid a penny, and a 20 percent copayment after that.

The skimpy, overpriced, private coverage like this left one in six Massachusetts residents unable to pay their medical bills last year. One in six unable to pay their medical bills.

Meanwhile, rising costs have forced our legislature to rob Peter to pay Paul. Funding cuts have decimated safety-net hospitals and clinics. Today the State announced that health reform funding would be cut by $115 million as of July 1. Only 115 million. And our State Treasurer Cahill opines that Massachusetts could no longer afforded reform. That is in today's Boston Globe.

As research I published in the New England Journal of Medicine showed, a single-payer reform could save about $400 billion annually by shrinking health care bureaucracy enough to cover the uninsured, and to provide first-dollar coverage for all Americans. A single-payer system would also include effective cost containment mechanisms, like bulk purchasing and global budgeting. As a result everyone would be covered, with no net increase in U.S. health spending.

But these savings aren't available, are not available unless we go all the way to single payer. Adding a public insurance plan option cannot fix the flaws in Massachusetts to our reform. A public plan might cut private insurer profits, which is why private insurance companies hate it, but their profits account for only about 3 percent of the money squandered in bureaucracy. Far more goes for marketing, to attract healthy profitable members, and demarketing, to avoid the sick. And tens of billions are spent on the armies of insurance administrators who fight over payment, and their counterparts at hospitals and doctors' offices.

All of these would be retained in the public plan option. And overhead for even the most efficient competitive public plan would be far higher than Medicare's, which automatically enrolls seniors when they turn 65, disenrolls them only at death, deducts premiums automatically from Social Security checks, et cetera.

Unfortunately, competition in health insurance involves a race to the bottom, not the top. Competition in health care is a race to the bottom and a competing public plan would be pushed to the bottom. Insurers compete by not paying for care, by denying payment and shifting costs onto patients or other payers. These bad behaviors confer a decisive competitive advantage. A public plan option would either emulate them, becoming a clone of private insurance, or simply go under.

A kinder, gentler, public plan option would quickly fail in the marketplace, saddled with the sickest, most expensive patients, whose high costs would drive premiums to uncompetitive levels.

In contrast, the single-payer reform would radically simplify the payment system and redirect the vast savings to care. Hospitals could be paid like a fire department, receiving a single monthly check for their entire budget, eliminating most billing. Physicians; billing would be similarly simplified.

Eight decades of experience teaches that private insurers cannot control cost or provide American families with the coverage they need. A government-run clone of private insurer, a

government-run clone of private insurers called a public plan option cannot fix these flaws. Only single-payer insurance can. Thank you.

Mr. Pallone. Thank you.

[The prepared statement of Dr. Woolhandler follows:]

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

Mr. Pallone. Dr. Goodman.

STATEMENT OF JOHN C. GOODMAN

Mr. Goodman. Thank you, Mr. Chairman, members of the committee. Every single health care system in the world today faces three fundamental problems: cost, quality, and access. In our own country, health care spending is rising at twice the rate of growth of income, and has been doing so for 40 years. If that continues, clearly health care will crowd out everything else that we care about.

But we are not worse in this respect than other developed countries. Over the last 40 years the real rate of growth of health care spending per capita in the United States has been just slightly below the OECD average. We have quality problems in this country. But despite those problems, we appear to, overall, deliver a higher level of quality than just about any other country. We are number one in the world, for example, in survival of cancer patients.

We have access problems in this country, but I think we do better than just about any other country with a heterogeneous population. The U.S. population gets more preventive care by far than Canadians, for example. Americans get more mammograms, more Pap smears, more PSA tests, more colonoscopies, by quite a

considerable margin than the Canadians do.

Low-income white Americans appear to be in better health than low-income white Canadians. The minority population of the United States seems to do better in our health care than the Inuits or the Crees in Canada, or the Aborigines in Australia, or the Maori of New Zealand.

Now, what about the proposals being considered by Congress right now? What will they do for the problems of cost, quality and access? When Peter Orszag was head of the Congressional Budget Office last year, he examined all of the major proposals that can Candidate Barack Obama was making to lower health care costs, preventive medicine, coordinated care, electronic medical records, evidence-based medicine and so forth. And what the CBO concluded was that none of these proposals would make any significant difference in rising health care costs.

On the other hand, if we spend an additional $150 billion a year on health care, that almost certainly will contribute to health care inflation, making the problem of cost worse, not better.

What about the problem of quality? Well, there is nothing that I have seen in any of the proposals being seriously discussed that would appear to make any significant difference in the quality of care that Americans receive.

But on the other hand, if we create an artificial market in which insurance companies are forced to community rate their

products to millions of people and do so annually, they will very quickly discover that they want to seek to attract the healthy and avoid the sick. And once enrollment occurs, they will seek to overprovide to the healthy and underprovide to the sick. That is good if you are healthy. It is not going to be good if you are sick.

So we are setting in place an artificial market in which the incentives to underprovide are going to be very strong. And the more competitive that market is, the more insurers will be inclined to act on those financial incentives.

What about access? Well, again, we do have access problems in this country. No doubt about it. But we are not going to solve those problems by putting millions of people into Medicaid and encouraging private -- people with private plans to drop their private coverage and enroll in Medicaid, as a number of the proposals now would do. Basically that is what Massachusetts did. Massachusetts cut its uninsured rate in half, and it did so by putting thousands of of people into Medicaid and thousands more into private plans that are paying Medicaid rates. And those people are finding they have difficulty in obtaining access to care.

A study just last month concluded that the wait to see a new doctor in Boston is more than twice as long as it is in any other U.S. city. And for Massachusetts as a whole, the number of people who go to hospital emergency rooms today for non-emergency care is

as great as it was 3 years ago, before the Massachusetts health care plan was started. Medicaid is not a solution for the problems of the uninsured.

The cancer studies show that in terms of delays in treatment and delays in detection, being on Medicaid is only marginally better than being uninsured. And when people drop private coverage to join Medicaid, they are leaving a plan which allows them to see almost any physician, go to almost any facility, get care fairly promptly, and go into a system where there are long delays and where there are much fewer choices.

So the real danger, Mr. Chairman, is that we are about to pass legislation that will not only not lower the cost of care, but will make it higher; that will not improve quality, and may actually cause quality of care to go down; and may even make health care less accessible for millions of people. Thank you.

Mr. Pallone. Thank you, Dr. Goodman.

[The prepared statement of Mr. Goodman follows:]

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

Mr. Pallone. Thank all of you.

Now we will take questions. We will give you questions from individual panel members. We have 5 minutes each, and I will start with myself.

And this is about the public option. As you know -- and this is to Dr. Wolfe or Dr. Woolhandler, or both of you -- as you know, the discussion draft would create a public option to compete with private plans to offer coverage within the new health insurance exchange. Uninsured Americans would choose to enroll in any of the plans in the exchange, either public or private, and there has been concern expressed in some quarters that this public option would inevitably evolve into a single-payer system.

For example, last Friday, when the discussion draft was released, Scott Sirota, the head of BlueCross and BlueShield Association warned -- and I will quote -- that the proposed creation of a government-run health plan would jeopardize the coverage of 160 million people who receive their benefits through their employer today.

An independent analysis by the Lewin Group estimates that tens of millions of people would shift to a government plan, dismantling the private market that is free to innovate without the political pressures that often stifle efforts to innovate in government programs like Medicare.

Now, we are going to have BlueCross BlueShield and the Levin

Group here tomorrow. But what I wanted to ask you today is whether you think Sirota is right. Will the public option strangle the private health insurance industry and become a single-payer system?

I will start with Dr. Wolfe and Dr. Woolhandler.

Dr. Wolfe. We have heard the same things that you have heard, Congressman Pallone, that somehow or other the public option is really a Trojan horse or a stalking horse for the single payer. What that would mean would be that if a public option were to pass, alongside with the private, that it would allow the public option to be as good as it can be. And essentially, if that were the case -- which I don't think is going to happen -- it might in fact lead to single payer.

I think there is zero possibility that anything that anyone is remotely considering as the public option would lead to a single-payer program. I think that it is more likely that it would give bad word or bad reputation to a public option because it would be so emasculated. I mean, at this point, I would say that the chances are 50/50 that either the public option would be completely scuttled -- which I think is possible,, President Obama said yesterday he wouldn't be opposed to signing a bill even it if didn't have that -- or it would be so emasculated that it won't be competitive as it should be with the private plan. So I just don't think that that is realistic at all. I think that this is sort of scare tactics from the right, which includes the entire

health insurance industry.

Mr. Pallone. And Dr. Woolhandler, because I want to get to another question.

Dr. Woolhandler. A public plan option is not single payer, nor would it lead to a single payer. As you have envisaged it in the tri-committee report, it is going to be an identical clone of private health insurance with a public label on it. And that still might be okay if competition and health care were about giving people care. But competition health insurance is about not giving people care, about competing to enroll a lot of people and not cover them. And if you don't behave like that, if you don't misbehave like that, you go out of business in a competitive market.

So a private insurance clone with public label is not going to solve this problem. It is really irrelevant to the problem of access to care. And I appreciate the private insurance industry doesn't want it. They don't want any new competitors. But they are wrong when they say that what is here in this bill is going to lead to single payer. That is not true.

Mr. Pallone. Well, I am probably going to say something that you won't want to hear. But I am beginning to feel more and more that, since I am getting so much opposition from the insurance industry that the public option is going to hurt them, and so much opposition from single payers that the public option won't work, that I actually now believe that we have a great discussion draft

because neither group likes it. But that is not a question. That is just my comment.

I wanted to ask Dr. Woolhandler, on the bankruptcy issue, I know you did this important study on bankruptcies and health insurance, and as you testified this afternoon, your study found that medical bills and illnesses contribute to over 60 percent of all personal bankruptcies. Three-quarters of people with these medical bankruptcies have insurance at the start of their illness. It was a real eye-opener for me.

In the discussion draft, we have consumer protections that would prevent the abuses of the past, practices like medical underwriting and preexisting conditions exclusion and rescissions which deny or take away coverage just when it is needed most. So I am happy with these consumer protections in our discussion draft.

And I wanted to know, you know, whether you thought the House discussion draft addresses some of these critical consumer protections adequately, based on your research.

Dr. Woolhandler. There is nothing in the draft that would have protected families from bankruptcy. The average family in medical bankruptcy had unpaid medical bills of about $17,000. And in your draft you would allow people to have out-of-pocket expenses of about $10,000 per family per year. So in less than 2 years, if you had a serious illness, you could accumulate $17,000 in out-of-pocket expenses that bankrupted families in our

study.

So the protections you have, maybe they are better than no protections, but based on the actual circumstances that drove people to bankruptcy in our study, no, the bill would not protect people from bankruptcy.

Mr. Pallone. Okay. I know we are not going to agree on everything, but I do think that it is important that these insurance abuses be eliminated, and we are certainly making an effort in that regard. Thank you very much.

The gentleman from Indiana, Mr. Buyer.

Mr. Buyer. Thank you very much.

Dr. Goodman, the legislation mandates a massive expansion of the Medicaid program that some believe could lead to well over 20 million Americans becoming enrolled, then, into the Medicaid program. First of all, I would like to know your thoughts about this as a proposal. And do you believe that there will be a similar crowd-out effect as is currently being seen in the SCHIP program?

Dr. Goodman. Well, I do. And I think that is what is intended; that when you make something available for free, even if the quality is not as good, people will tend to drop the high-priced alternative. That is what happened in SCHIP. That is what happened in TennCare in Tennessee. That is what happened in Hawaii. So we have quite a number of examples of people dropping private coverage to take advantage of public plans.

What happens in Medicaid is that it is really an inferior insurance plan. It pays, in many places, 40 percent below what the private market is paying. And so the Medicaid patient is the last patient the doctor wants to see at the end of the day. So you have increasingly long waits to see doctors, difficulty finding new doctors that will even see Medicaid patients, and pretty poor results when it comes to serious health care like cancer care.

Mr. Buyer. And in those cases that you just discussed, where the crowd-out effect had occurred within the SCHIP program, what was the impact upon insurance premiums because of the crowd-out? Did they increase or decrease?

Dr. Goodman. I don't know what the effect has been on insurance premiums. On the crowd-out, the Congressional Budget Office estimated that the bill that Congress passed in January, that would put 4 million new children into SCHIP, as many as half those children would leave private coverage in order to enroll in that coverage.

Mr. Pallone. Dr. Goodman, I am told your microphone may not be on. Is it?

Dr. Goodman. Can you hear me now?

Mr. Pallone. I was more concerned about the transcription. Okay. Thank you.

Dr. Goodman. When those children had private insurance they could see almost any doctor, go to almost any facility in the area

where they live. Once they go into Medicaid they could see far fewer physicians, go to fewer facilities, and their choices are more limited and their wait for care is longer.

Mr. Buyer. There have been some comments with regard to -- that a public option plan would be able to compete on a level playing field with private insurance. Are you familiar at all at the tax revenues that are paid into the States and the Federal Government because of the insurances, the tax on their revenues? I mean, I guess if we were to have a public plan that would compete equally with private plans, my question would be, would we need to exclude these companies from State and Federal taxes in order for us to be able to compete on a level playing field?

Dr. Goodman. What a level playing field means to me is that the public plan doesn't get any advantages. It cannot do what Medicare now does and use the monopoly buying power of the State to push the rates it pays down below 30 percent below market. It can't use the criminal law to enforce its contracts when everybody has to use the civil law. And it can't avoid the payment of taxes on revenues. And it is allowed to go bankrupt. But if you protect it the way Medicare is protected, having protections that private insurance does not have, then that is not a level playing field.

Mr. Buyer. And that public option with regard to the coverage of health would be far greater than perhaps a private plan, would it not?

Dr. Goodman. Well, I don't know. I wouldn't object to competition if it is a real level playing field. If it is a real level playing field, you just create a corporation; you can call it a corporation, let it sink or swim on its own, and I don't think it would much matter. But if it has advantages that Medicare now has over private insurers, it would matter a lot. And when you hear these estimates from Lewin and others, they are assuming it would have the advantages that Medicare has that private insurers do not.

Mr. Buyer. It is hard for me to imagine this competition, to create a public option and say that it will be on an equal plane with private insurance. And the reason I say that is I am sitting here with my colleague, John Shadegg -- and Joe Barton was here. There were five of us that worked really hard when we were creating the Medicare drug discount card program, and then our analysis into the Medicare Part D, and we were trying to create choice and competition in the marketplace. At the same time, my Democrat colleagues were questioning whether or not that would be ever be successful. In particular, the Chairman, Henry Waxman, was very critical of what we were doing, and wanted a government position in there.

But in the end, we went pro-market forces and were able to reduce the price. As a matter of fact, we got all the estimates all wrong. In the end, we were able to save tens and billions and billions of dollars. And now trying to provide that same analysis

into this one, to me, it creates a heterodox. And you are taking doctrine which people know and understand, and giving it a completely different definition. And so we are screwing up words, languages, and it just doesn't fit. I yield back.

Dr. Goodman. May I answer that?

Mr. Pallone. Was it a question? Go ahead.

Before you go, let me just mention we are going to have -- well, we have three votes pending. I will hear from a couple more members and then we will recess. But go ahead, Doctor.

Dr. Goodman. Part B competition I think is working well, better than anyone predicted that it would work. But that is different than what we are now talking about. What most people don't realize is that Medicare is, almost everywhere, administered by BlueCross. Now, do we really think that BlueCross administering Medicare is any more efficient than BlueCross administering other plans? No, of course not.

So why is it that Medicare has an advantage? It is because of advantages that are created by government, by law. So a level playing field would mean that anything administered by BlueCross plays by the same rules. And then I think it really wouldn't matter whether we call it public or not.

Mr. Pallone. Thank you. Chairman Dingell. Questions?

Mr. Dingell. Not at this time, Mr. Chairman. Thank you.

Mr. Pallone. Ms. Eshoo?

Ms. Eshoo. Thank you, Mr. Chairman, for holding these series

of hearings. And to all of the witnesses, I respect and admire the work that you have done and your testimony here today. There are great passions around single payer. I know that from some people in my own district, others in California, and certainly people across the country.

Let me ask you about something that I think important to the American people. In fact, I think they kind of have it in their DNA. Nobody likes -- no American, I don't think, really likes a one-size-fits-all. They really like to have choice. So I know that -- I mean, single payer doesn't provide that.

But I am asking you very sincerely, do you believe that this would -- do you think that single payer could in any way preserve choice for patients? Because as I understand single payer, it is just -- it is the one system that is paid by one outfit, the Federal Government, and that is it.

Dr. Woolhandler. Okay. Well, from the patient's point of view --

Ms. Eshoo. And we have learned a lot from -- and I was here, I was here for the health care debate in 1993-1994. And if there was anything that I heard from my constituents it was, don't force me into a plan. If I have what I have and I like what I have, that is what I want to stay with.

Dr. Woolhandler. Well, the choice that patients care about is that they are able to choose any doctor or hospital they want. And of course, that kind of choice is enhanced and expanded in

single payer. In a single-payer system you go to any doctor, you go to any hospital. So that is the choice patients care about. Once they know the bill is going to get paid, they don't care about how the insurance person is. They care about the doctor and the hospital.

From the doctors' point of view, the choice we want is to be able to do what is best for our patients and not have to ask permission from some private insurance bureaucrat or be told we can only refer patient X to doctor Y because of restrictions. So choice is actually bigger.

The important choice, the choice of doctor is hospitals is bigger.

Ms. Eshoo. What the Democrats are proposing in the bill does preserve some choice that matches somewhat what you just described. And that is that they have a choice of doctors, they have a choice of hospitals.

Dr. Woolhandler. But that is actually generally not a characteristic of private HMO coverage in this country.

Ms. Eshoo. Well, as it stands today. But I think that we have to ramp-up what we are talking about, because we are comparing and contrasting new ideas. We know what is broken. I mean, we don't need panels of people and all kinds of hearings to reiterate what is broken. We are looking at how to fix this thing.

So, you know, again, I mean I admire your work. I really

think that if we were starting from scratch, from total scratch in the country, probably what you all described today is what would be built. But we are not starting from scratch, and that is why I think a public option is so important.

Can you tell the committee how you think a single-payer system would affect innovation in health care, which I think is so important because we constantly have to be pushing the edges of the envelope out in our country on this? It is what makes the best part of caring for people in our country, the high end of it, something that is admired by people in different parts of the world.

So can you enlighten us on that and how you think your proposal would do that?

Dr. Wolfe. One of the things that gets focused on so much with single payer is that the government collects the money and pays the bills. Anyone can go to any doctor and hospital. But the very important element that doesn't get talked about very much is that you have a single data system. So for example, in Ontario, they can easily look at every patient in Ontario who got a certain prescription drug over a 2-year period, and then look to see how many of them had to get hospitalized because of something that is suspected to be an average reaction.

Ms. Eshoo. That is tracking the statistics. I am talking about innovation in medical devices and biotechnology.

Let me ask one last question here because I only have 17

seconds left. How do you pay for your system that you are advocates of?

Dr. Woolhandler. Well, the beauty of single payer is it contains its only funding.

Ms. Eshoo. How do you pay for it?

Dr. Woolhandler. You simplify administration. Currently, administration --

Ms. Eshoo. What is the savings over 10 years?

Dr. Woolhandler. It is $400 billion a year. So that is 4 trillion. You don't really save it because you take that same 4 trillion and use it to cover the uninsured and plug the holes in coverage for people who now have these crummy private policies. But you don't raise total health spending by a single penny. You just simplify administration, capture just under 400 billion annually by administrative simplification, and then you use that to provide care.

Ms. Eshoo. Thank you, Mr. Chairman.

Mr. Pallone. Thank you. I am going to ask Mr. Gingrey next, and then we will recess after him.

Dr. Gingrey. Mr. Chairman, thank you. I am going to go straight to Dr. Goodman with my questions, because I don't think any constituents in the 11th of Georgia, or any stakeholders, whether they are doctors or hospitals or especially insurance companies, would want to hear me ask any questions of Dr. Wolfe or Dr. Woolhandler, based on their testimony. I would like to

address a couple of questions, though, to Dr. Goodman.

Dr. Goodman, many of my constituents fear that a government-run council making health coverage determination for a government-run insurance plan will impede or stop their ability to receive quality health care and eventually result in a government-run health care system where it is bureaucrats in Washington controlling their health care decisions.

Some of my Democratic colleagues say that a government-run plan will only provide choice and not lead to a single-payer system.

Now, my concern, of course, is that it will -- and the old expression, if it walks like a duck and it quacks like a duck, you can bet that it probably is a duck. And speaking of ducks, you mentioned long wait times in other foreign countries like Canada.

In Norway, for instance, patients can expect to wait an average of 133 days for a hip replacement, 63 days for cataract surgery, 160 days for knee replacement, 46 days for bypass surgery, after having been approved for the procedure.

Well, Dr. Goodman, it seems that quality health care is not only the doctor you see, but the amount of time it takes to get through the door. In your opinion, are waiting times symptomatic and consistent with a government-run health care system?

Dr. Goodman. Well, yes. And you get long waits because you make medical care free to the patient, and you limit resources. And so demand exceeds supply at every margin. So you wait for

everything.

I might point out that we are getting a waiting problem in our health care system, too. We are inching toward Canada without changing anything about how we pay for health care, and I am concerned about that. On the Health Board, you know, I have to rely on Senator Daschle and the book he wrote and what he said about --

Dr. Gingrey. The book titled Critical? Is that the book?

Dr. Goodman. The book that Senator Daschle wrote about health care.

Dr. Gingrey. Critical, I think, was the name of that book.

Dr. Goodman. Now, Senator Daschle pointed to the British example of the Health Board with the acronym NICE and he said, what do they do? They compare treatments and they compare costs, and they compare benefits and they look at effectiveness. And quite frankly, in Britain there is sort of a cutoff point. They don't want to spend much more than $35,000 to save a year of life. And that means that in Britain, people often do not get cancer drugs that are routinely available in the United States and on the European Continent.

So yes, I am very concerned about that. And I am concerned, not that the government is going to tell doctors what to do, because even in Britain it doesn't always tell doctors what to do, but that it will give cover to health plans that already have an economic incentive to underprovide to the sick anyway. And if the

Health Board is saying, you know, that expensive drug is experimental and we really don't need to buy it, that is all the health plan would need by way of guidance in order to deny coverage.

Dr. Gingrey. Well, let me reclaim my time, because I did want to put out some statistics which speaks to exactly what you are saying, because you stated in your testimony that health care plays a leading role in determining the outcomes for diseases such as cancer, diabetes and hypertension. As a physician, practicing 26 years, OB-GYN, I cannot agree with you more.

Focus on cancer just for a moment. You mentioned that the 5-year survival rate of women diagnosed with breast cancer in the United States is 90 percent, versus 79 percent for women in Europe. You also mentioned the United States has a better relative survival rate than Norway for colon, rectal and breast cancer, lower rates of vaccine preventable pertussis, measles, Hepatitis B. Given that we do live in a global economy where breakthroughs in medical science and technology can be shared with patients in other countries half a world away, I am curious as to your thoughts for this disparity. What is the difference?

These survival rates are significantly different.

Dr. Goodman. In the first place, there is a difference in diagnosis. And remember -- take mammograms. American women get more mammograms than Canadian women do. They get more Pap smears than Canadian women.

Then there is the treatment. And regardless of the state of medical science, people in other countries may not get the same treatment that we get.

And then there is access to expensive but effective drugs. And in other countries, that is controlled more than it is in the United States. So those are three things I would point to.

Dr. Woolhandler. I would just like to go on record as saying I disagree completely with what Dr. Goodman is saying. I don't think that is supported by the scientific evidence.

Dr. Goodman. Well, I would like to say that I have a paper here with more than 100 peer-reviewed studies that we drew on to make these statements.

Mr. Pallone. We are going to have to --

Dr. Gingrey. Mr. Chairman, thank you. I realize my time has expired. And I appreciate Dr. Woolhandler's comment. And Dr. Goodman, thank you for responding to those two questions.

And I yield back, Mr. Chairman.

Mr. Pallone. Thank you. We have three votes and we will be back maybe half an hour or so. The subcommittee stands in recess.

[Recess.]

RPTS JURA

DCMN HERZFELD

[3:39 p.m.]

Mr. Pallone. The hearing of the Subcommittee on Health will reconvene. And I apologize. What did I say, we would be back in half an hour? I obviously misjudged that. Hopefully we will have some time now, though.

And our next member for questions is the gentlewoman from Illinois Ms. Schakowsky.

Ms. Schakowsky. Thank you, Mr. Chairman. I regret that I didn't hear all the testimony, but I am quite familiar with both Dr. Wolfe and Dr. Woolhandler. And I also want to refer a bit to Dr. Goodman's testimony which has been told to me.

I am a supporter of a single-payer, something that has been used to sort of beat me over the head, because I understand that it is going to -- I believe that the compromise that we have that -- that the President and the bill, the draft bill, endorses is something that I endorse as well, because I think that it is an important beginning to controlling costs and to providing -- and to providing good service.

But I do find it pretty ironic, when I say "beaten over the head," I am talking really about the other side of the aisle, and people who, I can't quite figure it out, find that it is quite all right -- and I don't know what the public interest rationale is -- is to defend the private insurance industry, which has had their

way with us for all these years without much accountability and gotten us into this mess, and why those of us who are single-payer advocates who are willing to compromise, but the other side who are all for just the insurance industry are not, talking about giving Americans a choice. And I find it not very collegial and certainly not in the best interest of providing health care to all Americans, which, after all, is the goal of the exercise, not to figure out how we can prop up the private insurance industry. Those of us who have agreed to the compromise think that they ought to be able to compete. But that is not the principal goal here. And we are willing to set up a situation where it is -- you know, maybe it is easy enough for them to do, but not if they continue to do what they have been doing. They are going to clearly have to change their ways in order to compete. I am really sorry, I guess -- I am not -- about that, but that is the reality.

I was just talking to a representative of Cook County Hospital, Dr. Goodman, who was telling me that in Cook County Hospital, which is our public hospital, the wait for colonoscopies, hip replacements, and certain gynecological services is up to 2 years. So let us be clear that there are certainly people waiting in line now.

And I have to tell you, my understanding is -- you can correct me if I am wrong -- that you said if you compare white patients in the United States to white patients in Canada, the

outcomes are the same; but if you compare minority patients to Aborigines, we are doing better. Oh, my God. I cannot believe that you said that in a public hearing. We are all Americans, and to somehow separate out those minorities and compare them to Aborigines as opposed to white Americans, minority Americans, all Americans, Canadian Americans -- Canadians, et cetera, that would be reasonable. The other comparisons are offensive. And I don't know if you want to comment on that or defend yourself on that.

Mr. Goodman. I am not sure you heard my testimony. I said we have access problems. And there have been lots of studies that show that --

Ms. Schakowsky. Did you make that comparison?

Mr. Goodman. These problems are more severe for minorities in the United States than the white population. But it is also true in Canada, it is also true in New Zealand, it is also true in Australia. And if you compare our progress to theirs, we are ahead of them. We are doing better than they are doing.

Ms. Schakowsky. Well, let me ask about this. Dr. Wolfe and Dr. Woolhandler, Dr. Goodman has testified that, again, if you compare whites to whites, that we are -- it is about even. But I wondered if you could actually talk to us about how we are doing compared internationally to other countries that actually do provide health care for all of their citizens.

Dr. Wolfe. Well, in my testimony I referred to what percentage of people in the 30 OECD countries have insurance. And

as I said, for 27 of the 30, it was over 96 percent. But in the same report, which just came out a few months ago, they also asked the question: How many people in various countries have an unmet care need? And that is sort of what they are talking about. Unmet care need was defined as unfilled prescriptions or missed medications; medical problems; didn't visit a doctor; missed tests, treatment or follow-up. And here the comparisons are really striking.

In the United States, for people who were below average income, below average income, over half of them had an unmet care problem, 52 percent; whereas, in Canada, it was 18 percent, just about a third as much. And even for the people with -- that was below average income. For people with above average income, again, it was three times more likely in the United States to have an unmet care problem.

When you look at these seven countries --

Ms. Schakowsky. So what you found contradicts what Dr. Goodman just said, that we are doing better.

Dr. Wolfe. That is right. OECD -- and this is generally agreed upon, and the United States is one of 30 countries that belong to it. They produce very interesting data not only on health, but other measures, and they put these out frequently. These are valid comparisons, interestingly, and they really go against what Dr. Goodman said earlier, a couple hours ago, that there are more access problems here, there -- that there are more

access problems in other countries than here. There are more access problems whether you are above average income or below average income in the United States than in other countries. And obviously one of the reasons is that people are all insured, and they don't get thrown out of emergency rooms as people frequently do in the United States, violating the patient dumping law.

Mr. Pallone. We are going to have to move on.

Mr. Shimkus.

Mr. Shimkus. Mr. Chairman, can I defer and come back in the next Republican round so I can listen? Can I just defer, whoever is next on the list?

Mr. Pallone. You want Mr. Shadegg to go first? Sure.

Mr. Shadegg.

Mr. Shadegg. Thank you, Mr. Chairman.

Mr. Goodman, do you agree with the statement of Mr. Wolfe that there are frequent violations of the laws requiring the treatment of patients at hospital emergency rooms in the United States? And are you aware of any studies that show that?

Mr. Goodman. I am not, but --

Mr. Shadegg. I don't think your microphone is on.

Mr. Goodman. No, I am not. But I do concede we have an access problem, and I think the waiting in hospital emergency rooms in this country is atrocious. We had in Dallas a man who waited 19 hours and died before he ever got care. So I don't know if any law was violated, but I don't think that should be

happening.

Dr. Wolfe. If I could respond.

Mr. Shadegg. I am sorry, my time is limited.

I would agree with that. Can you tell me, since he challenged you on the point made earlier, would you reiterate the point made earlier and explain to me or contrast for me waiting times or waiting periods in the United States under the current system versus those experienced in England or Canada?

Mr. Goodman. Well, see, what I think is happening in our hospital emergency rooms is exactly what happens in Toronto and exactly what happens in London. We are rationing care here just like they are rationing care in other countries. And to talk about everybody having access to care just because they are paper insured is nonsense. The reality is that lots of people aren't getting care they need when they need it in a timely way around the world. And I think that if you look at the data, we do a reasonable job with a heterogeneous population compared to other countries. We could do a lot better, but let us not pretend that they are way ahead of us, because they are not.

Mr. Shadegg. Let me make a statement. I am unaware of waiting periods in the United States at any facility, emergency room or otherwise, of months. And I am very much aware of waiting periods in Canada for various procedures that go more than a month. That is not a question; that is my statement.

What is your suggestion or what would you do as opposed to --

I presume you do not favor a public plan?

Mr. Goodman. No, I don't.

Mr. Shadegg. What would you suggest we do rather than moving to a public plan?

Mr. Goodman. I think we ought to focus with the problem we began with, and that is the uninsured. What should we be doing for them? Right now, if they buy their own insurance, they get no tax relief whatsoever. Right now, if your employer -- your employer is not allowed to buy for you insurance that you can take with you when you leave a place of employment. It is illegal in every State to buy personal portable insurance, which is the only kind of insurance that people can take with them in and out of the labor market and from job to job.

Mr. Shadegg. You are familiar with the legislation that I introduced that would allow individuals to buy health insurance that was qualified under a Federal law, and then written to comply with one State's law and then be sold in multiple States?

Mr. Goodman. I am, and I think that is a good idea.

Mr. Shadegg. And would that bring down the cost of insurance?

Mr. Goodman. I think it would.

Mr. Shadegg. And would that reduce the number of uninsured?

Mr. Goodman. I think it would.

Mr. Shadegg. What would be the best mechanism you think for making insurance portable for those Americans who do not have

health insurance? And would it include a refundable tax credit as I have proposed and others such as Congressman Ryan and Senator Coburn?

Mr. Goodman. The Coburn bill is a wonderful bill, but even without going that far, we need to give tax relief to people who buy their own insurance. We need to allow employers to buy the kind of insurance that people can take with them and is individually and personally owned. And we need to get rid of a lot of these State regulations which force up the price of insurance and price way too many people out of the market.

Mr. Shadegg. That last point is exactly what we were doing with my legislation that would let you buy a policy essentially filed in 1 State and then sold in the other 49.

Mr. Goodman. That would be the practical effect of it. Yes.

Mr. Shadegg. It would be the practical effect of reducing those mandates and thereby bringing down the cost of health insurance?

Mr. Goodman. That is right.

Mr. Shadegg. You and I have talked about refundable tax credits and about the outrage of a current American law which says that if you get tax -- if you get health insurance through your employer, it is pretax, but if you buy it on your own, it is taxed. We have been talking about that for how many years now, John?

Mr. Goodman. At least two decades.

Mr. Shadegg. It seems to me --

Mr. Goodman. And it is just as bad now as it was two decades ago.

Mr. Shadegg. If we just changed that law and said we are going to allow all Americans who want to buy health insurance to do so on the same tax-favored basis as businesses can do, that would create dramatically more competition in the health insurance industry, wouldn't it?

Mr. Goodman. Well, but, more importantly, it would allow people who are on their own to have tax relief and would encourage them to buy insurance which they are not now buying.

Mr. Shadegg. If we coupled that with a refundable tax credit for those who can't afford health insurance, which is what I would propose doing, we would both bring down the cost of health insurance for all Americans and drive up quality; would we not?

Mr. Goodman. That would be the most important thing, most important change in the health care system: Give every American a refundable tax credit. Let it be the same for everybody. And in the latest Coburn bill I think it is $5,700 for a family. So the first $5,700 is effectively paid for by the government for everybody. And then additional insurance comes, after tax, out of our own pockets. It would radically change the kind of insurance we have. It would change everyone's incentives. Nothing would -- that I can think of that has been proposed recently would have a bigger impact on the health care system.

Mr. Shadegg. The Republican-proposed refundable tax credit for health care has been on the table for years by Senators, like Senator Tom Coburn, and I, who have been advocating it. That would have solved the problem of America's uninsured a long time ago; Would it not?

Mr. Goodman. It would go a long way toward it.

Mr. Shadegg. Thank you very much.

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

Mr. Pallone. Mr. Weiner.

Mr. Weiner. Thank you, Mr. Chairman.

Is there consensus of the three of you on the panel that the administrative costs for private insurance claims is much higher than what it is for the Medicare system? We will start with you, Mr. Goodman.

Mr. Goodman. There probably isn't a consensus here, because the statistics that you heard earlier count the private insurers' costs of collecting premiums, but they ignore the government's cost of raising taxes. If you want to make a fair comparison, you have to compare apples with apples and oranges with oranges.

Mr. Weiner. So the administrative costs, you mean the IRS?

Mr. Goodman. Yes.

Mr. Weiner. If you back out the IRS for the purpose of this conversation, then it is obviously -- is there any disagreement that the Medicare system is much more administratively efficient than private insurance?

Mr. Goodman. Well, if you mean by backing out the IRS, we ignore the cost of getting public funds, but we count the cost of getting private funds, then, yes, Medicare would be cheaper.

Mr. Weiner. Is there anything that we can learn from how Medicare does things administratively? Is there an obvious place that we can find that that efficiency is found? Dr. Woolhander, would you have a sense of is there something in that? I know, for example, that insurance companies benefit to some degree monetarily from delays and inertia. Right? If they don't pay, for example, a doctor, reimburse a doctor or a hospital for a 30- or 60-day period of time, they make money on the money that they are not allocating. There are things like that.

But are there other elements that we can learn if we wanted to teach the private insurance companies? Which is what President Obama said the other day in his press conference, he thought it might be instructive for the private guys to copy some of the things that the public model does. Is there any one or two things that jumps out at you that makes Medicare more efficient?

Dr. Woolhandler. There is a lot of things, but you couldn't transplant them to private insurance, because private insurance makes their money by not paying the bill, by collecting lots of premiums and not paying. So there is lots of expenses they have that are essential to their competitive strategy. So they want to be very, very careful to recruit healthy people.

Mr. Weiner. I understand that, but you are answering a

different question. I understand they are not going to want to do it. I am asking you, if you were to say, here is two or three things that Medicare does that they do more efficiently than private insurance, like are there a couple that may come to mind that might inform the committee's deliberations here?

Dr. Woolhandler. Medicare is universal, and it does use the IRS to collect money and the Social Security System, which is a very efficient way to do it because those things exist already anyway, and they are not going to disappear or get any smaller.

Mr. Weiner. So their building apparatus is much more efficient.

Dr. Woolhandler. They are collecting of -- the equivalent of premiums is much more efficient. Also, Medicare doesn't do any cherry-picking. They don't try to attract healthy people and keep sick people out. They can't. It would be illegal. They take everyone. So they don't have any so-called marketing expenses, which is really about recruiting healthy people and keeping sick people out.

Mr. Weiner. Dr. Wolfe, let me ask you this question. Doctor, feel free to weigh in when he is done. The argument made against single-payer -- and I don't know how persuasive it is, and, frankly, I plan on offering single-payer as an option here when we mark up the bill. But the argument that is made is there are a lot of people for whom their present insurance plan is satisfactory. They say that they are satisfied with it, they like

the doctor relationship, they don't mind getting the bills. They like what they have chosen.

And a political argument is made that essentially says don't, when you are trying to do something this big and difficult, pursue what Dr. Goodman has been pushing; try to solve the problem without creating the big tumult around people who don't generally see there would be a problem. That is a pretty persuasive argument on a political level; I mean, to say to 120-, 130-, 140 million people, we are not going to touch your thing that you have.

How do you respond as an advocate for single-payer for the idea that while it might be more efficient for the reasons you stated in your testimony, we may be permitting the perfect to be the enemy of the good by creating an untenable political dynamic? Why don't you give us your response for that.

Dr. Wolfe. I think the main response is that people would be concerned if you thought they were going to disrupt the relationship they had with their doctor, with their dentist, with their physical therapist, with their hospital. And the single-payer is looking only at how the money is collected and how the bills are paid. There is no reason why anyone who is going to Dr. A would not be allowed to go to Dr. A if there was a single-payer system. In fact, they might also want to go to Dr. B, who they would have liked to go before.

Mr. Weiner. Because, in your vision of the single-payer, a

doctor would be compelled to participate; otherwise, they wouldn't be able to be a doctor in the United States because they would be opting out so many patients?

Dr. Wolfe. Right. In Canada and lots of other countries, if you are going to receive money for delivering medical care, you can't discriminate against this or that kind of patient, so that, if anything, the doctor-patient relationship would be enhanced instead of disrupted. A patient could go to a doctor that they couldn't have gone to before because that doctor wasn't in their pool. There is no such thing as your limited pool of doctors or hospitals, for that matter, you can go to.

So in terms of -- the disruption is really a disruption of the health insurance industry, not of the doctors, not of the patients. I mean, the reason why 60 percent of the doctors in Massachusetts in a study published a couple years ago support single-payer is that they are getting sick and tired of spending so much time in their offices fighting with insurance companies to pay bills, hiring people that are not delivering medical care, but are just sort of engaging in phone or e-mail or fax wars. So I think that if the focus is the patient, then it is less disruptive.

Mr. Weiner. I thank you. And my time has expired. I would just caution you, Dr. Wolfe, that what you are answering is a substantive question, and mine was a political one. Someone who has Oxford who then is going to go to a single-payer is going to

lose their Oxford whether they get the same doctor or not. That is the rhetorical challenge that we have as advocates for a better system. But I appreciate the candor of your answer.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

I am just going to ask Members, I know we each have 5 minutes, but this is the first of three panels. Just try to at least end your questions within the 5 minutes. I don't have a problem if the panelists' answers go beyond the 5, but I want our questions or comments to end at the 5 minutes, otherwise we are going to be here until 8:00 or 9:00 tonight.

Next is Mr. Shimkus.

Mr. Shimkus. Thank you, Mr. Chairman.

There is a couple ways that Members could come to these hearings. This is a very important issue. And I think we all come in all the seriousness that we should.

You know, first, just on this rush to move, I have talked about in the energy bill having a discussion draft that people can't really talk about because we know the discussion draft will not be the bill. It is not going to be it. So when we end up marking the bill, we are going to get a bill on a Friday, just like the energy bill, which will have 300 more pages that my staff will try to e-mail me at home that they hope that I will read and go over to be prepared for a markup.

So this process is -- the health care is broken, this

legislative process. Now, we can do it in this committee. We did it in FDA reform. We really did. Democrats worked with us, we compromised, we got a good bill. We got a bill that passed out on a voice vote. Major reform in the Food and Drug Administration. And I think people are -- you win some, you lose some. Overall we are pretty happy. We didn't have that in energy, and we are going to have a Texas death match fight on the floor come Friday. We are not going to have it here, and so we are going to have another Texas death match fight whenever this moves to the floor. And it is just too important of an issue to do that.

So I have always been struck by why don't we move -- I mean, there is an incremental process, and people understand that, and call our bluff. Let us get insurance to more people. Let us try associated health plans. Let us try giving people tax incentives. Prove us wrong that a private system doesn't work, and then the public option might be the default. Maybe a one-payer might be the default.

I was in Chicago at the American Society of Plastics, and I talked to a legislative luncheon with some of my colleagues. One of the guys there whose spouse was attending sold medical technology, and he had just come back from Canada. This hospital was excited to buy their second MRI, and they are going to reduce their wait list from 8 months to 4 months for an MRI. I am not making this up. We all know, there are horror stories on both sides. So my plea is for us to try to move in a way that we can

try to cover people before we bring what I believe is the heavy hand of government.

Let me go to questions. Let us talk about this, Mr. Goodman, first, and I will let people chime in. I am not really trying to incentivize one side or the other. Usually I do that, but not here. Let us talk about this Medicare thing, and let us address -- every time politicians talk about saving the government money, what is the first thing off our lips? Waste, fraud, and abuse. And where do they point that this waste, fraud, and abuse is? Medicare and Medicaid. And my friend from New York talked about the cost of this. Shouldn't the cost of waste, fraud, and abuse be part of this calculation if we are going to compare private insurance with a government-backed product?

Mr. Goodman. Well, it should be. And in my opinion, the thing that Dr. Woolhandler praises about Medicare and Medicaid is, in fact, one of its faults. It spends been too little on the administration. You ought to spend some resources watching where the dollars go. And apparently there is an enormous amount of fraud in Medicaid and Medicare, and you are not going to get rid of it if you don't spend some resources to find out where the dollars are going.

Mr. Shimkus. And the percentages of like 30 percent claims, that are paying claims that shouldn't be paid. So 10 percent. I can't even read my notes anymore. But there is a credible cost, if you are going to claim you are going to save money on waste,

fraud, and abuse, that it ought to go into. That would be good money to go after, the return on the investment.

Let me just finish with this in my time, and I want to be respectful to the Chairman. The Massachusetts example just recently released, what are they doing? They are going to raise their costs, they are going to cut services, they are going to reduce their beneficiaries. That was just announced today. What does it make us feel like that is not where we are going to be if we move to a one-payer system or a public option?

Dr. Woolhandler. The one aspect of Massachusetts that is very prominent, and it is actually in this bill, in the tri-committee bill that we haven't discussed much --

Mr. Shimkus. The draft language. There is no bill. A bill is a bill when you actually drop it and it gets a number.

Dr. Woolhandler. The tri-committee draft includes an individual mandate, just like Massachusetts, which is, of course, what the private insurance industry wanted. They said that was their number one thing that they wanted was an individual mandate. And it is here in this bill called "individual responsibility."

Mr. Shimkus. But Massachusetts is cutting benefits, raising premiums, and reducing -- cutting service.

Dr. Woolhandler. Absolutely. Absolutely. Because it is not affordable what they have done. And the individual mandate piece hasn't worked. It has been very punitive, and it is here in the tri-committee draft. And it is a complete gift to the private

health insurance industry, just as it was in Massachusetts, because it is saying that the government is going to make it illegal not to buy private insurance. And that is actually something that needs to be discussed and is really totally caving in to the insurance industry no matter what else is in this bill.

Mr. Pallone. Mr. Deal.

Mr. Deal. I would like to follow up, Dr. Wolfe, on something that you said about how your world of a single-payer would work. And I believe you said it in response to an earlier question that, in a single-payer world, physicians would either be in the system accepting the payments that the system dictates that they are entitled to, or else they would not be able to practice, period. Is that correct?

Dr. Wolfe. Well, they can practice privately and collect money from patients. There is nothing to stop that. In the United Kingdom the so-called Harley Street physicians are physicians who aren't part of the national health service. They practice. They have expensive practices for patients who can pay them.

The only point I was making is that the Canadian system, which is called Medicare for everyone in the country, is one that if a physician wants to take care of patients who don't have money to go to a private doctor, then that physician needs to participate.

The physicians in Canada actually make reasonably large

amounts of money with the kinds of prices that are placed on the services by the government. So it is not -- it is restrictive only to the sense that if someone really wants to practice medicine for someone other than a group of very wealthy people, they participate in the program. Again, they are in private practice; they are not working for the government, they are just getting paid by the government.

Mr. Deal. One of the concerns that we currently have is doctors who will not take Medicare patients simply because reimbursement rates they consider are not adequate.

Under the proposal that we are looking at, the public option plan, as I understand it, keys reimbursements to Medicare reimbursement rates. Now, one of two things is going to happen. Either the public option plan is not going to be able to get any doctors to sign up to participate without coercion to do so, or the private plans are going to decide that the only way they can compete with the government is to ratchet down their reimbursements to the Medicare levels; and, therefore, the private insurance market providers are going to have the same complaints that they currently have in our Medicare reimbursement system.

Dr. Goodman, maybe I could ask you to comment on that.

Mr. Goodman. Well, I think you are exactly right, except I don't think it will be all one way or the other. With that kind of system, what we will gravitate to is a public system in which most people will be enrolled, and the doctors will be paid

below-market rates. And then there will be a private system, just like they have in the United Kingdom, or some version of that, and anyone who has the money will buy better coverage, and they will be seen first by the doctors, and they won't wait as long. And Britain has a two-tier system, and what you are pointing toward would be a two-tiered system for the United States.

Dr. Wolfe. Could I just respond briefly to that? Which is, one of the reasons that we are opposed to this public-private option is that it does cause some of the exact things you are talking about. Why should it be that a given doctor should not get the same amount of money for seeing patient A versus patient B versus patient C versus patient D? In other words, what I am saying is that under a single-payer system, the doctor could see any patient they want; the patient could go to any doctor they want without the fear that this doctor won't see them because they are not getting paid as much as they would be paid if they had some other insurance.

It is bewildering to a doctor and their staff to have to look at a patient and say, do they have this plan or plan number 10 or plan number 20? And if they have that, does it cover this or that or whatever? It is just an unbelievably complicated matrix, as opposed to just saying you go to the doctor, and whenever you are or whoever you are, the doctor gets reimbursed the same amount. I think that that kind of twofold system that is possibly built into the draft bill that we are discussing isn't a good idea. But it

is not the only reason the draft bill is not a good idea.

Mr. Deal. We agree on that last statement.

Dr. Woolhandler. I would just have to say as a practicing physician in Massachusetts not only do I take Medicare and welcome it, but essentially every doctor in the State of Massachusetts takes Medicare. And, you know, none of us are going to the poorhouse. So I know there is people who can command even higher payments than Medicare pays, but Medicare payment is generally compatible with a pretty good standard of living for the medical profession. So I wouldn't worry too much about that issue, personally, coming from Massachusetts.

Mr. Deal. Well, coming from Georgia, I can tell you firsthand that we are having physicians who will refuse to continue to treat long-term patients that they have had for many, many years when those patients become Medicare-eligible simply because of the reimbursement rates, and they consider them to be inadequate. And my State at least, I think, is experiencing that kind of problem currently, and I just don't want to see us magnify that problem.

I believe my time is up. Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Dr. Burgess.

Dr. Burgess. Thank you, Mr. Chairman. You had no choice but to come to me, and I appreciate the time. And just for the record, I always saw Medicare patients in my practice in

Louisville, Texas, because my mother told me I had to, and it made it very simple to follow that rule.

Dr. Goodman, Dr. Wolfe testified just a moment ago that, in Canada, the doctor-patient relationship is enhanced by having a single-payer system. Is that your opinion also?

Mr. Goodman. No. No. No, it is not. I think in general third-party payment undermines the doctor-patient relationship, and that the ideal relationship is for the patient to control the dollars, and that is why I have advocated for many years the health savings account. I would like to see patients control a third or fourth of all the dollars. And for chronic patients, they can control even more than that.

And we are doing this in Medicaid, by the way. We have a cash and counseling pilot program under way in more than half the States where the Medicaid homebound disabled control their dollars. They can hire and fire the people who provide them with services. There is 98 percent satisfaction. Well, there isn't any health care system in the world where you get 98 percent satisfaction.

So we know that health care can be more satisfying, and we can meet the needs of patients in a better way if we reduce the role of the third-party payer, whether it is government or private.

Dr. Burgess. And I actually agree with that as well, and I have often wondered why we don't construct a system where it is

possible for an individual to have more of a longitudinal relationship with their insurance company. If an insurance company or a Medicare system is a necessary evil, why would we not construct one where there is some sensitivity to the purchaser on the part of the seller just like there would be in any other transaction?

We heard just a moment ago from the gentleman from New York about there being a policy versus a political question. I also wonder if the back door into the policy that is desired, which may be a single-payer system, is to not involve ourselves in political incrementalism at this point in order to achieve that desired goal.

Dr. Wolfe, I wonder, do you see that as being part of the trajectory or part of the desired outcome of the -- I realize it is not a bill, but the draft that we have in front of us this afternoon?

Dr. Wolfe. I think I alluded a little bit to this earlier, but I think that we now have essentially 44 years since the last health insurance was passed, Medicare and Medicaid. And many people hoped, and I think sincerely, that somehow during the 44 years we would incrementally be able to cover more people with health insurance, and it just hasn't happened. I mean, we have the same insurance companies, some new ones that are more HMOs and so forth than there were back then, but I think the incrementalism just hasn't worked, and particularly compounded by the economic

problems of the last year or two, things are getting tougher and tougher. I would expect that the number of uninsured will rapidly go over 50 million, it is close to that now, if we had numbers from 2009.

So I don't see -- back to your question directly. I don't see anything in this draft bill, as we are correctly talking, it is a draft bill. It is. And there is a lot of distance between here and, if anything -- I say "if anything" seriously -- is going to come to the floor. But I don't think there is anything that is in the draft bill that, to me, could be rationally viewed as a stalking horse as a way towards a single-payer. If anything, one could argue that it is away from a single-payer. Because if it is changed and comes to the floor with some form of a public partnership with the private, it is going to be so bad that, if anything, it will move away from the single-payer rather than towards it.

Dr. Burgess. Like Ranking Member Deal, I do agree on that last point.

Let me just ask you a question, because my time is going to run out. There has been some allusions to Canada versus the United States. My understanding, correct me if I am wrong, the Canadian system, their health care system, is on a budget. Their Parliament passes a budget every year, just as we do, and their health care expenses are going to be budgeted. Ours, in this country, we have the largest single-payer system in the world. It

is called Medicare and Medicaid. We don't budget for that; we just simply say, send us your bills, and we are going to pay them, and we will draw down the Federal Treasury or expand the deficit in order to do that.

Do you think we should look more at Canada's budgetary system as a way to controlling some of our costs in our public system, in our Medicare and Medicaid system?

Dr. Wolfe. Well, one of the advantages of having a single-payer, single-insurer collector of money is that you can more easily do what is called in Canada global budgeting. So for a given hospital, for instance, instead of counting every --

Dr. Burgess. But you have already got 50 percent.

Dr. Wolfe. But I am saying they are not doing it.

Mr. Pallone. Can I just ask Dr. Wolfe to answer the question, because the time has expired.

Dr. Wolfe. The answer to the question is in Canada global budgeting is a good idea. We could benefit from it here. I don't think that Medicare has been run as efficiently as it could be. The administrative costs are certainly low, and there have been some forms of price control on everything other than prescription drugs. So I think we could learn from that. But Medicare has now been around for 44 years, and, if anything, for a bunch of reasons it is getting worse than it was at the beginning. So we need to go back to some of the original principles of Medicare.

Dr. Burgess. Some of our distributional issues would become

greater, though, with a budgetary constriction.

Mr. Pallone. Dr. Burgess, you are a minute over. You can't ask any more questions. We have got to move on. Thank you.

Let me thank all of you. We appreciate it, and I think it was a good discussion. I am sorry that you were interrupted so long with the votes.

Mr. Pallone. Let us ask the next panel to come forward, please. This panel is on State, local, and tribal views. I ask our panelists to be seated.

Now, let me just warn everyone that you are seated out of order, so I am not going to ask anybody to change, but I am going to call Members to speak on the order that I have here. So let me introduce everyone.

First is Honorable Michael Leavitt, who is former Secretary of U.S. Department of Health and Human Services. Thank you for being with us. I know you can't stay the whole time, but that is fine. We have you first.

Second is my good friend, the Honorable Joseph Vitale, who is chairman of the Committee on Health, Human Services and Senior Citizens of the New Jersey State Senate, who his district is in my congressional district, and he has been here before, and we appreciate your coming today as Senator Vitale.

Then I have W. Ron Allen, who is the chairman of the Jamestown S'Klallam Tribe.

And then we have the Honorable Jay Webber, who is a State assemblyman from my State of New Jersey. Welcome.

And then is Dr. Raymond S. Scheppach, who is the executive director of the National Governors Association.

Then we have Robert S. Freeman, who is deputy executive director of CenCal Health, California Association of Health

Insuring Organizations.

And finally is Ron Pollack, who is executive director of Families USA, again, a frequent visitor to this subcommittee.

So we will start with the Secretary Leavitt. Thank you for being here.

Let me mention again, I think you have probably heard it enough times, but 5 minutes. We ask you to speak for 5 minutes. Keep it to that. Your written testimony will become part of the record. And, of course, after you are finished, we will have questions from the panel.

Secretary Leavitt.

STATEMENTS OF MICHAEL O. LEAVITT, FORMER SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOSEPH VITALE, CHAIRMAN, COMMITTEE ON HEALTH, HUMAN SERVICES, AND SENIOR CITIZENS, NEW JERSEY STATE SENATE; W. RON ALLEN, CHAIRMAN, JAMESTOWN S'KLALLAM TRIBE; JAY WEBBER, STATE ASSEMBLY, STATE OF NEW JERSEY; RAYMOND C. SCHEPPACH, PH.D., EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION; ROBERT S. FREEMAN, DEPUTY EXECUTIVE DIRECTOR, CENCAL HEALTH, CALIFORNIA ASSOCIATION OF HEALTH INSURING ORGANIZATIONS; AND RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

STATEMENT OF MICHAEL O. LEAVITT

Mr. Leavitt. Thank you, Mr. Chairman. And thank you for your acknowledgement of my inability to stay the whole time. But I am pleased to be here.

My formal statement, I will summarize it by saying I have listed 10 things in this draft that I believe could be unifying principles, I have listed 10 things that I believe are serious problems, and 10 ways I think those could be resolved. So the committee will have access to that. And to the extent that you have questions for me, I would be happy to respond to them either in writing or later publicly.

I was intrigued, however, by conversation in the earlier panel, and I would like to take my time to respond to the question

of Medicare's efficiency. I suspect I am the only, or at least one of the only, people in this room who has actually overseen Medicare, and I would like to answer the question as to its relative efficiency, if I could.

If the question is does Medicare issue checks on a more efficient basis than anyone else, I think it is important to answer that: Yes, Medicare issues checks more efficiently than anyone else on the planet. And we should, because Medicare issues about 1 billion of them a year.

The problem isn't its administrative efficiency. The problem is what it pays and how it pays it.

Medicare has three fundamental problems, in my assessment. The first I call silo syndrome. Silo syndrome is a function that everything is paid without coordination. So it isn't how efficiently it pays; it is the fact that it pays the wrong things and pays too many things, and does not require any level of coordination.

If we were to impose on, say, the automobile industry the process of finance in the health care industry, you would walk into a car dealership and you would say, I want to buy a car. The dealer would say, we can see you do. Pick one out, and we will send you the bills later. And a few months later or weeks later, you would get one from the chassis maker, you would get one from the tire manufacturer, you would get one from the dashboard people, one from the windshield, and one from the dealer. And the

dealer would say, you were in the showroom for a while, then you went to the salesman's office, and then there was that $21.97 cup of coffee you thought you were getting because you thought you were thirsty.

The point is that if there was a steering wheel that was $800, the manufacturer of the car under the current system would say, we can't afford that because we have got to deliver it for $23,000.

In the health care system, if the crutch's provider in a knee operation says, we want $400 for the crutches, we just provide it. There is no coordination.

So it is not the fact that we are able to issue checks efficiently; it is that all of the care is siloed and uncoordinated, and that runs up the costs. So what might look like efficiency, I would suggest to you, is not.

The second problem with Medicare is that it has what I call chronic more. Everything is oriented to more.

And the third point I would say is that it is quality indifferent.

So it isn't efficient because it can issue more checks than anyone on the planet. It is inefficient because it is siloed, because it is quality indifferent, and because every incentive leads to more. And I suspect you will see that reflected in my testimony as to why I oppose and why I hope our country will not go to a public option plan. For us to adopt a system that has

moved our country financially toward what I believe will be its most devastating financial crisis and then put more people in it is like suggesting that we are going to cure obesity with a perpetual regimen of double calories.

That is not the solution, and I have listed in my testimony a series of suggestions on how I believe this bill could be unifying, how the bill could be become a bipartisan proposal, and I am very hopeful that that can occur. This country badly needs for every American to have access to insurance. We desperately need to reform the system. And I hope very much that this will be a moment where we can do so on a bipartisan basis. Thank you.

Mr. Pallone. Thank you, Mr. Secretary.

[The information follows:]

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

Mr. Pallone. Senator Vitale.

STATEMENT OF JOSEPH VITALE

Mr. Vitale. Thank you, Chairman Pallone and members of the committee. I am Joe Vitale. I chair the Senate Health Committee in New Jersey, and pleased to be here again. I was here a couple years ago when we were debating the reauthorization of SCHIP and what it meant to my State and to the millions of parents and children who we are now blessed to cover under that program.

I wanted to highlight some of the sentinel points of New Jersey's journey toward health care reform as well as my personal view as a State legislator, a leader in health care reform, and as a small business owner as well, to discuss the access to affordable and dependable health care for not just the 1.3 million uninsured New Jerseyans, but the remaining 45-some million Americans.

New Jersey has learned many lessons as we grappled with the complexity of reform over the past several years. Our State's reform efforts will benefit the proposals being discussed here in Washington now.

When SCHIP was first adopted in 1998, New Jersey initially offered enrollment for children whose family income did not exceed 200 percent of the Federal poverty level. Shortly thereafter, we

increased eligibility to 350 percent of Federal poverty for those kids, recognizing that we needed to do more, that New Jersey was an expensive place to be low-income, and we needed to get those kids insured because the parents couldn't afford the insurance on their own or through their employer.

In addition to expanding affordable access to kids, we also began to welcome parents into our program through a waiver by CMS whose families' income did not exceed 150 percent of the Federal poverty level. These legislative initiatives became the foundation upon which we in New Jersey have begun to build a framework for providing universal, portable, affordable, and sustainable health care access to New Jersey's remaining 1.3 million uninsured.

Our efforts began nearly 3 years ago with the formation of a working group comprised of 22 policy experts representing a wide variety of experience and professional background. I believed then, as I do today, that New Jersey could not have enacted our most recent reforms without taking the necessary time to painstakingly understand the complexity of reform's impact on the diverse group of stakeholders health care encompasses.

Our working group met for 2-1/2 hours every week, worked on a daily basis with staff to process the input from those sessions, and traveled the country from San Francisco to Chicago to Washington to meet with other States actively reforming their systems. We shared the reform efforts each of us were undertaking

and met with national policy groups with expertise in health care access, quality, cost modeling, efficiency, and insurance reform. It was through those efforts that we were able to offer a thorough and well-planned legislative proposal that enjoyed overwhelming bipartisan support approval moving from announcement to passage into our law in a short 4 months.

Our most recent initiative accomplished much. It increased eligibility for more working parents whose income did not exceed 200 percent of the Federal poverty level. We established a buy-in program for children whose families' income exceeded our SCHIP cap of 350. This program was created after negotiating with two of our State's leading health plans, who agreed to offer an excellent benefit design at a very low price. This program does not use any State or Federal dollars.

We implemented a kids first mandate that required all eligible children to enroll in either a free or very low-cost health insurance program in our State. It required the Department of Treasury to include a check-off on all State income taxes, tax returns that seeks information on filers regarding the health insurance status of household dependents. This provision enabled New Jersey to be the first State in the Nation to utilize the express enrollment process approved here in Washington and CHIPRA. It also directed our State Department of Human Services to design a cost-effective and thorough enrollment outreach program, and to design a minimum hardship exclusion or premium hardship exclusion

that does not allow an enrollee to jump out of coverage, that provides for an income set-aside that can lower their premium to an affordable level, but also maintains them in coverage and not out of coverage.

It also instituted a number of reforms so individuals or employer market that made those policies more affordable will dedicate a larger percentage of collected premiums to the actual provision of care.

I am proud of what we have accomplished in New Jersey. We have been one of the most progressive States in offering expanded access to hundreds of thousands of children and working parents, and we are currently well on our way toward comprehensive and transformational reform. But, as you know all too well, States can only do so much. We have limited finances. We have limited political will. And with States having different programs at different levels for children and for parents in some States, it becomes just undependable and unreliable.

We in New Jersey, though we are proud of the work we have done and the great steps and strides we have made to insure hundreds of thousands of kids and many parents in our State, we need the Federal Government. We need your leadership and the leadership of your colleagues and the President to make sure that the remaining 1.3 million who are uninsured today and those who will become uninsured have access to the same kind of health care that we all enjoy; that they will have the same kind of card that

we all have. And, in some cases, I know we all take for granted maybe the health care that we do have, but for them, they wake up every day with the fear that they will get sick, their kids will get sick, they won't have the ability to pay. And a national program that brings together in a large group those millions of Americans who need our help is well justified and well needed. And I want to thank you for the effort.

Mr. Pallone. Thank you, Senator.

[The prepared statement of Mr. Vitale follows:]

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

Mr. Pallone. And thank you for waiting, all of you, actually. I know you have been here since early this morning. So I appreciate it.

Next is Mr. Allen.

STATEMENT OF W. RON ALLEN

Mr. Allen. Thank you, Mr. Chairman. My name is Ron Allen. I am the Chair and CEO for the Jamestown S'Klallam Tribe located up in Northwest Washington. And I am also an officer at the National Congress of American Indians. And my testimony presented to you and the committee is on behalf of our organization that represents and advocates for all Indian Nations from Alaska to Florida, representing over 560 Indian Nations and communities and 4 million people.

As I listened to the dialogue all day today, we find it interesting. When we talk about the unmet needs of health care, no one knows that more than Indian Country. I was listening to some interesting comments this morning about how America is high represented in cancer recovery rates and diabetes recovery rates, et cetera. Well, in Indian Country we have the highest level of cancer rates and deaths and diabetes crisis, tuberculosis exposure, et cetera, than any other ethnic group or any other sector of our society. And it reflects the incredible unmet needs

in our Indian communities.

But what we do believe is that this initiative that is being advanced by the Congress and by the administration is an important one. We agree that the idea of addressing and reducing costs and providing competent care and affordability and quality is something we all look forward to, and that the Indian tribes across America concur that that has to happen.

We want to remind the Congress, it seems like every time a key piece of legislation that emerges, that the tribal governments are a part of the American political family, and that we are governments, and that we are very unique in America as governments and as employers, as governments and our businesses that are important to the revenue generation for our essential services, including health care in our communities. And any legislation that is advanced to address a subject matter as this must include our government.

So we appreciate what is being advanced in all the different components of this proposed bill, but we do want to point out there is a number of issues that we are concerned about, and that we would urge you as the committee and as the Congress to consider these specific conditions that are essential for the services to be provided to the Indian communities because of our unique conditions and how services are provided to the American Indian, Alaskan Native peoples across the Nation.

We need the legislation to exempt American Indians and

Alaskan Natives from mandates and penalties. We need this legislation to exempt tribal governments from the employee-employer penalties. It is essential that the American Indians, Alaskan Natives should be eligible for those insurance subsidies, and that the portability component is also essential for our people as well. It explicitly states that the Indian Health Service and the tribes are essential community providers so that is clear that that is how the services are being provided.

And another key component that we are concerned about is making sure that it is clear that the health care services that are provided to the Indian people, that they are exempt as income. The IRS wants to identify these resources as taxable income, and for the Indian communities we have paid for it. They are reflected in our treaties and the commitments of this Nation. This Nation is great because of the commitment of the Indian communities across the Nation, and so, therefore, that as prepaid health care, they should not be taxed for services that have been long overdue from this Nation to our communities.

So these aren't just a wish list. They are critically important to make it effective to fulfill what we believe is the unmet need for our communities consistent with a lot of sectors of America.

The Health Care Improvement Act is important, and it does need to be passed and addressed, but it is not -- this does not replace that bill, that legislation, that is fundamental for

Indian Country and is so important for all of us.

There are many other points I could address, but I think that I have highlighted the main issues. Our testimony has identified a long list of issues and recommendations that we have made to you, and we look forward to working with you, the committee members, the staff, and the President, on making this happen to raise the level of health care for all people, including American Indians and Alaskan Natives.

Thank you, Mr. Chair.

Mr. Pallone. Thank you, Mr. Allen.

[The information follows:]

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

Mr. Pallone. Next is Assemblyman Webber. Thank you for being here as well.

STATEMENT OF JAY WEBBER

Mr. Webber. Thank you, Chairman. And I would like to thank the committee for the invitation.

My name is Jay Webber. I represent the 26th legislative district in the New Jersey State Assembly. I am here actually like Senator Vitale; I think we both take great pride in our State, but we have different views of the state of health care in our State. And one of the reasons that we are in such desperate need of reform in New Jersey is some of the things that we have done in the past.

My message to the committee, if I can leave one, is please don't do to the Nation what New Jersey has done to itself. We embarked on a series of reforms in 1992 with the intent of improving access to health care and health care insurance for our citizens. Many of the policies we put in place have been discussed already in the committee today, things like guaranteed issue, community rating. There were a series of mandated coverages that have continued to be piled on. And even as recently as this year, the legislature and the Governor raised the minimum loss ratios for insurance companies in our small-employer

and individual markets.

These reforms, so-called, have created what I would call a toxic mix for destroying the health insurance market in the State. Actually, one commentator called New Jersey the poster child for how to destroy the health insurance market. And the results have been rather predictable: Costs for health insurance in New Jersey have skyrocketed to the point where today the average premium for families on the individual market is as much as twice the national average. Small employers find themselves not being able to afford to provide insurance to their employees anymore. And consumers have fewer choices as fewer insurance companies write policies in the State.

The reforms in 1992 did not result in a reduction in the number of uninsured. Quite the contrary. Whereas in 1992 we had 13.9 percent of our population uninsured, after these reforms the uninsured population stands today at about 15.8 percent.

I have a lot more statistics in my written testimony to the subcommittee, but there is one story I would like to relate to you. A constituent wrote in to me just after the bill that Senator Vitale discussed earlier -- just after that bill was passed. A man named Fred, he is a CPA, his wife is quite ill with a lot of doctors bills. Very content with his coverage that his employer was able to provide him, but after the bill that the senator discussed was passed, and the minimum loss ratios were put into place, the insurance company stopped writing insurance in New

Jersey, and Fred lost his insurance coverage. His employer could no longer afford to purchase it.

RPTS SMITH

DCMN MAGMER

[4:40 p.m.]

Mr. Webber. There are stories like that being played out across the State as our attempts to reform the system wind up doing more harm than good. There are solutions that I advocate vigorously and many members of the legislature do advocate in New Jersey, the most prominent of which would be to allow New Jerseyans to purchase health insurance across State lines. Increasing competition and consumer choice will provide less expensive and higher quality health care to New Jerseyans. It will lower their premiums. And one study by University of Minnesota economists estimated that as many as 700,000 New Jerseyans would be able to afford to buy health insurance if they simply were allowed to purchase health insurance across State lines. That is 700,000 or almost 50 percent of the uninsured population in the State wiped off the uninsured rolls without spending a taxpayer dime. I think that is a significant reform that we should try.

There is great enthusiasm for that measure; and I have gotten unsolicited letters, e-mails all across the State, not just from constituents in my district, urging the legislature to go forward with it. I just think it is no longer acceptable to trap New Jerseyans in a State and in a system that they want to leave. We have New Jerseyans who are looking to purchase health insurance

out of State, would do it if they could, and insurers who would sell them insurance if they were allowed to come in and sell policies free of the underwriting rules and the coverage mandates that New Jersey puts on them, but we stand in their way with regulations and laws that block those transactions.

I discussed with a colleague of mine on the floor of the assembly why they opposed the Health Care Choice Act that I have sponsored in New Jersey, and the answer was quite simple, and it was rather disturbing. And the answer that I got was, we need their lives. We can't have New Jerseyans who would buy cheaper health insurance across State lines who might be uninsured today. We can't have them leaving the State because we want to do single payer, and we need their lives to subsidize the sicker and the older in the State.

I disagree with that approach; and it is disturbing to me that after -- you know, more than 20 years after Ronald Reagan went to the Brandenburg Gate and told the Soviet Union to tear down that wall in Berlin, that New Jersey continues to put up walls to trap its citizens in a system that is failing them and that they want to leave.

So if that is the enduring lesson that I can bring to you today, that is what I am trying to do. Again, I would respectfully request that the members of the committee and Congress not repeat the mistakes that New Jersey has made on a national level.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you, Assemblyman.

[The prepared statement of Mr. Webber follows:]

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

Mr. Pallone. Dr. Scheppach -- I had to ask how to pronounce it.

STATEMENT OF RAYMOND C. SCHEPPACH, PH.D.

Mr. Scheppach. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you today on behalf of the Nation's Governors.

I will very quickly focus on six issues, the first with respect to the insurance reforms.

Although we agree that the Federal Government probably should set the market rules with respect to guaranteed issue and renewability, we think the rate bands in the bill are too narrow. They should be broader so that States have the ability to go above those particular minimums.

We are also very concerned that a lot of the State insurance reform is being preempted essentially by the health choice administration in the bill. We think that States do a relatively good job of protecting consumers, but we think that the bill is going to add a lot of confusion with respect to who does regulation and who does enforcement. Is it the State, is it the Department of Labor, is it the independent agency or the Department of Human Services?

Finally, I think there is going to be a real challenge in

setting of market rules outside the exchange to be consistent with the ones in the exchange, because different rules would likely perpetuate the risk selection and fragmentation that exists in the marketplace today. With respect to the health insurance exchanges, it seems that the draft bill creates a super independent agency, the Health Choices Administration, to make just about every decision with respect to exchanges. There does not seem to be any clear advantage for States to design and administer the exchanges, and yet they have the expertise and capability and I think it is very important that the other subsidized population needs to be well coordinated with Medicaid.

The bottom line is, given the rigidity of the administrative rules here, I question at this time whether a substantial number of States would actually opt in to the system.

With respect to the Medicaid expansion, while governors differ somewhat on the Medicaid expansion, my sense is that they would question the necessity of increasing the eligibility of childless adults and parents over 100 percent of poverty. It seems that these individuals could be made directly eligible for the other subsidy and receive their benefits through the exchange.

Governors do, however, very much appreciate the fact that the committee is willing to have the Federal Government pay 100 percent of the expansion. The phased-in mandate to increase reimbursement rates for primary care physicians give States pause, but we do realize that it is a very, very small percentage of the

total reimbursement rate.

Governors do support the choice for individuals to move out of Medicaid into the exchange. However, we would not support requiring States to provide the wraparound benefit. This would also include the CHIP population. The problem is that the wraparound benefit is administratively difficult, and maintaining the additional benefits may weaken the negotiating power of the exchange in receiving the most competitive prices.

With respect to the dual eligibles, there is a number of provisions in the bill that we do think strengthen the integration of the dual eligibles, so governors are generally supportive of those provisions. And, also, with respect to the drug benefit rebates and a number of the provisions there, governors support that as well.

Just one final comment on the transition, that if and when this bill passes it is going to be a huge implementation role for States and others; and, therefore, I think that the bill should include specific provisions about some up-front money for States to build capacity to implement as well as certain certifications when the insurance reforms are done and what other components are willing to be administered.

Clearly, you have got to coordinate the individual mandate, the other subsidized population, as well as the employer mandate in the bill.

Thank you for the opportunity to testify. I look forward to

working with the committee as you move the bill forward.

Mr. Pallone. Thank you.

[The prepared statement of Mr. Scheppach follows:]

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

Mr. Pallone. Mr. Freeman.

STATEMENT OF ROBERT S. FREEMAN

Mr. Freeman. Mr. Chairman, members of the committee, my name is Robert Freeman; and I am here to represent five publicly run health plans that administer the Medicaid, SCHIP, and other programs for low-income individuals. We currently serve 9 and soon to be 11 California counties, and our group is the California Association of Health Insuring Organizations.

Today, I hope to provide a local perspective of what is currently being accomplished by our publicly sponsored health plans in California. I do so in the hopes that it may serve this committee as it addresses the massive task of national health care reform.

I would like to briefly describe how our health plans operate. I hope that it will further discussion by policy makers in relation to the health care delivery administration at the local level as opposed -- I mean, in addition to the State and national level.

County organized health systems are one of two public plan models in California, and we have been in existence for over 25 years. My plan, CenCal Health, was the first, beginning operations in 1983. Since that time, four other county organized

health systems have been established in California and one in Minnesota. These five plans have built on their success and will soon be effectively providing access to high-quality health care to over 880,000 individuals. That is larger than 25 State Medicaid programs.

Our governing boards consist of local government officials, physicians, hospital administrators, plan members and other health providers. We are independent of county government and function as a business. Although we are public entities, we have no guarantee of perpetuity so, like a business, if we don't do our jobs well, we can go away. We also operate full-risk contracts with the State of California, necessitating efficiency and innovation.

We are cost-effective. In relation to CenCal Health, 92 cents out of every dollar goes to the direct provision of health care services.

Further, the California legislative analysts, which is similar to the Congressional Budget Office, has stated that county organized health systems annually save the State of California $150 million over what it was would otherwise spend on its Medicaid program. As public entities, all governing board meetings are public, and board decisions are made in an open and transparent environment.

Our plans also have broad-based provider networks. We found the policy of broad-based provider networks to be very effective

in both providing member choice and building community support.

Speaking of my own plan, we have approximately 90,000 members and have 289 primary care physicians, 1,200 specialists, 9 hospitals, and 113 pharmacies who serve our population in two counties.

We also believe that our broad-based provider policies have contributed to the high quality of care we provide to our members. The State of California has a series of indicators that annually measures to assess access to care and quality of care levels, mostly preventive. County organized health systems are consistently high performers in relation to these measures. We also score well in biannual consumer satisfaction surveys.

With this in mind, we believe that the public health plan concept currently works at the local level in relation to our plans. Further, in relation to the SCHIP program in California, public plans compete with private plans effectively and fairly, with neither private nor public model working from a disadvantage.

In the areas of Medicaid expansion and creating vehicles who serve currently uninsured, we are in favor of both concepts. Expanding the Medicaid programs is an existing means to provide health coverage to currently uninsured individuals. The infrastructure to provide the care already exists, as do significant State and Federal standards, requirements, and regulations to protect members, providers, and others.

The health insurance exchange concept outlined in the draft

legislation seeks to create a fair and reasonable means of providing access to care and quality of care and choice. We do suggest that extra care be given to ensure the development of a health exchange will do no harm to existing health care programs and safety nets in our communities that currently work well. Our association believes the transparency provisions in the draft legislation are essential to build and maintain public trust in the delivery system.

I will conclude my remarks by requesting the committee to take a good look at local delivery of health care options in relation to national health care reform. We believe including such a local component would promote community involvement, investment, and enthusiasm in national health care delivery as all health care delivery is local.

Thank you for your time.

Mr. Pallone. Thank you, Mr. Freeman.

[The prepared statement of Mr. Freeman follows:]

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

Mr. Pallone. Mr. Pollack.

STATEMENT OF RON POLLACK

Mr. Pollack. Thank you, Mr. Chairman. Thank you and members of the committee for your prodigious patience. Very much appreciated.

I want to thank you for the draft bill that has been offered. We think it goes in the right direction for a number of reasons. I was asked by the staff to focus my remarks on the changes with respect to the Medicaid program, and so I will focus my comments on that.

As you know, Medicaid provides coverage today for almost 60 million low-income people, approximately half of whom are children; and we think that Medicaid is the right vehicle to provide coverage for the poor. Medicaid provides certain things that simply don't exist today in the private marketplace that I think are absolutely critical for low-income populations.

A recent article in Health Affairs pinpointed how important it is to provide cost-sharing protections for low-income people; and if they don't have those cost-sharing protections, it means they are unlikely to get the services that they need.

Well, Medicaid rises to that challenge. Medicaid does not require premiums or enrollment fees. Copayments for individual

services are limited normally to nominal amounts. Certain kinds of services are exempt from cost sharing, things like preventive care for children, emergency services, pregnancy related services; and certain populations also are exempted from cost sharing: foster children, hospice patients, women in Medicaid, breast or cervical programs. These are very important protections that simply do not exist in the private sector.

But, over and above that, Medicaid provides certain kinds of services. For example, for children, early and periodic screening, diagnosis, and treatment was very important so that children get preventive care and any diagnosis that shows that something needs to be taken care of does get treated. Transportation is provided to doctors' offices for appointments and to community health centers. There are appeals rights that are very important that do not exist in any similar robust fashion in the private sector.

There aren't insurance market problems like you have in the private sector, kinds of problems that would be corrected over time with the bill that you have introduced.

Medicaid provides good health outcomes. As the Kaiser Commission on Medicaid and the Uninsured reported in May of this year, those in Medicaid are less likely to lack a usual source of care. Obviously, that is true, compared to the uninsured, but it is also true compared to those with private insurance. They are more likely to have a doctor's appointment in the last year. They

do not have an unmet health need with the same frequency as those who are uninsured and those that have private insurance. Low-income women are more likely to have a pap test in the past 2 years.

So Medicaid does provide very significant services for this important population, and it does so while costing approximately 20 percent less to cover people in Medicaid than it would cost if they purchased coverage in the private market.

Now, building on Medicaid and strengthening the eligibility standards is something that I believe is close to consensus agreement. There was huge support for this from the various stakeholders: American health insurance plans, Blue Cross/Blue Shield, American Medical Association, American Hospital Association, AARP, NFIB, Chamber of Commerce, Business Roundtable. We all reached agreement about the importance of doing this.

And one of your favored colleagues of the past, Billy Tauzin, and we at Families USA have agreed that it is very important to extend eligibility, as this draft bill does, to 133 percent of the Federal poverty level.

So I want to concentrate on why I think that measure is so important. We have huge differences today between different populations, children, their parents, and other adults who do not have dependent children. For children, due to the confluence of the Children's Health Insurance Program and Medicaid, in almost every State children are eligible for coverage if their income

standards are below, family standard is below 200 percent of poverty. And in some States, as you know, Mr. Chairman, some States have exceeded that.

However, for parents, in only 16 States and the District of Columbia does the eligibility standard even reach the Federal poverty level, which, mind you, for a family of three is only $18,310. Indeed, the median income eligibility standard among the 50 States, as you will see in the chart at the end of my testimony, is only 67 percent of the Federal poverty level, roughly $12,300 for a family of three.

Mr. Pallone. Mr. Pollack, you are a minute over. If you could summarize.

Mr. Pollack. I apologize. I would just say I think this would be very helpful if we did extend eligibility, irrespective of family status; and I am glad that the committee appears to want to go in that direction and pay for those costs. Thank you.

Mr. Pallone. Thank you.

[The prepared statement of Mr. Pollack follows:]

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

Mr. Pallone. I want to thank all of the panelists.

Now we are going to go to questions, and we are going to start with Ms. Schakowsky.

Ms. Schakowsky. I appreciate your beginning with me, Mr. Chairman. I really have just one question.

Mr. Freeman, I wanted to, first of all, thank you for flying from California to testify this evening. And I really want to thank all of you. I was in the State legislature in 1993 and testified at a very similar panel about what the State of Illinois was doing. So it is a little bit deja vu for me too.

I want to congratulate your county and the other California counties that operate health plans and for providing a public option for families enrolled in Medicaid and the CHIP program.

I wanted to ask you about a provision in the discussion draft that is intended to reduce waste and increase value for Medicaid taxpayers, for the taxpayer dollars that your State and the Federal Government is paying. The provision would require that all Medicaid-managed care plans have a medical loss ratio of at least 85 percent. You have already testified that your plan's medical loss ratio is a pretty remarkable 92 percent. So I think everybody understands that that means -- 85 percent, it would mean that of every Medicaid dollar that is paid to the plan, at least 85 cents are used to pay for health care services furnished by hospitals and doctors and other providers. No more than 15 cents

on the dollar could be used for marketing administration or, in the case of private, for-profit plans, payouts to shareholders.

So do you believe that it is reasonable for taxpayers to expect that any well-managed plan, whether public or private, have a medical loss ratio of at least 85 percent? We have heard from some that that is somehow unreasonable, so I would like to hear what you say about that.

Mr. Freeman. Well, I will just respond from our own experience.

First of all, the California CHIP program has that requirement. So every plan --

Ms. Schakowsky. Same requirement?

Mr. Freeman. Yes, same requirement. And as for our plan and our sister plans, none of our plans have had an issue of meeting that requirement on a consolidated basis. It has never been an issue for us.

Ms. Schakowsky. You looked like you wanted to say something. Do you have that at all? Do you have a requirement on loss ratio?

Mr. Vitale. Yes, thank you, Congresswoman. We just changed our medical loss ratio in New Jersey from 75/25 to 80/20, which means that more money will be directed toward providers and the care that they provide to reimbursement with regard to doctors and hospitals.

It is something that works in our State. It hadn't been changed in years. So we took an incremental step. We had

discussed 85/15, but we settled at 80/20, which literally puts millions of dollars more into the providers' side of the equation and a little less money into the profit side of the insurance industry.

It did not cause any disruption in the insurance industry market. A couple of small companies closed and moved out, but that was unrelated to the 80/20 change. It is just that more money is now spent on the provider side, then less in the pockets.

Ms. Schakowsky. Does anyone else want to comment on that? Yes.

Mr. Webber. I just take a very different view from Senator Vitale on the issue. And in fact, Guardian, which is a not a small provider, the representative was in my office last week saying the 80 percent loss ratio made us leave the State. They simply couldn't be profitable in New Jersey after the loss ratio went to 80 percent.

And that is actually what caused the constituent that I referred to during my testimony to lose his coverage. The insurance company told him flat out that because New Jersey is going to impose an 80 percent loss ratio and because they are going to make us write in the individual market, which is not profitable for insurers in the State, we are going to pull out of New Jersey and you are going to lose your coverage.

So there is a difference of opinion from the legislators in New Jersey as to whether this 80 percent loss ratio is a good

thing.

Mr. Scheppach. The only comment I would make is that we are dealing with three separate populations in Medicaid. You have got the women and children, you have got the disabled, and you have got the long-term care. I am just saying that the mix there, because the disabled and long-term care are more intensive in terms of managing, if it is done correctly, integrating the services. So States that have an unusual percentage of that might have more difficulty meeting that than other States.

Mr. Vitale. I just wanted to follow up on my colleague's response to you. I appreciate your years in the State legislature and understanding the nuances of that business.

When I spoke with the Department of Banking and Insurance and I learned that Guardian and a small company left, their letter to the Department had nothing to do with the MLR, with the medical loss ratio. In fact, it had to do with other reasons.

You know, there are -- most every -- well, actually, every insurance company who writes in New Jersey already has a higher MLR by practice. We put it -- we codified it into law. They don't.

There isn't one company that is going to leave that State. They are profitable. Some of it is difficult, just like any other business. But for those who are in that State, whether it is Horizon or it is Blue or it is anyone else, they are doing just fine. They would always like more.

And when a lobbyist or a representative from an insurance company will come to my office and complain to me that they are going to make less this year, well, that is just what they do. They will want to put the fear into any legislator that, if something changes, if the dynamic in the insurance industry changes, if they are made to pay more to providers and put less in their pocket, then the sky is going to fall and the world will end for them; and none of that has happened.

Ms. Schakowsky. Thank you very much.

Mr. Pallone. The gentleman from Georgia, Mr. Gingrey.

Dr. Gingrey. Mr. Chairman, I am not quite ready. If you could come back to me, or if I am the only one I will get ready.

Mr. Pallone. Sure.

Mr. Shadegg, do you have questions?

Mr. Shadegg. I do, Mr. Chairman. Thank you very much. I would like to ask each of the witnesses a set of three brief questions. I would like just a quick answer to them, if I could.

First would be, do you have a copy of the tri-committee discussion draft? Yes or no. When did you receive it, and have you had a chance to read the entire bill?

Mr. Allen, do you have a copy?

Mr. Allen. Yes, we do have a copy. We received it Friday. We have reviewed it as best we can over the weekend.

Mr. Shadegg. I understand the "we". I like the pronoun. Have you read the bill personally?

Mr. Allen. No, I have not.

Mr. Shadegg. Mr. Vitale?

Mr. Vitale. We have received a copy in our office, and we have not reviewed it yet. Thank you.

Mr. Webber. I have got an answer to only one of your questions, the first one. No.

Mr. Shadegg. You don't have a copy of the bill? You were not provided a copy of the bill?

Mr. Webber. No.

Mr. Shadegg. Okay. Doctor.

Mr. Scheppach. Yes, I have a copy of the bill. I received it Friday; and, yes, I have read the entire bill.

Mr. Shadegg. Thank you. You are the first.

Mr. Freeman.

Mr. Freeman. Yes, we received the bill. We received it Friday around noon California time. And I have read -- I think I am on Page 115.

Mr. Shadegg. Out of?

Mr. Freeman. 852.

Mr. Shadegg. Thank you.

Mr. Pollack.

Mr. Pollack. I did receive the bill on Friday. I have read portions of the bill. Our staff has read the entire bill.

Mr. Shadegg. Thank you very much.

Assemblyman Webber, I appreciate your testimony. I was able

to watch it from my office. I do appreciate your efforts on behalf of consumers; and I, as you know, share your interest in allowing the across State purchase of health insurance so that we could bring some competition to the market and bring down cost.

But I guess we are looking at a broader debate here. We are looking at the government becoming vastly more involved in the insurance sector and, quite frankly, getting the government or giving the government a much larger role kind of between patients and their doctors.

You made a plea in your testimony for not -- for the Congress not to do what has been done in New Jersey. I presume that is a reference to the 1992 legislation in New Jersey and also to guaranteed issue and community rating. Can you expand on that?

Mr. Webber. Well, again, the health insurance market is not healthy in New Jersey. In fact, it is very sick. We had at many as 28 insurers writing policies in the State back in the early '90s; and due to these reforms undercutting their ability to underwrite effectively and efficiently, mandating coverages, putting in minimum loss ratios that are not profitable, we are down to about only five companies that really write policies on the individual market to any great degree. So consumer choice has been virtually eliminated, certainly diminished in the State.

And, Congressman, I am eager to take on the challenge of health care reform at the State level; and we have talked about this many times, actually. If we had the opportunity to get at it

and allow New Jerseyans to get out of State and create a system in which they could really shop for policies that suit them, instead of the policies that the politicians in Trenton think are suitable for them, I think we would go a long way to making health care and the delivery of health care better in New Jersey, and then we can get at the rest of the uninsureds.

Mr. Shadegg. Mr. Pollack seems to be concerned, and I think justifiably so, about uninsured Americans, about those people who do not have health insurance coverage at all. If we provided everyone in New Jersey and indeed everyone in America who does not have insurance right now and who cannot afford to buy health insurance right now with a refundable tax credit, that is, cash from the Federal Government to go buy a health insurance policy of their own, do you believe that would take care of, number one, their health insurance needs? And, number two, would it benefit them to let them make those choices? Or is it better to put them in some form of, I guess, a Medicare program or a program like the tri-committee draft?

Mr. Webber. No, I think there is broad consensus that people want more control over their health care decisions. Certainly the refundable tax credit would help. But I have to tell you that, as I understand it, the range for a family would be around $5,000; and in New Jersey that is not even going to buy half of the average premium for a family. So New Jersey would need a little more reform.

If we had the opportunity, for example, to buy health insurance policies across State lines and got a tax credit to purchase that, then we could really start to eliminate the uninsureds from the rolls.

Mr. Shadegg. Many of us have advocated not only a refundable tax credit but the creation of more insurance pools, allowing more pooling mechanisms so people would have have more choices and obviously creating a level playing field in terms of taxes so people could buy health insurance on the same tax basis that a company can. Would you support those reforms? And do you think those would help the people of New Jersey?

Mr. Webber. Well, absolutely; and that is why I am eager for the States to get a shot at this and really take our cut, not in the way that New Jersey has tried it but in the way New Jersey can try it going forward. And association group plans like you are talking about, certainly, after health care choice and interstate purchase of health insurance, would be one of the top things we would want to do.

Mr. Shadegg. Thank you very much for your work in this area. And I think Mr. Chairman, I concluded my last question within the 5 minutes.

Mr. Pallone. And I certainly appreciate that.

Mrs. Capps, our Vice Chair.

Mrs. Capps. Thank you, Mr. Chairman; and I thank you all for your patience and your testimony today.

I particularly want to thank and welcome my constituent, Mr. Robert Freeman. The program that he described, CenCal, and the counties that I represent in Congress, I can attest to the fact that you, since its beginning, which I was a part of as a community member and also one who worked in public health nursing in the school districts, that it is very successful, very effective, and now has grown to include two counties and is part of, as you describe, the alternative ways of delivering Medicaid, which we know as MediCal, and Healthy Families in California.

Now, I want to give you a chance to expand further but ask you some -- two or three questions. One of the complaints that we are hearing from many who oppose a public plan option is that it would we weed out unfairly, they say, private competitors. Can you elaborate on how CenCal competes and does business alongside of private entities for the Healthy Families Program, which is how we term the SCHIP in California? Are there still private plans offering coverage? And how do you get along with one another?

Mr. Freeman. Thank you, Mrs. Capps.

Sure, in the California SCHIP program it is called Healthy Families. It is set up as a competitive model where they have the States divided into regions and in those regions counties where you would have multiple plans compete for the Healthy Families business, usually three or four health plans in a designated area. And in those areas where, like in Santa Barbara and San Luis Obispo counties where we are from, we are a public plan and we

compete with private insurers, as well as those other areas of the State that have public plans.

And in the 10 years that the Healthy Families Program has been going, the competition between the public and private models has been, we think, effective. It has been friendly. It has been, I think, successful in providing choice and in giving options for those subscribers as to which health plan they would like to join.

Recently, actually, we have had a couple of the private plans pull out of our area because -- I don't know their reasons. I am assuming the business situation changed. But -- so now we are one of only -- instead of four plans, we are one of two plans in both Santa Barbara and San Luis Obispo counties. And we do think one the advantages of our plan is because we are created by -- of the community, we can't exit the market place. We wouldn't. Our mission is to serve our service area.

But, in general, I think the competition has -- it has done as it was intended to do at the time.

Mrs. Capps. Actually, I described San Luis Obispo County where the number of private providers has dwindled in large part because of the lack of providers. It is a very rural area, and the reimbursement rate being so low, and that there really is a monopoly in the private sector. So this really is the only choice that families eligible for Healthy Families can choose.

My second question, does the county organized health system,

as you have experienced it, have bipartisan support both within our county and the State? It is not particularly seen as a partisan program, is it? Does it enjoy broad-based support, I am asking.

Mr. Freeman. It does. All of our plans enjoy, I think, bipartisan support at both the local and State level. I think anytime you have a public program that delivers what the policymakers intend it to do and is very watchful and efficient with taxpayer monies, I think that is something that either -- no matter what your party affiliation, that is good public policy. And our assemblymen and State senators and county supervisors of both parties and over time have been supportive, because they do see it is a community run plan where the community actually -- the health care community gets together to solve problems.

Mrs. Capps. And I know the State appreciates it, because you have saved a great deal of money and provide also very individualized services to your constituents.

Mr. Freeman. We do our best, and we think we have been successful.

Mrs. Capps. And you do have representation on your board, all of those sectors. I have talked with many of them.

Finally, can you tell us how you contract with providers, and especially with safety net providers in the community?

Mr. Freeman. Sure. Safety net providers make up -- first of all, we contract with all the safety net providers in our

community; and we consider that county clinics, community health clinics, all the hospitals. We have all the hospitals. And we also, which is fairly unique for a Medicaid plan, we do cover long-term care. So we contract with all the skilled nursing facilities. And we think that it has been -- it is very effective.

We know that -- it is important to us that these safety net providers stay healthy, because they do see a large portion of our membership. They are open at times when our members can get to them.

And we have also been very mindful that some of these, especially some of these skilled nursing facilities, really are watching every penny. So we do our best to make sure they get paid as quickly as possible; and at times in the past we have literally cut checks early so they can meet payroll and so forth, because it is in our interest for them to survive. They are part of our community, they are partners with us, and it is certainly in our interest to make sure they are as viable as possible.

Mrs. Capps. Thank you. Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Mr. Pitts.

Mr. Pitts. Thank you, Mr. Chairman.

I would like to thank the panel for your testimony, especially thank Assemblyman Webber for your comments.

I would like to ask you, Assemblyman, why does health care in

New Jersey cost so much? Is it because of the mandates?

Mr. Webber. There is a lot of things that drive the cost of insurance in New Jersey. Certainly, the underwriting rules, notice guaranteed issue, that is, the insurance companies have to take all comers, regardless of their health condition, and then the community rating that has been modified recently, that also drives up the cost of insurance for many.

There are other New Jersey specific reasons. I mean, it is an expensive place to live and work and provide the medical care as well.

But, in addition to those factors, we do have as many as 45 mandated coverages for everything from mammograms to cervical cancer to Wilms tumor and infertility treatments, and there is a series of mandated coverages that also drive up the cost.

Mr. Pitts. How has the price of health insurance increased since New Jersey enacted these mandates? Can you give us examples of the amounts of increases?

Mr. Webber. Well, it is difficult to pin down how much each mandate costs and increased the cost of insurance. But the estimate is that for every 1 percent of increase in the health insurance premium that mandates cause as many as 8,000 people in the State lose their health coverage because their employers can no longer afford to provide it for them or because they can no longer afford to purchase it themselves. So just in the last, I believe, 7 years we have had over 110,000 people in the State join

the uninsured rolls.

At the same time, we are putting in rules and mandates. We have mandated over 15 coverages in the last 7 or 8 years in the State. So we can continue to increase the costs even as people find it more and more unaffordable to purchase health insurance in New Jersey. And I just think that is backwards. We need to start looking for ways we can provide more efficiently health insurance to our constituents.

Mr. Pitts. In your testimony, you mention that your legislation maintains your State's core consumer protections. What are those protections?

Mr. Webber. The legislation would require out-of-State insurance companies to come in and be certified by the State Department of Banking and Insurance, the New Jersey DOBI. In order to do that, they would submit themselves to jurisdiction to be sued in the State of New Jersey; and if there were complaints or appeals, they would have to submit themselves to the jurisdiction of the Department of Banking and Insurance to rectify those problems.

So a New Jerseyan who would purchase, say, a policy from Colorado wouldn't be going to Boulder to fight with the insurance company. They could go to Trenton or the local Department of Banking and Insurance representative.

I think that strikes the right balance. It gives New Jerseyans the opportunity to purchase health insurance that meets

their needs in terms of the mandated coverages and the underwriting rules that might be written in another State, but it maintains protection for New Jersey consumers and allows them to deal with their insurance companies in their home State.

Mr. Pitts. And do you think that a public plan like the one in the discussion draft before us will lead to crowding out of the private insurance market?

Mr. Webber. Well, again, I haven't seen the bill. But I think, just intuitively, when there is a government plan available, subsidized by the taxpayers, without any real profit motive or incentive, there are going to be private companies who will dump their employees into what we call New Jersey Family Care, or whatever alternative government program is available, especially as those income levels rise for eligibility in New Jersey.

Now we have 350 percent of poverty. There are going to be employers who recognize that they can still have their employees covered by insurance and not have to pay for it themselves. I think intuitively, yes, they will start to crowd out private health insurance.

Mr. Pallone. The gentleman's time has expired.

I know the clock is a little weird there. I apologize for that. I am going to recognize myself for 5 minutes.

This discussion about the protections, if you will, it really goes to the heart of a lot of what we are dealing with in this

bill. I mean, I have to be honest with you. When I -- you know, Members from other States are constantly telling me that they want to make sure that, you know, that individuals can get insurance regardless of pre-existing conditions.

I mean, the proposal before us says that insurance companies can no longer be able to engage in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. They can no longer exclude coverage or treatments for pre-existing conditions. It limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors, I mean. It is a very important part of the discussion draft. And frankly, when I -- you know, I am proud of the fact that in New Jersey those kinds of discriminations are not allowed. Okay?

So the other thing you have to understand is that, you know, the Insurance Trade Association, AHIP I guess it is called, they have told us that they are willing to accept new regulations at the Federal level with limitations on their underwriting rating practices, no more pre-existing condition exclusion.

How is it -- and I have to get to three questions, so I am going to ask you first, Assemblyman Webber. How is it that the trade association thinks that we should include these provisions and you don't? What is the theory?

I mean, obviously, they think they can sell insurance nationally. They are suggesting that these New Jersey provisions

be put into the Federal legislation. Why are they advocating that?

Mr. Webber. Well, I can't speak for the insurance industry, for sure. And when there is a big hammer hanging over your head, I think insurance companies might be willing to compromise more than they otherwise would.

Let's say this. There are better ways to deal with people with pre-existing conditions and those we call the chronically uninsured or chronically uninsurable than to require guaranteed issue of all insurance policies.

Mr. Pallone. And I just don't have a lot of time, and I want to ask Senator Vitale. I mean, my fear is just the opposite, that if we don't include these provisions or, as you suggest in New Jersey, that we simply deregulate, it would have major consequences. I mean, I would ask Senator Vitale to respond that. I mean, this is a cornerstone of what we are trying to do is to not allow, you know, to have these protections at a Federal level. You have them at the State level. What happens if we don't have them?

Mr. Vitale. Well, it has been very meaningful for the consumers in New Jersey to have guaranteed issue, one of the few States that enjoys that provision. It guarantees that insurance companies shall write a policy and can't exclude someone because of pre-existing conditions. So, essentially, it is take all comers.

Imagine an environment in New Jersey, as bad it is in our State for those who are uninsured and every other State, for an insurance company to cherry-pick who it is that they would like to ensure. Will they decide not to insure women of child-bearing years because they are higher risk and they are going to be expensive?

Mr. Pallone. And gender is one of the things that has been used. Exactly.

Mr. Vitale. That is right. And will they decide not to insure an older New Jerseyan, a pre-Medicare New Jerseyan because he or she is at higher risk of anything, heart disease, kidney disease, cancer? The older you get, the sicker you get. It is a fact of life. Will they only want to insure children?

When you purchase insurance out of State without the safeguards provided in our State, they will only take those who are in good condition who are considered to be a good risk, leaving those in New Jersey who are considered to be a higher risk, women of child-bearing years, older men and women, out of the mix. And the way the insurance business works -- and I don't need to give you this lesson -- is it is about pooling risk with healthy lives and sick lives together and risky lives and less risky lives together and you come up with an average price.

Mr. Pallone. I don't mean -- I know I am going to have to cut you off. Regardless of the debate -- and I am going to move on to Mr. Allen and just make a comment here. Regardless of the

debate, though, about whether you think we should deregulate in New Jersey and people should go to other States -- I mean, the bottom line is that what the discussion draft would do would be to basically say that insurance companies would have to apply these rules federally across the country. And I mean, if the Insurance Trade Association says it is okay, I frankly don't understand why it wouldn't be.

But let me just go to Mr. Allen, very quickly, because I am concerned -- you know, I want you to comment, if you will. The discussion draft raises Medicaid eligibility levels to 133 percent of Federal poverty in every State. In addition, it makes available income-based subsidies for persons obtaining insurance coverage in the new health insurance exchange. I think these provisions are very important for Native Americans; and I just wanted you to comment on them, if you could.

Mr. Allen. Well, without a doubt. I spend a lot of energy on the Travel Advisory Council for CMS with regard to Medicaid rates. I can't tell you specifically, you know, because I am not the one who actually administers it with my tribe. But we can get back to you in terms of, is it enough? Is it going in the right direction? And I think it is. Off the top of my head, knowing what we have been trying to do with regard to the recovery rates for the tribes, that it will help us immensely.

Accessing Medicare and Medicaid has been real challenging for the tribes in terms of the policies they administer over there.

So it has been difficult for us, and we are looking forward to our new opportunities. I can say that if this bill incorporates some language in there that strengthens it and puts provisions in there that it improves our ability to, as providers, whether it is through the Indian Health Service or the tribal clinics and hospitals, then it is definitely going to improve our ability to raise the level of services to all of our people.

Mr. Pallone. I mean, we are trying. I mean, you probably know that the Indian Health Care Improvement Act, which you know is my bill, that I am the prime sponsor, is coming up in Resources tomorrow. We have been trying since the beginning of the year to incorporate a lot of the provisions of that, you know, in SCHIP and the stimulus and also protections in this health care reform or in Native Americans. And we will still try to move the other bill. But we do want to and we are really trying, as much as possible, to address some of the disparities that we know exist with Native Americans. I just wanted you to know that.

Mr. Allen. I would also like to inform you, Mr. Chair, that, you know, times are changing for tribes in terms of how we provide services. So our clinics and hospitals provide services to both Indian and nonIndian alike now. It has changed. Where in the old days where we just provided services to the tribal citizens; and now, because of the diversity of our communities and the communities around us where, like my community, the providers actually bailed out in the community, so we basically took on that

role. So we have a clinic right now where 95 percent of our patients are nonIndian.

Mr. Pallone. I appreciate that, and I know I went over. But I am just concerned that -- I want to make sure that the Native American concerns come out.

Mr. Gingrey.

Dr. Gingrey. Mr. Chairman, thank you for doing that.

Mr. Chairman, you were just, I think, asking Representative Vitale in regard to why, in the State of New Jersey, this situation where there would be guaranteed access, community rating, all of these mandates that make it untenable for many insurance companies to continue to do business in the State of New Jersey. And the chairman said, well, gee, you know, AHIP says it is okay, and they are buying into that across the country.

But I would suggest that they, as soon as we -- if we did this -- and I hope we do -- pull out the mandate that everybody has to have health insurance, the mandate that they have to do it, and employers also have to provide it, that would be at the point at which AHIP would say all of a sudden no longer are we going to accept community rating and universal mandated coverage.

So I will just throw that out there.

Let me ask a question of Representative Webber. Your State, as you said in your testimony, has had massive decrease in insurance carriers, I think from 28 in 1992 down to seven insurance carriers now in the individual health insurance market.

Do you think that a public plan like the one we are discussing in this draft before us, do you think it will lead to maybe some of these private carriers coming back into New Jersey or, rather, a further crowding out and lesser numbers participating?

Mr. Webber. Well, I can't see any of the private insurers coming back just because there is a public plan now being made available. You know, there will be fewer lives on the private insurance market. I would assume -- you know, bear in mind we might have seven companies writing policies, but if you are writing policies and charge $18,000 a year in premiums, you are really not intending to cover anyone. So we really have fewer than seven who are still writing policies seriously in the State. I don't think it is going to get any better anytime soon.

Dr. Gingrey. Let me ask your colleague from New Jersey, the Honorable -- is it Vitale? And I heard that -- in fact, it is right here in this document -- that New Jersey has in fact enrolled people earning as much as $295,000 a year in public coverage. Yet 23 percent of children below 200 percent the Federal poverty level are uninsured. How can that happen in the State of New Jersey?

Mr. Vitale. Well, let me -- I appreciate that question, but it is a question that has been asked and answered during budget hearings in New Jersey, of which I am a member, also. But it is a question that has a very simple answer, and the answer is that there were as many as three or four individuals who applied for

coverage in New Jersey who lied on their forms when they applied for New Jersey family care. And it was through the process of an audit that we discovered that lie. And it was corrected. In fact, I wrote additional legislation that required not only that people fill out more information on their form in terms of their income but that Treasury do a back check against their wages and the filing so we know exactly what they are earning in the year that they are claiming they want to be a member of the program.

So it was a matter of fraud on behalf of the three or four individuals that made big headlines. But -- and, unfortunately, tried to give a black eye to the hundreds of thousands of honest New Jerseyans and parents and children who are doing the right thing.

Dr. Gingrey. Reclaiming my time. I mean, I have got a sheet here of all the States and the average annual premiums in the individual market. In New Jersey, it is $5,300. And you go down to Wisconsin, it is $1,200. And I think we are getting some answers in regard to what the problem is in New Jersey.

Mr. Pollack, in the limited amount of time I have left, let me just ask you this. I know you have been involved in health care reform for a long time. You had a lot of things to say about Medicare Part D and government controlling prices and setting prices of drugs and things like that. But your organization is, you know, well respected, of course, and has a lot of opinions on all this.

Let me just ask you a quick question, though. Shouldn't we require States to ensure that low-income children are covered, let's say in the CHIP program, before opening up coverage to middle- and high-income families?

Now, I ask that question really in a way for my colleague, Representative Nathan Deal, who is the ranking member, as you know, on the Subcommittee on Health that has a bill to that effect, that had an amendment when we were working on the CHIP program to say that if we are going to expand it, let's at least assure that 95 percent of those who are intended in the original bill between 100 and 200 percent of the Federal poverty level that we cover them before going up to 300 and 350 percent. Your response.

Mr. Pollack. Well, Congressman, I don't think it is one or the other. The CHIP legislation, which the President signed in February, is designed to accomplish what you just described, namely, making sure that more children who have been eligible for CHIP actually enroll in the program, and the States are actually provided financial incentives in order to do that work.

Now, when you are talking about 200 percent of the Federal poverty level, remember, for a family of three, that is approximately 36, $37,000. The average cost of family health coverage today is approximately $13,000. So that is more than one-third of their income. And so if you go above 200 percent of poverty, you are helping people who otherwise could not afford to

provide coverage for their children.

And I don't think those two goals that you described are antithetical to one another. I think we can do and should do a much better job of getting kids enrolled who have been eligible and who are not in the program; and, at the same time, we should make coverage more affordable for those people who simply can't afford it, even though their incomes are above 200 percent of poverty.

Dr. Gingrey. I thank you.

Mr. Chairman, I know that my time has expired. I appreciate your patience on that. Thank you, Mr. Pollack.

Mr. Pallone. Thank you.

The gentlewoman from Florida, Ms. Castor.

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

Since we have some experts on local and State initiatives, I would like you all to address a concern I have. You know, all across America, local communities have stepped up to fill the void because they don't have anywhere else to turn.

For example, in my hometown in Tampa, Hillsborough County, we have, for the past 15 years, provided an initiative where if you do not have health insurance from any other place, if you don't qualify for Medicaid or Medicare, and you are a working family below about 200 percent of poverty, the county has created a partnership with local hospitals and community health centers so that these folks don't end up in the emergency room and county

government doesn't pay those very high costs out of property taxes, which everyone hates.

It is very successful, and it has created a robust primary care system of 12 clinics, and hospitals are reimbursed and the doctors there are reimbursed. And now, with our health reform initiative, it looks like we, the Feds, now will come in and we will cover the cost for the people that my community were covering. And that is great. That is going to be great for my taxpayers. But I hate the thought of losing this award-winning local clinic system of primary care system that we have.

And there are other communities across the country, I think -- Oakland, California, maybe, San Antonio, Texas, others, plenty of others -- that have these. How do we, in transition, ensure that these terrific initiatives on the local level survive?

Mr. Vitale. Well, I think the program in Tampa is wonderful, and it is programs like that in New Jersey that we are trying to emulate. We have called them collaborative care models. We are working with local hospitals who are in close proximity to federally qualified health centers and other clinics to transition the uninsured, or even the insured, who present in an emergency department with what is really non-emergent illnesses or injuries.

We are required, of course, to take all comers, but those who present at an emergency department really don't need to be there. So we are working with our local hospitals. So it is a great model.

I think the question, I hope, I think is, how are those providers, those caregivers, doctors and nurse practitioners and nurses reimbursed for the care they would provide?

Ms. Castor. So is it -- Dr. Scheppach, is it State leadership that needs to step in, because the States will have so much of the responsibility when we are talking about the 133 percent of poverty? It is going to be through Medicaid that they will be covered.

Mr. Scheppach. Yeah. I mean, there is a lot of programs now. Some States do programs with State-only dollars and a lot of the locals do. So there are those sort of tiered effects. This is probably going to be -- if this bill were to pass, it is going to be a transition, I suspect, of 4 to 5 years before you transition. And I think to some extent what States would do would be to work with communities to ensure that they are doing part of the eligibility. That is feeding in. Because all the problems in Medicaid and SCHIP, oddly enough, is finding these kids and getting them, in fact, enrolled. And I think we are going to have the same problem with the other subsidized populations.

RPTS JURA

DCMN HERZFELD

[5:39 p.m.]

Mr. Scheppach. What worries me very much about this bill, however, is that the entire sort of gateway or alliance is Federal. So now you are going to have the Federal Government in the middle of this doing insurance regulation for those qualified plans, and then you have got States outside that doing nonqualified plans. So I think the coordination problem is going to be greater going forward. I would worry about that.

Mr. Pollack. Congresswoman, your community is well known as doing something that is exceptional. Obviously so many communities across the country don't do that. And it is one thing to provide primary care as community health centers do. Often people who get primary care may have difficulty getting access to a specialist.

But your question and what Ray was just talking about, I think, tells us that, yes, there is going to be a transition, but it makes a whole lot more sense to put that lower-income population into Medicaid that exists rather than create the exchanges and overburden those exchanges which are going to have significant difficulty reaching out to larger portions of the population. Let us keep that lower-income population, at least for the time being, in Medicaid. Let us see how the exchanges function. But also, let us make sure that the protections that

now exist uniquely in Medicaid continue to be provided to that low-income population.

Mr. Freeman. If I could finish up and briefly add that, again, we think that all health delivery is local. And I think we also believe that the ability of local communities to address their own needs is very effective, and what has happened in your community is a perfect example.

And also, when you have the local delivery, you really do -- you do encourage physicians and hospitals and other health care providers to really talk to each other and work towards this common goal of how can we make the community that we all live in a better place for all of their citizens.

So we are big believers in really having whatever comes out of the Federal health care reform take a look at what is working at the local level and hopefully maintaining that.

Ms. Castor. Good. I look forward to working with you all on that.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Mr. Shimkus.

Mr. Shimkus. Thank you, Mr. Chairman. And I have got a couple points I want to try to drive, but I will try to be quick and pretty efficient.

Senator Vitale and Assemblyman Webber, when constituents have problems with the New Jersey program, do they call your offices?

So you have -- and that is probably not part of the calculations of the costs. We do the same thing. We have Medicare, Medicaid. We have, I have at least, one person full time to address those constituent concerns, and they are not easy, and they are bureaucratic. And I was just wondering, if we take on this as a national health care plan, guess what? We get it all, gang. We are going to get all the caseload calls. And that is why you guys support it, because then they won't be calling your offices. No.

Let me -- and just for the record, Medicare D is very successful. Medicare and Medicaid for the 60 years that it was here, still here, did not do what the private sector did, which was provide prescription drugs to people who had private insurance. You can't have modern medicine without prescription drugs. Although we have carried a system that didn't have it, and we fixed it, and we are under budget, provide better service, and the quality of service is high. And I think we can do that in this private sector debate, I really do, if we would just give it a chance.

Let me -- I want to go to Mr. Allen real quick. The Indian Health Service -- I don't have any Indian tribes, so I am not as familiar -- isn't it a one-payer system?

Mr. Allen. It is referred to as a payer of last resort, so it requires that the tribes tap the insurance system or the Medicare or Medicaid, and then if there is still a gap in providing services to the tribal citizen, then we access the IHS

monies.

Mr. Shimkus. Okay. Let me go to your encouragement to move people, I think, from the Indian Health Service to this insurance plan. I guess a better way to ask this is in your testimony, you do -- you want to exempt the mandates and penalties from the Indian tribes; is that correct?

Mr. Allen. Yes.

Mr. Shimkus. Why would you want to -- and we will have problems with that. I know there is tribal issues and sovereignty issues and stuff, but if we are going to do a one-size-fits-all arena, we are going to have to do a one-size-fits-all arena. I am not sure how we start exempting.

One of the -- and you want -- in your testimony you also talk about you want exemption from employer mandates that should be exempt even for the Indian tribes that have the benefit of the casinos and golf courses and tourism issues; is that correct?

Mr. Allen. Yes.

Mr. Shimkus. And you want that exemption also to employees of that facility that may not be American Indians?

Mr. Allen. Say again?

Mr. Shimkus. Say you have an employee at a casino that is not an American Indian.

Mr. Allen. Yes.

Mr. Shimkus. And you are pushing for some exemptions of the mandates for the insurance provided to them.

Mr. Allen. Yes. Our argument is that the tribal government, those businesses are under the umbrella of the tribal government, and as a tribal government, that it should be exempt.

Mr. Shimkus. I got it.

I have got one last question, and I want to try to be respectful of the time.

Senator Vitale, Assemblyman Webber, what is your FMAP percentage? Do you know? Do you know what FMAP is? Do you know what your percentage is?

Mr. Vitale. For those who are Medicaid and those childless adults covered in Medicaid are 33 percent of the Federal poverty level.

Mr. Shimkus. But what is our share? What is the Federal payment?

Mr. Vitale. Now, what is it --

Mr. Shimkus. I think you are 50 percent. Who is California? Freeman?

Mr. Freeman. I believe it is 50 percent.

Mr. Shimkus. What would you say if there are States that have higher FMAP rates? Would you say that is intrinsically unfair and un-American that this Federal Government would allow some States to get a higher Federal reimbursement for Medicaid versus others? Senator Vitale?

Mr. Vitale. Well, we are for --

Mr. Shimkus. I am just talking about fairness. We are all

citizens of the United States. The Medicaid is a Federal program, shared with the State. We do -- we have a ratio of what we are going to compensate. Would you say it is fair that some States pay less than other States?

Mr. Vitale. I would say that it is unfair that some States get less, and New Jersey is one of those States.

Mr. Shimkus. So I will take that as yes.

And I am going to end up with Assemblyman Webber.

Mr. Pallone. This will have to be the last question.

Mr. Webber. The same question. You are talking to a guy from a State who gets pennies back on the dollar that we send down to Washington. So I am not going to advocate for New Jersey to give money away, if that is the question.

Mr. Shimkus. No. Should every State be given the same ratio?

Mr. Webber. I don't think I am an expert.

Mr. Shimkus. Say yes.

Mr. Pallone. You can't tell him what to say.

Mr. Shimkus. Let me tell you, if the bottom line is if Mississippi gets 76 percent return, and you are getting 50 percent, should we change the law?

Mr. Pallone. Don't answer the question, because he is a minute over. We have to try to stick to the time.

All right. Mrs. Christensen.

Mrs. Christensen. Thank you, Mr. Chairman. I think just a

few brief questions.

Mr. Allen, like Chairman Pallone, I am a member of Natural Resources, and there are several others of us on this Health Subcommittee and on the big committee, so we definitely have an interest in addressing the issues of the Native Americans in our country, and the tri-caucus, I will tell you, has taken a position of equity for American Indians as well as territories. But we haven't really addressed some of those exemptions that you have put in your testimony, so that is very helpful to us.

But the urban Indians, the Indians who are not on the reservations, we generally have had problems in coverage and reaching that population. Do the recommendations in your testimony address the unique issues of that population, or are there other recommendations that you might want to add?

Mr. Allen. The answer is, yes, we have additional recommendations. The provisions in the bill go a long way to helping fill the gap. There is a lot of very positive conditions in there, including access to subsidies.

The issue for us will be that over half of our citizens of each of the tribes in general are outside what we call the service area, and they are in urban communities, et cetera. And if we are able to access the resources to serve them if they are underserved, then we can fill that gap. We can close that gap. That has been an historical gap for the tribes.

This testimony is in collaboration with the National Indian

Urban Centers, and they work very closely with us trying to fill that gap. But there are service centers who have been severely underfunded historically and don't even come close to providing the quality care that this bill is intended to address.

Mrs. Christensen. Thank you.

Dr. Scheppach, my Governor and Governor deJongh of the U.S. Virgin Islands is an active member of NGA and has signed on to the policy statements on health care reform, energy, and many of the other ones. We have a particular issue with Medicaid and wanting to get the cap lifted, at least begin to move in that direction. Does the NGA have a position on the territories if you support it? Are you supporting my Governor in his attempt to move the cap?

Mr. Scheppach. I sure am. We do have a policy position to support all the territories in raising the cap. Yes.

Mrs. Christensen. Thank you.

Mr. Pollack, it is good to see you here. You have told us about some of the reports on Medicaid that show -- that are positive, but there are also some other reports that, while, yes, there is increased access to services and to care, there is still some reports that show that the outcomes are not as good as they need to be. And you didn't really have a chance to talk about where we may need to go to improve on Medicaid, which I feel we definitely need to do. Medicaid patients are often in another line if they are not in the back of the line because they are Medicaid patients. The cost, as you said, of providing that

service is lower than the private insurance market, but part of that is because they don't pay, and so the providers do not locate or they move out of poor areas. So we have access issues.

You know that I have proposed that we put the Medicaid patients into the public plan. I am not going to necessarily ask you to comment on that, but do you have some suggestions as to how we can improve Medicaid outcomes? How can we improve Medicaid and make it not only just so that patients can get to a physician, which is often a problem, but that we can ensure that they have better outcomes?

Mr. Pollack. I think one of the biggest problems that exists for those people on Medicaid is sometimes they have difficulty getting a doctor, and that is largely a function of the payments that are provided, that are given to providers.

I am happy to see that in this draft bill there are some improvements made with respect to payments to primary care doctors. I think there is also, I think, hope for improvements because there is an experiment proposed here, a pilot program for medical homes. So I think those kinds of things will lead us in a much better direction in making care actually much more accessible for people on the program.

Mrs. Christensen. My time is up, so I don't get to go back to the public plan issue. We will talk about that again.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

Mr. Green.

Mr. Green. Thank you, Mr. Chairman. I just have one question.

Dr. Scheppach, in your testimony, you mentioned you would opposed changes to Medicaid that was drawn in an unfunded mandate. And having served 20 years as a State legislator, I can relate to that. And you say States must take into consideration not only actual costs of including individuals on their roles. I understand why you oppose a Medicaid expansion if it is unfunded, but what about a mandate to cover the population the States are already supposed to be covering under Medicare? And I will give you an example.

In Texas, we have approximately 900,000 uninsured children; 600,000 are Medicaid-eligible but unenrolled, and 300,000 are SCHIP-eligible but unenrolled. And I would like Texas to cover those children, and I would like to mandate 12 months of continuing eligibility under both programs to do so. Texas has that responsibility cover these children, but has repeatedly allowed these kids to drop off the SCHIP and Medicaid roles in order to avoid paying the State match. We cannot continue to allow children to remain uninsured so States can avoid paying their match.

Short of federalizing Medicaid, what can we do to ensure States cover the individuals under Medicaid that they are responsible for covering? And I can understand what my colleague

Mr. Shimkus -- although as a lawyer probably the worst case I have ever seen of leading the witness when you say, "Please answer yes." I don't quite go that far.

But what can we do short of federalizing Medicaid to get States like Texas and maybe Florida from my colleague Ms. Castor to cover more of the children particularly, since we have had SCHIP since 1997, whereas Medicaid for 30 years?

Mr. Scheppach. In all seriousness, one of the problems with Medicaid is it is three sort of programs in one. It is women and kids, it is the disabled, and it is the long-term care. And it is the long-term care that we think is the biggest problem because the demographics are changing and so on, and a lot of the dollars really go there. The women and children are relatively inexpensive and a good investment.

And so the problem is, is that Medicaid now is 22, 23 percent of the average State budget, about what all elementary and secondary education is. And right now, from a State perspective, we are looking at about 180 billion in terms of shortfalls over the next 3 years. So what you are seeing, and I think you are beginning to -- Texas is a little bit better off than a lot of States, but it also has a problem of basically raising the State's share to cover those.

I think at some point Medicaid needs to be restructured so that the long-term care portion of the population goes into a separate trust fund or so on. States, I think, understand it is

sort of their responsibility, women and children, because it is also a population they have to work with in terms of welfare and other things. So I don't think the women and kids are a huge problem.

Mr. Pollack. Mr. Green, I would say there are two things in response to your question. First, we obviously can do a whole lot better in terms of the enrollment process. It is rather cumbersome, and particularly the reenrollment process. After the year is up, and a child has been eligible, they have to reenroll. If they fail to do that for whatever reason, they are off the rolLs. And there is a lot of churning in the program.

So we can do a lot more in terms of outreach and better enrollment. And the CHIP legislation that passed in February actually, I think, provides some opportunities to make that happen.

But with respect to Texas, there is a very important thing. One of the things we know is that children are less likely to enroll if their parents can't enroll with them. And in Texas the eligibility standard for parents is a meager 27 percent of the Federal poverty level. So if you have got a parent and two kids or two parents and one child, if that family has income in excess of $5,000 a year, they are ineligible. The parents are ineligible.

So I think one of the things this bill does is it allows the parents to enroll with the children, and I think that will help

solve the problem you are talking about.

Mr. Green. Well, and I have a concern again about the churning, because I know in 2003 when some tough budget decisions like our legislators have to make, they cut a bunch of children off of CHIPS. And they knew how to do it; they made them reenroll every 6 months. And you can quantify it very quickly to say you know how many kids are going to drop off because the parents just can't do down and stand in line at the Health and Human Services office. So that is the concern.

Thank you, Mr. Chairman, for your patience.

Mr. Pallone. Thank you. And I think that concludes the questions for this panel. But I want to thank you. I know it is late, and I know you had to wait a long time, but we really appreciate your input, because what you are saying at the State, local, and tribal level is very important in terms of what we are doing with this health care reform.

Mr. Allen. Mr. Chair, could I correct one point that I said that was not right in the record? The Congressman from Illinois asked were we asking the tribal government and our casino, our businesses to be exempt? We are asking that our governments are exempt, not our businesses. So that is a distinction that I think he was asking that question, and I wasn't quite clear.

Mr. Pallone. All right. Thank you for that clarification.

And thank you all, really, for being here. Thank you.

Mr. Pallone. And we will ask the next panel to come forward, and this is our panel on drug and device manufacturer views.

I want to welcome all of you. I know the hour is late. It is already 6:00, and we may end up having votes, too, to interrupt us, but hopefully not. And I am changing the order a little bit because Mr. Gottlieb, I know, does have to leave.

So let me first introduce Dr. Scott Gottlieb, who is a resident fellow at the American Enterprise Institute.

And then to his left, I guess my right, is Thomas Miller, who is chief executive officer, workflow and solutions division, for Siemens Medical Solutions, USA.

And then we have Kathleen Buto, who is vice president for health policy at Johnson & Johnson. Thank you for being here.

And William Vaughan, senior health policy analyst for Consumers Union. He is no stranger to this committee.

And finally is my friend Paul Kelly, who is vice president of government affairs and public policy of the National Association of Chain Drug Stores.

And you know the drill: Five minutes, but your written testimony in complete becomes part of the record.

And we will start with Dr. Gottlieb.

STATEMENTS OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; THOMAS MILLER, CEO, WORKFLOW AND SOLUTIONS DIVISION, SIEMENS MEDICAL SOLUTIONS, USA; KATHLEEN BUTO, VICE PRESIDENT FOR HEALTH POLICY, JOHNSON & JOHNSON; WILLIAM VAUGHAN, SENIOR HEALTH POLICY ANALYST, CONSUMERS UNION; AND PAUL KELLY, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS AND PUBLIC POLICY, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

STATEMENT OF SCOTT GOTTLIEB

Dr. Gottlieb. Thank you, Mr. Chairman. I would like to submit my oral statement for the record.

I just want to pick up on some themes that were discussed in some of the earlier statements. It is a pleasure to be here, by the way. I am from the 12th Congressional District of New Jersey, and my parents still live there, so it is a pleasure to be here with you.

There was a lot of discussion around Medicare's efficiency in some of the earlier testimony, and the issue of rationing also came up tangentially in Medicare.

With respect to Medicare's efficiency -- and I worked at the agency for a period of time under Dr. McClellan -- one of the things that Medicare lacks is clinical expertise on the staff, and I think it has become quite apparent in recent years. If you look

at the structure of Medicare, they have about 20 physicians in the entire organization. If you look at private plans, by comparison they will have literally hundreds. And I think this gets to an important consideration when you talk about why Medicare is able to operate with less overhead. It is in part because they are not doing a lot of clinical review, for better or worse, in the context of the kinds of reimbursement decisions they have made and even the kinds of coverage decisions they make.

Just anecdotally, they made about 165 different decisions with respect to cancer products since 2000 without a single oncologist on the staff of the organization. And why this is important, I think, with respect to the intersection of talking about Medicare's efficiency and the low overhead that they operate with, and then you get into discussions around rationing, is because it is without a doubt that we already engage in issues of rationing with respect to the Medicare program. We are doing it right now in the context of coverage decisions and reimbursement decisions and how we go about coding. And my fear is that if we expand government control over health care, we are going to have to do those things much more.

If you look at the kinds of proposals that have been put forward in front of this committee, as well as the proposals in the Senate, and you look at some of the cost containment measures in those proposals, they are really not very robust. Comparative effectiveness, product medical records, paying for prevention, all

those individual proposals might have merit on their own, but there is a reason why the Congressional Budget Office hasn't assigned meaningful savings to them.

And so the fear is, of people who talk about the potential for rationing inside a government program, is that in the absence of being able to control costs with policy prescriptions that are embedded in these bills, ultimately the default case 2, 3, 4 years from now will be to have to engage in more robust rationing decisions inside the Medicare program or whatever other government scheme we come up with. And if you look at the draft legislation in the Senate and the House, you see multiple references to quasi-independent advisory committees that we could certainly contemplate could become vehicles for that sort of rationing.

So why is this important in the context of thinking about Medicare structure and its efficiency and its overhead? Well, if one of the reasons why Medicare is efficient and operates with a low overhead is because they don't have a lot of clinical expertise, the intersection between an organization that is going to be called upon to engage in more decisions to deny access on the basis of their own clinical judgment and their reading of the clinical literature with an organization that doesn't have a lot of clinical expertise is, quite frankly, frightening. And it was frightening in certain instances, anecdotally, when I was at the organization.

And so in my written testimony today I tried to lay out a

couple suggestions for how we could improve that process, because if we are to go down a road where we will have a system that has to make more clinical judgments in the context of what they decide to reimburse people for and give people access to, the least we should expect is that organization is clinically proficient, it is rigorous, it is based on good science, it is a transparent process. And we have none of those things today.

And so some of the proposals I laid out in my written testimony was the creation of an advisory committee structure on Medicare where you subject decisionmaking of that body to external therapeutically focused advisory committees. Certainly if we contemplate a public insurance plan that will be making similar kinds of decisions either initially or eventually, we should create a similar structure. I think we also need to contemplate what the structure is for making coverage process decisions, reimbursement decisions, coding decisions, and making clinical considerations in the context of these programs.

If you look at the structure right now of Medicare, if you were to ask anyone in a company, or if someone in a company, CEO, asked one of the subordinates who works on Medicare coverage processes what is the process, they would be hard-pressed to delineate that process in a clear and coherent fashion, certainly not with the same clarity that you would be able to explain the FDA review process, which is very clear, very structured.

Finally, in the proposals before this committee, there is a

proposal for the creation of a comparative effectiveness center agency, if you will. I think before we step into that, once again we need to think about the structure for how that information will be used. And in many contexts of government decisionmaking, when scientific information is being created by a government entity, there is very clearly delineated in legislation regulation what the threshold is for an actionable piece of data. When will a piece of data reach sufficient scientific rigor to be deemed actionable for a regulatory body? Certainly this is a case at FDA where you have a clear threshold for actual information in the context of the paradigm around P equals .05. There is no contemplation of what the threshold will be for actionable information on the part of any government organization with respect to comparative effectiveness information. And I think marrying the criteria inside CMS and any other government plan with the criteria used by FDA for consideration of comparative information, it certainly would be a step in the right direction, and I recently wrote a long paper on this and put it out for the American Enterprise Institute.

But in summation, Mr. Chairman, I don't see a lot of elements in the proposal before this committee that we could have confidence are truly going to bend the cost curve in a way where we are realigning reimbursement with the kinds of outcomes we want to see these programs achieve. And in the absence of that kind of reimbursement scheme, I fear we are just going to have more of the

kind of wasteful spending that we have seen under Medicare; that the marketplace for health care is inefficient not in spite of Medicare, but, frankly, because of the way Medicare pays for things. And so if we go down the route where an organization like Medicare --

Mr. Pallone. I know you said you are summarizing, but you are a minute and a half over.

Dr. Gottlieb. I am finishing right now -- make more decisions, I think the least we can do is make sure it is a clinically rigorous process.

Thank you, Mr. Chairman.

Mr. Pallone. Thank you.

[The information follows:]

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

Mr. Pallone. Mr. Miller.

STATEMENT OF THOMAS MILLER

Mr. Miller. Thank you, Mr. Chairman. It is an honor to be here. I represent Siemens Health Care. It is one of the largest medical technology companies on the planet. And I can only say to you, when I was a young medical physics student at MIT studying quantum electrodynamics, I thought that was hard, but the task in front of you folks seems to be a lot more difficult than that.

In the written testimony, we talked about four what I would call myths surrounding medical-imaging technology, and we tried to dispel those myths. And the myths were, first, that medical-imaging technology increases the cost of care. We would actually argue just the opposite.

It is amazing that the phrase "exploratory surgery" has vanished from our vocabulary. It is because of imaging. It used to be 30 percent of appendectomies were unnecessary; we were cutting open healthy kids. We don't do that anymore. It used to be the patient coming into an ED with stroke symptoms would be observed, and now we use a CT scanner with clot-busting drugs to take care of them with potentially millions in cost savings for care later. And CT angiography is now being used to intervene in intermediate-risk chest pain patients, avoiding healthy patients

going for angiography.

One thing in common with all these examples. We introduced something that seems to be expensive, that raises costs, but the total cost of care actually goes down.

The second myth that I wanted to address was that the financial self-interest of physicians has led to technology overuse: The evil physicians are just lining their pockets by ordering unnecessary exams. That is not true. Over 90 percent of imaging tests are ordered by nonradiologists, read by radiologists who have no financial link. In fact, medical imaging increases have happened also in Canada, a nation we have talked about a lot today, and there is no financial incentive to do so.

Imaging is being used more. It is being used more because of the diagnostic confidence. You know, I am a physician, I want to know what is going on with my patients, I will order an image.

Further reductions in reimbursements are the best means to reduce costs. We would actually argue just the opposite. Demand and supply in medical imaging are decoupled. By reducing reimbursement, you reduce supply. You do nothing to affect demand. And the DRA, which was implemented a couple of years ago, resulted in dramatic cuts, saving up to three times what the CBO estimated. Our business was affected by it by a 30 percent reduction, and we ended up laying off a bunch of people. I hate laying off people. That wasn't pleasant.

But last but not least, anyone that even attempts to argue

that the use of advanced medical technology does not produce health care outcomes will have a fight with me. And breast cancer is the best example. It has been cited here before. It used to be a death sentence. It is not anymore. We find it earlier.

So what are our suggestions and recommendations to the committees? First, we wish to applaud the committee on four things: First of all, the attempt to permanently fix the Medicare physician fee schedule sustainable growth rate formula; second, the abandonment of the Ways and Means Committee formula fix that would have created a separate expense target for radiology; the lack of a recommendation for radiology benefits managers. Personally, I like physicians to manage my care. I also wish to thank the House committees for not increasing utilization calculation on equipment in the draft from 50 to 95 percent, as some people estimate.

Let me make one point clear. A 95 percent utilization assumption would result in rationing care. We finance many of our customers. We know what their P&Ls look like, and medical imaging centers will close. Access will plummet, especially in rural areas. Wait times will result possibly for time-critical care, and hospitals in their current capital constraints state can't pick up the slack.

Now, 75 percent, your recommendation, is better than 95 percent, but there has no credible data for either number. I think we had better study it and figure out what the access impact

is before we do either.

So how do you get costs under control? What would we recommend? Well, you could do what Massachusetts General Hospital did and have physicians develop appropriateness guidelines. They reduced diet patient CT growth from 12 percent per year to 1 percent per year, despite of the fact their outpatient visits went up. We could get behind that.

We have been a strong advocate for accreditation requirements, containing the Medicare improvements for patient providers back to 2008, which assures that if you don't meet the accreditation, you don't get paid.

We support comparative effectiveness research. It might surprise you, but we do. We are a fan of our technology. We think it does good. But we support it only if it looks at the entire longitude of care, because as we have said, we believe in some cases the cost for imaging will go up, but the resulting expenses longitudinally will go down.

And, finally, we commend other legislative efforts to fund medical-imaging research. Specifically, we need to find a diagnostic imaging test for prostate cancer to benefit men like mammography has benefited women. The PRIME Act in House Resolution 353 does exactly this.

To conclude, medical imaging not only improves health care, it saves lives, and it also contributes to cost reductions in health care. So we should be careful of any policy that could

reduce access.

I thank you for the privilege of representing Siemens Health Care in this national dialogue and your patience.

Mr. Pallone. Thank you, Mr. Miller.

[The information follows:]

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

Mr. Pallone. Ms. Buto.

STATEMENT OF KATHLEEN BUTO

Ms. Buto. Thank you, Mr. Chairman. My name is Kathy Buto. I am vice president of health policy for Johnson & Johnson, and we really appreciate the opportunity to be here to comment on the discussion draft. We very much support enacting legislation this year to provide coverage for all Americans, and we look forward to working with the committee toward that end.

By way of introduction, I want to just say that I focus on a broad array of health policy issues for Johnson & Johnson worldwide in many countries, including China and India as well as the United States, and I have spent much of my career on these issues, including 18 years with the Health Care Financing Administration where I was involved with implementing changes in Medicare and Medicaid and in efforts to pass earlier health care reform legislation.

I am going to focus on really four things, and leave to you my written testimony on a number of other provisions that we support in the bill: wellness and prevention, comparative effectiveness research, part D of Medicare, and the public plan. So first wellness and prevention.

As an employer that has focused for more than 30 years on

improving the total health of our employees, we strongly support the inclusion of prevention benefits and zero cost sharing to promote greater wellness in the population. Our CEO, Bill Weldon, was invited recently to meet with President Obama along with other executives to describe their experiences in reducing risk factors in the workforce. And I will just give you one example. At Johnson & Johnson over a 10-year period beginning 1995-1999 and measuring a difference in 2007, we reduced smoking from 12 percent in the workforce to 4.3 percent. And we had many results like that, which are in the written testimony. So we believe that this is critical. We at J&J have saved about $250 million over 10 years through these efforts.

Now, comparative effectiveness research. We are very pleased that the bill includes an enterprise that will focus on improving the evidence physicians and patients can use to make treatment and care decisions. And while we have great respect for the Agency For Healthcare Research and Quality under Carolyn Clancy's leadership, we actually believe a public-private entity provides a stronger long-term framework with transparency of methods and processes, inclusion of stakeholders, and a focus on clinical comparative effectiveness research. We think a public-private entity can build trust and collaboration, which is critical in this important area; leverage additional research dollars of physician and academic groups as well as industry; and create a broader-based constituency for sustainable funding resources for

this enterprise.

Rather than provide a single assessment of cost effectiveness, we believe the entity should provide information that allows the market to determine the relationship between clinical value and costs for different patients of varying plans. And I would include, for example, minorities and women who have particular issues in this kind of research.

Now, switching to Medicare Part D. We want to commend the committee for taking on this difficult issue of closing the coverage gap or doughnut hole over time. The pharmaceutical industry's recent proposal to provide discounts of 50 percent for the majority of beneficiaries in that gap we think is going to complement your approach by providing immediate relief in reducing those costs.

We also want to applaud the committee for allowing payments to be made through AIDS drug assistance programs and the Indian Health Service to count toward meeting the out-of-pocket threshold as well.

Let me conclude by talking a bit about the public plan. We certainly support having a health insurance exchange that can provide information for the public on different options, and we support a number of the other changes proposed, such as administrative simplification and insurance reforms. We think these changes are going to actually make the government plan unnecessary, and we believe concerns about a public plan takes the

focus off sort of job number one, which is achieving coverage of all Americans and identifying sustainable financing approaches as well as making fundamental changes in the system of care.

Providers like the Mayo Clinic -- and they were recently cited in an Atul Gawande article in the New Yorker as providing highest quality care at the lowest cost -- have been very vocal about their concern that the public plan is going to use Medicare rates and therefore not cover actual provider costs. Cost shifting will ultimately lead to higher-cost private plans and ultimately a dominant public plan that underpays. We are concerned, and our industry is concerned, because systematic underpayment of providers will undermine the market base system that allows incentives to find cures for cancers, Alzheimer's, and other dread diseases.

We also are concerned about government negotiation of pharmaceutical prices reducing the willingness of our industry to undertake risky and long-term investment needed to produce important treatments. And we also think this threatens American leadership in medical innovation in ways that we don't fully understand and would be hard to anticipate.

The last point on this is that biologics promise to be a major avenue for breakthrough medicines and one we know the committee is considering. We have been at the forefront in the U.S. and other countries of supporting a regulatory pathway for biosimilars that assures patients safety and preserves incentives

for life-changing and life-saving medicines. We have strongly supported H.R. 1548, introduced by Representative Anna Eshoo, which has over 100 cosponsors.

I will leave to you the written testimony which enumerates a number of other provisions in the discussion draft, such as the Medicaid eligibility; expansion of funding for community health centers, which we have recently supported in a bill introduced by Representative Clyburn and others; as well as a focus on health disparities and health literacy; and a process to make payments between two physicians from industry more transparent.

So thank you again for the opportunity, and we look forward to working with you.

Mr. Pallone. Thank you.

[The information follows:]

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

Mr. Pallone. Mr. Vaughan.

STATEMENT OF WILLIAM VAUGHAN

Mr. Vaughan. Thank you, Mr. Chairman and Members, for inviting us.

Consumers Union is the publisher of Consumer Reports, and we don't just test tires and toasters; we try to help people with medical products. And we do strongly endorse the approach taken in the tri-committee draft, assuming that additional savings are found or progressive financing to make sure that it is budget-neutral and sustainable over time.

We believe the draft is a plan that can give all Americans that peace of mind of health security and an affordable quality system. The draft bill has done an excellent job of identifying a number of savings, both large and small, but we hope you can dig deeper for some more savings to stop that Pacman that is gobbling up our GDP. Gotta try.

As for PhRMA's pledge for $80 billion in savings, wow, that is great. Congratulations to PhRMA, but I think it was Ronald Reagan used to say, trust but verify. We hope that you can get this in legislative language in a way that CBO would score it for $80 billion in savings.

We like the drafts bill trying to close the doughnut hole,

and we really like the provisions on helping low-income people in Part D. We would like to see that doughnut hole closed faster, but that would take more money, and we suspect that PhRMA is likely to say, hey, we have given at the office, go away. But we hope you will keep pushing on that door a little bit.

There should be no excuse whatsoever to reduce the pressure for the maximum use of generics in Part D. In fact, you might want to consider an amendment to get a rebate from Part D plans that are poor in doing generic substitution.

There are a lot of other sources of money on the table. H.R. 1706, by Mr. Rush and seven others of this committee, would ban reverse payments from brand companies to generics to keep the generic off the market. Yesterday the FTC Commissioner said: Gee, that would save the government about $1.2 billion a year and consumers $3.5 billion a year. Hope you guys can do that one.

We have supported Mr. Waxman's follow-on biologics, but we have got to find a solution. Last June -- as of last June, Europe had approved over 10 of these, and I am assuming they have gone higher, and we are sitting here paralyzed. And so we hope you can come together and work something out, because that is essential.

The June MedPac report that has just come out in talking about FOBs also suggested maybe take a look at reference pricing. Why pay more for something that doesn't bring more to the table than what you are already paying?

We urge you to also support giving Medicare negotiating

authority in Part D. Once you get a good food and drug safety program in place on imports, let us have reimportation or free trade in pharmaceuticals. And, a new idea, require rebates to Medicare for drug inflation in excess of population growth and CPI, except -- except -- no rebate on a new kind of drug, a new molecular entity that the FDA would identify. This would get you a handle on spending, but move the industry more towards really breakthrough research. If my wife sees an ad on TV for a fourth type of ED, she is going to throw something at the TV. I mean, we need lifesaving breakthrough research, and not just more of some of these "me too's."

The other areas, we love comparative effectiveness research provisions in your bill. Save the consumers a ton of money. If you want to see how it works for consumers, the last page of my testimony takes a look at heartburn medicine and proton pump inhibitor stuff. And if you look at the science that the comparative effectiveness research brings, there is no particular difference between a $20 pill and that purple pill. And working with your doctor, check it out. We always say check with your doctor first, but why in the world would you start with a $200-a-month medicine when you can get a $20-a-month one that is just about as good?

Finally, we endorse the physicians' payment sunshine provision in this bill. That is the one that would disclose how much drug and device companies are giving to doctors and med

schools. We think those gifts aren't totally free. They come with some strings of influence, and we need to stop that.

Thank you so much for your time.

Mr. Pallone. Thank you, Mr. Vaughan.

[The information follows:]

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

Mr. Pallone. Mr. Kelly.

STATEMENT OF PAUL KELLY

Mr. Kelly. Thank you, Chairman Pallone and Ranking Member Deal. National Association of Chain Drug Stores appreciates the opportunity to testify today.

I am Paul Kelly, vice president of Federal Government affairs, and I am substituting today for Carol Kelly, our senior vice president, who was ill and sends her regrets. But I really appreciate your indulgence in allowing me to pinch hit.

NACDS represents the Nation's chain pharmacies, whose 40,000 pharmacies and 118,000 pharmacists fill 2.5 billion prescriptions a year. That is 72 percent of all prescriptions nationwide. Pharmacies are the face of neighborhood health care. There is a community pharmacy, on average, within about 2 miles of every American.

One of pharmacy's major contributions is helping with medication adherence. Simply put, adherence is taking medications correctly. It has major implications for patient health and for health costs. Nonadherence leads to long-term health complications that diminish the quality of life, and nonadherence has been estimated to cost $177 billion annually. I am here to make recommendations that will help prevent this problem from

getting worse.

Preventing it from getting worse involves preserving access to pharmacies. Essential to this is reforming the pharmacy-Medicaid reimbursement system. As you know, the Deficit Reduction Act of 2005 would set pharmacy reimbursement for some generic drugs at 36 percent below cost. The issue is complex, but it boils down to a basic principle. This is unworkable for pharmacies, as it would be for any health provider. Unless Congress intervenes, current policies would put 20 percent of pharmacies at risk, most of which serve low-income individuals.

Last year Congress blocked implementation of these severe Medicaid cuts until October 1, which we appreciate. We also appreciate that members of this subcommittee, including you, Chairman Pallone and Mr. Deal, remain highly cognizant of this issue, and we really appreciate your leadership, Mr. Pallone, in keeping this issue on the radar screen. We are also grateful that the committee draft recognizes the need to address this problem, and there is an AMP provision in that legislation. But as this legislation unfolds, we would emphasize there are several essential reforms that we think are needed to ensure a patient-centered Medicaid AMP policy.

First, average manufacturer price, or AMP, which will be used as a basis for reimbursement to pharmacies, must be defined correctly.

Second, AMP-based Federal upper limits should be determined

using weighted average AMPs rather than the lower AMP. And we sincerely appreciate that the draft includes this provision.

Third, Federal upper limits should be set when there are three sources of supply, the brand and two generics. Setting limits prior to that when there are two sources of supply is premature.

Fourth, there is a concern that the multiplier of 130 percent that is proposed in the draft is not sufficient to ensure pharmacies are reimbursed fairly.

And, fifth, we deeply appreciate the provision in the draft to strike the requirement to post brand and generic AMPs on a public Web site until AMPs are based on an accurate definition.

Now, regarding the cost of nonadherence and increasing the quality of care. We appreciate the recognition of medication therapy management as part of the medical home concept in the committee's draft. MTM, medication therapy management, is preventative care and includes services designed to help ensure drugs are used appropriately to maximize health and reduce adverse medication events. Pharmacist-provided MTM services have been shown in one study to reduce overall health care costs -- overall costs by $12 for every dollar invested.

Our recommendation is to enhance and expand the medication therapy management program in Medicare Part D, and we thank Congressman Ross and Congressman Murphy of this subcommittee for their leadership on this issue.

We have other recommendations, including the need to maintain patients' access to diabetes management tools through their neighborhood pharmacies. Two current rules related to the treatment of durable medical equipment and Medicare jeopardize access to diabetes care and jeopardize patient health. We recommend that health reform legislation address this misapplication of these rules to pharmacies, which pharmacies are already licensed and highly regulated by the States. We are the good actors when it comes to Medicare durable medical equipment, and additional hurdles and costs are simply counterproductive. We thank Congressman Space for his leadership on this issue.

In closing, part of the value of pharmacy is its ability to help patients stay on medication therapy. The improvement of lives and reduction of long-term costs is worth fighting for, and we look forward to working with this committee in pursuit of those goals.

Thank you again for your support, Chairman Pallone, and look forward to answering any questions.

Mr. Pallone. Thank you.

[The information follows:]

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

Mr. Pallone. And we are going to go to questions, and start with the gentlewoman from the Virgin Islands Mrs. Christensen.

Mrs. Christensen. Thank you, Mr. Chairman. And I know the hour is late. I am not going to have a zillion questions. But I want to start with Mr. Miller.

And, first of all, let me say that no one supports -- I don't support, and I know you don't support -- unnecessary or duplicative tests. That being said, though, I really appreciate as a physician your defense of physicians in your testimony and your defense of the diagnostic technologies. As you said, and I had made note of this before you said it, I think we have forgotten how far we have come from the days when you had to undergo anesthesia, one risk; laparotomy, another risk, to make these diagnoses. But my question -- you said that your experience is really in HIT. Is that correct? Did I read that in your testimony?

Mr. Miller. I have actually experience in both diagnostic imaging, HIT, as well as therapies.

Mrs. Christensen. Sure. But I wanted to ask about HIT. I think you were very clear in your defense of the technologies. We have been told by many that the projected savings from HIT are grossly exaggerated. And I wondered if, based on your long-time experience on HIT, if you had any thoughts on whether that was the case, or whether we would be realizing the savings that we think

we are.

Mr. Miller. The answer to the question is, unfortunately, it depends. If we simply say that what we will do is digitize all information for all patients at all times and think that will lead to productivity, I think we are misguided. I don't know about you, when I get an e-mail with a huge attachment to it, I still print it out. And I used to run with the largest health care information technology businesses in the world.

The fact of the matter is, just like pharmaceuticals, to get efficiency out of health care information technology, you need the right information about the right patient and the right context of care going to the right provider at the right time. It is a lot different than just a big file full of data. If a patient is coming to me with severe chest pain, I don't want to know about the mole that was removed last week as the first thing I see in the file. I want to know whether they are taking medication. I want to know what contraindications for medications there may be. This requires a little more intelligence.

So I think the potential is there. We certainly have customers who have realized a lot of potential. But the devil is in the details, and an inexpensive HIT system which simply takes all data, logs it, and makes it available will not change productivity. Productivity rhymes with activity, not with information.

Mrs. Christensen. Thank you.

Ms. Buto, we applauded J&J's wellness and prevention programs and also the recent proposal by PhRMA to cut the cost of medication during the doughnut hole by 50 percent. We also appreciate your support for elimination of health disparities in the community health centers that you stated in your testimony. We do have a point of departure on the public plan which the tri-caucus is fully supporting, and which I think this committee is bending over backwards to ensure that it does not undermine our market-based system.

But I wanted to ask about the CER issue. I have joined with other Members in legislation that goes so far as defining the committee that will oversee it and ensuring that the membership on that committee, representative of all of the stakeholders, important to the tri-caucus as well. We directed that research must be done on women and racial and ethnic minorities so that we will really have the best science for everyone. And, further, we direct that the outcome of that research would only be used to provide clinical guidance.

Does this address some of the concerns that you raised, or are there others that remain?

Ms. Buto. It sounds like your approach really does address many of the concerns I have raised. And I think the other issue that once you dig below the surface on minorities and women and other subpopulations is as we get closer to personalized medicine, I think we are beginning to realize we need a different approach

doing the clinical trials that actually helps us sort so that we can provide and be more targeted in the treatments we develop. And we are trying to figure out how to do that in a way that gets those targeted treatments that, again, will be better value for money in the system, but also will get to subpopulations, minorities, women, and others who will benefit. And we are still sorting through that. But I think that is part of the equation as well, and it sounds like your approach would allow for that kind of research to go on.

Mrs. Christensen. Thank you, Mr. Chairman.

Mr. Green. [Presiding.] Congressman Deal for 5 minutes.

Mr. Deal. Thank you.

Mr. Kelly, you are familiar, I think, with H.R. 3700 from last Congress that was introduced by Chairman Pallone. I believe you have generally been supportive of the language that was in that piece of legislation. What is missing from this draft that was in the bill Chairman Pallone introduced last year, 3700?

Mr. Kelly. There are some differences. We certainly appreciate that the committee in its draft bill has recognized the importance of this issue and included improvements to the existing law in the bill. We also appreciate your leadership over the years in trying to be helpful in this issue as well.

As I understand it, H.R. 3700 defines AMP in a way that reflected pharmacies' acquisition costs, which is our top priority and really central to this debate. The committee's draft

currently does not include that, and that is an important priority of ours, and we look forward to continuing to talk to the committee about that. That is reflected in our written statement. That is one of the major issues.

Mr. Deal. You mentioned that States should consider both components of reimbursement when determining what they are going to pay pharmacists for. What are those two components? And would you explain why it is important to consider both components?

Mr. Kelly. Certainly. Thank you.

Historically, pharmacies have been paid for the drug product itself and for dispensing the product; so reimbursement here and then a dispensing fee here. In Medicaid, the States on average reimburse the pharmacy $4.40 to dispense the products. All the evidence indicates that it costs the pharmacy about $10.50 to actually dispense a prescription drug when you consider all the overhead that is involved with running a modern pharmacy today. So it is important to make sure that reimbursement for the drug product is right, which is why getting the AMP definition is so important when it comes to Medicaid product reimbursement, which the Federal Government has sole jurisdiction over. The States control the dispensing fees in the Medicaid program.

And I tell you, this committee and Congress could really help us quite a bit with CMS on this issue of dispensing fees. When DRA was passed, there was a ton of legislative history which indicated the expectation was and the encouragement was that

States would allow for increased dispensing fees for pharmacies. Well, about a half a dozen States have submitted State plan amendments requesting just that, and CMS has shut down every single one of them. In fact, just this week the State of Washington submitted a State plan amendment that would have increased fees by a nickel, and CMS shot it down. So to the extent folks on the committee can be helpful in that regard, CMS, we would sure appreciate it.

Mr. Deal. So the two products. One is control at the Federal level, that being the payment for the drug itself, which is the AMP issue that you alluded to, and you don't think this draft addresses that issue as clearly as the Pallone legislation did. And then the second component being the dispensing fee, which is a State issue by and large, is still left that way under this draft legislation. Is that correct?

Mr. Kelly. There is nothing in this draft that we have seen that indicates any policy changes on dispensing fee. And you are right, there is product reimbursement, and that relates directly to how you define AMP and how you reimburse and calculate the AMP.

Mr. Deal. I believe when we were dealing with the MMA, we tried to make sure that seniors had a pharmacy that was going to be close enough and accessible enough for them to handle their pharmacy needs. I don't think there is any language of a similar nature in this draft. Did you find anything that would address that issue? And, if not, is that something we should be concerned

about?

Mr. Kelly. We have not seen that in this draft. And you are right, that is a part of the Medicare drug benefit. They actually use the TriCare health care program access standards for community pharmacies, access to community pharmacies.

Look, seniors want access to pharmacies. Most citizens want access to pharmacies. They want it to be convenient. That is very important. As I said in my testimony, there is a pharmacy within a couple miles of everybody, on average, in the country.

You know, I am not sure how those access standards would fit into the context of this bill. It made sense for the drug benefit when you were creating that, but I am just not sure at this moment whether it would fit into the context of this particular bill. It came up very recently, as you know, and we are still kind of combing through it, quite honestly, to get a sense for that.

Mr. Deal. Thank you.

Mr. Green. Congresswoman Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Mr. Chairman.

I would like to start with Mr. Vaughan, and I welcome you. And I don't know if I have seen you in this role before, but you have been on the Hill for a long time, too.

In your written testimony, you identified as a cost-saver legislation that I introduced with Representative Berry, H.R. 684, the Medicare Prescription Drug Savings and Choice Act, which allows Medicare to negotiate for lower drug prices.

RPTS SMITH

DCMN NORMAN

[6:38 p.m.]

Ms. Schakowsky. I am wondering if you could talk a little bit about how that would reduce costs.

Mr. Vaughan. Yes, and thank you for that cosponsorship. And it would probably be -- you know, we have got good competition in generics and stuff -- this would be a place where in a biologic that came in at one of those very, very, very high prices, if the Secretary could work with it a little bit, bring the price down -- and I know it works.

I happened to work for the Chairman of the Ways and Means Health Subcommittee in 1989 when the first big blockbuster biologic came in, EPO for folks with kidney disease. And as I recall, the company wanted a launch price, and the Chairman was saying, whoa, we are the monopoly buyer, everybody in the kidney program is in Medicare. And you have got a monopoly company. Let's negotiate. The then-Secretary didn't particularly want to do that, and it took a lot of press releases and screaming and hollering and threats of hearings and stuff.

But I do really believe that that jawboning by just one, not just, by a subcommittee chairman on the Hill pushed the Secretary enough that we got that price down $3, $4 a unit. We should have gotten it down, 8 or 9, you know, if the Secretary had been a little more gung ho on it. But that company recovered its entire

investment in that drug in 9 months, and is making over a billion dollars a year in profit from Medicare from that drug now. And we didn't do a very good job negotiating, but we saved billions. But it can work.

Ms. Schakowsky. So we don't have to imagine it.

Yes, Ms. Buto.

Ms. Buto. Bill, I have to kind of disagree with your memory on this. I was at HCFA at the time. I actually did negotiate that price. And it was done way before the chairman got involved, because the company came to us saying, this is an ESRD drug. ESRD is a Medicare population. And we decided that -- I decided I couldn't do this alone. So I got the Inspector General's Office and the Office of Management and Budget to sit down with us, and we went through SEC filings. This was a company with one drug and one drug in the pipeline, and we did the best we could around the table to do that. I think you all came along; and I think rightfully so, said, you know, can't we maybe take another dollar off? You did that legislatively.

Ms. Schakowsky. So you can fight that out later. But the point is it worked.

Ms. Buto. My point was this: In spite of the fact that it was one company with one drug, we had a very difficult time actually doing the negotiation. That was actually my point.

Mr. Vaughan. It is difficult, but you did get some money out of it. And I stand corrected. Congratulations to you for having

started it all.

Ms. Buto. It wasn't about money. Can I just make the point? It was about making sure that ESRD beneficiaries had it at the moment that FDA approved it. We wanted to make sure because there was no other market that there wasn't a huge delay before they could get access, and that was the reason we needed to set a rate. Because otherwise, Medicare waits for a year or so, and the rates are set in the marketplace, right?

Mr. Vaughan. Yes.

Ms. Buto. It was about access.

Ms. Schakowsky. It is about access. But I think if we institutionalize this notion of Medicare being a negotiator, with the huge network that it represents, that we can do better than we do right now.

Ms. Buto. I disagree that.

Ms. Schakowsky. You don't agree with that?

Mr. Vaughan. I do agree.

Ms. Schakowsky. Well, don't insurance companies regularly negotiate for their subscribers?

Ms. Buto. They do, and they set formularies, and my experience with Medicare is that it has been reluctant, shall we say, to set formulary restrictions on what Medicare will cover, because the notion is that -- and we always had this underlying our coverage policy -- is that the beneficiary population is very diverse and usually fairly chronically ill. And so to exclude

certain things just to get price down --

Ms. Schakowsky. Well, in our bill, in the bill actually that we are talking about, we do set a formulary in the draft for the public option, right?

Oh, in my bill we actually talk about a formulary so that we can negotiate. I guess my time is up.

Mr. Green. [Presiding.] Out of time, thank you. Congressman Pitts, 5 minutes.

Mr. Pitts. Thank you, Mr. Chairman. Thank you, panel, for your wonderful testimony.

Mr. Miller, you said that a large part of imaging is done without any association to the financial self-interest of the ordering physician. You also said that the increases in use of imaging are perhaps too often attributed to a financial incentive in ordering the test.

Do you believe that one possible reason for the rise in imaging could be the practice of defensive medicine? Do physicians order tests to protect themselves from potential medical liability?

Mr. Miller. I can only speculate that that could be the case, in some cases. I can also state that if, when we speak to our customers and ask them, because it is important when we design machines we ask them, you know, why do you order tests? What are you trying to look for, what are you trying to discover? The great majority of time they are really telling us we want to be

able to see this disease process. We are having difficulty because we don't know if the patient has X versus Y.

Now, in knowing if a patient has X versus Y before they treat, if that is defensive, then I can only agree with you. It is probably also good medicine.

Mr. Pitts. MedPac has given us clear indication that it feels there is a tremendous overuse of medical imaging and that we should rein in the use and reimbursement of such use.

Do you feel that there is overuse, and what do you feel is the appropriate way to get at that issue?

Mr. Miller. I don't think that there is overuse, by and large. Are there cases of overuse that might crop up in someplace or another? Yeah, probably. However, as I stated in my testimony, what we really believe and support as an industry is appropriate in this criteria. I do believe that we should have guidelines which are physician-created and physician-administered that guide people to say, for this type of symptoms, this test is appropriate. For patients with this background of illnesses, this test is appropriate.

Doing so may have, however, two consequences. There are times when a test won't be ordered because it is inappropriate. There are other times -- and we see this just as often -- that a patient will be subjected to a slowly increasing series of tests. They will come in with chronic headaches and then something has been going on for a long time, and an X-ray of the head will be

ordered. An X-ray of the head will show you the skull. Not many headaches caused by the skull.

So sometimes it could lead to actually an increase in the type of imaging that is ordered, a temporary increase in cost. But our argument has been and what I have tried to put forward is that, knowing the patient's condition precisely, characterizing the disease in detail before you start to treat, is probably the best way to save cost in health care; because there is nothing more expensive, more wasteful or more unethical than treating a patient with the wrong treatment for their disease or, even worse, starting the treatment for a disease they don't have.

Mr. Pitts. I have just a couple of questions on the DRA. You mentioned in your testimony the large reductions that the DRA imposed to medical imaging, and that during the first year of implementation, that growth in imaging was reduced to only 1.9 percent.

What do you think the reasons were for growth in previous years? And do you feel that the DRA was the only factor in this slowing of the growth? And what was the impact of the DRA and the dissemination of new updated technologies to patients? What would be the impact on future cuts to advanced imaging technology, such as CT, MRI, PET, nuclear imaging, do you think this would -- what impact?

Mr. Miller. Well, we have an advantage that we do business in about 180 countries of the world, so we can look at use

patterns not only in the United States, but in many other countries and see trends and see changes. The DRA had a sudden drop in imaging growth, which we didn't see in any other countries at the same time. So, in other words, it must have been the DRA. We didn't see it happen in Canada, we didn't see it happen in China. We didn't see it happen in South Africa, any country in Europe, et cetera. DRA happened, growth was reduced.

In other countries where there has been no DRA and no financial linkage that would cause overuse, we have seen medical imaging increase year over year in almost every other market we are in. It is increasing in China, it is increasing in Australia, it is increasing in Germany. It is increasing everywhere, because, as I said, we are substituting more expensive physical and invasive tests with things that are noninvasive, more comfortable for the patient and, frankly, looked at as whole as cheaper.

I think the DRA did cause in some parts of the country, some of our customers to, frankly, go out of business. I don't think that it resulted in a sea change in care, but we start to get it to limit. And therefore, what I would argue is in some ways -- I hate to phrase it this way -- we gave once at the office. We took a large cut in our industry and we are now at the point where more reimbursement cuts to the supplies of a service will definitely cause reduction in access.

Mr. Pitts. Thank you. Thank you, Mr. Chairman.

Mr. Pallone. [Presiding.] Thank you. Mr. Green.

Mr. Green. Thank you, Mr. Chairman. The Chair got back. Otherwise I was going to recognize myself for 2 hours to answer -- ask questions, because I know we were all having so much fun today. But I appreciate it, Mr. Chairman.

Let me first ask, Mr. Miller, you mentioned in your testimony the large reduction that the Deficit and Reduction Act imposed on medical imaging, and that during the first year of implementation that growth in imaging was reduced by only 1.9 percent.

What do you think the reasons were for the growth in previous years, and do you feel like that the DRA was the only factor in slowing that growth?

Mr. Miller. The growth was starting to slow somewhat in previous years. There were years in which the growth was faster. It started to slow even before the DRA. But the DRA was a quantum-step change in the growth of imaging. As I have stated before, I believe the growth in imaging has simply to do with its utility.

One of the best examples I can give is that we will probably see a growth in the use of computer tomography in the management of chest pain. That is going to grow. And it is going to grow and, frankly, if it were my family members or me, I would want it to grow, because right now the standard of care in many places for chest pain is, you either sit for a long time to get blood tests, the blood tests determine whether your myocardium is dying. Or

you get put in a cath lab for a very invasive exam. A CT-scan for chest pain has an almost 100 percent negative predictive rate. In other words, if it doesn't show you have disease, you can go home.

You are therefore avoiding two things. You are avoiding either sitting around the ED, or if it is late at night, getting checked into the hospital. Or you are avoiding a $10,000 catheterization. Forget about the ethical issues. And I believe, if people have informed me correctly, you have some experience with this.

Mr. Green. I do. And I have to admit I joked a few years ago that I got belt and suspenders when I was diagnosed for having a heart problem. And it turned out, I did the catheter, and then they said, well, why don't we see if we can do the scan? And I sat there and watched it, and I felt like I was getting lobbied with a hospital gown on, and paying for it at the same time.

But I appreciate that because I know in this bill we are concerned about that. I just don't want, and I don't think members want to cut off some of the newer technologies we can get that are less invasive and that actually can be cheaper than, for example, a catheter.

Mr. Miller. I think that the point I want to make I can best make by one also very personal experience, my father; 18 months ago my dad had a stroke. Amazingly, I was in the neighborhood when it happened. I showed up at the emergency room when he had it. The emergency room was outfitted with a state-of-the-art

CT-scanner, from us. And they were able to rule out hemorrhage. He was a candidate for a clot-busting drug. When he came to the ED he could barely speak. Part of his face was paralyzed. After the drug, some hours later, he now speaks perfectly with his grandchildren.

Now, I would ask you, was that expensive? Yes. But what would be the cost of the rehabilitative care over the rest of his life had that not been available? The real issue in looking at these costs is we must look longitudinally over the entire not only episode of care, but the entire sequence of care.

Mr. Green. Let me go on, because I have questions and only limited time.

Ms. Buto, I have been working on a piece of legislation, H.R. 1392, which removes the prompt-pay discount to extend it to wholesalers from the average sales price of Medicare Part B drugs. Most of these drugs are oncology therapies, including chemotherapy, and are administered in physicians' offices or in outpatient settings. As you know, many oncology practices have been reimbursed for these Part B drugs at 2 percent under the price they purchase the drugs because of the prompt-payment discount.

One point of opposition to the bill is that some believe the passage of this legislation and the removal of the prompt-pay discount will result in higher costs to the government if manufacturers raise drug prices, because the physicians will be

reimbursed at the proper rate of the drugs.

I believe the price increases in the Part B drug market are largely a function of the level of competition for these drugs rather than a result of the terms included or excluded from methodology. Would you agree that? And do you believe that the removal of the prompt-pay discount will directly result in drug manufacturers raising their prices?

Ms. Buto. I do agree with your position, and the prompt-pay discount is really a factor in the average sales price that recognizes the cost of doing business. So we really don't think it is a legitimate factor that should go into the average sales price.

I agree with you as well that it is the competition among the different drugs in a class that are going to drive the average sales price, not removal or adding of this factor to the ASP.

Mr. Pallone. Mr. Green, as you can see, the time -- the electronic timing devices have ceased to exist.

Mr. Green. I promise not to take my 2 hours, Mr. Chairman

Mr. Pallone. You are almost at a minute over. From now on, I am going to have to tell you manually what the time is.

Mr. Green. Oh. Can I just get one more question?

Mr. Pallone. Sure. Go ahead.

Mr. Green. Again, Ms. Buto, as a strong supporter of H.R. 1548, the pathway to biosimilars is sponsored by Representatives Eshoo, Inslee and Barto, and I saw your testimony

in support of the bill as well.

I am particularly concerned with the patient safety, and this bill allows for clinical trials and the approval of biosimilars.

Could you elaborate for the committee on why clinical trials for biosimilars are an important part of the approval process for biosimilars? And I believe it is important to allow innovator companies to have adequate time to make a return on their investment. There is no incentive for these innovator companies to develop these lifesaving treatments, if you don't allow that. Can you discuss the data exclusivity provision of H.R. 1548?

Mr. Pallone. Quickly, please.

Ms. Buto. Very quickly. And I can just say I am not an expert on this, but I will tell you that our clinical experts are available to the committee. And one of them was an official in the Biologic Division at the FDA.

But briefly, the reason clinicals are so important is that biologics are generally protein-based compounds and they are not chemicals. So they are not, they can't easily be, in fact, they cannot be replicated. And that is why the clinical studies are so important.

Our own experience is, even when we changed the bottle stopper on our biologic, it created an immunogenicity problem that created some real adverse effects. So you can make a small change. If you are not careful in doing the studies, you won't know between the innovator and the biosimilar. So it is

important.

Mr. Green. Thank you for your time.

Mr. Pallone. Thank you. From now on I am going to have to -- oh, it is back up. All right. Here we go. Great. All right. Next is Mr. Shadegg.

Mr. Shadegg. Thank you, Mr. Chairman. And I trust I will get the same indulgence.

Mr. Miller, I want to begin with you. I have my own experience. I had bypass surgery, I think 7 years ago now, and I am a huge fan of the work that you and Ms. Buto do. I think it is vitally important that we fund that kind of research and that we fund both the development of drugs, cutting-edge drugs and of cutting-edge biologics.

I believe I heard you, Mr. Miller, say that you like a physician to manage your health care. Was that -- is that what you said?

Mr. Miller. Yes, that is.

Mr. Shadegg. And I take it you would agree with me that some of us who have concerns that physicians won't be able to manage health care if we have government-controlled single payer, whatever you want to call it, health care -- at least if it put a bureaucrat between you and your physician, you would be concerned about that, would you not?

Mr. Miller. I would be more than concerned.

Mr. Shadegg. Okay. Great. I believe at one point you said

that something would cause access to plummet and especially in rural areas. I take it that is any limitation on technology or on the availability of analytic devices such as the type you are advocating -- imaging?

Mr. Miller. Here is the point I was trying to make. In many rural areas if the reimbursement rates were driven by a formula that insisted on a 95 percent -- which is not in this draft -- but a 95 percent utilization rate, there will be rural medical imaging centers that will just go out of business. I mean, we know this. They will go out of business. You might say, well, that is okay. They can just drive a little further to a hospital, get imaged there.

Hospitals these days have capital constraints. They are not ordering extra capacity because they can't afford it. And even worse than that, I mean, populations are getting older. Imaging exams are being dominated not by the technology, but getting the person into the room, calmed down, on the table, comfortable with the exam and getting back off. There is a limitation to what you can do.

And frankly, one last point. The high-tech stuff supports some low-tech stuff. Mammography, for example, gets supported by some high-tech stuff. That will also go away.

Mr. Shadegg. I think your point is exactly right on; that imaging has, in fact, in the long run brought down the cost of health care, and I think restraints placed on imaging have been a

mistake.

You said that you support, and your company supports, comparative effectiveness research so long as it is looked at in the entire -- I think you said longitude of care. I would agree with that. But my concern is if that longitude of care is looked at by a government bureaucrat only looking at dollars and cents, as opposed to a physician or a group of physicians looking at both cost and benefit, I am deeply concerned that comparative effectiveness research could, quite frankly, put the government in the position of devastating both drug development or pharmaceutical development and device development. If somebody is sitting in there kind of second-guessing you guys, I don't know how it doesn't restrain your capital.

Mr. Miller. We have the same fear. We have the fear that if it is not done right, it can simply be a way to restrain technology development, which would be horrible for the United States. We are are a net exporter of health care technology. That would be a huge mistake.

However, we look at all technology we develop and ask ourselves a single question: Does it change the care of the patient in cost, quality and time? All three factors must be simultaneously considered. And if so, comparative effectiveness research can be a good thing. If not, as you imply, and in the way in which you imply it, I would be dead-set against it.

Mr. Shadegg. Ms. Buto, I believe you testified very

similarly. I believe in very carefully selected language you said, in the hands of physicians, in the hands of people using it for valuable purposes, comparative effectiveness research can be very good; but that if it is, in fact, used to ration care, as it perhaps has been done in other countries, that would not be good. Am I correct?

Ms. Buto. You are correct. We have had the experience where treatments for which there is no alternative have been denied based on the application of a cost-effectiveness threshold that most people would admit is kind of arbitrarily set. So I do think it is valuable. I think in this country, people will use it; physicians will use it and patients will use it. So I have no doubt that it will -- the value proposition will enter in, but at the right level, rather than being set at a national level by a national entity.

Mr. Shadegg. You also expressed concern about government negotiation of drug prices. Do you fear that if we had a single-payer system or if we get a public plan that has the power of the government behind that?

Ms. Buto. Yeah. I was reading the discussion draft and there was government negotiation within the public plan section. That has great concern for us, as I say. I think our concern really comes from the cascade of public plan dominating, and then a public plan really becoming more commodity-based in its approach, trying to squeeze down cost by setting prices. That

will definitely inhibit innovation.

And again, we think this country has been a leader in innovation, and we want to maintain that leadership as well as the strong position in the economy that these biologic and pharmaceutical and device companies play in making our economy strong.

So there are a lot of reasons, but the real fear is that you have a cascading effect that results in really a commoditization and lack of incentive for the research to go on to develop new treatments.

Mr. Shadegg. I want to thank all the witnesses for their testimony. I want to thank the Chair for his indulgence. And I just want to conclude by saying, for me, the single greatest fear I have of either a public plan which would compete with and, I believe, ultimately undermine and destroy private health care insurance, or a single-payer insurance, is that it will end innovation.

And I mean, right now we have clinical effectiveness research done by the government. If you put forward either a pharmaceutical, saying it will reduce John Shadegg's blood pressure, or a device that will perform a prostate cancer operation on him, you have got to prove that it is clinically effective.

And I am all in favor of doctors or insurance companies being able to use comparative effectiveness to look at the cost

effectiveness of my care. I want somebody to say look, Congressman, this drug will be financially much better now for you than that drug.

But putting comparative effectiveness authority in the hands of a bureaucrat whose job it is to meet numbers criteria rather than to assure, first and foremost, patients' care, I believe is very dangerous and, I believe, for the world.

I mean, it seems to me -- I happened to just drive down here from New Jersey yesterday and passed Johnson and Johnson's headquarters. And I know that that is a central part of the economy of New Jersey. And I just pray that we don't do something that will drive capital away from the cutting-edge research that we have, because I am sitting here alive today because of the work you all have done, and I would like America to stay out front. And I fear that under any publicly government-run program, we are going to inhibit that capital, and we are not going to have the kind of cutting-edge medicine that you get when free markets invest and explore for those drugs or those biologics.

Mr. Pallone. Thank you. The gentleman from Ohio, Mr. Space.

Mr. Space. Thank you, Mr. Chairman. And I would like to thank the witnesses for their indulgence. I know it has been a very long day. And I may be the last member to question you. I am sure you are happy to here that.

I come from Ohio's 18th Congressional District. It is a very rural district. It is, for the most part, within Appalachian

proper. And one of the things that we suffer from is a lack of access.

Mr. Kelly, I want to thank you for referencing my bill in your testimony, which I have had a chance to review. This bill is designed to exempt those pharmacists who have, in good faith, practiced without fraud or abuse from the surety bond requirements imposed by the last administration as a part of the Medicare DME system.

And in our district, we have got -- I have got one county that has one pharmacist in the entire county. We have a significantly higher-than-average incidence of diabetes, and the diabetes we do have is not being properly managed. Many of the people that I represent don't have the insurance to purchase test strips, for example, which is a very critical component of the management process for those who suffer from diabetes, Type 1 diabetes in particular.

And I am interested in your thoughts on H.R. 1970 -- that we dropped, concerning the exemption of those pharmacists -- and as to how it will affect those pharmacies that are really serving as the primary interface with much of the health consumption community, as well as how it may affect the ability of people who are either uninsured or have policies that don't provide significant coverage and their abilities to purchase things like test strips or other DMEs.

Mr. Kelly. Certainly. I thank you, Mr. Space. And as to

your bill, H.R. 1970, we fully endorse it and support it and appreciate your introducing it.

The cost of chronic care has been chronicled a lot in this debate on health care reform, and it is very important to get a handle on chronic care. Only 50 percent of the folks with chronic conditions take their medications as they are prescribed. And that is a problem. The people who can help them with that are pharmacists in communities like yours and across the country, in every community, low income and upper income, across the country.

As it relates specifically to these new requirements, the surety bond requirement that the last administration imposed, CMS actually predicted -- projected, I should say -- that 25,000 DME suppliers would probably drop out of the program as a result of this new surety bond requirement. And this surety bond would apply to each and every pharmacy in a chain of pharmacies. And that is a big deal, not just to members of mine who have 6,000 pharmacies across the country, but half of our members have 20 or fewer stores in their chain. So we have a lot of small business people operating pharmacies across the country. That is going to be a huge expense and a huge hassle to them to obtain a surety bond just to continue to provide diabetes testing supplies and testing strips and glucose monitors to diabetic patients.

In Medicare, seniors overwhelmingly obtain their diabetes testing supplies from their local neighborhood pharmacies. And they are going in there to get their insulin already.

Mr. Space. All right. And many of these DMEs, glucose monitors and test strips, for example, are over-the-counter products. These are not prescriptive products, correct?

Mr. Kelly. That is absolutely right. The patient is able to walk in and obtain that equipment from the local pharmacist. Our concern, as you have articulated, is that this new requirement and others would really hassle pharmacies out of this program. And that destroys continuity of care. And we are talking a lot in the health care reform debate about the importance of continuity of care. It is especially true with chronic conditions like diabetes. If a patient can't get their diabetes testing equipment at the same place where they are already getting their insulin, it doesn't make a lot of sense to us, and you are going to break that bond that is so important right now for good care.

Mr. Space. Thank you, Mr. Kelly. And I yield back the balance of my time, all 12 seconds.

Mr. Pallone. Thank you Mr. Space. Unfortunately for the panel, I still have questions to ask. Hopefully, I will be the last one, unless someone else shows up.

I wanted to start with -- I wanted to ask Ms. Buto a question; then I wanted to ask Mr. Miller. I will try to get both of these in in the 5 minutes or so.

Ms. Buto, the President reported 2 days ago that the White House had reached a deal with pharmaceutical manufacturers to cut costs for seniors, with incomes up to $85,000, in the donut hole

by 50 percent for brand-name drugs. AARP CEO Barry Rand, along with Senators Baucus and Dodd and representatives of the pharmaceutical community were involved in reaching the deal.

We agree with the importance of rectifying this major flaw in the prescription drug bill that left seniors with no coverage between $2,700 and $4,350. And the discussion draft fills about $500 of this cost immediately and then phases out the donut hole for all Medicare beneficiaries over time. And the discussion draft reinstates the ability of the Federal Government to get the best price for prescription drugs for the most vulnerable low-income Medicare beneficiaries. Those savings are used to fill the donut hole for all Medicare beneficiaries.

And my question is -- and I asked AARP the same question yesterday -- can you clarify for me, do you see this proposed provision in the draft as working together with the commitment by the pharmaceutical manufacturers, thereby filling the donut hole for seniors; or do you view your agreement with the White House in lieu of that discussion draft provision?

Ms. Buto. First let me just clarify something and make sure that I have your question correct. You know, we feel that the 50 percent discount will provide immediate relief, obviously. A provision that we like in the discussion draft is closing the donut hole over time. A provision that we don't like is applying Medicaid rebates to Medicare. So I don't know if that answered your question.

But I want to be really clear that we do think that closing the donut hole over time in the immediate term, being able to provide these 50 percent discounts, will help a lot in making that more possible. We are hoping it will reduce the cost for the committee of getting to that closure. But we don't support the transfer of Medicaid rebates to Medicare.

Mr. Pallone. Okay. Well, I understand where you are coming from. I just wanted to make sure, because of course AARP said that they would like to see us go all the way in the way that the discussion draft proposes. And obviously I agree with the discussion draft. I just wanted to get your opinion on that.

Let me get to Mr. Miller. And I am going back to the point that Mr. Shadegg touched on about the comparative effectiveness research, you know, in the context of the health reform effort. The discussion draft would create a permanent center for comparative effective research. And the purpose of the center is to support research to determine, and I quote, the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated and managed clinically.

In my opinion, it is simply about arming doctors with the best info possible to help them make decisions with their patients. It says nothing about insurance or cost effectiveness. In fact, the draft would prohibit the center from mandating coverage policies.

But even with all that, you know, we get the attacks from -- that this research somehow is going to ration care or reduce access to new technology.

So I have two questions. Do you believe that thoughtful, methodologically appropriate comparative effective on this research focused on patient outcomes will help or hurt patients? And secondly, Siemens, I know, is on the cutting edge of medical imaging technology because it is, you know, it is basically a revolutionary company. Won't this research simply validate the quality of your products?

Mr. Miller. In both my written and oral testimony, I said I am for comparative effectiveness research, with a caveat. And the caveat was that it looks longitudinally across care, and it looks to validate which technologies result in ultimately, as I mentioned before, the lowest cost, lowest time, and the best quality for the entire episode of patient care.

We engage in competitive effectiveness research all the time in the company. We will have people come to us and say, every year we have budget time, and our engineers all want to spend all of the money on everything. And we are big, but we still have limited budgets like everyone does. So we have to decide do we invest in this new MR, do we invest in this new CT, or this new ultrasound, or this new thing that no one's ever thought of yet?

To do this we engage in our own form of comparative effectiveness research. It may be done more or less well, but

these are exactly the same kind of questions that we actually ask when we decide where we invest our innovation dollars. So therefore, we can't be against it in truth. And plus, if all of the statements I made in both written and oral testimony are true, if I truly believe them, I have nothing to fear. In fact, what should happen, if I am right, is that you will end up spending more money on my technology because it improves patient outcomes. So I support it. It must be done the right way. The devil is in the details, but the concept is absolutely supportable.

Mr. Pallone. All right. That is what I wanted to find out. And I appreciate it. And I think that --

Ms. Buto. Mr. Chairman, if I could just add just one other point to what Mr. Miller said.

Mr. Miller. You are not going to fight with me.

Ms. Buto. No, no. I am not going to fight with you.

I think the other thing, too, to talk a little bit about is the fact that I think the appropriate comparisons are really across -- in dealing with the condition across the different modalities. One might be a device, one might be a drug, one might be watchful waiting. So I think people tend to think drug to drug, device to device.

And the other thing that has recently come in is the geographic variation in the costs are actually being driven by variation around process of care. So more visits, more testing around a treatment can make a big difference. So I think, you

know, as the committee considers this, just the complexity of the issues and going beyond just the notion of drug-to-drug, device-to-device, to get that bigger picture of what comparisons were really after.

Mr. Pallone. I understand. And that certainly makes sense to me. I think we are done with the questions and done with the whole hearing. But really, thank you again. Because I think, again, your panel as well as the others were very helpful in terms of what we are trying to achieve here with health care reform and so we certainly appreciate it.

You may get written questions within the next 10 days. We would ask you to respond to them and get back to us as quickly as possible.

[The information follows:]

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

Mr. Pallone. Now, again, as yesterday, the committee is going to recess -- the subcommittee, I should say, is going to recess and reconvene tomorrow morning at 9:30 to continue our review of the discussion draft. So the committee stands in recess. Thank you.

[Whereupon, at 7:24 p.m., the subcommittee recessed, to reconvene at 9:30 a.m. Thursday, June 25, 2009.