STRENGTHENING EMPLOYER–PROVIDED HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON
EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 10, 2009

Serial No. 111–6

Printed for the use of the Committee on Education and Labor

Available on the Internet:
http://www.gpoaccess.gov/congress/house/education/index.html

U.S. GOVERNMENT PRINTING OFFICE

47–723 PDF WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON EDUCATION AND LABOR

GEORGE MILLER, California, *Chairman*

Dale E. Kildee, Michigan, *Vice Chairman*
Donald M. Payne, New Jersey
Robert E. Andrews, New Jersey
Robert C. "Bobby" Scott, Virginia
Lynn C. Woolsey, California
Rubén Hinojosa, Texas
Carolyn McCarthy, New York
John F. Tierney, Massachusetts
Dennis J. Kucinich, Ohio
David Wu, Oregon
Rush D. Holt, New Jersey
Susan A. Davis, California
Raúl M. Grijalva, Arizona
Timothy H. Bishop, New York
Joe Sestak, Pennsylvania
David Loebsack, Iowa
Mazie Hirono, Hawaii
Jason Altmire, Pennsylvania
Phil Hare, Illinois
Yvette D. Clarke, New York
Joe Courtney, Connecticut
Carol Shea-Porter, New Hampshire
Marcia L. Fudge, Ohio
Jared Polis, Colorado
Paul Tonko, New York
Pedro R. Pierluisi, Puerto Rico
Gregorio Sablan, Northern Mariana Islands
Dina Titus, Nevada
[Vacant]

Howard P. "Buck" McKeon, California,
Senior Republican Member
Thomas E. Petri, Wisconsin
Peter Hoekstra, Michigan
Michael N. Castle, Delaware
Mark E. Souder, Indiana
Vernon J. Ehlers, Michigan
Judy Biggert, Illinois
Todd Russell Platts, Pennsylvania
Joe Wilson, South Carolina
John Kline, Minnesota
Cathy McMorris Rodgers, Washington
Tom Price, Georgia
Rob Bishop, Utah
Brett Guthrie, Kentucky
Bill Cassidy, Louisiana
Tom McClintock, California
Duncan Hunter, California
David P. Roe, Tennessee
Glenn Thompson, Pennsylvania

Mark Zuckerman, *Staff Director*
Sally Stroup, *Republican Staff Director*

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR AND PENSIONS

ROBERT E. ANDREWS, New Jersey, *Chairman*

David Wu, Oregon
Phil Hare, Illinois
John F. Tierney, Massachusetts
Dennis J. Kucinich, Ohio
Marcia L. Fudge, Ohio
Dale E. Kildee, Michigan
Carolyn McCarthy, New York
Rush D. Holt, New Jersey
Joe Sestak, Pennsylvania
David Loebsack, Iowa
Yvette D. Clarke, New York
Joe Courtney, Connecticut

John Kline, Minnesota,
Ranking Minority Member
Joe Wilson, South Carolina
Cathy McMorris Rodgers, Washington
Tom Price, Georgia
Brett Guthrie, Kentucky
Tom McClintock, California
Duncan Hunter, California
David P. Roe, Tennessee

C O N T E N T S

STRENGTHENING EMPLOYER–PROVIDED HEALTH CARE

Tuesday, March 10, 2009
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 10:32 a.m., in Room 2175, Rayburn House Office Building, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews, Hare, Tierney, Kucinich, Fudge, Kildee, McCarthy, Holt, Sestak, Loebsack, Courtney, Kline, Wilson, McMorris Rodgers, Price, Guthrie, and Roe.

Staff present: Tylease Alli, Hearing Clerk; Jody Calemine, Labor Policy Deputy Director; Carlos Fenwick, Policy Advisor, Subcommittee on Health, Employment, Labor and Pensions; David Hartzler, Systems Administrator; Jessica Kahanek, Press Assistant; Therese Leung, Labor Policy Advisor; Sara Lonardo, Junior Legislative Associate, Labor; Joe Novotny, Chief Clerk; Megan O'Reilly, Labor Counsel; Michele Varnhagen, Labor Policy Director; Robert Borden, Minority General Counsel; Cameron Coursen, Minority Assistant Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Professional Staff Member; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairman ANDREWS [presiding]. Good morning. The subcommittee will come to order. We thank you for your participation today. It is a pleasure for you to join us for—to us to have you join us as we embark in what promises to be a challenging and, I would hope, historic consideration of how best to reform the healthcare system of our country.

We are very fortunate to have a range of talent on this subcommittee on both sides of the aisle, and it is my intention, along with my friend, Mr. Kline, to try to draw upon each of those talents of the members of the subcommittee in the best way we can to produce ideas and a work product that meets the president's mandate, the president's challenge to try to enact legislation in 2009 that reforms our healthcare system.

I want to say from the outset how pleased I am to be able to share this responsibility with Mr. Kline for the second consecutive

Congress. He is a person who is well versed on the issues, is very easy to communicate with, believes deeply in his views and is a strong advocate for them, but is also a fair and balanced person. And it is a pleasure to work with him. I feel privileged to have this opportunity once again.

I am honored to be joined today by my science and technology advisor, my 16-year-old daughter, Jacqueline, who was bitterly disappointed that she didn't get to go to the Usher hearing. This is her consolation prize. Small consolation, indeed.

And also pleased I am able to be joined by my cousin and her husband, Laurel Schull and Walt Schull. They are very important people in my life, and they give me a way to understand these issues. They are both retired educators. They worked very hard for their health insurance over the years, and it is very important to them as they continue in their lives. And they, among many other people, give me a prism through which I can understand these issues. So I am delighted that you are here today.

On Thursday at the White House, President Obama challenged the Congress and the country to enact healthcare reform legislation in 2009. This will be this subcommittee's first effort to meet that challenge and rise to the occasion. The president, I think, very well articulated what most Americans want. I think he articulated the consensus of what Americans want when it comes to change in health insurance.

First of all, I think most Americans want to choose their own doctor or healthcare provider. We feel very passionately that we want to be connected to the person we have chosen to be the pediatrician for our children or the OB/GYN for our wives or daughters, or our own dentist, our own psychiatrist, whatever it is that we want to deal with. Americans feel very strongly about the sanctity of the doctor/patient relationship, and I believe we should do whatever we can to preserve and enhance that relationship.

The second thing that I think most Americans believe about healthcare is it is costing them too much out of their take-home pay. Healthcare out-of-pocket costs for Americans have risen about five times as quickly as wages have risen in the last decade or so.

That means, for a lot of Americans who are fortunate enough to have health insurance, to have a job, and who have received a pay increase in that job, that they very often find they took a pay cut anyway because their out-of-pocket contribution in healthcare went up by more than their paycheck did if they are among that increasingly dwindling group that has a job and gets a pay raise.

So I think most Americans understand that they want healthcare costs to eat up a smaller portion of their paycheck or their family wealth. That certainly goes for small businesses, as well. Small businesses—all business, particularly small businesses, are struggling to cover the people who work for them and their families, and finding it increasingly difficult to do so.

One hundred and sixty-nine million Americans derive their health insurance through an employer/employee relationship. And it is for that reason that this subcommittee and the full committee will be actively engaged in the process of writing and debating, and eventually legislating, bills on this subject.

There are different views about whether the employer/employee system should continue to be a basis for the provision of healthcare. I believe it should be, but I understand there are different views. What I do assure all members of the subcommittee and the full committee is that we will have our full and robust opportunity to weigh in on that debate legislatively as the year goes on because the employee/employer system is such an important part of the care that is presently provided.

This morning, we are going to begin our examination of these issues with a focus on the question of how much it is costing employers who choose to insure, to help carry the burden of employees and dependents of those who do not insure.

Now, notice the formulation I use for this. Employers who choose to insure in recognition of the fact that, in virtually all cases in our country, the law today is that whether or not to insure one's employees is a matter of choice. We are very fortunate that many, many American employers make that choice, and they cover collectively 169 million people.

Other employers do not do so, some by choice and some by necessity. This committee fully understands that there are millions of American entrepreneurs who are struggling to stay alive, and it is—they are not providing health insurance not because they are indifferent to their employees or because they do not understand the value of health insurance, but because providing health insurance would wipe out any net profit they have in their businesses. It is simply not a viable option for a lot of businesses in the country.

There are other employers, however, who are not insuring their employees as a matter of choice and not of necessity. It is within their business purview, under present law, to make that choice. There are a variety of reasons for making that choice. Some are presumptively legitimate. Some are probably illegitimate.

The purpose of today's hearing is to quantify and understand the cost of that choice that has been made. In other words, for employers who are in a position to provide health insurance but choose not to, what happens to the people who are not insured, and who pays for their care?

This morning, I am certain, as we meet, there are at least hundreds of thousands, probably millions of Americans, receiving care in doctors' offices, hospitals, clinics and other settings, and they are not able to pay their bill. When they are not able to pay their bill, someone else pays for it.

We have a system in this country, and I am thankful that we do, that people are not turned away, at least they are not supposed to be turned away, when they approach an emergency room or another healthcare provider and don't have an insurance card. I don't want to live in a country where people are turned away under those circumstances.

But when they are accepted in that emergency room or accepted in that medical practice, someone pays for the care that they receive. In some cases, that someone is a healthcare institution or provider who simply eats the cost and provides free or reduced-price care. In other cases, that cost is passed along to other people who pay premiums in the healthcare system, in which case the cost

is passed along to each of us who pays healthcare premiums in some way.

In other respects, that cost is passed along to taxpayers when uninsured people are covered by public programs whether at the state or federal level. So our focus this morning is going to be to focus in on the question of how much is it costing for the employees who are not insured when they access healthcare, and who is paying for it. I think that is an important question, as we go forward, to frame this discussion.

Again, I am very grateful to have a chance to work with the colleagues that we have on this subcommittee. We are very grateful for this morning's panel.

And at this time, I would like to turn to my friend and the ranking member of the subcommittee, Mr. Kline, for his opening statement.

[The statement of Mr. Andrews follows:]

Prepared Statement of Hon. Robert E. Andrews, Chairman, Subcommittee on Health, Employment, Labor and Pensions

Good morning and welcome to Health, Employment, Labor, Pensions (HELP) Subcommittee's first hearing of the 111th Congress on "Strengthening Employer-Sponsored Health Care." The purpose today's hearing is to initiate a series of hearings on health care reform. This morning, the Subcommittee will focus its attention on the problem many US employers offering health benefits to their employees are facing today; the cost shifting of covering health care for the uninsured. Furthermore, we will examine the reasons as to why this cost shifting is occurring and whether "shared responsibility" amongst all is employers is essential to reforming our health care system in the least disruptive way.

In the United States today, over 169 million working Americans receive their health insurance through their employer. Moreover, these same employers contribute $386 billion to partially cover the cost of the $2.4 trillion we spend as a nation on health care annually.

The success of employer-sponsored health care is due in large part to the purchasing pooling power of these noteworthy employers. However, as the cost of health care continues to precipitously increase, due in large part to the artificial inflation of pricing, many small to large employers have been forced to drop coverage to their employees. As the number of employers offering health coverage decreases, the number of uninsured increases, as well as the burden imposed onto insured employers and their employees to cover the cost of the uninsured. This cost shifting is reflected in their increased premium rates, co-pays, and deductibles and sometimes in the retraction of benefits.

Coverage continues to grow increasingly unaffordable to employers, which has contributed to the precipitous decline in employer-sponsored health coverage over the past decade. In particular, small employers with low to middle-income workers have struggled to meet these rising costs. Furthermore, while over five million Americans have lost coverage during the past decade, it is expected that in the next four years, premiums will rise by another 20 percent, which will result in an additional 3.5 million Americans unemployed and without benefits. In the absence of health care reform in the United States, experts estimate an additional 53 million Americans will be uninsured by 2011.

I believe that an all employer participation component is an essential element to health care reform. Such an approach is seen as the less disruptive method to reforming our health care system. Furthermore, it is estimated that an all employer participation component would increase the number of insured Americans by 83 percent, as well as drive down the overall cost of the system, prevent further erosion of health benefits for workers, as well as protect their right to choose their own doctor and maintain their existing level of benefits.

Mr. KLINE. Thank you, Mr. Chairman, for your kind words about me and your other colleagues. I too am looking forward to working with you and our colleagues on this committee. I am delighted to

see that you have a very, very special guest here this morning. It is a pleasure to meet her.

I don't have a special guest here this morning, but I would like to yield for just a moment to Mr. Wilson, who does.

Mr. WILSON. Thank you, Ranking Member Kline.

It is an honor that I have with me today shadowing the Honorable Tiperu Nasura. Member of Parliament Nasura is a member of the East African Legislative Assembly. She is a Parliamentarian representing Uganda.

Chairman ANDREWS. Please stand, Ms. Nasura, so we can recognize you. Thank you for coming. Welcome. It is great to have you with us.

Thank you, Mr. Wilson.

Mr. KLINE. Thank you, Mr. Wilson.

Again, thank you, Mr. Chairman. I want to thank the witnesses for being with us today as we take up this morning's work.

As the chairman said, we began this in the 110th Congress, addressing many of the issues confronting our nation's healthcare system, including efforts to improve healthcare quality, access and affordability. And clearly, we are going to be doing it again in this Congress, not only in this committee, but across the board.

An important lesson we learned during the last Congress was that, though imperfect, the employer-based healthcare system has been successful in many ways. As we try to address weaknesses in the current system, we must be careful not to undermine a voluntary approach that provides the most common form of healthcare coverage for individuals and workers below retirement age.

The current employer-based voluntary system delivers high quality coverage for over 160 million Americans. American businesses are true innovators when it comes to improving the healthcare system. Private sector employers are leading efforts to help people improve their health through wellness and disease management programs, improving the quality of healthcare, and helping people learn the true costs of medical services.

The driver behind the successes of the employment-based system is the federal ERISA law. The existence of ERISA and its preemption of state insurance laws means that American businesses can provide uniform, high-quality benefits to all their employees across state lines, and that means companies don't have to worry about following 50 different sets of rules in order to offer insurance, which prevents headaches and saves money.

Notwithstanding the success of ERISA, employers, employees and their families are very concerned about rising healthcare costs. While we explore solutions, I want to caution against proposals that would undermine ERISA by pulling one string at a time. However well intentioned, doing so would be an invitation to add benefit mandates and increases taxes on employers, which would likely stifle job creation and seriously undermine employers' ability to provide efficient, affordable healthcare coverage.

At the same time, I would be remiss to not recognize the fact that ERISA stands at the crossroads of healthcare reform, which makes it all the more important that we do not unravel the system, but rather initiate comprehensive reform.

Finally, attempting to define good actors and bad actors in the employer-sponsored system is fraught with danger. When we explore the issue of the uninsured, we must be mindful of the dangers of assigning a one-size-fits-all solution which may be difficult because of the different characteristics within a given population.

For example, millions of people who already qualify for government programs have failed to take advantage of that coverage for a wide variety of reasons. Creating costly new programs to ensure such people, which would come on top of existing federal and state subsidies for uncompensated care, may not be necessary or wise.

In addition, we must not forget that this committee has taken the lead in efforts to improve the current system, including efforts to help small businesses obtain affordable health coverage comparable to that provided by large companies. Private voluntary efforts to control healthcare cost growth and improve quality can be accomplished more quickly than using government programs, and should be encouraged.

I am hopeful we can continue to work together to reach consensus on measures to provide more affordable and efficient ways of providing healthcare benefits. I look forward to this morning's hearing and, again, thank our witnesses for being with us today.

I yield back.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Ranking Republican Member, Subcommittee on Health, Employment, Labor and Pensions

Good morning. I would like to thank my colleagues and the witnesses who have joined us today.

This morning's hearing continues our work—which we began in the 110th Congress—in addressing many of the issues confronting our nation's health care system, including efforts to improve health care quality, access, and affordability.

An important lesson we learned during the last Congress was that, though imperfect, the employer-based health care system has been successful in many ways. As we try to address weaknesses in the current system, we must be careful not to undermine a voluntary approach that provides the most common form of health care coverage for individuals and workers below retirement age.

The current employer-based system delivers high quality coverage for approximately 160 million Americans. American businesses are true innovators when it comes to improving the health care system. Private sector employers are leading efforts to help people improve their health through wellness and disease management programs, improving the quality of health care, and helping people learn the true costs of medical services.

The driver behind the successes of the employment-based system is the federal ERISA law. The existence of ERISA, and its preemption of state insurance laws, means that American businesses can provide uniform, high quality benefits to all their employees across state lines. And that means companies don't have to worry about following 50 different sets of rules in order to offer insurance, which prevents headaches and saves money.

Notwithstanding the successes of ERISA, employers, employees, and their families are very concerned about rising health care costs. While we explore solutions, I want to caution against proposals that would undermine ERISA by pulling one string at a time. However well-intentioned, doing so would be an invitation to add benefit mandates and increase taxes on employers, which would likely stifle job creation and seriously undermine employers' ability to provide efficient, affordable health care coverage. At the same time, I would be remiss to not recognize the fact that ERISA stands at the crossroads of health care reform, which makes it all the more important that we do not unravel the system, but rather initiate comprehensive reform. Finally, attempting to define "good" actors and "bad" actors in the employer-sponsored system is fraught with danger.

When we explore the issue of the uninsured, we must be mindful of the dangers of assigning a one-size fits all solution may be difficult because of the different char-

acteristics within a given population. For example, millions of people who already qualify for government programs have failed to take advantage of that coverage for a wide variety of reasons. Creating costly new programs to insure such people—which would come on top of existing federal and state subsidies for uncompensated care, may not be necessary or wise.

In addition, we must not forget that this Committee has taken the lead in efforts to improve the current system—including efforts to help small businesses obtain affordable health coverage comparable to that provided by larger companies. Private, voluntary efforts to control health care cost growth and improve quality can be accomplished more quickly than using government programs, and should be encouraged. I am hopeful we can continue to work together to reach consensus on measures to provide more affordable and efficient ways of providing health care benefits.

With that, I'd like to welcome our six distinguished witnesses today. I look forward to everyone's testimony.

Chairman ANDREWS. Thank you, Mr. Kline.

Well, welcome, ladies and gentlemen. Here is the procedure we are going to follow.

We have received your written statements, the witnesses, and they will be entered into the record without objection. Also without objection, the opening statement of any member of the subcommittee who wishes to submit an opening statement will be submitted to the record.

We will ask you, ladies and gentlemen witnesses, to give us a 5-minute synopsis of your written testimony this morning. Again, we have had access to your written testimony, had a chance to review it.

You will notice in front of you a light box. The green light means you can start talking. The yellow light means you are within a minute of your 5 minutes being up. The red light means we would ask you graciously to stop.

When we started this process a couple years ago, I mistakenly told people that there was a trapdoor underneath your seat and, if you talked beyond the 5 minutes, it would open. The trapdoor did not exist at that time, I will confess, but I am not telling you whether it does this morning or not.

So we ask you—the reason we ask you to adhere to the 5-minute rule is that, as you see, a number of members are here. It gives the members a chance to interact with you and ask you questions and learn from you.

We are going to now read the biographies of the witnesses, and I will start with Mark Derbyshire. Mr. Derbyshire, welcome.

He is the owner of Park Moving and Storage in Aberdeen, Maryland. Mr. Derbyshire is a small business owner who is going to tell us about his current struggles with the high cost of healthcare for his employees. Welcome, Mr. Derbyshire.

Bruce Pyenson is a principal and consulting actuary in the New York office of Milliman Incorporated. He has been with the firm since 1987, and works with employers, providers, HMOs and healthcare businesses. Mr. Pyenson has authored several reports on healthcare reform, among other topics. Welcome, Mr. Pyenson. Glad to have you with us.

John Sheridan is the president and CEO of the Cooper Health System in Camden, New Jersey, the hospital at which I was born. The hospital overcame that setback and has thrived since then.

Mr. Sheridan is responsible for the operations of Cooper University Hospital and more than 50 satellite offices. Mr. Sheridan has been with Cooper since July of 2005. Prior to that, he was a senior partner and co-chairman of the law firm of Riker, Danzig, Scherer, Hyland & Perretti. Mr. Sheridan graduated from St. Peters College and received his law degree from Rutgers Law School. John, welcome. Nice to have you with us this morning.

Now, Mr. Courtney is going to introduce our next witness because he hails from Connecticut.

Mr. COURTNEY. Thank you, Mr. Andrews, and thank you for holding this hearing today. We could not have a hearing on insurance without a witness from Connecticut because, as everyone from Woody Allen on down has observed that Connecticut and insurance are synonymous.

And Jim Winkler from Hewitt & Associates in Norwalk, Connecticut, is here to testify this morning. Hewitt & Associates is a firm that consults with employers all over the world, and certainly all over the country. He is intimately familiar with, again, a lot of the pricing issues, quality issues, which are critical to us coming out with good ideas in this committee. And he is a graduate of University of Notre Dame and has an MBA from the University of Hartford.

And I would yield back.

Chairman ANDREWS. Welcome, Mr. Winkler. We are glad to have you.

Neil Trautwein is returning to the committee. He joined the National Retail Federation in 2006 and has served as its vice president and employee benefits policy counsel since that time.

Mr. Trautwein previously was an assistant vice president on union resources policy at the National Association of Manufacturers. He holds a bachelor's degree from the University of Louisville and a law degree from the George Washington University. Welcome back, Mr. Trautwein. Glad to have you with us.

And then our final witness, Dr. Thorpe, hails from Dr. Price's district, so I would yield to him so that he can do that introduction.

Dr. PRICE. Thank you, Mr. Chairman. I appreciate that.

I am privileged to introduce Dr. Ken Thorpe, who is a Robert Woodruff Professor and Chair of the Health Policy and Management Department of the Public Health School at Emory University, where I did my residency training.

He currently teaches public health and health resource allocations in health policy. From a public health perspective, he has always been knowledgeable and productive in his work. I have had the privilege of working with him as both a physician and as a state Senator, and we welcome him here today.

He received his BA from the University of Michigan, my alma mater as well, his master's from Duke, and a Ph.D from the Rand Graduate Institute. So he is a huge Wolverine fan, so Go Blue, and welcome, Dr. Thorpe.

Chairman ANDREWS. You guys didn't do very well last year, did you? That is all right. We have a lot of Michigan people associated with the committee, too, so that is okay. That is okay.

All right. We are going to start with our first witness, Mr. Derbyshire. Welcome. We are going to proceed with the witness

testimony, then begin with questions from the members. So welcome, Mr. Derbyshire. Happy to have you with us.

STATEMENT OF MARK DERBYSHIRE, OWNER, PARK MOVING AND STORAGE

Mr. DERBYSHIRE. Okay. Thank you for having me.

Again, my name is Mark Derbyshire. I am the owner of Park Moving and Storage in Aberdeen, Maryland. My parents started the business in 1956 as a small company, and Aberdeen is outside of Baltimore. It is just a small town.

And in the area, there are many small businesses that we have to compete for employees from my industry and from other industries. I currently have about 30 full-time employees, and I invest a lot of time into them because I want to attract people who are interested in staying with the company for a long time.

One of the benefits I am most proud of is, of course, providing health insurance. Times are tough. Good workers are looking for the best opportunities. It is important to me to limit turnover so I can try to make sure that the people I invest in, invest my time and energy, are committed to the company. I do not want to train people that might leave as soon as something better comes along.

I have learned that higher compensation, the higher the motivation, and that is one of the reasons I provide health insurance. Also, I know my workers want to give 100 percent to their jobs. But if they have health problems that are left untreated, they can't. That hurts them, and it hurts my bottom line.

It is not easy to provide health insurance to all the employees. Every year, the premiums go up, and every year I have got to go back to the employees and ask them for a little bit more. Right now, I am paying 85 percent of their premiums, individual rates, and 75 for the family rates. I can't continue to pay more. Year after year, the premiums are going at double-digits.

Often, we small business owners are attacked for not providing health insurance. What people fail to realize is that high cost of administration coverage for each employee in addition to the rising cost of premiums. For a small business to increase costs for fuel and raw material, along with the decreased revenue, can be a lethal combination.

Many of my fellow business owners have been struggling with the idea of ending employee's health insurance to reduce overhead. All around me, companies fold under the pressure of rising health costs, and they stop offering the benefit altogether. That choice I hope will not be one I have to make. I worry about what would happen to our employees if they do not have health insurance, and I cannot afford to have productivity decline because people are sick.

Businesses like mine that do not provide health insurance end up bearing the brunt of the cost for the uninsured workers of other companies. That hardly seems fair, especially for small businesses like mine that—tight profit margin. It is difficult to provide insurance for my own workers.

I cannot afford to have premiums go up every year to help pay for the care of uninsured workers of other businesses or my competitors. When those uninsured workers end up in the emergency room, the cost of that care shows up in the hospital bills for my

workers. My insurance companies, in turn, pass these higher costs to me in higher premiums. Those of us who do the right thing by providing health insurance now have to bear the unfair burden placed on my businesses that do not do their fair share in paying for healthcare costs.

It is a vicious cycle. When premiums go up, businesses drop coverage, resulting in more uninsured workers. Those of us who continue to do the right thing by providing insurance get left holding the bag. Every year, that bag gets heavier. This year, I do not know if I am able to continue paying for coverage for families.

I try not to think about what would happen if I get rid of this benefit, what would happen to my employees, their kids, worried that some people would look for other jobs and that I might have a tough time finding the same caliber of hard-working, high quality employees. If all businesses were required to offer health insurance, the burden would be lightened for all of us that are providing health insurance, and all businesses.

Businesses like mine need the federal government to help us level the playing field. All businesses should pay their fair cost of health coverage so that none of us have to take the extra burden.

Thank you.

[The statement of Mr. Derbyshire follows:]

Prepared Statement of Mark Derbyshire, Owner, Park Moving and Storage

My name is Mark Derbyshire. I'm the owner of Park Moving and Storage in Aberdeen MD. My father started the small packing and moving business in 1956. Aberdeen is a small town near Baltimore. In the area there are many small businesses and we often find ourselves competing to attract good employees. Park Moving and Storage employs about 30 full time employees and I invest a lot in them. I want to attract people who are interested in staying with the company for a long time.

One of the benefits that I am most proud to offer our employees is health insurance. Times are tough and good workers are looking for the best job opportunities. It is important to me to limit turnover so I try to make sure that the people I invest my time and energy in are committed to the company. I do not want to train people that might leave as soon as something better comes along. I have learned that the higher the compensation, the higher the motivation and that is one of the reasons why I provide health insurance. Also, I know my workers want to give 100 percent to their jobs, but if they have health problems that are left untreated, they can't. That hurts them and hurts my bottom line.

It is not easy to provide insurance to all of our employees. Every year, the premiums go up, and every year I have to go back to our employees to ask them to give a little more. Right now we pay for 85% of the premiums for individual coverage and about 75% for family coverage. I can't continue to pay more, year after year as premiums go up by double digit percentages

Often, we small business owners are attacked for not offering health benefits. What people fail to realize is the high cost of administering coverage for each employee, in addition to the rising cost of the premiums. For a small business the increased costs for fuel and raw materials, along with decreased revenue can be a lethal combination. Many of my fellow business owners have been struggling with the idea of ending employee health coverage to reduce overhead. All around me companies fold under the pressure of rising health care costs and stop offering benefits altogether. That's a choice I hope I will not have to make. I worry about what will happen to our employees if they do not have health insurance. And I cannot afford to have productivity decline because people are sick.

Businesses like mine that do provide health insurance end up bearing the brunt of the costs for the uninsured workers of other companies. That hardly seems fair—especially for small businesses like mine with tight profit margins. It difficult enough to provide insurance for my own workers. I cannot afford to have my premiums go up every year to help pay for the care of the uninsured workers of other businesses or my competitors. When those uninsured workers end up at the emergency room, the cost of that care shows up on the hospital bills for my workers. My insurance company passes on those higher costs to me in higher premiums. Those

of us who do the right thing by providing health insurance now have to bear the unfair burden placed on us by businesses that do not do their fair share in paying for health care costs.

It is a vicious cycle. When premiums go up, businesses drop coverage, resulting in more uninsured workers. Those of us who continue to do the right thing by providing insurance get left holding the bag. Every year the bag gets heavier. This year, I do not know if I will be able to continue offering family coverage. I try not to think about what would happen if I got rid of this benefit. What would happen to my employees' kids? I worry that some people will look for other jobs and that I might have a tough time finding the same caliber of hard working, high quality employees.

If all businesses were required to offer health insurance, the burden would be lightened for those of us who already provide insurance. Businesses like mine need the Federal Government to help us by leveling the playing field. All business should pay their fair share of the cost of health care coverage so that none of us have to take on an extra burden.

Chairman ANDREWS. Thank you, Mr. Derbyshire, very much for your testimony.

Mr. Pyenson, welcome. I think you need to push the "On" button on your microphone there.

Mr. PYENSON. There we go.

Chairman ANDREWS. And if we don't like what you say, push it and we will turn it off, okay?

STATEMENT OF BRUCE PYENSON, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN, INC.

Mr. PYENSON. Well, good morning, Chairman Andrews and members of the subcommittee. It is really my honor and privilege to be speaking to you today.

I am Bruce Pyenson. I am an actuary with Milliman. It is a consulting firm, and we consult to a broad spectrum of the healthcare industry on actuarial issues and healthcare management expertise.

We have seen, even before this economic crisis, that the cost of healthcare has made it more and more difficult for employers and others to buy health insurance, and that of course has only gotten worse with the recent crisis. In my view, the most important, and the single-most important issue, is the high cost of healthcare. It should be the number one issue in the healthcare debate, and I was gratified to see that mentioned very prominently in the recent summit.

Two weeks ago, a few of my colleagues and I published a report entitled, "Imagining 16 to 12," which refers to the current spending of the United States on healthcare, at 16 percent of GDP, and the fact that the enormous amount of waste in the system accounts for at least 25 percent of that. In fact, we say that we can reduce our spending by becoming more efficient, from 16 percent to 12 percent, and still cover the uninsured.

Much of the spending in the healthcare system today goes to services or administration that could be done more efficiently or do not bring value to patients, and even where some of that spending goes to services that harm the patient or fix mistakes that should not have been made.

Fortunately, the magnitude—that huge magnitude of waste is illuminated by points of excellence in our healthcare system that exists in locales around the country and can actually apply those examples of excellence to the national averages and come up with

numbers like what we came up with in our report, that we could dramatically reduce healthcare spending.

Now, to get to 12 percent, we developed actuarial models that composite the best practices from those locales, and we applied those models to the entire US. So while our models show that we can reduce healthcare spending by 25 percent, we could actually reduce it by more than that and use the savings to cover the uninsured. That is not unique to our study. There have been a number of others that have come out with studies that show that considerably more than 25 percent of healthcare spending is waste or inefficiency.

We consider that 12 percent as a target, not as a budget, but it is a foundation for consensus on healthcare. In short, we think that rationalizing care, efficient use of resources, is far superior to rationing it.

Now, as with any economic change, there are winners and losers. In my view, the biggest winners in a more efficient healthcare system will be the consumers and the patients and the uninsured. Other winners will be those that can adapt to a system that has incentives for efficiency. And of course, the losers will be organizations that can't adapt to a quality and efficiency-based system.

Our report includes recommendations for system and reimbursement change. I believe those can win consensus. In short, it means shifting payment and care towards evidence-based practices to reduce hospitalizations, avoid unneeded diagnostics, shift long-term care from nursing home to the home and provide quality care at the end of life. And again, patients will be the big winners.

However, I think a focus on reducing cost is actually much harder than arguing about which of the tactics to adopt. Chairman Andrews, at the White House summit last week, you raised important issues, that employers who offer health benefits indirectly pay for cost-shifting from those who don't.

I think many issues go into the calculation of premium rates for insurance. I would point out that employers also pay for cost-shifting from inefficiency, and not just within their own programs. Driving down the cost of healthcare makes all of that much more practical.

I would like to note, in closing, that Milliman itself does not endorse any specific legislation, and I am presenting views that are found in the report.

[The statement of Mr. Pyenson follows:]

Prepared Statement of Bruce Pyenson, FSA, MAAA, Principal & Consulting Actuary, Milliman, Inc.

Good morning, Chairman Andrews and members of the Subcommittee on Health, Employment, Labor and Pensions. It is my pleasure and honor to testify before you today on "Strengthening Employer-Based Health Care." My name is Bruce Pyenson. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I am a Principal with Milliman, a leading actuarial firm. Milliman's clients span healthcare—we provide actuarial and care management expertise to insurers, hospitals, employers, Medicaid programs, advocacy groups and many others. I have been with Milliman for 22 years and have specialized in healthcare costs, benefits, and the value of treatment. Today, I present on the need for and possibility of reducing healthcare costs.

Even before the current economic crisis, we observed that high healthcare costs were pushing many employers to reduce or drop health insurance, and the affordability crisis has only accelerated in recent months. In my view, the single most im-

portant problem in healthcare is that it costs too much, and cost should be the number one issue in the healthcare debate.

Two weeks ago, several colleagues and I published a report entitled, "Imagining 16% to 12%." The title refers to the fact that we are spending over 16% of our GDP on healthcare, but if we got rid of the waste, we could spend under 12%. In fact, there is so much waste in the system that, at 12%, we could also cover the uninsured. My comments today are based on that report, and I ask that the entire report be included in the hearing record.

Much spending in our healthcare system goes to services or administration that could be done more efficiently or that do not bring value to patients. Even worse, some spending also goes to services that harm the patient or to fix mistakes that should not have been made. Fortunately, the huge magnitude of waste is illuminated by comparing national averages to the bright spots of healthcare excellence.

To get to 12%, we developed actuarial models that composite best practices from locales across the US—and we applied those models to the entire US. Our models show that we could reduce healthcare spending by 25% after covering the uninsured, while improving the quality of care. Other researchers have come to similar conclusions using different approaches. We consider 12% a target for what is possible, and a foundation for consensus on healthcare reform, not a budget. We believe rationalizing care—in other words, efficient use of resources—is far superior to rationing it.

As with any economic change, there will be winners and losers under our vision. The biggest winners would be the uninsured, consumers and patients, who would see improved quality and coverage. Other winners will include those who adapt to an efficiency and quality-driven delivery model. Losers include those who can't adapt.

Our report includes recommendations for system and reimbursement changes, which, I believe, can win consensus. In short, these changes include shifting payment and care toward evidence-based practices to reduce hospitalizations, avoid unneeded diagnostics, shift long term care from nursing home to the home, and provide better quality care at the end of life. Patients will be the big winners. However, keeping the focus on reducing waste and cost is much harder than arguing about which tactics to adopt.

Reducing U.S. healthcare spending by 25%—from 16% of GDP to 12%—would be less of a reduction than many prominent estimates of healthcare waste. Even at 12%, we would still spend far more than any other country. Speaking here in 2009, I am not suggesting to further shrink the GDP. Rather, healthcare payers (governments, employers, and individuals) could reallocate more than half a trillion dollars realized each year, using the money for increased wages, infrastructure investments, deficit reduction, reduced taxes or prices.

Chairman Andrews, at the White House summit last week you raised the important issue that employers who offer health benefits indirectly pay for cost-shifting from the uninsured. Many factors and complex calculations can go into insurance premiums or costs that employers pay. I would add that employers also pay for inefficiency—and not just inefficiency in their own programs. In my opinion, driving down costs through efficiency is the key to solving cost-shifting or, at least, making cost-shifting tolerable.

I would like to note that there was no external funding for "16 to 12." Our report reflects the findings of the Milliman co-authors, of which I was one. The report does contain important details about our findings, sources and methodology. Please note that Milliman does not endorse specific legislation.

Thank you for the opportunity to present to you today.

ATTACHMENT: *"16 to 12"*

[The referenced attachment may be accessed at the following Internet address:]

http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/imagining-16-12-RR02-01-09.pdf

---

Chairman ANDREWS. Thank you very much, Mr. Pyenson. We appreciate that.

Mr. Sheridan, welcome to the committee.

STATEMENT OF JOHN SHERIDAN, CEO, COOPER UNIVERSITY HOSPITAL

Mr. SHERIDAN. Good morning. Mr. Chairman, thank you for the opportunity, and also to your fellow members of the committee for the opportunity to address you this morning.

I am the president and CEO of Cooper University Hospital, which is based in Camden, New Jersey. It is a major teaching hospital and a regional tertiary care center serving southern New Jersey. It is also a level one trauma center, and we are the clinical campus for the Robert Wood Johnson Medical School in Camden.

Camden City is one of the poorest cities in the United States, with approximately 40 percent of its households living below the federal poverty level, and Cooper is the city's main healthcare provider. While the national recession has impacted Cooper's finances, the Camden environment and its poor economy has presented financial challenges to us for decades.

We have managed to grow over the past 8 years by recruiting some of the top doctors in the country and developing clinical centers of excellence, and this has enabled Cooper to attract New Jersey residents who at one time relied on the major medical academic centers in Philadelphia for their healthcare.

Our strategy is to attract suburban insured patients to help us carry out our mission for the people of Camden. Cooper's payor mix represents a microcosm of the financial care—I am sorry, of the healthcare financial dynamics at work in New Jersey. Those without healthcare insurance and patients qualifying for charity care and Medicaid totaled over 38 percent of Cooper's patient base in 2006, and this number has grown over the past 3 years to nearly 41 percent.

Cooper receives state funding for its charity care services, but they cover only about 50 percent of the costs. Medicaid funding typically in New Jersey covers 60 to 70 percent of costs. Thus, for Cooper, this uninsured and under-insured population combined represents approximately 30 percent of our costs over the past 3 years but only about 15 percent of our revenue.

The reason why 38 percent of Cooper's patients account for only 30 percent of revenue is explained by the fact that the uninsured typically use hospitals for less acute primary care type services, thus their hospital costs per person is lower than average. However, this represents a huge misallocation of resources in our healthcare economy in that expensive hospital resources are being utilized to provide that which could be done very well at the primary care physician level.

What are the economic consequences of this pattern? Hospitals such as Cooper must shift expenses to those with health insurance. Patients with employer-sponsored health insurance constitute just over 30 percent of our patient base and approximately 30 percent of our costs. However, this segment of our business over the past 3 years represents about 40 percent of our revenue.

Unfortunately, these underlying dynamics of our healthcare economy are not sustainable. As costs are shifted to the paying patients, premiums rise and individuals and businesses aren't able to pay for health insurance coverage. This increases the number of uninsured and under-insured, which leads to further cost shifting.

The picture I have drawn of Cooper and the healthcare economy in Camden can be found throughout New Jersey, albeit to somewhat lesser extent in the state as a whole. Over the last 6 years, the percentage of uninsured, charity care and Medicaid hospital cases have grown from 14.8 percent to 18.5 percent. Insured cases have declined from 47.6 percent to 41.9 percent.

During the same period, provision of hospital charity care service priced at Medicaid rates grew from 624 million to 945 million annually. This represents an annual growth rate of 8.6 percent per year.

These trends regarding the decline of healthcare coverage and increase in uninsured and under-insured in New Jersey are taking a serious toll on the hospital industry. More than half of New Jersey's hospitals are operating in the red, and eight hospital have closed their doors since 2002.

In conclusion, it would seem clear that employer-sponsored healthcare insurance has been, and will continue to be, crucial to the financial health of hospitals such as Cooper and New Jersey's healthcare economy. However, businesses have a right to be seriously concerned about the increasing cost of healthcare. The trends are not sustainable. The cornerstone of healthcare reform is the expansion of insurance coverage to all Americans, and employer-sponsored plans will play a key role.

It will also be important for there to be stability in health insurance premiums so that businesses and individuals are able to adequately plan to meet their obligations. This in turn will require a decline in the rate of healthcare cost inflation. We stand ready to do our part to better manage care and reduce unnecessary hospitalizations and improve the quality and cost efficiency of healthcare services.

Thank you.

[The statement of Mr. Sheridan follows:]

Prepared Statement of John Sheridan, CEO, Cooper University Hospital

"How significant is uncompensated care due to free rider employers in the health care system in the rising cost of health care; particularly, insurance premiums, deductibles, co-pays and other cost-sharing arrangements?"

Good morning. Thank you, Chairman Andrews, for your introduction. I would like to thank the Chairman and his fellow esteemed members of this Committee for the opportunity to address you on this important topic.

Cooper University Hospital, based in Camden, New Jersey, is a major teaching hospital and regional tertiary-level referral center serving the southern New Jersey region. Cooper University Hospital is the flagship of The Cooper Health System. It is the premier university hospital serving South Jersey and the Delaware Valley. As the core clinical campus for the Robert Wood Johnson Medical School in Camden, Cooper is a national leader in medical education and research. With its comprehensive services and cutting-edge technology, the hospital is renowned for its prestigious Centers of Excellence in cardiology, cancer, critical care, trauma, orthopedics and neurology. Cooper has embarked on a $500 million expansion of its Camden Health Care Campus including the new $220 million patient Pavilion which opened in December 2008. Cooper and its community partners earned a 2008 Smart Growth Award from New Jersey Future for the vision of the Health Sciences Campus in Camden.

As many of you are aware, Camden city is one of the poorest cities in the United State, with approximately 40% of its households living below the federal poverty level. Cooper is the city's main health care provider, serving as its community hospital and provider of primary and sub-specialty medical care. As a consequence, Cooper is the largest provider of charity care services in South Jersey and is recognized

as a "safety-net" hospital—one of the largest providers of charity care services in New Jersey.

While the national recession has taken a serious toll on Cooper's finances in the course of the past year, the Camden environment and its poor economy has presented difficult financial challenges for Cooper for decades. We have managed to grow over the past eight years by recruiting some of the top doctors in the country and developing clinical centers of excellence with national reputation. This has enabled Cooper to increase its patient utilization and attract New Jersey residents who in the past have depended on the major academic medical centers in Philadelphia.

Cooper's payer mix presents a microcosm of the healthcare finance dynamics at work in New Jersey and the country at large. Fundamentally, healthcare providers such as Cooper with a great volume of patients that are uninsured or under-insured, must shift their costs to their paying patients. Those without healthcare insurance, and patients qualifying for charity care and Medicaid, totaled over 38% of Cooper's patient base in 2006, and this number has grown over the past three years to nearly 41% in 2008. While Cooper receives State funding for its charity care services, it only covers approximately 50% of the costs of these services; Medicaid funding typically covers only 60-70% of costs. Thus, for Cooper, this uninsured and underinsured population combined represents approximately 30% of our costs over the past three years, but only 15% of our revenue.

The reason why 40% of Cooper's patients only account for 30% of Cooper's costs is explained by the fact that the uninsured typically use hospitals for less acute, primary-care related services. Thus, their hospital cost-per-person is lower than the average. However, this represents a misallocation of resources in our health care economy in that expensive hospital resources are being utilized in place of less expensive physician-based primary care.

So Cooper is a safety-net health care provider, and we are there for our patients without regard for the patients' ability to pay for care—a mission Cooper has maintained for 120 years. But what are the economic consequences of this pattern of hospital utilization? Hospitals such as Cooper must shift expenses to those with health insurance.

Patients covered under Medicare insurance represent 30% of our patient base and Medicare rates pay close to actual cost of care, though in recent years, Medicare has not kept up with the increased cost of providing care.

Patients with employer-sponsored health insurance constitute just over 30% of our patient base over the past three years, and approximately 30% of our cost structure. However, this segment of our business over the past three years represents approximately 40% of our revenue. One might say that this premium of ten percent over the cost of care for this segment of business represents part of the price of the social contract to care for those unable to pay for themselves.

Unfortunately, the underlying dynamics of our healthcare economy are not sustainable. As costs are shifted to the paying patients, premiums rise, and individuals and business are unable (or unwilling) to pay for health insurance coverage. This increases the number of uninsured and underinsured, which leads to further cost shifting, and the precarious healthcare economy we all face today.

Increasing health care insurance coverage will help to stabilize the inflation of health care expenses. While this is a necessary component of health care reform, it will be insufficient to reduce health care costs, unless greater resources are allocated to primary care and the proper clinical management of chronic diseases. There are numerous primary care initiatives and interventions being tested around the county, and at Cooper as well, which demonstrate that we can substantially reduce health care expenses by "case management" and patient education which facilitates better disease management and reduction in the use of expensive emergency departments and hospitalization.

The picture I have drawn of Cooper and the healthcare economy in Camden can be replicated for the State of New Jersey. Over the last six years, the percentage of uninsured, Charity Care, and Medicaid hospital cases have grown from 14.8% to 18.5%, while non-governmental health insurance payers including commercial, HMO, and point of service health insurance coverage has declined from 47.6% in 2002 to 41.9%. Approximately 90% of this category is employer-sponsored, according to O'Conco Healthcare, a prominent health care consultancy.

During the same time period, provision of hospital charity care services—priced at Medicaid rates, which are approximately 60%-70% of actual costs—grew from $624MM to $945MM—a 51% increase over six years. This represents an annual growth of demand for charity care services in New Jersey of 8.6% per year. New Jersey State payments for hospital charity care services have grown from $381MM in 2002—covering 60% of hospitals' charity care services priced at Medicaid rates—

to $715MM in 2008—covering 75% of charity care at Medicaid rates. The cumulative impact on the hospital industry of the shortfall in hospital payments for New Jersey charity care represents $2.32 billion over the past six years!

These trends regarding the decline in health care coverage and increase in the uninsured and underinsured in New Jersey, along with the continued deficit in hospital charity care funding, have take a serious toll on the hospital industry. More than half of New Jersey hospitals are operating in the red and eight hospitals have closed their doors since 2002.

It is useful to put these trends in perspective of the business community in New Jersey, and the pressure it faces in response to the continued increase in health care costs and the cost of health insurance coverage.

In 2008 the New Jersey Business and Industry Association's annual "Health Benefits Survey" found that health insurance costs rose by an average of 9.4 percent in 2007. Employers spent an average of $7,139 per employee. More startling, it found that costs have doubled in the past six years, given the effects of compounding. In spite of this, the vast majority of employers in New Jersey are continuing to provide health insurance coverage for their employees (98% of companies with 51+ employees and 95% of companies with 20-50 employees), though the beneficiaries have faced increased out-of-pocket expenses. Very small companies, however, seem to be reaching the breaking point. Some 75% of companies with 2-19 employees provided coverage last year, but 92% provided coverage just four years ago. Many small employers continued to provide coverage by cutting costs in other areas. Sixteen percent of small employers limited salary increases and another 10 percent scaled back hiring.

The latest New Jersey Business & Industry Association's Health Benefits Survey was conducted in January 2008, and included over 1,000 New Jersey businesses, 88 percent of whom were small companies with 2-50 employees, representing all major industry sectors and all 21 New Jersey counties. Among their findings:

- The average cost of $7,139 per covered employee in 2007 included coverage of both full-time employees with no covered dependents and full-time employees with covered spouses and/or dependents. This was the amount paid by the employer. It did not include the share of premium costs paid by employees.
- The average increase of 9.4 percent for all companies in 2007 followed increases of 11.3 percent in 2006, 12 percent increase in 2005, and 11.2 percent in 2004. Factoring in increases of 13.2 percent and 15 percent recorded by the NJBIA survey in 2002 and 2003, and given the effects of compounding, employers paying these average cost increases would have seen their costs double over the past six years.
- The cost of health insurance, as a percentage of wages and salaries, also rose for many companies last year. The average cost of $7,139 per employee represented 15 percent of reported average wages of $47,414. This is up from 2006, when employer health insurance costs represented 13.5 percent of average wages.
- As a group, employers do not expect their health plan costs to moderate anytime soon. Survey participants anticipate that their costs will increase by an average of 9.7 percent in 2008.
- The proportion of the smallest companies, those with 2-19 employees, sponsoring coverage has fallen as costs have risen. Seventy-five percent of this group reported providing coverage in the current survey, down from 92 percent four years ago. The average size company in this group has six employees.
- When companies that no longer provide coverage were asked why, 76 percent said they could no longer afford it. Another 10 percent said they were unable to satisfy the State's requirement that at least 75 percent of their workforce participate in the plan.

Nationally, the American Hospital Association is a useful source for data on uncompensated care nationwide. Among its findings:

- In the aggregate, both Medicare and Medicaid payments fall below costs and the shortfall has been growing.
- Combined underpayments rose from $3.8 billion in 2000 to nearly $32 billion in 2007
- For Medicare, hospitals received payment of only 91 cents for every dollar spent by hospitals caring for Medicare patients in 2007
- For Medicaid, hospitals received payment of only 88 cents for every dollar spent by hospitals caring for Medicaid patients in 2007
- In 2007, 58 percent of hospitals received Medicare payments less than cost, while 67 percent of hospitals received Medicaid payments less than cost

I have attached some relevant data on these trends provided by the AHA below in Table #x.

The AHA's policy position on the uninsured echo's the Institute of Medicine's report which focuses on the "cost of health care, particularly the cost and access to

health care insurance, as well as the decline in employer sponsored health care as the key contributing factors to the recent rise in the uninsured. Solving the problems of health care coverage will be a critical step in solving the burden of hospital uncompensated care."

In conclusion, it would seem clear that employer-sponsored healthcare insurance has been and will continue to be crucial to the financial health of hospitals such as Cooper and New Jersey's healthcare economy. However, employer-sponsored healthcare insurance is endangered. Businesses have a right to be seriously concerned about the cost of their coverage and the increasing cost of health care. The trends are not sustainable. The cornerstone of health care reform will be to expand insurance coverage to all Americans, and employer-sponsored plans will necessarily play a key role. It is likely that business will need substantial incentives to increase their participation, particularly small businesses that are unable to afford coverage for their employees. Secondly, it will be important for there to be stability in health insurance premiums so that businesses and individuals are able to adequately plan for meeting their obligations. This, in turn, will require a decline in the rate of healthcare cost inflation. Health care providers stand ready to do their part to better manage care and reduce unnecessary hospitalizations, and improve the quality and cost-efficiency of health care services.

I would be pleased to take any questions that members of the committee may have.

REFERENCES AND SOURCES OF DATA

1. O'Conco Healthcare Consultants, Hospital Utilization by Payer Mix, 2002-2008. NJ MIDS Data.

2. New Jersey Hospital Association, Trends in Charity Care Funding in NJ, 2009.

3. New Jersey Business and Industry, Changes in Employer-Sponsored Health Insurance Coverage.2008.*http://www.njbia.org/news—newsr—080429.asp;http://www.njbia.org/hbs08.ppt.*

4. American Hospital Association, Underpayment by Medicare And Medicaid: Fact Sheet, November 2008

5. American Hospital Association, Uncompensated Hospital Care Cost Fact Sheet, November 2008

APPENDIX- SUPPORTING DATA

Hospital Utilization- Cases By Health Insurance Payer - All NJ Hospitals by Data Year- Table #1

	Total Cases						
	2002	2003	2004	2005	2006	2007	2008**
Govt Payer (minus Medicaid)	460,773	496,937	518,724	521,679	525,041	527,230	514,077
Total - Medicaid & Uninsured	162,860	188,170	205,866	207,355	207,225	211,623	199,313
Total- Commercial & POS	523,863	505,368	490,179	485,862	488,121	487,168	452,791
Total	1,101,090	1,129,873	1,139,664	1,136,066	1,141,030	1,142,576	1,079,908

**2008 data incomplete

	Percentage of Cases By Payer Type						
	2002	2003	2004	2005	2006	2007	2008**
Govt Payer (minus Medicaid)	41.8%	44.0%	45.5%	45.9%	46.0%	46.1%	47.6%
Total - Medicaid & Uninsured	14.8%	16.7%	18.1%	18.3%	18.2%	18.5%	18.5%
Total- Commercial & POS	47.6%	44.7%	43.0%	42.8%	42.8%	42.6%	41.9%

	Percentage of Total Charges By Payer Type						
	2002	2003	2004	2005	2006	2007	2008**
Non Medicaid Govt Payer	56.1%	58.0%	58.4%	58.0%	57.5%	56.7%	57.9%
Total - Medicaid & Uninsured	12.7%	14.2%	15.1%	15.0%	15.3%	15.8%	15.7%
Total- Commercial & POS	34.8%	32.4%	31.7%	32.2%	32.7%	33.4%	32.7%

NJ State Charity Care Shortfall Trend- Table #2

State Fiscal Year	Charity Care Documentation (Services @ Medicaid Rates) *($ in millions)*	Charity Care Funding (Payments to Hospitals) *($ in millions)*	Charity Care Shortfall (Payments vs. Services) *($ in millions)*
1994	$327.3	$383	**$56**
1995	$327.3	$400	**$73**
1996	$402.7	$310	($93)
1997	$407.2	$300	($107)
1998	$463.2	$320	($143)
1999	$483.0	$320	($163)
2000	$518.1	$320	($198)
2001	$601.1	$356	($245)
2002	$624.4	$381	($243)
2003	$577.7	$381	($197)
2004	$778.1	$381	($397)
2005	$812.0	$583	($229)
2006	$910.0	$583	($327)
2007	$941.8	$583	($359)
2008	$945.7	$715	($231)
2009	$945.3	$605	($340)

TABLE #3

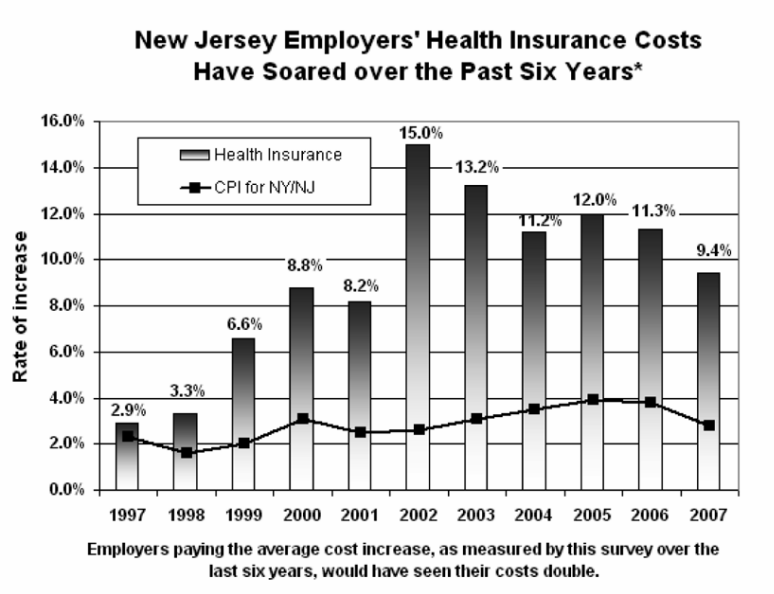


TABLE #4

National Government Underpayment for Hospital Services for Medicare and Medicaid 2000-2007 (in Billions)

Year	Hospitals	Medicare	Medicaid	Total
2000	4915	$1.3	$2.5	$3.8
2001	4908	$2.3	$2.0	$4.3
2002	4927	$3.3	$2.3	$5.5
2003	4895	$8.1	$4.9	$13.0
2004	4919	$15.0	$7.1	$22.1
2005	4936	$15.5	$9.8	$25.3
2006	4927	$18.6	$11.3	$29.9
2007	4897	$21.5	$10.4	$31.9

Source: Health Forum, AHA Annual Survey Data, 2000-2007
Note: Medicare and Medicaid payments include all applicable payment adjustments-Disproportionate Share, Indirect Medical Education, etc.; payments include both fee-for service and managed care payments.

TABLE #5
National Uncompensated Care Based on Cost*: 1980-2007 (in Billions), Registered Community Hospitals & Uncompensated % of Total

Year	Hospitals	Care Cost	Expenses
1980	5828	$3.9	5.1%
1981	5812	$4.7	5.2%
1982	5796	$5.3	5.1%
1983	5782	$6.1	5.3%
1984	5757	$7.4	6.0%
1985	5729	$7.6	5.8%
1986	5676	$8.9	6.4%
1987	5597	$9.5	6.2%
1988	5499	$10.4	6.2%
1989	5448	$11.1	6.0%
1990	5370	$12.1	6.0%
1991	5329	$13.4	6.0%
1992	5287	$14.7	5.9%
1993	5252	$16.0	6.0%
1994	5206	$16.8	6.1%
1995	5166	$17.5	6.1%
1996	5134	$18.0	6.1%
1997	5057	$18.5	6.0%
1998	5015	$19.0	6.0%
1999	4956	$20.7	6.2%
2000	4915	$21.6	6.0%
2001	4908	$21.5	5.6%
2002	4927	$22.3	5.4%
2003	4895	$24.9	5.5%
2004	4919	$26.9	5.6%
2005	4936	$28.8	5.6%
2006	4927	$31.2	5.7%
2007	4897	$34.0	5.8%

Source: Health Forum, AHA Annual Survey Data, 1980-2007
*The above uncompensated care figures represent the estimated ***cost*** of bad debt and charity care to the hospital. This figure is calculated for each hospital by multiplying uncompensated care charge data by the ratio of total expenses to gross patient and other operating revenues. The total uncompensated care cost is arrived at by adding together all individual hospital values. The uncompensated care figure does not include Medicaid or Medicare underpayment costs, or other contractual allowances. Moreover, the figure does not take into account the small number of hospitals that derive the majority of their income from tax appropriations, grants and contributions.

Chairman ANDREWS. Mr. Sheridan, thank you very much for your testimony.

Mr. Winkler, welcome to the subcommittee.

STATEMENT OF JIM WINKLER, HEALTH MANAGEMENT PRACTICE LEADER, HEWITT ASSOCIATES

Mr. WINKLER. Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify at this important hearing.

My name is Jim Winkler, and I am the health management consulting practice leader at Hewitt Associates. At Hewitt, we consult with large employers, helping them improve employee health and reduce absence through better program design. In addition, we are the leading provider of benefits outsourcing services, administering health and welfare benefit programs for 195 employers representing nearly eight million participants.

I am pleased to focus my remarks today, as requested, on the experience of large employers, the majority of whom do provide healthcare coverage today. While large employers are not a homogenous group, I do want to be clear in saying that employers and Hewitt support the concept of healthcare reform and believe that all efforts to cover working Americans should build upon and fur-

ther strengthen the employer-based system which provides coverage to more than 160 million participants today.

Employers have a vested interest in the health and productivity of their workforce, and the employer-based system has helped foster that interest. However, despite the positive actions of employers, there are many problems to solve in the current US healthcare system.

As we all know, healthcare is too costly. Average annual healthcare costs for a typical large employer will exceed $13,000 per employee by 2014, a 50 percent increase over current costs. Both employers and employees will find it difficult to afford such an increase.

We also believe that systemic changes are needed to reverse current cost acceleration. The federal government, employers and health plans must work together to change the payment system to better focus physicians and hospitals on wellness, primary and preventative care, with strong incentives for evidence-based medical treatment.

Finally, we spend too much on chronic conditions without measurable quality. We must attack the root causes of smoking, poor nutrition, obesity and physical inactivity by providing financial incentives for healthy behaviors.

This will not only lower healthcare costs, but will also reduce absence. This is critical, as lost workforce productivity is a very real cost to the US economy.

The cost of healthcare for large employers and their employees is higher because of gaps in coverage and differences in reimbursement rates between public and private healthcare programs. Large employers pay somewhat higher premiums to cover provider costs for uncompensated care.

Further, employers fund higher cost for medical treatments because Medicare and Medicaid payment rates are comparatively lower than rates for employer-sponsored group health plans. Large employers are concerned that cost shifting could increase further if rising healthcare costs encourage small and medium size businesses to drop health coverage in order to remain competitive, particularly in these difficult economic times.

So how do we address these issues? In our written testimony, we identified five imperatives for healthcare reform, and I would like to highlight three of them today.

First is we need to preserve and promote the employer-based healthcare system that generally works, while imperfect, for 160 million people today.

Second, we must protect and strengthen federal ERISA preemption of state laws to promote uniformity in coverage and reduce administrative costs. The vast majority of large employers operate across multiple states, and they must be able to continue to offer administratively efficient uniform benefit packages to their employees.

And third, we must allow employers flexibility in how they meet any new standards for health coverage. For example, they should be able to demonstrate that their plans are equivalent in value to any standard benefit requirements, similar to the rules in place for the retiree drug subsidy under Medicare Part D today.

As I noted at the outset, large employers support healthcare reform that will lead to sustained affordability for themselves and their employees. How large employers react to specific reform proposals will depend in large part on the many critical details in any proposed reform and whether or not large employers view that specific reform as likely to increase versus mitigate their healthcare costs.

The earlier that Congress can make details available for discussion and analysis, the better that employers can react. Congress has the challenge of sorting through the details of how reform will be accomplished, with competing approaches and viewpoints. Hewitt would be pleased to offer its data analysis and its experience in helping the subcommittee evaluate the impact of detailed reform plans on coverage provided by large employers today and in the future.

Thank you.

[The statement of Mr. Winkler follows:]

Testimony
on Behalf of Hewitt Associates LLC

By James M. Winkler
Health Management Consulting Practice Leader

Before

U.S. House of Representatives

Committee on Education and Labor
Subcommittee on Health, Employment, Labor, and Pensions

Hearing on

Strengthening Employer-Based Health Care
March 10, 2009

Hewitt Offices—U.S.

California
Newport Beach
San Francisco

Connecticut
Norwalk

District of Columbia
Washington

Florida
Orlando
Miami

Georgia
Atlanta

Illinois
Lincolnshire
Chicago

Maryland
Hunt Valley

Massachusetts
Waltham

Michigan
Troy

Minnesota
Minneapolis

Missouri
St. Louis

New Jersey
Bridgewater

New York
New York

North Carolina
Charlotte

Ohio
Independence

Pennsylvania
Philadelphia
Pittsburgh

Texas
Irving
The Woodlands

Virginia
Falls Church

About Hewitt Associates

Hewitt Associates (NYSE: HEW) provides leading organizations around the world with expert human resources consulting and outsourcing solutions to help them anticipate and solve their most complex benefits, talent, and related financial challenges. Hewitt consults with companies to design and implement a wide range of human resources, retirement, investment management, health management, compensation, and talent management strategies. As a leading outsourcing provider, Hewitt administers health care, retirement, payroll, and other HR programs to millions of employees, their families, and retirees. With a history of exceptional client service since 1940, Hewitt has offices in more than 30 countries and employs approximately 23,000 associates who are helping make the world a better place to work. For more information, please visit www.hewitt.com.

I. Introduction

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to testify at this important hearing on the future of America's employer-based health care system. My name is Jim Winkler, and I am Hewitt Associates' Health Management Consulting Practice Leader. I am pleased to focus my remarks today, as requested, on the experience of large employers, the majority of whom provide health care coverage today.

Hewitt Associates is a global human resources outsourcing and consulting company, providing services to major employers in more than 30 countries and employing 23,000 associates worldwide. Headquartered in Lincolnshire, Illinois, we serve more than 2,000 U.S. employers from offices in 30 states, including many of the states represented by the members of this distinguished Subcommittee.

As one of the world's premier human resources services companies, Hewitt Associates consults with large employers to design their health plans and evaluate bids by competing health providers. In addition, we are the leading provider in Benefits Outsourcing services, administering health and welfare plans for 195 clients representing more than 7.5 million participants. Our access to large employers led us to create the Hewitt Health Value Initiative™ database, which contains detailed information on more than 1,800 health plans throughout the U.S., including 350 major employers and more than 13 million health plan participants. This rich data source allows us to analyze the impact of rapidly rising health care costs on employers and employees.

II. Hewitt's View of the Challenges

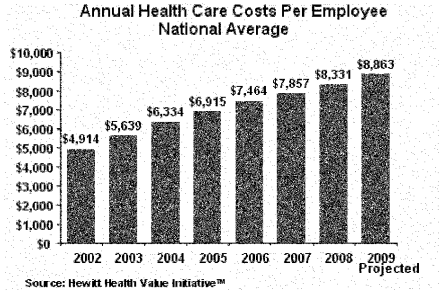
We agree, Mr. Chairman, with the view that the employer-based health care system must be preserved and strengthened as part of any viable health reform plan. Large employers support the urgent need for health reform and the objective of providing universal coverage. Further, employees and their families must have confidence that reform will not disrupt their existing coverage. Nationwide, employer-sponsored health care plans provide health care coverage to 160 million participants. Data from the Kaiser Family Foundation shows that 99% of employers with 200 or more employees offered health benefits in 2008, the latest data available.[1]

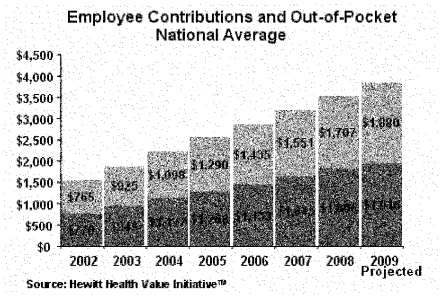
The employer-sponsored model works well because it allows the pooling of risks and because group purchasing lowers health care costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. Employer-based plans typically waive pre-existing conditions and do not increase premiums or limit coverage based on health status. Employers have a vested interest in the health and productivity of their workforce, and the employer-based system has consistently produced innovative health care solutions. The poor health of employees not only affects an employer's health care costs; it can also directly affect employer costs in terms of lost productivity, absence from work, and higher disability costs.

[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2008.

As good as it is, this system is increasingly at great risk, given the combination of cumulative increases in health care costs and the current severe economic downturn. Despite the positive actions of many employers, there are many problems to solve in the current U.S. health care system. Among the most pressing:

- **Health care is too costly.** Most large employers that Hewitt has surveyed see the need for health reform, if not in 2009, then at least in the next four years. According to Hewitt data, annual large-employer health care costs (i.e., total costs for all health plan participants divided by the number of employees) have more than doubled since 2001 and are projected to reach $8,863 in 2009. Over the same period, annual employee contributions and out-of-pocket costs are expected to increase by 190% to $3,826.[2]





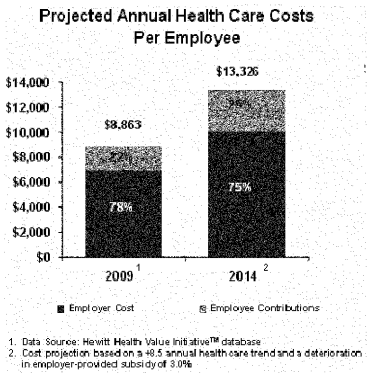
Average Employee Contribution

Average Employee Out-of-Pocket Costs

[2] Estimates calculated from the Hewitt Health Value Initiative (HHVI) database.

Many large employers fear that rising health care costs may encourage small- and medium-sized businesses to drop health coverage to keep their business competitive, especially during this severe economic downturn. Such a trend will lead to large employers (who are doing the right thing in offering and heavily subsidizing coverage) having to assume an even larger economic burden because of a variety of factors, including increased costs they pick up indirectly through cost shifting. Cost shifting is discussed in more detail in Section III.

- **Systemic changes are needed.** Systemic changes must be made in our health care delivery system if we hope to mitigate or reverse the current cost acceleration. For example, our health care system rewards physicians when they provide more services for sick care, rather than rewarding them equally for spending time to help patients avoid the 80% of illnesses that are lifestyle-related. Employers and health plans must work together to radically change the payment system to reimburse physicians and hospitals for excellent primary care supplemented with appropriate specialty care and chronic care management. Without meaningful change soon, large employers fear that rising costs will make health care unaffordable for millions more Americans. According to Hewitt data, on their current trajectory, average annual health care costs per employee will rise from $8,863 per person in 2009 to $13,326 per employee by 2014.[3] Employers will have difficulty subsidizing the additional cost, and employees will increasingly be unable to afford the increasing contributions.



- **We spend too much on chronic care and do not achieve desired quality outcomes.** Hewitt estimates that among large employers, approximately 51% of employees or their family members have a chronic health condition.[4] This includes often largely preventable conditions like diabetes and cardiovascular disease that are afflicting the U.S. population at alarming rates. The direct and indirect costs of cardiovascular disease and stroke alone were $475.3 billion in 2008.[5] There are many studies

[3] Estimates calculated from the Hewitt Health Value Initiative (HHVI) database.
[4] Hewitt Associates, *The Road Ahead: Employee Views on Health 2008* survey, April 2008.
[5] The American Heart Association (AHA) and National Heart, Lung and Blood Institute.

documenting this trend, including major contributions by Mr. Kenneth Thorpe, who is testifying before the Subcommittee today. For example, one recently published Milken Institute study estimates that the total cost of managing chronic health diseases in the U.S. is $1.3 trillion annually, with $1.1 trillion spent in lost productivity and $277 billion spent on treatment. That same report also identifies a $1.1 trillion savings opportunity by addressing avoidable chronic disease early, which assumes just a moderate behavior change by participants.[6]

To slow the upward trend of health care costs, Hewitt believes that health reform must attack the root causes of poor nutrition, obesity, and physical inactivity in this country. Public and private employers, governments, and those in the health care system can start by offering financial incentives to employees and their families to engage in healthy behaviors. Many large employers already have promising efforts under way. Allowing those financial incentives to be tax-favored would further accelerate the necessary focus on health and wellness.

- **The real cost of health care goes well beyond premiums.** While many people are justifiably focused on the high price tag for health coverage, lost workforce productivity is another real cost that the ailing health care system exacts from the U.S. economy. On average, eight in every 100 employees take an extended absence in a given year, with the average absence lasting about *42 days*. For an employer with 20,000 employees, that adds up to the equivalent of 260 full-time employees not working for an entire year, or almost $13 million in lost productivity.[7] Further, health care safety issues, such as adverse drug reactions, dispensing incorrect prescriptions, and poor patient compliance, lead to preventable injuries, extended illnesses, and even death. By investing in the health of their workforce and by helping to improve patient safety, employers enhance the quality and longevity of employees' and their families' lives. At the same time, they gain better control over health care costs and employee productivity.

- **Health care information technology is antiquated.** PricewaterhouseCoopers estimates that as much as $315 billion of annual health care spend is essentially the wasted cost of operational inefficiencies resulting from a lack of electronic connectivity in the health care system.[8] Federal health care reform should encourage the creation of a centralized, digitized, and accurate medical record system driven by 21st century technology to reduce duplicative treatments and medical errors and improve coordination of care among providers. Employers view the recent incentives for Health Information Technology (HIT) in the ARRA law as a very positive direction, with the Congressional Budget Office projecting that the vast majority of physicians and hospitals are now more likely to adopt electronic medical records within a decade.

III. Large Employers Are Shouldering More Costs

The cost of health care for large employers and their employees is higher because of gaps in coverage and differences in reimbursement rates between public and private health care programs. Under the current system, the cost of health care for employers offering good health coverage to their employees is higher than it "should be" due to a combination of the following factors:

- **Private payers are charged somewhat higher fees to offset a portion of the costs for uncompensated care.**

  Economists who have studied the costs shifted to private plans by providers seeking to offset uncompensated-care costs have estimated different ranges. A recent Congressional Budget Office report put the cost of uncompensated care at 5% of hospital costs and 1% of physician costs.[9] We believe it is

[6] Milken Institute, *An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity and Economic Growth* report, October 2007.
[7] Hewitt Associates, *The Nuts & Bolts of Leaves of Absence 2008* survey, December 2008.
[8] PricewaterhouseCoopers, *The Price of Excess: Identifying Waste in Healthcare Spending*, April 2008.
[9] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* report, December 2008.

reasonably conservative to assume that the additional cost incurred by private plans to offset provider costs for uncompensated care is about 2% to 3% of an employer's health care costs. Based on the current data, economists do not agree, with some projecting higher ranges and some projecting lower ranges.[10]

- **Large employers provide coverage for their employees' working spouses who have no coverage or who have less generous coverage at their own employer.**

  Spouses frequently choose coverage under the employee's plan when the spouse's employer doesn't offer a health plan or when the employee's plan is perceived as superior in terms of cost, benefits, or access. Large employers then pay more because they are providing medical coverage for another company's employee. Hewitt conservatively estimates that large employers could see a net savings of 5% to 8% of their total health care costs if all employees were to get coverage from their own employers.

  If a health care reform package provides universal coverage while retaining and strengthening the employer-based system, minimizing uncompensated care and requiring all employees to enroll in their own employers' health plans could give large employers a potential savings of 7% to 11%.

- **Providers shift costs to employer-sponsored plans to make up for reimbursements from public programs that are lower than the total costs of providing care.**

  Employers also see higher price tags in their medical plans because Medicare and Medicaid payment rates are set by law and are comparatively lower than rates for employer-sponsored group health plans. It is no secret that providers receive much higher payments from private insurance plans than from public plans. Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents "cost shifting" from public to private plans. But the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example, according to a 2008 Milliman actuarial study,[11] Medicare reimburses hospitals at an average of 70% of private plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private plan rates and pays physicians at an average of 53% of private plan rates.

  It is desirable, but perhaps not fiscally feasible, to close this gap in public/private reimbursement rates to providers. At a minimum, health reform should ensure that the payment differential does not worsen further, because this would create even more cost-shifting pressure on private payers and potentially lead to a two-tier system where employers offering their own plans are at a significant cost disadvantage.

IV. Five Imperatives for Health Care Reform

Hewitt believes that comprehensive health care reform must start by first addressing the very real issues that drive up cost, preventing more employers from participating and more individuals from taking advantage of the public and private health care programs available to them.

Accordingly, we believe that federal health care reform must focus on the following priorities:

1. **Preserve and promote the employer-based health care system.** Reform should seek to both protect and expand the number of employers who provide health care for their employees. Over the years, the

[10] For different views on the degree to which uncompensated care increases the cost for private payers, see, for example, The Kaiser Family Foundation analysis at http://www.kff.org/uninsured/upload/7809.pdf and the Families USA report at http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html.

[11] Milliman, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers* study, December 2008.

system has encouraged employers to be innovators of health care solutions. Recent innovations include evidence-based plan design, value-based design, pricing transparency, and consumer-oriented incentives. There are promising outcomes emerging from extensive wellness and disease management programs that encourage participants to engage in healthy activities, identify their health risks, and manage their illnesses. By investing in the health of their workforce, employers help make employees and their families healthier, while also gaining better control over health care costs and employee absences. The employer-based system has also preserved broad access to primary care, specialists, and hospitals, as well as on-site services and pharmacies.

2. **Preserve and strengthen federal ERISA pre-emption of state laws to promote uniformity in coverage and reduce administrative costs.** The vast majority of large employers operate across multiple states and they must be able to continue to offer uniform benefit packages to their employees. Allowing states to require these employers to comply with varying state and/or local government mandates would raise employer costs even further and result in unequal benefits for their employees. This would create an unnecessarily costly and complex administrative burden with conflicting reporting, withholding, and disclosure requirements from jurisdiction to jurisdiction.

3. **Allow employers flexibility in how they meet any new standards for health care coverage.** Employers must be permitted to satisfy any federal mandate for employer health care coverage by demonstrating that their plans are equivalent to the "standard" benefit requirements, based on either the plan's design or the plan's actuarial value. Any new requirements must not disrupt existing benefits or add unnecessary compliance costs. This is similar to the approach taken under the Medicare Part D retiree drug program and the Massachusetts health care law, both of which focus on the plan's actuarial value rather than simply a benefit-by-benefit checklist. Further, such an approach must permit a multistate employer to offer consistent benefits in all states, pre-empting state-specific criteria.

4. **Encourage greater use of health information technology to reduce costs and improve quality.** A federal government effort to provide consistent and efficient health information technology would help employers reduce their health care costs and improve the quality of care. An integrated health system would provide quality reporting, improve health care outcomes, and reduce duplication and medical errors. The health care system would benefit enormously from the kinds of dramatic productivity gains achievable through appropriate health IT and related business process re-engineering that has transformed business and industry throughout the world.

5. **Provide incentives for employees and their families to engage in healthy behaviors.** Health care reform should enable an increased focus on wellness initiatives and programs designed to encourage healthy behaviors, including adoption of tax-free wellness rewards for individuals who take action to improve their health.

V. Details Really Matter

In a recent Hewitt survey of large employers, 9 out of 10 say that health care reform needs to happen, if not in 2009, then at least over the next four years. But these employers have not yet reached consensus on a preferred approach. In part, that is because the details really matter. Take, for example, an employer mandate, or "pay or play." Most large employers do not currently support an employer mandate based on the limited information currently available. Hewitt itself does not endorse a pay or play approach at this time, in part because the critical details required to fairly evaluate such a plan are still not defined. The specifics of such a mandate will greatly influence the impact and the reactions of large employers and their employees.

For example, with respect to an employer mandate, these are just some of the details to be carefully evaluated:

- What would be the form and size of a "meaningful" employer contribution? Would it be a fixed dollar amount or percentage of pay? At what economic level would the requirement be set?
- Would the mandate apply to both part-time and full-time workers? There would be more consensus around full-time employees. Mandating contributions for part-time employees is more controversial. Part-time workers often change jobs frequently, and workers who take these jobs as supplemental family income often have coverage available through other sources.
- Would the mandate apply to covering all family members? And would the contribution amounts for large employers be the same for single employees and married employees? Many large employers now tier the employer and employee contributions to provide equitable treatment for single employees, single parents, and larger households.
- Would a working couple still have a choice between their respective employers' plans? And if so, how would that work in terms of any mandated contribution?
- Could employers satisfy the mandate by substantiating that they provide a plan of equivalent value to the standard? Or would they have to comply on a benefit-by-benefit basis?
- If a national health exchange is created, would large employers and their employees be permitted to participate in this program? Or would participation be available only to individuals and small businesses?
- Would employees of large employers be permitted to opt out of the employer's plan and enroll in a national health exchange plan? And if so, what would be the terms and the consequences for opting out of the employer's plan? The group health plan "insurance" concept would face a sure demise if younger and healthier employees could opt out and take the full average employer health care contribution with them.

VI. Conclusion

In closing, Mr. Chairman and Members of the Subcommittee, Hewitt believes that employers should remain in the health care system and that reforms that lead to lower health care costs will go a long way toward enhancing the employer-based health care system. Congress has the challenge of sorting through the details of how that would be accomplished, with many competing views. Hewitt would be pleased to offer its data analysis, experience, and consulting and administrative expertise in helping the Subcommittee evaluate the impact of detailed reform plans on coverage provided by large employers today.

Chairman ANDREWS. Thank you, Mr. Winkler, and I am sure that we will call upon you and your expertise for that assistance. Thank you.

Mr. Trautwein, welcome.

STATEMENT OF E. NEIL TRAUTWEIN, VICE PRESIDENT AND EMPLOYEE BENEFITS COUNSEL, NATIONAL RETAIL FEDERATION

Mr. TRAUTWEIN. Thank you, Mr. Chairman, Ranking Member Kline and members of the subcommittee.

By way of introduction, the NRF is the world's largest retail trade association. We represent all retail formats and channels to

distribution. We represent an industry with more than 1.6 million retail establishments everywhere from Main Street to commercial streets. We represent 24 million employees, about one in every five American workers today.

We had 2008 sales of about $4.6 trillion, though obviously, in the current economy, that is a goal we won't reach in the coming year.

We, too, strongly support the voluntary employer-sponsored healthcare system, even though times are tough, and even though we have a tough population to cover. Even in the best of times, we endure wafer-thin profit margins, and it is really tough, particularly as you go down in size, for many retailers to survive. We really have no choice, in the current environment, but to manage the cost of labor very, very carefully in as cost-effective a way as possible.

Maintaining that balance between healthy workers and the running of the business is not always easy. In fact, it can be borderline impossible, even in the best of times.

I have attached the NRF's comprehensive healthcare reform proposal to the end of my written testimony. I would be happy to answer any specific questions on this.

But we share the concern among the panel on lowering healthcare costs. That really, to us, is the key to making healthcare reform work. Lower the cost of coverage, the more people who can obtain the coverage.

I would like to focus on our shared goal of strengthening the employer-based system. As I noted, retailers, by and large, are still committed to this voluntary system even in these tough times. This mix of compensation, both wages and benefits, are part of how employers have distinguished themselves in attracting employees through the years. In a minute, I will talk about an alternative to an employer mandate that we think makes better sense in terms of leveling the playing field.

We share the concern of larger employers. In fact, we have many large retailers that the rising cost of care will threaten our ability to maintain the benefit. We also agree with President Obama, that the current cost trajectory is unsustainable. We have to bring healthcare costs back down to earth.

We also need to be able to find the quality in healthcare, something that has been sorely lacking. An NRF small independent retailer recently testified before another committee of this House that his customers know more about the pet products on his shelf than they do the doctor down the street, and that is something that we all can work to improve. People should be able to select the best quality care, just as they choose between different retailers on a daily basis.

I would like to focus on three particular reform elements, some of which have already been discussed, that some might have you consider. First, a mandate on employers to provide coverage or pay into a public fund we feel would have the perverse effect of lowering wages and lowering the number of jobs in the local community. In the current environment, we can't afford new government mandates or minimums on the coverage we offer, and I would ask who will be available to pay doctor bills if there are no jobs in hand to help pay for the coverage.

We would urge consideration, instead, of an individual mandate to obtain basic health insurance coverage, and thus leverage voluntary employer contributions, keeping employers in the mix in supplement of the basic benefit, and to help employees accept the coverage we offer. We have a number of employees who don't accept the coverage we offer today.

Second, we would strongly urge you not to disrupt the federal ERISA law, which we agree with many of our panelists is the backbone of the employer-based system. Without ERISA, multi-state employers—and retailers are also multi-state employers—we couldn't offer common benefit packages across state lines.

We don't agree with the proposition that ERISA pre-emption should only be brought to plans that meet federal minimums on the composition of benefits or on the size of employer contributions to plans. Unraveling ERISA will take employer dollars off the table and greatly complicate the task of achieving healthcare reform and universal coverage.

Finally, we would urge you to reject efforts to limit or eliminate the tax-favored treatment of employer-provided health insurance. Efforts to cap or eliminate the employee income tax exclusion could create a backlash against healthcare reforms as employees face higher taxes for benefits over the cap or lower benefits to stay under the cap. Enacting healthcare reform is going to be tough enough without creating big constituencies against it.

Finally, in conclusion—I see my light is up—we want to be able to play a supportive, positive and nonpartisan role in furthering healthcare reform. We really feel like the talking phase has gone long enough, and we hope to get to enactment of the right kinds of healthcare reform .

Thank you, Mr. Chairman.

[The statement of Mr. Trautwein follows:]

Prepared Statement of E. Neil Trautwein, Vice President and Employee Benefits Policy Counsel, National Retail Federation (NRF)

Mr. Chairman, Ranking Member Kline and honored members of the Health, Employment, Labor and Pensions Subcommittee, I thank you for the opportunity to appear before you today and to share our views regarding the employer-based health care system. My name is Neil Trautwein and I am Vice President and Employee Benefits Policy Counsel of the National Retail Federation (NRF).

The National Retail Federation is the world's largest retail trade association, with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet, independent stores, chain restaurants, drug stores and grocery stores as well as the industry's key trading partners of retail goods and services. NRF represents an industry with more than 1.6 million U.S. retail establishments, more than 24 million employees—about one in five American workers—and 2008 sales of $4.6 trillion. As the industry umbrella group, NRF also represents more than 100 state, national and international retail associations. www.nrf.com.

The retail industry is one of the biggest supporters of the employer-based health insurance system—despite not having an easy workforce population to cover. We have a fairly young workforce (though increasingly with a significant senior cohort) coupled with a high turnover rate. We employ half of all teenagers in the workforce and a third of all workers under 24 years old. More than a third (35 percent) of our workforce is part-time. Two-thirds of our part-time employees are women. Often retail industry employees are second wage earners, mainstays of family economies. Frequently, qualified retail workers opt-out of the coverage we offer because they already have alternative coverage through a family member or another job. Smaller retailers often experience problems making health insurance plan participation requirements because too many employees opt out.

As a labor-intensive industry, retailers are strong advocates of quality and affordable health coverage in order to help keep our employees healthy and productive. As an industry that frequently endures wafer-thin profit margins or worse, we are also well acquainted with the need to manage the collective cost of labor in as cost-effective a manner as is possible. Maintaining balance between these two imperatives is not always easy—it is borderline impossible, even in the best of times * * * and these are far from being the best of times.

We hope to work with you and other members of the U.S. House and Senate to bring about enactment this year of real health care reform including meaningful relief from rising health care costs—that is the key, in our view, to reaching universal access to health coverage. Recognizing that health care would be a key priority regardless of the outcome of the November 2008 elections, NRF proposed a comprehensive solution to increasing access to more affordable health coverage in our "Vision for Health Care Reform." We believe our reform vision can lead to a sustainable path to preserve the voluntary employer-based health care system. Please allow me to first focus on our shared goal of strengthening employer-based health coverage, particularly three key issues that could bear on the future of employer-based health coverage.

Strengthening Employer-Based Health Care

Most everyone loves employer-based health coverage, though the degree of their affection for it varies greatly. Retailers by and large are still committed to this voluntary system, even in tough times like these. We still have an interest in keeping our employees healthy and at work. This mix of compensation—wages and benefits—is a key element in how one employer distinguishes itself from another in attracting employees.

Employer commitment to voluntary coverage is strained by the high cost of care and coverage and the wildly uneven quality of medical care today. We agree with President Obama and OMB Director Orszag that the current cost trajectory is unsustainable. For the reform to succeed and for the sake of our collective financial future, we must bring health care costs back down to earth.

It can be as hard to find quality in health care today as it is to follow the shells in a confidence game. We simply must work together both to demystify health care as well as to make it more accessible and user-friendly. The commitment to health information technology (HIT) already enacted this year will make that task easier, but we will all be challenged by resistance to comparisons on cost and quality.

Threats to Employer-Based Health Care

We strongly urge policymakers to be wary of three reform elements that some would have you consider. A mandate on employers to provide coverage or pay into a public fund would have the perverse effect of reducing jobs or depressing wages. Retailers are struggling particularly in the current environment to keep our doors open. We do not need and cannot afford any new government mandates or minimums on the coverage we offer. Surely maintaining and expanding employment while lowering health care costs should be our collective goal.

We would urge, however, consideration of an individual mandate to obtain basic coverage and leverage voluntary employer contributions with government subsidies to help employees to accept available coverage or purchase other coverage. That is clearly a better and more sustainable path towards universal coverage.

We would also strongly urge you not to disrupt the federal ERISA law that is the crucial backbone of employer-based health coverage. Without ERISA, multistate employers could not offer common benefit plans across state boundaries. We also reject the idea that ERISA preemption should only be granted to plans that meet federal minimums on the composition of benefits or the size of employer contributions to plans. Reducing the number of plans that enjoy ERISA preemption will take most of those employer dollars off the table, further complicating and increasing the cost of our task of reaching universal coverage.

Finally, we urge you to reject efforts to limit or eliminate the tax-favored treatment of employer-provided health insurance—the single largest federal health care expenditure. Efforts to cap or eliminate the employee income tax exclusion could create a backlash against health care reform as employees face higher taxes for benefits over the cap or lesser benefits to fit under the cap.

I would argue that the task of enacting and implementing health care reform will be difficult and controversial enough without exciting large scale employee opposition to it. Taxing or reducing health care coverage for some to fund coverage expansion for others is too high a price to pay.

NRF Vision for Health Care Reform

The National Retail Federation's Vision for Health Care Reform[1] was approved in final form by the NRF Board of Directors in January 2008. We are proud of this document, but are also flexible enough to look beyond its corners for other good ideas. We are aggressive proponents for enacting the right kinds of health care reform as soon as is possible. We hope to be a nonpartisan ally in this crucial effort.

Elements of our Vision document were recommended by a special Health Care Taskforce and associated Health Care Taskforce Workgroup formed by the NRF Board in 2006. Both groups contained both small and large retailers, chain restaurants and representatives of member state associations. Individual subworkgroups (Retail Industry and Health Care; Innovation in Health Care; Innovations in Plan Design; and Ongoing Policy Debates) were formed to study the health care crisis in depth before developing these recommendations for the NRF Board. Our Vision document is the product of that intensive review process.

Four Pillars for Reform

The four key elements of the NRF Vision are to: improve health care quality; lower health care costs; increase access to coverage; and reform state health insurance markets. Stated differently, our proposal seeks to increase access to a value-oriented health care and coverage system.

We believe that until we can create better value in health care and coverage, we will never be able to spend enough collectively to expand quality and affordable health coverage to all Americans—a goal we retailers share. The challenge, clearly, will be getting there. Retailers who don't offer consistent value to their customers don't survive; amazingly the same is not true for our health care system.

Improving Health Care Quality

We spend more than any other nation on health care but get only middling to poor returns on life expectancy, disease states and other health care quality indices. Connecting the myriad disorganized elements of our health care system through health information technology (HIT) will help, as will development of consumer friendly interoperable electronic personal health records.

One of the biggest changes will be the development of consumer-friendly comparative cost and quality information. An NRF small independent retailer recently testified before another House committee[2] that: "[his] customers know more about the pet products on [his] shelf than they do about the doctor down the street, and that is not right." People should be able to select the best quality care just as they choose between retail competitors on a daily basis. Competition encourages lower prices and better quality. More and better competition could do wonders for health care.

Lower Health Care Costs

We believe that the key to making health coverage more accessible lies in reducing its cost. This should be the central goal in all health care reform efforts.

We have identified a number of proposals in this area including: better engaging consumers in self-management and value-conscious shopping for care; promoting wellness and better managing chronic conditions; and preserving the federal ERISA law to help more employers sponsor uniform benefits across state boundaries.

Increase Access to Coverage

As I have noted previously, reducing the cost of health coverage will help many more businesses and individuals gain access to that coverage. Increasing access will help better spread insurance risk and help reduce overall costs.

We believe that we can reach universal coverage (a goal we retailers share) without mandating that employers provide coverage. We would urge the Congress to consider requiring all individuals to obtain a basic level of health coverage and make it as easy as possible for employers to voluntarily offer employees access to coverage.

As noted previously, the problem with employer mandates—either to provide coverage or provide specific coverages—is that they directly increase the cost of coverage and hence the cost of labor. Higher labor costs mean fewer employees to enjoy less coverage: the opposite effect that pro-mandate policymakers seek.

As rational businesspeople, our members want to employ as many people as they can afford to employ and their business can support. Employer mandated health insurance will distort that balance and leave everyone—including the employer—un-

---

[1] A copy of the complete NRF health care reform proposal is attached at the end of this testimony.

[2] Dave Ratner (Dave's Soda and Pet City) on behalf of NRF, House Small Business Committee, February 4, 2009

happy. I would surmise that someone would gain from an employer mandate, but who will pay the doctor bills if people don't have jobs? It is a classic lose-lose proposition.

We also continue to support various pooling mechanisms to facilitate purchasing of coverage, particularly for small businesses. We urge policymakers to be wary about trying to transplant the bulky and bureaucratic Massachusetts exchange to other states: there was a particular set of circumstances that helped make the Massachusetts Connector possible. Policymakers might have done just as well (or better) by implementing an electronic portal-type exchange (like the commercial "Travelocity" website, but for health insurance) at lower cost and better choice.

State Insurance Market Reform

In order to help encourage more affordable access to state-based and regulated insurance coverage, we urge steps to help reduce the complexity and expense of state markets. Weeding out or applying sunset dates to coverage mandates, encouraging more flexible plan designs (especially for part-time workers) and shoring up access to high risk pools or carriers of last resort for the medically uninsurable will all help. We would also encourage the states to enact less restrictive rating reforms to help encourage lower-paid employees to obtain coverage and thus reduce costs for older workers in the process.

Building Consensus for Reform

As proud as we are of our Vision for Health Care Reform, we are under no illusion that Congress or the Obama Administration will turn to us and say "oh, there's the final answer." I would venture that there is no industry in America—and practically no American—without big ideas for health care reform. There are quite a few ideas that have appeared in Congress and during the recent Presidential campaign as well.

But, we do hope that our Vision will help add to the growing consensus around reform. I would be glad to discuss any of the elements of our proposal that interest you in greater depth.

Our members want, need and expect to see real relief from rising health care costs enacted and are determined to play a positive role in the reform cause. Success will also depend in part on whether a strong pro-reform coalition can be built among the myriad, diverse and frequently contrary interests outside the political process.

It's relatively easy to build a coalition of the disaffected to oppose reform. We hope to work with you to help build a stronger coalition of the eager and willing supporters of reform. The talking phase has gone on for long enough, at least in our view.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. In sum, we urge you to work to create a value-oriented health care system that promotes lower cost and higher quality care and coverage for employers of all sizes and individuals from all walks of life. We urge you to carefully consider the downstream implications of specific proposals on the cost and quality of care and coverage and particularly how different proposals interact. We look forward to working with you to help promote the enactment of positive health care reform.

NRF Vision for Health Care Reform

The retail industry employs one out every five workers in today's economy and is an important source of health coverage for our associates and their dependents. The industry is eager to assist in efforts to improve the quality, cost and access to health coverage. Americans deserve better value for our collective health care dollar. The National Retail Federation supports the following principles to help reform our nation's health care system:

Improve Health Care Quality—we need better value (defined as the quality and cost of care) from our health care system. We spend more than any other country but lag behind other countries in leading health care indicators.

- Promote the implementation of health information technology as quickly as possible to transform health care administration from paper to interoperable electronic records. This will allow health care professionals to better coordinate care and also make timely clinical information available to health care professionals to help reduce medical errors and avoid duplicative or unnecessary procedures.
- Promote the development of an interoperable, electronic Personal Health Record that can be used by licensed health care professionals in any setting and can be used by patients to transfer their medical history as they move from plan to plan.
- Encourage the use of evidence-based medical standards wherever possible.

• Encourage the availability of comparative health cost and quality information (e.g. transparency). Encourage the availability of this information in easy-to-understand consumer guides.
• Encourage a team-based approach to medicine with the patient as an active participant in managing his or her health. (Electronic medical records can help).
• Encourage quality-based payment programs (a.k.a. value-based purchasing) and other payment reforms to encourage the highest quality integrated care.
• Facilitate the reporting of information through financial incentives for providers.
• Lower Health Care Costs—the key to making health coverage more accessible is in reducing its cost. The NRF believes effective measures to improve health care service delivery and reduce costs must be a first and central focus of health care reform at any level.
• Support initiatives that serve to engage consumers in managing their health and shopping for high quality and lower cost health care services when needed.
• Promote initiatives to promote wellness within the workforce and better manage and prevent chronic illness conditions.
• Preserve the federal ERISA law to help employers sponsor uniform benefits across state boundaries.
• Permit the medical management of covered benefits (including mental health benefits) to help provide necessary and equitable coverage.
• Enact medical liability reforms to reduce the downstream costs of medical litigation. Reforms should clearly differentiate process failure, human error, negligence and malpractice, including errors caused by obsolete processes and practices.
• Continually work to eliminate waste and inefficiencies in the health care system.
• Establish a "no tolerance" position on fraud and abuse by health care service providers and consumers alike.
• Encourage participation in local and regional reform coalitions that align themselves with broader national initiatives that are consistent with this vision.

Increase Access to Coverage—reducing the cost of health coverage will help many more businesses and individuals gain access. Increasing access will spread insurance risk and help reduce overall costs. In addition, the NRF recommends the following steps:
• Consider requiring individuals to obtain health insurance coverage. Encourage but do not require businesses to offer employees access to coverage.
• Consider voluntary coverage options for part-time workers that emphasize wellness and prevention coverage and help protect against catastrophic health expenses.
• Consider group purchasing or other risk-pooling programs to increase access to coverage for small businesses and individuals. Encourage access to state, regional or national high risk pools or carriers of last resort for the medically uninsurable.
• Consider tax credits for individuals or small businesses to help make coverage more affordable.
• Consider creating personal health savings accounts to accumulate personal savings and voluntary contributions from one or more employers, along with public subsidies or credits and individual funds to help pay for health insurance premiums.
• Add additional flexibility to Health Savings Accounts (HSAs) to make them more attractive to businesses and individuals. Allow Health Reimbursement Arrangements (HRAs) and Flexible Spending Accounts (FSAs) to more effectively coordinate with HSAs. Allow FSA funds to roll over from year to year.

State Insurance Market Reform—in order to encourage more affordable access to state-regulated insurance coverage, the NRF recommends the following principles:
• Help reduce the complexity and cost of coverage by encouraging lawmakers to refrain from passing benefit coverage mandates, employer mandates or mandatory employer contributions.
• Consider setting a sunset date for existing coverage mandates or allowing the coexistence of lower-cost benefit coverage alternatives.
• Consider more flexible plan designs (especially for part-time workers) that emphasize wellness and prevention coverage and help protect against catastrophic health expenses.
• Encourage states to maintain access to high risk pools or carriers of last resort for the medically uninsurable.
• Consider less restrictive rating reforms to encourage younger employees to obtain coverage and thus promote more equitable generational cross-subsidization.

Chairman ANDREWS. Thank you, Mr. Trautwein, for both the spirit and substance of your testimony. Thank you.

Dr. Thorpe, you are our clean-up hitter.

STATEMENT OF KENNETH THORPE, CHAIR OF THE HEALTH POLICY AND MANAGEMENT DEPARTMENT, EMORY UNIVERSITY

Mr. THORPE. I appreciate that. Thank you, Chairman Andrews, Representative Kline, members of the subcommittee, Dr. Price for that kind introduction and for his thoughtful leadership on this issue as well.

We all know the statistics, but I am going to give them to you anyways because they are grim. Since 1999, the cost of a family private insurance policy has gone up 119 percent. A typical family, either through lower wages or directly in premiums, pays about $12,600 a year on healthcare.

So in healthcare reform, we have got to find a way to get to the root cause of why healthcare spending is rising. We can come back to that, but it really deals with the absolute explosion in chronic disease prevalence that is fueled by a doubling of obesity in this country, and secondly, the fact that three-quarters of our total healthcare bill is linked to chronically ill patients that, particularly in the Medicare program, we do a very poor job of managing, so we will have to come back and deal with that.

There are certain costs, as we talked about, associated with employer-based health insurance that are less apparent than we see in the frequent tallies of spending. I am going to focus on two of them. First are the costs associated with uncompensated care that is not directly paid for through federal or state sources. And second of the costs that employers bear who offer insurance for providing coverage to workers they don't employ—the spouses of their employees.

In 2008, the last year we had data, for the 47 million people who don't have coverage, they incurred expenditures of over $57 billion. So we are paying, through different sources and different arrangements, for the healthcare bills of the uninsured today. This is a very fragmented, very unorganized, and a very uncoordinated way.

When they can, hospitals and physicians shift the cost of these dollars that aren't explicitly paid for onto the cost of private insurers. Now, this differential pricing is seen as a rational market response to the ability and willingness of some payors to pay more than others, similar to what you find in the airline and hotel industries. Regardless of what we call it, it is clear that private insurers pay more for healthcare, and that these higher payments are used by providers to defray the costs of care for other patients, particularly the uninsured.

On its most recent report to Congress, MedPac reported that the average Medicare/Medicaid margins are projected to fall. The shortfall is made up for what MedPac characterizes as unusually high hospital margins on private payer patients; that is, a private insurance plan, on average, pays about 20 percent more than the cost of care in order to offset the losses that hospitals and healthcare providers face from underpayments in Medicaid and from nonpayments from the uninsured.

There is a second significant cost shift to employers in providing health insurance, however, that is even more opaque than the cost of uncompensated care, and that is the cost of providing health insurance to spouses.

Nationally, 51 percent of people under the age of 65 with private health insurance are covered through their own employer. Another 10 percent directly purchase private insurance, and the remaining 39 percent of individuals with private health insurance get coverage through their spouse and their spouse's employer. It is this last category I want to focus on.

In 2006, there were 31 million families in which both adults worked. An analysis I conducted at Emory showed that more than half of those families, 55 percent, received health insurance coverage through one, but not the other, employer.

Nationally, the costs of workers receiving health insurance through their spouses amounted to an increase of $46 billion in payments from employers that do offer health insurance. Employers who don't offer health insurance, for a variety of reasons that we can all understand, are called by some "free riders" because at least some of their workers get coverage by a spouse's employer.

As we have heard, many small employers would love to have health insurance. It is oftentimes just very expensive and not affordable to do so. And so we need to find ways to make healthcare less expensive.

Well, what are the costs of these free riders to businesses that offer insurance today? I already mentioned the one figure of $46 billion. Another way to think about it is that the incremental cost of employers that offer insurance of covering employees that are in firms that largely don't offer coverage is about $2,800 a year.

So if you think about it, the rise in the number of dual working families combined with the decline in the share of employers offering health insurance, is placing continued financial pressure on employers that continue to want to stay in the game.

So we really have three problems, in closing.

One, we have got to get to the fundamentals and find ways to make health insurance less expensive for everybody.

And two, we have got to deal with the fact that we are doubling and tripling up on employers that offer health insurance both through cost shifting from the uninsured, underpayments on the Medicaid side, and by the fact that employers who do offer insurance are paying for the costs of those workers that don't offer insurance.

In closing, thank you for inviting me to testify.

[The statement of Mr. Thorpe follows:]

Prepared Statement of Kenneth E. Thorpe, PhD Chair, Department of Health Policy and Management, Rollins School of Public Health; Executive Director, Center for Entitlement Reform, Emory University

Chairman Andrews and Representative Kline, as well as all the Subcommittee Members, thank you for inviting me here today to address important issues related to employer-based health insurance.

Employers in the United States face significant constraints on profitability due to rising health insurance costs. Many of these costs are well known:

• National health expenditures reached a record high last year: $2.4 trillion, about $7,900 per person.[1]

• A quarter of our nation's health spending is supported by businesses. The largest share of that spending—77 percent—is employer contributions to health insurance plans for their employees. In 2007, businesses spent a total of $518 billion dollars on health services: $398 billion in employer contributions to private health insurance premiums, $82 billion in contributions to the Medicare Hospital Insurance Trust Fund, and $38 billion to workers' compensation, temporary disability, and worksite health services. Health spending by private businesses grew 3.9 percent in 2006 and accelerated 5.6 percent in 2007.[2]

• Employer-sponsored health insurance (or ESI) covers 160 million individuals, about 62 percent of the nonelderly population. Overall, 63 percent of American businesses offer health insurance to their workers.[3]

• In 2008, the average employerbased health insurance premium for family coverage was $12,608, a rise of 5 percent from the previous year. Of that, employers paid $9,325 (74 percent) and workers paid $3,354 (26 percent). In contrast, the average cost for a single worker's health insurance was roughly half: $4,704. Of that, employers paid $3,983 (85 percent) and workers paid $721 (15 percent).[4]

• Since 1999, average family coverage premiums have risen 119 percent.[5] Premiums for employersponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 2000,[6] and health insurance costs are on track to overtake profits in this decade.[7]

However, certain costs associated with employerbased health insurance are less apparent in the frequent tallies of spending. Today I will focus on two: First, the costs associated with uncompensated care that are shifted onto America's employers. And, second, the costs employers bear for providing coverage to workers they do not employ, the spouses (and, increasingly, domestic partners) of their employees.

Shifting costs of uncompensated care to the private sector

In 2008, uncompensated care for America's 47 million uninsured ran to an estimated $57.4 billion. Overall, uncompensated care has been roughly 6 percent of hospital costs for many years, despite a steady increase in the percentage of people uninsured.[8]

When they can, hospitals (and physicians) shift rising uncompensated costs from the uninsured as well as the underinsured to private payers. Providers also subsidize belowcost reimbursements from Medicare, Medicaid, and CHIP through costshifting. The extent of this costshifting is uncertain, in part because some economists do not define charging private payers higher rates as "cost shifting." Differential pricing is instead seen as a rational market response to the ability and willingness of some payers to pay more than others, analogous to the airline and hotel industries.[9] In my view, however, regardless of what we call it, it is clear that private payers pay more and that these higher payments are used by providers to defray the costs of care for other patients.

Several potentially countervailing factors affect costshifting to private payers, such as:

• Patient mix: Uninsured and underinsured patients, along with Medicaid and CHIP beneficiaries, are disproportionately cared for in safety net facilities, which do not serve large numbers of privately insured patients, limiting private payer crosssubsidization. Of course, because these costs are supported by tax dollars, including corporate taxes, employers are bearing some of the burden, along with individual taxpayers. Estimates of the costs of uncompensated care vary, depending on what is counted, as do assessments of who pays. The Institute of Medicine puts public support from federal, state, and local governments at 7585 percent of the total value of all uncompensated care estimated to be provided to uninsured people each year.[10] An analysis I conducted of the costs of care for uninsured patients alone puts governments' contributions for this population at 33 percent, with the remainder covered by patients with private insurance.[11] Medicare patients, in contrast, are largely cared for in private hospitals, which can shift costs to privately insured patients. Medicare's recent decision to no longer reimburse hospitals for eight "never events," which several private insurance plans followed, may result in additional costshifting, as institutions seek to recover the costs of these rare but costly events, including wrongsite surgery, mismatched blood transfusions, and major medication errors.

• Hospital type: There is evidence that forprofit hospitals provide less uncompensated care but also costshift more than nonprofit institutions do. On the other hand, however, research by former CMS director Mark McClellan indicates that areas with forprofits have lower labor and capital costs, and, overall, about 2.4 percent lower levels of hospital expenditures per patient as do areas without forprofit hospitals. The net effect of lower costs overall on any costshifting has not been determined.[12]

• The level of uninsurance in the community: There are significant differences in communitylevel uninsurance rates across the nation, as well as within states and even counties. For example, in 2007, uninsurance rates ranged from 6 percent in Massachusetts to almost 28 percent in Texas. Within Los Angeles county, uninsurance rates for people under age 65 ranged from 6 percent to 45 percent in 2005. In addition to costshifting, research suggests that when communitylevel rates of uninsurance are relatively high, insured adults have difficulty obtaining needed health care and to be less satisfied with the care they receive.[13] Clearly, job loss is associated with health insurance loss. The current economic downturn has already resulted in larger numbers of uninsured individuals as well as increases in the numbers of Medicaid and CHIP beneficiaries, which may, in turn, result in additional cost shifting to private payers.

• Hospital negotiating power: Some hospitals, particularly large urban teaching hospitals, have sufficient market power to negotiate higher payment rates from employers and private insurers. So do some large physician groups. But research has not been definitive on the frequency and amount of shifting.

In sum, the costs of health care for uninsured, underinsured, and publicly insured individuals are, to an unknown extent, supported by higher payments from privately insured individuals and employers. In its most recent report to Congress, the Medicare Payment Advisory Commission, MedPAC, reported that average Medicare margins are projected to fall to 6.9 percent this year, a shortfall made up for by what MedPAC characterized as "unusually high hospital margins on privatepayer patients."[14] Rising premiums, along with higher copays and deductibles, result, in part, from this crosssubsidization. Because the majority of uncompensated care is paid for by governments through tax revenues, uncompensated care thus amounts to a double levy: once in the form of taxes and twice in the form costs hidden in escalating payments for employersponsored health insurance.

Shifting the costs of spouses to covered workers' employers

There is a second significant cost to employers in providing health insurance, even more opaque than the costs of uncompensated care: The cost of providing health insurance to spouses and domestic partners.

Nationwide, 51 percent of people under age 65 with private health insurance are covered through their own employer; another 10 percent directly purchase private health insurance. The remaining 39 percent of individuals with private health insurance receive coverage through their spouse or partner.[15] It is this last category of worker I will address.

In 2006, there were 31 million families (62 million adults) in which both adults were employed all or part of the year. An analysis I conducted with colleagues at Emory University showed that more than half of dualincome families (55 percent) received health insurance through one but not the other employer; a quarter of families elect separate coverage under both employers.[16] Nationally, the cost of workers receiving health insurance through their spouses amounted to $46 billion in 2006.

Employer contributions to health insurance premiums average 77 percent, as I noted earlier. However, there are notable locality differences in average contributions. For example, in the District of Columbia, the typical employer contribution to employeeplusone coverage is 81 percent, or about $6,265 per employee. In Louisiana, the average is just 68 percent for the same coverage.[17]

Employers who do not offer insurance—37 percent in 2008—have been called "free riders," because at least some of their workers receive coverage via a spouse's employer. There are significant differences in insurance offerings by firm size: Just under half (49%) of firms with 3 to 9 workers offer coverage, compared to 78 percent of firms with 10 to 24 workers, 90 percent of firms with 25 to 49 workers, and over 95 percent of firms with 50 or more workers.[18] Thus, larger firms are subsidizing health insurance in smaller firms. It is important to note that many smaller employers say they would like to offer health insurance, but cannot afford to do so. Because smaller employers have fewer employees to spread risk among, insurers consider their risk profile less predictable and more vulnerable to highcost claims.[19] As a result, premiums are considerably higher, often beyond the reach of employer and employee alike.

There are also disparities across business sectors. Industries that benefit the most from being freeriders include retail, agricultural, fishing, and forestry. Among U.S. dualincome families who receive ESI coverage and work in the retail or other services industry, 45 percent of workers receive insurance through their spouses' employers. In agriculture, fishing, and forestry, the percentage is slightly less at 42 percent. These aggregate figures mask noteworthy differences, however. Among the 73 percent of people working in the retail or other services industry covered under one policy, 45 percent are freeriders and 28 percent are the actual policyholders;

and, among the 74 percent of persons working in the agriculture, fishing, and forestry industry who are covered under one policy, 42 percent are freeriders and 32 percent are the actual policyholders. Populations of freeriders in other industries in the U.S. range from 21 to 34 percent. Freeriders are least prevalent in the mining and manufacturing industries, comprising only 21 percent of these industries' insured workers.

There are two ways to examine the costs of freeriders. The first is in terms of incremental cost savings to the freeriding employer—that is, how much the freeriding employer would have contributed to its employee's health insurance had that employee not been covered by her or his spouse. For each employee covered by a spouse's policy, the freeriding U.S. employer would have spent $2,886 in 2006 had that business provided health insurance to its own worker. Another way to examine the cost of freeriders is to calculate the cost to the employers who cover the working spouse of an employee. In 2006, the incremental cost to employers covering a worker from a freeriding firm was $2,713 per employee. Either way the costs are totaled, they are substantial: $46 billion versus $49 billion, respectively.

Conclusions

The rise in the number of dualincome families combined with a decline in the share of employers offering insurance is placing continued financial pressure on those employers that continue to offer insurance. The "doubling up" of both workers on a single policy results in added costs to those employers covering both workers. These issues raise important questions regarding equity in the distribution of spending among businesses in the United States.

Additional equity concerns are raised by costshifting from uninsured, underinsured, and publicly insured individuals to privately insured individuals and employers. This care is largely funded by governments through tax receipts from corporate and individual taxes. Rising premiums affect both employer and employee; in addition, employees face higher out of pocket costs in the form of increasing copays and deductibles. Uncompensated care thus amounts to a double levy: once in the form of taxes and twice in the form of costs hidden in escalating payments for employersponsored health insurance.

REFERENCES

[1] Andrea Sisko, Christopher Truffer, Sheila Smith, Sean Keehan, Jonathan Cylus, John A. Poisal, M. Kent Clemens, and Joseph Lizonitz, "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," Health Affairs Web Exclusive, February 24, 2009, *http://content.healthaffairs.org/cgi/reprint/hlthaff.28.2.w346v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=NHE&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=date&resourcetype=HWCIT* (accessed March 4, 2009).

[2] Centers for Medicare and Medicaid Services, Sponsors of Health Care Costs: Businesses, Households, and Governments, 1987—2007, *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg07.pdf* (accessed March 5, 2009).

[3] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2008, *http://ehbs.kff.org/pdf/7790.pdf* (accessed March 4, 2009).

[4] Ibid.

[5] Ibid.

[6] Henry J. Kaiser Family Foundation. Employee Health Benefits: 2007 Annual Survey. 11 September 2006. *http://www.kff.org/insurance/7672/index.cfm.*

[7] McKinsey and Company, "Will Health Benefit Costs Eclipse Profits?" The McKinsey Quarterly Chart Focus Newsletter, September 2004, *http://www.mckinseyquarterly.com/newsletters/chartfocus/2004—09.htm* (accessed March 4, 2009).

[8] Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," Health Affairs, September/October 2008; 27(5): w399w415, *http://content.healthaffairs.org/cgi/reprint/27/5/w399* (accessed March 4, 2009).

[9] Michael A. Morrisey, "Cost Shifting: New Myths, Old Confusion, and Enduring Reality," Health Affairs 22 (2003): w489—w491, *http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.489v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=cost+shifting&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT* (accessed March 4, 2009).

[10] Institute of Medicine, Hidden Costs, Values Lost Uninsurance in America, Washington, D.C.: The National Academies Press, 2003.

[11] Families USA, Paying a Premium: The Added Cost of Care for the Uninsured, June 2005, *http://www.familiesusa.org/assets/pdfs/Paying—a—Premium—rev—July—13731e.pdf* (accessed March 6, 2009).

[12] Mark B. McClellan, Administrator, Centers for Medicare and Medicaid Services Department of Health and Human Services, "Tax Exemption for Hospitals and Federal Payment for Uncompensated Care," Testimony before the House of Representatives Committee on Ways and Means, May 26, 2005, *http://www.hhs.gov/asl/testify/t050526c.html* (accessed March 4, 2009).

[13] Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care," February 2009, *http://www.iom.edu/Object.File/Master/63/122/America's%20Uninsured%206%20pa ger%20FINAL%20for%20web.pdf* (accessed March 4, 2009).

[14] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, page xiv, March 2009, *http://www.medpac.gov/documents/Mar09—EntireReport.pdf* (accessed March 6, 2009).
[15] U.S. Census Bureau, Current Population Survey, Annual Social and Economic (ASEC) Supplement, Table HI05: Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2007, *http://pubdb3.census.gov/macro/032008/health/h05—000.htm* (accessed March 6, 2009).
[16] Kenneth E. Thorpe, Jennifer Flome, and Katya Galactionova, Health Insurance Coverage of DualIncome Families: The FreeRider Effect and the Cost to Employers, Missouri Foundation for Health, December 2006.
[17] Kaiser Family Foundation, Kaiser State Health Facts: Average EmployeePlusOne Premium per Enrolled Employee for EmployerBased Health Insurance, 2006, *http://www.statehealthfacts.org/comparetable.jsp?ind=272&cat=5* (accessed March 5, 2009).
[18] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2008.
[19] National Health Policy Forum, NHPF Background Paper: Health Insurance Coverage for Small Employers, April 19, 2005, *http://www.allhealth.org/BriefingMaterials/healthinsurancecoverageforsmallemployers297.pdf* (accessed March 4, 2009).

Chairman ANDREWS. Well, thank you, Dr. Thorpe, and thank you to each of our witnesses for doing a very, very good job this morning and giving the committee a lot to think about.

We are now going to begin the question phase of the hearing, and I will begin.

There are 30 million people who live in a family that is headed by someone—the 30 million uninsured people living in a family headed by someone who is working but uninsured, 30 million out of the 47 million. We have heard Dr. Thorpe testify that the cost of uncompensated care nationwide is about $57 billion a year. we heard Mr. Winkler testify that, in premiums alone, a conservative estimate is that premiums are 2 to 3 percent higher for insuring employers than they would be but for this uninsurance problem.

And I thought it was striking to hear Mr. Sheridan talk about the fact that, at Cooper Hospital in New Jersey, 30 percent of their patients are people insured, but they pay 40 percent of the bills in the hospital. I think I got that right. So there is a significant cost shift there.

I also think that we have heard a consensus, and I think this is very true, that improvements in quality and ways to address chronic disease problems is absolutely a major component of controlling costs. I don't think there is any doubt about that. But in addition to that, there is the problem of shifting the costs of uninsured people onto insured people.

Mr. Trautwein, I just want to focus on a person who might be in Mr. Sheridan's hospital this morning who makes 27, $28,000 a year, maybe working for one of your members, or a similar employer, and is not insured. Her children are now insured because of SCHIP, but she is not. And she goes into Mr. Sheridan's hospital because she has a severe problem and requires hospitalization.

If I understand correctly, your proposal that you want to have us help deal with this is that we pass a law requiring her to get health insurance coverage, an individual mandate on her. In my state, that would cost her, at a minimum, just for herself at a minimum, between 2,500 and $3,000 a year at a minimum. How is she going to pay for that?

Mr. TRAUTWEIN. Well, in our view, a better way to level the playing field and make sure that everybody gets basic coverage, beside the—for the young woman in the hospital, she would have had preventative care, would have identified the condition.

Chairman ANDREWS. But she doesn't. She is uninsured.

Mr. TRAUTWEIN. Exactly. I think everybody should have health coverage, basic health coverage, and we should find a way for employers to stay in the game by supplementing that coverage with additional benefits. States could also supplement that coverage.

But it is a dilemma for hospitals to pay for that treatment. It is a problem under current law.

Chairman ANDREWS. But if I may, I think it is a dilemma for her because your proposal is to pass a law saying she has to buy health coverage the way she has to buy auto insurance. How is she going to pay for it? Where is the money going to come from?

Mr. TRAUTWEIN. Well, I think we need to ease access in the marketplace. I think insurance is more expensive in New Jersey than perhaps it should be.

Chairman ANDREWS. What if we achieved a 35 percent reduction in health insurance premiums, though I doubt very much we could, and it would cost her $2,000 instead of $2,500? How is she going to pay for it?

Mr. TRAUTWEIN. Well, I think the federal government should subsidize access to income on an income-graduated basis, to that——

Chairman ANDREWS. Well, now President Obama has talked about that as well, and he has proposed paying for that by repealing the tax cuts for the top 5 percent and by getting rid of the Medicare Advantage program. That is how he would pay for it. How would you pay for it?

Mr. TRAUTWEIN. I am certainly not a budget expert. The politician in me, or the student of politics that is in me, would say it would be difficult to support a proposal that concentrates on such a narrow slice of the tax scale and——

Chairman ANDREWS. So you would want to tax everybody, not just the top 5 percent?

Mr. TRAUTWEIN. Well, after all, access to health coverage has been a shared goal from many different constituencies for a very, very long time. And figuring out how we build on the employer dollars that are currently in the system, how we cover that cap for people who don't have access to employer-based coverage while maintaining jobs and building the economy is a tough job.

Chairman ANDREWS. It is a very tough job.

Mr. TRAUTWEIN. And we would do well to work with you and others to get to that end.

Chairman ANDREWS. We welcome your participation. And obviously, I am pointing out what I think is where the rubber will meet the road.

We sat in the White House last Thursday and heard a lot of very good-willed people talk about improving quality and productivity. I think we all agreed with that. Talked about the proposition that covering everyone will help reduce costs for everyone, which I think just about everybody agreed with.

But the reality here I think is that short-term productivity improvements will never pay for the subsidies necessary to cover 47 million people, and that the job that is in front of us, this figuring out how to pay for that—and by the way, I commend you for making a proposal in your testimony.

I am not sure that I embrace an individual mandate. I certainly don't embrace it without a very sufficient subsidy to pay for it. But I think the Federation deserves a lot of credit for not ducking that question and raising the point that you did.

We are now going to turn to Mr. Kline for 5 minutes.

Mr. KLINE. Thank you, Mr. Chairman. And again, thanks to all the witnesses for really terrific testimony on a very, very tough subject and one which, as I said in my opening comments, we are going to be dealing with as a Congress and as a nation as we try to work through what the new paradigm is going to be in providing health insurance.

I don't think any of us sitting here today know exactly what that is. As Mr. Winkler said, the large employers, as I am paraphrasing here, are sort of waiting to see what the critical details are. Well, as are we all, as we work towards what those critical details are going to be, because it is very, very important.

The idea of everyone owning their own health insurance is one that appeals to many of us. Again, the devil, as they say, is in those details, or how you are going to pay for it. What is the federal government's role? What is the state government's role? How would you do that?

And again, as I said in my opening statement, as we go through this, and I think that Mr. Winkler and Mr. Trautwein and others probably all agree, we cannot afford to pull the string on the sweater, if you will, of ERISA and look around and find that we don't have 47 million uninsured, but over 200 million uninsured.

With that, let me turn to Mr. Pyenson, if I could. You know, really an interesting study, and I think probably very helpful as we look at—start to look underneath at how this is going to work.

You commented that waste and inefficiency in the healthcare system exists, and everybody in this room would agree with that. There is no question, is there, in big, big numbers.

And you pointed out that healthcare management experts know thousands of ways—I think that is in your testimony—to improve the system. Why hasn't this been done already?

Mr. PYENSON. Well, that is a great question, Mr. Kline, and thank you.

The challenge of changing the healthcare system to make it more efficient is, in my view, largely one of the incentives that are in place in the current healthcare system. We are addressing the issue here this morning of federal pre-emption on the employer's space compared to the state regulation.

I would point out that there is a bigger issue with the federal and state counterpart, which is between Medicare and Medicaid. And the largest insurance company in the world is the federal Medicare program, and the interaction between Medicare and Medicaid has, in my opinion, been a destructive one for patients and for efficiency. We see that most profoundly in the interaction of patients in nursing homes on Medicaid, which is a huge issue, as we all know, for state Medicaid budgets.

And unfortunately, with poor quality care, those patients often end up in the hospital where Medicare pays for their hospitalization. So the lack of coordination of getting better care to the nurs-

ing home patients, which the states can't afford to do, is a challenge.

If they had better care, the benefit would accrue to Medicare. So fixing that interaction between the federal and state programs I think is one of the keys to creating incentives in place. The other piece of that, of course, is that no single insurer or employer has anything close to the clout that the Medicare program has.

Mr. KLINE. I am not sure that answers the question of why we haven't improved the system. I mean, I would certainly agree, and I think most people in this room would agree, although I never presume to talk for the chairman.

But it is clear that, with Medicare and Medicaid, to follow up on your point, we hear complaints all the time about enormous waste there, but also about underpayment. We know stories of doctors and facilities, healthcare facilities, who are saying they won't take Medicare patients, for example, because the reimbursement rate is so low. So we have this huge insurer, if you will, in the federal government, a huge program that is not paying, or is reimbursing at such low rates that people are turning it down.

It does seem to me, and I know it is frustrating to all of us, that we all know of waste and abuse and inefficiencies. You have pointed them out. And yet, we can't seem to get at those and to make the improvements. It looks like that employers and employees and providers would be clamoring for those efficiencies.

Well, magically, my time has run out here, so thanks very much. I yield back.

Chairman ANDREWS. You noticed it?

The chair recognizes the gentleman from Illinois, Mr. Hare, for 5 minutes.

Mr. HARE. Thank you, Mr. Chairman. Thank you for having the hearing. It is a very important issue.

Mr. Derbyshire, just a couple questions to you. What would you like to see the federal government do to help spread the burden of covering the uninsured? And then the second part of that question was how can we as a government make it easier for small businesses like you to continue to provide healthcare coverage for employees?

Mr. DERBYSHIRE. What I would like to see, and—is that—and I said in my testimony, I would like to see more employers, all across the board, be able to—there be a mandate that all employees pay sort of a tax to offset the premiums that I am paying for now by insuring the uninsured so that that would level the playing field and reduce my premiums and balance the cost of insurance among all employers and all my competitors.

Mr. HARE. Thank you.

Dr. Thorpe, in your opinion, how can we guarantee coverage for these 47 million Americans that—including 9 million kids who are uninsured? Do you know of any systems at the state level that have been successful, or do we need to just start from scratch, from your opinion, completely overhaul this healthcare system?

Mr. THORPE. Well, on the coverage side, I think that, as Mr. Trautwein talked about, I think you have to look at a requirement for individuals to purchase coverage, but with the caveat that, if you are going to do that, to the chairman's point, that we have to

make sure that the healthcare is affordable. So, we just can't require it, but we have got to make sure that what people pay for health insurance is reasonable, and that will be part of the discussion that we have about healthcare reform.

So Massachusetts did this a year ago. They went from a very—10 percent of the population uninsured. Now they are down to 3 percent of the population uninsured in a very short period of time.

They could have done more on the cost side. They could have probably done more on the affordability side, but I think that is certainly—if we are going to get to universal coverage, we have to go the direction of requiring people, I think, to purchase it, and make it affordable.

On the cost side, that is where I think we do need more sweeping reforms. To the point that Mr. Kline was raising, why don't we do this, I think the problem is is that to really get at the underlying cost drivers really means that we are going to have to do three things, and they are major things.

One, we are going to have to change the way that we pay for healthcare, I think led by the Medicare program, to look more towards bundled payments, episode-based payments.

Two, we are going to have to redesign our healthcare delivery system. If all the money in healthcare is linked to chronically ill patients, and if we have a delivery model that has very little to do with managing those patients to keep them out of the hospital and keeping them from being re-admitted to the hospital, then we need to really look very hard at redesigning our delivery model.

And the third thing, which is a fairly sweeping reform, is that we need to do a better job of preventing disease in the first place. There are great models out there, great case studies that are school-based, community-based, workplace models that have lowered cost and improved productivity that we need to understand how they are designed. We need to replicate them and scale them.

So those are all going to be fairly major changes on the cost side.

Mr. HARE. Thank you.

Then, my last question would be to Mr. Winkler. You talked about several reasons why healthcare costs are so high. How much of these costs are administrative or caused by antiquated health information technology or record-keeping? In other words, of this high cost, how much of this is just administrative and duplicative stuff that we are spending so much on? I have heard it is up to a third of what we are spending.

Mr. WINKLER. Really sort of two parts to that. One is the administrative cost that large employers have for coverage overall, which for larger employers, generally, runs 10 to 12 percent, a little different than for smaller employers.

But to the point specific to healthcare information technology, we have seen estimates. We don't, at Hewitt, have a specific number, but I have seen estimates ranging anywhere from probably 20 percent on the low side to 30 percent on the high side, I think similar to what the gentleman from Milliman alluded to before.

I think the challenge in capitalizing on that is figuring out not only how you broadly adopt technology, but what incentives you can build into the system for the medical community to use that,

for patients to avail themselves of it, and then, ultimately, for the payment model to track along with that.

Mr. HARE. Thank you, Mr. Chairman.

Chairman ANDREWS. Thank you, Mr. Hare.

Gentleman, Dr. Roe, is recognized for 5 minutes.

Dr. ROE. Thank you, Mr. Chairman, and thank you all for being here. It made my head swim to hear all this again.

And I practiced in a facility like yours, Mr. Sheridan, and just left one not long ago.

Mr. Chairman, in Tennessee, we had a program called TennCare, which virtually bankrupted the state. The governor backed off from that and started a new program where the employer pays $50 a month, the employee pays $50, and the state pays $50. So there is a shared responsibility. Now, it is not a Cadillac plan, but it is a basic health plan.

And Mr. Winkler, what you said a moment ago is absolutely correct. Taking care of chronic disease is one of the biggest challenges I had in the practice of medicine for over 30 years is to convince people to do that. And I think you have to change incentives. I think we are going to have to change incentives.

Right now, I am incentivized to take care of sick people. That is how I get compensated. And we have got to change that scheme where physicians and providers are compensated for wellness.

Now, we had a program in Johnson City, where I was—in Tennessee, where I was mayor before I came here—and the city employees, where we did a chronic disease management, diabetes, hypertension and cholesterol management. And right now, we are seeing our healthcare costs not go up at nearly the level of—of the national level. So those disease management programs do work.

One of the things that I have become incredibly frustrated with, though, and I—actually, Mr. Pyenson, I want you to kind of look at this. Back in the 1980s and 1990s, remember, managed care was going to be the—that was how we were going to control costs.

And all we did was manage to shift that money around, but we didn't control the costs. And right now, I hear information technology, and our practice just moved, 70 of us—it was one of the most painful things I have ever done in my life, is to change from a paper record to an electronic medical record. We have 70 providers and 350 employees in our practice. And that has been about a 2-year process to get there.

Do you really think that a 25 percent reduction is possible, and are you—with this information technology, or is this just another wishful thing that we are going about, another exercise I have seen once before?

Mr. PYENSON. Thank you very much, Mr. Roe.

I think information technology is certainly going to be very good for the information technology companies. If you examine the organizations that are extremely efficient and the locales that are extremely efficient, it is interesting that there is—it is hard to attribute that efficiency to information technology.

But of course, information technology has to be a boon to everything, just as it has to the retail sector and every other sector, and I am certainly not opposed to it.

In the "Imagining 16 to 12," we emphasized that we want people to imagine the possible. It is possible because we see those sorts of efficiencies in locales, typically with integrated physician/hospital—physician practices, where the incentives are for the sorts of things that Dr. Thorpe and others this morning have addressed.

And we believe those sorts of programs are using existing knowledge optimally, so I truly think it is possible, and it is really creating the environment where the talents and the skills of medical professionals can really be used.

Dr. ROE. Mr. Chairman, one of the things that you mentioned a minute ago I have spent a lot of time thinking about, is where we have 47—45, 47 million people in this country that are uninsured. And obviously, the payments of Medicaid and Medicare don't cover the costs in many situations. And so that is an issue that hospital systems and physicians and providers have to deal with.

Well, you have got half of the people who are uninsured are in families who work, who are offered insurance at their current business, but they can't afford it. It looks to me like some sort of tax credit or subsidy would help immediately take a lot of those people off the rolls.

Any comment from any of you about that?

Mr. TRAUTWEIN. Certainly it is a problem for retailers with a lot of part-time workers. A third of our workforce is part-time. And getting those eligible for coverage to accept is a real problem.

So we share your belief that subsidies can help get people into coverage. Tax credits can be a little bit cumbersome to administer, and it may be that a subsidy is a cleaner way to approach that. But we strongly support it.

Dr. ROE. Thank you, Mr. Chairman.

Chairman ANDREWS. Thank you, Dr. Roe, for bringing your experience and perspective to the committee. We are glad to have you with us, very much so.

Now, a different experience and perspective, one of the, I guess, two nurses in the House? Three nurses in the House—our friend from Long Island, Mrs. McCarthy, who practiced nursing before joining us here in the House, is recognized for 5 minutes.

Mrs. MCCARTHY. Thank you, and I thank you for the hearing. And obviously, I am going to go to the nursing issue because it was mentioned on home care, end-of-life care. This is something that I certainly experienced, because I did a lot of private duty during my nursing career.

But with that being said, we are seeing a lot of the care, especially coming out of the hospital, going to healthcare aides. And the charges that a healthcare aide gets, her salary is probably—her or his salary is probably between seven and $8. The company that she works for probably picks up the $13 or $14, or if not more, on that, and that is something I think we need to look at.

But you can't just bring people home, even for end-of-life, unless you have the experience of someone being able to take care of somebody there, and that is where high-tech does come in. A number of programs that we have seen in my hospitals out on Long Island, where there is a camera there to work with the aide and to work with the patient so that an RN or a doctor every morning, or if there is a problem, can get immediately—does that patient

need to go to the hospital, or is it just something that can be taken care at home?

So I do believe that there is a lot to do, but the end-of-life care is a discussion that this country needs to have. And it is a serious conversation, because there are many patients that are in ICU that will never have a chance of surviving. And the cost to those patients, and to the hospital, is extremely high.

While we were talking, I was just looking, and I was doing a little bit of math for my healthcare. We have government healthcare, obviously, and I pay $159 a month. Then, we add up my co-payment for my insurance.

By the way, I have got good insurance, Blue Cross/Blue Shield. I have got everything in there, bells, whistles and everything else like that. It comes out, on my share, $2,258, which I feel is reasonable for a year for a single person.

So I think one of the things that I was interested in, Mr. Derbyshire, on your testimony, that you are paying 85 percent of premiums for individual coverage. Do the workers actually know how much you are paying out for that care? How transparent are the insurance companies about their costs, both to the employees and to the employer? These are things that need to be worked out and to be looked at.

I know that we were trying to have a bill come through on the federal level, anyhow, where a business like yours could connect with many other businesses. And I think the National Association of Manufacturers Retail would like to see that so they can bring it up to the larger employee companies that have lower costs. And I would just like your opinion on that.

Mr. DERBYSHIRE. Yes, thank you.

Yes, they do know the cost. I do pass it on. I had a critical junction of whether I could continue to pay family, because that is just a phenomenal cost. I cap it at $50 a week that comes out of their paycheck, and it has been that way for years. I just cannot pass anything more onto them, because my employees are lower middle class.

A pooling system, yes, anything to reduce costs would be very attractive. I know in Maryland, the state that I am from, of course, they regulate pricing—the state regulates pricing through the insurance company of groups of 50 employees or under. So my rates are somewhat controlled in the state, and I don't know what the impact that is compared to other plans.

Did I answer your question?

Mrs. MCCARTHY. It does.

Mr. DERBYSHIRE. Okay.

Mrs. MCCARTHY. Thank you.

Mr. DERBYSHIRE. You are welcome.

Mrs. MCCARTHY. Now, I will throw this out to anybody. To what extent do you believe that healthcare costs are contributing to our current economical crisis? And I will throw that out to anybody out there.

Mr. THORPE. I will take a shot.

Well, I think that if you look at it on two dimensions, certainly if you look at it from the business perspective, rising healthcare

costs are one of the less controllable aspects of the overall level of compensation, and it has done two things.

One is that it leads to lower wage increases for individual workers. And two, for some companies that can't fully shift it back, they are finding that it, (A) cuts into profits, (B) cuts into their ability to make capital investments and improvements in their operations, and (C) puts them at a competitive disadvantage in a global economy.

So from the business perspective, I think it is clear. If you look at state and local governments, it is a major source of uncontrollable growth in those budgets, which means that it is either going to crowd out other state and local functions, or you are going to have to look at tax increases to pay for it.

We have seen the budget numbers at the federal level. You know, Medicare is the big issue in terms of entitlement reform, in terms of driving the budget deficit, and we need to have a coherent strategy that really deals with the core issues around why Medicare spending is rising and really take that issue on.

And just finally, from an individual standpoint, we know the tradeoffs that families have to make in terms of do they keep health insurance or not. We know the numbers, and we can debate them on how prevalent of a role that plays in individual bankruptcy cases, but is a big deal in terms of people losing their homes when they can't afford to pay their bills.

So I think it is a major component and contributor that has to be to the economy. It is 16 percent of our overall GDP, so it really is a key issue that, at the same time we are dealing with trying to find ways to fix the economy, we really need to get to the core of this issue of healthcare costs as well.

Chairman ANDREWS. Gentlelady's time has expired.

Mrs. MCCARTHY. Thank you.

Chairman ANDREWS. Thank you very much.

Turn to a gentleman from Connecticut who has made a significant contribution already in the area of pre-existing conditions, Mr. Courtney for 5 minutes.

Mr. COURTNEY. Thank you, Mr. Chairman.

And I would actually like to follow up on that issue a little bit with Mr. Thorpe, because, I mean, your description of the free riders, the spouses who kind of gravitate towards lowest cost, I mean, really that is not the only issue for families.

I mean, to take a hypothetical in Connecticut, if somebody works at Pratt & Whitney where the large group plan and the spouse is a realtor, and if you are expecting the self-employed realtor to pull her or his burden, I mean, the fact of the matter is there is obviously a huge pricing difference in terms of the small group/self employed market versus the group.

But frankly, there are also other issues in terms of the fact that pre-existing condition exclusions, high deductibles, I mean, which really undercuts the ability of wellness and prevention programs. I mean, really, it is not—it is a totally rational decision for that spouse. And to sort of characterize it as, a "free rider" I think is a little pejorative, in my opinion.

And frankly, it kind of—again, I think there are other structural issues in the market that need to be fixed to help families not sort

of go in the direction that maybe is more burdensome for the large group plans. I was just wondering if you could comment on that.

Mr. THORPE. Well, I completely agree with you, and that is why, when I said it, I characterized that very carefully as, "Some call them free riders." And they are—this was just a description of the facts, the underlying reasons why it happens. I completely agree with you on that. So there is a good reason for why—and rational reasons for why a spouse would choose to go to a more generous policy at lower cost.

I think the solution to it is some of what we have been talking about here. One is to get more comprehensive coverage to everybody through the workplace, and that obviously—if you think about it from the employer that is offering the coverage, they really have a triple-whammy.

Healthcare costs a lot anyways. They have built into the cost of their premium 2 to 9 percent, so we can debate what the number is, due to uncompensated care from the uninsured, and they are covering the cost of spouses that are working for companies that don't offer.

So a way to deal with that is to expand coverage to get the uninsured piece out, broaden the employment based system so that employers that don't offer coverage, or individuals that don't get coverage through employers can now afford to do it by requiring them to acquire coverage, but making it affordable. Provide the requisite government funding to make sure that they can afford it, and that way it spreads the burden out more evenly.

Mr. COURTNEY. But it is more than a funding issue, which it clearly is, and I think all the witnesses are pretty much agreed on that. But it is also—I mean, we have to do something structurally to the market for the small firm and to the system.

And the president has talked about this, that we have got to create some kind of pooling mechanisms that allow the risk to be spread out and the harshness of some of the underwriting rules to be relaxed more. Because, I mean, there is just no question that, if you are somebody who has got any kind of chronic illness and you are out there in a small group area, I mean, you have got a major problem in terms of trying to find a plan. And all the mandates in the world and all the subsidies in the world are really, not by themselves, enough to sort of fix that problem.

And I don't know if, Mr. Winkler, you wanted to focus on that in terms of whether we have got to create structures for the smaller—and I realize you do group as a general rule, but——

Mr. WINKLER. Well, I think—and Mr. Derbyshire underscored the challenges, that the employers who really are squeezed are those sort of in the middle of that under-50 group, which in most states are already pooled in some capacity, as he described in the state of Maryland.

But if the employer is just above that, on up to the large insurers that organizations like Hewitt work with, who find themselves, I think struggling with some of the purchasing dynamics that you have described, that does logically make it such that a married couple would look and say, "My coverage from XYZ Large Employer is more attractive for us as a family than the coverage underneath." And there may be sort of group cooperative or pooling

mechanisms that could work in that smaller above-50 lives market that could help.

Mr. COURTNEY. And Mr. Derbyshire, I mean, you must talk to a lot of your colleagues from the business community, I mean, where these pricing differences and pre-existing condition rule differences are much harsher than families and individuals who are—and companies that have large groups to spread out the risk.

Mr. DERBYSHIRE. Well, I don't know. I think in Maryland, they do regulate it, that the—in the Maryland system, with the health maintenance plan, that you have to accept everyone into the plan. So there aren't preconditions that would leave you out of the plan.

But—am I answering your question?

Mr. COURTNEY. It is, and that is by law and by government intervention. That is the case.

Mr. DERBYSHIRE. Right—exactly.

Mr. COURTNEY. And that is helpful for us to know that in terms of dealing with that problem.

Chairman ANDREWS. I think it is one of the reasons why the gentleman introduced his legislation in the last Congress. I know that he has, once again, taken a step forward on that. And I think the president has expressed his interest in the same concept the gentleman from Connecticut is interested in, so I think we will move forward.

The gentleman from Michigan, Mr. Kildee, is recognized for 5 minutes.

Mr. KILDEE. Thank you, Mr. Chairman. Thank you for assembling this panel. You all, collectively and individually, have been very helpful. I appreciate it very much.

I will address my question to the—friend that is down there, end of the table. In Flint, Michigan, employers for years would seek to hire those whose spouse worked at General Motors. General Motors basically is self-insured using Blue Cross/Blue Shield as their fiscal agency. That, along with their own direct employees being insured, adds about well over $1,000, sometimes $2,000 to the price of a car.

Now, General Motors right now is in the midst of trying to qualify for additional funds under the Troubled Assets Recovery Program. One of the things they are required to do is to change their—they have switched over their health program now to the Union, and it is called the Voluntary Employer Beneficiary Association.

But the federal government now is asking them to give half the money for that in General Motors stock rather than dollars. General Motors' stock is not that great a shape right now. This is an enormous company, a large company, that—I talked to Rick Wagoner yesterday. He is spending so much of his time trying to settle this healthcare program.

What we can we do, first of all, to relieve a company like that that is really, really in difficulty and let them get back to the business while keeping up their responsibility of producing cars? Do you have any suggestions of what we might do?

Mr. THORPE. I appreciate the question.

I would sort of point to five things, and this kind of relates to the dialogue I just had with Mr. Courtney on this issue. And the five things that I would focus on would be:

One is to move towards an individual requirement that people have health insurance.

That, two, that you put in appropriate funding, federal funding to make sure that it is affordable for families to buy insurance through another employer if they choose, or through a health insurance exchange if they want to go that direction. That then spreads the cost out in a much broader way.

So at a place like, as I mentioned in my statistics, if you have got half of the family sort of doubling up—and my mom got coverage through GM exactly for that reason, because it was a great policy—that is two things to do.

I think the other three is that you have got to make sure, if you go in this direction, that you have got to require guaranteed issue, that you have got to make sure that people, when they apply, they get a guarantee issue to it. The health insurance industry is certainly on board with that.

We have got to reform how we do rates in terms of how premiums ratings are established. And you have got to find new pooling mechanisms to deal with issues around a lot of the inefficiencies around individual and small group coverage. The president has put on the table one approach through these health insurance exchanges. There are others that we could look at, as well, but those would be five things that I would do.

And then, one last thing, and it goes back to the healthcare cost issue, those unions are now in a position of managing a pot of dollars. And unless they find a way to change the growth trajectory of per capita spending in that union mix, those dollars are going to run out much faster than they think.

Mr. KILDEE. Thank you very much, Dr. Thorpe. I like your concise answer, and I just, again, think this has been a very, very helpful hearing.

Thank you, Mr. Chairman.

Chairman ANDREWS. Thank you, Mr. Kildee, for your participation.

I would like now to call on the ranking member for any concluding comments he may have.

Mr. KLINE. Thank you, Mr. Chairman.

And again, thank you to the witnesses today. It has been a great panel, a lot of discussion.

I think that there is a universal recognition that we have a problem. There is not a universal recognition on what those critical details might be, and that is part of what we are about. So I thank you very much for your thoughtful presentation and your terrific answers to the question.

And I thank you for the hearing, Mr. Chairman. I yield back.

Chairman ANDREWS. Thank you.

I would also like to add my words of appreciation for the way the witnesses have helped us on our project, our journey to try to learn more about how to fix this problem.

I think everyone's comments were offered in the spirit of instruction and cooperation, which emanated from the White House summit last Thursday. We appreciate you picking up on that spirit.

It occurs to me that our job is a huge one, and it is to convert a dysfunctional relationship between cost and coverage into a func-

tional and positive one. If you don't control costs, more people become uncovered. They don't have health insurance. As more people become without health insurance, costs go up, for that and a number of other factors.

So we really embark upon an effort to try to figure out ways that we can reduce cost pressures on American families and businesses. We have explored several of them today.

One of them is trying to find a way to get everyone insured, which I think is the top priority on the list. We have looked at increasing productivity in dealing with a medical technology, which is very important. Each of the witnesses, one way or another, has talked about dealing with the chronic diseases that absorb a huge percentage of healthcare outlays, and I think we can find common ground on that.

Again, I am very pleased that each of the witnesses, in his own way, was able to start to tackle the issue that policymakers have failed to tackle for 40 years, which is acknowledging the fact that there is a significant cost to getting everyone insured—how do you pay for it? And I do think that the president set an excellent example by giving his answer to that question. I think you gentlemen have followed that example by giving your own in various ways, in various positions, and it is now up to us to do the same thing.

If we are able to have a mature and intelligent process, it will lead to an answer, and I believe it will lead to the president signing a health reform bill in 2009 that will very much benefit the country. If we shy away from that issue, if we tiptoe around it, we will be right back where we have been for four decades, which is describing the problem, but not solving it.

I think you have given us a very strong start to go about the business of solving the problem. We thank you for that participation.

As previously ordered, members will have 14 days to submit additional materials for the hearing record. Any member who wishes to submit follow-up questions in writing for the witnesses should coordinate with the Majority staff within 14 days.

[The statement of Mr. Kucinich follows:]

Prepared Statement of Hon. Dennis J. Kucinich, a Representative in Congress From the State of Ohio

Thank you Mr. Chairman for holding this hearing on what I believe to be possibly the most critical economic and moral issue we face today. Our haphazard, complex, regressive, inefficient method of delivering health care has been in desperate need of an overhaul for decades.

I am glad to see that Congress and this Administration is serious about bringing the American people health care reform. As we begin to navigate the options for reform, we should be asking difficult questions. Will costs be contained? If so, how? Will there be anyone left uninsured? Will the 50 million underinsured increase in ranks? Will we continue to have the best health care for those lucky enough to afford it and poor quality care for those who cannot?

I believe the root of our health care problems is simple: It is the health insurance companies. They make money by denying care and in so doing, they drive up health care costs. Their success is partially evidenced by the growth they have caused. The growth in professionals who actually deliver health care since the 1970s is under 300%. But the increase in administrators—those who do not deliver care—is upwards of 2400%. Increases in complexity of health care demand more bureaucracy to handle it.

Unfortunately, employer based health care relies on health insurance companies. But we will not solve our health care problems with the insurance industry still

thriving. Because American businesses provide health insurance for over 60% of the country, American employers are bearing the burden of this inefficient system. It is making them less competitive than their international counterparts whose health care systems are far less expensive, not to mention more efficient, equitable, and comprehensive.

Employer based health care also means that people who get sick enough to lose their job, will also lose their insurance when they need it the most. It means there will continue to be a substantial number of uninsured. It means that health care will continue to be the number one source of contention between labor and management. And because insurance companies make money when they are successful at denying care, they will continue to sell products that leave people financially vulnerable.

Millions of Americans are under the false assumption that having insurance necessarily means they are insured. Only after they get sick do they realize that their plan leaves them extremely financially vulnerable. One of the most important statistics in the health care field summarizes this problem. About half of all bankruptcies in the US are tied to medical bills. Of all those medical bankruptcies, three-quarters of those had insurance before they got sick. They had insurance and they still went bankrupt. Doesn't that defeat the purpose of insurance? Imagine what would happen to our economy if we could get rid of those medical bankruptcies by fully insuring everyone. That is what HR 676 does.

HR 676 builds on a model with proven success in the US and abroad. It eliminates hundreds of billions of dollars in administrative waste and uses that money to cover everyone in the US for all medically necessary services with no copayment, no premium and no deductible. Everyone in the U.S. would get a card that would allow access to any doctor at virtually any hospital.

The support for HR 676 is undeniable. HR 676 had 93 cosponsors in the previous Congress and is up to 64 in this Congress so far. More than a third of the Members of this Subcommittee are now cosponsors or were cosponsors in the previous Congress. A 2008 poll published in the Annals of Internal Medicine showed that 59% of all doctors and over 70% of pediatric subspecialties support a plan like H.R. 676, which dispenses with the myth that doctors don't want it. It is supported by the American College of Physicians, deans of major medical schools, former editors of the New England Journal of Medicine, and former Surgeons General. They are joined by groups like the Presbyterian Church USA, the US Conference of Mayors, and State legislatures in Kentucky and New Hampshire who have endorsed H.R. 676. Single payer bills have twice been passed by the California legislature in the last three years and are currently making their way through other state legislatures like Minnesota. HR 676 has been endorsed by 484 union organizations in 49 states including 39 state AFL-CIOs.

Finally, thousands of advocates all over the country represent the American people whose support for a plan like H.R. 676 is consistently greater than 50%. A February New York Times/CBS News poll found that, "59% [of Americans] say the government should provide national health insurance, including 49% who say such insurance should cover all medical problems." The poll found that only 32% think that insurance should be left to private enterprise. Many members on this Subcommittee know how strong the grassroots movement behind this bill is because they are getting the calls about it.

As we evaluate a path forward on health care, I urge my colleagues to stand up to the health insurance companies and demand a proven model that guarantees comprehensive health care for everyone, controls costs, and provides high-quality care.

[The statement of the American Benefits Council, submitted by Messrs. Andrews and Kline, follows:]

Prepared Statement of James A. Klein, President, the American Benefits Council

Dear Chairman Andrews and Ranking Member Kline: I am writing to respectfully request that the summary of our views and attached report of the policy recommendations of the American Benefits Council's (the "Council") on health care reform be included in the record for subcommittee's March 10, 2009 hearing on "Strengthening Employer-based Health Care". The Council is a trade association representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's

members either sponsor directly or provide services to retirement and health plans covering more than 100 million Americans.

Summary of Views of the Council on Health Care Reform

The American Benefits Council believes we can, and must, achieve a more affordable, inclusive and higher quality health care system. Our vision for health care reform was drawn from the diverse expertise and experience of our members, particularly our Board of Directors, which shaped a set of 10 practical prescriptions to improve our health care system. Each of these prescriptions is aimed at achieving a stronger, more sustainable health care system to serve the needs of all Americans.

These are times of extraordinary economic turmoil and some have suggested that health reform may need to wait until we address other more urgent economic recovery priorities. We take the opposite view. Addressing the nation's health policy challenges is an integral element of—rather than an obstacle to—economic recovery and personal financial security. We agree with President Obama, OMB Director Orszag and a growing number of members of Congress, economists and business leaders that the current rate of spending for health care is not sustainable for individuals, employers, state or federal government or the American economy. Health reform is an urgent national priority and requires our best, collective efforts to see that it is achieved as swiftly as possible.

We believe that the employer-based health care system that now serves as the primary source of health coverage for more than 160 million Americans provides a solid foundation for health care reform. We need to build on that foundation by moving toward more affordable, higher quality health care services. Indeed, without such measures, it will not be possible to reach the widely shared goal of providing health coverage to all Americans.

We believe that a vitally important component of maintaining a strong employer-based health system starts with protecting the federal regulatory framework established by the Employee Retirement Income Security Act (ERISA) which allow employers to offer valuable benefits to their employees under a single set of rules, rather than being subjected to conflicting and costly state or local regulations. While employers that operate in multiple states or on a national basis consider ERISA's framework essential to their ability to offer and administer employee benefits consistently and efficiently, this regulatory approach also translates into better benefits and lower costs for employees. In addition, holding employer-sponsored benefits accountable under a single set of rules, interpreted by a single regulatory authority, is also fundamentally fair to all employees covered under the same plan regardless of where they may live.

In addition to strengthening employer-based health coverage, we believe that public health insurance programs such as Medicaid, Medicare and the Children's Health Insurance Program (CHIP) must be improved, particularly by moving toward payment systems that reward health care providers who consistently meet evidence-based performance standards and away from payments based simply on the quantity of services delivered. Our recommendations for health care reform also call for the establishment of a federal eligibility floor for coverage for adults under Medicaid and more effective outreach and incentives for states to reach the more than 10 million individuals who are estimated to be eligible for health coverage under state-based health programs, but are not yet enrolled.

Health care reform will also require measures to ensure that those outside of employment-based health coverage are able to obtain meaningful, affordable coverage through the individual health insurance market. Our proposals include recommendations that would ensure that any person without health coverage through an employer and who is not otherwise eligible for coverage under a state or federal health insurance program could obtain at least one individual market insurance plan in any state that meets minimum federal requirements. These products would also be exempt from additional state benefit mandates, but for all other purposes—such as consumer protections, solvency requirements, rating rules and other requirements—state standards would continue to apply.

We also believe that reformed state-based high risk pools that meet minimum federal standards for coverage and rating can play a significant role in helping to keep the individual insurance market more affordable and competitive. In order to keep coverage affordable for those enrolled in high-risk pools, we propose that premiums paid by enrollees in these state-based programs be limited and claims expenses that exceed the funding from enrollee premiums be shared by state and federal governments.

The Council and its members believe that all Americans need and deserve health care coverage. A key condition for closing the coverage gap would be the establishment of a federally-prescribed individual obligation for all Americans to obtain at

least a basic level of coverage in a reformed health care system. We also recognize, and support, the need for federal premium subsidies to make coverage affordable for lower-income individuals who do not qualify under an income-based public program such as Medicaid or CHIP. Individuals could meet their health coverage obligation by electing coverage offered through an employer, by enrolling in a plan in a reformed individual insurance market, or through a state or federal health insurance program such as Medicaid, Medicare, CHIP or a state high-risk pool.

The Council's recommendations call for ten "prescriptions" for achieving health care reform and our "Condition Critical" report includes over 40 specific and practical policy recommendations for achieving them:

PRESCRIPTION #1: BUILD ON WHAT WORKS

Building on—and not undermining—our voluntary, employer-based health coverage system is the best foundation for health care reform. We believe that the best reform options are those that strengthen, not impede, the voluntary employer-based system.

PRESCRIPTION #2: MAINTAIN A FEDERAL FRAMEWORK

A single set of federal rules, rather than a state-by-state approach, for health care reform is essential, particularly for employers with a national or multi-state workforce. In particular, health care reform should maintain the fundamental concepts and provisions of the Employee Retirement Income Security Act (ERISA).

This framework makes it possible for employers to maintain and administer a uniform set of benefits for their employees and allows for innovative benefit practices to be applied consistently for all plan participants, regardless of where they live.

PRESCRIPTION #3: IMPROVE THE QUALITY AND EFFICIENCY OF HEALTH CARE

Urgent action is needed to make our health care system more efficient and ensure more consistent delivery of high quality care.

In particular, a nationwide interoperable health information network should be adopted by a specified date to permit the exchange of vital health records and patient information much more efficiently and to provide a backbone for a wide range of emerging quality improvement initiatives.

PRESCRIPTION #4: PROVIDE CLEAR, RELIABLE INFORMATION TO MAKE BETTER HEALTH CARE DECISIONS

A transformed health care system is one that makes price and performance information easily accessible so consumers can quickly determine where to find those providers who have a proven record of delivering high quality care.

A more transparent health care system will also give health care providers the tools they need to compare their performance with other professionals in their field in order to support and encourage continuous quality improvement.

PRESCRIPTION #5: MAKE HEALTH COVERAGE AN INDIVIDUAL OBLIGATION FOR ALL AMERICANS

All Americans need to be part of a health coverage solution and we each have an obligation to obtain at least a basic level of coverage in a reformed health care system. An obligation to obtain coverage must also be accompanied by income-based premium subsidies to make health coverage affordable for lower-income individuals. To encourage employer-sponsored coverage whenever possible, these subsidies should be applied to assist qualified individuals with their share of the premium whenever such coverage is available

PRESCRIPTION #6: ESTABLISH A MINIMUM STANDARD FOR QUALITY, AFFORDABLE HEALTH COVERAGE

A federal minimum standard for a basic and affordable level of coverage should be developed as a benchmark for whether individuals have met their health coverage obligation. Key components of this basic benefit standard would be established by a broad multi-stakeholder advisory panel. The standard should also permit individuals to meet their coverage obligation by enrolling in a plan that is at least actuarially equivalent to the basic benefit standards.

PRESCRIPTION #7: REFORM THE INDIVIDUAL INSURANCE MARKETPLACE FOR THOSE WHO DO NOT HAVE ACCESS TO EMPLOYER-BASED COVERAGE

All those without access to employer-based coverage should be able to enroll in a basic benefit plan in the individual insurance market that meets federal minimum coverage requirements or in an enhanced and affordable state high risk pool that provides comparable coverage.

PRESCRIPTION #8: STRENGTHEN STATE SAFETY-NET HEALTH INSURANCE PROGRAMS

Sensible improvements are needed in public programs providing health coverage, including establishing a federal eligibility floor for coverage of adults under Medicaid. Stronger incentives are also needed for states to reach the more than 10 million individuals estimated to be eligible for coverage under state-based health programs, but are not yet enrolled. Premium subsidy programs should also be expanded for individuals eligible for coverage under both an employer-sponsored plan and Medicaid or the Children's Health Insurance Program (CHIP).

PRESCRIPTION #9: IMPROVE TAX POLICY TO MAKE HEALTH COVERAGE MORE AFFORDABLE AND ACCESSIBLE

Current tax rules must continue to permit employers to deduct their expenses for the cost of health benefits they provide to employees.

In addition, rather than subjecting employees to income and payroll taxes on the cost of employer-sponsored health care coverage, we believe that favorable tax treatment should be extended to individuals who do not have access to health coverage under an employer plan and who obtain coverage in the individual insurance market.

PRESCRIPTION #10: ENABLE EMPLOYERS AND EMPLOYEES TO DEVELOP RETIREE HEALTH CARE SOLUTIONS

An above-the-line tax deduction should be permitted for retiree health insurance premiums. Employers and employees should also have a wider range of options to fund retiree health care needs, starting by improving existing benefit vehicles.

Finally, the most important prescription for health reform may well be the willingness of all major stakeholder groups to engage in a collaborative effort to develop health reform solutions. As an organization whose members either directly sponsor or administer employee benefits covering more than 100 million Americans, we are committed to working with all those who believe, as we do, that health reform is both urgently needed and can only succeed if it is developed through an open, consensus-based process. If we take this path and are guided by a set of pragmatic prescriptions, we can succeed in achieving fundamental and urgently needed health care reform.

We look forward to working with this Committee, the Obama Administration, and other major stakeholders in our health care system in developing sensible solutions to deliver on the promise of making quality, affordable health care a reality for all Americans.

ATTACHMENT: *"Condition Critical: Ten Prescriptions for Reforming Health Care Quality, Cost and Coverage"*

[The referenced attachment may be accessed at the following Internet address:]

http://www.americanbenefitscouncil.com/documents/condition—critical2009.pdf

---

And without objection, the hearing is adjourned.

[Whereupon, at 12:04 p.m., the subcommittee was adjourned.]