Testimony
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"America's Need for Health Reform"

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Chairman Pallone, Ranking Member Deal, and distinguished Members of the committee, I thank you for the opportunity to testify on the topic of health care reform.

We are in the middle of a great debate on health care in the United States. We see it in the major debates led by Massachusetts and California. We see it discussed in more than a dozen states from Maine to New Mexico. We see the health reform debate in the many bipartisan and strange bedfellow efforts that have developed. We see the debate in the reform collations that have formed, such as HCAN and Better Health Care Together. And lest we forget, the debate is happening at every kitchen table in the country, since health costs are part of our economic meltdown. Of course, some on this committee have been a part of the fight for better health care for a long time, and I'd like to thank Mr. Dingell in particular for his leadership.

But for the first time in 15 years, there promises to be a major health care debate here in Congress. Both the Republican and Democratic nominees for president have engaged in a serious health care discussion. Everyone here knows the twin problems of our broken status quo:

- *45 million uninsured.* Health insurance is how we access care in the United States today. It is virtually the first question you are asked when you call a physician's office or go to the hospital.
- *Skyrocketing costs.* The cost of our health care system is astronomical and constantly growing. Total health care spending in the United States doubled between 1996 and 2006, and without reform it is expected to double again in the coming decade.

Given the limited time and the impressiveness of the panel, I want to use my time to talk about the importance of health reform to:

- *Address health care for all and cost-containment simultaneously.* Effective cost containment requires that everyone have coverage, and covering all requires that coverage must be affordable.
- *Strengthen the role of the group market.* Grouping health risk in the marketplace through employer-based benefits is one of the few things we do well in the U.S. health system.

Use of the individual market will undeniably weaken care delivery as more Americans become subject to pre-existing exclusions, higher cost sharing, and absent benefits.

- *Use care in exploring tax credits.* Reforming the tax treatment of health insurance may be an important part of health reform. However, done poorly, it could actually diminish Americans' access to coverage. For a health insurance tax credit to work properly to expand coverage, it must make meaningful insurance coverage affordable, reflecting both family size and the rate of medical inflation. And it must not threaten employer-sponsored health insurance, which most Americans have and want to keep.

Addressing coverage for all and cost containment simultaneously

Health reform will be most successful when we try to achieve coverage for all and cost containment at the same time. In fact, the two are on different sides of the same Rubik's cube. We'll only solve both problems at the same time, and I would encourage the committee to think about health reform as a need to aggressively pursue both.

There is a false dichotomy held by some that there is an either/or choice in health reform—that either we achieve coverage for all first or that we will attempt to contain the skyrocketing costs first. The extremist version of this view holds that cost containment should be the only goal because the system is so broken and expensive that the government can't take steps to cover more people. But this approach misses the point entirely. The question is not whether we can afford to ensure that all Americans have health coverage. The question is whether or not we can afford to leave people behind.

Health insurance works best when it is continuous. Disease management and prevention are not short-term or intermittent activities. Even short periods of uninsurance can lead to diminished health status as individuals lose access to the care they need. In addition, continuous health coverage is the key to coordinated care. Care delivery in our health care system is already highly fragmented, with many patients receiving care from multiple providers, particularly high users of care such as the elderly and those with chronic conditions. This is a top-cost driver that we can

only address by continuous, coordinated care. Study after study has found that we can contain health care costs through better management of chronic disease.

Coverage for all will also help contain costs by reducing cost shifting and thus bringing some measure of sanity to how we finance our health care system. As a Brookings Institution economist has noted, broadly expanding coverage is "a precondition for effective measures to limit overall health care spending." In addition, Karen Davis of the Commonwealth Fund, who is a panelist today, has also offered very effective analyses on the link between coverage expansion and cost containment.

Strengthen the role of the group market

If we as a country can ever agree on the need for coverage for all, then the next question is what kind of insurance.

It is a fact that, in our health insurance system, the group market is more efficient than the individual market. Insurance works on the fundamental premise that risk is shared across a broad range of people. The idea is that everyone can pay a little over time and across populations in return for medical care and financial security when things go wrong.

Our health insurance markets began with employment-based coverage, and the group approach remains the central principle of our health care system today, with 60 percent of the non-elderly in employer-sponsored insurance. Grouping risk is also the principle behind public programs like Medicare. And it is the basis of health plans like those proposed by progressives, who talk about the importance of creating insurance connectors or clearing houses as a means of bringing people together to buy insurance as a group.

In contrast, conservatives have talked about promoting, and deregulating, the individual market for health insurance. Their approach does the following:

- *Limits coverage.* While risk on the group market is pooled through employer groups, the individual market is fundamentally different. Insurers must assess the risk of each individual applicant, using medical underwriting to guess at how expensive their care will be. There is an obvious business incentive to cherry-pick just the healthiest of applicants. Americans seeking coverage on the individual market with even minor pre-existing medical conditions, let alone chronic conditions, will pay higher premiums—if they are offered coverage at all.

  And even if a family on the individual market is offered insurance, there is no guarantee they can keep it. California has a highly regulated market, and yet thousands of people have had their coverage cancelled after they filed claims. One California health plan recently agreed with state regulators to reinstate roughly 950 people who had their coverage canceled once they needed it. Chairman Henry Waxman recently held an Oversight and Government Reform Committee hearing examining this critical problem of rescissions.

- *Eliminates benefit protections.* State governments mandate benefits be included in benefit packages, something that has been cited by conservatives as increasing the cost of insurance and placing it out of reach. Certainly, if we looked at all required benefits across all 50 states, anyone could cite one provision of one law somewhere. But for insurance to have any value, it needs to cover the treatments and services people need and deserve. We have rules because the insurers have the incentive to play a game of musical chairs where they all hope some other insurer will get the sickest patients.

- *Increases paperwork costs.* The individual market is simply more administratively expensive than the group market. This is obvious. The marketing and underwriting costs alone drive up costs.

- *Increases cost sharing.* No one benefits from health insurance they can't afford to use. And cost sharing on the individual market is often high. Consumer-driven care, with its

high deductibles and requirements for individuals to pay "first dollar" for any care is increasingly prevalent. This type of cost sharing creates a disincentive for patients to seek the preventive care and disease management services that help control costs and improve health in the long run. It is a particular problem for those with chronic disease, and thus significant need to access the system.

Much of the disagreement between the role of the individual market and the group market rests on the belief of free-market economists that buying health care is akin to buying any consumer good, like a car. Of course, individuals have a role to pay in the health care system, and we need greater transparency in pricing, quality-of-care data, and comparative effectiveness information to help them play that greater role. But the reality is that deciding between the costs and benefits of various cancer treatments like chemotherapy, radiation, and surgery will simply never be the same as choosing between purchasing a Dodge, Pontiac, and Lincoln. We have extreme market failures in health care that require government intervention, including:

- *Incentives for insurance companies to cherry-pick (or later drop those from coverage who are sick).* Private insurance companies will always try to limit their losses by avoiding giving care to those who need it.
- *The moral hazard faced by individuals who may choose to not get coverage for themselves or their children.* Because of the cost of insurance, some individuals and their families will gamble that they can avoid getting sick to avoid paying premiums.
- *Fee-for-service incentives for providers instead of incentives that reward prevention and wellness*. We continue to fail to put sufficient emphasis on chronic care and disease management in our health care system.

In short, it is a dangerous mistake to overstate the role that consumerism can play in health care that will cost lives if we get it wrong.

Use care in the possible use of new tax credits

Tax credits are one of the mechanisms that cut across the political spectrum. Progressives and conservatives both have talked about their use. From the progressive point of view, tax credits are used in conjunction with strengthening both public and private health insurance through expansion of Medicaid and the State Children's Health Insurance Program, two very effective programs. The tax credits are also designed as subsidies that would limit premiums to a given percentage of income to truly help ensure that health care is affordable.

In contrast, conservatives focus on tax credits to the exclusion of other types of expansion. Also, instead of focusing on limiting the cost of the premium to individuals, the tax credit is typically fixed and unrelated to the cost of insurance—leaving individuals to cover the cost left over by the credit. Tax credits must be a sufficient size to make insurance affordable for them to even be considered as an approach.

A chance not to be missed

I can only imagine what would be different today if we have gotten health reform in 1993-1994. Would we have millions of uninsured today? Would we have so many companies taking their jobs and capital overseas? Would we be losing more than a $100 billion a year in economic productivity? Would we have more than 25,000 citizens a year who die because they are uninsured? There is no way to know. But what we do know is absent health reform, all of those things will continue to be true. I will do everything I can to help this committee with the critical role it will play on health reform, especially on patients' rights and protections. We can't miss the chance to get health reform right. We can and must take advantage of this opportunity and get this right for the American people.