Testimony of

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on

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Chairman Miller, Congressman McKeon, members of the Committee, I appreciate the opportunity to testify before you today on the problems middle class Americans face in securing affordable health care. Families, businesses and governments are struggling with ever-increasing costs of care. Every year about a million people are added to the rolls of the uninsured, now numbering almost 47 million. People with insurance are seeing their benefits dwindle and health costs consume their wages. Even people with insurance find themselves unable to pay medical bills and going without needed care.

Increasingly, our health insurance system fails to protect us when we get sick. The following snapshot of the precarious state of our employer-sponsored health insurance system (based on the research literature) tells us why.

- **Most people without health insurance are working.** Four out of five people without health insurance are in families of workers, most of them working full time, primarily in jobs that do not offer health insurance.

- **Fewer firms offer health benefits.** Between 2000 and 2006, the proportion of firms offering health benefits fell from 69 percent to 61 percent.

- **Growing health costs stymie growth in earnings.** The cost of health insurance for those fortunate enough to have it grew 87 percent from 2000 to 2006. In the same period, workers' earnings increased only 20 percent, barely more than the rate of inflation (18 percent).

- **Even insured families face substantial financial burdens.** In 2003, almost one in five families with employer-sponsored coverage spent more than 10 percent of their incomes on health insurance premiums and health services. In other words, they were underinsured.

- **Underinsurance places the greatest burdens on people who get sick.** In 2003, one in six adults with private health insurance (almost 18 million people) reported problems paying their medical bills. People with serious health conditions experienced payment problems at almost twice the rate of the other privately-insured. Overall, over a quarter of people with payment problems reported that costs led them to skip medical tests, leave prescriptions unfilled or postpone care.

Given these conditions, it is not surprising that calls for health reform—indeed, calls to secure meaningful health insurance for all Americans—can be heard in state houses from Massachusetts to California, in business board rooms as well as consumer caucuses, and, as evidenced here, in the halls of Congress. Even President Bush has joined the conversation. Health reform proposals abound.

As we consider these proposals and move forward—as we must—it is important to remember that there are many ways to get to a fairer, more affordable, more secure health care system. But it is just as important to remember that not any way will get us there. Success demands that we know the difference between proposals that will achieve our goals and proposals that will not.

There are three critical elements to effective reform that will actually guarantee all people coverage that gets them access to needed health care. A proposal that has these three elements—adequacy, affordability, and availability of benefits—gets a Triple A rating because of the concrete ways it expands coverage that works.

Adequacy of coverage **-** The first element would define a set of benefits that protect people when they're sick. That means it has to cover the full range of medical services; limit cost-sharing to levels that are reasonable in relation to people's incomes; and cap out-of-pocket spending to what people can realistically afford. An adequate benefit can't be a donut—with a hole like the Medicare drug benefit; and it can't be Swiss cheese—with all kinds of limits that expose people to unexpected costs. In assessing adequacy, we

must beware of at least two other types of proposals: those that don't specify benefits, but leave it to insurers to define what's covered, and those that require deductibles so high they impede access to care. In short, a proposal with adequate benefits differs from proposals based on the premise that any insurance, being better than none, is good enough. That's simply not true if the goal is meaningful access to care.

Affordability of coverage - Element number two would create the subsidies that make adequate insurance affordable. We have abundant evidence that without subsidies, low and modest income people will not buy insurance voluntarily. This makes intuitive sense. Two-thirds of the uninsured have family incomes below twice the federal poverty level ($40,000 for a family of four). Do we really think it reasonable for families with these incomes to spend upwards of $11,000 (the average cost of reasonably comprehensive coverage in 2006)?

In assessing affordability, we must beware of proposals that require people with low or modest incomes to buy insurance without a subsidy. Personal responsibility is important; and everyone should pay a fair share. But a mandate without a subsidy is either punitive or pretend; it either shouldn't happen or it won't happen. In contrast to such misguided mandates, proposals that provide significant subsidies (assuring coverage at no cost for people with very low incomes and requiring partial contributions that increase with income) establish a reasonable mandate—at a price people can afford.

Availability of coverage **-** The third element would assure what might be called a "place to buy"—somewhere that makes adequate, affordable health insurance available to everyone without regard to health status. That "place" could offer a choice of health plans, like members of Congress get; it could be or look like Medicare; or, if the rules were changed, it could be existing private insurance plans. In assessing availability, we must beware of proposals that send people shopping for insurance in a market where insurers deny coverage to people when they need care (like the current non-group health insurance market) or charge more based on age or health status, or otherwise cherry-pick us when we're healthy and avoid us when we're sick. The proposal has to work for us when we're sick.

An effective health reform proposal can only deliver this Triple A protection if it has sufficient financing behind it—whether from individual, employer, or taxpayer contributions or some combination thereof. And it can only sustain that protection over time if it includes a way to slow health care cost growth—not only for people who are now uninsured but for everybody, including those of us who depend on Medicare and Medicaid. We can all be better off—and more willing to commit to universal coverage—if we invest in research to determine which medical services work and which don't, and in information and payment systems that help providers deliver the former and avoid the latter.

As you well know, debating the merits of alternative health reform proposals is a daunting task. Our history is filled with debates that generate far more heat than light.

For decades, instilling fear among those of us who have health insurance—even if it costs too much or covers too little—that political action will make us worse off, not better off, has taken health reform off the political agenda. But it may be that the worse cost and coverage get, the harder it will be to scare us away.

Whether that happens will depend on whether we can trump fear with confidence that we can do better. We can. Thirteen years ago, Harry and Louise—fictional characters in the health insurance industry's ad campaign—misleadingly, but effectively, picked apart the Clinton health reform proposal, asserting over and over "there's got to be a better way." We don't need fictional characters today to tell us the system is broken. Our moms and dads, brothers and sisters, friends and co-workers fill that role every day. The time for debate and discussion was a decade ago. The time for action is now.