

**HEALTH CARE ACCESS AND AFFORDABILITY—
EFFECTS ON FAMILIES, COMMUNITIES, AND
HEALTH CARE PROVIDERS**

HEARING

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SPECIAL HEARING

APRIL 30, 2003—WASHINGTON, DC

Printed for the use of the Committee on Appropriations



Available via the World Wide Web: <http://www.access.gpo.gov/congress/senate>

U.S. GOVERNMENT PRINTING OFFICE

89-042 PDF

WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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HEALTH CARE ACCESS AND AFFORDABILITY—EFFECTS ON FAMILIES, COMMUNITIES, AND HEALTH CARE PROVIDERS

WEDNESDAY, APRIL 30, 2003

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:33 a.m., in room SD-124, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senators Specter and Harkin.

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Senate Labor, Health and Human Services, Education Subcommittee on Appropriations will now come to order. Senator Specter should be joining us shortly. He is on a train getting here right now and I guess has been delayed a little bit. I am sorry. I better turn on my mike here.

Again, I want to thank Senator Specter, our chairman, for having this series of hearings. I think this is the first of three hearings we are having on the issue of health care accessibility and affordability.

This subcommittee has a lot of responsibility in this area. And we want to get as much information as possible to make sure that we are able to address this issue forthrightly and to help get information for our fellow Senators and members of the Congress as to the dimensions of the health care problem in America as it deals with accessibility and affordability. So I just appreciate Senator Specter's having this series of hearings.

I want to thank all of you for joining us today on this issue. It is the top issue in America. Even a recent poll, even with the war and the aftermath of the war, a recent poll showed that this is still the top concern of most Americans.

I have recently held some roundtable discussions in Iowa on this issue, traveling around the State, and some of the stories you hear just break your heart when you get real people in to talk about it.

I had a farmer who was going through bankruptcy. He has lupus, his insurance costs rose to \$13,000 a year. He does not know what he is going to do. We have another farmer here today, Mr. Petersen, who is going to speak about his situation, the plight of a lot of farmers without health coverage.

I had a 55-year-old man who became ill, lost his job, and could not afford COBRA. And now all they are doing is he and his wife are just sort of trying to wait until he can get on Medicare.

We have—and it is not just individuals per se that are being affected. Businesses, especially small businesses, I cannot tell you how many small businesses I had come to my meetings and, you know, these are small businesses. I remember one had—employed like 55 people, if I am not mistaken. And like 10 years ago, they had a health care plan that covered their workers and their families.

Then the cost got so high, they had to drop the families. And then it kept getting higher and higher, until where they had to have higher and higher deductibles and co-payments to where it is almost not much of a benefit any longer at all.

As this guy said to me, he said, you know, he said, “These people who work for me, these 55 people who work for me,” he said, “these are not just people that work for me. They are my neighbors. They are my friends. We go to the same church. Our kids go to the same schools. And it is—you know, it is,” he said, “and it is”—he said, “I am not—finally, I cannot even give them health care coverage any longer.”

We have got school districts—when I was in Ottumwa, I remember, I had a couple of school districts come forward. One small school district in Southeastern Iowa, their health costs had gone up 62 percent in a year, 62 percent. And then there were other school districts who were 50 percent, 48 percent. I mean really huge increases. And as the superintendent of the school said, you know, “When these costs go up like this, we can do a couple of things. One, we can cut coverage or we can cut salaries, because most of the money in a school district goes for salaries for school teachers.” He said, “Now if we cut coverage, we lose teachers, because they will say, ‘Well, we can go some place else. We can go outside the State or we will go somewhere else, maybe get a better deal.’ If we cut salaries, the same thing happens.” So he said, “Because of rising health care costs,” he said, “we are losing our hard-working teachers.”

So anyway, these are the things I am picking up all over the State, and I—one other figure, right now, if I am not mistaken, and some of you may correct me, I believe health care costs are now somewhere in the neighborhood of about 15, 16 percent of GDP right now, somewhere in that neighborhood. Our GDP is going up at about 2 percent a year, forecast over the next several years. Health care costs are projected to go up about 9 percent, 8 to 9 percent a year. At the end of this, these next 9 years, by the end of this decade that we are in now, health care costs could consume somewhere over 25 to 27 percent of GDP, by the end of this decade.

That is not even taking into account the baby boomers and Medicare and everything else that is coming down the pike. So we really have a crisis on our hands. And we have to be about the business of addressing this, and how we are going to solve this health care accessibility and affordability.

Last point, as was brought out to me time and time again that most people in America do get health care, even if they do not have insurance, even if they are not covered, they do get health care, but

they get it when they are the sickest and when they walk in the emergency room, that is. And that is the most expensive health care you can provide. Whereas, if they could get to people earlier with preventative care and supportive care, it would not cost so much.

So that keeps coming home time and time again, that that really is sort of the last resort of those who do not have insurance, and that is to show up at the emergency room if they have one close by.

So with that, again, I thank you all for being here.

STATEMENT OF RISA LAVIZZO-MOUREY, M.D., M.B.A., PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE ROBERT WOOD JOHNSON FOUNDATION

Senator HARKIN. We have a distinguished list of witnesses today. We have Dr. Risa Lavizzo-Mourey—

Dr. LAVIZZO-MOUREY. Exactly right.

Senator HARKIN [continuing]. Who became The Robert Wood Johnson Foundation president and CEO in January of 2003. Prior to her current position, she was a member of The White House Task Force on Health Care Reform, also served as a consultant to The White House in health policy issues. Dr. Lavizzo-Mourey earned an M.D. degree from Harvard Medical School and an MBA from the University of Pennsylvania.

We will start with you, then I will then go to Dr. Kellermann, and Ms. Scanlan—you made it all right.

Ms. SCANLAN. Thank you.

Senator HARKIN. I heard you were stuck on the Parkway. Thank you so much for being here.

Then we will go to Ms. Kane, and then last with Mr. Petersen.

So, Dr. Mourey, we will start with you, and then after your testimony, I will then introduce Dr. Kellermann, and then on down the list.

Dr. LAVIZZO-MOUREY. Very good.

Senator HARKIN. So welcome to the panel. And all your statements will be made a part of the record in their entirety. And please if you could sum up in 5 or 7 minutes or something like that, I would appreciate it.

Dr. LAVIZZO-MOUREY. Very good. Thank you, Senator. And I thank all of the members of the subcommittee for this invitation.

As you have heard, my name is Dr. Risa Lavizzo-Mourey. I am the president of The Robert Wood Johnson Foundation, who has a mission to improve the health and health care of the American people.

For those of us fortunate enough to have health insurance, we know what to do if we become ill or develop symptoms of an illness; we simply call the doctor. But for those who do not have health insurance, it is more difficult.

As a physician, I have grappled with this issue and watched people choosing between health care and paying their bills. I still recall a mother facing a situation when I was a young physician, when a young mother brought her 18-month-old boy into the emergency room. He had a high fever, and she was understandably very concerned. It did not take very long to figure out that he had a

pneumonia and needed treatment in the hospital, intravenous antibiotics.

When I went in to talk to her and tell her that it was a treatable illness, I suspected that she was going to be relieved, but instead, she wept. And through her tears, she told me that she was uninsured, they had already had one hospitalization, and the family simply could not face more debts.

To avoid hospitalization, she said that she and her husband would do anything. They would take off from work. They would treat the child at home. Yes, they were a working family. They had to choose between health care for their child and paying their bills. I struggled with what to do, and ultimately our team decided we could safely send him home on oral antibiotics. Thankfully, that little boy recovered.

But 20 years later, millions of uninsured families are still facing barriers to health care, crippling debt, and even personal bankruptcy.

Who are these people? Most of them are working families, fully 8 out of 10 are working families. Most of the uninsured are either not offered coverage or the premiums that they have to face through their jobs are simply beyond their budget.

Now, unfortunately, going without insurance, even for a short time, is risky. It leads to delaying health care and avoiding treatment that can alleviate serious illnesses.

In a sobering report by the respected Institute of Medicine, an estimated 18,000 Americans die each year because they lack health insurance. This report is from one of our most trusted research institutions and should remind us that this problem is truly a matter of life and death for far too many.

We all agree that this situation is unacceptable. The question we now face is how to forge a constructive and non-partisan national discussion that is based on reliable, objective information. The Robert Wood Johnson Foundation is fully committed to helping our Nation do both, and I am here to tell you what we have done to date, and what we plan to do, and hope that we can help in any way in the future.

Over the past three decades, The Robert Wood Johnson Foundation has made access to health care a top priority. The foundation has addressed this complex problem in numerous ways.

First and foremost, it has done so by supporting fundamental research into the economic underpinnings of the problem and the health and economic consequences of being uninsured in our society.

The Foundation has lent a hand to practical efforts as well. We have helped the private sector and the States develop new private and public options for coverage through our State Coverage Initiatives program, and we have supported efforts of volunteer doctors and clinics through Volunteers In Health, and we have worked to enroll Americans in Medicaid and SCHIP, and to make these programs more efficient and family-friendly through our Covering Kids and Families Program.

Currently, the Foundation is leading the way on several fronts. We are trying to raise awareness about the plight of the 41 million Americans who are uninsured through constructive, nonpartisan

national debate on this issue. We are also supporting the development of reliable, non-partisan information about problems and solutions.

Let me tell you just a bit more about each. To raise awareness and encourage a non-partisan discussion, we developed and led Cover the Uninsured Week just a little while ago—and I want to thank Senator Harkin and Senator Specter for their participation in those activities. As some of you may know, it was co-chaired by former Presidents Gerald Ford and Jimmy Carter, and the Foundation was able to forge a unique partnership between business and labor, consumer groups and health care groups, and ideologically diverse partners such as the Chamber of Commerce, the AFL–CIO, the American Medical Association, The American—Health Insurance of America Association, and AARP, as well as Families USA.

These groups and 160 national organizations and 700 local organizations, including every major religious denomination, and 200 elected officials participated in over 875 events in all 50 States and the District of Columbia. A total of 20 U.S. Senators, including as I said, Senator Specter and Senator Harkin participated, 43 Members of the House participated in the week's activities.

I think that this demonstrated that Americans want this problem solved. The meetings were non-partisan in nature and set the right tone for future discussions designed to meet the interests of our Nation.

Raising awareness and supporting a constructive, national discussion is necessary—

Senator HARKIN. If you could kind of wrap up—

Dr. LAVIZZO-MOUREY [continuing]. Surely—

Senator HARKIN [continuing]. Because the light—

Dr. LAVIZZO-MOUREY [continuing]. But not sufficient. Yes, sir.

In addition, we support numerous other research activities that I will just highlight briefly. Covering America is a project that the Economic and Social Research Institute is working on. It is a philosophically diverse group of health care scholars and the important thing to note about this work is that it will propose an analysis of solutions ranging from Federal tax income credits to Medicaid and SCHIP, to Medicare buy-ins, and there will be cost and coverage implications and analyses that associate—are associated with them. They will be available later on this year, actually in the summer. And we would hope that they could be helpful to members of the committee.

PREPARED STATEMENT

Let me just say that everyone at The Robert Wood Johnson Foundation is committed to helping this committee and any other of our policymakers who would like our help. We invite your questions about future research we might do, so that with you we can make sure that the young family I talked about 20 years ago does not have to face this kind of tragedy in the future.

Thank you, Senator.

[The statement follows:]

PREPARED STATEMENT OF RISA LAVIZZO-MOUREY

Mr. Chairman and members of the subcommittee, good morning. My name is Dr. Risa Lavizzo-Mourey. I am the president and chief executive officer of The Robert Wood Johnson Foundation in Princeton, NJ, the mission of which is to improve the health and health care of all Americans. Thank you for inviting me to testify this morning.

Those of us fortunate enough to have health insurance know what to do if our child becomes ill or we develop symptoms of an illness: We call the doctor.

But for more than 41 million uninsured Americans, the choice is not so easy. It can mean choosing between the health of your child and paying your other bills.

It can mean getting lifesaving early diagnosis and treatment, or postponing care until it is too late.

As a physician, I have watched people grapple with these terrible choices too often. I still recall a mother facing such a cruel choice some 20 years ago when I was a young physician, just out of medical school, working in an emergency room in rural Massachusetts.

The young woman brought in her baby boy who was about 18 months old, as I recall. He had a high fever. He was breathing rapidly. The young mother was understandably anxious and concerned. I ordered an x-ray, examined the child, and determined that he had pneumonia. I informed the mother, expecting her to be relieved. It was treatable, and he would be fine. We just needed to admit him, get him on some I.V. antibiotics, and watch him.

Instead, she wept.

She explained to me that her boy had already had one hospital admission and the family still faced debt from that stay.

She didn't know how they could handle another big hospital bill. Couldn't she take him home?, she asked.

She and her husband would do everything they could. They would take time off work. They would watch him around the clock.

Wanting to do the right thing, to live up to my physician's oath to first do no harm, I struggled with what to do. I prescribed oral antibiotics and talked to her at length about how to care for her young child and monitor him at home.

Thankfully, that little boy recovered.

But 20 years later:

—Children are still going without the care they need because their parents cannot afford the costs.

—We still have millions of Americans of all ages who live sicker and die younger because they lack health insurance.

—Families are still going into crippling debt or personal bankruptcy to get the medical care they need.

Who are these people?

Most of the uninsured today are in working families—fully 8 out of 10 of them.

Most of the uninsured either are not offered coverage through their jobs or face premiums and co-pays that are simply beyond their budget.

Unfortunately, going without insurance, even for a short time, is very risky; including the deadly results of delaying medical care for serious, life-threatening problems.

In a sobering report, the respected Institute of Medicine estimated last year that 18,000 Americans die each year because they lack health insurance. This report from one of our most trusted research institutes should remind all of us that this problem is a matter of life and death for too many.

We all agree that this situation is unacceptable. The question we face is how to forge a constructive and non-partisan national discussion based on reliable, objective information. The Robert Wood Johnson Foundation is fully committed to helping our nation do both, and I am here to tell you about what we have done to date, and what we plan to do, until this problem is solved.

Over the past three decades, The Robert Wood Johnson Foundation has made access to health care its top priority. The Foundation has addressed this complex problem in numerous ways.

First and foremost, it has done so by supporting fundamental research into the economic underpinnings of the problem and the health and economic consequences for the uninsured and society.

The Foundation has also lent a hand to practical efforts. We have helped the private sector and the states develop new private and public options for coverage through the *State Coverage Initiatives* program, supported the efforts of volunteer doctors and clinics through *Volunteers In Health*, and worked to enroll Americans in Medicaid and the State Children's Health Insurance Program (SCHIP) to make

these programs more efficient and family-friendly through our *Covering Kids and Families* program.

Currently, the Foundation is leading the way on several fronts. We are raising awareness about the plight of more than 41 million uninsured Americans and encouraging constructive, nonpartisan national discussion about the issue. We are also supporting the development of reliable, non-partisan information about the problem and proposed solutions.

Please let me tell you more about each.

To raise awareness and encourage a non-partisan and constructive national discussion, we developed and led *Cover the Uninsured Week*, a week long series of events in March 2003, co-chaired by former presidents Gerald Ford and Jimmy Carter. The Foundation forged a unique partnership of business and labor, consumer and health care groups, ideologically diverse partners such as the U.S. Chamber of Commerce and the AFL-CIO, The American Medical Association, The Health Insurance Association of America, AARP and Families USA. These groups and 160 national and 700 local organizations, including every major religious denomination, plus almost 200 elected officials participated in more than 875 community events in all 50 states and the District of Columbia. A total of 20 United States Senators, including two members of this committee, Senators Specter and Harkin, and 43 members of the House participated in the Week's activities. The Week demonstrated that Americans want this problem solved. The meetings were non-partisan in nature and set the right tone for future discussions designed to serve the best interests of our Nation.

The results of *Cover the Uninsured Week* speak for themselves. Preliminary reports indicate that the Week generated significant coverage on the plight of the uninsured, making it a truly unprecedented effort to raise awareness about the uninsured. The Week also brought together Americans of all points of view to begin a constructive, national discussion about possible solutions that might attract widespread support in American society.

While the plight of the uninsured demands new approaches, there are things we can do now to help alleviate the problem. As you know, many uninsured children are eligible for low-cost or free health care coverage through the SCHIP or Medicaid, but their parents are unaware that their children are eligible. Since 1997, the Foundation has been working through its *Covering Kids and Families* initiatives to address this problem. These programs have been active in all 50 states and the District of Columbia. State and Foundation-funded local coalitions have worked with almost every governor and state Medicaid agency to remove administrative and other barriers to enrolling children and adults in SCHIP and Medicaid. In all, we have committed more than \$150 million to these efforts.

In August 2003, we will launch our fourth annual *Covering Kids and Families* "Back to School" campaign that uses paid and free advertising to let families know that they may be eligible for low-cost and free health coverage through SCHIP and Medicaid. Since 1997, the campaign has generated more than half a million calls to state and federal toll-free information lines, including the federal government's 1-877-KIDS-NOW number. Through this campaign, more than 4,000 organizations nationwide have been actively engaged in finding, enrolling and retaining eligible children in Medicaid and SCHIP.

Helping public programs work better, raising awareness about the problem and supporting a constructive national discussion are necessary but not sufficient steps for solving the problem of the uninsured. Another key element is reliable, non-partisan research about the problem and solutions. With our funds we are supporting the following research and education projects, among many others:

The Institute of Medicine's six-part study on the consequences of being uninsured. The fifth report will be released this June, and I urge you to read it and all of the IOM reports on this issue.

Covering America, a project of The Economic and Social Research Institute. Through this project, a widely respected and philosophically diverse group of health care scholars and analysts has developed a set of proposals that, if enacted, might help provide coverage for all Americans. The first round of the project produced ten proposals, which include new approaches using federal income tax credits, Medicaid and SCHIP expansions, Medicare buy-ins, and organized insurance purchasing. We have commissioned the Lewin Group to produce estimates of the costs of those proposals and their expected impact on coverage. These estimates will be coming out this summer, and we would welcome the opportunity to share them with you. We believe that these wide-ranging ideas, and estimates of their potential effects, will help lawmakers as they grapple with ways to expand health insurance coverage.

If you or your staff, have any questions that you would like to have the Foundation consider for future research that might serve to advance our understanding of

the problem or of proposed solutions, please do not hesitate to let me know now during your questions today or any time in the future.

Last but not least, allow me to mention *The Alliance For Health Reform*, Co-Chaired by Senators Frist and Rockefeller and the *National Health Policy Forum*, headed up by Judy Miller Jones. Both projects provide your staff and others with objective information, well-rounded discussions and issue briefs on the issue of the uninsured as well as other urgent health policy matters.

We fund these and many other projects, because we believe that good solutions will flow from good information and that such information must be considered separate and apart from partisan concerns.

That's a tall order, but as president of The Robert Wood Johnson Foundation, I believe that is what our nation needs. This is most pressing for the uninsured families like the one I helped some two decades ago as a young physician.

I appreciate your invitation to participate in this hearing and look forward to your questions and comments.

Senator HARKIN. Thank you very much, Doctor.

I will just tell the witnesses, these lights are set for 5 minutes.

They are set for 5 minutes, but if you go over a couple of minutes, that is fine.

STATEMENT OF ARTHUR L. KELLERMANN, M.D., M.P.H., SCHOOL OF MEDICINE, EMORY UNIVERSITY, MEMBER, INSTITUTE OF MEDICINE

Senator HARKIN. Next we have Dr. Kellermann, professor and director of the Center for Injury Control, Rollins School of Public Health at Emory University. In 1999, Dr. Kellermann was elected as a member of the Institute of Medicine. He received his M.D. from Emory University School of Medicine and his MPH from the University of Washington.

Dr. Kellermann, welcome and please proceed.

Dr. KELLERMANN. Good morning, Senator Harkin, members of the subcommittee. I am Arthur Kellermann. I am a practicing emergency physician and Chair of the Department of Emergency Medicine at the Emory School of Medicine in Atlanta.

I also co-chair the Institute of Medicine's Committee on the Consequences of Uninsurance. Over the past 2 years, our committee has systematically studied the consequences that lack of health insurance posed for individuals, families, entire communities, and the country.

The committee's work is supported by The Robert Wood Johnson Foundation. To date, we have issued four of six planned reports. Our fourth report, entitled "A Shared Destiny: Community Effects of Uninsurance," was released last month.

In these reports, our committee reached the following conclusions: First, people are not uninsured by choice. Most are uninsured because health insurance is not offered by their employer or coverage is unaffordable.

Second, health insurance contributes to improved health outcomes for children, as well as adults. Conversely, uninsured people are more likely to receive too little medical care, to receive it too late, and as a result, they tend to be sicker and to die sooner.

Third, when even one member of a family lacks health insurance it can jeopardize the health and the financial well-being of the entire family, including its insured members.

Fourth and very important, uninsurance can adversely affect the financial viability of a community's health care institutions and providers. This, in turn, can result in reduced access to primary

care, to specialty services, and to hospital care, particularly emergency medical services and trauma care.

Uninsurance influences access to health care across the entire community, because the delivery of care to the insured and the uninsured is intertwined. Historically, hospitals and health care providers use surplus revenue from insured patients to subsidize the cost of providing uncompensated medical care to the uninsured.

However, over the past 25 years, public policies and enhanced market competition have eroded these margins. The effects of this erosion have been felt most strongly in inner city neighborhoods and in rural areas with sizeable uninsured populations. It has also been felt in parts of the health care system, such as public hospitals and academic medical centers that serve many uninsured people.

Through taxes, we all pay for the care of uninsured persons, either through local delivery of services or public insurance programs, such as Medicaid.

Public funding accounts for up to 85 percent of the estimated \$34 billion to \$38 billion in uncompensated care costs that were incurred by uninsured patients in 2001. However, responsibility for financing and delivering care to the uninsured is badly fragmented. There is no guarantee that health care providers who treat uninsured patients will be reimbursed.

Currently the only health care to which Americans have an explicit, legal right is care in the emergency department. The Federal Emergency Medical Treatment and Labor Act, EMTALA, requires hospital emergency departments to care for everyone in need, without regard for their ability to pay. However, no Federal funds are allocated to compensate hospitals or doctors for the cost of EMTALA mandated services.

Unfortunately emergency department crowding, a nationwide problem worsened by rising uninsurance rates now threatens everyone's access to lifesaving emergency care, insured and uninsured alike.

At the community level, local taxpayers bear much of the cost of caring for uninsured persons. Federal and State institute programs, like Medicaid, alleviate but do not eliminate the financial demands that uninsurance places on communities. The subsequent strain on State and local budgets can hurt community economies.

Because many urban health departments today have been forced to divert scarce resources from traditional public health activities to direct provision of health care services to the poor, uninsurance also poses a threat to the detection, reporting and treatment of infectious disease outbreaks, including emerging infectious diseases such as SARS or a potential act of bioterrorism.

In communities with high rates of uninsurance, the capacity of local EMS or ambulance systems and emergency departments to handle a mass casualty event, such as a terrorist strike or a natural disaster may be compromised. Problems like these put everyone at risk.

PREPARED STATEMENT

Our committee believes that there is enough evidence today to justify the immediate adoption of policies to address the problem

of uninsurance in our Nation. It is both mistaken and dangerous to assume that uninsurance in the United States harms only the uninsured. At the community level, the insured and the uninsured have a shared destiny.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF ARTHUR L. KELLERMANN

Good morning, Mr. Chairman and members of the Subcommittee. My name is Arthur Kellermann. I am chair of the Department of Emergency Medicine, Emory University School of Medicine and Director of the Center for Injury Control, Rollins School of Public Health, Emory University. I also serve as Co-Chair of the Committee on the Consequences of Uninsurance of the Institute of Medicine. The IOM is part of the National Academies, originally chartered as the National Academy of Sciences by Congress in 1863 to advise the government on matters of science and technology.

Over the past two years, this Committee has systematically studied the consequences that lack of health insurance poses for individuals, families, entire communities, and our society. After a brief downturn at the end of the 90's, the number of uninsured has resumed growth and now stands at over 41 million persons—roughly 16.5 percent of the U.S. population under age 65. The committee is supported by The Robert Wood Johnson Foundation and to date has issued 4 of its 6 planned reports. Our fourth report, entitled *A Shared Destiny: Community Effects of Uninsurance*, was released last month. Two more reports will follow this year. The fifth will estimate the economic and social costs resulting from uninsurance nationally. Our sixth and final report will present principles for assessing the potential impact of various strategies to expand coverage.

With the release of the 4 reports we have produced to date on the consequences of uninsurance, our Committee has provided the most complete, evidence-based picture of the many adverse effects of uninsurance—from the impacts on individuals to the effects on families, to the consequences for entire communities. In these reports, the committee has reached four main conclusions:

- First, people are not uninsured by choice. Most are uninsured because insurance is not offered by their employer or coverage is unaffordable.
- Second, health insurance contributes to improved health outcomes for children and adults. Conversely, uninsured people are more likely to receive too little medical care and to receive it too late, and as a result, they tend to be sicker and to die sooner.
- Third, when even one member of a family lacks coverage, it can jeopardize the health and financial well-being of the entire family, including insured members.
- Fourth, uninsurance can adversely affect the financial viability of a community's health care institutions and providers. This can result in reduced access to primary care, specialty services, and hospital care, particularly emergency medical services and trauma care.

The nation's more than 41 million uninsured persons are not isolated individuals. They are members of communities. In our 4th report, *A Shared Destiny*, we conclude that uninsurance has serious community wide effects. Based on our findings, we believe that it is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured. In our report, we cite evidence that the financial strain of treating large numbers of people without health insurance can hurt the viability of local governments and local health care providers. This can produce "spillover effects" across the community, including reduced access to emergency services and trauma care, loss of access to specialists, and reduced availability of hospital-based services. These effects can compromise access to health care community-wide, and ultimately damage a community's economy. In this report, our Committee establishes a framework for thinking about how the effects of uninsurance ripple throughout communities. We also assess the existing base of evidence and propose a research agenda to learn more about community-level effects.

The presence of a large uninsured population can affect an entire community's access to health care because the delivery of care to the insured and the uninsured is interrelated. This connection is evident if we examine the streams of funding that pay for uncompensated care. When the proportion of uninsured residents increases, or revenue from other sources such as private insurance is reduced, providing uncompensated care to uninsured people has a severe financial impact on health care institutions and providers.

Over the past 25 years, public policies to control health care costs, including promotion of competitive health care markets, have constrained the amounts that insurers pay to providers. This has eroded the financial support that allowed providers to subsidize their uncompensated care. The effects of this erosion have been felt more strongly in communities with large or growing uninsured populations, particularly inner city neighborhoods and rural areas as well as parts of the health care system that serve large numbers of uninsured people, such as public hospitals.

Responsibility for financing and delivering care to the uninsured in the United States is fragmented and ill-defined. As a result, many state, county, and municipal facilities serve as providers by default. The patchwork of federal, state, and local requirements for provision of minimal services typically do not specify the scope of benefits, or guarantee that providers will be reimbursed. Public funding for safety-net care is considerable, accounting for up to 85 percent of the estimated \$34 billion to \$38 billion in uncompensated care costs incurred by uninsured patients in 2001. However, there is little evidence that the public funds that pay for the bulk of uncompensated medical care for uninsured patients are being allocated or targeted efficiently.

In *A Shared Destiny*, we find that uninsurance had adverse impacts on ambulatory care:

- Individuals in lower-income families, nearly one-third of whom are uninsured, delay seeking care or go without needed care more often in communities with high rates of uninsurance than do their counterparts in communities with fewer uninsured members.
 - Community health centers that serve a large or increasing number of uninsured people report that their capacity to provide primary care to their clients, insured as well as uninsured, is becoming increasingly strained.
- Uninsurance can place a severe financial stress on hospital outpatient and inpatient departments, sometimes resulting in fewer available services. For example,
- In contrast to the rest of our health care system, hospital emergency departments or ERs are required by federal law to care for everyone in need, without regard to their ability to pay. Yet in recent years, ERs have become terribly crowded, reducing everyone's access to life-saving care. Uninsurance is not the primary cause of overcrowding in hospital ERs, but rising uninsured rates can worsen emergency room overcrowding and add financial strain on hospitals. Trauma centers are affected as well. Because trauma victims are more likely to be uninsured, hospitals in communities with large numbers of uninsured may decline to open a trauma center, or decide to scale back or close an existing center in response to financial stress.
 - Higher rates of uninsurance in communities are associated with decreased availability of on-call specialists to hospital ERs. Primary care providers also report difficulty in obtaining specialty referrals for patients, particularly those who are members of medically underserved groups.
 - Hospitals in urban areas with higher rates of uninsurance have less total inpatient capacity, offer fewer services for vulnerable populations, such as AIDS patients, and are less likely to offer trauma and burn care. Hospitals in rural counties with higher uninsured rates have lower financial margins and fewer intensive-care beds, offer fewer psychiatric inpatient services, and are less likely to offer high-technology services, such as radiation therapy.
 - When public jurisdictions respond to the financial pressure of uninsurance and other stresses by converting their hospitals to private ownership, the availability of vital but unprofitable services may be adversely affected.

Local taxpayers bear a heavy economic burden of subsidizing uncompensated health care at the community level. Federal public insurance programs, such as Medicaid, alleviate but do not eliminate the financial demands that uninsurance places on communities. Strains on state and local budgets that result from serving uninsured populations may hurt the community economically. When local governments need additional funds to care for uninsured people, the money must be raised somehow. This may require higher local taxes or budget cuts elsewhere. If, however, local governments cannot raise new funds for health care and instead cut support, providers may be forced to reduce their services or leave the area entirely. This can weaken a community's economic base and reduce access to health care for everyone.

Uninsurance poses a threat to the control of communicable disease by delaying the detection, treatment, and reporting of infectious disease outbreaks, which may include emerging infectious agents such as SARS and perhaps someday those linked to bioterrorism. Hospital emergency departments and health departments play critical roles both in infectious disease surveillance and in caring for low-income populations, who are more likely to be uninsured. When high rates of uninsurance make emergency department crowding worse, the capacity of the emergency care system

to handle a sudden influx of patients from a natural disaster or terrorist strike is compromised. To meet the burden of caring for the uninsured, health departments may be forced to shift scarce resources from traditional population-based public health activities, such as monitoring water quality and restaurant inspections to the delivery of personal health services to uninsured persons. This can weaken the ability of local health departments to contain outbreaks of infectious disease and other public health threats.

The IOM Committee on the Consequences of Uninsurance believes that there is sufficient evidence to justify the immediate adoption of policies to address the lack of health insurance in our nation. It is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured. When analyzing health care at the community level, it is evident that the insured and the uninsured have a shared destiny.

Thank you for inviting me to present the work of the IOM and the Committee on the Consequences of Uninsurance. I am happy to answer any questions that you may have about our work and to provide the Subcommittee with more copies of reports, executive summaries, and CD-ROMs. More information about the IOM Committee is available at <http://www.iom.edu/uninsured>.

Senator HARKIN. Thank you, Dr. Kellermann.

Would you give me the name of that bill again? You called it the Federal Emergency—

Dr. KELLERMANN. EMTALA is the nickname. It is the Federal Emergency Medical Treatment and Labor Act. It used to be called the Emergency Medical Treatment and Active Labor Act. And it is the only legal right to health care that most Americans have.

Senator HARKIN. Medical Treatment—

Dr. KELLERMANN. EMTALA is the nickname.

Senator HARKIN. EMTALA. I need more—I am going to need more information on that.

Dr. KELLERMANN. And it is a classic unfunded mandate.

Senator HARKIN. Yes.

Dr. LAVIZZO-MOUREY. Non-funded mandate.

Senator HARKIN. Non-funded mandate. Well, I need to know more about that. Thank you very much, Dr. Kellermann.

Dr. KELLERMANN. You are welcome.

STATEMENT OF CAROLYN F. SCANLAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

Senator HARKIN. Next we will turn to Carolyn Scanlan. Since June 1995, Ms. Scanlan has served as the president and CEO of the Hospital and HealthSystem Association of Pennsylvania. Ms. Scanlan received a degree in psychology from Skidmore College and a masters degree in health services administration from Russell Sage College.

Ms. Scanlan, welcome to the committee. As I said—I do not know if you were around, but I said earlier that all the statements would be made a part of the record, and so please proceed as you desire. Thank you.

Ms. SCANLAN. Thank you, Senator, and thank you for requesting these hearings. For the hospitals in Pennsylvania, the issues of access to care for all is very important, and we are glad to be here representing the chairman's State.

We represent the 272 licensed acute care, rehab, and psych hospitals in Pennsylvania. And our mission, along with our members' mission is to advance the health of individuals and the communities throughout Pennsylvania. We do commend you for holding

this hearing and appreciate the opportunity for expressing our views.

Hospitals, as we have heard from the prior two witnesses, play a key role in the patchwork system that has developed in our country for the provision of health care to the low income and uninsured individuals. We provide care 24 hours a day, 7 days a week, to all who need it, and in particular, through our emergency departments through EMTALA requirements, which we would follow legally, but which we also believe care in the emergency room is a moral imperative for hospitals.

We are proud of what we do in Pennsylvania. In 1 year, without any public hospitals—I want to repeat that—there are no public hospitals in Pennsylvania, neither at the State level, the county level, or the city level. And so the voluntary, not for profit system in Pennsylvania absorbs all of what we talk about.

We took care of nearly 2 million people last year. We took care of 33 million people in an outpatient setting. We provided nearly \$1 billion in uncompensated care, \$19 billion of care that was reimbursed.

We employ almost 300,000 people in the State, and we are one of the major contributions to the economic well-being of Pennsylvania. For that, we think we have a mission and a role.

As we heard from Dr. Lavizzo-Mourey, The Robert Wood Johnson Foundation has been particularly involved in this issue. In a recent study that they did in preparation for the care of the uninsured, we indicated that there are 2.4 million Pennsylvanians out of 12 million—that is our overall population—under the age of 65 that are—were uninsured during the period of a year. That is nearly 10 percent or 20 percent of our population. Seventy percent of that group was uninsured for a period of 6 months.

The health and—the uninsured has been a concern for us for many years. And we have worked with the State for outreach and active enrollment of children in our State's Children's Health Insurance program, which has been around for many years prior to the federally mandated program.

Medical assistance, which is another form of being able to get uninsured people health care, and a newly established program in our State for low-income working adults called Adult Basic, which is funded from a portion of Pennsylvania's share of the national tobacco settlement funds. But that is not enough. And we need to be able to expand this further.

Doctors, nurses, and hospital executives entered the health care field because we care about the quality of health care that people receive. We care about the health of the entire State. And we see people, children, adults, and seniors who are not receiving proper care simply because they cannot afford it. And that needs to change.

Our emergency departments, as Dr. Kellermann has indicated, across—as evident across the country are overcrowded. Forty-five percent of our hospitals are operating in what they consider over capacity. And more and more of the hospitals have to divert their ambulances to other facilities because they lack the staff and space to care for those additional patients.

Our emergency departments do not have the capacity to take on the even greater burden of the growing uninsured. And even more importantly, as we all already heard, we know all too well, that this setting is not the most appropriate or cost effective treatment for chronic diseases such as hypertension, asthma and chronic disease, and certainly does not allow for ongoing continuity of care around prevention and primary care.

In my statement, I have a list of six items, which we believe would help to incrementally work off of existing programs that are in place, both for children, for Medicaid adults, tax policies, as well as others. But in the end, we are all going to have to approach and look at the overall programs and make some fundamental changes on how we view care for the uninsured.

PREPARED STATEMENT

The partnership between Federal and State government, and health care providers is essential in order to make sure that in the Commonwealth of Pennsylvania, as well as across this Nation, the care and the health of all of our citizens is appropriate, acceptable, and leads to quality lives.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF CAROLYN F. SCANLAN

Mr. Chairman and members of the Subcommittee, my name is Carolyn F. Scanlan, and I am president and chief executive officer of The Hospital & Healthsystem Association of Pennsylvania (HAP). HAP is located in Harrisburg and has more than 250 member hospitals, health systems, and other health related organizations serving patients across Pennsylvania. The mission of HAP is to advance the health of individuals and communities and to advocate for and provide services to members who are accountable to the patients and communities they serve. Mr. Chairman we commend you for holding this hearing and appreciate the opportunity to present our views on health care access and affordability.

Hospitals play a key role in the patchwork system that has developed in our country for the provision of health care to low income and uninsured individuals. Our over 250 member hospitals provide 24 hour per day, seven days per week, access to health care to all without regard to ability to pay. Pennsylvania hospitals and health systems provide over \$980 million in uncompensated care annually. We believe that a healthy hospital and health care system is vital to the ability of both urban and rural communities alike to care for their most vulnerable citizens.

A recent report by The Robert Wood Johnson Foundation Hospitals estimates that approximately 2.4 million Pennsylvania residents under age 65—almost one out of four—were uninsured at sometime in 2001–2002. About 70 percent of this group was uninsured for a period of over six months.

The plight of the uninsured is something hospitals are acutely aware of and concerned about. The health care of the uninsured has been a concern for us for many years. We have worked with the state to outreach and actively enroll children into our state's Children's Health Insurance Program (CHIP), Medical Assistance, and the newly established program for low-income, working adults, adultBasic. But these are not enough to stem the tide. One solution for the continuing problem of the uninsured is to expand insurance coverage. It is something that is the right thing to do to help people in our community.

Doctors, nurses and hospital executives entered the health care field because we care about the quality of health care people receive. Everyday we see people—children, adults and our seniors—who are not receiving proper care simply because they cannot afford it. And that needs to change.

But we're also concerned about addressing the problem of the uninsured because we recognize the impact the cost of treating the uninsured has on our ability to provide the best possible care. While Pennsylvania is home to over 250 hospitals, there are no public hospitals in Pennsylvania, which makes us very different from the other larger states. With uncompensated care costs growing, it directly affects our

ability to provide the best care possible. This represents, on average, over 4.8 percent of hospital's net patient revenue, but it can range as high as 20 percent. How many fiscally responsible entities can continue to do business when almost 5 percent of their business is unpaid, and in some cases 15–20 percent? The reality is they cannot and in Pennsylvania we continue to see service elimination, closure of hospitals, and significant stresses on those that remain.

Hospitals provide care 24 hours-a-day, seven days-a-week to our communities—when health care needs arise, when disaster strikes a community, when an uninsured child needs care, when others have closed for the night, when there's no place else to turn. Many times those without health insurance see the emergency room of their local hospital as the only place to go to for care.

Our emergency departments are already overcrowded. 45 percent of hospitals in the mid-Atlantic region of our country say their emergency departments are operating “over” capacity. More and more, hospitals are forced to divert ambulances to other facilities because they lack the staff and space to care for additional patients. Our emergency departments cannot take on a greater burden of treating the uninsured. Even more important, as we know all too well, this setting does not allow for the most appropriate or cost effective treatment of chronic diseases such as hypertension, asthma and other chronic illnesses, and it does not allow for ongoing preventive or primary care.

Collectively, we have crafted national and state partnerships in regard to Medicaid, children insurance programs, and other programs to expand access to health care. However, there are still large numbers of Americans and Pennsylvanians who are uninsured. And, as you, at the federal level, and Pennsylvania state government address this year's government budgets, these expanded programs and the providers who deliver the health care programs are in jeopardy. Therefore HAP, in conjunction with its national partner the American Hospital Association, supports legislation that:

- Expands coverage to parents of children enrolled in SCHIP and Medicaid; simplifies the enrollment process, and expands coverage to children through the age of 20.
- Expands Medicaid and SCHIP allowing states to include legal immigrant children and pregnant women. And allow states to expand Medicaid to include single, childless adults.
- Establish payment accountability mechanisms that ensure adequate Medicaid payments for hospitals.
- Creates refundable tax credits to make health care coverage more affordable for low-income individuals and their families.
- Establishes a tax credit for employers that make additional health insurance premium contributions on behalf of their low-income employees.
- Extends the period for which COBRA is available and provides a refundable tax credit for individuals and families to help offset the cost of coverage.

It is critically important that both the federal and state governments fund the existing programs, including Medicaid, appropriately in order to continue meeting the health care needs of our most vulnerable people. Nationally, nearly 45 million poor, disabled and elderly people rely on Medicaid for their care. The Pennsylvania Medicaid program last year met the health care needs of approximately 1.7 million disadvantaged Pennsylvanians, many of them children and our senior citizens. Over its nearly 40-year history, Medicaid truly has become the nation's health care safety net.

The importance of this role has never been more critical than today. The current economy has forced many Americans out of work, pushing them and their families into the ranks of the uninsured. Medicaid has historically served as a buffer to the perils of an uncertain economy by providing access to health services for those who cannot afford it. In hard economic times, the numbers of those eligible for Medicaid typically increase. Pennsylvania currently faces a budget shortfall that could be as high as \$2 billion, and projections are pushing that figure even higher next year. Our state's Medicaid program is struggling to make ends meet and will be enacting “draconian” payment cuts to hospitals and other providers as a means of assuring recipients continued eligibility. This will be devastating to our hospitals.

It is imperative that any federal action to address the current crisis, and any federal efforts to change the current structure of the Medicaid program, must not put further financial pressure on the states nor diminish the guarantee of coverage for our most vulnerable Americans.

HAP is concerned about the Administration's proposal, which seeks fundamental change to the Medicaid program. The proposal reduces and weakens coverage for vulnerable populations. It also appears to dismantle the disproportionate share hospital payment (DSH) program. DSH is our nation's primary source of support for

safety net hospitals that serve the most vulnerable Americans—the uninsured, the underinsured and Medicaid beneficiaries.

In Pennsylvania, a 2001 report of a bipartisan committee of our state legislature found that in hospitals are paid an average of only \$.74 for every dollar in services provided to Medicaid recipients, and provide nearly \$1 billion in uncompensated care annually. Eligible Pennsylvania hospitals were only paid \$255 million in DSH (state and federal) in fiscal year 2002. Eliminating DSH would only further exacerbate the financial deterioration of Pennsylvania's hospitals, 70 percent of which lost money last year on patient care. This underscores the importance of the DSH program in maintaining access to health care for Pennsylvania's poor. It is the poor, disabled and elderly that would be affected.

HAP believes that the current fiscal and economic crises faced by states demands immediate and meaningful federal support. That support could be in the form of an increase in the federal Medicaid matching percentage or other relief that would allow states to use such funds to help support their Medicaid programs, as we all work to improve economic conditions. States should not be forced to radically transform their programs to receive such fiscal relief, nor should they be compelled to reduce future spending to repay the federal support given now.

HAP believes that this nation has an obligation to care for the neediest of our society. Federal accountability to a set of meaningful benefits for this population must be maintained, whether delivered through traditional fee-for-service or through managed care. An approach that requires coverage of the mandatory Medicaid population, but allows states absolute flexibility in deciding which non-mandatory populations and health care services will be covered in the future, begins to erode the guarantee to coverage that has long been a fundamental feature of the Medicaid program. Optional services, but medically necessary services, such as prescription drugs for the poor, elderly, and disabled, could be eliminated. Health services to more than 12 million children, parents, disabled and elderly people could stop if these populations are dropped from Medicaid, thereby swelling the ranks of the uninsured, and ultimately stressing the nation's already fragile health care system.

HAP believes that adequate provider payment is critical to ensuring that Medicaid beneficiaries have access to needed quality health care services. Current Medicaid law has minimal protections that are mostly geared to making the payment rate-setting process more public. HAP advocates that these current protections be strengthened.

HAP also believes that federal oversight of state Medicaid programs serves as an important tool in protecting access to health care services for vulnerable people. The federal government oversight role ranges from requiring states to oversee Medicaid managed care plans to make certain enrollees have access to quality health care providers, to assuring the financial integrity of the program by making certain states spend their Medicaid funds on health care. The Administration's approach would significantly weaken this oversight role for the federal government and virtually eliminate state accountability for the management of their programs.

The Medicaid program has played a vital role in providing access to health care services to millions of Americans over its 40-year history. It has provided vitally needed services to pregnant women, children, poor elderly, the disabled and other medically needy citizens. The current fiscal crisis faced by states should not be the impetus for dismantling the program and abandoning its mission of serving those in our country who need help the most. States need immediate and meaningful fiscal relief and any flexibility granted state governments should not put at risk the essential mission of the Medicaid program. Abandoning people's health care needs will not help turn our economy around.

HAP stands ready to assist the committee as it works to meet the challenge of sustaining access to health care for the poor. At the same time, to assure the vitality of the health care system in Pennsylvania, we need to address the Medicare program along with the challenges of treating the uninsured and the underfunding of the Medicaid program.

Medicare patients represented over 55 percent of Pennsylvania hospital's inpatient admissions in 2002. Medicare hospital payment increases historically have been less than government-acknowledged costs. On average, Pennsylvania hospitals' have only a 4.3 percent increase in their Medicare inpatient payments over the past six years, while hospitals costs increased by 22 percent nationally over the same time period. Each year Pennsylvania hospitals have had to cope with a shortfall in Medicare inpatient payments. In 2002, 32.6 percent of Pennsylvania hospitals had a negative total Medicare margin. This is largely due to the \$3.1 billion cuts hospitals experienced in the Medicare program with the Balanced Budget Act, even after the partial restoration of funding with subsequent legislation. The entire Medi-

care program must be adequately funded, including outpatient services, graduate medical education, psychiatric and rehabilitation units and skilled nursing.

In 1998, 28 percent of Pennsylvania hospitals' bottom lines were in the red. Medicare and Medicaid cuts have spread the red ink and now more than 40 percent of Pennsylvania hospitals have negative bottom lines. The statewide average total margin of 2.26 percent is far below the 4 percent minimum margin level that most economists consider essential to sustain financial viability. Yet Pennsylvania hospitals are operating efficiently. A 2001 report to the state's Legislative Budget & Finance Committee found Pennsylvania hospitals to be one of the most efficient in the nation with costs 6 percent to 7 percent lower than expected. Pennsylvania hospitals have eliminated as much capacity as possible. The number of set up and staffed beds has declined 18 percent since 1995.

Yet along with reimbursement pressures and aggressive efforts to operate efficiently, Pennsylvania hospitals are facing skyrocketing costs. Hospitals' incurred costs of providing care increased 44.6 percent from 1997 to 2001. Labor costs are rising due to continuing workforce shortages. Between 1997 and 2001, hospitals labor costs grew 38.8 percent. Hospitals' costs for pharmaceuticals, supplies, and other services increased 24.1 percent from 1997 to 2001. Blood costs increased more than 20 percent in the last year and more than 117 percent since 1997. Spiking energy prices are wreaking havoc with hospital operating budgets. Energy costs rose 4.7 percent in March and 7.4 percent in February. In 2001–2002, Pennsylvania hospitals spent more than \$8.3 million on emergency preparedness and expect to spend \$24.6 million this year alone. Hospitals are also anticipating a growing capacity crisis as the nation is seeing the 15-year decline in hospital inpatient volume indicators leveling out. Therefore, the number of acute care beds needed nationally is expected to increase 46 percent by 2027. Given Pennsylvania's aging population, we expect the demand for access to acute care to grow in our state as well.

It is important to take a moment to specifically address Pennsylvania soaring medical liability insurance premiums which have forced physicians to leave practice, move or suspend services and resulted in overwhelming financial burdens to hospitals. Medical liability premiums rose an average of 86 percent over the past 12 months, and 23 percent of hospitals reported premium increases exceeding 200 percent. The federal government—through its funding of Medicare, Medicaid and other programs—pays an additional \$28 billion to \$47.5 billion a year for health care due to the costs of medical liability coverage and defensive medicine. From 1975 to 2000, medical liability premiums rose 505 percent in the nation, Pennsylvania's increase was more than 1,400 percent during this time. States with limits on non-economic damages in medical liability cases saw premiums rise the least: California premiums rose just 167 percent from 1975 to 2000. Only a few short years ago, there were more than 30 medical liability insurers active in the Pennsylvania market. Today there are only two major insurance companies left.

Nearly 7 in 10 Pennsylvanians believe the medical liability crisis will likely affect their medical care. Four in 10 Pennsylvania adults say they are very concerned they will have trouble finding a doctor when they need one due to the rising cost of medical liability insurance. A national survey also showed that 78 percent of Americans are concerned that access to health care may be compromised because of soaring liability premiums. Some 71 percent agree that medical liability lawsuits are one of the main factors behind rising health care costs.

The uninsured, reimbursement cuts and underfunding in Medicare and Medicaid, and growing cost pressures including medical liability premium increases have forced hospitals to reduce services, layoff staff, close programs, and forego modernizing equipment and buildings. At the same time the need for hospital services is growing and Pennsylvania's hospitals are struggling to maintain this level of care and service to their communities.

The foundation of one of our state's most important economic assets—our health care system is eroding. The federal government plays a critical role in keeping the promise of providing health care to America's elderly and poor by adequately funding the Medicare and Medicaid programs. Pennsylvania's hospitals cannot continue to be reimbursed less than the cost of care and provide care to the uninsured. If hospitals are to continue to provide the care patients and communities need, then immediate action must be taken.

Mr. Chairman, I want to thank you for the opportunity to comment on this important challenge facing health care today. Health care access and affordability affects families and communities throughout the Commonwealth as well as other parts of the nation. We appreciate your help in trying to ensure that affordable health care is available to Pennsylvania families. I would be happy to try to answer any questions you or the other members of the Subcommittee may have.

Senator HARKIN. Ms. Scanlan, thank you very much for a very strong statement. I will get back to questions later. Very good. Thank you.

STATEMENT OF LANETT KANE, R.N., PEOPLE'S CLINIC, CEDAR FALLS, IA

Senator HARKIN. Next we go to Lanett Kane. Ms. Kane is now serving as a nurse at the People's Clinic in Cedar Falls, Iowa. She has worked at the clinic for over 13 years, serving in a variety of positions. And Ms. Kane resides in Cedar Falls, Iowa.

Ms. Kane, welcome to the hearing.

Ms. KANE. Good morning, and I am honored to be here. Again, my name is Lanett Kane. I work at Peoples Community Health Clinic in Waterloo, Iowa as a family practice registered nurse.

I have worked at PCHC for 13 years and, of course, have done a variety of duties there. I have been a nurse for a little over a year. At PCHC, I work for less money and have no opportunity in getting help in repaying roughly \$12,000 in student loans compared to similar jobs in the community. But I decided to stay at PCHC due to the diversity in our patient population and our mission statement, which is to serve the underserved.

Working at PCHC has shown me first hand the hardships people endure due to the lack of or shortage of insurance. I have also seen many successes when people with chronic health problems finally have access to health care coverage. Under insurance/no insurance is an epidemic problem at my job. I have the rare opportunity not only to witness the devastating effects on our patients, but I also realize the devastating impact poor health care has in our society as a whole.

PCHC began 27 years ago in the basement of a church with one doctor and one nurse. Currently we serve 13,048 patients with 53,393 encounters. Of those encounters 39 percent were Medicaid, 6 percent were Medicare, 24 percent were third-party payer, and 31 percent were self-pay.

Taking care of a large number of patients who have inadequate health care is difficult and costly. Seventeen percent of our patients are limited English speaking and require translation services.

We have a full-time position to enroll patients in the patient assistant program for medications. For patients with chronic medical problems, it takes a team approach to make a difference—doctors, nurses, aids, nutritionists, social worker, homeless outreach worker, case managers, substance abuse counselors, and clinical pharmacists.

Most of the ancillary services that we provide are not reimbursed by third-party payers. The limited education, increased social and economic struggles of our patients not only affects the productivity of our providers, but also affects our ability to recruit and retain providers.

There are so many stories I could share that I see on a daily basis, it is hard to narrow it down to just a few that epitomize the crisis that we face at PCHC everyday. One of them is a family, both parents work. They bring in \$2,800 a month before taxes. They pay \$220 a month for their health insurance, but they have to pay a \$500 deductible per person before the insurance kicks in.

The insurance coverage does not pay for preventative care or prescriptions.

One of the children has an ongoing medical issue which requires daily medication which costs \$20 to \$30 a month. Within 2 months this family had three trips to our office, two acute visits at \$20, a well child visit with immunizations cost them \$300, and two medications at \$40. Mom's statement to me while I was giving the immunizations was "I do not even know why we have insurance."

Once a child turns 19, they are no longer covered on their parent's insurance, or they do not qualify for Title 19, or they do not make enough money.

One of our patients, who had Diabetes Type 1, turned 19 and no longer had insurance to cover her medicine. She struggled to pay for medicines and rarely was able to check her blood sugars on a glucometer in order to adjust her insulin. She attempted to work, but lost several jobs because of her health. Eventually, once her health dramatically declined, she qualified for Medicare/Medicaid. At this point her health insurance, our tax dollars, covered 4 years of dialysis, two heart surgeries, and numerous hospital stays secondary to complications of her diabetes. She died at age 36.

It is not unusual at our clinic or the ER to see patients arrive seriously ill because they delayed getting treatment due to lack of medical coverage. I will never forget a 40-year-old man who came to the clinic with a severe life threatening infection to his leg. The infection started as a small skin infection around his ankle. After 5 days of waiting, the infection spread up his leg, to the tissue below his skin and into his bloodstream. The infection had already begun affecting other major organs. He was having a difficult time breathing and his blood pressure was very low. He was rushed to the ER and air lifted to the University of Iowa Hospital.

He eventually recovered from this infection but not before having two leg surgeries, one of those being an amputation, 10 days in the ICU on life support, and a total of 6 weeks in the hospital. Had this patient been seen in the beginning, it would have cost approximately \$65.

Health care is much more expensive for people with no insurance. This group of people has nobody negotiating their group rates.

PREPARED STATEMENT

Our society loses when someone loses his leg because of delayed treatment due to no insurance. Our society loses when someone is hospitalized as a direct result of inability to afford medicines. Our society loses when an uninsured person has major surgery and will need to declare bankruptcy due to inability to pay. Our society loses when a person dies at the age of 36 due to inadequate health care coverage. We cannot afford to lose any more.

[The statement follows:]

PREPARED STATEMENT OF LANETT KANE

My name is Lanett Kane and I work at Peoples Community Health Clinic in Waterloo, Iowa as a family practice registered nurse.

I have worked at PCHC for thirteen years. In the course of my time there I have been a scheduling clerk clinic aide, medical records clerk and lead worker, homeless outreach worker, peri-natal case manager, and accounts receivable clerk. I have

been a nurse for a little over a year. At PCHC, I work for less money and have no opportunity in getting help in repaying about \$12,000 in student loans compared to similar jobs in the community. But I decided to stay there due to the diversity in our patient population and its mission statement: to serve the underserved.

Working at PCHC has shown me first hand the hardships people endure due to the lack of or shortage of insurance. I have also seen many successes when people with chronic health problems finally have access to health care coverage. Under insurance/no insurance is an epidemic problem and at my job, I have the rare opportunity to not only witness the devastating effects on our patients, but I also realize the devastating impact poor health care has on our society as a whole.

PCHC currently serves 13,048 patients with 53,393 encounters. Of those encounters 39 percent were Medicaid, 6 percent were Medicare, 24 percent were third party payer, and 31 percent were self-pay.

There are so many stories I could share, it is hard to narrow it down to a few that epitomize the crisis that we face at PCHC everyday. I would like to begin with a family of five that I have treated. Both parents work and bring home about \$2,800/month before taxes. They pay \$220/month for health insurance for themselves and their three children, but have to pay \$500 deductible per person before the insurance will kick in. This insurance coverage does not pay for preventative care or prescriptions.

One of the children has an ongoing medical issue which requires daily medication which costs the family between \$20 and \$30/month. Within two months this family had three trips to our office: two acute visits at \$20, a well child visit with immunizations at \$300, and two medicines at \$40. Mom's statement while in the office was, "I don't even know why we have insurance."

Once a child turns nineteen they are no longer covered on their parent's insurance, or they don't qualify for Title 19, or they don't make enough money to afford health insurance. And college age adolescents/young adults need to have access to health coverage. We see many health concerns in this age group at PCHC. Many cannot afford the office visit or the medicine to treat STD's, depression, stomach ulcers, obesity, diabetes, beginning symptoms of hypertension, and common illnesses. One of our patients, who had Diabetes Type 1, turned nineteen and no longer had insurance to cover her medicine. She struggled to pay for medicines and rarely was able to check her blood sugars on a glucometer in order to adjust her insulin. She attempted to work but lost several jobs because of her health. Eventually, once her health dramatically declined, she qualified for Medicare/Medicaid. At this point her health insurance (our tax dollars) covered four years of dialysis, 2 heart surgeries, and numerous hospital stays secondary to complications of her diabetes. She died at the age of 36.

It is not unusual at our clinic or the ER to see patients arrive seriously ill because they delayed getting treatment due to lack of medical coverage. I will never forget a 40 year-old man who came to the clinic with a severe life threatening infection to his leg. The infection started as a small skin infection around his ankle. After five days of waiting, the infection spread up his leg, to the tissue below his skin and into his bloodstream. The infection had already begun affecting other major organs. He was having difficult time breathing and his blood pressure was extremely low. He was rushed to the ER and air lifted to University of Iowa Hospital. He eventually recovered from this infection but not before having two leg surgeries, one of those being an amputation of the leg, 10 days in the ICU on life support, and a total of 6 weeks in the hospital. Had this patient been seen at the beginning of his illness, his office visit and appropriate medication would have been a combined cost of about \$65.

Recently I treated a 42 year-old female with diabetes Type 2 and hypertension. She has a four year college degree and is a teacher at a small private school that is unable to offer health coverage to employees. Due to lack of insurance she is unable to afford all of her medications to control her diabetes and hypertension. Her income is too high to qualify for help through pharmaceutical patient assistance program. Her chronic illnesses are taking a toll on her body and she now is requiring heart surgery. A hospital stay for open heart surgery is \$30,000. How will she pay for that with an income of \$18,500/year? She works, teaches our children, pays her taxes, and this is the best we have to offer her!

It's not just the people we treat at PCHC who struggle with rising health costs. Like other small businesses, PCHC is feeling the affect of trying to offer its employees adequate health care coverage. Currently it costs \$208/month for family coverage thru PCHC and \$82/month for single coverage. Some of our employees are unable to afford the insurance or have a hard time paying the deductible or the co-pay.

Our society loses when someone loses his leg because of delayed treatment due to no insurance. Our society loses when someone is hospitalized as a direct result of inability to afford medicines. Our society loses when an uninsured person has major surgery and will need to declare bankruptcy due to inability to pay. Our society loses when a person dies at the age of 36 due to inadequate health care coverage. We can't afford to lose any more.

Senator HARKIN. Ms. Kane, thank you very much, a very powerful statement. Thank you. Yes, you have seen it.

STATEMENT OF CHRIS PETERSEN, FARMER, CLEAR LAKE, IA

Senator HARKIN. Next we turn to Mr. Chris Petersen. Mr. Petersen is a family farmer in rural Iowa. He is the vice president of the Iowa Farmer's Union, president of the Prairie Land Farmer's Union, and a member of the National Farmers Union. Mr. Petersen is a lifelong Iowan and currently resides in Clear Lake, Iowa, with his wife and two children.

Mr. Petersen, welcome.

Mr. PETERSEN. Thank you, Senator Harkin. I appreciate this opportunity to talk about health care. Again, my name is Chris Petersen. I am a family farmer from Clear Lake, Iowa. I am here today to share my personal story and the stories of other rural farmers in Iowa about the lack of health care available to us.

Years ago when I started farming, I worked in a factory where I received health benefits, but in 1992 I started farming full time on my own. I had to find my own health insurance for me and my family, so I signed up on a private policy. We stayed on that for about 3 years until profits declined from the family farm, and with the increasing costs of health insurance at that time also, we dropped the insurance.

In 2001, because of the decline in farm profits, I had to file a personal bankruptcy. Since money was tight my family and I were forced to go without any health coverage at all from 1995 till January 2001. My wife, two teenage kids and I were uninsured for those 5 years. During that time, if we got sick, we could not afford to go to the doctor. We just had to hope for the best and put faith in the Lord.

Since 2001 I have gone to part time farming and taken other jobs, and am finally able to again buy health insurance from a private insurer. But the price for that insurance has doubled since the last time we had insurance. My wife and I are in our forties now. And it is a priority that we have access to health care that we need. Unfortunately, over the last 2½ years the cost has accelerated to the point we may have to reconsider our options.

As costs have increased, we have done everything possible to make sure we could afford the monthly fees for our health insurance. We have cut our dental and vision benefits. We have cut some of the preventative care, such as out-of-hospital blood work, increased our deductible from \$1,000 to \$3,000. Now, we are basically left with insurance for catastrophic health emergencies, and even with just that we pay nearly \$400 a month. And the cost of our insurance is still rising, to the point at which it is outpacing our ability to pay for it.

At this point, we might be forced to join the other millions of people lacking health insurance in this country again. And if we lose our health insurance, how on earth are we going to pay for my

wife's and I—we are on blood pressure medication; I am on Nexium—the very medication that prevents us from getting sick in the first place?

I got another surprise here about 6 weeks ago, I applied for some life insurance and through the diagnostic testing, I—they found out I am borderline diabetic, so I have got that facing me now. So that is another good reason to have health insurance.

As a family farmer, I do not have 401(k)s, vacation time, or health care benefits. I have had to choose between health care and shelter and food in the past, and we are almost at that point again. Because I and my wife who also has worked full-time throughout our marriage as an assistant director of daycare where they have absolutely no benefits, we earned enough income not to be eligible for Medicaid. Nevertheless the cost of keeping my wife and I covered, I feel, is outrageous.

My kids are 22 and 19 years old now. I have discouraged them from farming, and urged them instead to work in town. They have found average-paying jobs that, yes, they offer health insurance, got to pay for it, but they do not use it because they cannot afford to pay for it. It would cost at least one-third of their paychecks. These are kids trying to begin life.

My daughter, she is going to be getting married here in a few months. And, you know, there is priorities. You need a home. You need food, things like that.

Both my kids are going without health care because it is just too expensive, and, of course, they do not qualify for Medicaid.

There are many other families in Iowa who are even worse off. A good friend of mine has struggled with health problems, including rheumatoid arthritis and lupus, since 1994. When his lupus becomes active in his system, the rheumatologist tries to find other medications to bring it back under control and into a dormant state again, which is extremely expensive. This friend of mine has raised hogs for his entire life, but can no longer do so because of his medical condition. He is currently applying for disability benefits, but even if he qualifies, he will not receive any health care assistance for 2 years.

Although my friend and his family have health insurance through the Farm Bureau, right now, without the co-pays or anything, they are paying \$1,111.30 a month for health care coverage.

I seen the lights on. I have got other examples here. It is just atrocious what is going on out in rural America. I feel we were in a vicious cycle, without being able to have access or affordable preventative care, family farmers like me and my friends wind up being forced to emergency rooms to obtain care, which is very expensive. And that is why farm families like my own send their spouses and kids to town to get jobs. But in Iowa, as in many other places, there are less and less of those good-paying jobs that have health care. So it is a vicious circle we are creating here.

PREPARED STATEMENT

We need to do something to make health care more affordable and accessible. If we do not fix this problem, it is only going to get worse. And, you know, if the cost of health care keeps accelerating, who and how many Americans will have the ability to pay for it?

Thank you for inviting me to share this.
[The statement follows:]

PREPARED STATEMENT OF CHRIS PETERSEN

Thank you Senator Harkin: My name is Chris Petersen, and I'm a farmer in Clear Lake, Iowa. I'm here today to share my personal story and the stories of other rural farmers in Iowa about the lack of health care available to us.

Awhile back I worked in a factory where I received health benefits, but in 1992 I started farming full time on my own. I had to find my own health insurance for me and my family, so I signed up on a private policy. We stayed on that for about three years until profits from family farming dropped, and in 2001 I had to file for bankruptcy. Since money was tight my family and I were forced to go without any health coverage at all from 1995 to January 2001. My wife, two teenage kids and I were uninsured for those five years. During that time, if we got sick, we couldn't afford to go to the doctor. We just had to hope for the best.

Since 2001 I've gone to part time farming and taken other jobs, and am finally able to again buy health insurance from a private insurer. But the price for that insurance has doubled since the last time we had insurance. My wife and I are in our forties now. It's a priority that we have access to the health care we need. Unfortunately, over the last two and a half years the cost has accelerated to the point that we may have to reconsider our options.

As costs have increased, we've done everything possible to make sure we could afford the monthly fees for our health insurance. We've cut our dental and vision benefits, cut some preventative care, such as out-of-hospital blood work, and increased our deductible from \$1,000 to \$3,000. Now, we're basically left with insurance for catastrophic health emergencies, and even with just that we pay nearly \$400 every month. And the cost of our insurance is still rising, to the point at which it's outpacing our ability to pay for it. At this rate, we might be forced to join the other millions of people lacking health insurance. And if we lose our health insurance, how on earth are we going to pay for my wife's blood pressure medicine or my Nexium—the very medication that prevents us from getting sick in the first place?

As a family farmer, I don't have 401k's, vacation time, or health care benefits. I have had to choose between health care and food in the past, and I'm almost at that point again. Because I work hard I earn enough income not to be eligible for Medicaid, nevertheless the cost of keeping my wife and I covered is outrageous.

My kids are 22 and 19 years old now. I've discouraged them from family farming, and urged them to instead work in town. They found jobs that offer them health insurance, but they don't use it because it would cost at least one-third of their paychecks. My kids are going without health care because it's just too expensive, and they do not qualify for Medicaid.

There are many other families in Iowa who are even worse off.

A good friend of mine has struggled with health problems, including rheumatoid arthritis and lupus, since 1994. When his lupus becomes active in his system, the rheumatologist tries to find other medications to bring it back under control and into a dormant state again, which is extremely expensive. This friend of mine has raised hogs for his entire life, but can no longer do so because of his medical condition. He is currently applying for disability benefits, but even if he qualifies, he won't receive any health care assistance for another two years.

Although my friend and his family currently have health insurance through the Farm Bureau, they pay \$1,111.30 every month for their medical premium coverage. But if they tried to change to another group plan with a lower premium cost, he would be required to have a separate medical plan—and it is highly likely that this insurance company would deny coverage for his current or future health problems, because it is a preexisting condition. With their deductibles and all the co-pays from medical expenses, the out of pocket cost is starting to really take a toll on their family monthly budget.

I have another close friend, who has had Psoratic Arthritis for 15 years. Her fingers are turning sideways. Her toes are so swollen sometimes it's a struggle to put shoes on. To make matters worse, as a hairdresser she has to use her fingers constantly and stand on her feet all day.

Four years ago, my friend's husband was run over on the job site of a county job. In addition to losing her husband and best friend, she also lost her family's main source for income, and her only source for medical insurance. She was able to get care through Cobra for three years, but every month, the payments have gone up. The first month it was \$585.00, then two months later it was \$600.00, then it was going to \$700.00 at the beginning of the New Year. Now she has a private insurer,

and pays \$5,600.00 a year. To save money, she quit taking her medicines and stopped having blood work taken. She sends her son to Canada for her medications, although they are not the right strengths and do not help much.

We're in a vicious cycle. Without being able to have access to affordable preventative care, family farmers like me and my friends wind up being forced to the emergency room to obtain care, which is far more expensive.

That's why farm families, like my own, send their spouses and kids to get town jobs, so they can get health insurance or access to health care. But in Iowa, and many other places, there are less of those jobs available, especially in rural America.

We need to do something now to make health care more affordable. If we don't do something soon to fix this problem, it is only going to get worse for my family, and families like mine all over America.

Thank you for inviting me to share our stories with you.

Senator HARKIN. Well, Chris, thank you very much. I asked you to come because you had been at one of the health care forums we had in Iowa and I was very touched by your story and the fact that you had so many friends and people you had worked with who had similar kinds of situations, because, again, I think it is always important as both you and Ms. Kane—well, as all of you have—to put a human face on this. I mean, we are talking—this is not an abstract theory we are talking about. These are real people that are suffering out there.

So, again, I thank you all for your testimony, for your testimony and for your involvement in our effort to try to seek some way out of this.

I want to commend The Robert Wood Johnson foundation for Covering the Uninsured Week. We—if other States had the same kind of rollout that we did in Iowa, then it must have been—I am sure it had an impact across the country, because it was quite a rollout in the State of Iowa for that entire week, because what it really did is it—there are so many people out there that think that, well, this is sort of their fault, that they are sort of, well, it is they have a special case.

Cover the Uninsured Week got a lot of information out that “I am not alone. It is not just me. Every—there is a lot of people like me out there.” And perhaps this now can give us the kind of spark to move ahead to try to do something on it.

I would be the first to say that I do not have the answer. I cannot sit here and write an answer out as to what it is. But I keep coming back to this: You know, we started the human genome project with this subcommittee 12, 13 years ago, if I am not mistaken, 14 years ago, mapped and sequenced the entire human gene, phenomenal.

Senator Specter and I worked together on that for 13 years. We are doing great breakthrough research on all kinds of medical conditions in this country. We have got the best scientists. We have the best researchers. We have got the National Institute of Health with all that it does. We have got great hospitals.

I mean, I have been all over the world. You cannot find better hospitals than what we have in this country, health care professionals. And yet we cannot figure out how to cover the uninsured. I mean, do not tell me that this is some unsolvable problem and we have to go on year after year like this. And so I hope that somehow we can, through these stories, through your involvement, all of your involvement, we can begin to map some way out of this.

Since I mentioned The Robert Wood Johnson Foundation, I will start again with Dr. Lavizzo-Mourey: That was quite a week. A lot of information got out, a lot in the papers, a lot on television. As I said we had a lot of activities in my State of Iowa.

So what is next? I mean, what do we do now? I mean, what is The Robert Wood Johnson Foundation looking at as a follow up on this? Do you know? Can you inform us of that?

Dr. LAVIZZO-MOUREY. Well, Senator, first of all, I think that the efforts of people like you, and more particularly the people at the community level who got a chance to, as you say, talk to one another and hear that they are not only not alone, but that they may be able to develop relationships that can help solve this problem, was a benefit of that week's activities across the country that I just want to underscore.

Having individuals and groups at the local level continue those efforts is something that we certainly support and encourage going forward. I think that for us, we need to be a resource to people like you who are looking for solutions, so we emphasize that there is research that we want to fund to answer the questions that policy-makers have.

Moreover, we are looking at whether or not having subsequent events like Cover the Uninsured Week next year and beyond are ways to continue to bring people together around this important issue, so that we raise the awareness and make sure that that 56 percent who say that is a priority gets to an even higher number as they really understand the consequences of being uninsured.

Senator HARKIN. Ms. Scanlan, you said that you do not have any public hospitals in Pennsylvania, and I was sort of wincing at that, but I guess that is not really unusual. I think there are a lot of places without public hospitals.

Ms. SCANLAN. I think Pennsylvania is a little unique. Most States do have at some level—

Senator HARKIN. At least one—

Ms. SCANLAN [continuing]. At least one public hospital—

Senator HARKIN [continuing]. Or something.

Ms. SCANLAN [continuing]. In the major city or cities—

Senator HARKIN. Yes, that is true.

Ms. SCANLAN [continuing]. And some State involvement. In Pennsylvania, all of that was divested about 15 years ago. Pennsylvania is an old mining State, as you probably know, and there were a lot of small hospitals that the State ran in those mining towns. And those were all converted into non-public hospitals.

The two major cities, in particular Philadelphia, had public hospitals—a public hospital in Philadelphia, which was converted and enclosed.

Senator HARKIN. You must have a lot of—well, I know Pennsylvania has an active community health center organization as we do in Iowa. And I know both Senator Specter and I have been strong advocates of the community health center system, which has been around a long time. And it has been building, but a lot of people are not aware of it, and the good they can do.

I do not have at my fingertips how many community health centers are in Pennsylvania, but are you aware of them, and are you—do you work with them, and how are they serving this population

of underserved people? Now, because where Ms. Kane works—you work at a community health center.

Ms. KANE. Yes, I do.

Senator HARKIN. That is right. And so she gave a breakdown on sort of the percentages of, well, people that were uninsured and stuff I cannot remember off the top of my head. But, yes, the People's Community Health Clinic in Waterloo—that is a community health center, 39 percent were Medicaid, 6 percent Medicare, 24 percent third-party payer, and 31 percent no coverage. Do you—do you have any idea what—do you work at some of these in Pennsylvania? And can you tell me some about that?

Ms. SCANLAN. We do. The hospital association actually funds an organization called the Institute for Healthy Communities. It works with 95 health care partnerships around the State, which are comprised of community health centers, hospitals, and other community leaders, both religious, lay, in order to reach out to the communities to deal with the issues around health care status.

One of the issues that is important to hospitals is to be part of those partnerships, and so a great many of our hospitals support those partnerships financially. They have created free clinics to work along with community health centers, which while they bear a burden for the uninsured, cannot bear the entire burden, or else they would not be able to operate and continue into the future.

So collectively, I think we have tried to put our arms around this. But it is at best a safety net. People generally do not seek care until they need it, and if you are uninsured, you wait until you drastically need it as Ms. Kane indicated. And we want to be able to have all individuals feel that they should be getting preventive care and to be seeking it when they need it.

Senator HARKIN. That has been my observation of community health centers is that they do provide that preventive health care of immunization and checkups and physicals, things like that. The other thing that occurred to me—and I have been to People's Community Health Center there in Waterloo several times—is that a lot of people do not know that it is available. They just do not know that it is there, and you—I just saw a report that claimed we could cover one-third of the uninsured if they enroll in the public programs they are eligible for.

Ms. SCANLAN. We know in Pennsylvania that we are—that there are individuals who would be eligible for Medicaid or the Children's Health Insurance program that do not enroll for a series of reasons. One they are uninformed, and so when those people present themselves in the hospital either through the emergency room or through another outpatient clinic, we work with them to get them enrolled in the program.

However, with both of those programs, there is a viewed stigma of being on a public program and some individuals are not comfortable with that. And so then we work with them to get them to free clinics or the community health center or any other opportunity where they can get care. Our goal is to make sure that every child has a doctor and every family has a support system where they can go for health care.

Senator HARKIN. We have got to get more—that is why this whole Cover the Uninsured—we have got to get information out to

people as to the accessibility of some of these places where they can go. I have talked to so many people who felt that, well, they could not go to a community health center because they were not "poor." Well, there is no income guideline. Anybody can go to a community health center.

Ms. SCANLAN. We were part of the Cover the Uninsured and had major events in Philadelphia, Pittsburgh and in our capital of Harrisburg. We got great press coverage. I think we were able to draw people in who had not been part of groups together before. And so we really thank The Robert Wood Johnson Foundation for that, as well as our colleagues at the national level.

But I, like Dr. Lavizzo-Mourey, think we need to do a lot more and we do need State and Federal help in this partnership as well as funding.

Dr. LAVIZZO-MOUREY. Senator, I would just comment that one of the things that we tried to do at the beginning of every school year is have a back-to-school campaign to highlight for parents that going back to school is a good time to think about their children's health care and getting them enrolled in some of the programs that many of them just do not know they are eligible for. And, as you know, if kids are not covered and do not get those immunizations and so on, they have adverse outcomes. So you are so right that getting the word out is a critical part of the solution.

Senator HARKIN. Dr. Kellermann, the IOM, Institute of Medicine, issued four reports, did you say, on—

Dr. KELLERMANN. Yes, sir. We have issued four. We have a fifth report that looks at the economic impact of this problem on the American people that will be coming out in the next several weeks. And we have a final report in October. So there will be six total reports.

Senator HARKIN. The economic one will be out, did you say, by June or something like that?

Dr. KELLERMANN. June 17 is the planned release date for that report.

Senator HARKIN. Okay.

Dr. KELLERMANN. I would like to—you mentioned, sir, the human genome project, and I think it is important for American citizens to remember that that was a magnificent scientific achievement, and it has great potential for health in this country.

But the reality for most Americans today is that your chances of living a long, healthy and productive life depend a lot more on your zip code than on your genetic code. And it is the community level impact of this problem that goes beyond the 41 million Americans today who lack health insurance and affect over 200 million Americans with health insurance.

You and I both know that the States have a tremendous fiscal crisis right now. And in contrast to the Federal Government, they cannot deficit spend. Many of those States are looking at enormous cuts in their Medicaid programs and their SCHIP programs.

If that happens, two immediate consequences will occur. One, we will have potentially another 1.5 million Americans pushed from Medicaid roles to the uninsured. But, two, and very, very importantly, many of the health care providers today that care for the

uninsured are highly dependent upon Medicaid revenues to meet their mission.

If those health care providers, the doctors, the primary care nurse practitioners, the hospitals lose those revenues, not only will those providers of care to the uninsured and Medicaid beneficiaries be severely impaired, but those providers are also providing mission critical services to the entire community.

Grady Hospital in Atlanta is a case in point. It is not only the only public hospital for Metro Atlanta, it is the only level one trauma center for North Georgia. It is one of the only two burn units for the entire State. It is one of the State's only neo-natal intensive care units. It is the key training hospital for two medical schools. It is the only poison control center for the entire State. When providers like that get slammed, everybody will suffer. This is an extremely dangerous situation.

Senator HARKIN. We are joined by our distinguished chairman. And as I said earlier, the chairman, Senator Specter, has called these three series of hearings to look at the impacts of underinsured and uninsured. This subcommittee has a lot of responsibility in this area. Great testimony here from Dr. Kellermann, who is on the board with the Institute of Medicine, and the reports we were just talking about, they are coming out.

We have Dr. Lavizzo-Mourey who is with The Robert Wood Johnson Foundation; Ms. Scanlan, who is from your home State of Pennsylvania and talking about the situation. And we had Ms. Kane and Mr. Petersen. So they have all had their—have given their testimony.

We have had questions and some dialogue here on the Institute of Medicine's coming out with—well, they have had four reports. They are coming out with another one in June on the economic impact and—

Dr. KELLERMANN. The final report is going to look at promising strategies for addressing the problem and some of the parameters that policymakers may want to consider in looking at potential solutions to covering the uninsured.

Senator HARKIN. I know Senator Specter was involved also with The Robert Wood Johnson Foundation and Cover the Uninsured Week. I know you were unavoidably detained this morning, Senator Specter. I do not know if you wanted to come in now, or do you want me to finish my questioning or—

Senator SPECTER. Well, if I might make a statement or two.

Senator HARKIN. Sure.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER [presiding]. I thank you for beginning the hearing. There are so many conflicting hearings that it is not possible to attend them all. I have just come from a hearing with Secretary Ridge on Homeland Security, and we have a hearing on the judiciary nominations.

I discussed this hearing yesterday with Ms. Scanlan when I talked to the hospital administrators of Pennsylvania, and I thank you, Senator Harkin, for suggesting these series of hearings. Senator Harkin, I think, had planned these hearings when he was

chairman, and it is a precarious position being chairman of this subcommittee because it changes from time to time.

Senator HARKIN. Go back and forth over—

Senator SPECTER. Yes. But when it changes, as both Senator Harkin and I have said, it is a seamless exchange of the gavel. We do not have any partisanship here at all, and I think this subcommittee for the past decade-plus has been a model of bipartisan cooperation as we have increased funding in NIH, and tackled the really tough problems at CDC, et cetera. And we intend to keep it that way.

Senator Harkin, why don't you finish your round of questioning? And then I will have some questions of my own.

Senator HARKIN. I appreciate that. Again, I thank you very much, Mr. Chairman, for having these hearings, for your great leadership of this subcommittee. And you are right; we have been back and forth as chairman and ranking member, going back over almost a dozen years, and it has been seamless. And I just want you to know that I appreciate all that you do in leader-ing or leading this subcommittee, making sure that we continue to address the health needs of our country. And I—it has just been a real privilege and a joy to work with you, Senator Specter, over all these years.

I just—I was sort of just kind of getting to Mr. Petersen. Mr. Petersen is a family farmer in Iowa. Ms. Kane is a nurse at a community health center in Waterloo that I visited before. But Chris was talking about his own situation and his own family, and so many people around him.

Is there—do you think or can you talk about whether there is any kind of a difference between those who live in rural areas, small towns, small communities, what kind of differences that are there, farmers, farm families, small farmers, people who live in small communities? What is that situation like in terms of insurance coverage? How do you—what is your sensibilities on that, Chris? Any differences between that and, say, living in Des Moines or Chicago or Omaha, or some place like that?

Mr. PETERSEN. Yes, economic impact, that is a big thought. I agree with the comment down the table here a couple of minutes ago that it depends on your zip code what kind of health care you get.

The rural areas, as you know, there is a lot of budget cuts going on. The small rural hospitals, not only in Iowa, but throughout the Midwest, are taking the hits. They are not getting the money. Iowa has got a severe problem with Medicare reimbursement, so that really hurts Iowa.

So we are denied health care access, period. You know, whether we can afford it or not, we are not getting the care that we need in the rural areas.

You know, the economic impact of this stuff, a lot of us we go get health care because we will figure out how to pay for it later because the object is to have a quality of life and live a long life. And what happens when this is going on, it not only hurts the hospitals and the doctors and the—and everybody else, but there is a lot of bankruptcies going on, being filed over health care costs. And,

you know, I would be very interested in knowing the percentage of bankruptcies filed in this country because of health care costs.

Senator HARKIN. I have heard from several sources in Iowa that that is a high percentage of the bankruptcies, at least in Iowa. I cannot speak about any other States, but—

Mr. PETERSEN. Yes. I would feel that that is another very critical reason to address this issue, because it is affecting everybody.

Senator HARKIN. I have to leave. I am going now down to—Mr. Ridge is there, and I am on that subcommittee also, and I have to engage him on a couple of things dealing with homeland security. Senator Specter just came from there. So I am going to have to leave.

But, Dr. Kellermann, before I leave, can you hold up the copy of that—I did not get to that in my questions, and I spoke to you about it before the hearing started.

Dr. KELLERMANN. I am happy to loan it to you, if you want to share it with Mr. Ridge.

Senator HARKIN. Thank you.

Dr. KELLERMANN. But, Senator Specter, this was a cover story in U.S. News World Report that came out a couple of years ago almost. And the cover story says, “Crisis in the ER: Turn away and huge delays are a surefire recipe for disaster. What you can do.”

Sir, the date of this issue was September 10, 2001. Nothing has been done on this issue or this problem since that time. You have mentioned homeland security. This is emphatically a homeland security issue. And the challenges of uninsurance and the financial strain, particularly on our trauma care system, is an enormous homeland security issue and one that so far has not hit the radar screen as squarely as some of the other homeland security issues have.

Senator HARKIN. Thank you. Thank you all for coming great distances to be here. Thank you for your testimony. And especially to my two friends from Iowa, thank you for—and you, Ms. Scanlan, thanks for coming from Pennsylvania. I thank all of you for what you are doing.

I do have to leave, and I thank you, again, Mr. Chairman.

Senator SPECTER. Thank you, Senator Harkin.

You might be interested to know as Senator Harkin departs that he serves on six subcommittees of Appropriations, as do I.

Senator HARKIN. Yes.

Senator SPECTER. And in two other rooms, there are other subcommittee hearings. There is a subcommittee hearing on Defense Appropriation where Senator Harkin sits, as do I.

Senator HARKIN. Yes.

Senator SPECTER. And then he has other committees. He has the Agriculture Subcommittee, and it is an impossible job. And the chairs which are vacant here would be filled by Senators who are at other hearings too. And it is a sort of testament to how many complex problems we have to deal with.

Senator HARKIN. Yes.

Senator SPECTER. I have only a few questions to add. I am due at another hearing, as I said, with the Judiciary Committee.

But I have discussed, as I commented earlier, with Ms. Scanlan—at a meeting yesterday with hospital administrators, I

noted the presence of Scott Malan, who is the vice president of the Pennsylvania hospitals group.

This is a problem and one of the questions which came up yesterday, which is a continuing issue is: How do we cover the 41 million Americans who are now not covered? What can we do to extend coverage short of a single payer system where there seems to be a lot of concern that that would involve a bureaucracy, which we do not want to undertake?

Ms. Scanlan, let me begin with you, as a fellow Pennsylvanian.

Ms. SCANLAN. We suggest in our testimony, Senator—and thank you for holding these hearings, by the way. We all acknowledged you before your presence, and so wanted to do it in your presence also.

We suggest in our testimony, Senator, that there are in the current manner of programs ways to expand most programs, both Medicaid, children's health insurance program, and others, both at the Federal and State level, and perhaps on a short-term basis dealing with some of the tax issues.

Unfortunately, those have been tried, and we continue to tinker with those. I think they help some, but not all of the population, evidenced by the 41 million or 42 million, whatever the number has grown to now, of the uninsured.

It is a difficult problem. I know that we, at the national level, have tried to fix it several times, because it is so complicated. It is a complicated program to try to create, but I would suggest that there are a series of ways including looking at the current infrastructure of providers, health care plans, community health centers, individual practitioners or clinicians that, with appropriate funding, could begin to reach out and offer the kind of care to all of those 41 million.

Senator SPECTER. When you talk about appropriate funding, one of the issues which has concerned me for many years and I have introduced legislation on, is the very high cost in the last few days, few weeks before death and the really inadequate information being distributed to people about living wills and about making a decision.

Nobody should decide for anybody else when the life support systems will be turned off. But people can make their own judgments on that, and can make a determination. It is a very difficult situation for a family to have to decide when to, so called, "pull the plug." And there have been suggestions of enormous savings there.

Dr. Kellermann, do you have any idea about the extent of the savings that could be obtained if families were to have a more informed decision for determining when life supports end?

Dr. KELLERMANN. Since I am here today on behalf of the Committee on the Consequences of Uninsurance, we are looking at economic impacts of the general issue of uninsurance in our next report, but I—we have not as a committee specifically addressed end-of-life issues, although other reports by the Institute of Medicine have. There are substantial costs.

Senator SPECTER. Dr. Lavizzo-Mourey, do you have any thoughts on that subject?

Dr. LAVIZZO-MOUREY. The foundation, as you may know—and by the way, let me just say thank you for having these hearings, Sen-

ator. As a fellow Philadelphian, I do appreciate your leadership on this matter.

The foundation has invested for a long time in trying to, not only understand the costs associated with end-of-life care but to also address the issues of quality of care and the quality of life that the family and the patient experience. We know that it is cheaper to provide palliative care than it is to provide high tech unnecessary and oftentimes unwanted end-of-life support. But I do not have at the tip of my fingers a dollar amount. We can certainly look at that and get back to you and your staff, Senator.

Senator SPECTER. That would be helpful. Ms. Kane, do you have any thoughts as to how we can cover the 41 million Americans who are now not covered?

Ms. KANE. I think, working in the community health centers, I think they are a great place, because we do base it on a sliding fee scale according to their income with a set, you know, \$10, if—for service. I think number one is: We do have to get the word out. A lot of people are not aware of community health centers.

I think the—my thought just left my head. Just getting, I suppose, getting past that, knowing that people, number one, were out there to give them health care, that you do not have to have money up front. We are not going to hound you with guns at your door, send you letters. We would rather, you know, I suppose lose that \$65 than have the person lose their leg.

Senator SPECTER. Mr. Petersen, you are a family farmer in rural Iowa. I heard the reference made to Waterloo, is that true?

Mr. PETERSEN. Clear Lake.

Senator SPECTER. Clearly.

Mr. PETERSEN. Yes.

Senator SPECTER. Clearly, is that—when you say “Clearly,” is that the name of a town?

Mr. PETERSEN. Clear Lake. Pardon me.

Senator SPECTER. Oh, is that close to Waterloo?

Mr. PETERSEN. No. I am located in North Central Iowa, right close to Minnesota.

Senator SPECTER. Well, what was the reference to Waterloo?

Ms. KANE. I am Waterloo.

Senator SPECTER. You are from Waterloo?

Ms. KANE. Yes.

Senator SPECTER. Okay. Well, even though you are not from Waterloo, Mr. Petersen, I know of another farmer who lived in Waterloo who pursued a political career, ran for the House of Representatives in the State of Iowa. He told me that when he was elected to the House of Representatives, he made more money than he did when he was farming. And then he later ran for the U.S. House of Representatives and was elected. And then he ran for the U.S. Senate and was elected. And now he is chairman of the Finance Committee. And that man is?

Mr. PETERSEN. I am very good friends with Senator Grassley.

Senator SPECTER. You have got it. So in conclusion, Mr. Petersen, you ought to consider a political career.

CONCLUSION OF HEARING

Thank you all very much for being here. That concludes our hearing.

[Whereupon, at 10:45 a.m., Wednesday, April 30, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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